USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM - *Mahefa Miaraka*

Cooperative Agreement No. AID-687-A-16-00001

FY2017 Annual Report
October 1, 2016 to September 30, 2017

USAID FROM THE AMERICAN PEOPLE

Mahefa Miaraka

JSI RESEARCH & TRAINING INSTITUTE, INC.

USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM - *Mahefa Miaraka*

FY2017 Annual Report
October 1, 2016 to September 30, 2017

Cooperative Agreement No. AID-687-A-16-00001

Submitted to:
Dr. Jocelyne ANDRIAMIADANA, AOR
USAID/Madagascar in Antananarivo, Madagascar

Prepared by:
JSI Research & Training Institute, Inc.
USAID Community Capacity for Health Program – *Mahefa Miaraka*
JSI Research & Training Institute, Inc.
Résidence Lavalley
Près Lot IIK 50H Mahatony
Alarobia, Antananarivo (101)

Tel: 20.22.425.78/ 79

Cover photo:
Photo: A member of the Andranofotsy women's group, dances during a ceremony welcoming USAID and Ministry of Health officials to the Chez Moi filming, JSI Research & Training Institute, Inc. Photo Credit: Melanie Borcover

DISCLAIMER:
This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this document are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.

Table of Contents

Executive Summary **1**

Introduction **3**

Intervention Area 1 (IA 1): Community Engagement and Ownership of Health Services 4

Sub IA 1.1 Increasing Skills and Competencies of CHV 4

Sub IA 1.2 Sustainability of the CHV Model 18

Sub IA 1.3 Strengthening of Community Structure to Improve Health and Sanitation Planning 18

Sub IA 1.4 Promoting Universal Health Care Access and Coverage 19

Intervention Area 2 (IA2): Behavior Change and Health Promotion **20**

Sub IA 2.1. Community-Level Health Promotion and Sensitization 20

Sub IA 2.2 SBCC Capacity of Community Stakeholders 24

Sub IA 2.3 Innovations to Promote Adolescent and Youth Health 26

Intervention Area 3: Health Service Planning, Management, and Governance **28**

Sub IA 3.0 Reinforcement of GOM Capacity 28

Sub IA 3.2. Pharmaceutical and Commodity Forecasting 30

Sub IA 3.3. Health Data Quality, Management, and Use 30

Sub IA 3.4. Referral System Strengthening between CHVs and CSBs 32

Monitoring and Evaluation, Learning Management, and Cross-Cutting Issues **33**

Sub IA 4.1 Program Monitoring, Evaluation, and Performance System 33

Sub IA 4.2 Learning Management 34

Challenges and Proposed Solutions for FY2017 ..... **36**

Administrative and Financial Management **38**

Sub IA 0. 1 Operation (Administration, Finance, and Partnership) 38

Sub IA 0. 2 Administration 38

Sub IA 0.3 Financial Management 39

Annexes

Annex 1. Dashboards of Key Health Indicators
Annex 2. Activity Table FY2017
Annex 3. Project Performance Review, PPR
Annex 4. Program Monitoring and Evaluation Plan (PMEP)
Annex 5. Environment Monitoring and Mitigation Report (EMMR)
Annex 6. List of Communes in *Mahefa Miaraka* Program in FY2017
Annex 7. Success Stories
Annex 8. International Trips at the End of Q3 FY2017

List of Tables

Table 1 – PNSC Coordination Structures Created in the Program Region in FY2017 4
Table 2 – Percentage of CHV Reporting Rate (Report Received) by Region 6
Table 3 – Referral of WRA and CU5 Cases from CHVs to CSBs or Mobile Clinics in FY2017 9
Table 4 – Sayana Press Use by Regions, Comparison of Q2 and Q4 FY2017 11
Table 5 – Materials and Tools Distributed to CHVs in FY2017 15
Table 6 – CHV Malaria Services by Regions in FY2017 17
Table 7 – Number of People Reached by Key Health Messages in FY2017 21
Table 8 – IEC Materials Developed and Disseminated in the Program, FY2017 23
Table 9 – Program's Participation in the Health and WASH Days Celebration in FY2017 25
Table 10 – GOM Officials Participating in Training of Trainers in FY2017 28
Table 11 – Program Cost Share as of September 30, 2017 40
Table 12 – Program's Cumulative Expenses as of September 30, 2017 41

List of Figures

Figure 1- Mahefa Miaraka's Regions and Districts 3
Figure 2- CHV Technical Training in FY2017 5
Figure 3- Growth Monitoring for CU5 in FY2017, by Quarter 7
Figure 4- Number of Cases Received and Cases Treated by CHVs for c-IMCI in FY2017 8
Figure 5- Family Planning Users in the Program, by Quarter in FY2017 10
Figure 6- Regular Family Planning Users in the Program by Age Group, FY2017 10
Figure 7- New Family Planning Users in the Program by Age Group, FY2017 11
Figure 8- Couple Years of Protection in FY2017 12
Figure 9- Children Referred and Vaccinated for DTCHepHib3 in FY2017 13
Figure 10- Stock-out of Child Health Tracer Products, by Quarters FY2017 14
Figure 11- Stock-out of Family Planning Health Tracer Products, by Quarters in FY2017 15
Figure 12- CHV Malaria Services by Quarters in FY2017 18
Figure 13- Number of People Reached in FY2017 20
Figure 14- Household Cards on Essential Family Practices 22
Figure 15- Sanitation and Hygiene at CHVs' Health Hut as of September 30, 2017 26
Figure 16- Photo Collage from the High-Visibility Events in FY2017 27
Figure 17- CHV Attendance at the Monthly Meetings at CSBs by Quarters in FY2017 29
Figure 18- Onsite Supportive Supervision Received by CHVs in FY2017, by Region (n=7,085) 29
Figure 19- Progress in Quality of the CHV Monthly Reports in FY2017* 30
Figure 20- Percentage of CHV Reports Submitted On Time by Quarter in FY2017 33

Acronyms and Abbreviations

ACT	Artemisinin-based combination therapy
ANC	Antenatal care
CHV	Community health volunteer
CHX	Chlorhexidine
c-IMCI	Community-based integrated management of childhood illnesses
CoSan	*Comité de Santé* (health committee)
CSB	*Centre de Santé de Base* (basic health center)
CU5	Children under 5
DDS	*Direction des Districts Sanitaires* (Directorate of the District Health Development)
DLP	National Malaria Control Program
DPLMT	Directorate of Pharmacies, Laboratories and Traditional Medicine
DPS	*Division de la Promotion de la Santé* (Division of Health Promotion)
DSFa	*Direction de la Santé Familiale* (Division of Family Health)
DRSP	*Direction Régionale de la Sante Publique (*Regional Health Office*)*
EFP	Essential family practice
EMAR	*Equipe de Management Régionale* (Regional Health Management Team)
EMAD	*Equipe de Management de District* (District Health Management Team)
EMMR	Environmental Mitigation & Monitoring Report
FP	Family planning
FY	Fiscal Year
GBV	Gender-based violence
GOM	Government of Madagascar
HMIS	Health management information system
IA	Intervention area
IFA	Iron folic acid
IR	Intermediate result
IPTp-SP	Intermittent preventive treatment during pregnancy with sulfadoxine-pyrimethamine
JSI	JSI Research & Training Institute, Inc.
LLITN	Long-lasting insecticide-treated bed net
MAHEFA	*Malagasy Heniky ny Fahasalamana* (Community-Based Integrated Health Program)
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
MOU	Memorandum of Understanding
MUAC	Mid-upper arm circumference
PLGHA	Protecting Life in Global Health Assistance
PNSC	*Politique Nationale de Santé Communautaire* (National Policy for Community Health)
PSI/ISM	Population Services International /Integrated Social Marketing Project
PSM	Procurement and Supply Management
RLG	Radio listening group
RDT	Rapid diagnostic test
SBCC	Social behavior change communication
SDSP	*Service de District de la Santé Publique* (District Health Office)
USAID	United States Agency for International Development
USG	United States Government
VAT	Value Added Tax
WASH	Water, sanitation, and hygiene

Executive Summary

During its first implementation year, (October 1, 2016-September 30, 2017), the USAID Community Capacity for Health Program, locally known as Mahefa Miaraka, made significant progress assisting community health volunteers (CHVs) to provide quality health services to remote communities. By the end of the reporting year, the Program has implemented its activities in all of the 4,887 fokontany in the seven Program regions. Despite the reduced obligation, which resulted in decreased programmatic activities in Q3 and Q4 compared with the plan stated in the Cooperative Agreement, the Program produced strong results and achieved the majority of its revised annual targets.

As part of its end of the fiscal year exercise, the Program team made sure that all CHVs' monthly reports were processed. Due to inaccessibility of some sites, at the end of each quarter some CHVs' reports were not processed on time for the quarterly progress report submission. As a result, data from some monthly reports were not presented in the quarterly progress reports submitted in FY2017. The newly added processed CHV data caused changes in some data already reported in Q2 and Q3 progress reports.

The following highlights summarize the Program innovations and main achievements in FY2017.

Advanced Implementation of the National Policy on Community Health

In FY2017, the Program team at the central level was part of the committee to revise the new National Policy on Community Health or *Politique Nationale de la Santé Communautaire* (PNSC). As part of the committee, the Program team shared lessons learned and good practices from field implementation with the Ministry of Health (MOH) to help integrate them into the revised PNSC. At the regional, district, commune, and *fokontany* levels, the Program provided an orientation workshop on the PNSC and monitored the creation of the PNSC coordination structures at all levels. As of September 30, 2017, all local governments in the Program area had established their PNSC structures at all levels in the Program areas in line with the recommendations from the National Policy for Community Health. Due to funding shortage in FY2017, the Program conducted an orientation workshop for 6,973 PNSC structure members, or 11 percent of the total members, to the PNSC and their roles in managing and coordinating community health activities during this fiscal year. The remaining members will receive training in FY2018.

Introduced the use of key health indicator dashboards for program review and disease outbreak prevention and/or response

Since May 2017, the Program developed and introduced dashboards with results of key health indicators to 509 CSB out of 732 (70 percent), all District Health Offices (*Service de District de la Santé Publique, SDSP*), and all Regional Health Offices (*Direction Régionale de la Santé Publique*, DRSP) in the seven Program regions. These indicators were jointly selected by the Government health staff and the Program team and are presented in Annex 1. The user-friendly dashboards helped the local health offices to monitor health progress in their respective area and, in some cases, to prevent disease outbreaks. This is the first time dashboards have been routinely used by the district and regional health offices for tracking health indicators. The MOH has discussed the possibility of sharing this innovation beyond the Program regions with the Program team.

Operationalized new MOH initiatives and assisted community health volunteers in adjusting to evolving role assigned by the Ministry of Health

In FY2017, the MOH added several approaches and activities for CSB implementation at the commune level and CHV implementation at the community level which require more effort and time. These approaches and activities are: 1) Reaching Every Child approach for immunization, 2) community surveillance and response to outbreaks such as plague, 3) verbal autopsy on maternal

deaths, 4) increased number of health campaigns, and 5) reports related to these additional CHV tasks. Following each of the MOH's new initiatives for the community level, the Program team assists in developing the training curriculum, materials, and work tools at the national level, and then helps to roll out the cascade training for the regional health officials through to the CHVs. After the CHV training, the Program team and government officials provide monitoring and supervision support to CHVs to make sure that they carry out these new tasks successfully and in a manner that is manageable within their available time. Fifty-three percent of the supervision visits were conducted by CSB heads.

Scaled up new MOH-approved health products and services for use at the community level

In order to roll out three new health products (7.1% chlorhexidine or CHX, misoprostol, and Sayana Press) in the six regions in FY2017 (Analanjirofo region did not yet roll out these new products) is not yet part of t, the Program provided refresher trainings and coordinated with the Integrated Social Marketing (ISM) Project to ensure the products are available for CHVs. A total of 5,682 CHVs participated in the refresher training. Out of this number, 2,648 CHVs reported distributing the three health products to newborns and women of reproductive age (WRA). As a result, 4,405 newborns (81 percent of total births visited by CHVs) were treated with CHX upon their birth, 1,798 women reported using misoprostol after birth (33 percent of total women giving birth visited by the CHVs in the six Program regions) provided by either the health center (*Centre de Santé de Base*, CSB) or a CHV. A total of 20,870 women (17 percent of those using injectables) used Sayana Press provided by CHVs as a family planning method. As these three health products become more consistently available, it is expected that more people will use them.

Ensured the continuum of care from CHVs to government basic health centers *(Centre de Santé de Base*, CSB)

The USAID Community Capacity for Health Program's main mandate is to ensure continuum of care in specific services for children under 5 (CU5) and WRA from the community level (CHVs) to the commune level (CSBs). During the reporting year, a total of 672,291 CU5 received services in community-based integrated management of childhood illnesses (109,018), nutrition (263,048), and vaccination (66,215). Out of this total, 300,225 or 45 percent received services from the CSB, and 372,066 or 55 percent received care from the CHVs. Similarly, among a total of 196,484 WRA who received antenatal care (105,898 for ANC1 and 4), including vaccination (61,920 for TT2) and assisted delivery (28,666) at the CSB, 62,826 or 32 percent were referred by CHVs. In the area of family planning (FP) services, 150,407 WRA or family planning regular users received FP services from CHVs and 251,761 from CSB (48,061 are for Long Term Methods).

During FY2017, management and compliance systems continued to support program work. The main achievements of the USAID Community Capacity for Health Program during the reporting period are presented in more detail according to the Intervention Area (IA). Tables detailing the activities conducted, the Project Performance Review (PPR), and the Program Monitoring and Evaluation Plan (PMEP) are included in Annexes 2, 3, and 4 respectively. In addition, the environmental compliance actions during FY2017 are presented in Annex 5.

Introduction

USAID awarded the five-year Cooperative Agreement (No. AID-687-A-16-00001) for the USAID Community Capacity for Health Program to JSI Research & Training Institute, Inc. (JSI) on June 6, 2016. JSI collaborates with three partners for Program implementation: *Action Socio-sanitaire Organisation Secours*, Family Health International 360, and Transaid. The Program has two objectives and three intervention areas (IAs):

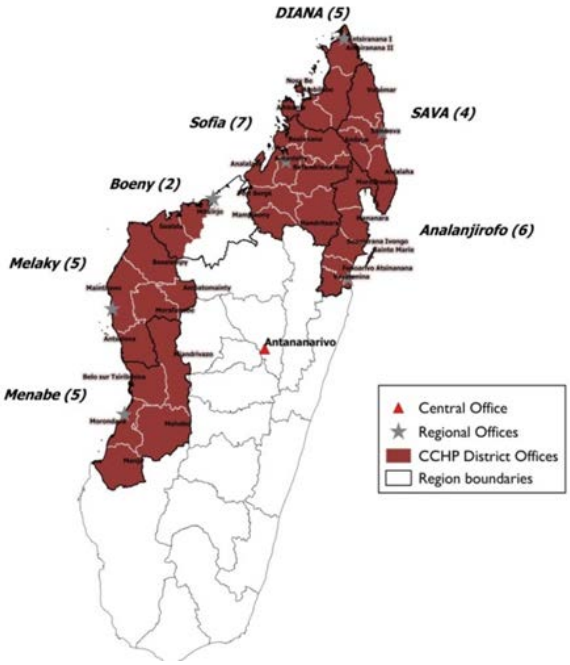
Objective 1. Strengthen public sector capacity to plan, deliver, and manage community health services
Objective 2. Strengthen community engagement in health

IA 1. Community engagement and ownership of health services
IA 2. Behavior change and health promotion
IA 3. Health service planning, management, and governance.

The Program reflects USAID's commitment to providing high-quality community health services that integrate with the formal health system; addressing key drivers of maternal, newborn, and child mortality; and responding to client needs while promoting visibility of community health in Government of Madagascar (GOM) efforts to reduce maternal, newborn, and child mortality. The Program contributes directly to the USAID/Madagascar Health Population and Nutrition's Intermediate Results (IRs) 1 and 2 health sector strategy, for which the development objective is "Sustainable Health Impacts Accelerated for the Malagasy People."

The USAID Community Capacity for Health Program, locally known as *Mahefa Miaraka,* operates in a total of 4,887 fokontany, 456 communes, and 34 districts in the Analanjirofo, Boeny, DIANA, Melaky, Menabe, SAVA, and Sofia regions. A full list of the communes in the Program regions is presented in Annex 6. The Program will provide services to approximately 6.1 million people, or 23.3 percent of the country's total population.

Figure 1- Mahefa Miaraka's Regions and Districts[1]



[1]Number of districts in each region is in parentheses.

Intervention Area 1 (IA 1): Community Engagement and Ownership of Health Services

Overall Achievements in FY2017

- All of the 5,374 PNSC coordination structures at the regional, district, commune, and fokontany levels (100% of the total) were established (compared to 3,643 at the beginning of the year)
- The Program oriented 6,973 members of the PNSC coordination structures (11 percent of the total) on the PNSC
- A total of 3,453 CHVs received training and materials in community-based integrated management of child illnesses, c-IMCI, 5,932 CHVs in community data management, 6,575 CHVs in nutrition and water, sanitation and hygiene, 7,877 CHVs in social behavior change communication, 5,682 CHVs in 7.1% Chlorhexidine (CHX) and misoprostol, 6,410 in community surveillance, and 4,284 in pharmacovigilance
- CHVs provided a total of 263,048 children under 5 (CU5) and 150,407 women of reproductive age (WRA) with integrated services
- CHVs referred a total of 212, 648 cases to CSBs, among them, 123,429 were CU5 and 89,219 were WRA

Sub IA 1.1 Increasing Skills and Competencies of CHV

1.1.1 Reinforcement of Capacity of Members of PNSC Structures

PNSC Coordination Structures. In FY2017, the local government created all coordination structures for the National Policy for Community Health (*Politique Nationale de Santé Communautaire* or PNSC) in line with the recommendations from the PNSC (Table 1). The Program team received a copy of all official records of the creation of the PNSC structure and submitted a copy to the Division of the District Health Development (*Direction des Districts Sanitaires*, DDS) for their record as well. A total of 6,973 PNSC structure members or 11 percent of the total members received an orientation workshop on the PNSC and their roles in managing and coordinating community health activities during this fiscal year from the Program.

Table 1 – PNSC Coordination Structures Created in the Program Region in FY2017

Coordination Committees for Community Health Structure	Coordination Committees	Members
Comité de Coordination pour l'Approche Communautaire – Région (Coordination Committee for Community Health at the Regional Level)	7	163
Comité de Coordination pour l'Approche Communautaire – District (Coordination Committee for Community Health at the District Level)	34	912
Commission Communale de Développement de la Santé (Commune Commission for Health Development)	456	5207
Comité de Santé Fokontany (fokontany Health Committee)	4877	9844

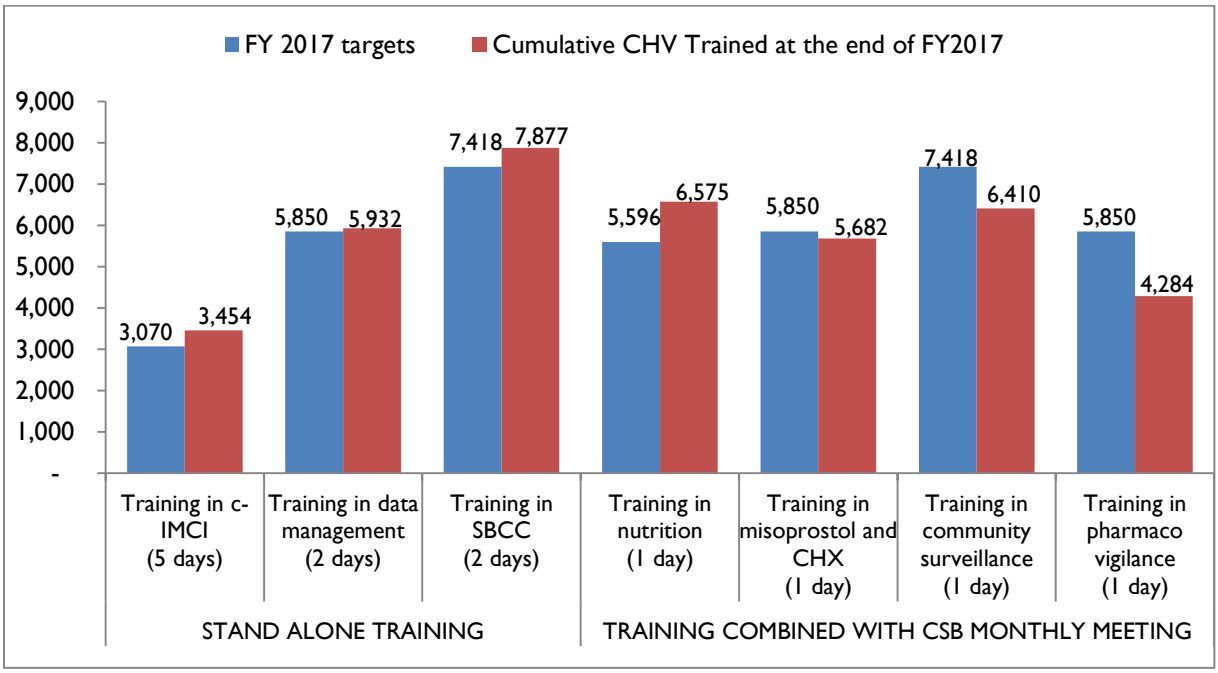
1.1.2 Pre-Service Training, Continuing Learning, and Supervision of CHVs

CHV Training. At the end of FY2017, a total of 9,844 CHVs were selected by their communities and then officially nominated by their respective commune in the seven Program regions. According to the PNSC, the community health volunteers can provide two types of services: family planning for women of reproductive age (WRA) and c-IMCI for children under age five (CU5). Before CHVs are

able to provide these services, they must complete the five-day pre-service training organized by their CSB heads, pass the practicum at their CSB, and receive a certificate from the CSB heads. In addition to these two main trainings, CHVs in the Program regions receive training on other topics, including community data management; nutrition and water, sanitation, and hygiene (WASH); social behavior change communication (SBCC); 7.1% chlorhexidine; misoprostol; Sayana Press; and community surveillance, including the Reach Every Child approach for immunization.

Among the 9,844 CHVs registered in the Program regions, 80 percent (7,877) received training in FY2017 in one or more of the following topics: in family planning, c-IMCI, community data management, nutrition and WASH, SBCC, 7.1% chlorhexidine, misoprostol, or Sayana Press from the Program. Despite a shortage of funding in FY2017, the Program exceeded targets for some training topics and came close to meeting the other revised annual targets for CHV training (Figure 2). A total of 3,454 received c-IMCI training: 5,932 in community data management, 6,575 in nutrition and WASH, 7,877 in SBCC, 5,682 in chlorhexidine and misoprostol, 6,410 in community surveillance and 4,284 in pharmacovigilance. All the CHV trainings were conducted by the CSB heads. In FY2018, the Program will train all community health volunteers in the complete set training topics so they can become functional, meaning that they will begin providing quality integrated health services.

Figure 2- CHV Technical Training in FY2017



<u>CHV Monthly Meeting at CSB</u>. In addition to the technical training conducted by CSB heads, all CHVs (per the PNSC) are required to attend a monthly meeting that is called by the CSB heads who supervise them. The Program provides both technical and financial support for the monthly meetings, at which the CSB heads provide in-service training and updated technical information to CHVs, in addition to checking and approving their monthly reports. The highest CHV attendance rate at the CSB monthly meeting in FY2017 was during Q4, with 5,680 CHVs (80 percent) participating in a meeting in one month (September 2017). The Program experienced a steady increase in meeting participation during the reporting year, from 2,582 in January to 5,680 in September 2017. The increase resulted in a positive impact on the quality of the CHVs' monthly reports, which showed a decreasing error rate, from 43 percent in January to 1 percent in September 2017 (Table 2).

Table 2 – Percentage of CHV Reporting Rate (Report Received) by Region

Regions	Reported in Q2 FY 2017	Reported in Q4
Analanjirofo	N/A*	N/A
Boeny	87%	99%
DIANA	55%	87%
Melaky	77%	84%
Menabe	66%	86%
SAVA	35%	76%
Sofia	76%	84%
Total	**69%**	**84%**

Note: The CHVs in Analanjirofo that already received c-IMCI training haven't yet completed their practicum at a CSB, therefore they haven't yet began providing services in FY2017.

Community Health Data. Another purpose of the CSB monthly meeting is for CHVs to submit monthly reports to their supervisors. CHV community reporting is detailed in IA3 (section 3.3.1 on CHV Monthly Reporting to CSB; 3.3.2 on Integration of Data from CHV Routine Reporting into MOH's HMIS), and cross-cutting section 4.1.2 on Data Reporting, Quality, and Use.

Supervision of CHVs. The Program staff and government officials continued to conduct supervision visits to make sure the CHV services met quality norms and were within national standards. During FY2017, a total of 5,134 CHVs received supportive supervision: 2,714 or 53 percent by CSB heads, 2,081 or 36 percent by Program staff and the rest by the *Equipe de Management de District* (district health management team, EMAD) and the *Equipe de Management Régionale* (regional health management team, EMAR). All supportive supervision visits were conducted based on supervision forms the Program developed jointly with the MOH. The on-site supervision sessions positively impact the CHVs' work in several ways, including motivating the CHVs, increasing use of CHV services, and reinforcing the CHV role as part of the public health system in the eyes of the community. More information on CHV supervision is presented under section Sub IA 3.0 on Reinforcement of GOM's Capacity to Provide Technical Training and Supportive Supervision to CHVs.

The supportive supervision conducted by CSBs is combined with outreach activities. During these activities, CHVs assist the CSB staff members in providing health services to community members, especially women and children. The outreach activities build CHV skills as they receive on-the-job training through working directly with CSB staff and provide additional motivation for the CHVs. In addition, the outreach activities offer the CHVs an opportunity to gain social recognition as CSB staff assistants while giving higher-level health services for community members. More information on CHV supervision by GOM officials is presented under IA3.

1.1.3 Quality of Community Health Volunteers Services

Services Provided by CHVs in FY2017

This section presents information on the integrated health services CHVs provided in the Program regions during FY2017.

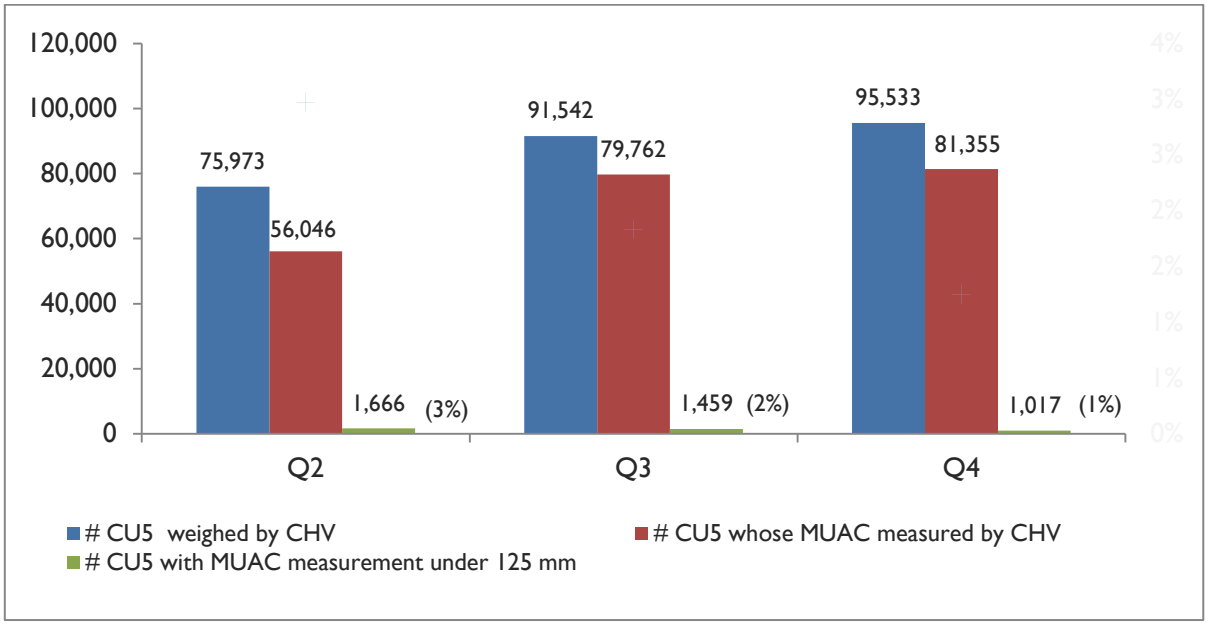
CHV Services in Maternal, Newborn, and Child Health

Prevention of postpartum hemorrhage and newborn cord infection (using misoprostol and chlorhexidine (CHX) 7.1 percent): At the very end of the MAHEFA Program, all functioning CHVs

received training on CHX and misoprostol. Therefore, the MAHEFA Program team did not have an opportunity to monitor the use of these two products before the close of the field activities in February 2016. During FY2017, a total of 5,682 CHVs received refresher trainings on misoprostol and CHX in order to revitalize the use of these two products. Afterwards, 2,648 CHVs reported distributing 6,772 doses of CHX and 2,324 doses of misoprostol to pregnant women. The majority (78%) of the distribution was reported in Q3 and Q4 (1,499 or 22 percent in Q3 and 3,764 or 56 percent in Q4 for CHX), compared with 348 or 15% misoprostol in Q3 and 1,940 or 84% in Q4. As a result, 4,405 newborns (81 percent of total births visited by CHVs in the Program) received CHX upon their birth, 1,798 women reported using misoprostol after birth (33 percent of total women giving birth visited by the CHVs in the six Program regions) provided by either the health center (*Centre de Santé de Base*, CSB) or CHV.

Nutrition: Throughout the year, CHVs continued to provide growth monitoring services via routine weighing and measurement of middle-upper arm circumference (MUAC). CHVs keep a record of all CU5 in their community. In FY2017, CHVs recorded a total of 309,219 CU5s (120,141 in Q4) in the program regions. Of the children recorded, CHVs weighed 85 percent (263,048), and measured the upper arm circumference (MUAC) of 70 percent (217,166). Over time, there has been an increase in the number of CU5 benefitting from these services (Figure 3). In Q4, one percent of CU5 had a MUAC measurement under 125 mm compared to two percent in Q3. The slight decrease in the CU5 malnutrition rate indicated by the MUAC could be a result of more regular growth monitoring service activities; nutrition messages provided by CHVs.

Figure 3- Growth Monitoring for CU5 in FY2017, by Quarter

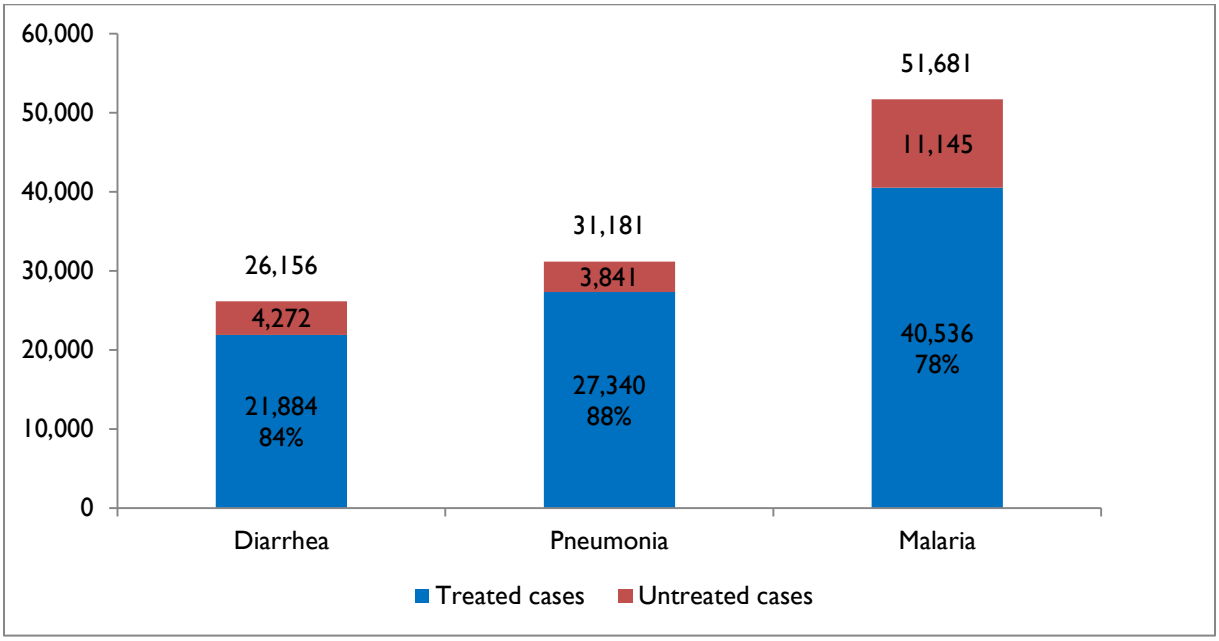


CHV uses timer to check a child with respiratory problem in Belo Sur Mer district, Menabe

c-IMCI Services for Children under 5. A significant part of a CHV's mandate is to provide CU5 services, including diagnosis, treatment, counseling, and referral to CSBs as necessary. Key results in this area are presented below. Information on the Program's malaria activities that are not part of the c-IMCI services on malaria are presented later in the report. As shown in Figure 4 below, 109,018 CU5 presented to CHVs with symptoms related to c-IMCI in FY2017, but only 89,760 cases (82 percent) received treatment. A high stock-out level (pages 14-15) during

the year could have led to non-treatment among the CHV-reported c-IMCI cases. Out of 109,018 CU5 seen by CHVs in FY2017, almost half (47 percent or 51,681) were seen for malaria. Out of this total, 78 percent (40,536 cases) tested positive for malaria and received artemisinin-based combination therapy (ACT). CHVs saw 31,181 CU5 cases with simple pneumonia in FY2017, out of which 88 percent (27,340) received CHV treatment. Similarly, out of the total 26,156 CU5 cases CHVs saw with simple diarrhea, 21,884 received treatment.

Figure 4- Number of Cases Received and Cases Treated by CHVs for c-IMCI in FY2017



Referral Services for Women and Children under 5. One of the CHVs' main services is to provide counseling and referral services for women to the CSB for ANC visits, follow-up, and delivery, in addition to long-term methods for family planning. The ANC visits are opportunities for women to receive malaria-prevention therapy, including intermittent preventive treatment during pregnancy with sulfadoxine-pyrimethamine (IPTp-SP), long-lasting insecticide-treated bed nets (LLITN), iron folic acid (IFA), and tetanus vaccinations. CHVs also referred CU5 for danger sign evaluation, vaccination, and treatment of malnutrition, among other CSB services. Table 3 shows the number of individuals referred and the types of referrals by CHVs during FY2017. During the reporting year, CHVs referred 69,520 women and 123,429 CU5 to the CSB. Of the referred women, 23 percent (20,896) were counter-referred by CSB for follow up services with the CHVs. CHVs referred a total of 108,603 CU5 for vaccination, representing 88 percent of the CU5s referred to CSB for any reason.

The table below also shows a decrease in the number of cases CHVs referred for services at the CSB, from 60,915 total cases in Q2 (40,839 CU5 and 20,076 WRA) to 54,917 in Q4 (31,236 CU5 and 23,681 WRA). Among the 123,429 CU5 cases referred in this fiscal year, 37 percent (45,314) of them received treatment as demonstrated by the counter-referral slips that are returned from the CSB to CHVs. The counter-referral rate for CU5 cases increased throughout the year from 29 percent in Q2 to 39 percent in Q3 and then to 43 percent in Q4. Among WRA cases referred by CHVs for services at the CSB and Maries Stopes' mobile clinic in FY2017, only 20,704 or 28 percent reported having received the treatment as documented by the counter-referral slips available at the CHVs. Over time, a similar positive trend is observed in the increasing rate of the counter-referral for WRA cases throughout the year from 23 percent in Q2, to 29 percent in Q3, and 32 percent in Q4 (Table 3).

Table 3 – Referral of WRA and CU5 Cases from CHVs to CSBs or Mobile Clinics in FY2017

Referral services by CHVs	Number of women or CU5 referred in FY2017			
	Q2	Q3	Q4	Total
First prenatal consultation including tetanus vaccination, IFA, intermittent preventive treatment in pregnancy, and LLITN	8,063	8,819	8,546	25,428
Pregnant women for fourth ANC	6,814	8,100	8,296	23,210
Pregnant women for delivery	4,033	4,663	5,492	14,188
Pregnant women for vaccination	7,920	9,755	8,718	26,393
Long-acting contraception	1,404 (238 CSB and 1,166 Maries Stopes)	4,181 (605 CSB and 3,576 Maries Stopes)	3,675 (1347 CSB and 2,328 Maries Stopes	6694
Subtotal: number of women referred to CSBs	**20,314**	**26,368**	**26,009**	**72,691**
Pregnant women with confirmed counter-referral from CSB back to CHVs	4 733 (23% of referred cases)	7 531 (29% of referred cases)	8 440 (32% of referred cases)	20 704 (28% of referred cases)
Cases of CU5 referred for vaccination	35,254	46,433	26,916	108,603
Cases of CU5 referred for malnutrition	1,188	873	606	2,667
Cases of sick CU5 with danger signs (newborns, malaria, acute respiratory infection, and diarrhea) for treatment of complicated cases and water treatment	1,442	1,407	1,605	4,454
Cases of sick CU5 from miscellaneous causes	2,955	2,641	2,109	7,705
Subtotal: number of CU5 referred to CSBs	**40,839**	**51,354**	**31,236**	**123,429**
CU5 with confirmed counter-referral from CSB back to CHVs	11 903 (29% of referred cases)	20 060 (39% of referred cases)	13 351(43% of referred cases)	45 314 (37% of referred cases)

*Note: Program CHVs began to report their services in Q2 FY2017.

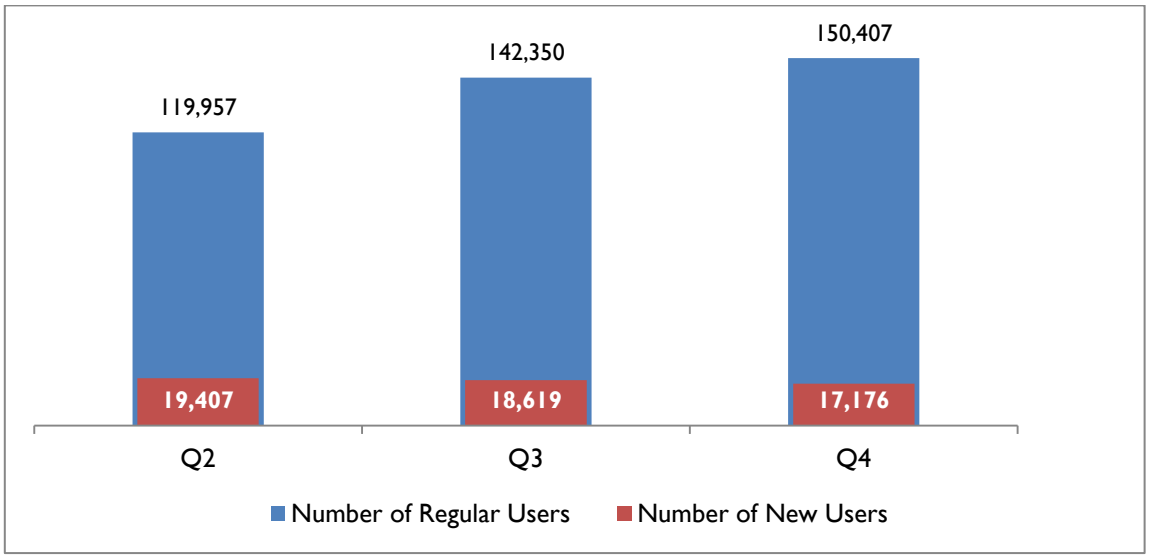
CHV Services in Family Planning and Reproductive Health

For the majority of the women in the seven Program regions, the distance to the nearest health facility and the need for transport to arrive there are significant barriers to receiving care. Moreover, more than half of the communes in the Program areas are inaccessible by car or truck for at least four months out of the year. Almost one third are inaccessible for almost half of the year. For these reasons, community health volunteers play a key role in providing family planning services to women of reproductive age. Figure 5 shows that at the end of FY2017, functional CHVs reported that they provided FP services to 150,407 regular users. There is a steady increase in the overall number of family planning users, both new and regular users, throughout the reporting year. The increase is most likely caused by several factors, including increased knowledge among community members on family planning as a result of the social behavioral change communication (SBCC) activities, more

regular service provision by CHVs and improved availability of family planning products, correct and on time reporting by CHVs, and more supportive supervision received by the CHVs.

The number of new users in each quarter is stable (19,407 in Q2, representing 16 percent of all users in the quarter; 18,619 in Q3, representing 13 percent of all users in the quarter; and 17,176 in Q4, representing 11 percent of all users in the quarter). This stability could be explained by the fact that all CHVs who reported providing FP services come from the former MAHEFA Program districts since the *Mahefa Miaraka* Program has not yet started family planning activities in the new districts. These communities, therefore, have been receiving FP messages and services for a longer period of time (Figure 5).

Figure 5- Family Planning Users in the Program, by Quarter in FY2017



Regular Users of Family Planning. Figure 6 shows that the largest group of family planning (FP) regular users are women ages 25 years old and above, at 42 percent (63,243 women). The second largest group of regular users of family planning CHVs see is women between 20-24 years of age, at 32 percent (47,841 women). There are 5,256 adolescents (4 percent of the total regular users in FY2017) , between 10-14 years old, who are regularly visit CHVs for family planning, which is a 1.5 times increase from 3,442 in Q3. These figures show that there is an ongoing need for FP services among this age group and, as they become regular users, they will encourage their peers to consult with CHVs for family planning services as needed.

Figure 6- Regular Family Planning Users in the Program by Age Group, FY2017

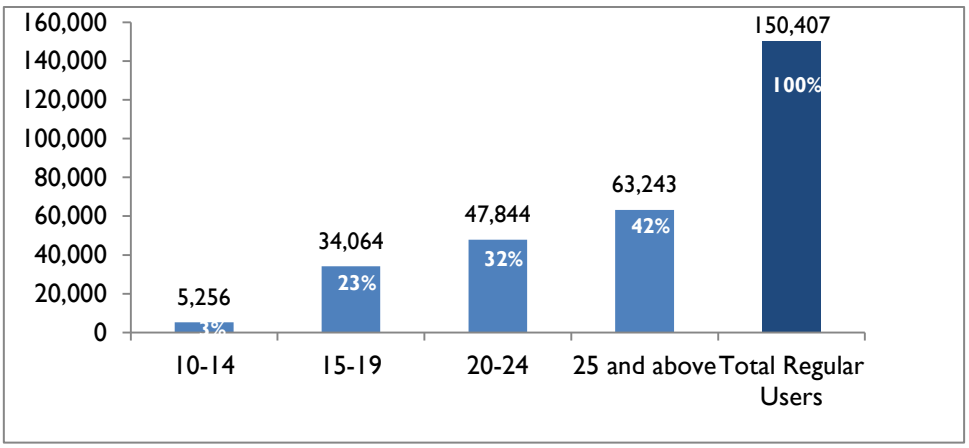
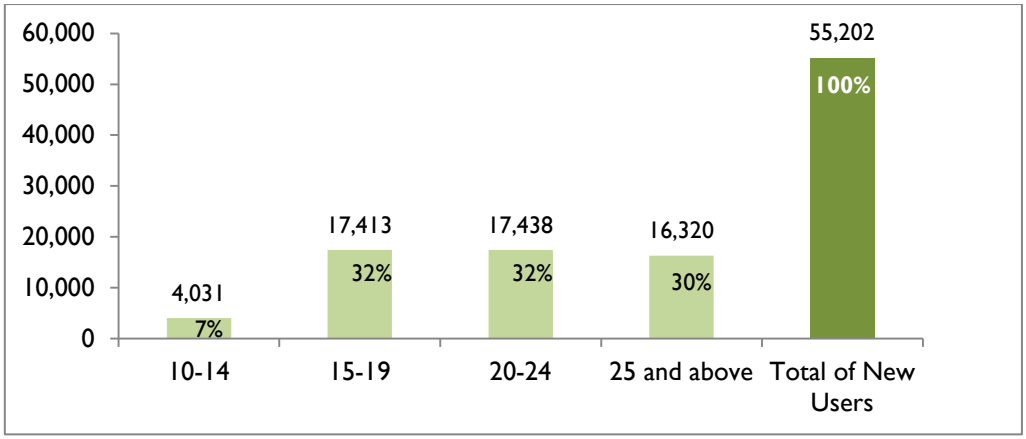


Figure 7- New Family Planning Users in the Program by Age Group, FY2017



New Family Planning Users. Figure 7, above, shows that in FY2017, women under 25 years old constituted the majority of the new users (at 70 percent of the total new users or 38,882 out of 55,202). Seven percent of the total (or 4,031) were adolescents 10–14 years old.

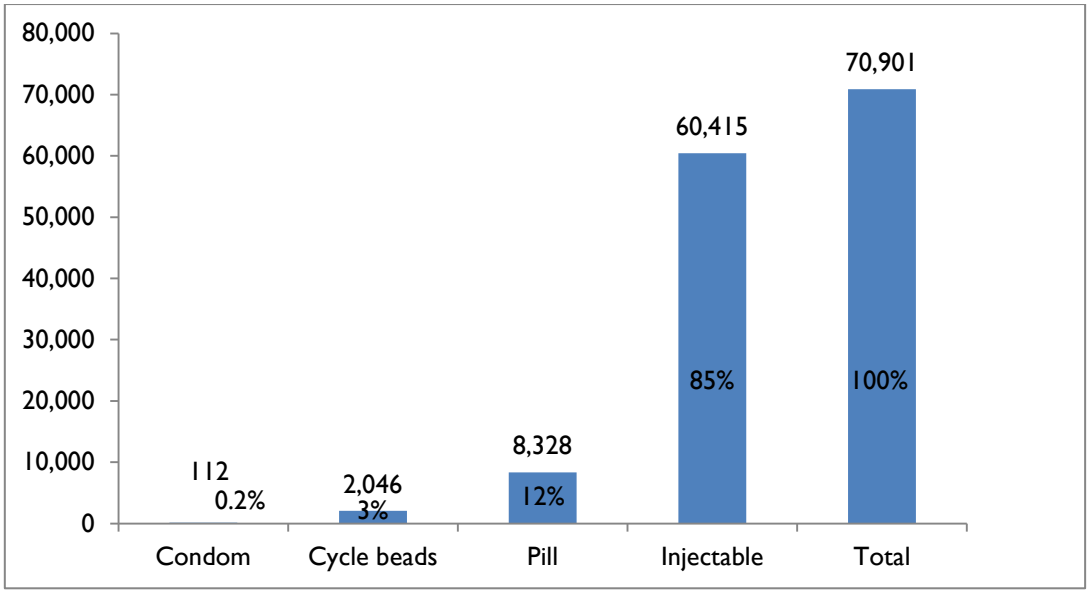
New Family Planning Products Offered by CHVs. In FY2017, CHVs began to offer Sayana Press as a new family planning product for women. During the year, CHVs reported administering Sayana Press to 20,870 women (Table 4). The table also shows a steady increase of Sayana Press use among women who received services from CHVs, from 1,236 in Q2, to 4,375 in Q3 (representing 3.5 times increase) and 20,870 in Q4 (representing 4.8 times increase). The noticeable increase between Q3 and Q4 could be a combination of the shortage of intramuscular DMPA and more acceptance of the subcutaneous DPMA. More information on Sayana Press use in the Program is presented in Annex 7: Success Stories. Sayana Press use in Menabe region constitutes half of the total number in FY2017.

Table 4 – Sayana Press Use by Regions, Comparison of Q2 and Q4 FY2017

FY2017	Boeny	DIANA	Melaky	Menabe	SAVA	Sofia	Total
Q2 (Jan–Mar 2017)	10		43	773		410	1,236
Q3 (April–June 2017)	140	189	254	2,717	46	1,029	4,375
Q4 (July-September)	541	991	2,267	10,968	384	5,719	20,870

Couple Years Protection (CYP). At the end of September 2017, the Program recorded 70,901 couple years of protection, which surpassed the annual target of 53,000 in the Program Monitoring and Evaluation Plan (PMEP) (Figure 8). Comparing this finding with the fourth year of the former MAHEFA Program, where the project reported 69,207 CYP in the FY2014 annual report, the *Mahefa Miaraka* Program's achievement in its first implementation year is impressive. With regards to the types of family planning products used, the preferred method is the injectable method, used by 122,365 women (81 percent), the second most preferred method is oral contraceptive methods, used by 24,228 women (16 percent). The least used method of family planning in the program regions in FY2017 is spermicide, used by just 205 individuals (0.1 percent). The family planning pre-service and refresher training for CHVs in the program regions includes the United States Government (USG)'s regulations and requirements on family planning and abortion, including the Protecting Life in Global Health Assistance (PLGHA). The Program team monitors CHVs' respect of the USG requirements during supportive supervision sessions.

Figure 8- Couple Years of Protection in FY2017



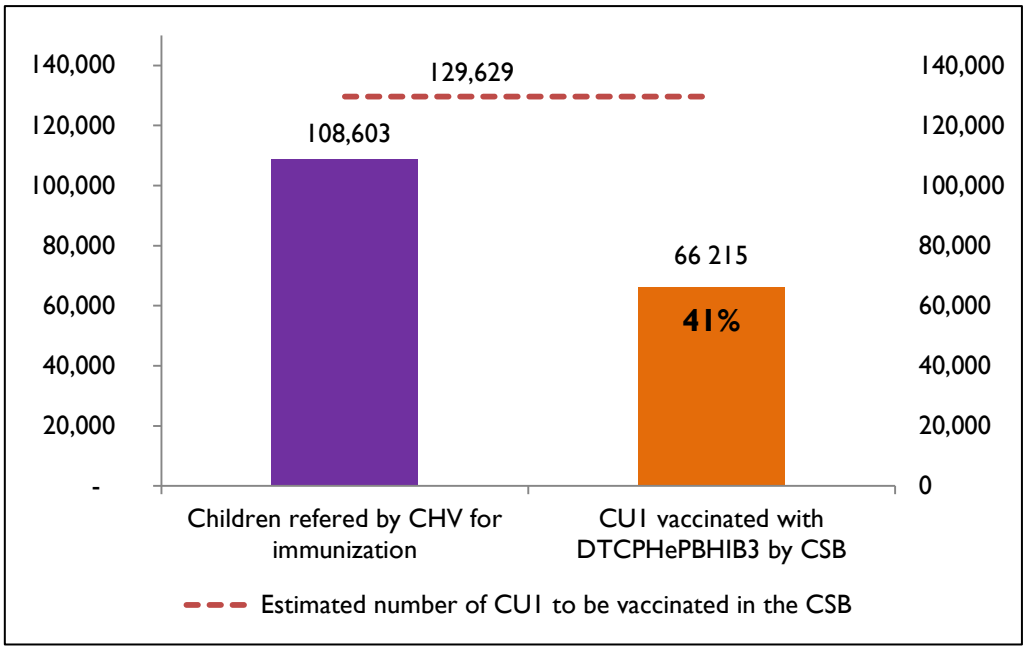
CHV Services Related to Immunization and Community Surveillance

CHV Services Related to Immunization. In addition to the routine services provided in their community, community health volunteers play an important role in assisting CSB heads in the MOH's annual health campaigns, namely the April and October Maternal and Child Health (MCH) Weeks, and the polio campaigns. Before the campaign, CHVs receive a list of children from the CSB heads so they make a door-to-door reminder and ensure those children are present during the campaign to receive health services such as vaccinations, deworming, and Vitamin A. Similarly, CHVs have a list of pregnant women in their community so they inform them about campaigns and make sure they come to receive pre-natal services, especially during the MCH weeks.

On a regular basis, and as shown in Table 3 on referrals and counter referrals between CHVs and CSBs, in FY2017 CHVs referred 108,603 CU5 for vaccination and 45,314 cases (out of the total of 66,215 vaccinated) or 37 percent of referred cases reported receiving vaccination on DTCHepHib3 at the CSB (as evidenced by the counter-referral slips returned from CSB to CHV). On a regular basis, CHVs are trained to keep an updated list of CU5 in their community so they can follow up and make sure the children receive and complete their vaccinations. Additionally, CHVs use the Essential Family Practices (ESP) sheets on care for CU5 (by age groups) to promote awareness and adoption of good practices regarding vaccination. More information on the use of ESP sheets is reported under IA2.

The practice of combining CHV supervision and outreach activities conducted by CSB heads (described in more detail in the supportive supervision section above) is becoming more and more systematic in the Program areas. During the outreach sessions, CHVs work as CSB's assistants, providing vaccination (oral) and other services to women and children. Figure 9 shows a number of children vaccinated for DTCHepHib3 in the program areas and the number of CU5 cases CHVs referred for vaccination. While there are a number of other factors contributing to the vaccination rate, it is clear from the high number of referred cases that CHVs play a key role in augmenting the vaccination rate (41percent against the number of children in the program area that should be vaccinated at the CSB).

Figure 9- Children Referred and Vaccinated for DTCHepHib3 in FY2017



(Sources: GeSIS with 83 percent CSB completeness rate, January-September 2017)

CHV services in Community Surveillance. In FY2017, the MOH added community surveillance to CHVs' responsibilities. The Program technical team at the central office worked closely with the MOH technical teams to develop and prepare training curriculum and job aids for CSB and CHV use. Afterwards, the Program conducted cascade training for 6,410 CHVs on community surveillance, including how to use the job aids and how to report to CSB heads. In the districts where the Maternal and Child Survival Program (MCSP) Project works, the Program coordinated with the MCSP vaccination team to conduct the training at the district and commune levels. The training also includes the community-level Reaching Every Child approach.

The CHVs also play a key role in the response to health outbreaks. In FY2017, there were three declared malaria outbreaks in the Program regions (Melaky, Boeny, and Sofia), and three declared plague outbreaks in SAVA, Analanjirofo, and Menabe regions. CHVs assisted the CSB heads in the response to the outbreaks by working as assistants during the emergency response, interfacing between community leaders and the CSBs, mobilizing the communities according to the emergency team's instruction, and sensitizing people during and after the outbreak to prevent future outbreaks.

Since the onset of the plague outbreak in August, the Program has assisted the MOH in its response to plague by taking part in the activities carried out by the crisis committee at national, regional, and district levels. Once the MOH has provided the curriculum, the Program will train the CHVs.

1.1.4 Women- and Youth-Friendly Environment and Services

Situation Analysis on Gender-Based Violence (GBV). During this quarter, the Program finalized a study protocol on GBV and submitted the document to the MOH Ethics Committee and the JSI Institutional Review Board (IRB). The Program received the approval of the MOH Ethics Committee, however, due to a reduced FY2017 budget the study will be conducted in FY2018.

1.1.5 Health Commodities and Work Tools for CHVs

Health Commodities for CHVs. As previously presented in the Program's progress report, the stock-out level for all health tracer products was high. The Program team worked very hard to improve the situation by coordinating with all relevant stakeholders and, as a result, the stock-out rate drastically decreased in September 2017. Figures 10 and 11 show an overall steady decrease in the stock out rate of the child health tracer products reported by CHVs. Program efforts continue to reduce the overall stock out of child health and family planning tracer products. Additionally, Program teams at the field and national levels continue to provide accurate and timely reports on CHVs' stock outs in the regular coordination meetings GOM and USAID implementing partners organize.

In FY2017, there were three main events that have had a major impact on the stock out of health products at the community level namely:

- Discontinued of ViaSur since July 2017 means that the CHVs can only resupply from the CSB (Zinc and ORS), instead of two sources as in the past.
- Discontinued of Confiance means that CHVs can only resupply from the CSB (intramuscular Depoprovera), instead of two sources as in the past.
- Cyclic shortage of ACT and or RDT at CSB level, which is the only source of malaria product for CHVs.

Unfortunately, the impact of these three above points is likely to continue into early FY2018, which is the beginning of the rainy season.

For the child health tracer products shown below, CHVs resupply the following products from the ISM project: Zinc-ORS as ViaSur, Amoxicillin and CHX (with stock out rate in Q4 at 28 percent, 26 percent and 44 percent respectively). Additionally, CHVs resupply malaria products (RDT, Actipal and ASAQ [infant and child]), and misoprostol at the CSB. The stock out rate CHVs reported for malaria products remained high throughout FY2017, from 100 percent in Q2 to 58 percent in Q4 for infant Actipal and ASAQ, and from 63 percent in Q2 to 52 percent in Q4 for child Actipal and ASAQ. The data for family planning tracer products (Figure 11) shows that the injectables (Depoprovera/Magestron) and oral contraceptives (Lofemenal/Mycrogynon) are one of the health products with the lowest level of stock outs at the end of Q4, at 17 percent and 19 percent, respectively. As the injectable is the most used family planning method in the Program, used by 122,365 women (81 percent), it is likely that CHVs will make sure to have this in stock, ultimately contributing to a lower stock out rate compared to other health products.

Figure 10- Stock-out of Child Health Tracer Products, by Quarters FY2017

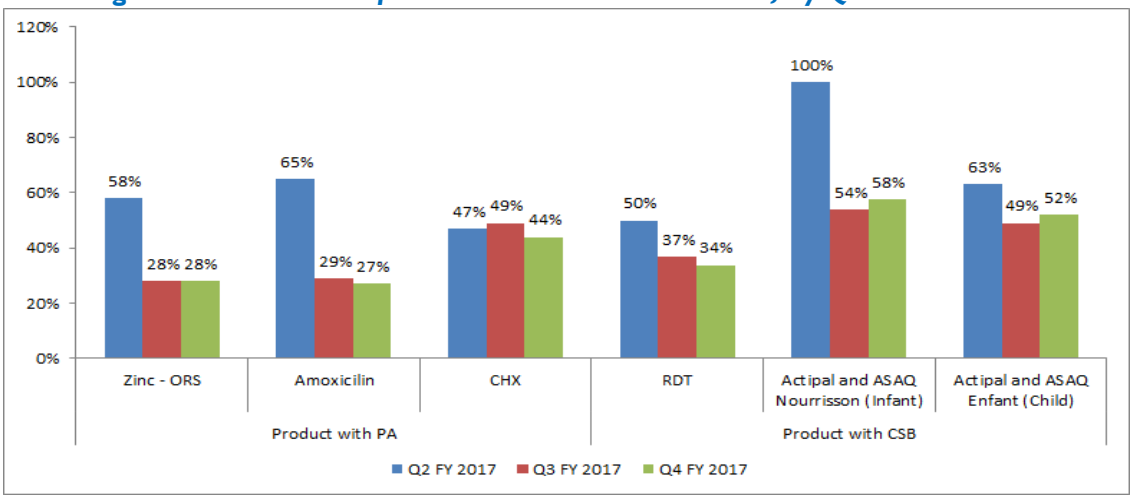
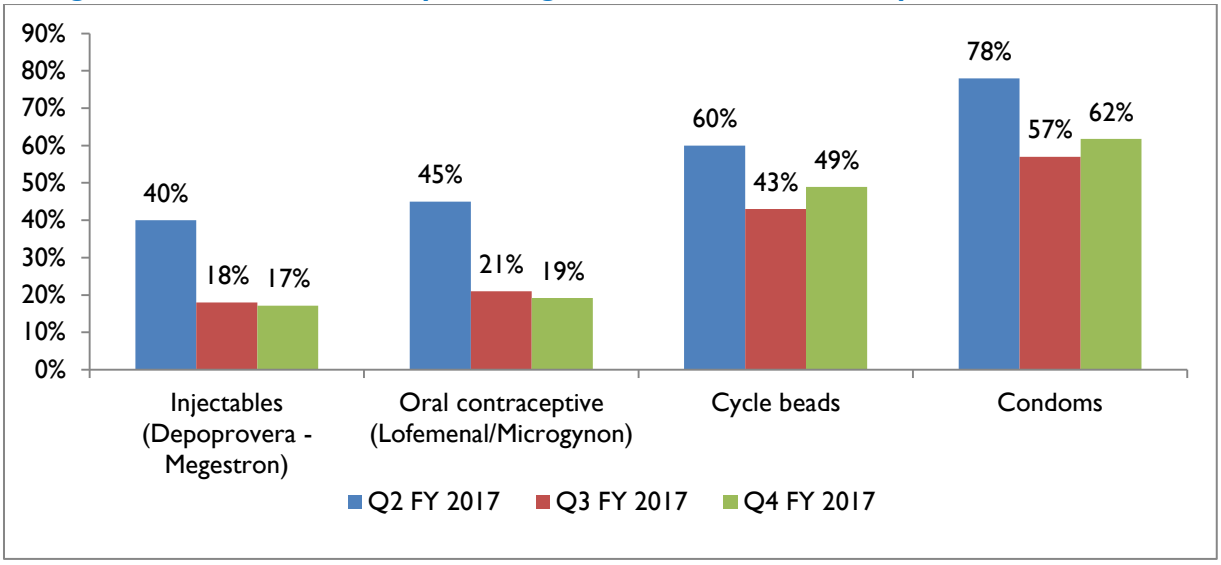


Figure 11- Stock-out of Family Planning Health Tracer Products, by Quarters in FY2017



CHV Work Tools. As in the previous Program, in FY2017 the Program continued to ensure that CHVs had the necessary tools and materials to perform their activities properly. The Project provided all materials and tools CHVs use to the CSB heads and staff members as well so they could support CHVs in using them correctly. Table 5 presents the materials and tools the Program distributed and the CHVs currently use. Due to shortage of funding in FY2017, the Program could not provide more materials to CHVs. All CHVs will receive necessary materials and tools in FY2018.

Table 5 – Materials and Tools Distributed to CHVs in FY2017

CHVs' tools (all CHV tools were also provided to CSB)*		
IEC tools	**Management tools**	**Work tools**
1. Women's health card 2. Child's health card 3. Family planning invitation card 4. CHV's newsletter ZARA NY EFA 5. Household card on essential family practices for households with pregnant women *(Fiche ménage Femme enceinte)* 6. Household card on essential family practices for households with newborns 0-11 months *(Fiche ménage enfant 0 à 11mois)* 7. Household card on essential family practices for households with infants 12-23 months *(Fiche ménage enfant 12 à 23 mois)* 8. Household card on essential family practices for households with small children *(Fiche ménage enfants 24 à 59 mois)*	1. CHV Community health record book (*Registre intégré*) 2. CHV Community Monthly report (*Rapport Mensuel d'activité*) 3. Referral & counter-referral forms 4. Stock management forms 5. Family planning individual client form (*Fiche individuelle PF*) 6. C-IMCI individual client form (*Fiche de prise en charge PCIMEc*) 7. Additional monthly report form for CHVs (*RMA Additif*) 8. Job aid for community surveillance	1. Family planning demonstration folder 2. Band to measure mid-Upper Arm Circumference (MUAC) 3. SALTER scale 4. Timer

*Note: Materials for CHVs that do not require specific management (e.g., notebooks, T-shirts, bags) are not presented in the table.

1.1.6 Motivation Activities for CHVs and FKT Heads

Due to the reduced budget in FY2017, the financial motivation activities for CHVs were limited. Financial and non-financial activities are presented below.

Financial Motivation Activity for CHVs. In FY2017, the four cooperatives called eBox that were established under the former MAHEFA Program in Menabe and Sofia regions continued their activities. This year, both eBox cooperatives in Menabe received an additional 1,446 recycled bicycles (two times for the Miandrivazo eBox and one time for the Bemanonga eBox). A total of 104 community actors in Menabe benefitted from the eBox activity in FY2017 (27 members of the Miandrivazo eBox received between 67 to 100 USD or 200,000 to 300,000 MGA as shared profit, whereas 77 members of the Bemanonga eBox received an average of 33 USD or 100,000 MGA). Some members of the eBox are part-time eBox employees; therefore they receive payment for their work in addition to their share of the profits. The 4 E-boxes in place benefit 169 members out of which 58 percent are CHVs.

Non-Financial Motivation Activity for CHVs/Community Support. . Community support is considered one of the motivation sources for CHVs. One way that communities demonstrate support is by building health huts, or *Tobys,* where the CHVs can provide services. In FY2017, the Program recorded a total of 1,511 newly built health huts that communities built for CHV use in the Program regions, surpassing the FY2017 annual target of 1,205 *Tobys.* Of those built, 86 percent (1,302) are equipped with chairs, a table, and shelves; 49 percent (734) also have a waste pit; and 40 percent (608) have a latrine. The Program will continue to encourage communities to make sure that all *Tobys* have basic equipment, latrines, and waste pits.

Non-Financial Motivation Activity for CHVs/Chez Moi Television Program. A particularly unique non-financial motivation for community health volunteers was a recent filming with the Chez Moi television program, which is broadcast across Madagascar. Mahefa Miaraka partnered with TVM to produce two episodes of the popular renovation show to give a toby (health hut) in Andranofotsy a makeover and spread key WASH messages. The Andranofotsy CHVs were honored to receive important visitors from USAID and the Ministry of Health who attended the filming of the renovation. The CHVs in Andranofotsy are dedicated, high-preforming volunteers who participated in the renovation and were featured in interviews throughout the show's two episodes, which aired on national television. The episodes were an exciting and innovative way to recognize the Andranofotsy CHVs and celebrate their work within the community, in addition to raising awareness of and validating the work of other CHVs across the country. The episodes have inspired other CHVs to work hard in the hopes they may be able to participate in something similar in the future.

1.1.7 Malaria Activities in the Program

Support to SDSP and CSB for Prevention of Malaria Outbreaks. Since Q3, the Program district team began a monthly review meeting with *Service de District de la Santé Publique* (SDSP) to review CHV health performance in all of a district's communes. The Program generated a dashboard of 19 selected indicators (see Annex 1) and with the SDSP reviewed the community health performance of each commune in a given district to monitor trends and identify potential outbreaks of diseases like malaria. In Q4, all the Program district teams reported discussing the dashboards with the SDSP team, while the dashboard has been introduced to 509 out of 732 CSBs, or 70 percent.

Community Health Volunteers' Role in Malaria Prevention and Control. In Q4, CHVs in the Program regions continued to provide c-IMCI services and promote key messages on malaria prevention using long-lasting insecticide-treated bed nets LLITN, destroying mosquito habitats, seeking treatment for fever, and highlighting the importance of ANC visits including IPT use. The CHVs' c-IMCI services and other malaria services for pregnant women are presented below. Messages on malaria

prevention and control are part of the key health messages diffused through multiple communication channels in the Program.

Promoting the Use of Long-Lasting Insecticide-Treated Bed Nets (LLITN) at the Community Level. The USAID Community Capacity for Health Program promotes the use of LLITN through multiple communication channels: radio diffusion, social behavior change communication (SBCC) activities conducted by the CHVs and fokontany heads, and high visibility events such as health days and campaigns. Additionally, the Program promotes the use of LLITN on the household card that explains the importance of sleeping under mosquito nets, especially for CU5 and pregnant women. More SBCC reporting is presented in IA2.

Malaria Diagnosis and Treatment by CHVs. As malaria is one of the most serious health issues in the Program's seven regions, CHVs have an important role in promoting practices such as sleeping under insecticide-treated mosquito nets, destroying mosquito habitats, and seeking health services for fevers, especially among CU5. In FY2017, CHVs received a total of 119,633 CU5 cases with fever and tested 82 percent (or 97,636) of those using a Rapid Diagnostic Test (RDT) kit. The reason for not testing the remaining CU5 may be a shortage of RDT kits (information on stock out on pages 14-15), including gloves, considering that CHVs are trained to automatically test all CU5 fever cases with RDT and to use gloves for infection prevention. Of the 97,636 CU5 tested, 53 percent (51,681) were positive for malaria. Unfortunately, only 78 percent of the malaria positive cases received ACT treatment, which may have to do with ACT availability, already discussed on page 14. Table 6 also shows that Melaky and Boeny regions have the highest positive rates in the program area, at 66 percent and 62 percent, respectively. Melaky and Boeny regions also have the highest percentage of CU5 malaria positive cases treated by CHVs, at 87 percent and 85 percent respectively. In SAVA, only half of the CU5 testing positive for malaria received treatment by CHV. More information on malaria activities is presented in the end of this IA.

Table 6 – CHV Malaria Services by Regions in FY2017

Malaria services by CHVs	**Analanjirofo***	**Boeny**	**DIANA**	**Melaky**	**Menabe**	**SAVA**	**Sofia**	**Total**
CU5 fever case	26	5,762	4,662	31,496	40,782	2,458	34,447	119,633
CU5 with fever tested with RDT by CHV	13	3,110	3,842	27,612	33,307	1,267	28,485	97,636
CU5 with fever tested positive with RDT	2	1,935	924	18,337	16,577	279	13,627	51,681
CU5 with fever treated with ACT by CHV		1,653	606	15,961	12,344	140	9,832	40,536

*Note: Only 24 CHVs in Ste-Marie District currently provide c-IMCI services in Analanjirofo region.

Figure 12- CHV Malaria Services by Quarters in FY2017

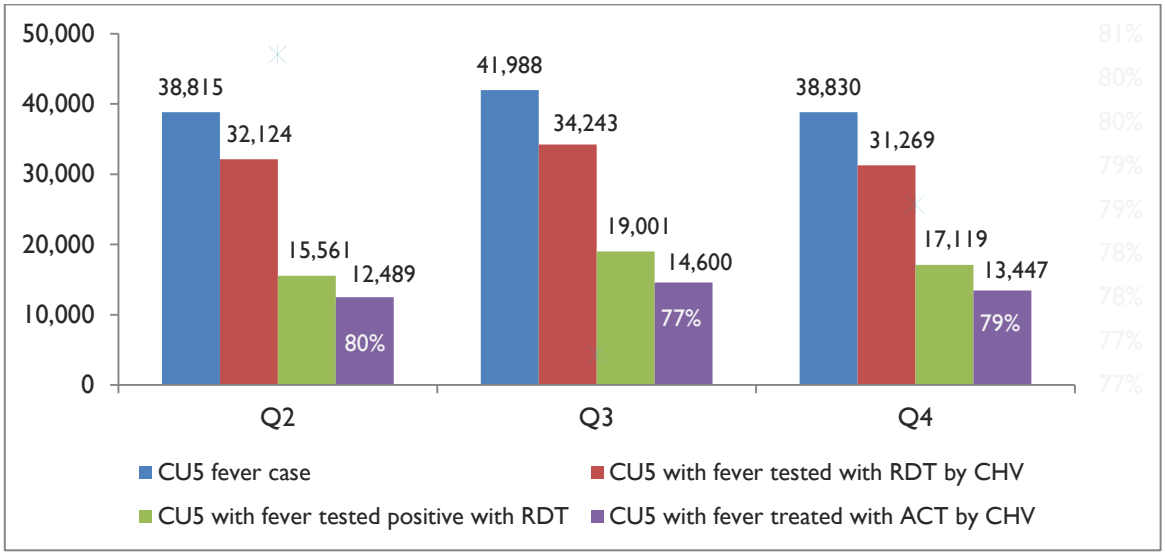


Figure 12 shows that malaria cases among CU5 and CHV malaria services in the Program areas declined slightly throughout FY2017. In Q2, 83 percent (32,124 out of 38,815) of CU5 cases with fever who were seen by CHVs were tested with RDTs, compared to 82 percent (34,243 out of 41,988) in Q3 and 81 percent (31,269 out of 38,830) in Q4. In all three quarters, about half of the CU5 cases tested were malaria positive (48 percent in Q2, 56 percent in Q3 and Q4). With regards to treatment, the majority of the CU5 cases testing malaria positive received treatment by CHVs (80 percent in Q2, 77 percent in Q3, and 79 percent in Q4).

Referral of Pregnant Women for Malaria-Prevention Therapy with Sulfadoxine-Pyrimethamine (IPTp-SP). One of CHVs' main services is to provide counseling and referrals to the CSB for ANC visits, follow-up, and delivery. These visits are opportunities for women to receive malaria- prevention therapy, including intermittent preventive treatment during pregnancy with sulfadoxine-pyrimethamine (IPTp-SP), LLITN, and IFA, as well as other care, including tetanus vaccinations. As reported earlier, during the year CHVs referred a total of 25,428 pregnant women to a CSB for their first ANC visit, 23,210 for their fourth ANC visit, and 14,188 for delivery.

Sub IA 1.2 Sustainability of the CHV Model

The activities designed to make sure that CHVs are fully integrated in the public health system are supervision and monthly reporting, which have been described above.

Sub IA 1.3 Strengthening of Community Structure to Improve Health and Sanitation Planning

1.3.1 Functionality and Reinforcement of Community Health Structure

The Program activities designed to strengthen the capacity of PNSC coordination structure members were reported above under section 1.1.1.

1.3.2 Using Champion Commune or KMSm Approach to Manage Community Health

In FY2017, the Program reviewed and modified the KMSm approach to make it friendlier to the communities which in turn will make it easier for community leaders to own and use. After the

modification, the Program team revised the training curriculum for community leaders. Due to shortage of funds in FY2017, the Project will roll out KMSm activities in FY2018.

Sub IA 1.4 Promoting Universal Health Care Access and Coverage

1.4.1 Increase Access to Health Care via Health Financing Scheme

A total of 17 *mutuelle de santé* (community health insurance) groups out of 33 that were created during the MAHEFA Program are still functional and carrying out activities as of FY2017. The Program team held a workshop with several *mutuelle de santé* groups, including those that are no longer functional, to draw from their experiences and share lessons. Afterwards, the 17 functional *mutuelle* groups revitalized their membership pool by sensitizing an additional 548 people. Twenty-eight people reported using the *mutuelle de santé* mechanism to receive treatment at the CSB during FY2017. Apart from the E-box contribution is to allocate 5 percent of its benefit to the *mutuelle de santé* and ETS functioning. In FY 2017, the Miandrivazo Cooperative in the Menabe Region has contributed 500 USD to three local community insurance schemes, including ETS.

Through a survey, the Program planned to identify and promote different community-based health financing schemes that could be relevant to the Program regions in FY2017. However, due to the funding shortage, the Project postposed the survey to Q1 FY2018. The Program team has designed and prepared the study protocol and is ready to submit it to the National Ethics Committee for approval in Q1 FY2018; the Program has already submitted the document to JSI's IRB.

1.4.2 Increase Access to Health Care via Emergency Transport

Health Evacuation. In FY2017, the Program encouraged each fokontany to develop its own health emergency evacuation plan. The plan is modified from the GOM's emergency evacuation form for use for health evacuation purposes. The health evacuation plan includes essential information like actions to be taken in case of a health emergency, contact numbers for the closest health facilities, and means of available transportation. At the end of FY2017, almost half of the fokontany in the Program regions (49 percent or 2,393 out of 4,887 fokontany) had already developed their health evacuation plans, surpassing the FY2017 annual target of 2,234. The health emergency evacuation plan is posted at the CHV hut or at another public place in the fokontany and the Program also has a copy. In FY2018, the Program will encourage all fokontany to develop a health evacuation plan and monitor its use.

Emergency Transport. In FY2017, the Program team assessed the conditions of the means of emergency transports provided during the former MAHEFA Program. The results of the assessment show that out of a total of 145 means of emergency transports inventoried, 66 of them (46 percent) are in functional condition and are used by the community. By the end of September 2017, communities repaired 17 out of 79 broken means of emergency transport with financial assistance from the Program to purchase parts that cannot be produced locally. The remaining 62 non-functioning means of transport will be repaired during FY2018. During the year, the Program transported a total of 76 people via emergency transport (24 CU5, 39 pregnant women, and 13 others).

Intervention Area 2 (IA2): Behavior Change and Health Promotion

Key Achievements:

1. The number of people received health messages from different Program communication channels in FY2017 is 3,744,923. In FY2017, CHVs delivered key health messages to a total of 1,267,783 people (608,902 people through the education sessions, 522,473 people who came for services at the health huts, and 138,408 people through home visits). Note: If the same people are reached more than once by one dissemination source, they will be counted one time. If they receive messages from different sources, they will be counted more than one time.
2. In all, 41 local radio stations (11 at the regional level and 30 at the district level) diffused key health messages on average two-three times per day, 12 days per month.

Sub IA 2.1. Community-Level Health Promotion and Sensitization

During this reporting year, the USAID Community Capacity for Health Program continued to carry out activities to promote healthy behaviors and increase uptake of health services and products. In particular, the Program continued to develop information, education, and communication (IEC) tools; to create materials including media products; to diffuse audio products through local radio stations; to conduct a series of trainings; and to provide IEC and work tools for community actors on the SBCC approach. As a result, a total of 3,744,923 people were reached and received key health messages through the Program's SBCC activities. Details are presented below.

People Reached by SBCC Activities

As reported above, the Program used multiple communication channels to promote key health messages and EFPs: 1) CHV counseling efforts (at health huts, home visits, and community-based education sessions); 2) media activities; and 3) high visibility events. Figure 13 shows the number of people reached through different communication channels in FY2017. Media activities, especially radio diffusion, reached the largest number of people, delivering health messages to 1,965,162 people. The second-biggest source of information is the CHVs, who reached 1,267,783 people through their SBCC activities (522,473 people in their counseling sessions in their health huts, 138,408 people through home visits and 608,902 people by community-based education sessions). In total, CHVs conducted respectively 105,504 home visits, 58,287 education sessions, and 41,060 high visibility events to reach people in their areas.

Figure 13- Number of People Reached in FY2017

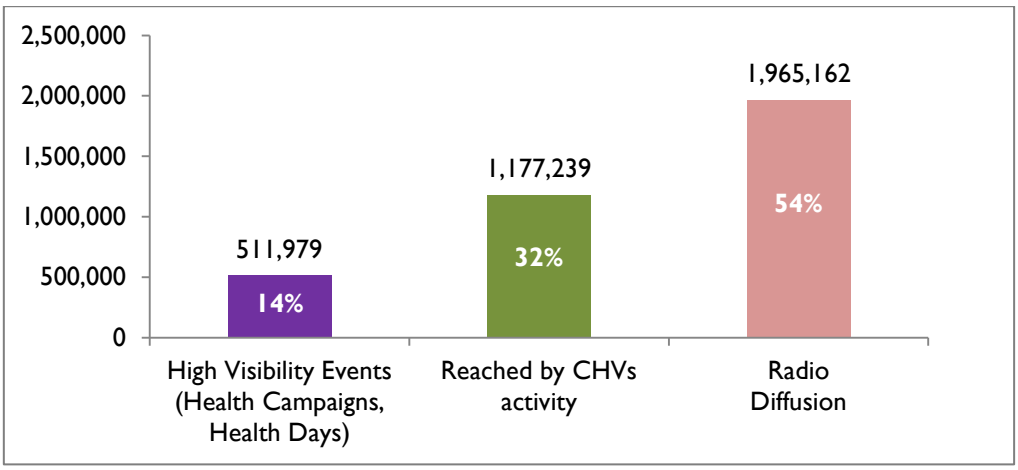


Table 7 shows key messages delivered through the Program's communication channels. These key health messages were presented in different formats (media and printed), delivered regularly through multiple communication channels, and designed to complement each other. The possibility of community members adopting healthy behaviors increases when the same message is received multiple times in different formats. In other words, the number of times people receive the same messages through different channels is an important factor that leads to behavior change.

Table 7 – Number of People Reached by Key Health Messages in FY2017

Key messages	Q2			Q3			Q4		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Maternity without risks with malaria prevention	119,587	98,450	**218,037**	135,757	116,681	**252,438**	116,393	369,842	**486,235**
Family planning	167,433	135,368	**302,801**	185,431	155,663	**341,094**	275,004	175,373	**450,377**
Exclusive breastfeeding	119,489	99,009	**218,498**	140,057	113,175	**253,232**	114,778	324,968	**439,746**
Vaccination	207,734	171,352	**379,086**	237,532	200,552	**438,084**	173,907	249,753	**423,660**
c-IMCI including malaria prevention	166,485	154,236	**320,721**	182,563	162,144	**344,707**	160,548	226,456	**387,004**
Nutrition	122,542	104,132,	**226,674**	139,679	120,796	**260,475**	249,177	132,056	**381,233**
Youth and adolescent health	114,771	101,899	**216,670**	126,351	114,099	**240,450**	110,094	250,634	**360,728**
Communicable diseases	147,131	134,789	**281,920**	145,319	136,743	**282,062**	123,251	141,955	**265,206**

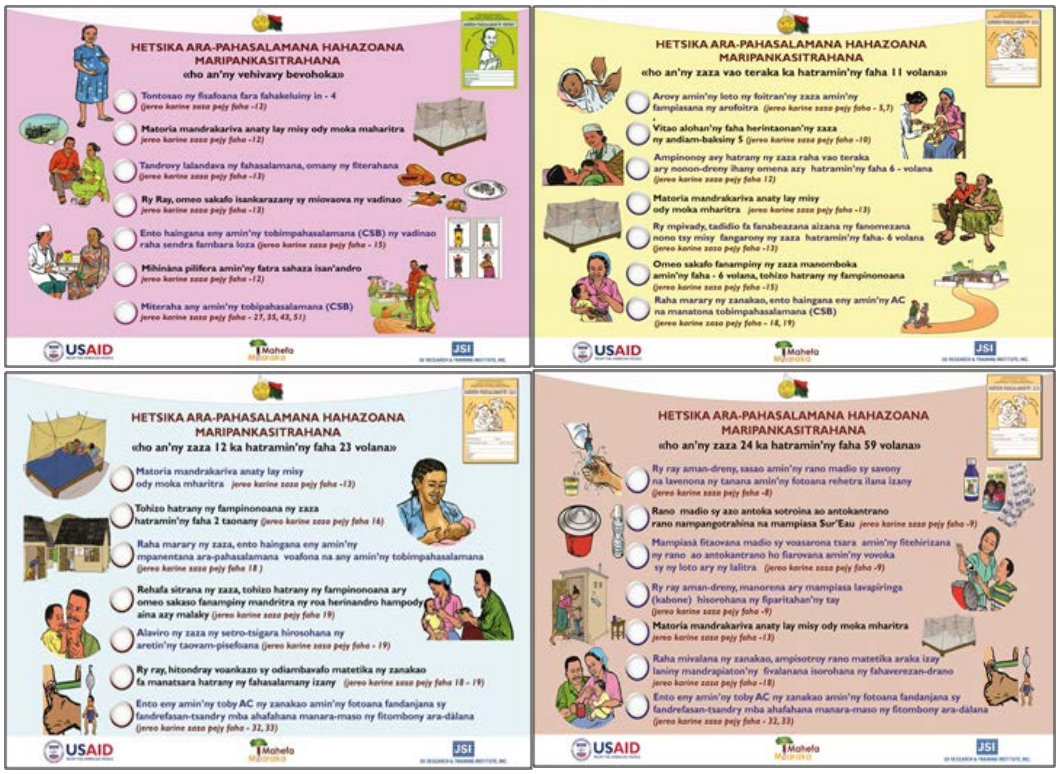
2.1.1 SBCC Strategy, Approaches, Materials, and Tools

Review of the Radio Listening Group (RLG) Approach and Tool. In FY2017, the Program reviewed the RLG approach and training guide for the facilitators of the radio listening group. In addition to the radio spots developed for regular diffusion, the Program team designed 29 radio clips, 11 dramas, and 18 folktales on key health messages and essential family practices (EFP) that are designed to be entertaining and appealing for local audiences. Also, in FY2017, the Program discussed and signed a memorandum of understanding (MOU) with the Executive Secretary of the National Committee on AIDS (*Secrétariat Exécutif du Comité National de Lutte contre le sida, SE/CNLS*). The Program will receive 1,000 radio posts from the SE/CNLS. This year, the Program also began a partnership discussion with the National Office on Nutrition (*Office National de Nutrition)* for joint development of key messages on nutrition. In FY2018, the RLG activities will take place at the community level.

Development of Household Cards on Essential Family Practices. In FY2017, the Program designed and developed five household cards on specific EFP that are relevant to the following households/ families: 1) those with newborns from 0–11 months, 2) those with infants from 12–23 months, 3) those with young children from 24–59 months, 4) those with pregnant women, and 5) those with youth. Additionally, the Program designed three more household cards relevant to all households on: 1) malaria; 2) water, hygiene, and sanitation (WASH); and 3) nutrition. The Program uses health messages from the women's and children's health cards to develop household card EFP to encourage families to adopt good health practices (becoming a model household, *ménage modèle*) and expand the adoption to other families (becoming *ménage parrain*). The approach to using these cards at the

community level is presented under Section 2.2.2 SBCC Activities at the Community Level. In total, the Program distributed 338,580 household cards for CHV use in FY2017. The four household cards are shown in Figure 14.

Figure 14- Household Cards on Essential Family Practices



2.1.2 Repositioning the Women's and Children's Health Cards as the Cornerstone of SBCC Strategies

In FY2017, the Program distributed a total of 240,468 health cards (120,234 women's and 120,234 children's) to the CHVs for use at the community level. Additionally, Program staff distributed a total of 46,220 health cards (23,110 women's and 23,110 children's) for use at the government health facilities or CSB. The Program reinforces the use of the MOH health cards for women and children by using the key health messages from the women and children's health cards to develop the household cards for community level use. This year, the Program also reprinted the women's and child's health cards in larger format for CHVs and CSB so they can be used as job aids.

2.1.3 Development and Dissemination of Information, Education, and Communication

Development and Use of IEC Materials. In FY2017, the Program team participated in the national efforts to harmonize and streamline the SBCC messages led by relevant ministries, namely the MOH, the Ministry of Youth and Sports; the Ministry of Population, Social Protection and Promotion of Women; and the Ministry of Water, Energy, and Hydrocarbon. Table 8 presents the IEC materials the Program developed and disseminated in FY2017. All the IEC products the Program uses are approved or developed jointly with the relevant Ministries.

Table 8 – IEC Materials Developed and Disseminated in the Program, FY2017

Types of IEC Materials	Technical themes	For Use By	Dissemination Channels
Printed Materials (developed by the Program)			
1. Household card for essential family practices on pregnant women	Family planning Maternal, newborn, and child health including WASH, nutrition, vaccination, CHX, and misoprostol	Household	Care group approach via CHV and fokontany heads
2. Household card for essential family practices on newborns (0-11 months)	Maternal, newborn, and child health including WASH, nutrition, malaria, and vaccination	Household	Care group approach via CHV and fokontany heads
3. Household card for essential family practices on Infants (12-23 months)	Maternal, newborn, and child health including WASH, nutrition, malaria, and vaccination	Household	Care group approach via CHV and fokontany heads
4. Household card for essential family practices on young children (24-59 months)	Maternal, newborn, and child health including WASH, nutrition, malaria, and vaccination	Household	Care group approach via CHV and fokontany heads
5. Job aids health cards	Maternal, newborn, and child health including WASH, nutrition, malaria, and vaccination	CHVs and CSB	Education sessions including counseling and home visits
6. Family planning invitation card	Family planning	WRA	CHV via regular users of family planning
Media Products (developed and diffused by the Program)			
7. 29 Radio clips	All technical themes of the Program	Community members	Radio diffusion
8. 11 dramas	All technical themes of the Program	Community members	Radio diffusion
9. 18 folktales	All technical themes of the Program	Community members	Radio diffusion
Media Products (developed by GOM and diffused by the Program)			
10. 15 radio clips on exclusive breastfeeding	MNCH (nutrition)	Community members	Radio diffusion
11. 44 radio clips on gender equality	MNCH and gender equality	Community members	Radio diffusion
12. 23 radio spots on family planning	Family planning	Community members	Radio diffusion
13. Radio spots on polio	Vaccination	Community members	Radio diffusion
14. Radio spots on menstrual hygiene	WASH	Community members	Radio diffusion
15. Radio spots on plague	MNCH	Community members	Radio diffusion

Media Activities for Promotion of Key Health Actions. In FY2017, the Program identified radio stations available at the regional, district, and commune levels and signed a contract with 41 stations. During FY2017, the radio stations diffused the audio products developed by the Program on a regular basis (two-three times a day, three days a week every month of the year). Products include: tales; dramas; and spots on family planning, gender equality, WASH, nutrition, vaccination, maternal and newborn care, malaria prevention, and other health messages issued by MOH during disease outbreaks and health campaigns. Radio diffusion remains the highest source of message delivery reaching a total of 1,965,162 people in FY2017.

Sub IA 2.2 SBCC Capacity of Community Stakeholders

2.2.1 SBCC Skill-Building for Community Leaders

The Program is committed to building the capacity of community leaders, including fokontany heads and community health volunteers, to carry out the SBCC activities in their own communities. In FY2017, the Program trained 7,877 CHVs and 33 fokontany heads on SBCC including use of household cards. As in all of the Program's trainings, the SBCC training followed the cascade approach where the first training of trainers was conducted jointly by government trainers. After the training, CHVs and fokontany heads received IEC materials to carry out SBCC activities in their communities (Table 7). The remaining CHVs and fokontany heads will receive the SBCC training in FY2018 and will carry out the SBCC activities afterwards.

2.2.2 SBCC Activities at the Community Level

SBCC Activities Conducted by CHVs. CHVs play a key role in delivering key health messages at the community level. On a daily basis, CHVs deliver key health messages through the following activities: 1) counseling sessions for clients (CU5 and WRA) who come to receive services at the health hut; 2) home visits; and 3) community-based education sessions. In FY2017, CHVs received and provided counseling to a total of 372,066 CU5 and 150,407 WRA in their health huts; conducting 105,504home visits and organizing 99,347 community-based education sessions. Total numbers of people reached by CHVs' SBCC activities are already presented above.

Use of *Ménages Modèles* and *Ménages Parrains* (Model Households) Approach to Create Sustainable SBCC Activities at the Community Level. As described above, the Program promotes key messages from the women's and children's cards to create a household card for use at the community level through the approach called *Ménages Modèles* and *Ménages Parrains*. The text in Box below explains how the approach works.

What is the *Ménages Modèles* and *Ménages Parrains* Approach?

1. Through their routine prevention and promotional activities in their community, CHVs identify families with pregnant women or CU5 and try to convince them to adopt the practices on the household card relevant to their situation. For example, a family with a pregnant woman will adopt the practices on the household card forfamilies with pregnant women. CHVs give household cards to interested families.
2. CHVs support and monitor the family to adopt all practices on the household card. Once the family fully adopts all practices on the card, CHVs inform the fokontany head for verification.
3. The fokontany head verifies and, if successful, then publicly announces the family as a *Ménage Modèle*, or model family. The *Ménage Modèle* then receives a certificate.
4. After receiving the *Ménage Modèle* status, the family is encouraged to convince other families with the same condition to adopt practices on the same household card. For example, a family that is *Ménage Modèle* for pregnant women will identify other families with a pregnant woman and convince them to adopt the essential practices for pregnant women. The original *Ménage Modèle* informs the CHVs about the interested or adopted families.
5. CHVs and the original *Ménage Modèle* then support the interested families in fulfilling all the practices on the household card. When the adopted families succeed, the fokontany heads verify and then also announce them as a *Ménage Modèle*.
6. After assisting two adopted families in becoming Ménages *Modèle*s, the original *Ménage Modèle* is declared by and will receive a certificate from the CHV and fokontany head as *Ménage Parrain*.
7. CHVs continue to encourage *ménages modèles* in one area to become *ménages modèles* and *ménages parrains* in other technical areas.

As the process continues, it creates a snowball effect in the communities.

Participation in the GOM-Organized Health and WASH Days. In FY2017, CHVs, fokontany heads, and Program staff participated in many high-visibility events organized by the government. In total,

511,979 people received key health messages at these events. Table 9 shows all the health and WASH days celebrations with Program participation at district, regional, and national levels and the numbers of people reached through these high visibility events. The celebration activities commonly carried out in these events are: exposition and service provision booths; parades; debates; sports activities; speeches; competitions; radio and TV broadcasting; and activities like theater, role plays, concerts, and dance. All activities focus on the health or WASH themes linked to the event.

Table 9 – Program's Participation in the Health and WASH Days Celebration in FY2017

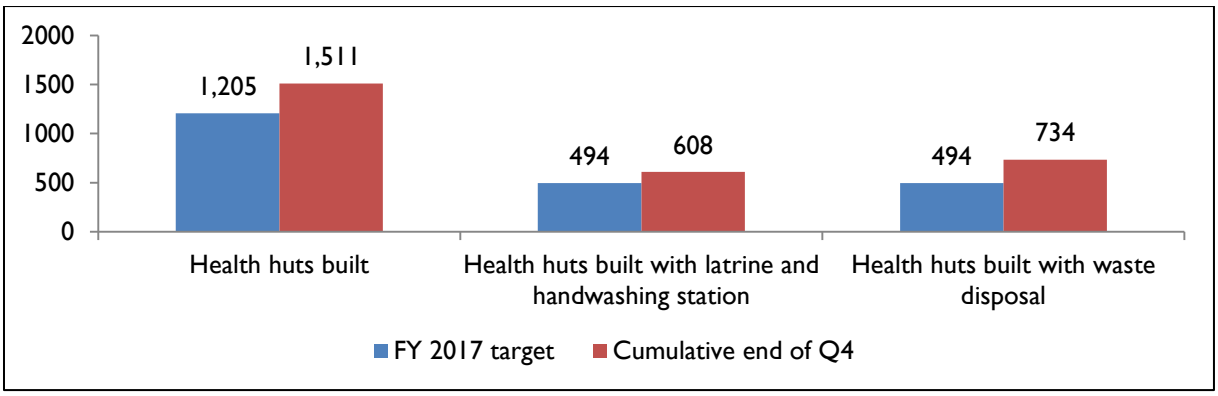
Health and WASH Days Participated by the Program (all seven regions and Antananarivo combined)	Number of People Reached
Global Handwashing Day	6,305
Maternal and Child Health Week	511,979
Polio Campaign	458,219
World Toilet Day	715
International Women's Day	26,788
World Water Day	2,726
Health World Day	3,861
Malaria World Day	112,970
Menstrual Hygiene Day	1,247
National Nutrition Day	16,840
International Youth Day & Children's Month	1,216
World Population Day	2,139
National Maternal Breastfeeding Week	105
World Contraception Day	760

A collage of photos from these events is presented in Figure 16.

Water, Sanitation, and Hygiene Activities (WASH)

Sanitation and Hygiene at CHVs' *Toby*: The Program continued to monitor the hygiene and sanitation facilities available at the health huts throughout the year. At the end of September 2017, the Program recorded 1,511 community-built health huts for CHV use. Figure 15 presents the sanitation and hygiene facilities communities have built at the health huts. The Program's strategy is to first encourage the community to build the health hut for CHVs. Once the hut is built and the CHVs begin working in the hut, the community is encouraged to build a latrine, handwashing station, and waste disposal pits. The gradual process makes it easier for the community to manage the expense. The Program will continue to make sure that all CHV health huts will eventually be equipped with hygiene and sanitation facilities.

Figure 15- Sanitation and Hygiene at CHVs' Health Hut as of September 30, 2017



Sanitation and Hygiene in the Community. The Program continued to promote the construction and use of improved latrines in all of its Program areas. At the end of September 2017, the Program recorded 6,067 new community-built latrines, surpassing the Program annual target of 5,988. With regard to the open defecation-free (ODF) evaluation and certification activities, the Regional Directorate for WASH evaluated a total of 266 communities and awarded ODF certificates to more than half (60 percent or 158 villages). The evaluation committee gives the communities that failed to pass the evaluation specific points to improve and sets the time for the next evaluation session.

DDS, USAID and Mahefa Miaraka demonstrate handwashing

Innovation: Television Highlight on WASH Activities in Menabe. The village of Andranofotsy in Belo sur Tsiribihina of Menabe region participated in the renovation of the latrine at CHVs health hut, which was featured and aired on national television. The episodes were an exciting and innovative way to promote WASH practices in the community.

Sub IA 2.3 Innovations to Promote Adolescent and Youth Health

2.3.1 Strengthening Local Structure to Promote Youth Health

During this year, the Program team supported and participated in a two-day workshop organized by the Directorate of Family Health (*Direction de la Santé Familiale, DSFa*) of the Ministry of Health. The goal of the workshop is to harmonize the key messages on youth reproductive health. A total of 88 messages related to the prevention of unwanted and early pregnancy, gender-based violence (GBV) and substance addiction among young people from all stakeholders and projects working in the area of youth reproductive health. The messages focused on youth behaviors, communication with parents, and family planning. The Program then submitted a list of messages to the MOH's Directorate of Health Promotion (*Direction de la Promotion de la Santé, DPS*) for final approval. The approved messages will then be used by all projects and development organizations in Madagascar for in-school and out-of-school youth activities.

2.3.2 School-Based Youth SBCC Activities

This year, the Program identified 38 schools to participate in the in-school family planning and reproductive health promotion and prevention activities. Jointly with the Regional and District Education Offices, the Program team contacted all of the identified schools and confirmed their interest in carrying out the activities in their school. The Program team also designed and developed

training curricula for different actors, including education officers, school teachers and administrators, parents, and students. The school-level activities will begin in Q1 FY2018.

2.3.3 SBCC Activities for Out-of-School Youth

Through the Program's multiple SBCC channels, namely the *Ménage Modèle* and *Ménage Parrain* approaches, as well as media diffusion and high visibility events, the Program expects to see an increase in the uptake of health services such as FP and the prevention and treatment of STIs, especially among youth. In addition, the CHVs promote the utilization of family planning services among youth at the community level through FP invitation cards. CHVs distribute FP invitation cards to young women who are regular FP users to give to other young women. In FY2017, CHVs distributed 44,585 FP cards to regular FP users.

Figure 16- Photo Collage from the High-Visibility Events in FY2017

Intervention Area 3: Health Service Planning, Management, and Governance

Key Achievements:

1. 709 CSBs conducted monthly meetings for CHVs in their catchment areas. Out of a total of 9,085 functioning CHVs, 5,680 (80 percent) attended these monthly meetings.
2. In FY2017, the Program began to participate in 262 regular review meetings with six regional health offices and 27 district health offices (SDSP), to review selected health indicators to monitor health performance at the commune and district levels.
3. 5,134 CHVs (73 percent of functioning CHVs) received supportive supervision visits in FY2017; out of which 2,714 CHVs or 53 percent were supervised by CSB heads.
4. Program staff participated in 80 GOM-led technical meetings and working groups.

Sub IA 3.0 Reinforcement of GOM Capacity

3.0.1 Coordination with MOH

Participation in Central GOM-Organized Technical Meetings and Workshops. In FY2017, the Program team took an active part in all GOM-led technical meetings and workshops relevant to community health activities. Examples of GOM health initiatives that Program staff participated in are:

- Preparation of the 2018 Country Malaria Operation Plan
- Quantification of the 2018 national FP product needs
- Revision of the community family planning and reproductive health training curriculum
- Revision of the National Community Health Policy
- Preparation of the family planning law
- Costed National Action Plan for Family Planning 2016-2020 (*Plan d'action national budgétisé pour la planification familiale 2016-2020)*
- National Family Planning and Reproductive Health Norms and Procedures
- National demographic dividend activities
- Community DQA tool development
- Universal health coverage
- Reaching Every Child approach in the expanded program on immunization

The Program team's participation in the workshops and meetings allows the Program to make sure its activities follow and respect the GOM's new or revised policies, norms, and standards. Additionally, the Program team is able to share field results and best practices to influence national-level decision making.

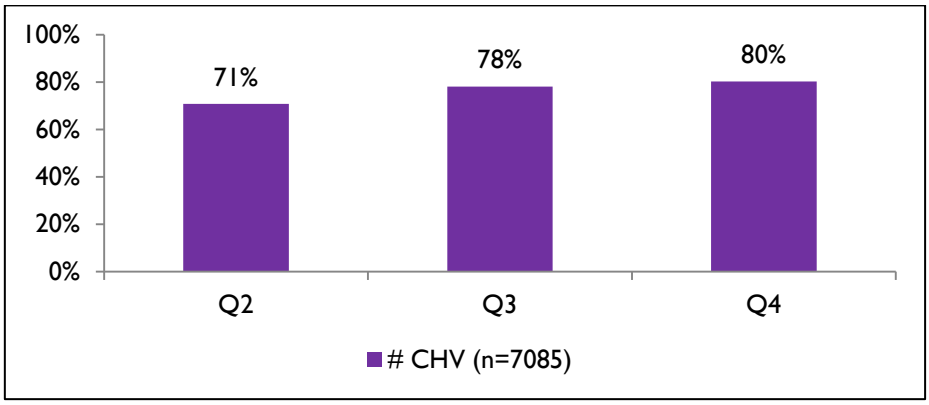
Capacity Building of GOM Officials. The cascading training approach resulted in a large number of GOM officials receiving training from the Program. A total of 4,325 GOM officials received an orientation from the Program on the PNSC, 1,075 on c-IMCI training of trainers (ToT), and 115 on social behavioral change communication and KMSm approaches ToT (Table 10).

Table 10 – GOM Officials Participating in Training of Trainers in FY2017

GOM Officials	PNSC Orientation	ToT on c-IMCI	ToT on SBCC and KMSm
GOM at regional level	212	54	9
GOM at district level	686	312	34
GOM at commune level	3,427	709	72
TOTAL	4,325	1,075	115

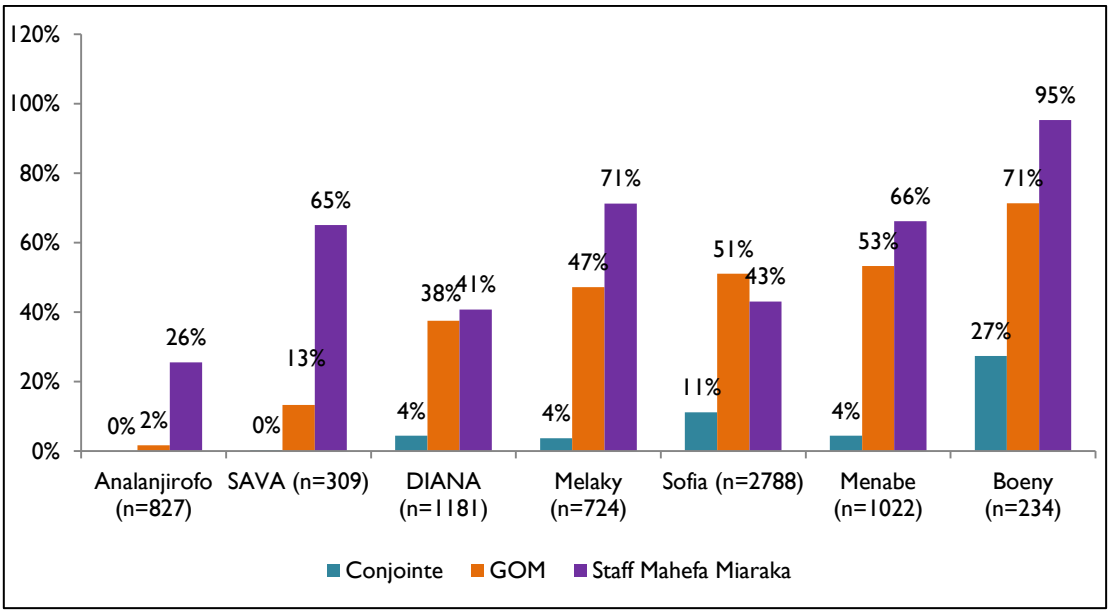
CHV Technical Supervision (monthly meetings and supportive supervision). CHV technical supervision is an important activity to ensure the quality of services CHVs provide. The USAID Community Capacity for Health Program conducts monthly meetings at CSBs and on-site supportive supervision in order to ensure that CHVs receive regular technical supervision. In FY2017, a total of 5,680 functioning CHVs attended the monthly meeting in September 2017, the highest monthly attendance for FY2017. The attendance rate increased throughout the year: 71 percent in Q2, 78 percent in Q3, and finally 80 percent in Q4 (Figure 17). The monthly meetings are an opportunity for CHVs to submit their monthly reports, receive updates and continued technical training, discuss work-related difficulties and challenges, and ask advice from CSB heads. Therefore, only functional CHVs are required to attend the monthly meeting since they are providing services.

Figure 17- CHV Attendance at the Monthly Meetings at CSBs by Quarters in FY2017



A total of 5,134 CHVs or 73 percent, in the Program's seven regions received supportive supervision in FY2017, out of which 66 percent were supervised by GOM (MOH, EMAR, EMAD and CSB heads) and 36 percent by the Program team (Figure 18). Similar to the monthly meeting at CSBs, supportive supervision is a good opportunity for CHVs to receive technical advice from the CSB and for the CSB to monitor if the CHVs provide good quality services in line with national norms and standards. The supervision visits by the CSB heads represented more than half of the supervisions conducted in FY2017 (2,714 or 53 percent). These supervisions visits are often combined with outreach activities, during which the CSB staff and the CHVs provided health services, including vaccination for children.

Figure 18- Onsite Supportive Supervision Received by CHVs in FY2017, by Region (n=7,085)



Sub IA 3.1. Introduction and Promotion of CSB Improvement

3.1.1 CSB improvements

This activity was postponed to FY2018 due to reduced funding in FY2017. The Program finalized the study protocol document for submission to the National Ethics Committee of the MOH. Due to the Committee's heavy schedule, the Program was instructed to submit in October 2017.

Sub IA 3.2. Pharmaceutical and Commodity Forecasting

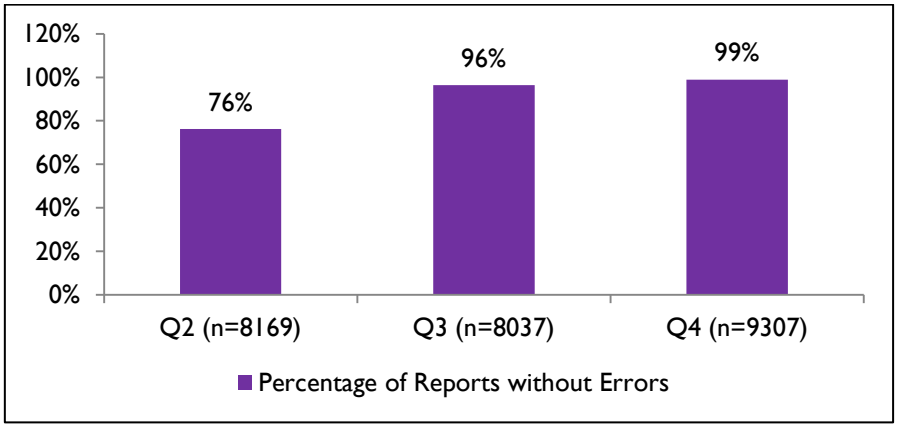
During this reporting year, Program staff participated in 23 meetings/workshops related to national supply of community health products, as reported in IA1. Additionally, the Program team attended a monthly coordination meeting with the team from the PSI/ISM and PSM projects to discuss details of collaboration at the national, regional, and district levels to ensure availability of essential health products for CHVs in the Program areas. Additionally, the Program also began to provide information on CHV stock outs regarding child health and family planning tracer products on a monthly basis at the national level (to PSI/ISM for the child health and family planning products other than malaria), as well as to the National Malaria Control Program or *Direction de Lutte contre le Paludisme, DLP* for the malaria products. As reported in IA 1, this effort has yielded promising results as the stock out rate continued to decrease from quarter to quarter during FY2017. The Program will continue to monitor, report, and coordinate at community and national levels to make sure the health products are available for CHVs to provide services.

Sub IA 3.3. Health Data Quality, Management, and Use

3.3.1 CHV Monthly Reporting to CSB

Quality of CHV Reports. In FY2017, the Program trained 5,932 CHVs on the correct use of the MOH's monthly report form and on the importance of data quality. The monthly review using CHVs' data (explained below) also reinforces the importance of correct and on-time reporting. CSB heads and CHVs are now more aware that the results of their work, as shown in the monthly dashboards of their performance, depend on the quality of their monthly reports. Monthly reports with missing or incoherent data, or that contain other errors will not be registered in the Program database, so the results appear as if the CHVs did not provide services. This practice has made both the CHVs and the CSB heads aware of the importance of good quality data and motivated them to make sure the CHV reports have no errors. As shown in Figure 19, the Program observed an increase in number of CHV reports without errors throughout the year.

Figure 19- Progress in Quality of the CHV Monthly Reports in FY2017*



*Note: CHVs began reporting in Q2 in FY2017.

Data Use: In FY2017, the Program team started a monthly review exercise with the government health offices at the district and commune levels. Using the list of health indicators, jointly selected by the DRSP and the Program team, the Program developed a dashboard of 19 selected indicators and now generates and shares this information on a monthly basis with the MOH teams at the regional, district, and CSB levels. The monthly review sessions helped the regional, district, and CSB teams monitor community health performance, the functionality and quality of the CHV services, and the quality and rate of CHV monthly reports, in addition to assisting them in identifying potential outbreaks. The monthly review meeting is also an opportunity for the SDSP, Program teams, CSB heads, and CHVs to make a joint plan to improve health performance in their respective communes and districts. By the end of September 2017, the Program participated in 35 meetings at the regional level (with participation from 21 district health offices or SDSP) and 227 meetings at the district level (with participation of 94 CSB).

3.3.2 Integration of CHV Data into MOH's Health Management Information System (HMIS)

At the beginning of Q1 FY2017, the MOH informed the Program team that 1) the Program should only enter CHV data but not CSB data, as previously discussed, and 2) MOH's GESIS (data) system can only be managed by SDSP staff. Therefore, the Program managed the CHV data in order to allow sharing with MOH at the district level and integrating into the MOH's current GESIS system. In addition, the CHV data are to be shared at the regional level. Since May 2017, the Program has been exporting monthly CHV data from the 24 districts where CHVs are functional into the SDSP's HMIS. As reported above, the Project also shares CHV data on a monthly basis with the MOH officials at the regional, district, and commune levels. As reported above, the Program team participated in 20 workshops and meetings at the national level related to Health Management Information System (HMIS) organized by the MOH.

3.3.3 Integrated Community-Based Surveillance of Preventable Diseases

During FY2017, The Program team had several coordination meetings with the MOH/DPEV/DDS, GAVI, and Maternal and Child Survival Program (MCSP) teams to improve vaccination coverage and completion in the program areas. The Program simplified the MOH's job aid on community surveillance for community-level use, including rolling out the "Reach Every Child" approach to strengthen immunization coverage. As reported under IA1, a total of 6,410 CHVs received training on community surveillance in FY2017 and started reporting to their CSB on the community surveillance and vaccination activities. Also during this year, the CHVs and Program teams in Analanjirofo, Boeny, Melaky, Menabe, SAVA, and Sofia regions participated in MOH's urgent efforts to respond to the malaria and/or plague outbreaks (photo collage below).

3.3.4 Data Use for Performance Review

As reported earlier under the section on "Capacity Building of GOM Officials," the Program started to use a list of selected indicators at the district level, generated by the Program database, to monitor program progress on a monthly basis and prepare improvement plans.

Sub IA 3.4. Referral System Strengthening between CHVs and CSBs

3.4.1 Referral System between CHVs and CSBs

Progress in this area was already reported under IA1.

3.4.2 Referral System between Health and Other Services

As already reported under IA1, the Program began a process to conduct a study on gender-based violence (GBV) to identify available services related to GBV in the program areas and how they can be linked to the current health-care system at the community level. The information generated from this study will be shared among relevant GOM stakeholders and community leaders in all Program areas. The study protocol on GBV was finalized, submitted, presented and approved by the National Ethics Committee in August 2017. Currently, the Program is preparing for the field survey which will take place in Q1 FY2018.

Monitoring and Evaluation, Learning Management, and Cross-Cutting Issues

Sub IA 4.1 Program Monitoring, Evaluation, and Performance System

Key Achievements:

1. Program data system is fully functioning and used on a regular basis for Program review.
2. CHV monthly reporting rates increased from 69 percent in Q2 to 84 percent in September Q4.
3. A total of 121 data quality assessment (DQA) sessions were conducted in FY2017, improving the quality of the monthly reports CHVs submit.
4. Data use (review of health indicators) is jointly done on a regular basis with the district and regional health offices.
5. The Program disseminated its results and innovations through four national-level conferences and three international-level conferences.

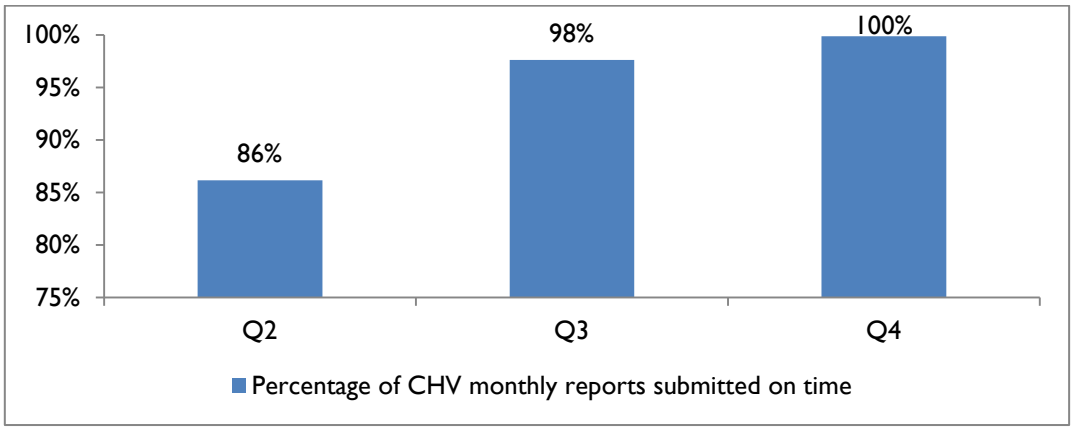
4.1.1 Data Management

During this reporting year, the Program team finalized the collection/reporting tools for use at all levels of the Program, from the fokontany level to the central level. To ensure a well-functioning information system, the Program conducted two workshops to build the capacity of Program staff members on: 1) the M&E system, including data collection tools and data processing for 227 program staff members at the district and regional levels; and 2) training on data quality and data use for 27 staff members at the regional and central levels.

4.1.2 Data Reporting, Quality, and Use

The PNSC and MOH's note (*article 3 of arrêté no. 21022/2015-MSANP*) states that all CHVs submit reports to the CSB detailing their health activities every month. CSB heads check and approve all CHV monthly reports (with signature and official stamp). The Program and/or the health district team processes only approved monthly reports. The average reporting rate among functional CHVs was 82 percent at the end of September 2017. Figure 20 shows a substantial improvement in the timing of report submission. At the end of FY2017, all the CHV reports received in the Program were submitted on time, compared to only 86 percent in Q2 (Figure 20).

Figure 20- Percentage of CHV Reports Submitted On Time by Quarter in FY2017



The Program team also conducted data quality assessments (DQAs) on a regular basis throughout FY2017. During the DQAs, the CHVs' monthly reports were checked against different health records kept at a CHV's health hut. The assessments are designed to make sure that the data are coherent and that CHVs correctly recorded their health data and then accurately transferred the

data into their monthly report forms. In total, the Program team conducted DQA for 121 sites (total of 242 CHVs). The assessments revealed the following: 1) a shortage or lack of integrated record books at the health hut or non-use of the record books for some services; and 2) errors in reporting some indicators for both CU5 and WRA. The results of the DQA were shared with CSB heads and Program staff so they can help CHVs make corrections and avoid similar errors in the future. In FY2017, the Program team developed and sent two job aids to CSB heads that addressed how to efficiently check CHV monthly reports and how to count and report FP users. The CSB heads are encouraged to review and use these two job aids to detect and make corrections immediately when CHVs make mistakes in their reports.

CSB heads checking CHV's monthly reports

4.1.3 Technology Use to Improve Health Services

As of the end of this fiscal year, the Program's data system allowed online access for Program staff at the regional and districts levels. Consequently, the Program's regional and district teams are now able to generate monthly dashboards or report on selected indicators themselves, instead of receiving these from the central office.

Sub IA 4.2 Learning Management

4.2.1 Studies, Surveys, and Review Workshops for Improvement of Program Performance

The studies and surveys planned in the Program were already reported under IA1, IA2, and IA3.

4.2.2 Dissemination

During this reporting year, the Program issued two editions of the Zara ny Efa community newsletter, which presents Program information, community actors' achievements, and technical updates for CHVs. Approximately 19,000 community actors, partners, and Program staff received these two editions (Box below).

Cover page for the two editions of the newsletter Zara ny Efa in FY2017

In addition to participating in the high-visibility events to share the Program innovations and achievements as reported in IA2, the Program disseminated its results in events both in and out of Madagascar. Examples of the Program's dissemination are presented below.

Support MOH to attend the 2017 Institutionalizing Community Health Conference (27 – 30 March, 2017), Johannesburg, South Africa

Dissemination at the ECOWAS Forum on Good Practices in Health (18 - 20 April, 2017), Ouagadougou, Burkina Faso

Dissemination at the Africa Transportation Technology Transfer (T2) Conference (08 - 10 May, 2017), Livingstone, Zambia

Dissemination at the Promotion of Essential Family Practices (PFE) (24 November 2016), Antananarivo, Madagascar

Dissemination at the MOH Grand Staff (28 November to 02 December 2016), Antsiranana, Madagascar

Dissemination at the America Week (25 – 26 April, 2017), Antananarivo, Madagascar

Sub IA 4.3 Cross-Cutting Issues

- **Sustainability Mechanisms.** As presented throughout this report, the USAID Community Capacity for Health Program continued to promote a sense of ownership among and develop the capacity of GOM officials at the local level and other community actors through start-up workshops and technical trainings. Using the cascade training approach, the Program trained GOM officials at each level to conduct the training for their own staff members.
- **Gender Equality and Female Empowerment.** The Program took actions to ensure and promote gender equality and female empowerment within the Program team, as well as in Program activities. *Mahefa Miaraka* continued to participate in national-level gender working group meetings.
- **Environmental Compliance.** During FY2017, *Mahefa Miaraka* started sharing the Program's Environmental Mitigation and Monitoring Plan (EMMP) with 13,304 people: CHVs, Fokontany heads, CCDS members, GOM, program staff, others. The Environmental Mitigation and Monitoring Report (EMMR) is presented in Annex 5. Additionally, the Program finalized the waste management plan poster CSBs and CHVs use according to the instructions from the Mission Environmental Officer (MEO).
- **Family Planning Compliance.** During the fiscal year, all 254 Program staff had completed and received certificates for the "US Abortion and FP Requirements – 2017" and "Protecting Life in Global Health Assistance and Statutory Abortion Restrictions" online family planning courses. All new staff will complete the course as part of their orientation.

Challenges and Proposed Solutions for FY2017

CHALLENGES	SOLUTIONS
1. Shortage of Essential Commodities	• Hold coordination meeting with MOH, PSI, and PSM • Negotiate availability of commodities at CSBs for CHVs with CSBs, SDSP, and *Direction Régionale de la Santé Publique* • Work with CSB heads and CHVs to manage stock available at the CSB level and make sure CSB heads share their stock with CHVs • Communicate with PSI at the regional level when the PSI supply points (PAs) have stock out
2. Support to peripheral staff at all levels to ensure program quality and achievement of objectives and targets.	• Through the orientation and internal technical workshops and regular meetings/interactions among the teams, all staff developed an in-depth understanding of the FY2017 work plan and technical procedures and standards
3. Uneven or limited GOM ownership of community activities, including training and supervising CHVs.	• Involvement of the GOM during the activities (launches, trainings, and monthly meetings) • Joint planning and making sure that all program activities are integrated into the MOH annual work plan and all challenges are discussed with the GOM for joint solutions
4. Safety of staff and security of Program financial resources for implementation of activities in the field levels (district and commune)	• Mobile banking • Use security agents at *Mahefa Miaraka* offices • Implementation of additional security procedures for regional teams
5. Inaccessibility in some sites due to rain and flooding	• Adapt the timing of some activities during this period
6. Some CHVs are unable to fill in the new record book and monthly report forms	• Identify gaps during supervision, monthly meetings, and verification at the SDSP and build capacity

CHALLENGES	SOLUTIONS
of MOH, including data on distribution of health cards and FP invitation cards	accordingly at CHV monthly meetings at CSB. • Conduct formative supervision for CHVs during on-site supervision visits by CSB, EMAD, and the program. • Use the peer approach to ensure that CHVs fill in correctly and check their management tools
7. Resurgence of malaria in some districts	• Remind the *Mahefa Miaraka* team at district level to report abnormal increases in cases in their areas as soon as possible • Reinforce malaria prevention activities by CHVs in their communities (LLITN use, and mosquito habitat cleaning).
8. Stock out of CHV management tools	• Organize dispatch of the tools to CHVs with the SDSP and CSB • Find local solutions
9. Low participation in the monthly meeting resulting in issue of timeliness of CHV report submission	• Collaborate with CSB to sensitize CHVs in participating in monthly meeting • Collaborate with CSB to collect late CHV monthly reports

Administrative and Financial Management

Key Achievements:

1. All 41 offices were fully staffed and equipped.
2. The Program signed a memorandum of understanding (MOU) with seven organizations and projects at the end of FY2017.
3. *Mahefa Miaraka* initiated electronic payments in selected zones.
4. Shortage of funding in FY2017 caused adjustments in program activities in Q3 and Q4.

Sub IA 0. 1 Operation (Administration, Finance, and Partnership)

0.1.1 Administrative and Financial System

Throughout FY2017, the administrative and financial teams in all offices continued activities according to the systems established. The Program's Operations Manual was revised to accommodate practical implementations in the field to ensure compliant and efficient work all the way to the CSB level, while continuing to preserve Program resources.

Sub IA 0. 2 Administration

At the end of September 2017, all program offices including at the district-level were all fully functioning. Monitoring visits and on-the-job support are regularly provided by central level staff to the regional and district teams.

0.2.1 Human Resources

By the end of September 2017, the program had filled 96 percent of all positions. Just as in the previous quarters, the Program faced a small number of resignations from staff in order to pursue Public Health courses, from staff having secured civil servant positions within the Government, or from staff having found positions in less remote areas. This staff turn-over rate will continue over the life of the Program considering the total number of staff and the high professional level of the Program staff. The Program's Human Resources systems are strong and the Program has built-in contingency plans to adapt for such turn-over that is inevitable for such large programs.

The transition between the outgoing and in-coming Director of Finance and Administration was smooth. The Program's finance and operations systems continue to be strong.

Different groups of regional and district staff had received a series of capacity building sessions throughout FY2017, as well as Program orientation for the next fiscal year's workplan. This served as important capacity building for regional and district staff and ensured streamlined efforts moving forward.

0.2.2 Information and Technology Systems

Efforts in Information Technology (IT) continued to focus on equipping the program team with necessary electronic equipment (laptops, printers, and cameras), the best use of such equipment throughout the Program's intervention zones, and the challenges faced due to power shortages. Maintaining connectivity with satellite offices remains a challenge with the poor quality of service ISPs outside Antananarivo. The Program is prioritizing the use of laptops over desktops to mitigate challenges faced by power shortages.

0.2.3 Procurement and Distribution Management

The procurement and distribution team provides bi-monthly updates to the technical staff on the supply chain process. Customs and administrative clearances for seven out of the nine four-wheel drive vehicles and 41 motorcycles for use at the regional and district program offices are still underway and follow-up is done regularly with MOH, the Customs Offices and the forwarding agent. The procurement and distribution of the CHV materials and kits continue to be improved including the latest practice of packaging the kits for each CHV and sending it to their CSB, instead of packaging the kits for each commune as previously done.

0.2.4 GOM and Partner Management

The Program continued to collaborate with several GOM offices on labor law, taxes, and other operations to ensure that the Program's operations are in line with the evolving national regulations. By the end of Q4, 26 MOUs had been signed with Public Health District Offices for the use of office space by Mahefa Miaraka staff.

In FY2017, the Program signed an MOU with seven organizations and projects namely:

1. **Blue Ventures**: The Program collaborates with Blue Ventures to strengthen population, health, and environment (PHE) interventions through integrated family planning, MNCH, and environmental conservation services in Belo sur Mer in the Morondava district in Menabe, and in Maintirano, Betanatanana, in the Maintirano district in Melaky and in Ambanja district in DIANA.
2. **Louvain Cooperation Madagascar**: The Program collaborates with Louvain Cooperation Madagascar to increase access to community health services and products in the six most underserved communes in the districts of Belo sur Tsiribihina and Morondava in the Menabe region.
3. ***Secrétariat Exécutif du Comité National de Lutte contre le Sida* (SE/CNLS):** The Program collaborates with SE/CNLS for the listeners' group activities in the seven Program regions.
4. **US Peace Corps:** The Program works with Peace Corps Volunteers on a variety of community health activities including malaria, WASH, and nutrition.
5. **Global Vaccine Alliance:** The Program works with the Global Alliance for Vaccines and Immunization (GAVI) program on the MOH's community vaccination activities.
6. **USAID/MEASURE Evaluation:** The Program works with MEASURE on the MOH's activities related to Health Management Information System (HMIS).
7. **Television Malagasy (TVM):** The Program works with TVM to produce and air television series on health and WASH messages.

0.2.5 Reporting to USAID and GOM

In addition to the timely submission of all other progress reports throughout the life of the Program, all progress reports (technical and financial) were submitted to USAID on time as stated in the Program's cooperative agreement. After the approval by the Program's agreement officer representative, the reports were uploaded to the DEC. For the GOM, only the regular monthly reporting for staff Income Revenue was due and was submitted by the due date.

Sub IA 0.3 Financial Management

0.3.1 Financial Procedures

During the year, the Program received the support from JSI's home office through a field visit from the Financial and Operations Manager of the Boston office. This support followed a strategic start up

visit from JSI's Director of Finance and Operations during Program start-up. This was an opportunity to perform a review of the administrative and financial operations of the Program. Process has been tracked back to the CHV level to the central office recording stage. Selected regional level document review was performed as well.

The scale-up of the mobile money cash transfer activity will be done on a request basis from the districts offices upon availability of reception by the ultimate beneficiaries as well cash-payment points at the commune level. This is an ongoing activity during this quarter and beyond.

0.3.2 Financial Reporting to USAID

As reported above, throughout FY2017, the Program submitted the required financial reports (SF425 and accruals reports) to USAID on a timely manner.

0.3.3 VAT (Value Added Tax)

The Program continued to submit VAT reimbursement requests to the MOH in order to comply with the procedure discussed with the Implementing Partners. As reported previously, the MOH agreed to process VAT reimbursements for the purchase of motorbikes on an exceptional basis. Follow-up is done on regular manner with the vendor.

0.3.4 Expenditures

The Program recorded a total of $ 229,806.31of cost share in FY2017. The collection of the Cost Share is running as planned, as shown in Table 11 below. The Program continues to seek cost share and will report to USAID on a quarterly basis.

Table 11 – Program Cost Share as of September 30, 2017

ORIGIN	USD
ASOS (for joint program activities)	57,575.82
BLUE VENTURES (for joint program activities)	9,978.21
WAHO – West Africa Health Organizations Ouest Africaine de la Santé (support a staff participation at the conference on CHX in Burkina Faso)	3,524.12
Government of China (for ACT)	76,071.27
Madagascar MOH (office space and minor rehabilitation)	82,656.89
TOTAL	**229,806.31**

A summary of Program expenditures through September 30, 2017 is presented in Table 12 below. The Program continues to report its expenditures distributed by source of funding.

Table 12 – Program's Cumulative Expenses as of September 30, 2017

BUDGET LINE ITEMS	TOTAL EXPENDITURES AS OF SEPTEMBER 30, 2017 (IN US$)	TOTAL EXPENDITURES BY FUNDING TYPE			
		A049-Malaria	A052-MCH	A053-FP/RH	A054-Water
SALARIES	1,861,986	824,405	568,119	316,759	152,703
CONSULTANTS	5,743	2,543	1,752	977	471
TRAVEL, TRANSPORTATION, AND PER DIEM	218,751	96,853	66,744	37,214	17,940
ALLOWANCES	100,615	44,548	30,699	17,117	8,252
EQUIPEMENT, MATERIALS, AND SUPPLIES	993,982	440,091	303,278	169,095	81,517
OTHER DIRECT COSTS	483,682	214,153	147,578	82,283	39,667
PROGRAM COSTS	2,900,264	1,284,109	884,912	493,390	237,853
SUBRECIPIENTS	471,524	208,770	143,869	80,215	38,670
TOTAL DIRECT COSTS	**7,036,548**	**3,115,474**	**2,146,952**	**1,197,050**	**577,073**
INDIRECT COSTS / OVERHEAD	292,483	129,499	89,241	49,757	23,987
TOTAL COSTS	**7,329,031**	**3,244,972**	**2,236,193**	**1,246,806**	**601,059**
COST SHARE	229,806				
GRAND TOTAL	**7,558,837**				

DISCLAIMER

This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this document are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.

USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM - *Mahefa Miaraka*

Cooperative Agreement No. AID-687-A-16-00001

FY2017 Annual Report
October 1, 2016 to September 30, 2017

ANNEXES

USAID FROM THE AMERICAN PEOPLE

Mahefa Miaraka

JSI RESEARCH & TRAINING INSTITUTE, INC.

USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM - *Mahefa Miaraka*

FY2017 Annual Report
October 1, 2016 to September 30, 2017

ANNEXES

Cooperative Agreement No. AID-687-A-16-00001

Submitted to:
Dr. Jocelyne ANDRIAMIADANA, AOR
USAID/Madagascar in Antananarivo, Madagascar

Prepared by:
JSI Research & Training Institute, Inc.
USAID Community Capacity for Health Program – *Mahefa Miaraka*
JSI Research & Training Institute, Inc.
Résidence Lavalley
Près Lot IIK 50H Mahatony
Alarobia, Antananarivo (101)

Tel: 20.22.425.78/ 79

DISCLAIMER:
This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this document are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.

List of Annexes

Annex 1. Dashboards of Key Health Indicators

Annex 2. Activity Table FY2017

Annex 3. Project Performance Review, PPR

Annex 4. Program Monitoring and Evaluation Plan (PMEP)

Annex 5. Environment Monitoring and Mitigation Report (EMMR)

Annex 6. List of Communes in Mahefa Miaraka Program in FY2017

Annex 7. Success Stories

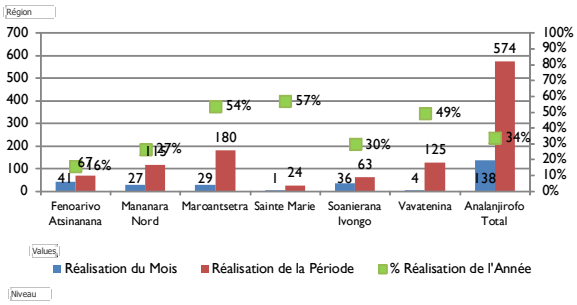
Annex 8. International Trips at the End of Q4 FY2017

TABLEAU DE BORD – COMMUNAUTAIRE

REGION ANALANJIROFO – Janvier à Août 2017

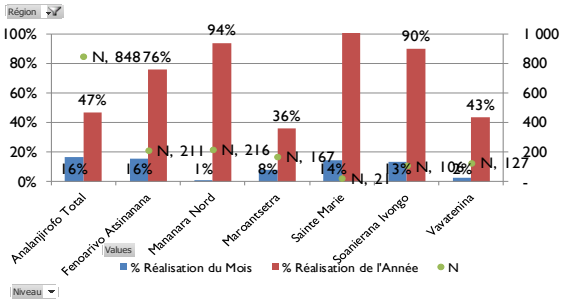
Les Structures PNSC

1. Nombre des AC fonctionnels en Prise en charge et Référence)



De janvier à août 2017, 574 AC (dont 138 au cours du mois d'août) sont rendus fonctionnels en Promotion de la Santé. Ce qui représente 34% de l'objectif de l'année.

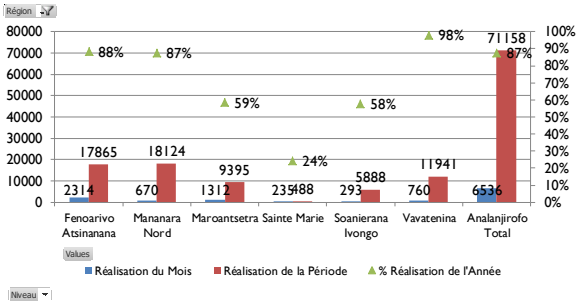
2. Pourcentage de fokontany avec site permanent et équipé



De janvier à août 2017, sur les 848 Fokontany, 16% (dont 13% au cours du mois d'août) ont un site permanent et équipé.

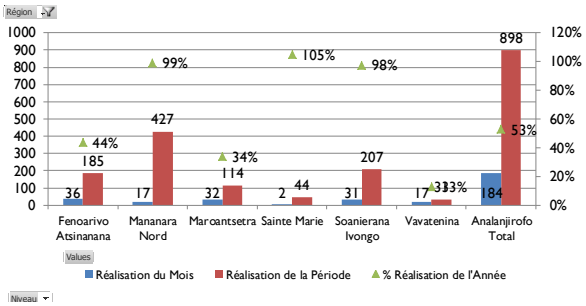
Les Services d'Accompagnements clés

3. Nombre de personnes sensibilisées par les AC



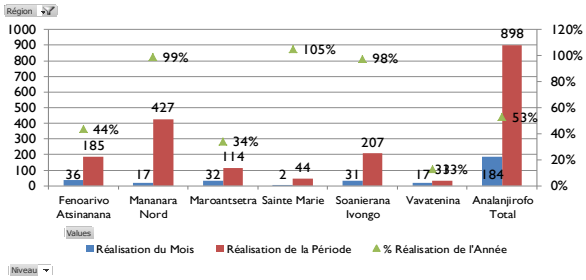
De janvier à août 2017, 71158 personnes (dont 116 au cours du mois d'août) ont été sensibilisés par les AC. Ce qui représente 87% de l'objectif de l'année.

4A. Nombre d'AC supervisés (non clinique)



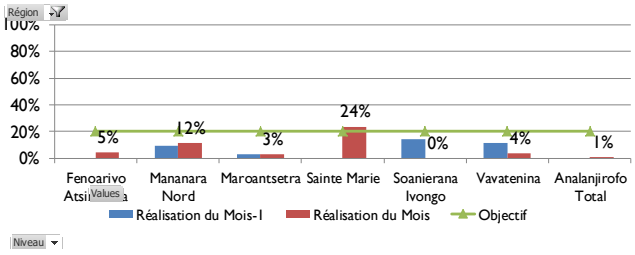
De janvier à août 2017, 898 AC (dont 184 au cours du mois d'août) ont été supervisés (non clinique). Ce qui représente 53% de l'objectif de l'année.

4B. Nombre d'AC supervisés (clinique)



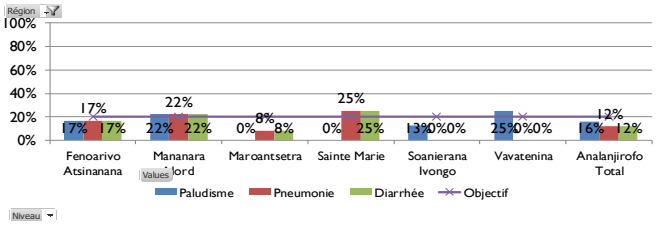
De janvier à août 2017, 898 AC (dont 184 au cours du mois d'août) ont été supervisés (clinique). Ce qui représente 53% de l'objectif de l'année.

5. Pourcentage des sites ayant rupture de stock en médicaments traceurs planning familial



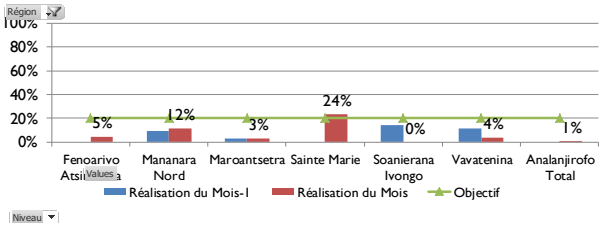
Au mois d'août 2017, 1% des sites ont une rupture de stock en médicaments traceurs PF. Ce pourcentage atteint un niveau supérieur à la limite à Sainte Marie (24%).

6. Pourcentage des sites ayant rupture de stock en médicaments traceurs pour le paludisme-pneumonie-diarrhée



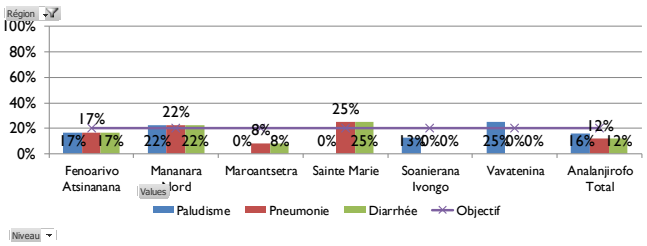
Au mois d'août 2017, respectivement 16%, 12% et 12% des sites ont une rupture de stock en médicaments traceurs pour le paludisme, pneumonie et diarrhée. Ce pourcentage atteint un niveau supérieur à la limite à Sainte Marie (25%) pour la pneumonie et diarrhée.

7. Nombre des CSB ayant rupture de stock en médicaments traceurs planning familial



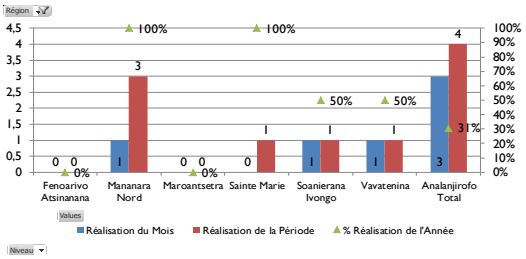
Au mois d'août 2017, 1% des CSB ont une rupture de stock en médicaments traceurs PF. Ce pourcentage atteint un niveau supérieur à la limite à Sainte Marie (24%).

8. Nombre des CSB ayant rupture de stock en médicaments traceurs pour le paludisme-pneumonie-diarrhée



Au mois d'août 2017, respectivement 16%, 12% et 12% des CSB ont une rupture de stock en médicaments traceurs pour le paludisme, pneumonie et diarrhée. Ce pourcentage atteint un niveau supérieur à la limite à Sainte Marie (25%) pour la pneumonie et diarrhée.

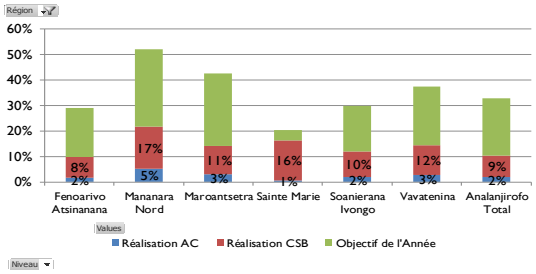
9. Nombre de village ODF



De janvier à août 2017, 4 villages (dont 3 au cours du mois d'août) ont été certifiés ODF. Ce qui représente 31% de l'objectif de l'année.

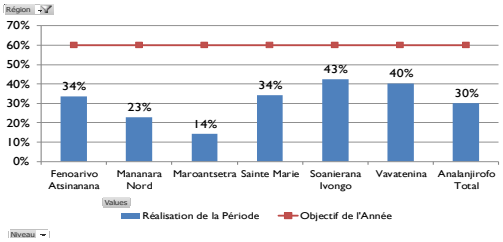
Les Services cliniques clés pour les Femmes en âge de procréer

10. Taux de Couverture Contraceptive des AC et CSB



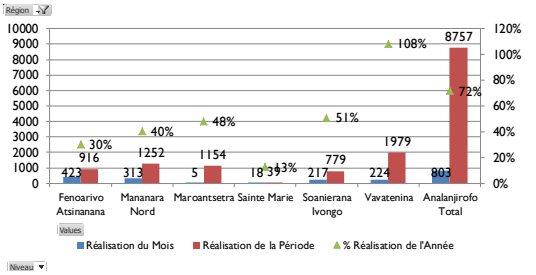
Au mois d'août 2017, le TCC des AC et CSB est de 11%. Ce qui représente moins de la moitié de l'objectif de l'année.

11. Taux d'accouchement au centre



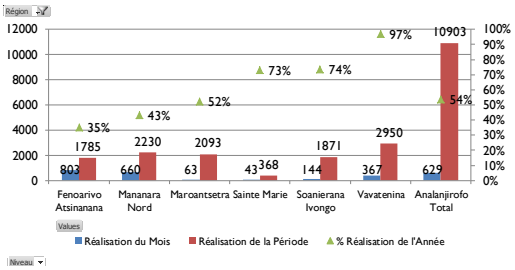
Au mois d'août 2017, 30% des femmes ont accouché au CSB. Ce qui représente moins la moitié de l'objectif de l'année.

12. Nombre de femmes enceintes référées pour CPN4



De janvier à août 2017, 8757 femmes enceintes ont été référées par les AC pour CPN4. Ce qui représente 72% de l'objectif de l'année.

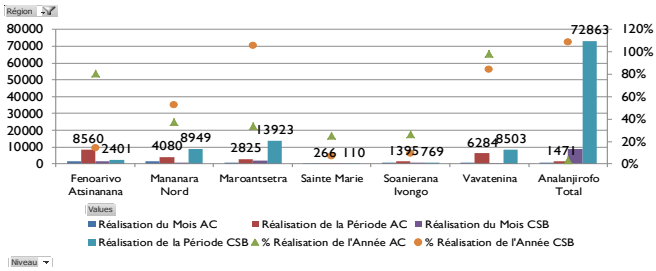
13. Nombre des femmes enceintes ayant fait 4 CPN



De janvier à août 2017, 10903 femmes enceintes ont effectué 4 CPN (dont 629 au cours du mois d'août). Ce qui représente 54% de l'objectif de l'année.

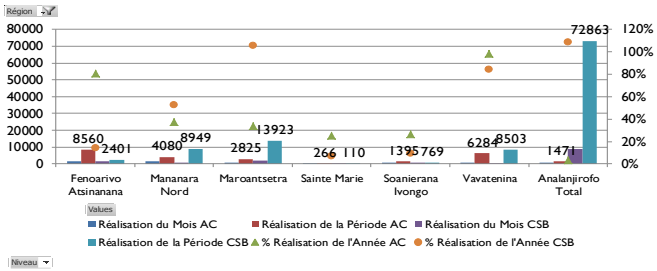
Les Services cliniques clés pour les Enfants de moins de 5 ans

14. Nombre des enfants < 5 ans TDR+ traités AC / CSB



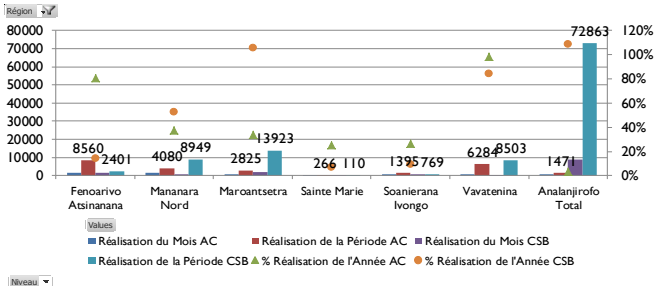
De janvier à août 2017, 1471 enfants de moins de 5 ans TDR+ ont été traités par les AC et 72863 par les CSB. Ces résultats représentent 5% et 100% de l'objectif de l'année respectivement pour les AC et CSB.

15. Nombre des enfants < 5 ans avec pneumonie traités AC / CSB



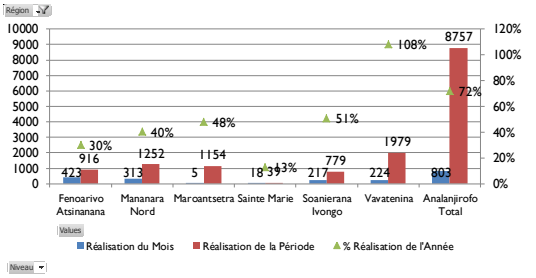
De janvier à août 2017, 1471 enfants de moins de 5 ans avec pneumonie ont été traités par les AC et 72863 par les CSB. Ces résultats représentent 5% et 100% de l'objectif de l'année respectivement pour les AC et CSB.

16. Nombre des enfants de moins de 5 ans avec diarrhée traités AC / CSB



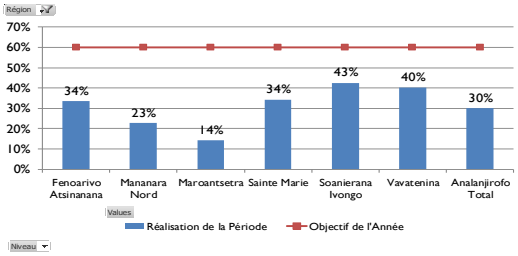
De janvier à août 2017, 1471 enfants de moins de 5 ans avec diarrhée ont été traités par les AC et 72863 par les CSB. Ces résultats représentent 5% et 100% de l'objectif de l'année respectivement pour les AC et CSB.

17. Références vaccination



De janvier à août 2017, 8757 enfants ont été référées par les AC pour vaccination. Ce qui représente 72% de l'objectif de l'année.

18. Taux de couverture DTC3



Au mois d'août 2017, 30% des enfants ont été vaccinés en DTC3 au CSB. Ce qui représente moins la moitié de l'objectif de l'année.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 Results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
0. Overall Field Operations														
0.0 Start-Up and annual planning Activities														
0.0.1 One-Time Start up Activities														
X	X	X	X	X	0	0	1	1	Conduct regional launch of the CCH program in the regions (combined with the regional annual start-up workshops)	# of regional launch workshops	5 (Boeny, Melaky, DIANA, SAVA, and Analanjirofo)	4	One region completed their workshop earlier than planned in FY2016	
0.0.2 Annual Planning Activities														
X	X	X	X	X	0	0	2	1	Submit next year (FY2018) annual implementation plan to USAID	Annual implementation plan submitted and approved by USAID	1	1		
0.1 OPERATIONS (Administration. Finance. and Partnership)														
0.1.1 Administrative and financial operations system														
X	X	X	X	X	0	1	1	4	Update as needed the program Operations Manual and Employee Manual and provide annual refresher training to staff	% of staff oriented on the updates	100%	100%		

The activity that carries over many fiscal years has the same activity code. The activity code under the same category continues from the last fiscal year.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 Results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
0. Overall Field Operations														
0.2 Administration														
0.2.1 Human Resources Management														
X	X	X	X	X	0	2	1	2	Recruit program staff as needed	% of staff recruited over the positions in the staffing plan	100%	93%		
X	X	X	X	X	0	2	1	3	Provide orientation to staff in CCH's operations, technical approaches, and M&E system	% of staff trained	100%	100%		
			X		0	2	1	4	Train relevant CCHP staff and stakeholders on FP compliance	# and % of relevant CCH staff who receive certificate from the FP online course	100%	100%		
										# and % of stakeholders who receive training on USAID FP compliance	N/A	NA		
X	X	X	X	X	0	2	1	5	Provide ongoing capacity building for staff at central, regional and district levels	% of staff benefiting from capacity building activity	100%	100%		

The activity that carries over many fiscal years has the same activity code. The activity code under the same category continues from the last fiscal year.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 Results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
0. Overall Field Operations														
0.2.2 Information and Technology System														
X	X	X	X	X	0	2	2	1	Set up and maintain IT system at program offices	# of CCHP offices with functioning electronic equipment	8	8		
X	X	X	X	X	0	2	2	2	Conduct training to staff in use and maintain computer equipment as part of staff orientation	% of staff trained	100%	100%		
X	X	X	X	X	0	2	2	3	Improve database for administrative and financial information	% of CCH office use electronic data base for administration and finance purposes	100%	100%		
0.2.3 Procurement and Distribution Management														
X	X	X	X	X	0	2	3	2	Develop the annual procurement plan	# of annual procurement plan developed	1 (FY2018)	1		

The activity that carries over many fiscal years has the same activity code. The activity code under the same category continues from the last fiscal year.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 Results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
0. Overall Field Operations														
X	X	X	X	X	0	2	3	3	Start and monitor procurement process based on annual procurement plan	% of procurement plan successfully carried out	100%	93%		
X	X	X	X	X	0	2	3	4	Communicate and inform CCH team members acquisition and distribution process and provide status updates on a regular basis	# of internal information sharing sessions on procurement and distribution organized	50	64		
0.2.4 GOM and Partner Management														
X	X	X	X	X	0	2	4	3	Establish formal partnership (via MOU) with US and non-US partners	# of partners with signed MOU	7	7		
0.2.5 Reporting to USAID and GOM														
X	X	X	X	X	0	2	5	1	Submit annual report to USAID	# of final report approved by USAID and uploaded on DEC	1 (for FY2016)	1		
X	X	X	X	X	0	2	5	2	Submit quarterly progress report to USAID	# of progress report approved and uploaded on DEC	4	3		

The activity that carries over many fiscal years has the same activity code. The activity code under the same category continues from the last fiscal year.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 Results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
0. Overall Field Operations														
X	X	X	X	X	0	2	5	3	Submit annual report to GOM	# of annual report submitted to GOM	1 (for 2016)	1		
0.3 Financial Management														
0.3.1 Financial procedures														
X	X	X	X	X	0	3	1	1	Set up and operationalize CCHP financial system	# of offices with functioning financial system in place	8	8		
X	X	X	X	X	0	3	1	2	Improve operations system as needed and orient staff	% of CCHP staff oriented on the new financial updates	100%	100%		
0.3.2 Financial Reporting to USAID														
X	X	X	X	X	0	3	2	1	Submit quarterly accruals report to USAID	# of accruals report submitted to USAID	4	4		
X	X	X	X	X	0	3	2	2	Submit quarterly financial report or SF425 form to USAID	# of SF425 submitted to USAID	4	3		
0.3.3 VAT														
X	X	X	X	X	0	3	3	1	Submit and follow-up regularly on VAT reimbursement requests with MOH/DLUM	# of VAT requests submitted to MOH (every year in May)	1	8	VAT requests were submitted monthly instead of annually	

The activity that carries over many fiscal years has the same activity code. The activity code under the same category continues from the last fiscal year.

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
1.1 Increasing skills and competencies of CHV in priority intervention to reduce maternal, neonatal and child mortality as well as in data collection and use														
1.1.1 Reinforcement of capacity of members of PNSC structures at commune and Fokontany level on CHVs' priority interventions														
X	X	X	X	X	1	1	1	1	Organize three-day regional start-up workshops with local stakeholders	# participants in regional start up workshops	185	265	Participants of the workshop also ncluded CDDS members and Mahefa Miaraka staff at district level, which were not originally planned.	
X	X	X	X	X	1	1	1	2	Organize the same workshop as above at the district and commune levels	# participants in the district and commune start up workshops	14 367	17 612	Though only 3 CCDS members per commune were invited, in reality more number of CCDS members attended the workshop.	
X	X	X	X	X	1	1	1	3	Identify and assist to create if the PNSC structure is not yet created at the commune and FKT levels (this activity is to be done during the district launch workshop)	# of PNSC coordination structure set up at the regional level	7	7		
										# of PNSC coordination structure set up at the district level	34	34		
										# of PNSC coordination structure set up at the commune level	456	456		
										# of PNSC coordination structure set up at the fokontany level	4 887	4 877		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
X	X	X	X	X	1	1	1	4	Provide orientation on PNSC, CHV's priority interventions and roles of PNSC local structures to support CHVs to carry out their activities (orientation to be done at the district launch workshop or COSAN FKT monthly meeting)	# of members at the regional and district levels oriented on PNSC, their role and CHVs activities	874	959		
										# of CCDS members oriented on PNSC, their role and CHVs activities	1 386	1 546	Though only 3 CCDS members per commune were invited, in reality more number of CCDS members attended the workshop.	
										# of FKT heads oriented on PNSC, their role and CHVs activities	4 555	3 881		
1.1.2 Pre-service training. continuing learning and supervision of CHVs														
X	X	X	X	X	1	1	2	2	Identify existing CHVs in each region during the regional and/or district start-up workshops including training they had already received	List of existing CHVs with training record	5	7		
X	X	X	X	X	1	1	2	3	**For on-going 24 districts**: Conduct refresher training for CHVs according to MOH's revised training curriculum (series of training can be carried out as seperate training or part of the monthly meeting at CSB)	# of CHVs who are trained in data management tools for on-going districts	5 850	5 932		
										# and % of CHVs who are trained, and certified in ongoing districts (c-IMCI)	2 485	2 556		
										# of CHVs who are trained on Miso and CHX in ongoing districts	5 850	5 682		
										# of CHVs who are trained on nutrition in ongoing districts	5 596	6 575		
										# of CHVs who are trained on Community surveillance in ongoing districts	5 850	5 680		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
X	X	X	X	X	1	1	2	4	**For new 10 districts:** Identify existence of CHV (CoSan FKT) and assist the FKT to select and nominate officially if it doesn't exist	# of FKT that have nominated CHVs	1 739	1 740		
X	X	X	X	X	1	1	2	5	**For new 10 districts:** Conduct initial training for CHVs in new districts	# of CHVs who are trained and certified in new districts (c-IMCI)	585	898	Due to reduced funding level in FY2017, the Program reduced the target. However, despite the reduced budget, the Program was able to reach the target.	
										# of CHVs who are trained on Community surveillance in new districts	1 568	730	Due to reduced funding level in FY2017, the Program conducted the training mainly in former districts.	
X	X	X	X	X	1	1	2	6	**For alll districts:** CHVs receive regular supervision visits from FKT head and CCDS members (CCDS will use tablet for continuing learning of CHVs) - more information on e-learning is presented under IA3	# CHVs who receive on-site supervision visits conducted by FKT heads - non clinical	952	952		
										# CHVs who receive on-site supervision visits conducted by CCDS member - non clinical	128	128		
										# of CHVs who receive on-site supervision conducted by CSB staff - clinical	3 030	2 714		
										# of CHVs who receive on-site supervision conducted by EMAD and EMAR - clinical	663	959		
										# of CHVs who receive on-site supervision conducted by MOH - clinical	30	30		
										# of CHVs who receive on-site supervision conducted by CCH staff - clinical	2 385	2 081		
										# of CHVs who receive on-site supervision conducted by CCH staff - non clinical	2 040	2 711		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
X	X	X	X	X	1	1	2	7	Support monthly meeting for COSAN FKT namely CHVs and FKT heads (organized by CSB) --- this activity is also reported under IA3)	# of CHVs participating in the monthly meeting	5 850	5 680		
										# of FKT heads participating in the monthly meeting	1 900	2 347		
										# of CCDS members participating in the monthly meeting	233	214		
X	X	X	X	X	1	1	3	1	Develop CHV service quality assessment tools	developped	5	5		
1.1.4 Women and youth friendly environment and services														
X	X	X	X	X	1	1	4	2	Design a study on gender-based violence	# protocol approved	1	1		
1.1.5 Equipment (appropriate work tools. job aid and materials) for PNSC structure at the commune and FKT level (CCDS and COSAN FKT)														
X	X	X	X	X	1	1	5	1	Provide necessary materials. tools and jobaids to CCDS members and COSAN FKT members (CHV and FKT chief). (materials for GOM are presented under IA3)	# of CCDS members who receive work tools, materials and jobaids	81	195		
										#of CHV who receive work tools, materials and jobaids	7 418	7 877		
										# of FKT head who receive work tools, materials and jobaids	1 900	1 976		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
1.1.6 Motivation activities for COSAN FKT (CHV) and FKT heads														
					1	1	6	2	Review motivation activities for COSAN (CHVs and FKT heads) namely social recognition through KMSm. CSC. exchange visits. income generation activities. participating in program activities at the regional and national levels	# of document describing motivation activities for the CCH program	1	1		
										# of community actors who receive paid employment or dividend from the eBox (note - paid employees should not counted twice if they are also member of the cooperative)	100	100		
										# of FKT-level actors who participate in the income generation activities	68	86		
X	X	X	X	X	1	1	6	3	Encourage the community to build and/or equip permanent health hut (Toby) for CHVs	# of CHVs who work in the Toby built by the community	2 411	3 022		
										# of Toby equipped with a minimum of table, chair and shelf	1 500	1 342		
1.2 Sustainability of the CHV model including full integration of CHV into the formal public system														
1.2.1 Supportive supervision to COSAN FKT namely CHVs and FKT heads (supervision by GOM presented under IA3)														
X	X	X	X	X	1	2	1	1	Support supervision visits to CHVs from COSAN, CCDS, and CCH staff) ---- same as activity 1.1.2.6 ---	# of FKT heads receive supervision visits conducted by CCDS members	Same activities (1.1.2.6) as above therefore not repeating here			
										# of CHV receive supervision visits conducted by FKT heads				
										# of CHV receive supervision visits conducted by CCDS members				

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
1.3 Strengthening of community structures. including CoSan and CCDS to improve health and sanitation planning														
1.3.1. Functionality and reinforcement of community health structure														
X	X	X	X	X	1	3	1	1	Identify exisitng and encourage the regions that haven't yet established PNSC structure at all levels and assist them to do so	# of region and district that have PNSC structure (coordination and operational structures) in place from regional to FKT level	Same activities (1.1.1.3 and 1.1.1.4) as above therefore not repeating here			
X	X	X	X	X	1	3	1	2	Support the district to convene a quarterly coordination/program review meeting among PNSC actors	# of district that convene quarterly coordination/program review meeting	9	9		
1.3.2. Using Champion Commune or KMSm Approach to manage community health														
X	X	X	X	X	1	3	2	2	Review one pager (including approach and indicators) on KMSm during the regional and district launch workshops	# of districts conducting the KMSm review sessions	34	34		
										# of KMSm tools developped and pretested	1	1		
										# of members of PNSC coordination structures KMSm participated in the KMSm pre-test	125	125		
1.4 Promoting universal health care access and coverage. including entitlement programs (e.g. GOM equity fund). micro-insurance (i.e. mutuelle) and emergency transport system														
1.4.1 Increase access to health care via health financing scheme (mutuelle. solidarity fund and equity fund)														
X	X	X	X		1	4	1	2	Design the situational analysis of micro health financing schemes	# of protocol approved by the national IRB	1	0		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity	2nd Sub - Activity						
Intervention Area 1 (IA1): Community Engagement and Ownership of Health Services														
X	X	X	X		1	4	1	5	Assist the communes to carry out their CCHP micro health insurance (mutuelle. solidarity and equity fund) (existing and new communes with mutuelle)	# of communes continuing their mutuelle activities (existing communes with mutuelle)	17	17		
X	X	X	X		1	4	1	6	Conduct a rapid review of the mutuelle de santé activities	# of people who participate in the review session # of workshop held	56	56		
1.4.2 Increase access to health care via emergency transport														
X	X	X	X		1	4	2	2	Conduct ETS review workshop with relevant stakehoders at the district. commune and FKT levels (to be done during the district launch workshop)	# of people who participate in the review workshop, by type of their role	1 020	1 055		
X	X	X	X		1	4	2	3	**For FKT with existing means of emergency transport provided by MAHEFA**: Continue support to FKTs to make sure the functionality and use of the emergency transports	# /% of USG- supported fokontany (village) with functioning ETS	100	95		
X	X	X	X		1	4	2	4	**For all FKT**: Assist CSB. CCDS and COSAN FKT (FKT heads and CHVs) to develop their health emergency evacuation plan and monitor use	# Fkt who have a written emergency evacuation plan	2 234	2 393		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
Intervention Area 2 (IA2): Behavior change and health promotion														
2.1 Community-level health promotion and sensitization to increase healthy behavior and uptake of health services and products														
2.1.1 SBCC strategy. approaches. materials and tools														
X	X	X	X	X	2	1	1	4	Based on the results of the review of SBCC strategy, approach and tools. update SBCC training curricula for use at the commune and FKT levels by CCDS, CSB, FKT heads and CHVs	# of training cirricula updated	2	2		
X	X	X	X	X	2	1	1	6	Based on the results of the evaluation, update or develop Small Doable Actions (SDA) for use in CCHP	# of small and doable actions adopted for CCH	56	49	Due to reduced funding level in FY2017, the Program reduced the number of household cards to develop in FY2017. They will be done in FY2018.	
X	X	X	X	X	2	1	1	7	Among the key actions above, identify 8-10 SDA for use at the community level	# of small and doable actions adopted for use at the community level	8-10	7		
X	X	X	X	X	2	1	1	8	Participate in the SBCC national coordination meetings to ensure coherence key health messages	# of meeting participated (at least one per quarter)	At least 4	16		
2.1.2. Repositioning the woman's and child's health cards as the cornerstone of SBCC strategies														
X	X	X	X	X	2	1	2	2	Encourage the use of women and children health cards to promote important health messages	# of women health cards distributed by CHVs	120 677	119 928		
										# of women health cards distributed by CSB	23 110	23 110		
										# of child health cards distributed by CHVs	120 677	119 928		
										# of child health cards distributed by CSB	23 110	23 110		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
Intervention Area 2 (IA2): Behavior change and health promotion														
2.1.3. Development and/or reproduction and dissemination of tools and information, education and communication (IEC) materials for use by CHVs and CSBs														
X	X	X	X	X	2	1	3	2	Update or develop SBCC tools and products based on the strategy and SDA (including new and emerging technical areas using the continuum of care, GBV, youth, FP invitation cards and capitalize use of health cards)	# of SBCC tools and materials updated or newly developped and aligned with the continuum of care	9	4		
X	X	X	X	X	2	1	3	3	Distribute revised SBCC tools and materials to, train CSB, CCDS, FKT heads and CHVs and monitor use	# of people exposed to health messages through CHV education sessions using IEC materials	865 025	608 902		
2.2 Capacity of community stakeholders to assess community needs, develop key messages and advocate for improved services														
2.2.1 SBCC skill-building for community leaders														
X	X	X	X	X	2	2	1	2	Train community stakeholders (COSAN: FKT heads and CHVs and CCDS members) on SBCC to promote and advocate for improved services and utilization per the continuum of care	# of CCDS members trained on SBCC	71	72		
										# of CHVs FKT heads trained on SBCC	7 418	7 877		
2.2.2 Roll out SBCC activities at the community level														
X	X	X	X	X	2	2	2	1	Participate in the GOM led health days celebration and health campaigns	# of health day celebration and campaigns participated	10	11		
X	X	X	X	X	2	2	2	2	Support community actors to carry out SBCC activities (accompanied and reported by CHVs and FKT heads)	# of beneficiaries exposed to health messages through CHV sensitization or IEC materials (home visit)	139 234	130 996		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
Intervention Area 2 (IA2): Behavior change and health promotion														
X	X	X	X	X	2	2	2	3	Identify radio reception zones and communities with access to radio in new communes	# of media products disseminated by types of products	13	13		
										# of radio station broadcasting health messages	28	28		
X	X	X	X	X	2	2	2	4	Revise facilitator materials for radio listening groups	# List of RLG updates	1	1		
										# of facilitator's materials developped	1	0		
X	X	X	X	X	2	2	2	6	Support CCDS and CoSan (non clinical side of CCDS and CoSan) to begin promotion of WASH activities including sale of sur'eau and latrine slabs	# of improved latrine newly built by households	5 988	6 067		
										# of people gaining access to an improved sanitation facility	27 545	27 908		
										# of villages that receive official ODF certification	279	156		
				X	2	2	2	7	Support CHV and CSB in good hygiene and waste management practices	# of permanent Toby with latrine and handwashing station with soap	494	842		
										# of permanent Toby equipped with waste disposal pit	494	1 138		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA Number	Activity Number	1st Sub - Activity No.	2nd Sub - Activity No.						
Intervention Area 2 (IA2): Behavior change and health promotion														
2.3. Innovations to promote adolescent and youth health, with a focus on reaching rural, underserved and married														
2.3.1 Strenghthening local structure to promote youth health														
2.3.2 School-based youth SBCC activities														
			X		2	3	2	2	Put in place youth health activities in school and train teachers	# of schools that participate in the high-visbility health day events organized by the commune, district and region	-	97		
										# of messages on youth developped and approved by MOH	TBD	0		
										# of schools selected and begin preparatory activities	38	38		
										# of GOM officials who participate in the preparation activities	6	6		
										# of parents who participate in the preparation activities	63	63		
										# of teachers who participate in the preparation	24	24		
										# of youth who participate in the preparation	13	13	-	-
2.3.3 SBCC activities for out-of-school youth														
			X		2	3	3	2	Work with married youth who are FP regular users to distribute FP invitation cards to their peers	# of FP invitation cards distributed by married youth who are FP regular users	87 750	44 585	Due to reduced funding level in FY2017, the Program conducted the training mainly in former districts.	
										% of new users of modern contraception (age 15-19)	TBD	39%		
										Couple-years of protection or CYP	53 000	70 901		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
3.0 Reinforcement of GOM capacity to provide technical training and supportive supervision to CHVs and community leaders														
3.0.1 Coordination with MOH														
X	X	X	X	X	3	0	1	4	Formalize existing MOH technical experts as cohort of national "community health champions"	National community health champion group established and functional	1	1		
										# meetings conducted by National community health champion group	4	11		
X	X	X	X	X	3	0	1	6	Hold regional quarterly review meetings	# of regional review meetings held	8	8		
										# of district review meetings held	43	43		
X	X	X	X	X	3	0	1	7	Work with MOH and USAID to establish and jointly manage a national technology platform for community health	# of meetings participated	5	5		
3.0.2 Capacity reinforcement and materials for GOM in community health at regional, district and commune level														
X	X	X	X	X	3	0	2	1	Conduct series of TOT for EMAR and EMAD on: a) community health b) priority interventions by CHVs including SBCC readjusted to match continuum of care model c) data management d) community logistics e) youth, women friendly services and GBV f) supportive supervision including use of tablet g) referral and counter referral --- training to be conducted in combination with MOH quarterly coordination meeting	# EMAR that become trainers and train CSB	35	47		
										# EMAD that become trainers and train CSB	207	269		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
X	X	X	X	X	3	0	2	2	Conduct series of TOT for CSB on: a) community health b) priority interventions by CHVs including SBCC c) data management d) community logistics e) youth, women friendly services and GBV f) supportive supervision including use of tablet g) referral and counter referral system --- training to be conducted in combination with MOH quarterly coordination meeting	# CSB that become trainers for CHV -- data on CHVs trained presented under IA1)	732	709		
X	X	X	X	X	3	0	2	3	Provide necessary materials, tools and jobaids to CCDS, CHVs, COSANs, and YPEs (materials for GOM are presented under IA3)	# of EMAR who receive work tools, materials and jobaids	35	47		
										# of EMAD who receive work tools, materials and jobaids	207	269		
										# of CSB who receive work tools, materials and jobaids	732	709		
3.0.3 Technical supervision by GOM for CHVs (monthly meeting and supportive supervision)														
X	X	X	X	X	3	0	3	1	Support monthly meetings (CHV *regroupements*) for CHVs and other COSAN members at CSB level	# of CHV participate in the monthly meeting at CSB	5 850	5 680		
										# of FKT heads participate in the monthly meeting at CSB	1 900	2 347		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
X	X	X	X	X	3	0	3	2	Support supervision visits to CHVs from COSAN, CCDS, CSB representatives, EMAD, EMAR, MOH, and CCH staff, including use of tablets (for CHV eLearning and report on supervision)	# of CHVs who receive on-site supervision conducted by CSB in the last three months	3 030	2 714		
										# of CHVs who receive on-site supervision conducted by EMAD -clinical in the last three months	663	870		
										# of CHVs who receive on-site supervision conducted by EMAR - clinical in the last three months	14	89		
										# of CHVs who receive on-site supervision conducted by MOH - clinical in the last three months	18	30		
										# of CSB who conduct CHV supervisions visits	601	657		
										# of EMAD who conduct CHV supervisions visits	68	141		
										# of EMAR who conduct CHV supervisions visits	14	11		
3.1 Introduction and promotion of non-clinical quality improvement process and tools (e.g patient flow, strategic use and placement of IEC materials), etc														
3.1.1 Non-clinical CSB improvements														
					3	1	1	2	Design CSB survey	Number of survey protocol approved by the national IRB	1	1		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
3.2 Pharmaceutical and commodity forecasting in order to ensure that CSBs order commodities in a timely manner, maintain appropraite stock levels and maintain appropriate storage conditions facility and CHV use														
3.2.1 Community logistics to ensure unruptured supply of health commodities at CHV														
X	X	X	X	X	3	2	1	1	Participate in GOM and USAID led logistics coordination groups	# of meeting participated	8	18	Due to continued issues on stock out at community level	
X	X	X	X	X	3	2	1	2	Hold coordination meeting with PSI/ISM program and set up regular meeting schedule	# of meeting held	5	9	Due to continued issues on stock out at community level	
X	X	X	X	X	3	2	1	3	Participate in DPLMT/UTGL activities related to commodities availability for CSB and CHVs	# of meeting held	4	9	Due to continued issues on stock out at community level	
3.3 Health data quality, management and use to improve patient outcomes; and reinforcement and/or development of community-based surveillance systems														
3.3.1 CHV monthly reporting to CSB														
X	X	X	X	X	3	3	1	3	Assist SDSP to process monthly reports from CSB data into MOH's HMIS system	# of district who successfully process CSB monthly reports into their HMIS	34	24		
X	X	X	X	X	3	3	1	4	Monitor a submission of the CHV's monthly reports to CSB	# of CHV monthly reports approved by CSB	21 121	27 729	More CHVs submitted their monthly report than planned.	
3.3.2 Integration of data from CHV routine reporting into MOH's HMIS														
X	X	X	X	X	3	3	2	2	Jointly with SDSP enter CHV monthly reports into computerized health information system (both for the program data base and for SDSP data base)	# of district who successfully integrate CHV data into their HMIS on a monthly basis	24	24		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
3.3.3 Integrated Community-based surveillance of preventable diseases														
X	X	X	X	X	3	3	3	1	Provide support as needed to DRSP in 16 IEP priority districts to implement action plans for emergency response	# campaigns and MNCHW participated	4	5		
X	X				3	3	3	2	Assist EMAR, EMAD and CSB in supporting CHVs to conduct community surveillance of preventable diseases based on MOH protocol	# of CHVs trained and conducted community preventable diseases surveillance activities	7 418	6 410	Due to reduced funding level in FY2017, the Program conducted the training mainly in former districts	
3.3.4 Data use for performance review														
3.3.5 Sharing best practices and lessons learned among CSB and other community health actors														
X	X	X	X	X	3	3	5	1	Jointly with MOH and DRS form the learning summit committee to develop scope of work including eligibility and process of the summit at both national and regional levels	# of selection criteria and selection process developed	1	0		
X	X	X	X	X	3	3	5	2	Organize annual regional learning summit (each commune submits 1 abstract to the district, district submits 2 abstracts to the region, region selects 1 abstract per district)	# of participants at the summit	420	0		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY217 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Intervention Area 3 (IA3):Health service planning, management and governance														
3.4 Referral system streghtening between CHVs and CSBs to increase preventive care and prompt treatment; and streghtening referral between health and other services (e.e gender violence)														
3.4.1 Referral system between CHVs and CSBs														
X	X	X	X		3	4	1	1	Review exisiting referral and counter referral system between CHVs and CSBs and identify ways for improvement	# Referal and counter referal document updated	1	1		
X	X	X	X		3	4	1	2	Jointly with EMAR/EMAD, monitor the use of improved referral system including CSB and CCDS using tablets to manage referral system of pregnant women and children with danger sign	# of pregnant women referred to health facility by CHVs and received ANC 4	20 627	23 210		
										# of pregnant women referred by CHVs for delivery at CSBs	12 173	14 188		
										# of CU5 referred to health facility by CHVs and received all of the series of vaccination	42 293	43 385		
										# of CU5 with danger signed referred from CHV to CSB	6 736	6 590		
										# and % of counter referred pregnant women who are seen by CHVs for follow-up	10 444	20 704	The Program monitors this very closely which made both CHV and their clients more aware of the importance of the referals and counter-referals.	
										# and % of counter referred CU5 who are seen by CHVs for follow-up	7 252	45 314		
										# of women referred by CHV for long-term FP who receive service from CSB	1 289	2 190		
										# of women referred by CHV for long-term FP who receive service from MSM mobile clinic	3 748	7 070		
3.4.2 Referral system between health and other services (e.g gender violence)														

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Cross-Cutting or IA 4. Monitoring and Evaluation, Performance and Learning Management														
4.1 Program monitoring, evaluation and performance system														
4.1.1 Data Management														
x	x	x	x	x	4	1	1	3	Train CCHP staff in the program M&E	# of people trained in the M&E	220	227		
x	x	x	x	x	4	1	1	4	Set up computerized data management system	# of computerized data system functional	1	3		
x	x	x	x	x	4	1	1	5	Manage routine program data from many sources: CHV's RMA, supervision trips, and program activities reports	% of reports submitted (by types)	75%	84%	More CHVs submitted their monthly report than planned.	
					4	1	1	6	Provide initial and on-the-job training to M&E staff and SDSP responsible for data management	# of M&E staff trained to manage data	128	127		
x	x	x	x	x	4	1	1	7	Conduct internal DQA at all levels	# of internal DQA conducted by CCH team	84	121		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Cross-Cutting or IA 4. Monitoring and Evaluation, Performance and Learning Management														
4.1.2 Data use														
X	X	X	X	X	4	1	2	1	Adapt database and dashboards for CCHP use	# dashboards developped	4	6		
X	X	X	X	X	4	1	2	2	Use the program routine data in the quaterly coordination meeting/program review	% of quaterly program review/coordination meeting held that presents program data	100%	-		
4.1.3 Technology use to improve health services														
X	X	X	X	X	4	1	3	1	Develop e-Health system for program use	# e-Health system developped	1	1		-
X	X	X	X	X	4	1	3	2	Test the e-health system in selected communes	# modules validated	3	3		-
4.2 Learning Management														
4.2.1 Studies, survey and review workshops for improvement of program performance														
X	X				4	2	1	5	Review of ETS system (conducted by CCH team during the regional and district start-up workshop)	# of review conducted	34	38		
X	X	X	X	X	4	2	1	6	Review of KMSm approach (conducted by CCH team during the regional and district start-up workshop)	# of review conducted	34	38		

Annex 2: Activity Table FY2017

Program codes									Planned activities	Indicators	FY2017 targets revised	FY2017 results	Explanation of delays/gaps	Next steps to address gaps
MNCH	MALARIA	NUTRITION	FP/RH	WASH	Sub-IA	Activity	1st Sub -	2nd Sub -						
Cross-Cutting or IA 4. Monitoring and Evaluation, Performance and Learning Management														
X	X	X	X	X	4	2	1	7	Review of referal and counter referal system between CHV and CSB (conducted by CCH team duirng the regional and district start-up workshop)	# of review conducted	39	38		
X	X	X	X	X	4	2	1	8	Review of selected community-based SBCC approaches namely YPE, menage parrain and RLG (conducted by CCH team during the regional and district start-up workshop)	# of review conducted	39	38		-
4.2.2 Dissemination														
X	X	X	X	X	4	2	2	1	Regional launch of the CCH program in the remaining regions (combined with the 3 day regional start-up workshops)	# of regional launch workshops	4	4		
X	X	X	X	X	4	2	2	2	Implement the Learning Management Plan	% of the activities in the plan that are carried out	100%	100%		
X	X	X	X	X	4	2	2	3	Feature program highlights in USAID newsletter on a quarterly basis	# highlights submited to USAID	4	7		
X	X	X	X	X	4	2	2	4	Present data in the CHV newsletter Zara ny Efa on a quarterly basis	# of Zara ny Efa editions	38 000	38 000		
X	X	X	X	X	4	2	2	5	Present program results in meetings, conference both national and international	# of meetings participated	10	29	More nationals meeting were organized by the MOH and partners	

ANNEX 3: PERFORMANCE PLAN AND REPORT

USAID codes	Technical themes/Indicators from approved FY2017 workplan	FY2017 Annual Target		Achieved in FY2017	DEVIATION	Comments
Family Planning						
7.2-2	Number of of USG assisted CHVs providing FP information, referrals, and/or services during the year	Male	3,268	3,158		On target
		Female	2,179	2,106		
		Total	**5,447**	**5,264**	**-3%**	
MCH						
No code	Number of newborns receiving chlorhexidine as part of the new born essential care	Boys	5,630	2,203		Due to the prioritization of the c-IMCI training and to the limited availability of CSB heads for CHV training, the CHX refresher training did not start until Q3. The Program will ctach up the difference in FY2018.
		Girls	5,630	2,203		
		Total	**11,260**	**4,405**	**-61%**	
WATSAN						
3.1.6.8-5	Number of communities certifies as "open defecation free" (ODF) as a result of USG assistance	**Total**	**279**	**158**	**-43%**	Due to reduced funding level in FY2017, the Program team could not follow up and support the communtities to achieve the open free defecation status as planned. In addition, the WASH government officials often were not available to make trips for ODF evaluation. The Program will ctach up the difference in FY2018.
3.1.1.2-2	Number of people gaining access to an improved sanitation facility	Male	13,772	13,954	-	On target
		Female	13,772	13,954	-	
		Total	**27,545**	**27,908**	**1%**	
NUTRITION						
3.1.6 9-1	Number of women reached with education on exclusive breastfeeding	Male	N/A	N/A		In April 2017 the Program resubmitted and received approval from USAID for its FY2017 workplan due to shortage of fund for the Program. Consequently, in this approved workplan, the target was revised from 210,000 to 126,000. However, the USAID Appsheet does not allow us to revise the annual target. This is why it may appear that the Program does not reach its FY2017 targets. In reality the Program surpassed the target for this indicator by 11% (140,057 women reached against 126,000 target) due to more sensitization sessions done by CHVs.
		Female	210,000	**140,057**		
		Total	**210,000**	**140,057**	**-33%**	

USAID codes	Technical themes/Indicators from approved FY2017 workplan	FY2017 Annual Target		Achieved in FY2017	DEVIATION	Comments
3.1.9.1-15	Number of children reached by USG-supported nutrition programs	Male	211,500	121,946		In April 2017 the Program resubmitted and received approval from USAID for its FY2017 workplan due to shortage of fund available for the Program. Consequently, in this approved workplan, the target was revised from 450,000 to 220,782. However, the USAID Appsheet does not allow us to enter the revised and approved annual target for this indicator. This is why it may appear that the Program does not reach its FY2017 targets. In reality, the Program surpassed the annual target for this indicator by 18% (260,475 CU5 reached against 220,782 target) due to more sensitization activities done by CHVs.
		Female	238,500	141,102		
		Total	**450,000**	**263,048**	**-42%**	
HL.9.2	Number of children under two (0-23 months) reached with community-level nutrition interventions trhough USG-supported programs	Male	104,181	83,366		In April 2017 the Program resubmitted and received approval from USAID for its FY2017 workplan due to shortage of fund available for the Program. Consequently, in this approved workplan, the target was revised from 221,661 to 120,684. However, the USAID Appsheet does not allow us to enter the revised and approved annual target for this indicator. In reality, in FY2017 the Program exceeded by 49% due to an increase of the number of counseling sessions given at the CHVs health huts (planned at about 7 people counselled per month per health hut but in reality reached 10 people per month per health hut).
		Female	117,480	96,858		
		Total	**221,661**	**180,224**	**-19%**	
HL.9.3	Number of pregnant women reached with nutrition interventions through USG-supported programs	**Total**	**59,956**	**48,638**	**-19%**	The target of an average of one pregnant woman per month was not reached by CHVs, only 0.8 pregnant woman per month was reached.
HL.9.4	Number of individuals receiving nutrition-related professional training through USG-supported programs	Male	2,901	3,873		Training was also conducted in some communes of the new districts of the Program.
		Female	2,965	2,702		
		Total	**5,866**	**6,575**	**12%**	

USAID codes	Technical themes/Indicators from approved FY2017 workplan	FY2017 Annual Target		Achieved in FY2017	DEVIATION	Comments
CUSTOM						
No code	Number of communities having developped a transportation system for health emergency	**Total**	**17**	NA	NA	In April 2017 the Program resubmitted and received approval from USAID for its FY2017 workplan due to shortage of fund available for the Program. Consequently, in this approved workplan, no target was set for FY2017 as the expansion of emergency transport will only start in FY2018. However, the USAID Appsheet does not allow us to enter the revised and approved annual target for this indicator.

USAID codes	Technical themes/Indicators from PPR exercise request on Friday, Oct 27, 2017 at 10:25 AM	FY2017 Annual Target		Achieved in FY2017	DEVIATION	Comments
MCH						
No code	Number of children who received zinc supplementation during an episode of diarrhea	**Total**	**32,700**	21,884	**-33%**	In April 2017 the Program resubmitted and received approval from USAID for its FY2017 workplan due to shortage of fund available for the Program. Consequently, in this approved workplan, the target was revised from 32,700 to 27,000. However, the USAID Appsheet does not allow us to enter the revised and approved annual target for this indicator. The Program achievement in FY2017 is 19% below the revised target (21,884 children against 27,000 target) due to less number of CU5 cases seen by CHV for diarrhea throughout the year and mainly during Q3. This could be caused by better WASH practices at the household level due to CHV's sensitization efforts.

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
Outcomes														
IR 1.1	ALL	% of households seeking care from CHV or health clinic	ALL	Household Survey (HS)	Baseline, Midline and Endline	38%	NA	N/A	N/A	N/A	43%	N/A	48%	
IR 1.2	ALL	% of CU5 who slept under ITN or in a house sprayed with IRS in the last 12 months the previous night	MALARIA	Household Survey (HS)	Baseline, Midline and Endline	88%	NA	N/A	N/A	N/A	88%	N/A	88%	
PMI-MOP	ALL	Percentage of pregnant women who slept under an ITN the previous night	MALARIA	Household Survey (HS)	Baseline, Midline and Endline	82%	NA	N/A	N/A	N/A	83%	N/A	83%	
IR 1.3	ALL	% of infants aged 0-5 months exclusively breastfed in past 24 hours	MCH	HS	Baseline, Midline and Endline	50%	NA	N/A	N/A	N/A	58%	N/A	70%	
IR 1.4	ALL	% of women who completed at least 4 ANC visits during their pregnancy among women with live birth	MCH	HS	Baseline, Midline and Endline	71%	NA	N/A	N/A	N/A	75%	N/A	79%	
PMI-MOP	ALL	Percentage of women who received 2 or more doses of SP for IPTp for malaria during their last pregnancy in the last 2 years	MALARIA	HS	Baseline, Midline and Endline	36%	NA	N/A	N/A	N/A	45%	N/A	54%	
IR 1.5	ALL	% of children 0-59 months with ARI symptoms in the last two weeks taken to a health facility or provider	MCH	HS	Baseline, Midline and Endline	63%	NA	N/A	N/A	N/A	68%	N/A	73%	
IR 1.7	ALL	% of households with soap and water at a handwashing station commonly used by family members	WASH	HS	Baseline, Midline and Endline	28%	NA	N/A	N/A	N/A	40%	N/A	48%	
IR 1.8	ALL	% of households in target areas practicing correct use of recommended household water treatment technologies	WASH	HS	Baseline, Midline and Endline	19%	NA	N/A	N/A	N/A	30%	N/A	38%	
IR 2.4	ALL	# of children U5 suspected of pneumonia receiving antibiotics by trained facility workers or CHVs in USG assisted programs	MCH	Program records	Quarterly	TBD	NA	26 700	27 340	69 500	165 500	165 500	82 700	

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
IR2.5	ALL	Percentage of children between 0-11 months of age who were fully immunized	MCH	HS	Baseline, Midline and Endline	N/A	N/A	N/A	N/A	N/A	35%	N/A	40%	
IR 2.5	ALL	% of children between 12-23 months of age who received their 3rd dose of DPT by 12 months of age	MCH	HS	Baseline, Midline and Endline	N/A	N/A	N/A	N/A	N/A	44%	N/A	49%	
IR 2.6	ALL	# of newborns receiving chlorhexidine as part of the newborn essential care package	MCH	Program records	Quarterly	TBD	NA	11 500	4 405	59 000	168 000	168 000	84 000	Due to the prioritization of the c-IMCI training and to the limited availability of CSB heads for CHV training, CHX refresher training did not start until Q3
IR 2.7	ALL	# of child cases of diarrhea treated in USG supported programs	MCH	Program records	Quarterly	TBD	NA	27 000	21 884	73 000	120 700	120 700	60 400	CHVs saw fewer cases of diarrhea among CU5 than expected, possibly related to better WASH practices at the household level due to CHV sensitization efforts.
IR 2.9	ALL	Couple Year Protection (CYP) in USG supported programs	FP	Program records	Quarterly	TBD	NA	53 000	70 901	169 500	179 000	201 000	100 500	CHVs working in districts where the former program had been active were able to redynamize their regular users at a higher rate than expected.
not available	ALL	Modern contraceptive prevalence	FP	HS	Baseline, Midline and Endline	49%	NA	NA	NA	N/A	51%	N/A	53%	
IR 2.10	ALL	# of regular modern contraceptive users, disaggregated by age and type	FP	Program records	Quarterly	204 622	NA	108 200	150 407	287 000	399 000	455 000	566 700	CHVs working in districts where the former program had been active were able to revatilize their regular users at a higher rate than expected.
IR 2.11	ALL	# of new modern contraceptive users, disaggregated by age, type and use of vouchers	FP	Program records	Quarterly	TBD	NA	23 600	55 202	67 000	111 700	111 700	55 800	CHVs working in districts where the former program had been active were able to revatilize FP activities and recruit new users quicker than expected.
IR 2.15	IA2	# of people gaining access to a basic sanitation facility as a result of USG assistance	WASH	Program records	Quarterly	TBD	NA	28 000	27 908	112 400	157 600	179 800	78 800	
IR 2.18	ALL	% of CU5 tested RDT positive who receive Artemisinin based-Combined Treatment (ACT)	MALARIA	Program records	Quarterly	TBD	NA	95%	78%	95%	95%	95%	95%	Achievement of this indicator was lower than expected related to high levels of stock-out of ACT.

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
IR 2.19	IA2	# of mothers/caregivers of children 0-23 months who received direct maternal infant and young child nutrition counseling at least once during last quarter through USG supported programs	Nutrition	Program records	Quarterly	TBD	NA	120 700	180 224	219 400	335 000	335 000	168 000	There was an increase in the number of counseling sessions given at health huts. Health huts (with average 2 CHVs/hut) were expected to give counseling to an average of 6.6 mothers/caregivers of children 0-23 months per month, but they were able to provide counseling to an average of 10 caregivers per month.
Intermediate Outcomes/Outputs														
N/A	ALL	Client satisfaction with health services in USG supported districts [1,2,3,4,5,6]	ALL	Program records	Quarterly	TBD	NA	NA	NA	CSB - 45% CHV - 55%	CSB - 60% CHV - 70%	CSB - 75% CHV - 80%	CSB - 75% CHV - 85%	
IR 2.1.4	IA1	% of trained providers who perform to established national guidelines and standards	ALL	Program records	Quarterly	TBD	NA	TBD	NA	TBD	TBD	TBD	TBD	
IR 2.2.1	IA1	% of CHVs provided with supportive supervision by CSBs in the last 3 months	ALL	Program records	Quarterly	TBD	NA	30%	35%	40%	50%	60%	60%	
IR 2.2.2	IA3	% of CHV referrals that completes referral at receiving service	ALL	Program records	Quarterly	TBD	NA	50%	NA	70%	80%	85%	85%	Due to reduced funding level in FY2017, the Program team could not follow up and support the communities to achieve the open free defecation status as planned. In addition, the WASH government officials often were not available to make trips for ODF evaluation.
IR 2.2.3	IA3	% of clients referred to health clinics who were counter-referred to CHV	ALL	Program records	Quarterly	TBD	NA	25%	28%	35%	45%	50%	55%	

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
IR 2.4.1	IA3	% of health service delivery points that experience stock outs of tracer essential drugs (MCH, FP) in last quarter	ALL	Program records	Quarterly	TBD	NA	40%	62%	35%	30%	25%	20%	This is the first year that the CHVs in the Program area began to provide services qnd reports to the Program. During the gap (between the two projects), the CHVs did not resupply regularly and the resupply points were not regular in their stock. Even when the Program re-start, it took time for the supply chain to return to normal. There was a noticeable decrese in the stockout of all products at CHVs between the start and the end of FY2017.
Outputs														
IR 1.6	IA2	# of communities verified as open defecation free (ODF) as a result of USG assistance	WASH	Program records	Quarterly	TBD	NA	279	158	447	894	1341	447	Due to reduced funding level in FY2017, the Program team could not follow up and support the communtities to achieve the open free defecation status as planned. In addition, the WASH government officials often were not available to make trips for ODF evaluation.
IR 1.1.1	IA2	# of people reached with USG supported health and WASH messages	ALL	Program records	Quarterly	TBD	NA	2 203 700	3 719 934	3 570 000	3 768 000	3 768 000	1 884 000	Some people can be counted more time as they may be exposed to various channels.
IR 1.1.2	IA2	% of WRA who know at least two sources for health services or products	ALL	HS	Baseline, Midline and Endline	53%	NA	NA	NA	N/A	59%	N/A	66%	
IR 1.1.3	IA2	% of caretakers of CU5 who cite that sleeping under an ITN every night prevents malaria	MALARIA	HS	Baseline, Midline and Endline	98%	NA	NA	NA	N/A	98%	N/A	98%	
IR 1.1.4	IA2	% of WRA who can name at least 2 modern contraceptive methods	FP	HS	Baseline, Midline and Endline	95%	NA	NA	NA	N/A	95%	N/A	95%	
IR 1.2.2	IA1	% of target population covered by risk pooling mechanisms	ALL	Program records	Quarterly	0,02%	NA	0,01%	0,002%	4%	6%	8%	10%	Revitalize communes with mutuelles did not occur at the expected rate; expansion to other communes is expected to start in FY2018.

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
IR 1.2.3	IA1	# and % of communities with an established emergency transport system from the household to facility	ALL	Program records	Quarterly	NA	NA	NA	NA	1,041 (20%)	1,821 (35%)	2,342 (45%)	2,602 (50%)	
IR 1.2.4	IA1	% of audience confident in their ability to seek care	ALL	HS	Baseline, Midline and Endline	74%	NA	TBD	NA	N/A	78%	N/A	80%	
IR 1.2.5	IA1	Percent of WRA who believe that their partner supports the use of modern contraceptives	FP	HS	Baseline, Midline and Endline	53%	NA	TBD	NA	N/A	58%	N/A	62%	
IR 1.3.1	IA1	% of community structures with a functional CCDS	ALL	Program records	Quarterly	NA	TBD	80%	100%	90%	95%	95%	95%	With the dissemination of the PNSC, all communes decided to set up CCDS
IR 1.3.2	IA1	% of community structures with a functional CoSan	ALL	Program records	Quarterly	NA	TBD	80%	99,8%	90%	95%	95%	95%	With the dissemination of the PNSC, all communes decided to set up CoSan
IR 1.3.4	IA1	# of community leaders that participate in activities to promote care seeking and healthy behaviors	ALL	Program records	Quarterly	TBD	TBD	3 000	2 347	4 887	4 887	4 887	4 887	Due to reduced funding level in FY2017, the Program reduced the involvement of the Fokontany heads in health activities. Fokontany heads activities will be resumed in FY2018.
IR 2.2	ALL	# of clients who received two or more services during a single facility or CHV visit	ALL	Program records	Quarterly	TBD	NA	228 000	522 473	741 000	782 000	782 000	391 000	More clients than expected were seen by CHVs especially in nutrition and family planning services.
IR 2.13	IA1	# of USG assisted CHVs providing FP information, referrals, and/or services during the year	FP	Program records	Quarterly	TBD	NA	4 842	5 264	8 824	9 314	9 314	9 314	The program estimated that 20% of CHVs turned over but this rate was 15%.
IR 2.1.1	IA1	# of pre-service or in-service curricula developed or updated to meet national standards and guidelines	ALL	Program records	Quarterly	TBD	TBD	TBD	8	TBD	TBD	TBD	NA	
IR 2.1.2	IA1	# of health workers who received in-service training	ALL	Program records	Quarterly	6 052	TBD	4 842	5 682	8 824	9 314	9 314	9 314	Due to reduced funding level in FY2017, the Program reduced the target but had been able to conduct the training finally.

ANNEX 4: Madagascar CCHP Performance Monitoring and Evaluation Plan Version: April 10, 2017 (Approved revised FY2017 workplan)														
USAID IR and Sub IRs	**CCHP IA**	**Indicator**	**Thematic Area**	**Data Source**	**Frequency of Data Collection**	**Baseline**	**FY2016 target (not full year)**	**FY2017 target**	**Achieved FY2017**	**FY2018 target**	**FY2019 target**	**FY2020 target**	**End-of-Project Target (not full year)**	**Explanation of gaps**
IR 2.1.3	IA3	% of health facilities receiving supportive supervision visits in the last quarter	ALL	Program records	Quarterly	TBD	NA	NA	NA	90%	95%	95%	95%	
IR 2.1.6	IA1	Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	MALARIA	Program records	Quarterly	6 052	NA	3 070	3 454	5 754	9 314	9 314	9 314	Due to reduced funding level in FY2017, the Program reduced the target but had been able to conduct the training finally.
IR 2.3.1	IA1	# of health agents who received management training	ALL	Program records	Quarterly	6 052	NA	6 060	5 932	6 486	10 046	10 046	10 046	
IR 3.1.1	IA3	% of target districts and health facilities that have a systematic approach to track and display priority indicators	HMIS	Program records	Quarterly	TBD	NA	40%	69%	60%	85%	90%	90%	
IR 3.1.2	IA3	# of people trained in web-based HMIS management	HMIS	Program records	Quarterly	TBD	NA	173	127	732	905	905	905	GOM HMIS staff were not included in the training
IR 3.1.3	IA3	% of USG supported districts that submit timely and complete reports to the regional level	HMIS	Program records	Quarterly	TBD	NA	75%	NA	85%	95%	95%	95%	Data to be submitted to the regional level should come from the MOH database (GESIS Com) from the district. However, DRSP still have some issues with the GESIS Com and information on submission at the regional level is then not known. The Program is not allowed to manage the GESIS Com.
IR 3.1.5	IA3	% of USG supported primary health facilities that submit complete reports to the District on time	HMIS	Program records	Quarterly	TBD	NA	75%	NA	85%	95%	95%	95%	MOH decided that the Program only enters the CHV data but not those of CSB
IR 3.3.4	IA3	# of individuals trained in logistics, supply chain, forecasting, and budgeting	Supply Chain	Program records	Quarterly	TBD	NA	NA	NA	9 482	9 981	9 981	9 981	
N/A	IA3	% of health facilities with operational commodity quantification and forecasting systems in place [2, 3]	Supply Chain	CSB survey	Baselin, Midline and Endline	TBD	NA	TBD	NA	N/A	TBD	N/A	TBD	

ANNEX 5:

ENVIRONMENTAL MITIGATION AND MONITORING REPORT

Fiscal Year 2017: 1st October 2016 – 30th September 2017

Title of the program: USAID Community Capacity for Health Program

Implementing Partner: JSI Research & Training Institute, Inc.

Country or Region: Madagascar, Southern Africa

Award number: Cooperative Agreement no. AID-687-A-16-00001

Program Area: 3.1 HEALTH

Pursuant to the USAID IEE issued in October 7, 2013, for the period of 2014-2018 to cover environmental mitigation and monitoring measures for the health sector (3.1), the Program will contribute to the USAID/Madagascar Health Sector Portfolio – Use of Selected health Services and Products increased and Practices improved. Therefore, in FY 2017 the Program will apply as appropriate mitigation measures related to activities classified under negative determination with conditions that may affect the environment along with their implementation, as set forth in 22 CFR 216.

Concerned Program Elements of the USAID/Madagascar Health Portfolio are as follows:

3.1.2. Malaria
3.1.3. Maternal and child health
3.1.4. Family planning and reproductive health
3.1.5. Water, hygiene and sanitation
3.1.6. Nutrition.

The intervention categories as per the current IEE that are appropriate to the program include:

- Healthcare worker/delivery agent training and capacity building; healthcare workforce training, strengthening, and development; strengthening support for health service delivery
- Social marketing, education, and behavior change communication (BCC), excluding WASH
- Procurement, storage, management, distribution and disposal of public health commodities and equipment, strengthening public sector supply chain management
- Water, sanitation and hygiene.

Life of Activity: FY2016 – FY 2021
Fiscal Year of Submission: FY 2017

Funding Begin: 06/06/2016	**LOA Amount:** $ 32,992,279 USAID: $ 29,992,981 Cost share: $ 2,999,298
Funding End: 06/06/2021	**FY2017 Amount :** $ 8,839,071 USAID: $ 8,035,519 Cost share: $ 803,552
ESR Prepared by: Chuanpit Chua-oon Chief of Party - JSI/Mahefa Miaraka	**Date:** March, 2017
Date of Previous EMMR: -	**Date of Most Recent IEE:** October 7, 2013

A. Status of the IEE

☒ **No revisions or modifications** of the IEE are needed.
☐ An amended IEE is submitted.

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

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

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

Approval of the Environmental Status Report (as appropriate)

AOR _____ Date:_____

MEO_____ Date:_____

REA _____ Date:_____

BEO _____ Date:_____

ENVIRONMENTAL STATUS REPORT

B. Status of Fulfilling IEE Conditions

In October 7, 2013, USAID issued a new IEE to cover the USAID/Madagascar Health, Population and Nutrition (HPN) portfolio "Use of Selected Health Services and Products Increased and Practices Improved" for the period 2014 – 2018. In the continuum of the CBIHP, the Community Capacity for Health Program CCHP/Mahefa Miaraka will therefore help achieve Goal 3 of the U.S. Madagascar Integrated Country Strategy 2015-2017, which states: "The Malagasy people and their environment remain resilient; they continually mitigate, adapt and transform from shockers or stresses." The Program's interventions will work toward Objective 3.2 of that goal, which is to "Improve health through increased use of targeted Malagasy health, nutrition, water and sanitation services."

This document presents activities planned under Mahefa Miaraka's Q4 period as per its FY2017 work plan approved by USAID on November 3, 2016.

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

As per the intervention categories mentioned above, Community Capacity for Health Program conducted following activities that are eligible for categorical exclusion of 22 CFR 216 during the present period of report: Start-up workshops of the program at district and communes levels (3,270 people gathered in QII).

Classes of actions as per 22 CFR 216.2(c) (2)	Actions implemented	Remarks
(i) Education, technical assistance, or training programs	In order to prevent and reduce waste, Mahefa Miaraka continued to adopt best practices from MAHEFA, as such : - minimize distribution of handouts at the above workshops gathering large groups of stakeholders including CHVs and fokontany leaders - Provide large bottles of water during workshops and trainings at all level of implementation of the program instead of individual bottles	

2. Environmental Mitigation and Monitoring Report – table for activities under negative determination with conditions.

During the FY 2017 QIII period, activities classified under negative determination with conditions in the 22 CFR 216.3 (a) 2 (iii), and as described in the IEE 2014-2018 include:

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

Under this category, the Community Capacity for Health Program planned refresher training activities for CHVs, in particular in c-IMCI (165 CHVs) and Misoprostol – CHX (5,481 CHVs) , and supportive supervision including malaria activities (7,492 CHVs) by the end of September 2017.

Planned activities	Recommended mitigating actions	Status of mitigative measures/ actions taken	Any outstanding issues relating to required conditions	Remarks
- Training/ supportive supervision *- Health care service delivery enhancement (excluding HIV/aids testing, surveillance and monitoring)*				
1.1.2.3 Conduct refresher training for CHVs according to MOH's revised training curriculum (training may be done few times. Some training may be done during the monthly CHV meeting)	Review and update as necessary training curricula and SBCC materials related to health care management and appropriate disposal using incinerators or improved burial pits at health facilities for medical waste, CHX tubes, used sharps, syringes and needles, and expired drugs	5,682/5,850 CHVs who are trained on Miso and CHX in ongoing districts in FY2017		
1.1.2.5 Conduct initial training for CHVs in new districts	Refresher and continued training, and supervision on appropriate handling, use, storage and waste disposal of CHX tubes, sharps, syringes and needles, gloves, expired drugs following the EMMP poster guide developed in MAHEFA and using safety boxes and/or burial pits	898 CHVs trained in c-IMCI in FY2017		
1.1.2.6 CHVs receive regular supervision visits from FKT head and CCDS members		952 CHVs receive on-site supervision from FKT head (N/A) (The indicator above has been reported during Q2, the annual target is already reached)		

Planned activities	Recommended mitigating actions	Status of mitigative measures/ actions taken	Any outstanding issues relating to required conditions	Remarks
1.2.1.1/3.0.3.2 Support supervision visits to CHVs from CCDS, CSB representatives, EMAD, EMAR, MOH, and CCH staff		5,375 CHVs received on-site supervision by CSB/EMAD/CCHP in FY2017		

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

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
- *Social marketing/education/outreach/community mobilization: Healthy Behavior Changes through multiple communication channels, including mass media, communication campaigns, education and technical assistance and training – Population behavior change regarding use and disposal of medical wastes, including condoms, medicines and other medical products, and expired pharmaceuticals – Social marketing for FP/RH products expanded to rural communities*				
2.2.1.2 Train community stakeholders (COSAN: FKT heads and CHVs and CCDS members) on SBCC to promote and advocate for improved services and utilization throughout the continuum of care	SBCC activities related to proper storage, use and disposal of used condoms, unused and expired drugs, used syringes, and washing of insecticide-treated nets	7,877 CHVs/FKT heads trained on SBCC in FY2017		
2.2.1.3 Conduct training on the CLTS approach for CCDS and FKT COSAN members		Due to reduced funding in FY2017, there was no training on WASH in FY2017.		

3. *Procurement, storage, management, distribution and disposal of public health commodities and equipment*

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
- *Supply chain strengthening activities: provision of technical assistance to strengthen stock management and distribution* - *Procurement and distribution of Family Planning pharmaceuticals, point-of-use water treatment, malaria test/Diagnosis kits*				
2.2.2.7 Support CHV and CSB in good hygiene and waste management practices	Equip the permanent health huts and CSB with disposal pit	734/1,511 permanent Toby equipped with disposal pits in FY2017		
3.2.1.2 Hold coordination meeting with PSI/ISM program and set up regular meeting schedule	CHVs will be provided with training or refresher training on stock management including expiry date and the appropriate related waste management processes to be followed as per the Madagascar National Waste Management Policy (2005)	5,682/5,850 CHVs trained in stock management of Miso and CHX in ongoing districts 898 CHVs trained in stock management of c-IMCI products in new districts		
3.2.1.3 Participate in DPLMT/UTGL activities related to commodities availability for CSB and CHVs		# of CHVs who sent full sharp boxes to the CSB for disposal	No CHVs reported during the present reporting period to bring back to the CSB any full sharp box.	

Planned activities	Recommended mitigating actions	Status of mitigative measures/actions taken	Any outstanding issues relating to required conditions	Remarks
3.2.1.4 Train CSB on commodities management including CHV commodity needs planning in line with MOH protocols	Storage of the products according to the information provided on the manufacturer's Materials Safety Data Sheet (MSDS) Return expired commodities to the health facility for CHVs Appropriate disposal of expired drugs following the Madagascar National Waste Management Policy (2005)	# CHVs with public health commodities returned back to the CSB	No CHVs reported during the present reporting period any expired drug and sent back to the CSB	This activity is N/A for this period of reporting as CHVs supplied with new products

4. Small-scale water supply and sanitation.

Planned activities	Recommended mitigating actions	Status of mitigating measures/actions taken	Any outstanding issues relating to required conditions	Remarks
- Water supply infrastructure and financing: small-scale sanitation infrastructure such as hygienic latrines, hand washing stations *- Social marketing/education/outreach/community mobilization: BCC for WASH targeted on hand washing with soap, safe disposal of feces, and safe storage of drinking water at point-of-use* *- Policy support and small business promotion: train village level providers to use and sell WASH related services and supplies*				
2.2.2.6 Support CCDS and COSAN to begin promotion of WASH activities including sale of sur'eau and latrine slabs	Building and use of appropriate improved latrines	6,067 new improved latrines built in FY2017		
	Support Local masons on producing slabs	312 local masons inventoried		
2.2.2.7 Support CHV and CSB in good hygiene and waste management practices	Equip the permanent health huts and CSB with latrines	1,511 permanent Toby equipped with latrine and hand washing station in FY2017		
			This indicator will be reported under the CSB survey in FY2018	
		734/1,511 permanent Toby equipped with disposal pits in FY2017		

Annex 6. List of Communes in *Mahefa Miaraka* Program in FY2017

The USAID Community Capacity for Health Program operates in 4,887 fokontany, 456 communes, and 34 districts in the regions of Analanjirofo, Boeny, DIANA, Melaky, Menabe, SAVA, and Sofia. The Program will work with 456 CCDS, 732 public CSB, and 9,844 CHVs to provide services to approximately 6,1million people, or 23.3% of Madagascar's total population. Details of the communes are presented in the table below.

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
ANALANJIROFO	FENERIVE EST	AMBANJA SAHALAVA	9	1	1	14
		AMBATOHARANANA	18	3	1	36
		AMBODIMANGA II B	20	2	1	40
		AMPASIMBE MANANTSATRANA	11	3	1	26
		AMPASINA MANINGORY	25	3	1	50
		ANTSIATSIAKA	19	2	1	38
		BETAMPONA	9	1	1	18
		FENERIVE EST	5	2	1	10
		MAHAMBO	26	3	1	52
		MAHANORO	6	1	1	12
		MIORIMIVALANA	8	1	1	16
		SARANAMBANA	16	2	1	30
		VOHILENGO	17	2	1	22
		VOHIPENO	22	3	1	41
	FENERIVE EST TOTAL	**14**	**211**	**29**	**14**	**405**
	MANANARA NORD	AMBATOHARANANA MNNR	11	1	1	24
		AMBODIAMPANA MNNR	14	2	1	27
		AMBODIVOANIO	15	2	1	30
		ANALANAMPOTSY	11	0	1	18
		ANDASIBE MNNR	8	1	1	16
		ANTANAMBAOBE	12	1	1	24
		ANTANAMBE	24	3	1	48
		ANTANANANIVO	10	1	1	18
		IMORONA	7	1	1	14
		MAHANORO MNNR	5	1	1	9
		MANAMBOLOSY	18	2	1	36

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		MANANARA NORD	21	1	1	34
		SANDRAKATSY	20	1	1	36
		SAROMAONA	14	1	1	18
		TANIBE	13	1	1	22
		VANONO	12	2	1	22
	MANANARA NORD TOTAL	**16**	**215**	**21**	**16**	**396**
	MAROANTSETRA	AMBANIZANA	3	1	1	8
		AMBINANITELO	12	2	1	26
		AMBODIMANGA RANTABE	7	1	1	15
		ANANDRIVOLA	9	1	1	16
		ANDRANOFOTSY	7	1	1	23
		ANDRONDRONA	8	2	1	14
		ANJAHANA	7	2	1	14
		ANJANAZANA	10	1	1	17
		ANKOFA	10	1	1	24
		ANKOFABE	9	1	1	18
		ANTAKOTAKO	12	2	1	25
		ANTSIRABE SAHATANY	6	2	1	12
		MAHALEVONA	6	2	1	12
		MANAMBOLO	10	2	1	20
		MARIARANO	5	1	1	12
		MAROANTSETRA	17	1	1	34
		MORAFENO	7	2	1	8
		RANTABE SUD	8	1	1	17
		SAHASINDRO	5	1	1	14
		VOLOINA	10	1	1	20
	MAROANTSETRA TOTAL	**20**	**168**	**28**	**20**	**349**
	SAINTE MARIE	AMBODIFOTATRA	21	10	1	44
	SAINTE MARIE TOTAL	**1**	**21**	**10**	**1**	**44**
		AMBAHOABE	19	4	1	38

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
	SOANIERANA IVONGO	AMBINANISAKANA	7	1	1	14
		AMBODIAMPANA	5	1	1	10
		ANDAPAFITO	16	2	1	32
		ANTANIFOTSY	12	1	1	24
		ANTENINA	13	4	1	26
		FOTSIALANANA	9	2	1	18
		MANOMPANA	7	3	1	14
		SOANIERANA IVONGO	18	2	1	36
	SOANIERANA IVONGO TOTAL	**9**	**106**	**20**	**9**	**212**
	VAVATENINA	AMBATOHARANANA I	12	1	1	24
		AMBODIMANGAVALO	8	3	1	16
		AMBOHIBE	14	2	1	28
		AMPASIMAZAVA	7	1	1	14
		ANDASIBE	12	2	1	26
		ANJAHAMBE	11	2	1	22
		MAROMITETY	19	2	1	39
		MIARINARIVO	14	3	1	30
		SAHATAVY	8	2	1	16
		TANAMARINA	5	0	1	10
		VAVATENINA	17	1	1	40
	VAVATENINA TOTAL	**11**	**127**	**19**	**11**	**265**
	TOTAL ANALANJIROFO	**71**	**848**	**127**	**71**	**1671**
BOENY	**MITSINJO**	AMBARIMANINGA	5	1	1	10
		ANTONGOMENA BEVARY	9	2	1	18
		ANTSEZA	7	1	1	14
		BEKIPAY	8	2	1	16
		KATSEPY	7	3	1	14
		MATSAKABANJA	12	3	1	24
		MITSINJO	10	3	1	20
	MITSINJO TOTAL	**7**	**58**	**15**	**7**	116

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
	SOALALA	AMBOHIPAKY	14	5	1	28
		ANDRANOMAVO	24	4	1	48
		ANTSAKOAMILEKA	8	3	1	16
		SOALALA	13	3	1	26
	SOALALA TOTAL	**4**	**59**	**15**	**4**	**118**
	TOTAL BOENY	**11**	**117**	**30**	**11**	**234**
	AMBANJA	AMBALAHONKO	7	1	1	14
		AMBALIHA	5	1	1	10
		AMBANJA	19	2	1	30
		AMBODIMANGA RAMENA	10	1	1	12
		AMBOHIMARINA	6	2	1	8
		AMBOHIMENA	5	1	1	10
		AMBOHITRANDRIANA	6	1	1	12
		ANKATAFA	4	1	1	10
		ANKINGAMELOKA	8	1	1	16
		ANOROTSANGANA	10	2	1	20
		ANTAFIAMBOTRY	7	2	1	14
		ANTRANOKARANY	10	2	1	20
		ANTSAHABE CENTRE		0	1	8
		ANTSAKOAMANONDRO	10	1	1	20
		ANTSATSAKA	8	3	1	12
		ANTSIRABE	16	1	1	32
		BEMANEVIKY H/S	8	2	1	16
		BEMANEVIKY OUEST	13	2	1	24
		BENAVONY		0	1	8
		DJANGOA	6	1	1	12
		MAEVATANANA	6	1	1	12
		MAHERIVARATRA	7	1	1	14
		MAROTOLANA	13	2	1	26
		MAROVATO	5	1	1	14
	AMBANJA TOTAL	**24**	**189**	**32**	**24**	**374**
DIANA	AMBILOBE	AMBAKIRANO	12	2	1	24
		AMBARAKARAKA	12	2	1	22

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		AMBATOBEN'ANJAVY	10	2	1	20
		AMBILOBE	11	1	1	22
		AMBODIBOANARA	8	1	1	16
		AMPONDRALAVA	7	1	1	14
		ANABORANO IFASY	12	1	1	24
		ANJIABE HAUT	8	1	1	18
		ANKARATRA SIRAMA	9	1	1	18
		ANTANABE	6	1	1	16
		ANTSARAVIBE	14	3	1	24
		ANTSOHIMBONDRONA	6	2	1	11
		BERAMANJA	20	2	1	36
		BETSIAKA	13	4	1	24
		MANAMBATO	7	2	1	14
		MANTALY	12	1	1	24
		TANAMBAO MARIVORAHONA	11	1	1	22
	AMBILOBE TOTAL	**17**	**178**	**28**	**17**	**349**
	ANTSIRANANA I	DIEGO SUAREZ	25	3	1	50
	ANTSIRANANA I TOTAL	**1**	**25**	**3**	**1**	**50**
	ANTSIRANANA II	AMBOLOBOZOBE	5	1	1	6
		AMBONDRONA	9	1	1	18
		ANDRAFIABE	5	1	1	14
		ANDRANOFANJAVA	8	1	1	16
		ANDRANOVONDRONINA	9	2	1	18
		ANIVORANO NORD	21	3	1	32
		ANKARONGANA	5	1	1	10
		ANKETRAKABE	10	1	1	20
		ANTANAMITARANA	5	1	1	10
		ANTSAHAMPANO	10	2	1	20
		ANTSAKOABE	2	1	1	4
		ANTSALAKA	6	1	1	12
		ANTSOHA	0	0	1	10
		BOBAKILANDY	5	1	1	10
		BOBASAKOA	3	1	1	6

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		JOFFRE-VILLE	3	1	1	6
		MAHALINA	6	1	1	12
		MAHAVANONA	22	2	1	44
		MANGAOKO	9	3	1	18
		MOSOROLAVA	6	2	1	12
		RAMENA	5	1	1	10
		SADJOAVATO	3	1	1	6
		SAKARAMY	5	1	1	10
	ANTSIRANANA II TOTAL	**23**	**162**	**30**	**23**	**324**
	NOSY BE	AMBATOZAVAVY	5	2	1	10
		AMPANGORINA	5	1	1	10
		BEFOTAKA	4	1	1	12
		BEMANONDROBE	8	3	1	12
		DZAMANDZAR	9	2	1	18
		HELL VILLE	11	1	1	22
	NOSY BE TOTAL	**6**	**42**	**10**	**6**	**84**
	TOTAL DIANA	**71**	**596**	**103**	**71**	**1181**
	AMBATOMAINTY	AMBATOMAINTY	12	1	1	24
		BEMARIVO	8	3	1	16
		MAKARAINGO	6	1	1	12
		MAROTSILEHA	8	2	1	14
		SARODRANO	5	1	1	10
	AMBATOMAINTY TOTAL	**5**	**39**	**8**	**5**	**76**
	ANTSALOVA	ANTSALOVA	13	1	1	27
		BEKOPAKA	12	1	1	23
		BEMARAHA ANTSINANANA	5	0	1	10
		MASOARIVO	10	3	1	20
		SOAHANY	8	3	1	17
		TRANGAHY	9	3	1	18
	ANTSALOVA TOTAL	**6**	**57**	**11**	**6**	**115**
MELAKY		AMBOLODIA SUD	9	1	1	18
		AMPAKO	6	1	1	12

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
	BESALAMPY	ANKASAKASA TSIBIRAY	7	1	1	14
		ANTSIRASIRA	6	0	1	12
		BEKODOKA	19	1	1	39
		BESALAMPY	8	1	1	18
		MAHABE	9	1	1	18
		MAROVOAY SUD	6	1	1	12
		SOANENGA	8	2	1	16
	BESALAMPY TOTAL	**9**	**78**	**9**	**9**	**159**
	MAINTIRANO	ANDABOTOKA	12	1	1	24
		ANDRANOVAO	5	1	1	10
		ANDREA	9	1	1	18
		ANKISATRA	8	1	1	16
		ANTSAIDOHA BEBAO	8	1	1	16
		ANTSONDRODAVA	8	1	1	16
		BEBABOKY SUD	8	1	1	15
		BELITSAKY	7	1	1	14
		BEMOKOTRA SUD	8	1	1	16
		BEREVO RANOBE	5	2	1	10
		BETANATANANA	14	1	1	30
		MAFAIJIJO	8	1	1	16
		MAINTIRANO	8	1	1	16
		MAROHAZO	10	2	1	20
		MAROMAVO	3	1	1	6
		TAMBOHORANO	7	1	1	15
		VEROMANGA	5	1	1	10
	MAINTIRANO TOTAL	**17**	**133**	**19**	**17**	**268**
	MORAFENOBE	ANDRAMY	17	1	1	33
		ANTRANOKOAKY	7	2	1	14
		BERAVINA	11	2	1	21
		MORAFENOBE	20	4	1	39
	MORAFENOBE TOTAL	**4**	**55**	**9**	**4**	**107**
	TOTAL MELAKY	**41**	**362**	**56**	**41**	**725**

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
MENABE	BELO TSIRIBIHINA	ABOALIMENA	8	1	1	16
		AMBIKY	8	1	1	16
		ANDIMAKA	11	1	1	22
		ANKALALOBE	12	1	1	24
		ANKIRONDRO	8	1	1	16
		ANTSOHA	7	1	1	13
		BEGIDRO ANKIROROKA	7	1	1	12
		BELINTA	9	1	1	18
		BELO TSIRIBIHINA	21	1	1	54
		BEREVO	8	1	1	16
		BEROBOKA NORD	9	1	1	16
		DELTA	10	1	1	9
		MASOARIVO	10	1	1	18
		TSARAOTANA	12	2	1	24
		TSIMAFANA	13	2	1	26
	BELO TSIRIBIHINA TOTAL	**15**	**153**	**17**	**15**	**300**
	MAHABO	AMBIA	7	1	1	14
		AMPANIHY	19	2	1	38
		ANALAMITSIVALA	5	1	1	10
		ANKILIVALO	9	1	1	18
		ANKILIZATO	28	2	1	54
		BEZEZIKA	5	-	1	10
		BEFOTAKA	12	1	1	22
		BERONONO	6	1	1	11
		MAHABO	7	1	1	14
		MALAIMBANDY	19	2	1	38
		MANDABE	16	2	1	32
		TSIMAZAVA	8	1	1	16
	MAHABO TOTAL	**12**	**141**	**15**	**12**	**277**
	MANJA	ANDRANOPASY	9	3	1	18
		ANKILIABO	18	3	1	35
		ANONTSIBE	13	2	1	24

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		BEHARONA	10	3	1	20
		BETSIOKY	5	1	1	8
		MANJA	13	2	1	26
		SOASERANA	7	1	1	12
	MANJA TOTAL	**7**	**75**	**15**	**7**	**143**
	MIANDRIVAZO	AMBATOLAHY	8	2	1	24
		AMPANIHY	7	2	1	14
		ANDRANOMAINTY	7	-	1	14
		ANKAVANDRA	14	1	1	27
		ANKONDROMENA	7	2	1	24
		ANKOTROFOTSY	15	2	1	18
		ANOSIMENA	5	2	1	18
		BEMAHATAZANA	7	1	1	6
		BETSIPOLITRA	7	1	1	9
		DABOLAVA	5	1	1	12
		ISALO	10	2	1	20
		ITONDY	7	1	1	16
		MANAMBINA	10	2	1	22
		MANANDAZA	9	1	1	16
		MIANDRIVAZO	8	1	1	18
		SOALOKA	13	1	1	20
	MIANDRIVAZO TOTAL	**16**	**139**	**22**	**16**	**278**
	MORONDAVA	ANALAIVA	23	2	1	46
		BEFASY	23	7	1	44
		BELO SUR MER	14	3	1	27
		BEMANONGA	26	3	1	52
		MAROFANDILIA	8	2	1	14
		MORONDAVA	18	1	1	36
	MORONDAVA TOTAL	**6**	**112**	**18**	**6**	**219**
	TOTAL MENABE	**56**	**620**	**87**	**56**	**1137**
SAVA		AMBALAMANASY II	11	1	1	22
		AMBALAVELONA	5	1	1	10

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
	ANDAPA	AMBODIANGEZOKA	10	1	1	20
		AMBODIDIVAINA	9	1	1	18
		AMBODIMANGA I	10	3	1	20
		ANDAPA	10	1	1	20
		ANDASIBE KOBAHINA	4	1	1	8
		ANDRAKATA	3	1	1	6
		ANDRANOMENA	5	1	1	10
		ANJIALAVABE	6	1	1	12
		ANKIAKABE NORD	5	1	1	10
		ANOVIARA	8	1	1	16
		ANTSAHAMENA	7	1	1	14
		BEALAMPOANA	9	1	1	18
		BELAOKA LOKOHO	7	2	1	14
		BELAOKO MAROVATO	6	2	1	12
		BETSAKOTSAKO ANDRANOTSARA	8	1	1	16
		DOANY	14	3	1	28
		MAROVATO	5	1	1	10
		MATSOHELY	6	1	1	12
		TANANDAVA	8	2	1	16
	ANDAPA TOTAL	**21**	**156**	**28**	**21**	**312**
	ANTALAHA	AMBALABE	13	1	1	26
		AMBINANIFAHO	9	2	1	18
		AMBOHITRALALANA	12	2	1	24
		AMPAHANA	16	3	1	32
		AMPANAVOANA	11	1	1	24
		AMPOHIBE	12	1	1	25
		ANDAMPY	12	2	1	26
		ANTALAHA	23	3	1	83
		ANTANANAMBO	15	2	1	27
		ANTOMBANA	21	2	1	51
		ANTSAHANORO	11	1	1	22
		ANTSAMBALAHY	9	2	1	18
		LANJARIVO	14	2	1	28

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		MANAKAMBAHINY ANKAVIA	8	**2**	1	8
		MAROFINARITRA	8	**1**	1	24
		SAHANTAHA	7	**1**	1	13
		SARAHANDRANO	7	**1**	1	14
		VINANIVAO	11	**2**	1	22
	ANTALAHA TOTAL	**18**	**219**	**31**	**18**	**485**
	SAMBAVA	AMBATOAFO	15	**1**	1	30
		AMBOANGIBE	13	**1**	1	26
		AMBODIAMPANA LOKOHO	12	**3**	1	24
		AMBODIVOARA	15	**2**	1	30
		AMBOHIMALAZA	9	**3**	1	20
		AMBOHIMITSINJO	8	**1**	1	16
		ANALAMAHO	9	**1**	1	18
		ANDAPABE	7	**1**	1	14
		ANDRAHANJO	9	**2**	1	18
		ANDRATAMARINA	11	**2**	1	22
		ANDREMBONA	6	**1**	1	12
		ANJANGOVERATRA	25	**1**	1	50
		ANJIALAVA	10	**1**	1	20
		ANJINJAOMBY	8	**1**	1	13
		ANTINDRA	14	**1**	1	28
		ANTSAHAVARIBE	22	**1**	1	44
		ANTSAMBAHARO	7	**1**	1	14
		BEMANEVIKA	12	**2**	1	22
		BEVONOTRO	22	**2**	1	40
		FARAHALANA	20	**1**	1	40
		MAHASOA ANTINDRA	13	**0**	1	28
		MAROAMBIHY	8	**1**	1	16
		MAROGAONA	10	**2**	1	20
		MAROJALA	13	**1**	1	26
		MORAFENO	12	**1**	1	26
		NOSIARINA	8	**1**	1	16
		SAMBAVA URBAIN	16	**2**	1	32

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
SOFIA		TANAMBAO DAOUD	13	3	1	26
	SAMBAVA TOTAL	**28**	**347**	**40**	**28**	**691**
	VOHEMAR	AMBALASATRANA	9	1	1	36
		AMBINANIN'ANDRAVORY	8	2	1	18
		AMBODISAMBALAHY	9	1	1	14
		AMBORIALA	5	1	1	18
		AMPANEFENA	15	1	1	10
		AMPISIKINANA	5	1	1	28
		AMPONDRA	4	2	1	10
		ANDRAFAINKONA	5	1	1	20
		ANDRAVORY	4	1	1	10
		ANTSIRABE NORD	17	5	1	10
		BELAMBO	7	2	1	10
		BOBAKINDRO	3	1	1	12
		DARAINA	8	2	1	14
		FANAMBANA	6	2	1	16
		MAROMOKATRA LOKY	5	2	1	10
		MILANOA	16	2	1	26
		NOSIBE	8	3	1	14
		TSARABARIA	11	3	1	20
		VOHEMAR	10	2	1	14
	VOHEMAR TOTAL	**19**	**155**	**35**	**19**	**310**
	TOTAL SAVA	**86**	**877**	**134**	**86**	**1789**
	ANALALAVA	AMBALIHA	14	1	1	28
		AMBARIJEBY-SUD	7	1	1	14
		AMBOLOBOZO	22	4	1	44
		ANALALAVA	15	3	1	36
		ANDREVOREVO	3	0	1	6
		ANDRIMBAVONTSONA	10	1	1	22
		ANGOAKA SUD	6	1	1	12
		ANKARAMY	16	5	1	40
		ANTONIBE	23	2	1	48
		BEFOTAKA NORD	17	2	1	35

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		BEJOFO	10	2	1	20
		MAHADRODROKA	10	1	1	20
		MAROMANDIA	10	1	1	20
		MAROVANTAZA	6	1	1	12
		MAROVATOLENA	11	2	1	22
	ANALALAVA TOTAL	**15**	**180**	**27**	**15**	**379**
	ANTSOHIHY	AMBALAFAMINTY	6	1	1	12
		AMBODIMADIRO	11	3	1	22
		AMBODIMANARY	18	2	1	36
		AMBODIMANDRESY	14	1	1	28
		AMPANDRIANKILANDY	16	2	1	32
		ANAHIDRANO	14	2	1	28
		ANDREBA	8	1	1	16
		ANJALAZALA	14	4	1	28
		ANJIAMANGIRANA	17	3	1	34
		ANKERIKA	12	2	1	24
		ANTSAHABE	23	3	1	46
		ANTSOHIHY	7	1	1	14
		MAROALA	7	2	1	14
	ANTSOHIHY TOTAL	**13**	**167**	**27**	**13**	**334**
	BEALANANA	AMBALAROMBA	5	1	1	10
		AMBARARATA SOFIA	7	1	1	14
		AMBARARATABE NORD	8	2	1	16
		AMBATORIHA EST	15	2	1	31
		AMBATOSIA	14	2	1	28
		AMBODIADABO	8	1	1	16
		AMBODIAMPANA	6	2	1	12
		AMBODISIKIDY	8	1	1	16
		AMBOHIMISONDROTRA	7		1	13
		AMBOVONOMBY	8	1	1	16
		ANALILA	6	1	1	12
		ANJOZOROMADOSY	8	1	1	16
		ANKAZOTOKANA	7	1	1	14

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		ANTANANIVO HAUT	7	2	1	14
		ANTSAMAKA	8	2	1	16
		ANTSIRADAVA	5		1	12
		BEALANANA	20	1	1	38
		BEANDRAREZONA	12	3	1	24
		MANGINDRANO	13	3	1	26
		MAROTOLANA	17	1	1	34
	BEALANANA TOTAL	**20**	**189**	**28**	**20**	**378**
	BEFANDRIANA AVARATRA	AMBARARATA	16	3	1	32
		AMBODIMOTSO HAUT	11	2	1	16
		AMBODIMOTSO SUD	15	2	1	30
		AMBOLIDIBE ATSINANANA	20	3	1	40
		ANKARONGANA	27	4	1	54
		ANTSAKABARY	21	3	1	42
		ANTSAKANALABE	19	3	1	38
		BEFANDRIANA AVARATRA	9	1	1	18
		BELALONA	14	4	1	28
		MAROAMALONA	10	2	1	20
		MATSONDAKANA	10	1	1	20
		MORAFENO	22	3	1	48
		TSARAHONENANA	36	5	1	72
		TSIAMALAO	26	4	1	54
	BEFANDRIANA AVARATRA TOTAL	**14**	**256**	**40**	**14**	**512**
	BORIZINY	AMBANJABE	13	1	1	26
		AMBATOMILAHATRANO	8	1	1	18
		AMBODIMAHABIBO	11	1	1	22
		AMBODISAKOANA	15	2	1	30
		AMBODIVONGO	12	1	1	26
		AMPARIHY	17	1	1	34
		ANDRANOMENA I	10		1	22
		ANDRANOMEVA	14	1	1	28
		IHOBAKA	9	1	1	22

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		LEANJA	22	2	1	56
		MAEVARANOHELY	13	1	1	26
		MAROVATO	20	2	1	40
		PORT BERGE I	11	1	1	22
		PORT BERGE II	20	1	1	34
		TSARAHASINA	19	1	1	38
		TSARATANANA	15	2	1	28
		TSININGIA	11	1	1	24
		TSINJOMITONDRAKA	26	2	1	52
	BORIZINY TOTAL	**18**	**266**	**22**	**18**	**548**
	MAMPIKONY	AMBODIHAZOAMBO	9	1	1	18
		AMBOHITOAKA	15	1	1	30
		AMPASIMATERA	17	2	1	34
		ANKIRIRIKY	13	2	1	26
		ANOVILAVA NORD	10	2	1	20
		BEKORATSAKA	23	2	1	48
		BETARAMAHAMAY	9	1	1	18
		KOMAJIA	11	1	1	22
		MALAKIALINA	17	1	1	42
		MAMPIKONY I	29	1	1	16
		MAMPIKONY II	16	2	1	64
	MAMPIKONY TOTAL	**11**	**169**	**16**	**11**	**338**
	MANDRITSARA	AMBALAKIRAJY	14	2	1	29
		AMBARIKORANO	3	1	1	12
		AMBARIPAIKA	6	1	1	12
		AMBILOMBE	7	1	1	16
		AMBINAN'IFANGO	7	1	1	20
		AMBOABOA	10	1	1	20
		AMBODIADABO MAITSOKELY	6	1	1	12
		AMBODIAMONTANA KIANGA	7	1	1	14
		AMBOHISOA	8	1	1	22
		AMBORONDOLO	4	1	1	8
		AMPATAKA MARORENY	6	1	1	12

Région	District	Communes	Fokontany	No. of CSB	No. of CCDS	No. of actual CHVs
		ANDOHAJANGO	12	1	1	30
		ANDRATAMARINA	5	2	1	10
		ANJIABE	8	1	1	16
		ANKIABE SALOHY	12	2	1	24
		ANKIAKABE FONOKO	6	2	1	12
		ANTANAMBAON'AMBERINA	8		1	18
		ANTANANDAVA	12	1	1	28
		ANTSATRAMIDOLA	9	1	1	18
		ANTSIATSIAKA	5	1	1	10
		ANTSIRABE CENTRE	8	2	1	16
		ANTSOHA	6	1	1	18
		KALANDY	14		1	28
		MANAMPANEVA	7	2	1	14
		MANDRITSARA	13	1	1	26
		MAROTANDRANO	16	2	1	32
		PONT SOFIA	5	1	1	12
		TSARAJOMOKO	6	2	1	20
		TSARATANANA	10	1	1	20
	MANDRITSARA TOTAL	**29**	**240**	**35**	**29**	**529**
	TOTAL SOFIA	**120**	**1467**	**195**	**120**	**3018**
	GRAND TOTAL	**456**	**4887**	**732**	**456**	**9844**

ANKIRANOMENA: A RURAL VILLAGE ON A MISSION TO PROVIDE A CONTINUUM OF HEALTH CARE

THIS SUCCESS STORY IS SUBMITTED TO USAID AS PART OF THE FY2017 ANNUAL REPORT

The USAID Community Capacity for Health program, locally known as Mahefa Miaraka, is a five-year (2016-2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaboration between the Ministry of Public Health, USAID, and JSI Research & Training Institiute, Inc. (JSI).

The Ankiranomena Fokontany (village), one of the most populated fokontany within the Dabolava commune, Miandrivazo District in Menabe region, is located at the end of a road, far from the commune center. Data from a 2015 census suggests that at that time, Ankiranomena was home to around 4,090 residents, of which approximately 800 were children under age five. Two Community Health Volunteers (CHVs), trained and equipped by the Mahefa Miaraka Program, are stationed there and partner with the Dabolava Basic Health Center (CSB) to provide health care to the people of Ankiranomena.

CHVs Josiane and Modeste receiving patients for the CSB counter-referral

Community Health Volunteers (CHVs) are the first recourse for Ankiranomena community members in the event one of them falls ill. Upon receiving a patient, CHVs first determine whether or not they can treat the illness using their resources and skills. If they are able to provide treatment, they do so. In the event they need additional support, they immediately refer their patient to the Dabolava CSB, where a doctor and midwife are available to provide more extensive medical care.

THE REFERRAL SYSTEM: CONSULTATIONS AT THE HEALTH HUT → HEALTHCARE AT THE CSB

Marcelline Ramiarantsoa, Head of the Dabolava CSB

CHVs diagnose each client and use a checklist to determine whether or not they will be able to provide sufficient patient support. They then fill out the community register and a referral card to send the patient to the CSB.

At the CSB, medical staff members receive the CHV-referred patients and administer appropriate care, depending on the illness. If necessary, they also refer patients to a higher level (such as a district or regional hospital). Upon completion of treatment, the CSB staff gives each patient a counter-referral card to be given to the CHV, instructing the CHV on any required follow-up care.

"Our CSB covers the care needs of 11,559 people. The CHVs play a major role in allocating this care because they are present in the Dabolava commune's six fokontany. They provide first aid, so when the patients arrive at the CSB suffering from malaria, for example, they have already received Paracetamol (Acetaminophen) to decrease the fever."

But the collaboration between the Dabolava CSB and its CHV is not limited to the referral and counter referral system. The Head of CSB explains:

"CHVs convince pregnant women to have antenatal care at the CSB. At each monthly meeting, we meet with each CHV to take stock of the health status of each pregnant woman and the progress of their pregnancy. As their delivery-date approaches, their CHV alerts us in person or through another member of the village and we move to the fokontany level."

MEET ANKIRANOMENA'S INDUSTRIOUS CHVS

The role of CHVs is to advise and refer patients to the CSB and to monitor and track patients who have been beneficiaries of their care. The Ankiranomena CHVs are among the best in the Dabolava commune, not only in terms of the number of children and pregnant women they refer, but also in terms of their strong motivation, their regular attendance at monthly CSB meetings, and the continuous community awareness they perform within their community every month during the Fokontany meeting.

CHV Modeste Razafindrabe,
age 56, started working with the Dabolava CSB in 2003 as a Family Planning (FP) instructor.

"When I was a child, I had a dream of becoming a doctor, but I couldn't because of a lack of means and education. But thanks to the continuous training I've received since MAHEFA Program and now through the Mahefa Miaraka Program, I feel just as proud as a doctor would, when the sick children who we see in our health hut are cured. Our presence also helps prevents households from seeking traditional healers when they are sick."

CHV Josiane Rasoarimalala,
age 52, started out in 2004 as a social mobiliser for the introduction and promotion of FP devices.

"I was born in this village, into a family of several brothers and sisters and grandchildren living all together. I would like to help them to live in good health. We are also recognized and respected by our community which makes it easier to advise them or refer them to go to the CSB when we cannot take care of them."

Josiane recounts one of the most severe cases she encountered as a CHV:

"The most difficult case we encountered was a four-year-old child with malaria, who upon arrival at our health hut experienced seizures and then lost consciousness. We had no time to even fill out the cards properly because the situation was so severe and urgent. So I closed the health hut and immediately accompanied the sick child and his mother to the CSB. We were able to use a bush taxi which passed by us on the way. At the CSB, the child was immediately given fluids via IV and was treated for three days. Fortunately, his health improved and he recovered."

CHVs make home visits under 5 with malaria, following a counter-referral from the CSB of a children

After that incident, Josiane noticed a change in the community. The child's mother had begun to testify to her neighbors about the advantages of going to the CSB. Previously, they had a fear of dying at the CSB, but the mother's testimony made them less afraid. She motivated her fellow community members to seek consultation from the CHVs more frequently.

Since the beginning of this year, Josiane and Modeste have referred:

71 CU5 referred for vaccination

20 CU5 referred for specific IMCI danger sign

81 CU5 counter-referred (vaccinated)

107 pregnant women referred for ANC4 and 101 for ANC1

26 pregnant women referred for delivery

MEET SOME RECIPIENTS OF CHV CARE

Mothers and children, CHV Josiane and Modeste's toby recipients

Mrs. Haingo, Mrs.Blondine, and Mrs. Malala have all brought their children to Josiane and Modeste when their children have had a fever or pneumonia in the past. Mrs. Blondine (middle) recalls,

"When my child experienced a high fever and a positive RDT (Malaria Rapid Diagnostic Test), Josiane gave me a referral card and advised me to immediately go to the CSB to see the doctor. When I arrived at the CSB, my child was taken care of and the next day he was much better. On my return I informed Josiane and Modeste of the medicines we had been given and they made a home visit a week later to check on the health status of my son. The presence of CHVs in our fokontany reassures us a lot because they can take care of our children and they always refer us if the case is too complicated. They convince us that it is better to spend 2,000 Ariary in bush-taxi fees to go to the CSB than to lose our child. "

The Mahefa Miaraka Program will continue to implement and improve the referral/counter-referral system by expanding community micro-insurance mutual funds and encouraging the use of other forms of microfinance such as equity funds and solidarity funds.

SAYANA PRESS: THE INNOVATIVE FAMILY PLANNING METHOD BOTH CHVS AND BENEFICIARIES PREFER

THIS SUCCESS STORY IS SUBMITTED TO USAID AS PART OF THE FY2017 ANNUAL REPORT

The USAID Community Capacity for Health program, locally known as Mahefa Miaraka, is a five-year (2016-2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaboration between the Ministry of Public Health, USAID, and JSI Research & Training Institiute, Inc. (JSI).

Located in Western Madagascar, the town of Belo sur Tsiribihina isn't easy to access. Cars must cross a river on a makeshift ferry (a wooden platform supported by two boats), as the river is too large to traverse and there are no bridges. Tourists wishing to visit the nearby Tsingy National Park must pass through Belo sur Tsiribihna, making it an isolated town accustomed to hosting many tourists. While the town receives many visitors, the residents have little opportunity to leave.

In the Tsaramandroso village, a few kilometers from Belo sur Tsiribihina, family planning services are crucial for many women. Whether they already have a family and wish to space or limit the number of children they have, or they are waiting to have children once they are more stable, many women rely on family planning services to have control over their lives.

Community health volunteers Olga Tsimiambina and Marie Liliane Rasolondrenibe (Solo) inside their health hut in Tsaramandroso.

Community Health Volunteers (CHVs) are a one-stop-shop when it comes to providing community-level health services. They do everything, including diagnosing malaria and pneumonia, vaccinating babies, actively promoting healthy practices regarding sanitation and hygiene, and providing family planning services.

The Mahefa Miaraka Program trains CHVs to provide family planning services at the community-level. Women seeking family planning will visit a toby (health hut) where a CHV will provide counseling on the various types of family planning options available, including condoms, birth control pills, injectables, and implants.

After properly washing her hands and disinfecting the patient's arm, CHV Olga injects 23 year-old Victoria with Sayana Press.

Sayana Press is an innovative way to deliver birth control, as it is made up of a needle attached to a reservoir with a pre-measured dose of hormones. This makes it easier for the CHVs to use because they don't have to worry about measuring out precise amounts of the right hormone, and don't have to worry about air bubbles or losing product. They simply insert the needle into the patient's arm, and squeeze the reservoir to release the product. It is simpler, more efficient, and much easier to learn.

The newest family planning option is Sayana Press, an injectable hormonal birth control that lasts for three months, and has replaced depo provera

in 1,035 villages

across the 7 Mahefa Miaraka regions.

As part of their training, CHVs learned proper hand washing techniques and how to correctly dispose of used needles.

"Sayana Press is wonderful. When we use Sayana Press, there is nothing to measure. We previously used depo provera, but it was more difficult. We aren't as nervous with Sayana Press. Sayana Press arrived and we were able to use it right away because it was so easy. It also hurts the patients less because the needle is smaller." – CHV Marie Liliane Rasolondrenibe "Solo"

CHVs report that being trained to use Sayana Press was quite easy. While using it felt a little strange at first, the Tsaramandroso CHVs received extensive training at the Belo sur Tsiribihina CSB (government health facility). The training ensured mastery of the new drug by requiring each CHV to practice injecting it six times. By the time each CHV was finished with their six practice injections, they felt very comfortable administering Sayana Press, especially compared to administering depo provera injections.

CHV Solo uses a Mahefa Miaraka job aid designed to determine when women need to return to receive their next injection of birth control hormones.

17 year-old Sayana Press user Claudiana confirms,

"There's nothing really bad about it, I've had no problems. It hurts a little, but I have recommended it to friends."

Claudiana is a student who wishes to complete her education before starting a family. Like many women, she chose to use Sayana Press because she felt it would be much easier than remembering to take a pill every day. Many young girls like Claudiana are encouraged by their mothers to seek family planning services so they can remain in school rather than drop out to raise children.

Sayana Press user Claudiana is injected with Sayana Press by CHV Solo. Claudiana has been using Sayana Press for 6 months.

Victoria, another Sayana Press user in Tsaramandroso, uses family planning services because she already has two children and does not wish to have any more. She has used depo provera for the last two years, but switched once Sayana Press became available. Similar to Claudiana, she chose injectable birth control hormones over other methods for its convenience.

CHV Solo is very happy to use Sayana Press.

In Tsaramandroso, around **50 women** come to the health hut **each month to receive Sayana Press** injections.

Interest in Sayana Press continues to grow as women spread the word about their satisfaction with the product. Throughout Mahefa Miaraka's seven regions, 5,912 CHVs in 3,047 villages have been trained to administer and counsel on Sayana Press.

Annex 8. International Trips at the End of Q4 FY2017

Approved Trips in FY2016-FY2017						Trip Situation Update Q4, FY2017		
No. of trips	**No. of travelers per trip**	**Origin**	**Destination**	**Trip purposes**	**Trips made in Q2, FY2017**	**Trips made in Q3, FY2017**	**Trips made in Q4, FY2017**	**No. of Remaining Trips**
JSI								
1	3	Madagascar	Uganda (conference changed to S Africa)	USAID's International Conference on Community Health. Participation of the Madagascar delegation at this conference is as requested by USAID/Madagascar. Two of the three participants are MOH staff.	1 for 3 people			Completed
1	2	Canada	Madagascar	COP and dependent travel to post (Completed FY 2016)		Completed in FY2016		
3	1	US	Madagascar	JSI/Boston Home office program support for Program start-up (Completed before September 2016 or FY 2016)		Completed in FY2016		
5	1	US	Madagascar	Boston Home office program support in FY2017. These trips are in the approved proposal budget and include trips that support systems, financial management and compliance, and one annual senior management visit; the number of trips was incorrectly transcribed in the last Work Plan. We hired a new Key Personnel – the Finance and Administration Director, and since the prior staffer in this position left	0	0	3	1

Approved Trips in FY2016-FY2017						Trip Situation Update Q4, FY2017		
No. of trips	**No. of travelers per trip**	**Origin**	**Destination**	**Trip purposes**	**Trips made in Q2, FY2017**	**Trips made in Q3, FY2017**	**Trips made in Q4, FY2017**	**No. of Remaining Trips**
				weeks before the new one could take over the functions, JSI was obliged to send home office staff in rotation to cover the supervisory functions.				
5	1	US	Madagascar	JSI technical support trips in FY2017. These trips include specialized clinical and HSS experts, monitoring & evaluation staff, strategic information and new technologies experts as needed, and the five trips are in the approved proposal budget.	1	0		3
2	1	Madagascar	US	COP annual home office meeting	1	0		Completed
1	3	Madagascar	US	Program staff orientation/training in Boston	1	0		1
1	2	Madagascar	UK	Staff orientation	0	0		1
FHI360								
1	3	US	Madagascar	FHI360 Home office program support	1	1		Completed
1	1	South Africa	Madagascar	FHI360 Home office program support	0	0		1
1	1	US	Madagascar	FHI360 Home office program support	1	0		Completed
1	1	US	Madagascar	FHI360 Home office program support	0	0		1
1	1	US	Madagascar	FHI360 Home office program support	0	0		1
Transaid								
1	1	UK	Madagascar	Transaid Home office program support for Program start-up (completed FY2016)		Completed in FY2016		

Approved Trips in FY2016-FY2017						Trip Situation Update Q4, FY2017		
No. of trips	**No. of travelers per trip**	**Origin**	**Destination**	**Trip purposes**	**Trips made in Q2, FY2017**	**Trips made in Q3, FY2017**	**Trips made in Q4, FY2017**	**No. of Remaining Trips**
1	1	UK	Madagascar	Transaid Home office program support	1	0		Completed
1	3	UK	Madagascar	Transaid Home office program support	2	1		1

*Two additional Community Capacity for Health staff members traveled internationally during Q3 on funds other than those of the Community Capacity for Health Program. Dr. Aymar Ramadany traveled to Zambia to attend the Africa Transportation Technology Transfer (T2) Conference from May 8-10, 2017. His travel was funded by Transaid. Dr. Robertine Rahelimalala traveled to Burkina Faso from the 18-20 of April to participate in a CEDEAO forum on Good Health Practices (Bonnes Pratiques en Santé – FBPS).

DISCLAIMER

This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this document are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.

---------- Forwarded message ----------
From: **Jocelyne Andriamiadana** <jandriamiadana@usaid.gov>
Date: Mon, Nov 27, 2017 at 3:16 PM
Subject: Fwd: Submission of FY2017 annual report
To: Chuanpit Chua-Oon <chuanpit_chua_oon@jsi.com>, Yvette Ribaira <yvette_ribaira@mg.jsi.com>, Eric Ramahandrisoa <eric_ramahandri
Cc: Verohanitra Rabearihanta <hrabearihanta@usaid.gov>

Hi Chuanpit,

The CCH Mahefa Miaraka FY2017 annual report is approved.
Thank you,

Jocelyne

...

2 Attachments

PDF Mahefa Miaraka F...

PDF Mahefa Miaraka F...