

TOLIARA PROVINCE CHILD SURVIVAL PROJECT

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ACRONYMES

AEN	: Actions Essentielles en Nutrition
ADBC	: Agents Distributeurs à base Communautaire
AEC	: Approche Enfant pour la Communauté
AEPE	: Approche Enfant pour Enfant
AME	: Allaitement Maternel Exclusif
ASB	: Agents de Santé de Base
ASOS	: Action Secours Organisation Santé
AT	: Agents de terrain
CAP	: Connaissance Attitude et Pratique
CCC	: Communication pour le Changement de Comportement
CHD	: Centre Hospitalier du District
CISCO	: Circonscription scolaire
CRESAN	: Crédit Sanitaire (Projet de la Banque Mondiale)
CSB	: Centre de Santé de Base
DAC	: Délégation de l'Animation Communautaire
DAR	: Direction de l' Animation Rurale
DIP	: Detailed Implementation Plan
DPS	: Direction Provinciale de la Santé
DSFA	: Direction de la Santé Familiale
EMAD	: Equipe de Management du District
FAR	: Femmes en Age de Reproduction
FDF	: Formation des Formateurs
FY	: Année Fiscale/Fiscal Year
GAIN	: Groupe d'Action et d'Intervention pour la Nutrition
GTDR	: Groupe de Travail pour le Développement Rural
HIAKA	: Hetsika Iadiana Amin'ny Kitrotro mahazo ny Ankizy
IEC	: Information Education Communication
IFP	: Institut de Formation des Paramédicaux
IHAB	: Initiative des Hôpitaux Amis de Bébé
INSPC	: Institut National de Santé Publique et Communautaire
IRA	: Infections Respiratoires Aigues
ISTs/SIDA	: Infections Sexuellement Transmissibles/Syndrome d'Immuno Déficience Acquise
JHU	: Johns Hopkins University
JNV	: Journées Nationales de Vaccination
LQAS	: Lot Quality Assurance Sampling
MCDI	: Medical Care Development International
MINSAN	: Ministère de la Santé
MSR	: Maternité Sans Risque
OMS	: Organisation Mondiale de la Santé
ONG	: Organisation Non Gouvernementale
PCEM	: Prise en Charge de l'Enfant Malade
PCIME	: Prise en Charge Intégrée des Maladies de l'Enfance
PCLS	: Président du Comité Local de Sécurité
PEV	: Programme Elargi de Vaccination
PF	: Planification Familiale
PFA	: Paralysie Flasque Aiguë
PFU	: Participation Financière des Usagers

PMPS : Projet Multisectoriel pour la Prévention du Sida
SIG/PF : Système d' Information pour la Gestion/Planification Familial
SSD : Service de Santé de District
TBC : Techniques de Base de Communication
TPCSP : Toliara Province Child Survival Project / Projet de Survie de l'Enfant à Toliara
TT2 : Tetanos Toxoïde 2
UNICEF : Fonds des Nations Unies pour l'Enfance
USAID : United States Agency for International Development
VCS : Volontaires Communautaires de Santé
VEMIMA : Vehivavy Miara-Mandroso (ONG Femmes Avancant Ensemble)
VISA : Visiter Identifier Sensibiliser Accompagner
3A : Apprentissage Auto Assisté

INTRODUCTION

The Toliara Child Survival Project implemented by Medical Care Development International (MCDI) is a cost extension from October 2002 to September 2006, funded by USAID for an amount of 1229843 \$. It includes the continuation of the activities in the District Health Service (SSD) of Betioky as well as the implementation of the activities in the SSD of Toliara II in the South-West of Madagascar. The estimated beneficiariness is about 63.791 children aged less than 5 years and 81.510 women of reproduction age.

The detailed analysis of the health situation in Toliara II and other sources identified child survival problem priorities as diarrhoeal diseases, poor immunization coverage, malaria, and ARI/pneumonia. Other identified major problems include the lack of exclusive breastfeeding practice and the extremely low use of modern contraception methods. The principal barriers related to maternal and infantile health in the province of Toliara are the access to health services, the low quality of the care provided by the health services, and the lack of knowledge and practice on the key child survival positive behaviors. The SSD of Toliara II and Betioky Sud are among the most populated in the poorest province of Madagascar. They have the same epidemiologic, organisational, and cultural profiles.

The project goal is to reduce the morbidity and the mortality of children aged less than 5 years and to improve the health of women of reproduction age in the districts of Betioky Sud and Toliara II through interventions based on Pneumonia/Acute Respiratory Infection case management (15% of effort), Malaria case management (15% of effort), diarrhoeal diseases intervention (15% of effort), Expanded Programme of Immunization (EPI) (20% of effort); Breast-feeding and Nutrition (15% of effort) and Birth Spacing Promotion (20% of effort). These interventions are implemented within the IMCI framework at both community and clinical level.

The main strategies to achieve the goal and the objectives of the project focus on (i) the capacities building at the Community level by the development of sustainable community based structures; (ii) the institutional strengthening of the Ministry of Health by improving the case management of childhood diseases, Behavior Change Communication (BCC) capacity at all level, and supervision strengthening of the health staff and other management, technical and organisational issues among the staff of the health district ; and (iii) the promotion and the facilitation of synergies with other partners including logistic supports, training modules and materials, equipment, and sharing of knowledge and acquired technical skills as well as the learned lessons. These strategies are enhanced by a BCC approach based mainly on the Community-based Health Volunteers (VCS) and the community participation, the implementation of the clinical and C/HH based IMCI, and the extension of the Community-based credit scheme which contributes to the access to health services.

For the 2004 fiscal year, the project especially focused on (1) the reinforcement of the health system through staff training, the reinforcement of the operational structure at the SSD level (EMAD) and (2) the implementation and reinforcement of the strategy of project BCC strategy including the VCS and its components, mass media and NGO involvement.

This 2004 Toliara CSP Annual Report describes the main activities carried out, the constraints and the problems which the project has faced during this fiscal year. The preparation of this report required a three-day workshop with the MCDI field staff as a whole, the representatives of the SSD of the areas covered by the project and the representatives of the Community Animation Service (Service de l'Animation Rurale : SAR). The drafting was under the responsibility of Dr. Josée Ratsirarson, Project Manager and of Dr. Rija Fanomezana, Project Health Information System Manager, under the useful

recommendations of the MCDI CS Coordinator. The first draft was sent to the MOH and the SAR for comments. The final version submitted to the MCDI Headquarter received the validation of the District Health Services of Toliara II and Betioky Sud, the Provincial Department of Health in Toliara and the Provincial Department of Rural Animation in Toliara.

A. Description of the achievements during the fiscal year (FY) 2004

A.1. Principal achievements

In general, MCDI carried out approximately 90% of its planned activities for 2004. The only activities which are not carried out are those in relation to the extension of the credit scheme. A mid-term survey of the quality of care provided to the children aged less than 5 years (IMCI) and a KPC survey using LQAS methodology to appreciate the progression towards the objectives were also undertaken. The fiscal year 2004 is also marked by a more active participation of MCDI in the determination of some general health policies (Agreement National Policies on Health Sector, Child Health Policy) and the start up of the SantéNet Project, the Mission funded health project, of which MCDI is among the consortium member. The following principal activities were carried out during the fiscal year 2004:

A.1.1. Project achievements during the fiscal year 2004

A1.1.1. Activities at the health care system level

A.1.1.1.1. *Implementation of the IMCI clinical*

- At the SSD of Toliara II level

(a) Clinical IMCI Training of trainers : MCDI, in collaboration with the Linkages Project, carried out in December 2003 the widening of the Pool of IMCI Trainers in the Toliara province by the training of 11 trainers on clinical IMCI. The participants are composed of 04 EMAD members of Toliara II Health District and 07 trainers from the Training Institute for Health-Care Providers in Toliara. The training was facilitated by the Provincial Health Department Office (DPS) trainers, MCDI, Linkages and Central MOH trainers. The trainers thus trained led the clinical IMCI training of the Health Care Providers in Toliara II.

(b) Training of the Toliara II's Basic Health Agents (ASBs) on Clinical IMCI (First care providers) : During this fiscal year 2004, MCDI organized two sessions of 06 days IMCI training for the 31 ASBs in Toliara II. The objectives of the training are (1) to reinforce the ASB's competence on under five child main diseases management according to the IMCI protocols, (2) to reinforce the capacity of the ASBs on the service reorganization in the CSB so as to allow the IMCI effective implementation and (3) to reinforce the implementation of the C/HH-IMCI at each health sector. All the Toliara II and Southern Betioky's CSBs have currently at least one ASB trained in IMCI. This activity brings up to 55 the number of the ASBs trained on IMCI. This training gave obvious knowledge acquisition of the ASB as regards on IMCI as can show the average of 13 points between the pre and post tests. Moreover, 02 medical doctors in training course in the SSD of Toliara II also benefited from this training.

In accordance with the national training curriculum, these clinical IMCI trainings (FDF and the two waves of training of service-providers) were made up of 6 half days of theory and 5 half days of hospital practical sessions.

(c) Follow-up of ASBs on IMCI : In accordance with the national recommendation on IMCI training, MCDI carried out, in collaboration with the EMAD, post-training follow-ups of all the CSBs in Toliara II. The objectives of these follow-ups are to reinforce the knowledge and competency

acquired by the ASBs during the formation and to assist the ASBs for the effective starting up of the IMCI activities of which especially the support on the services organization. The IMCI essential equipments for CSBs were provided during these follow-ups. On a quarterly basis, the EMAD and the MCDI carried out a supervision of the CSB during which the implementation of the PCIME was reinforced thanks to the use of a supervision tool oriented on the improvement of the quality of service. This tool was developed by the DPS in collaboration with MCDI.

(d) Evaluation of the quality of related clinical IMCI care at the CSB level : An evaluation of the quality of care provided to the children aged less than 5 years was carried out by MCDI in collaboration with the National Institute of Public Health and Community (INSPC) and the EMAD of Toliara II. This survey uses 04 tools including an observation of the service providers, an interview of the ASBs, an inventory of the IMCI technical panel and an interview of the mothers at the end of the consultation inspired from the MCDI HFA tools. The results of this investigation are in section M.

- At the the SSD of Betioky Sud level

(A) ASBs Follow-up on IMCI : MCDI focused its efforts on the follow-up and reinforcement of the Betioky Sud's care providers during this fiscal year 2004. This activity was carried out jointly with the IMCI Provincial Team and the EMAD. To do so, the team carried out grouped follow-up during the monthly reviews (each quarter) including 03 days of practical training courses at the District Hospital (CHD 1) in Betioky Sud. Each ASB is observed during the consultation of a sick child then a discussion will stem from all the ASBs on the positive points and issues which would need a detailed attention raised during the observation.

(b) Retraining on IMCI of ASBs : Just after each follow-up which is grouped and supported by IMCI audio visual aids, the ASBs follow a session of retraining from 2 to 3 days based on the weaknesses raised during the practical evaluation. 24 health agents from the 19 CSBs in Betioky Sud benefited from these kind of IMCI follow-ups. In addition, these grouped follow-ups made it possible to test and adapt the MOH IMCI follow-up tools.

Constraints for this activity

Concerning the follow-up : For the two districts of intervention of the TCSP, the main constraints met during the follow-ups are (1) the insufficiency of the number of patients to be consulted during the training courses practice - which limits the case study (2) the insufficiency of the number of supervisors during the practical training courses, implying the need for more extension of the pool of IMCI trainers and for coordinating well the follow-up raids of the training in order to favour optimal presence of the members of the pool of regional and local trainers for an effective supervision of the health agents. We could note that the follow-up of training is strongly requested by the service providers themselves but it is the capacity of the SSD to carry it out which is limited. The DPS should direct its supports toward that.

A.1.1.1.2. Implementation of the Nutrition Essential Actions (AEN) at the CSB level

AENs include the promotion of breast-feeding, complementary feeding, sick children feeding practices, pregnant and breast-feeding women feeding, Vitamine A, iron and iodine.

(A) Retraining of Betioky Sud's ASBs on AEN : Following the ASBs' initial training during the fiscal year 2003, MCDI - in collaboration with the SSD and the Linkages Project - led on April 2004 a

retraining of 26 ASBs and 05 EMAD members of the Betioky Sud on AEN. The seven components of AEN were reviewed during this retraining which lasted 3 days with a focus on the complementary feeding and pregnant women feeding components. This retraining reinforced the participants' capacity especially on evaluation of the feeding practices, counselling to be provided during consultation and micronutrient. Moreover, it enabled to identify two main lessons regarding the implementation of AEN at the CSB level : (i) the BFP principles are easily accepted and acquired by the health agents whereas (ii) the evaluation of the feeding practices in a sick child is not a current practice among health agents and it deserves to be supported during the various follow-ups and integrated supervisions .

MCDI, supported the Linkages Project in the training of 30 ASBs of the Toliara I SSD, Linkages' area of intervention, on complementary feeding, sick child feeding practices, growth monitoring and promotion.

A.1.1.1.3. Strengthening birth spacing services at the CSB level

(A) Retraining of the ASB on the FP : The project carried out an upgrading training of the 32 ASBs of Toliara II, previously trained in 2003. The training was carried out in order to reinforce the promotion and the services of Family Planning at the CSB level. It was about a 5-day training, using the PF training modules developed at the national level with an accent on the FP HIS sessions and the community-based distribution activities. The Project HMIS Manager led an additional session on the local use of data as a decision-making tool as regards PF. Currently, all the CSBs of Toliara II and Betioky Sud have all become FP sites.

(b) Improvement of the contraceptives supply system : In addition to the health agents' training, MCDI also brought supports to SSDs on the improvement of the contraceptive supply system through the reinforcement of the supply planning. This activity was carried out during the districts monthly reviews. With a methodology based on planning per problems solving, the principal problems at all levels were analysed and realistic solutions were brainstormed in a participative way. As a matter of fact, all levels (DPS, EMAD, ASB) took part in this exercise which is very constant as well in the frequency as in the follow-up of the implementation of the recommendations. This activity contributed to the improvement of the contraceptives availability at the CSB levels noted at the end of the fiscal year 2004 - 63% of the CSBs did not experiences stock out of contraceptives as opposed to 32% at the beginning of the project.

Constraints for this activity:

- Training of the second care providers of Toliara II (25 ASBs) which was planned for this fiscal year 2004 could not take place because of the overlapping of the activities and the priorities of the Ministry of Health as mentioned in section C : Constraints. Rescheduled 4 times because of unexpected activities within the SSD, this training will be rescheduled for the next fiscal year.
- Certain ASBs (the case of Ambatofotsy, Maroarivo in the SSD of Southern Betioky) which are not convinced of the PF or which has cultural constraints toward the PF (too much traditionalists) refuse to provide PF services in their CSBs. They sometimes manage to block the contraceptives supply system and the FP management tools.

A.1.1.1.4. Retraining of the ASBs on the Extended Immunization Program (EPI)

Like each year, MCDI supported the SSD of Betioky Sud and of Toliara II on retraining of the health agents of all the CSBs on EPI. This activity which is based on the MOH National Immunization Policy

was programmed in collaboration with the EMAD during each monthly review and is reinforced with each CSBs integrated supervision. 60 ASBs benefited from this retraining.

A.1.1.1.5. Training of the ASBs on the TBAs' Safe Motherhood and child health training modules

Before carrying out the training of TBAs whose ASBs belong as the trainers, MCDI, in collaboration with the EMAD of Toliara II and Betioky, carried out the training of the ASBs of the two health districts on the TBAs' Safe Motherhood and child health training modules. On the whole, 28 ASBs of Toliara II and 21 of Betioky benefited from the training. The modules used are those of the MINSAN which include two quite distinct components : (1) **guides for traditional midwives for a safe motherhood** during the 03 periods of pregnancy (during the pregnancy, the delivery, and the postnatal period) , **the identification of the danger signs during pregnancy** and (2) **the home based management of childhood diseases**.

To allow a better follow-up of TBAs activities, each traditional midwife is required to send a monthly report to the CSB of her health sector. For the illiterate ones, a new system was established by using tokens. The VCSs of the Fokontany where the TBAs live are also encouraged to contribute to the drafting and the routing of the report. The follow-up and the supervision of the TBAs are under the direct responsibility of the CSB Heads and/or midwives of the maternity of the health sector.

A.1.1.1.6. Training of the ASBs on Paludism

In collaboration with the Provincial Health Office and the EMAD members, MCDI proceeded in November 2004 to the training of 19 health gents and 07 EMAD members of Betioky on the malaria case management (MCM), on the epidemiologic surveillance and the malaria prevention promotion at CSBs level, including the chemoprophylaxis of pregnant women. This training was held to fill the gaps noted during the supervision visits on the quality of the MCM in the CSBs. The EMAD of Betioky noted that there is more and more violation of the national MCM protocol. The ASBs tend to treat as a first intention injectable quinine whatever the noted clinical case, whereas this drug is recommended to be used in third line treatment. It was a 5-day training using the national training modules. The DPS supported this training.

A1.1.2. BCC/IEC and Community Mobilization related Activities

The Project BCC Approach within the 02 SSDs aims at the capacity strengthening of the community as regards of health in order to promote behavior change among the population to adopt positive health attitudes and especially positive changes in the mothers practices leading to the improvement of maternal and child health.

The Project BCC/Community Mobilization Approach is based on Community Health Volunteers (Community Health Volunteers) acting as communicators within the community to convey the positive messages. This approach is reinforced by various activities aiming at the synergy within all partners (eg: the Child to Community Approach at the school level, the local NGO capacity building based approach.)

During this fiscal year 2004, the local authorities' involvement in the support of the Community health volunteers in the execution of their task is more and more significant. In the majority of the medical sectors, the VCS are also more and more supported by the SSD Program Officers (e.g. the VCS's involvement during the measles immunization campaign). Their follow-ups are structured and more

systematic due to the readjustment of the community activities follow-up tools.

In short, the efforts of MCDI were focused on (1) the reinforcement of making the VCSs operational within the whole health sectors, including increase in their geographic coverage, (2) the training of the VCS to ensure that each one of them received the complete package of trainings, (3) the celebration of successes regarding the change of behaviour of the community through health festivals (4) the integration of the local NGOs and (5) the testing of the *Child-to-community* approach.

At the end of the fiscal year 2004, the total number of the operational VCSs trained within the health districts of Betioky and Toliara II are respectively 453 and 440. The number of new VCSs set up during the fiscal year 2004 is 77 for Betioky (at the Communes of Ankilivalo, Andranomangatsiaka, of Ambatofotsy, Beantake, Beavoha and Tameantsoa) and 116 for Toliara II (Health sectors of Manombo, Miary, Anakao, Soalary, Ankilimivony, Efoetse and Beheloka).

A.1.1.2.1. Trainings of the Project Facilitators (Field Agents) and the Community Health Volunteers

For the majority of the trainings led among the Community partners, each trainer team is made up of at least 01 field agent, 01 member of the EMAD and/or a Community animation agent (from the Provincial Communication Department : SAR). The table below summarizes the trainings and the retraining that MCDI achieved during the fiscal year 2004 for the field agents and the VCSs.

Table n° 1 : Recapitulation of trainings of the Community Health Volunteers' trainings and the Field agents carried out during the fiscal year 2004

Topic	SSD of Toliara II	SSD of Betioky Sud	Comments
Basic communication techniques	Training of the 116 new VCSs	Training of 77 new VCSs. Which brings up to 100% (453/453) the number of the trained operational VCS. Training of 06 "Agent de Conservation et d'Environnement" (ACE) of the Beza Mahafaly Special Reserve (RSBM).	The training of the ACE enters within the framework of the collaboration between MCDI and the RSBM on the one hand, and of the launching of the approach integrated Health-Environment-Population Approach, on the other hand. For the SSD in Betioky, the majority of the trainings of the VCS were carried out by the MCDI Community Activities Manager in collaboration with the VEMIMA.
Home based Management of childhood illnesses	Training of 12 trainers made up of 06 field agents, 06 members of the EMAD Training of all the operational VCSs (440)	Training of 126 VCSs. What brings into 289/453 the total number of the VCS trained in Home based Management of childhood illnesses	The Home based Management of childhood illnesses) training includes principal components as the recognition of the danger signs, the reference, the sick child feeding, the care seeking attitude promotion, the home based treatments required to the sick child before the seeking for care and the follow-up of the sick child. It is a new

Topic	SSD of Toliara II	SSD of Betioky Sud	Comments
	Retraining of 402/440 operational VCSs (recycling)	Retraining of 70 VCSs	<p>training module on which MCDI plans to form all the VCSs even those having previously received similar trainings (case of the Betioky's VCSs).</p> <p>During the trainings and retraining of the VCS, it turned out that the allocated time requires prolonging because the module deals with three diseases at the same time. The module must also be adapted especially concerning the pathway to child survival session. This session is proposed to be cancelled owing to the fact that it is too complicated and is not easily understandable by the participants while disturbing the continuation of the training</p>
EPI Promotion	<p>Training of 11 trainers made up of 06 Field Agents, 05 members of the EMAD. (with a substantial average gain of 14 points per participant)</p> <p>Training of 394 VCSs (394/445 trained operational VCS)</p>	Training of 84 VCSs (100% of the VCS of Betioky trained on EPI promotion)	The TOT in EPI of Toliara II was facilitated by the Project HMIS Manager, the EPI promotion training of the VCSs was a little delayed by the vertical programs and the priorities of the MOH. Consequently, the retraining of the VCSs will be deferred for the next fiscal year. The average knowledge gain during these formations is of 12 points per participant.
Nutrition Essential Actions (AEN) training	<p>Training of 116 new VCSs on BFP</p> <p>Training of 388 VCSs (including the 116 new VCS) on complementary feeding, pregnant woman feeding practice</p>	<p>Training of 77 new VCS on BFP</p> <p>Training of 126 VCSs on complementary feeding, pregnant woman feeding practice</p>	<p>As decided at the end of the fiscal year 2003, the training on AEN was divided into 02 phases : training on BFP and complementary feeding, pregnant woman feeding practice. The initial training of the VCS includes mainly 02 topics: Basic Technical Communications and BFP.</p> <p>The VCSs trained on complementary feeding, pregnant woman feeding practice are those who already</p>

Topic	SSD of Toliara II	SSD of Betioky Sud	Comments
	Retraining of 52 VCS, on complementary feeding, pregnant woman feeding practice		benefited from a training on BFP during the fiscal year 2003 and who did not have complementary feeding, pregnant woman feeding practice training yet.
Birth Spacing Promotion		Training of 84 VCS. Which brings to 100% operational VCS of Southern Betioky trained on PF.	The training on PF of the VCS of Toliara II will be undertaken during the FY 2005.

Other lessons learned of VCS capacity strengthening related activities :

- the quarterly rhythm of retraining is suitable and feasible
- each contact with the VCSs must be taken as opportunity to make retraining, the follow-up and the reinforcement of their capacity. A package of activities to be carried out during each contact with the VCS should be established.

A.1.1.2.2. Reinforcement of the local NGOs capacity

As mentioned in the DIP, the reinforcement of the capacities of local NGOs is among the main project sustainability strategies. Working under an mentoring approach with MCDI, the VEMIMA NGO of Betioky became completely operational and autonomous and has acquired a lot of competences as regards of child survival interventions. Since the beginning of this cost extension project with, the VEMIMA NGO directly manages the planning, the implementation and the follow-up of the VCSs in collaboration with the SSD and the Community Animation Service (SAR). Since then, MCDI has focused its efforts on the reinforcement of the capacities of this NGO.

During this fiscal year 2004, MCDI carried out the retraining of 17 Vemima members on the complete package of trainings for the Community partners (basic Communication Technique , AEN, EPI, FP, home based case management of child illnesses, STIs/AIDS prevention and in community-based activities follow-up approach). Also, these 17 VEMIMA members benefited from a training on Community based HIS developed especially for NGOs.

As regards to the NGO MAMPIFOHA (Toliara II), MCDI held a workshop for its members on the general overview of Child Survival Projects (contexts, reasons of beings, changes of behaviors, priority messages). Also, 06 members of MAMPIFOHA could benefit from training on the topics of PCEM, TBC and AEN. However, Mampifoha remained non-operational because of frequent moves of its members and other internal problems. MCDI will provide its supports to reinforce the organisational capacity of this NGO during the FY 2005.

A.1.1.2.3. Celebration of successes : Community health festivals

The project adopted as strategy of reinforcement of the BCC activities the celebration of the acquired achievements. The principal activity of this celebration is the organisation of the Community Health

Festivals. For the fiscal year 2004, the celebration activities carried out largely exceeded those planned. They were carried out thanks to the close collaboration between MCDI and the SSD on the one hand, and to the active involvement of the authorities and the community, on the other hand. 17 festivals were carried out within more than half of the health sectors of Toliara II. For Betsioky, one festival was held in the health sector of Beavoha within the framework of the Child-to-Community Approach, in collaboration with Voahary Salama. For each festival, MCDI organized with CSB Heads contests on ‘good behaviours’ (eg : plumpy babies, completely vaccinated child etc.). The supports for mass animation like sketches, songs, village theatres developed during these festivals were all classified to be used as project audio visual communication supports. The festivals benefited from a broad media coverage and an exceptionally significant multitude of assistance of eminent personalities like senators, deputies, President de Faritany (Governor).

As a whole, these Community Health Festivals made it possible to reach more than 25 000 members of the community in 02 Districts with an average multitude of 1400 audience by festival.

During this year, lessons learned from this activity are :

- There is an appropriation of the process by the authorities and the actors : the Community festivals constitute for the authorities an favourable and ideal occasion to communicate with the members of the community not only for the health messages but also to spread the other messages related to their respective responsibilities. Moreover, the festivals allow the enhancement of the authorities within the community.
- Good collaboration with the authorities as well as active contribution of the VCSs and the CSBs are determining factors in the success of the festivals.
- The VCSs are very enthusiast for the festivals. Actually, VCSs are aware that the Community festivals constitute a major opportunity to reinforce their credibility among the members of the community.
- The festivals contribute to the institutionalisation of the Community Partners, mainly the VCSs, because of their recognition by the authorities.
- At all levels, the festivals turn out to be as a good means of BCC and Community Mobilization, to advocate and transfer knowledge for the health actions.
- The fact that the Mayors have been elected lately has a very great influence on their contribution and their involvement in the organization of the Festivals. Actually, the Mayors want to show to the present provincial authorities and their population their competence and their capacity of mobilization. The majority of the mayors gave zebu to honour the event. Which is exceptional in the cultural context of this area where only the imposing ceremonies are marked by a sacrifice of zebu. The value of the festivals thus enhanced due to the presence of zebu.
- The festivals are opportunities for the communal authorities to meet the provincial authorities and other actors to discuss the other aspects of the development of their commune.
- The festivals are also political opportunities for politicians (especially provincial and some times national : President of the Special Delegation of the Province, Deputies, Senators) to meet the population in order to spread their political visions. Which would undermine the credibility of such activities especially if part of the population has a different vision.
- A good organization and preparation of the festivals condition its success (consensual distribution of the contributions, the integration of beneficiaries population and the local actors like the VCSs, the Chairs of Fokontany and the Mayors).
- The valorisation of the concrete cases (for example plump babies) at the time of the festivals facilitates the participation of the authorities in the diffusion of the health messages and gives an appreciation on the impact of the activities.
- Evaluation tools and methodologies for the effectiveness of the festivals should be developed in

- order to measure the new acquired knowledges of the audience.
- The integration of the other topics (inauguration, official launching of an activity) sometimes overshadows the real objectives of the festival which are to reinforce the BCC and to dynamize all BCC actors (especially Community partners through their recognition by the authorities). Indeed, the divergence of interests regarding the orators makes that certain topics could be more emphasized than those related to health. Moreover, the speeches of the authorities sometimes tend to move away from the principal objective of the health festival. For a better conveyance of the messages which should target population, the festival must be focused only on one or two precise health topics.
 - The festivals reinforce the socio-professional relations between the various actors such as the SSD, the MCDI, Mayors, VCSs and population. However, the divergence of interests between these entities can be raised during of the festivals. *" We learn to know each other thanks to the festival, a Head CSB said "*
 - The festival is a means of reinforcing the organisational capacity of the field agents and ASBs. *" We learned much during the preparation of the festival " said the Head the CSB of Beroroha Marofoty".*
 - The festival is a good means of appreciating social cohesion, enthusiasm and solidarity within the community.

A.1.1.2.4. The VISA approach or ‘Reny Limy’

MCDI developed a simple and realistic approach known as VISA or ‘Reny Limy’ for perpetuating and reinforcing the approaches based on Community Health Volunteers. This approach not only aims to facilitate the reaching of the targeted mothers for the BCC messages but also to circumvent the problems of abandonment (turn over) of the Community partners related to the voluntary system thanks to a mechanism of renewal/recruitment of VCSs. The principles which direct the VISA approach are detailed in section G : success and innovative approaches. In practice, the approach is summarized as follows. Each VCSs is required to recruit 5 mothers in the community for a closer health education based on negotiation until these latter adopt of the key behaviours for their health and their children. Encouraged by the VCSs, the mothers who adopted the good behaviours, who are convinced of the benefits of the messages are invited to share with other women within their entourage the new knowledge, the messages and the benefits which they acquired. This aspect can take the form of public testimony during a BCC session held by the VCSs. They are called ‘*Sakelim-panentana*’ (or Promoter Aids in Mahafaly dialect) at this time. The convinced mothers are then invited to become VCSs in their turn. If they accept, each of them will be asked to recruit 5 other mothers to include them in the program and also asked to take part in the traditional activities of Communication for the Change of Behaviour and so on.

To launch the VISA approach at the SSD of Toliara II, MCDI trained during this fiscal year 2004 the 06 Facilitators of the Project which in their turn trained 402 VCSs out of the 440 operational ones. Among the trained VCSs, more than 70% (281) VCS currently have their Visa Mothers with an average of 02 mothers by CVA (either surroundings 560 VISA mothers) distributed to the level of all the health sectors of Toliara II.

For the SSD of Southern Betioky, the VISA approach has been implemented since 1999. The VCSs’ turn over rate is approximately 10% in two years. 570 new VCSs generated by the VISA approach are identified and operational, bringing to 949 the total number of Community Health Volunteers. 2788 mothers resulting from the VISA approach continue to support the VCSs to promote BCC through testimonies. 10 450 mothers were reached by the VISA approach.

Lessons learned from the the implementation of this approach are as follow :

- The BFP is the most effective entry point to start launching the VISA approach.
- The VISA approach accelerates the adoption of the key behaviors among the mothers.
- The passages of VISA Mothers to the “*Sakelim-panentana*” Mothers then to VCSs is not automatic. These passages require a sustained accompaniment on behalf of the VCSs and Field Agents in order to reinforce the VISA mothers enthusiasm.
- Certain principles of the VISA approach such as targeting first close relations and relatives but does not limit to them ; targeting those which do not practice ; to aim informally ; aiming at transforming the VISA mothers in "*Sakelim-panentana*" and the "*Sakelim-panentana*" to VCSs are not acquired yet.

A.1.1.2.5. Follow-ups of the BCC/Community Mobilization activities

(a) Adaptation of the IEC/BCC activities follow-up tools : MCDI developed tools for the Field Agents for the grouped and the field follow-up of the BCC/Community Mobilization related activities. The developed tools meet the needs for the follow-up which are to reinforce the capacity of the VCSs, to reinforce collaboration with the authorities, the BHAs and the VCSs ; to carry out a rapid evaluation of the approaches and progressions on the adoption of the promoted key behaviours.

After each field follow-up, the tools were continuously updated by the technical project staff and the EMAD members. The major gap of these follow-up tools are related to the lack of the evaluation of the collaboration between the VCSs and the other partners (ex: Asos, CBD, TBAs, Médicbrousse Association). These gap must be taken into account for the next fiscal year for better coordinating the VCS activities with those of the other Community partners.

(b) Follow-up of the BCC/Community Mobilization activities : The follow-up of VCSs is carried out in two stages, the grouped follow-up and the individual follow-up on the field. The grouped follow-up allowed MCDI to identify the most failing VCSs and to organize their follow-ups brought closer. The recapitulation of the activities of VCS follow-up during the fiscal year 2004 is summarized in the table below :

Table n° 2 : Recapitulation of the VCS follow-ups

Type of follow-up	SSD of Toliara II	SSD of Betioky Sud	Comments
Grouped follow-up	Among the 440 operational VCSs, 402 (91%) benefited from at least 02 grouped follow-ups	355 on the 453 operational VCSs (78%) benefited from at least 02 grouped follow-ups	The grouped follow-ups were also carried out during each session of grouped training or at any opportunity of grouping the VCSs. All the topics were treated and the efforts were also focused on the follow-up of the VISA approach. The follow-up teams are composed by the field agents, the EMAD members for Toliara II and MCDI Community Activities Manager, the members of VEMIMA and the members of the EMAD for Betioky.
Follow-up on the	165/440 (38%) VCS spread out	174 (38%) VCS spread out	As at the time of grouped follow-up, the individual follow-up is focused on all the topics with a

field	among 130/250 (52%) Fokontany benefited from this follow up	among 26 fokontany benefited from this follow up	specific focus on the VISA approach implementation. In addition to the teams mentioned above, the BHAs also took part in the field follow-up of VCSs.
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(c) Lessons learned from the VCS follow-up activities are as follow :

- (i) the rhythm of the VCS follow-ups must be periodic. The interval of follow-up should not be too much spaced and the quarterly rhythm is requested.
- (ii) the need for a field follow-up is strongly expressed by the VCSs. With a view of capacity strengthening - this need is being justified by the impact of the passage of the supervisors regarding the reinforcement of messages as well as the enhancement of the VCSs themselves among the members of the community.
- (iii) the field follow-ups constitute opportunities to reinforce messages and to raise the credibility of the VCS within the community.
- (iv) the reinforcement of the collaboration between VCSs in the field of implementation and follow-up of the BCC activities must be maintained in order to support the mutual aid within the VCSs.

A.1.1.2.6. Implementation of the Child- to- Community approach

The implementation of the Child-to-Community Approach (CTC) consists of training and responsibility given to children in primary schools. Thus, children are considered as the main messengers. In collaboration with Vohary Salama, the Betsioky Sud Education Department (CISCO) and the Management of the Basic Studies Office (Ministry of National Education), MCDI experienced the CTC during the fiscal year 2004 in the Commune of Beavoha which include 10 schools spread out into 11 Fokontany. While establishing the 07 objectives based on health and environment, the schools enter in competition between them to obtain the distinction of ‘*Ecole Flambeaux*’ at the end of the year. It is an alternative child-to-child approach.

During the FY 2004, MCDI carried out the training of 10 teachers from 10 schools on CTC. MCDI then organized with the CISCO of Betsioky of the quarterly follow-up of the schools to evaluate the progress in the implementation of the approach and especially to reinforce the CTC implementation. At the end of the school year, MCDI held a workshop of experience sharing between the teachers and the members of the community and one festival for celebrating the acquired achievements. While referring to the criteria of selection of the ‘*Ecole Flambeaux*’, 6 schools out of the 10 which took part in the program obtained the label.

The lessons learned during the CTC implementation during this FY 2004 are summarized in a collective awakening and a full participation of the entities concerned at all level. This fact can be accounted for the spirit of competitiveness among each village and each school which is generated by the implementation of the approach. Actually, there is a palpable change on the behaviour of the teachers as regards body and outfit cleanliness, and regularity (updated journal, reduction in the absenteeism, reduction in alcoholism at the school level). This change is also perceived among the pupils who take an active part, with the assistance of the teachers, in the improvement of the school physical environment. It is the same for the members for the Community management Board who, through the approach and while digging themselves the holes of the latrines, managed to circumvent the taboos. Regarding the CISCO people, the Pedagogic Action Zone Head Officers are more and

more motivated for the regular supervision and the follow-up of the teachers.

The only constraint met during the implementation of the CTC is that 02 schools among the 10 abandoned the program due to their closing-down related to the assignment of the teachers in the course of the school year.

A.1.1.3. Reinforcement of the Community-Based Service Providers

A.1.1.3.1. Training of TBAs on Safe Motherhood and child health

Within the framework of the involvement of TBAs in the suitable community based childhood illnesses management in which they are the reference people to mothers, MCDI proceeded during the fiscal year 2004 to train 110 TBAs (53 to Toliara II and 57 to Betioky Sud) on Safe Motherhood and child health management. Currently, all the health sectors within the Project areas are covered by trained TBAs.

The training included theoretical courses and practical training courses at the CSB. The modules used are those of the MOH including two quite distinct components (1) the guides for the traditional midwives for a safe motherhood for the 03 periods from the pregnancy (during the pregnancy, the delivery, and the postnatal period) and identification from the signs of danger during pregnancy and (2) *the management of the child health.*

Table n° 3 : Summary of TBAs training activities during FY 2004

SSD	Axis	Sector	Number	Trainers
Toliara II	Center–East	Manorofify, Antanimena, Mahaleotse, Ambohimahavelona	11	Members of EMAD
	North	Betsioky Somotse, Soahazo, Ankililoaka, Ankaraobato, Milenaky, Tsianisiha, Beravy haut, Tsiafanoky, Beroroha Marofoty, Benetse	20	Head of Center, or the midwife of the place of training, MCDI’s Quality of Care Advisor
	Center	Behompy, Miary, Maromiandra, Belalanda, St Augustin, Manombo, Andranovory	14	
	South	Beheloka, Anakao, Soalara, Ankilimivony	08	
Betioky Sud	South– East	Lazarivo, Soaserana, Soamanonga, Sakamasay, Ambatofotsy Belalitse	25	MCDI’s Quality of Care Advisor
	Center 1	Betioky, Ambatry, Beavoaha, Antohabato, Ankazomanga Ouest, Maroarivo, Beza Mahafaly	18	District Safe Motherhood Program Officer
	Center 2	Maroarivo, Betioky, Tongobory	14	Head of BHCs, or the midwife of the place of training

At the end of the training, each TBA was equipped with a Safe Motherhood kit including 1 draw sheet, 1 pack of 5 blades, a bottle of alcohol, 1 thread, 1 nailbrush and 1 piece of soap. Moreover, MCDI supported on the duplications of the modules (2 modules/mentors) and the report cards for the TBAs.

The major constraints met during the training of the TBAs were:

- Very low level of literacy of the TBAs which made learning a little difficult especially as the majority of the TBAs are rather old.
- The insufficiency number of women in the process of delivering during the practice sessions.

These two points imply the need for making a regular and closer follow-up and retraining of TBAs while recommending an active and significant participation of the BHAs.

For Betioky, palpable results are observed after the training of traditional midwives. 151 normal deliveries were carried out by 85 trained TBAs since their installation. This number varies from 1 to 6 deliveries per TBA. The majority of followed-up TBAs master the 07 general danger signs to be checked among pregnant women. So far, no incident has been mentioned or announced by the community or the BHAs.

A.1.1.3.2. Installation and reenergizin of the Community Based Distribution Approach

During the fiscal year 2004, following the requests expressed by the mayors during the Community health festivals, MCDI set up 20 Community Bases Distributors (CBD) Chloroquine spread out into 07 health sectors (Ambohimahavelona, Saint-Augustin, Andranohinaly, Andranovory, Miary, Mitsinjo, Maromiandra) in the district of Toliara II. Then, the 20 CDB and 03 MCDI Field Agents were trained on the malaria prevention and community based distribution activity management. The module used is that of the MOH.

In spite of the joint development of a scheme of integrated work, the installation of the 164 CDBs planned for this fiscal year 2004 was not carried out completely because of the overlapping of the activities and the priorities of the Ministry as mentioned above. This situation also entailed with the non realization of the follow-ups of the trained CDBs.

For Betioky SSD, MCDI with the CSB Heads made an inventory of the still operational CBDs and identified new potential CBDs. Approximately 18 CBDs among the 81 (21%) originally in place remain operational and continue to be supplied by the BHCs. The principal reasons are the nomadism, the explosion of the Saphir phenomenon involving frequent moves of the ADBC. During the fiscal year 2004, 05 new DBC per medical sector were identified but the training will proceed during year 2005.

The lessons learned from this activity

- The principal blocking factors met are related to the lack of conviction of the health agents on FP Promotion (case of Ambatofotsy Belalitse, Maroarivo in Betioky SSD) and to the existence of the interpersonal conflicts between the CBDs and the HBCs (intentional blocking of drug supply system and the management procedures) which disturb considerably the community based distribution operation.
- The criteria and selection mode of the CBDs must be re-examined. Priority must be given to the most efficient VCSs. This selection should not be entrusted only to the health agents. So the choice of the CBDs must involved the direct actors namely the field agents, the health agents and the MCDI and SSD BCC Manager.

- The reenergizing of the DBC also requires a reenergizing of the health agents through retrainings.

A.1.1.4. Direct supports to the SSDs related activities

A.1.1.4.1. Technical support for BHCs intergrated supervision planning and conducting, including the development of the supervision tools.

A draft of an integrated supervision tool of the BHCs was developed during this period. Its development required the organisation of a three-day workshop with the EMAD members and DPS Officers. This tool especially focuses on IMCI quality care and the availability of the critical resources at the BHCs level. This tool was validated by the DPS.

Once the tool was developed, the EMAD and the MCDI proceeded to the planning of the BHCs supervision as a whole within the district area of Toliara II. 04 supervising team spread out in 4 different axis were set up. Each team was composed of a district program officer, an administrative clerk, a service-providing agent and a technical advisor from MCDI. Then, All the BHCs received a supervision visit during that period. We can assert, even merely by the supervision achievement, that an important step was undertaken toward the capacity strengthening of the EMAD in this field. It must be noted that the BHCs benefited from that supervision thanks to the provided recommendations with a view to improve the work.

A.1.1.4.2. Technical support for the development of the district health development plan 2004-2006

Within the framework of project support on the development of the health district development plans (PDD), financed by the CRESAN and carried out by the JSI, MCDI as a support of the districts provided technical assistance to Toliara II an Betiok districts in the development of their trienal heath development plan. The planning pattern was produced by JSI. Dr. Rija Lalanirina, the MCDI HIS Manager ensured this support for the district of Betioky and Dr. Oliva Andriamahefa, MCDI Health Educator for the district of Toliara II. These two MCDI staff participated in all the phases of planning, to the data-gathering until the budgeting through useful advises and leadership. During this exercise, the TCSP related activities were integrated in the district plans.

A.1.1.4.3. Technical support for the realization of the monthly reviews of the two districts

One of the approaches of MCDI for the reinforcement of the EMAD and BHCs capacity in the areas of management program and follow-up/M&E is the support to the realization of the district monthly reviews. It is a monthly meeting of all heads BHCs with the technical and administrative responsables from SSD. MCDI benefits from this occasion to reinforce the capacity of care providers in the fiels of child survival (case management, promotion and education) by observation of the practice method by recycling BHAs. The MCDI support consisted to the supply of a facilitator for each district, to the participation on the design of the session plan, to the supply of the technical resources and logistics, to the reinforcement of the EMAD capacity and to the logistic financial support of the review.

A.1.1.4.4. Training of trainers of the EMAD members of Toliara II on the Community IMCI

A training of trainers in Community IMCI was held in December 2003 with the collaboration of the IMCI Provincial Officer. It's a 06 days of grouped formation reinforced by the method of Self Training Assisted according to Minsan recommendations. 11 traners whose 4 members of the EMAD were

trained.

A.1.1.4.5. Support to the realization of the catch up vaccination activities in advanced strategy in the two districts

In the framework of the EPI relaunch activities, supported by WHO, the support to the advanced strategies were envisaged. These supports were targeted firstly to problematic BHCs and most populated BHCs. MCDI has supported the districts of Betioky Sud and Toliara in the realization of these advanced strategies to include all the CSB of these districts. MCDI has taken part in the whole steps of this support including the logistic support and planning. This activity has favorably contributed to the increase of the immunization coverage of these two district during this year 2004. The activities of the advanced strategies were undertaken from October to December 2003 by respecting the passage for at least three times in each locality. MCDI dealt with the CSB not supported financially by WHO. 85% of the CSB was able to completely carry out the planned activities.

A.1.1.5. Health insurance credit scheme in Ankazomanga Ouest

The activity of the Ankazomanga Ouest health credit scheme knew a postpone following the suspension of the national cost recovery system for the period from October 2002 to October 2003. The total resumption of the national cost recovery system was effective only in May 2004. Consequently, the ankazomanga ouest health credit scheme had been started again. Activities below are carried out during this FY 2004 :

(a) Restarting of the credit scheme related activities :

- Meeting with the Credit Scheme Management Committees in April 2004 : planning and situation analysis (Management tool, members of office, cash in hand)
- The management tools were updated as well as members of Management Committees (change of members of Tokoendolo Office according to the request of the population).
- Training of the Management Committee members at the villages and central office level.
- Thorough Training on the credit scheme management and procedures including the use of management tools.
- Official restarting of the Credit Scheme

(b) Extension and replication related activities

- Identification of potential sites with preliminary analysis carried out by the Field Agent
- Discussion with MOH at all level on designing the best strategy for replication
- Preliminary identified sites (await for the MOH validation) : Antanimena, Andranohinaly, Ambohimahavelona, Mahaleotsy all of them within the Toliara II district
- Exporation of possible collaboration with Voahary Salama in replicating the credit scheme

A.2. Table illustrating progress toward the objectives (see results KPC and HFA 2004 in sections I and J for more information)

Objectives	Progress toward the objectives	Main planned activities achieved to date and indicators
PCM		

<p>1) Increase from 11 % to 45% the % of mothers of children aged 0-23 months with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day</p> <p>2) Increase from 25% to 65% the % of mothers of children aged 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek ...?</p> <p>3) Increase from 0% to 60% the % of clinical staff who will correctly use IMCI treatment protocols.</p>	<p>YES</p>	<p>The coverage found at the mid term evaluation using KPC and HFA on 2004 show clear progressions of these indicators (19% for objective N°1; 45% for objective 2; 27% for objective 3))</p> <p>06 Field Agents (Facilitators) are recruited and trained on the complete range of trainings which were programmed for them (TOTt, PCM, MCA, DCM, BFP, EPI promotion, Visa approach) except the FP promotion</p> <p>Up to now, 445 VCS are operational and are trained on the prevention and home cases management of ARI/Pneumonia, including the recognition of danger signs, reference and feeding practice of sick child. A training curriculum on ARI/Pneumonia for the VCS was developed. In addition, 55/60 Basic Health Agents are trained on TOT and supervision of VCS in relation to the PCM. This training was integrated within the clinical IMCI Training. More than 80% of the VCS trained thus received a quarterly retraining and a quarterly supervision as regards PCM. C/HH IMCI Supervision Tools were developed and made available at all level (CSB, EMAD, Field Agents).</p> <p>The MCDI supplied all actors on BCC (VCS, FA, Basic Health Agents, local authorities etc) with IEC supports. These supports are those developed by the IEC Task force and include mainly ‘‘gazety’’, counselling cards, child and maternal health card, posters. MCDI developed audiovisual BCC materials for TV and radio broadcasting use.</p> <p>To reinforce the social mobilisation activities especially in order to celebrate the perceived changes in behavior at all levels, MCDI organised health festivals in 25/50 health sectors (24/29 in Toliara II and 1/24 in Betioky). Festivals are time-consuming activities.</p> <p>All the activities based on a child-to-child approach were eliminated to avoid a duplication of efforts with the <i>Aide et Action</i> NGO which implements them in the two districts. However, within the framework of its Initiative of Integrated Health - Population – Environment Program, MCDI - in collaboration with Voahary Salama - implemented a Child for the Community Approach in 08 primary schools in Betioky.</p> <p>The implementation of the clinical IMCI component²³ started with the TOT of 11 IMCI trainers (DPS, SSD, IFP), the training of 55 BHAs, the efforts to make</p>
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Malaria		
<p>1) Increase from 3% to 20% the % of children aged 0-23 months who slept under an insecticide-treated bed net the previous night</p>	<p>NO</p>	<p>The coverage found at the time of investigation KPC and HFA on 2004 did not show acceptable progressions of these indicators towards the objectives (7% for objective N°1; 25% for objective 2; 21% for objective 3))</p> <p>The completed activities related to the ITN promotion were limited to the promotion of the messages on the benefits of using ITNs. These messages were broadcast through mass media and VCS. All that are related to the logistic aspect and distribution were not carried out yet (DBC, promotion of social group of facilitation of the acquisition of ITNs). The reason is the imminence of the application of a new Malaria Minsan policy on the change of the sale policy based on free distribution of ITNs. This implied prudence in the implementation of project approaches to remain in line with this MOH policy - which implies in-depth changes on the ITN promotion programme.</p>
<p>2) Increase from 13% to 50% the % of mothers of children aged 0-23 months with a febrile episode ending during the last two weeks who gave correct treatment at home</p>	<p>NO</p>	<p>Up to now, 445 VCS are operational and trained on the prevention and the home based case management of malaria. A training curriculum on malaria for the VCS was developed. More than 80% of the VCS received a quarterly retraining and a supervision on the fight against malaria. 55/60 Basic Health Agents (BHAs) are trained in TOT and supervision of VCS related to malaria. Clinical and C-HH IMCI Supervision Tools clinics were developed and made available at each level (BHCs, EMAD, FA).</p> <p>MCDI supplied all actors on BCC (VCS, FA, Basic Health Agents, local authorities etc) with IEC supports on malaria. These supports are those developed by the IEC Task force and include mainly ‘‘gazety’’, counselling cards, child and maternal health card, posters. MCDI developed audiovisual BCC materials for TV and radio broadcasting use.</p> <p>A rural-based radio program based on the listening group system was implemented in collaboration with ALT PR. This program promotes the messages on malaria and ITNs. All the activities related to the approach child-to-child were eliminated to avoid the duplication of efforts with the <i>Aide and Action</i> NGO.</p>

3) Increase from 31% to 80% the percent of mothers who took anti-malarial medicines to prevent malaria during pregnancy	NO	Clinical IMCI is implemented in all BHCs in the intervention area. 21/60 BHAs are trained on the prevention and treatment of malaria during pregnancy, 06 trainers (DPS, EMAD) are trained in TOT on the prevention and the protocol of treatment of malaria among pregnant women. As the IPT and the artemesinine are <u>in the course of adoption</u> in Madagascar, MCDI have not yet updated the training modules and curricula on malaria.
4) Increase from 0% to 75% the % of CBDs with no stock out of anti-malarial medicines during the preceding 6 months.	N/A	Although the anti-malaria drugs are available in more than 80% of the Health Centers thanks to efforts on the reinforcement of drug supply in the CSBs, only 20/184 DBC Chloroquine are trained on the algorithm of the treatment of paludism for the DBC and the management of chloroquine. However, the management tools for the DBC are developed and the supply of chloroquine of the 20 operational DBC was carried out regularly.
CDD		

<p>1) Increase from 34% to 65% the percent of children aged 0-23 months who have had diarrhoea in the past two weeks and who have been given more than the usual amount of fluids during a diarrhoeal episode</p>	<p>YES</p>	<p>The coverage found at the mid term evaluation using KPC and HFA on 2004 show clear progressions of these indicators (58% for objective N°1; 64% for objective 2; 60% for objective 3; 55% for the objective 4 and 45% for objective 5))</p>
<p>2) Increase from 24% to 55% the percent of children 0-23 months who had diarrhoea in the past two weeks and who were given the same or more than the usual amount of foods during a diarrhoeal episode</p>	<p>YES</p>	<p>420 VCS have been implemented, and trained on the diarrhoea prevention and home treatment including the TRO, on the follow-up of danger signs, on the reference and the feeding practice of the child with diarrhoea. They promote the messages about diarrhoea through various channels and means, including the Visa method. The training modules are adapted and available. The BCC supports and messages are adapted and available at all the levels. Moreover, thanks to its collaboration with Radio ALT, MCDI produced and broadcast more than 50 spots and educational programs on diarrhoea in the local radio stations in the project area . However, the activities at the school levels are left to the NGO <i>Aide et Action</i> because of concern about duplication of efforts. Only a local NGO (Mampifofo) was involved in the promotion of family and community BCC activities in relation with diarrhoea in the area. 05 support groups to promote home based available liquids for TRO, SRO and breast-feeding are in place and operational. The Visa approach is applied by all the operating VCS. On the other hand, the effort toward the installation and the <u>operationalization</u> of the Child Survival Inter Sectoral Committee were abandoned. This approach requires a little more stability of the members. Which is not the case because, being employed by the government, the latter have been often prone to frequent changes lately. Which prevents the normal functioning of the Committee.</p>
<p>3) Increase from 36% to 65% the % of children 0-23 months who had diarrhoea in the past two weeks and who were given the same or more than the usual amount or more breast-milk during a diarrhoeal episode.</p>	<p>YES</p>	<p>420 VCS have been implemented, and trained on the diarrhoea prevention and home treatment including the TRO, on the follow-up of danger signs, on the reference and the feeding practice of the child with diarrhoea. They promote the messages about diarrhoea through various channels and means, including the Visa method. The training modules are adapted and available. The BCC supports and messages are adapted and available at all the levels. Moreover, thanks to its collaboration with Radio ALT, MCDI produced and broadcast more than 50 spots and educational programs on diarrhoea in the local radio stations in the project area . However, the activities at the school levels are left to the NGO <i>Aide et Action</i> because of concern about duplication of efforts. Only a local NGO (Mampifofo) was involved in the promotion of family and community BCC activities in relation with diarrhoea in the area. 05 support groups to promote home based available liquids for TRO, SRO and breast-feeding are in place and operational. The Visa approach is applied by all the operating VCS. On the other hand, the effort toward the installation and the <u>operationalization</u> of the Child Survival Inter Sectoral Committee were abandoned. This approach requires a little more stability of the members. Which is not the case because, being employed by the government, the latter have been often prone to frequent changes lately. Which prevents the normal functioning of the Committee.</p>
<p>4) Increase from 52% to 80% the % of children aged 0-23 months who had diarrhoea in the past two weeks and whose mothers sought advice or treatment for the illness within 24 hours after the first sign of danger</p>	<p>YES</p>	<p>420 VCS have been implemented, and trained on the diarrhoea prevention and home treatment including the TRO, on the follow-up of danger signs, on the reference and the feeding practice of the child with diarrhoea. They promote the messages about diarrhoea through various channels and means, including the Visa method. The training modules are adapted and available. The BCC supports and messages are adapted and available at all the levels. Moreover, thanks to its collaboration with Radio ALT, MCDI produced and broadcast more than 50 spots and educational programs on diarrhoea in the local radio stations in the project area . However, the activities at the school levels are left to the NGO <i>Aide et Action</i> because of concern about duplication of efforts. Only a local NGO (Mampifofo) was involved in the promotion of family and community BCC activities in relation with diarrhoea in the area. 05 support groups to promote home based available liquids for TRO, SRO and breast-feeding are in place and operational. The Visa approach is applied by all the operating VCS. On the other hand, the effort toward the installation and the <u>operationalization</u> of the Child Survival Inter Sectoral Committee were abandoned. This approach requires a little more stability of the members. Which is not the case because, being employed by the government, the latter have been often prone to frequent changes lately. Which prevents the normal functioning of the Committee.</p>
<p>5) Increase from 33% to 65% the percentage of mothers of children aged 0-23 months who can cite at least two danger signs for diarrhoea as reasons to seek advice or treatment at a health facility</p>	<p>OUI</p>	<p>420 VCS have been implemented, and trained on the diarrhoea prevention and home treatment including the TRO, on the follow-up of danger signs, on the reference and the feeding practice of the child with diarrhoea. They promote the messages about diarrhoea through various channels and means, including the Visa method. The training modules are adapted and available. The BCC supports and messages are adapted and available at all the levels. Moreover, thanks to its collaboration with Radio ALT, MCDI produced and broadcast more than 50 spots and educational programs on diarrhoea in the local radio stations in the project area . However, the activities at the school levels are left to the NGO <i>Aide et Action</i> because of concern about duplication of efforts. Only a local NGO (Mampifofo) was involved in the promotion of family and community BCC activities in relation with diarrhoea in the area. 05 support groups to promote home based available liquids for TRO, SRO and breast-feeding are in place and operational. The Visa approach is applied by all the operating VCS. On the other hand, the effort toward the installation and the <u>operationalization</u> of the Child Survival Inter Sectoral Committee were abandoned. This approach requires a little more stability of the members. Which is not the case because, being employed by the government, the latter have been often prone to frequent changes lately. Which prevents the normal functioning of the Committee.</p>
<p>IMMUNIZATION</p>		

1) Increase from 30% to 60% the % of children aged 12-23 months who are fully immunized through the vaccination card	YES	The coverage found at the mid term evaluation using KPC and HFA on 2004 show clear progressions of indicator 1 (53%) but not the indicator 2 which records a regression (20%)
2) Increase from 34% to 65% the percent of mothers who received at least two tetanus toxoid (TT) injections before the birth of their youngest child	NO	The availability and the functionality of the cold chain were obviously improved (more than 80% of the CSB with refrigerators are functioning). The kerosene and vaccine supply were also improved) thanks to effort of project support. A team of 06 trainers as well as the whole staff in the BHCs are trained on the EPI
3) Reduce from 21 % to 10% or less the % of children aged 12-23 months who <u>default between DPT and DPT3 doses ?</u>	YES	National Policy and EPI related activities, including maintenance of cold chain and vaccines management. Health staff is also oriented to the EPI outreach activities and catch-up strategy within the framework of the PCIME to reduce missed opportunities. As per the SSD HMIS, the DTCP3 coverage increased from 36% to 64% these past two years. However, the problem of cold chain spare parts availability does not have a sustainable solution yet. 445 VCS are operational and are trained on EPI promotion. The messages are adapted and the materials of BCC are available at all levels. VCSs continuously promote the messages on immunization through various methodes and means including the Visa approach and the Community-based follow-up system. In addition, the supervision of the BHCs remains weak (less than 50% received a supervision in the past 6 months. The clinical IMCI is applied at all BHCs.
BREASTFEEDING		

<p>1) Increase from 2% to 35% the percent of children aged 0-5, months who are exclusively breastfed</p> <p>2) Increase from 24% to 55% the percent of mothers who initiate breastfeeding within one hour after giving birth</p> <p>3) Increase from 19% to 50% the percent of children aged 12-23 months who receive 5 or more feeds per day (meals and snacks) in addition to breastfeeding</p>	<p>YES</p> <p>YES</p> <p>YES</p>	<p>The coverage found at the mid term evaluation using KPC and HFA on 2004 show clear progressions of these indicators (34% for objective N°1; 42% for objective 2; 36% for objective 3))</p> <p>The Project trained a team of 06 trainers on TOT and on Nutritional Essential Actions (NEA), 60 BHAs on NEA and on the promotion of BFP/LAM, 7 BHAs on BFHI. 402 VCS are trained and active in health education related to the promotion of BF and NEA through various BCC methods, including the Visa approach. The support groups of BF are set up in 05 health sectors and active in the consolidation of the messages on BF. The messages on BF as well as BBC supports are developed. They are available at all the levels. The availability in vitamin A obviously improved. In fact, 68% of the CSB did not experience any stock out of vitamin A during the past 6 months against 34% into 2002. In general, more than 90% of the activities related to the BF promotion programmed for the whole duration of the project are carried out. As mentioned above, the activities related to the Child –to –child Approach are left to the NGO <i>Aide and Action</i>.</p>
CHILD SPACING		
<p>1) Increase from 9% to 25% the % of mothers who are not pregnant, do not want another child in the next two years or are not sure, and are using a modern method of contraception</p>	<p>YES</p>	<p>The coverage found at the mid term evaluation using KPC and HFA into 2004 show clear progressions of these indicators (22% for objective N°1; 4% for objective 2)</p> <p>91% CSB are adequately equipped with medical equipment and Family Planning supplies (HFA 2004) against 25% in 2002. 32/60 ASB are trained on PF and on the management of PF service. Neither the VCS neither the DBC are trained or operational yet for the promotion of the PF. The VISA approach is not applied yet on FP. The Community follow-up system of program defaulters is not yet implemented. However, MCDI worked in collaboration with ALT Radio for the implementation of a educational radio program by using the listening group approach. Through this program, MCDI began the promotion of the PF by broadcasting health messages.</p>

2) Increase from 21 % to 60% the % of women who can cite at least two ways of reducing the risk of HIV infection	YES	All VCS and BHAs are trained on the prevention of VIH/AIDS. They undertake BCC activities by integrating the HIV/AIDS messages within the package of messages which they have to disseminate. The messages and the BCC supports were developed by the MCDI within the framework of a project funded by the World Bank.
3) Increase from 0% to 75% the % of CBDs that have no stock -outs of condoms during the past six months	N/A	Only 20 CBDs/184 are implemented. They work for the moment on the malaria intervention only.
4) Increase from 1% to 40% the % of mothers who know the exclusive breastfeeding as a method of child spacing	YES	See BF Promotion section.

B. The factors which contributed to the realization of these achievements

Three essential factors contributed to the realization of these achievements

B.1. Very good collaboration with the MOH at all levels and the Service of Community Animation

The MCDI 2003 annual report is already put forward that good collaboration with MOH at all levels, specifically with the Toliara II and Betioky SSDs, and the Service of Community Animation constitute the main factor which contributed to the achievements of the activities. Again, this observation was confirmed during the fiscal year 2004. MCDI continue to work closely with these entities and its work plan is integrated in the SSD work plans. These partners are part of the implementation project team. The good work team is still very marked and the ownership of the project is very developed. All this made easier considerably the implementation of the project activities and the transfer of capacity to the local partners. During this fiscal year 2004, MCDI worked with the Provincial Health Department (DPS) to solve the problems mentioned below, especially with regard to the upheaval of the district programming .

B.2. The engagement and contribution of the Administrative Authorities in the implementation of the Project

This engagement has made easier the implementation of the project activities and the participation of the community. MCDI has founded a good collaboration with the authorities which adopted the process and developed ownership. The fact that the Mayors are lately elected pushed up their contributions and involvement because they want to be best differentiated among their predecessors while bringing a new breath to the villages. Thus, the majority of the festivals undertaken during this fiscal year, the commune always gave a zebu to mark their enthusiasm towards the project activities. This exceptional and honorary act of the commune means that the community grants a significant value to the project. Let notice, that it is the first time of the history of all other development projects in this very traditional area, that a project profited of such community contribution. However, it is important to note that certain political authorities use project activities as political means for propaganda. It is an issue that MCDI have to be careful because it may undermine the project credibility. This situation did

not block anything in the achievement of the activities but on the contrary it facilitated them. Lastly, unexpected effect of the project is noted during its implementation. The project has reinforced socio-professional relations among and between its various actors (SSD, MCDI, SAR, local Authorities, the Community Volunteers of Health, population, BHAs, other actors in development, Teachers). Also, the project constituted an opportunity for the communes and the provincial authorities to discuss the other aspects of the development of their commune and regions.

B.3. A participative methodology and strong team work

Since the design of the project, MCDI has preached the participative methodology of work and a team work building. Into this phase of implementation, this methodology results in the effective responsabilisation of the level of each team (including the Community), joint planning, information sharing, joint problem solving, the good organization of work. As a consequence we note a very strong motivation among the team, very good adhesion to the project mission, the team availability and especially the ownership of the project.

C. The factors which constrained or impeded the realization of these achievements and the solutions/actions taken

C.1. During this fiscal year 2004, a great migration of the population towards the new sapphire layers near the zones of the Project (10 communes/49) occurred. This issue involves on the one hand a lack of community based project resourcefulness (Health Volunteers Community, DBC, the Mutual insurance company members of the executive Committee, Health Personnel) and on the other hand the difficulty in targeting the beneficiary population of BCC activities. Consequently, the activities are not easily realizable and the planning is frequently prone to modifications. In fact the community based activities (Mutual, DBC and BCC) were largely disturbed by this phenomenon. As it is about a new phenomenon in which the Project did not anticipate, any corrective measures are not yet found. The VISA approach (see section G) may have its raison d'être in the resolution of this problem. The lesson which we can draw from this experience is that the community based approach on a concept to target the community as an actor is fragile in a community where there are far too many shifts in population.

C.2. The recrudescence of the rural insecurity in the project zone did not allow the implementation of certain activities in particular the trainings and the follow-ups of the community partners and all that requires a moving of the BHAs or VCSs (formation, monthly review).

C.3. The geographical factors are permanent constraints for the project. They are mainly the distance and the difficulty of the accessibility in some remote BHCs and communities, the time of excessive traveled related to the bad quality of the roads and the inadequacy of the transportations. These factors have constrained the project to allocate more resources for the execution of the activities and sometimes to remain flexible on the planning of the activities. These geographical problems limit also some activities such as the follow-up of Health Volunteers Community and the supervisions of the BHCs.

C.4. The project has many problems of vehicles breakdown during this fiscal year (on the whole 65 days immobilization conveys) which had serious consequences on the good development of the activities especially as the majority of the sites of intervention of the project require displacements to reach it. As a solution undertaken, the project recommended the use as much as possible public transportation (Bush-Taxi, high-speed motorboat) or cart. However, this new measure spends much

more time than with the Project own transportation means and sometimes presents risks (Especially the transport by high-speed motorboat for the littoral zones).

C.5. The over-planning of the principal partner which is the SSD : This situation is obvious for the SSD of Toliara II who suffer to an important influence of the decisions of the DPS and Central MOH. It was noticed that for the majority of the pilot projects undertaken by MOH or its implementing partners and of the specific activities of Minsan (ex : sentinel site of monitoring, celebration of the national or world days of health, evaluation of an unspecified program ...), Toliara II is almost the site suggested by the provincial and/or central level as the site of operation. The causes often evoked are the proximity of this district with the head place of the province, the presence of the community based activities that work well, the presence of MCDI as a support to the EMAD presupposing among the best performance of its EMAD. These activities often arrive in the way and are never taken into account in the planning of the SSD increasing considerably the load of work of this last without measurements of accompaniments being in place (increase in the personnel, reinforcement of logistics etc). This involves an important upheaval of the implementation of the activities in the action plan of this district. This situation is the main cause of non executed planned activities or deferred activities during this fiscal year 2004. This situation is beyond the control of MCDI.

C.6. The principal reason of some minim changes on the mothers behaviors noted during the mid term KPC survey is the conflicting messages conveyed by the Community Volunteers of Health and the BHAs. The latter are often evoked like not convinced of these messages, especially those in relation to the early breastfeeding after birth, and diffuse contrary messages with the national recommendations. MCDI will address this situation in the future through the reinforcement of training and the supervisions of the BHAs.

C.7. At the beginning of this fiscal year, the work context was also marked by the communal election in November 2003 which obliged the SSD to cancel the activities implying the moving of the Health Agents out of their place of work according to the recommendation from the political authorities of the Toliara Province. Besides, some of these health agents were presented for this election. For this reason the training of the health Agents on the PCIME was cancelled and deferred for the next quarter. For the same reason, MCDI also decided to suspend the VCS training activities for this period of election in order to avoid bad interpretations for the moving of the project team.

C.8. The cyclone Gafilo (Mars 2004) caused many property and human damages, causing a temporary paralysis of certain sectors. The MCDI districts of intervention are not beyond this catastrophe. Health sector has sudden a serious consequences whose destruction of certain health facilities, declaration of post cyclonic epidemic diseases, problems of water supply and foodstuffs, problem of essential drugs supply to the BHCs following the degradation of roads and immobilization of the BHAs. This situation has constrained the project to stop during approximately a month its own activities and to focus on the SSD supports to adress this emergency situation by the assignment of its logistics means (cars, office to be used as room for storage) and human ressources (03 MCDI technical staff and 06 Field Agents). Of his own initiative, the personnel of MCDI HO collected and transferred \$US 1000 to the field office as its contribution for this catastrophe. This funds was used to buy, convey and dispatch of free of charge 2500 bottles of Sur'eau© (hypochlorite solution of domestic use for water cleaning) for the households of the most damaged zones.

C.9. The other constraints mentioned in the DIP (educational, cultural and policy) did not have impact in the realization of the achievements during this fiscal year 2004. It should be noted on the contrary

a reduction of the frequent shifting of the MOH staff that made a certain stability of the environment of project operation.

D. Technical Assistance of the program

No technical assistance was planned during this fiscal year 2004. However, as a result of the collaboration between the MCDI and Andrew Lees Trust Foundation/Radio Project, a British foundation which works in the field of rural radio development, the MCDI TCSP benefited from a technical assistance on the development of educational radio broadcast programs based on the listening group system. For that, a group of specialists in message development and social organization coming from South Africa trained MCDI Facilitators (Field Agents) on how to facilitate focus group discussions, how to develop, prioritise and adapt the messages, how to develop educational radio programs, how to implement, to facilitate and to supervise listening groups. This technical assistance allowed the development of a twice-a-week educational radio broadcast program in the district of Betioky and the setting up of 35 operational listening groups, each of them was equipped by a free play radio from ALT/PR. Currently, Andrew Lees Trust Foundation/Projet Radio continues to provide technical assistance to the project for the follow-up of the listening groups. These technical assistances complement those brought by Linkages during the previous fiscal year.

During the workshop for the development of this annual report, the program team identified the needs in technical assistance in the below-mentioned field. These technical assistances will be programmed for the next two remaining years of the LOP.

- evaluation of the organisational capacity of MCDI Madagascar and NGO partners : this activity is already planned in the DIP but it requires technical assistance for its implementation.
- documentation of the Project successes and innovative approaches, mainly the VISA approach, the mutual insurance credit scheme, the BCC and Social Mobilization approach.
- reinforcement of capacity of the SSD Program officer on Quality Assurance.

E. Changes to be operated within the DIP

The changes to be operated within the DIP will be identified during the mid term evaluation which will be held in January 2005.

F. Description of the program management system

F.1. Financial management system The field office regularly prepares a quarterly budget according to the quarterly work plan that MCDI, SAR and SSD team develop jointly according to the work plan of the current year. The budget is submitted at each end of the quarter to the home office for approval and transfer of funds. Never before, has the field office suffered from any problem of lack of money which has impacts on the execution of the planned activities. A monthly financial report of expenditure carried out was sent to the home office. The home office financial audit is quarterly-based. The Field Office regularly benefits from counselling and practical guidance from the MCDI HO Administrators in order to manage the project finance well.

F.2. Human resources All the human resources necessary to the project execution are in place in accordance with the human resources plan scheduled by the DIP.

Capacity reinforcement of the field staff

- The Project Manager attended the Mini University DIP Workshop held in Johns Hopkins University Baltimore in June 2004. This conference was the opportunity to update and to acquire new knowledge on the technical and planning aspect of the child survival interventions, to get familiar with the network of child survival partners, experts and actors and finally to be updated on the procedures, mechanisms and requirements of the funding agency.
- The MCDI's Quality of Care Advisor and Health Educator followed a training on the Health System and Health Programs Management led by the National Institute for Public and Community Health in collaboration with the Ministry of Health and Family Planning. This training allowed a better planning of their activities and a better vision of the health sector development in Madagascar and the contexts in the health sector. Moreover, the MCDI's Health Educator followed a training in FP HMIS led by the UNFPA.
- The MCDI's HIS Manager and the President of the VEMIMA NGO followed a training on health and environment project design and M&E organized by ADRA Tamatave and Voahary Salama.
- The project facilitators (Field Agents) followed a training on the radio programs development as mentioned in the above technical assistance section.

The evaluation of the testing period of the field Agents was carried out in October 2003. This evaluation was focused on six fields: general knowledge of the MCDI, its environment and work organization ; knowledge of the Toliara CSP and its contexts; technical training of the field Agents ; knowledge of the Toliara II health situation; competence in reporting and facilitation; attitude and motivation for work. This evaluation made possible the reinforcement of the Field Agents' knowledge of the technical aspect of the project, of the CSHGP context, of the MCDI itself, the health situation and the project general philosophy.

F.3. System of Communication and team development

The field office maintains a permanent communication with the Home Office. At the field Office level, the communication is facilitated by a quarterly staff meeting during which staff proceeds, in a participative way, with the identification of the constraints and positive management points (technical and administrative issues) and problem solving. This working style facilitates the comprehension of the whole project by the staff, a fluidity of action among staff and a powerful team work. The field office produces annual and quarterly activity reports that it submits to the home office and the MOH after having had the validation of the SSDs.

The technical staff continues to hold a monthly meeting with the objective to make a review of the activity implementation, the technical issues and planning. The field office works on an annual activity planning from which the quarterly plan is drawn. The development of these plans calls upon the participation of key partners (SSD, SAR, DPS).

With these key partners, MCDI holds a monthly meeting during which one makes a review of the advancement of the activity execution, the analysis of the medical data for decision making, the analysis and the reinforcement of the relations of collaboration, joint planning, the review of the new directives from the MOH and the initiatives to be take to implement them. It is also an occasion for the whole project team to reinforce the team work.

MCDI took part in all the regional review meetings held during this year 2004 by the Provincial Department Health Office (DPS). MCDI took the opportunities of these meetings to share the lessons learned during the project execution, to inform the regional and central medical authorities on the progress of project activities. At the district level, the monthly review meeting, in which MCDI never failed to take part, was seized by the MCDI to discuss the CSB heads and the community appreciations on the project activities.

F.4. Relation between MCDI and the local partners

In general, MCDI especially maintains a very good collaboration with the key local partners (SSDs, local NGOs, SAR, DPS, local administrative authorities, the Special Reserve of Beza Mahafaly). These local partners form an integral part of the project implementation team and benefit from a capacity reinforcement in the field of child survival. These relations of collaboration were the subject of Memorandum of Understanding which defines the partners responsibilities in the project implementation. Indeed, in its sustainability strategy, MCDI chose a very participative approach in the whole process of activities execution in order to accelerate and facilitate the appropriation and the capacity building of local partners. This approach presents many advantages as well as limitations, among which, MCDI is *“condemned to follow the others' pace”*. This difference in rhythm causes a perpetual renegotiation of the work schedule. What was the case with the 02 SSDs which undergo of a centralized planning system (Top-Down). Many non scheduled programs are imposed by the Central MOH and disturb considerably the local programming.

A gap is also the weakness of communication between the project partners. If it exists, it does not imply all the key partners. MCDI must plan a kind of quarterly review workshops to maintain all the key actors informed on the progression and constraints of activities implementation in order to more involve all the stakeholders .

Partnership with Andrew Lees Trust/ Radio Project (ALT/PR) : The fiscal year 2004 was marked by the implementation of the collaboration protocol signed between MCDI and the Andrew Lees Trust Foundation/ Radio Project in August 2003. As mentioned above, ALT/PR provided technical assistance to the Project FAs for the development and the implementation of an educational radio broadcasting program. ALT/PR also provided about sixty free play radio for the listening groups of Betioky Sud and reinforced the material capacity of the local FM Radio called Radio Feon'ny Atsimo in Betioky Sud. This local FM Radio station is an initiative of MCDI and Special Reserve Project of Beza Mahafaly in order to reinforce health and environmental education. Currently, ALT/PR continues to take part in the follow-ups of the listening groups and the follow-up of the radio program.

Partnership with Linkages : Linkages continued to bring its support to MCDI on the implementation of the Nutrition Essential Actions by supporting the trainings of BHAs and the supply of BCC materials.

Partnership with the Special Reserve of Beza Mahafaly : The Special Reserve of Beza Mahafaly continues to support the project for the implementation of the Integrated Health, Population and Environment Initiatives program by supporting the implementation of the Child to Community Approach, the training of TBAs and Community Health Volunteers (VCSs). Its Environment Conservation Agents reinforce the health messages that the project has been promoting. MCDI provided them a training in BCC and key health messages. The Special Reserve of Beza Mahafaly continues to provide a logistic support of training for MCDI. Moreover, the Special Reserve of Beza Mahafaly contributed for the funding of the installation of the Radio Feon'ny Atsimo in Betioky Sud

from which MCDI benefits enormously on BCC promotion radio based programs. These Environment Conservation Agents (ACE) also participated in the educational radio broadcast based program. MCDI made 02 of these ACE participate in a training of radio animation in the field of health education and the production of the radio broadcasted programs. These trainings were organized in collaboration with Linkages in July 2003.

In addition, the project continues to benefit from its collaborations with its previous partners. As mentioned in the preceding annual report, these relations are materialized by the utilization of MCDI of the DPS and SAR's locals as offices, the assignment to the project of 03 employees of the SAR as project permanent personnel for the whole project duration, supply of trainers and reinforcement of the follow-up of Betsioky Sud community activities by the NGO VEMIMA.

Collaboration with the NGO Mampifoha : This NGO is targeted in the DIP as being among the NGOs to be reinforced. MCDI began collaboration with the reinforcement of technical capacity of the members of this local NGO in the field of the Child Survival interventions (BCC, control of diarrhoeal diseases, Nutrition Essential Actions, Community-based IMCI). However, due to internal problems beyond MCDI control, this NGO remained non operational during this fiscal year 2004.

Finally, MCDI explored possibilities of collaboration with (1) the Soarano Project (A Catholic Churches funded Water Management Project). It was agreed that the Soarano Project will target in priority the villages in the MCDI areas of intervention that express needs of water and sanitation activities. Soarano Project is willing to build wells and latrines in such villages if MCDI commits into supporting the villagers' request and supporting community mobilization ; (2) the NGO *Aide et Action* to explore opportunities of collaboration in the implementation of the Child-To-Child Approach (CTC) in the district of Toliara II. Given that *Aide et Action* is already implementing this approach in more than 145 primary schools, it was decided jointly that MCDI will no more invest in the implementation of the CTC Approach in Toliara II and will leave it under the responsibility of *Aide et Action* to avoid duplicating efforts. However, MCDI proposes to try to target the schools which apply the CTC Approach to complete the package of the teachers' training in the field of Child Survival interventions ; (3) the NGO *Action Secours Organisations Santé* (ASOS) for the harmonization of the community-based distribution activities. This Malagasy NGO obtained a funding from WWF for the implementation of Health Environment Activities in two communes in Toliara II

F.5. PVO's Coordination and Collaboration in the country

In the field of coordination and collaboration in the country, the fiscal year 2004 is especially marked by the active participation of MCDI in the development of some national policies and national strategies in the health sector in Madagascar.

1. The Agreement National Policy in the health sector. MCDI is a member of the restricted committee in charge of the designing and the drafting of the Agreement National Policy. Led by the Ministry of Health and Family Planning and benefiting a WHO technical assistance, this committee is composed of MOH technical services, NGOs including MCDI, WHO and others funding agencies specialists (USAID, UNFPA, UNICEF, World Bank, EU). Currently, the document of the agreement national policy is in its technical validation phase. By the end of 2004, the restricted committee is supposed to finalize and complete the final document.

2. The National Child Health Policy in Madagascar. Oriented on the integrated management of child

health and development, MCDI is a member of the extended committee for the development of this policy. This extended committee is especially in charge of the initial design and the technical validation of the policy.

3. The National Nutrition Policy : MCDI took part in the regional technical validation of this national nutrition policy for the Toliara Province.

4. Since May 2004, MCDI became a member of the National Technical Committee for the development of the C/HH-IMCI national strategies. This committee is in charge of the design and the drafting of these strategies based on the experiences in progress in Madagascar.

The successes of the Ankazomanga Ouest Health Credit Scheme implemented by MCDI make this pioneering initiative a reference in Madagascar for a health community financing mutual/risk sharing approach. MCDI is continuously requested by several national-scale NGOs (CARE International, NGO Ny Tanintsika, NGO Ny Ainga, Voahary Salama, GTZ) to provide support/technical advice in the design and implementation of their initiatives on mutual health insurance. For the year 2005, three site visits in Ankazomanga Ouest are planned by these interested NGOs so as to better learn from this initiative. MCDI is asked to replicate this model in other part of the country under the SantéNet Project activities.

MCDI is also frequently requested by NGOs that implement child and maternal health activities like ADRA (Project Mahatoky Toamasina/PF) or Voahary Salama NGOs (Forest Corridor of the Est/Santé-Population-Environment) to facilitate workshops on planning and designing projects. Very soon, MCDI will ensure the training of ADRA Madagascar's technical staff and Voahary NGOs HIS Managers on the LQAS methodology and its practical use in the Project M&E.

Another field of collaboration at the national level is the involvement of MCDI in the realization of the National Health Days (JNS) as a technical and financial partner and the realization of the national vaccination campaign against measles or *HIAKA 2004* as a member of the Regional Committee of Toliara. The JNS is a 05 days *global health council kind* manifestations held at the end of June 04 in the capital of Madagascar. It was having seen the participation of all the actors in health sector in Madagascar. MCDI took part in the design and the realization of the program and contributed financially as a partner. The HIAKA 2004 was held from September 08 to October 08, 2004 having as objective the vaccination against measles all infants between the age of 9 month to 14 years in all the territory of Madagascar. In addition to its direct participation in its two districts of support (Betioky Sud and Toliara II), MCDI sat as a member of the Provincial Steering Committee of Toliara. This committee was assigned to involve all stakeholders in this national campaign, to coordinate the campaign in the Toliara province and to mobilize allotted resources for this campaign. The committee was chaired by the President of *Farintany de Toliara* (Governor). Lastly, MCDI took part in the realization of the national campaign of mass vitamin A supplementation which was held from the 21st to 25th October 2003 by providing 08 facilitators and logistical supports.

In addition, MCDI continues to be a member (1) of the Nutrition Action and Intervention Group (GAIN) at the provincial level of Toliara and National level. This group is assigned to define the priority actions in the field of nutrition and food security, to develop suitable approaches and especially to harmonize nutrition related interventions and messages ; (2) of Voahary Salama which makes the promotion of the integrated Health-Population-Environment initiatives; (3) of the Toliara Province Health Development Steering Committee ; (4) of the Acute Flask Paralysis Surveillance Committee of Toliara Province. This committee was set up in October 2003 with an aim to reinforce the

epidemiologic surveillance and monitoring of the Acute Flaccid Paralysis for a Madagascar WHO certification as being a polio-free country, further to the National Immunization Days in 1999, 2000 and 2002 ; (5) of the Working group for Rural Development (GTDR) which is an advisory structure for the implementation of the Rural Development Regional Plan under the supervision of the Prime Ministry Office. Finally, MCDI continues to take part in the workshops for the IMCI national coordination and evaluation (Mars, May, Seven.)

G. Success and innovative approach

G.1. The VISA Approach is an innovative approach implemented by the Toliara Child Survival Project in order to perpetuate and reinforce the approaches based on the Community Health Volunteers. The VISA approach is implemented within the framework of the Project BCC Strategy. VISA stands for Visiting, Identifying, Sensitising and Accompany.

Objectives : This approach not only aims at facilitating the targeting of the mothers into behavior change, but also at perpetuating the CCC activities through the VCSs thanks to a mechanism of their renewal/ recruitment.

Principle : Each VCS is given the responsibility of following 5 mothers through a negotiation technique until these latter adopt the health key behaviors. To do so, they Visit them, Identify jointly the behavior problems of the mother/family, they Sensitise them i.e. identify and advise the key behavior to be adopted and Accompany i.e. to support them and encourage them to adopt these behaviors. Once having adopted a key behavior, mothers in the program are invited to become a VCS and to recruit 5 other mothers and so on.

The Toliara CSP CCC approach The Community Health Volunteers, grouped in the Village-based Animation Cells (CVA), were set up and were trained by MCDI to work directly with the mothers in order to educate them and to encourage them into a change of behaviours through various activities and approaches (counselling, talks, home visits, mass meetings, sketches, village-scale plays etc). They work in a voluntary way and maintain interactions with the Health Centres and the local authorities in the promotion of the community health. In addition, they are used as interface playing the role of “*belt of transmission*” between the community and the Health Centers.

Challenges in an approach based on the Health Volunteers Many PVO are concerned that the voluntary work would grow weaker in the long term, or at least the enthusiasm of the Volunteers would decrease with time. This situation is especially shown without a sustainable mechanism of motivation and accompaniment. The volunteers' enthusiasm goes up quickly at the beginning of the program, reach its maximum level to decrease gradually and reach a very low level corresponding to the phase of inactivation and “*demotivation*” of the Volunteers. Often, it is at this time that the PVO seek mechanisms (financial, material or not) to rectify the curve so that the Volunteers gain enthusiasm again for their voluntary work and so and so. However, motivations of these types can hardly be perpetuated. While bringing solutions to rectify the motivation of the VCS, the traditional approaches of many PVOs try more or less indefinitely to maintain the VCS in the program and hope for a continuation of the activities beyond the project ends. This idea often causes program failure when the support to the project reduces and causes a the perpetual problem of how to motivate volunteers.

The VISA approach is a simple approach which reduces this problem of abandonment in a voluntary based approach. This approach is based on the 3 following principles

(1) The Community Health Volunteers are not expected to remain indefinitely in the program : In contrast to the traditional approaches which keeps “indefinitely” the VCSs, MCDI recommends an approach leaving the door open to VCSs if they want to leave while thanking them for what they contributed to. One also leaves door open when those which left want to return. Our experience showed that about 10% of the VCS initially set up left in 2 years. It is only hoped that a VCS remains in the program the time for a one cycle of VISA.

(2) Optimize the phase when the Volunteers’ enthusiasm is maximum to start the recruitment of new Community Health Volunteers : VISA approach is a dynamic and internal approach of recruitment and supervision of the VCSs. From each phase during which the enthusiasm of the volunteers is optimal (initial phase or after a redynamization action taken), each VCS is requested to recruit 5 mothers in the community for a health education brought closer based on negotiation until these latter manage to adopt the key health behaviors. The mothers who adopted good behaviors and who are convinced of their benefits to the children's and the families' health are encouraged by the VCS to share new knowledge, health messages and the benefits which they acquired with other neighbored women. Then, they are invited in their turn thereafter convinced mothers to become VCSs. If they accept, each of them will be asked to recruit 5 other mothers to include them in the program and so on. A snowball effect is thus created.

(3) Initially target the members of your family To create an ownership and to reduce the problem of VCSs “*demotivation*”, MCDI encourages VCSs to initially target the members of their families in the VISA program. The cultural complexity which prevents the feasibility of the home visits in some communities is often broken by the family tie. The VCSs’ sense of responsibility regarding mothers VISA is thus increased.

Results This VISA approach solves not only the problem of dropouts among VCS, permanently creates “*new blood*” within the VCSs, which new blood gathers new enthusiasm, but it also allows a supervision/training by “a self-training” among VCSs. In addition, it allows an easier mechanism for follow-up of VCSs capacity and the coverage of their activities in the community level.

After two years of implementation in the district of Betioky Sud, the following results are noted :

- among the 420 VCSs set up initially by MCDI, 41 (10%) has left the program for various reasons ;
- 570 new VCSs generated by the VISA approach are identified and operational, bringing to 949 the total number of VCSs
- 2 788 mothers from the VISA approach continue to support the VCSs to promote behaviour changes through testimonies. We call this group “*sakelim-panentana*” (Promotor Assistant).
- 10 450 mothers were touched by the VISA approach.

H. Other aspects of the project

H.1. The participation of MCDI in the USAID Mission health project, the SantéNet project under the head of Chemonics : As a consortium member, MCDI will bring its expertise in 04 fields : community financing, mobile medical unit support, cost recovery system support and the installation of private doctors/clinics in rural area. In addition, the Toliara Child Survival Project will benefit the support of this new funding in the non covered fields by the CSHGP. This new USAID funded project is currently in its planning phase. MCDI fully took part in this planning.

H.2. Restarting of the Users' Financial Participation System (PFU) : Suspended since September 2002

due to a President decision, the PFU which is the official drug supply system in the CSB, was restarted again in October 2003 under a new version known as FANOME. The new system is focused on a philosophy based on the equity. Actually, the communal authorities are encouraged to implement mutual systems as well as equity funds. Since December 2003, all the CSB have applied the PFU and there is tendency towards a regular drug supply.

H.3. Within the framework of an internal exchange between MCDI Child Survival Projects, the Toliara Child Survival Project technical team provides a continuous technical assistance to the Parakou/Bénin Child Survival Project which has just started during this fiscal year 2004. The Parakou Child Survival Project thus could benefit from the experiences and the lessons learned from the Toliara Child Survival Project.

I- Mid term KPC survey to appreciate the progression towards the objectives

As part of the Toliara CSP mid term evaluation, a rapid KPC survey was carried out on October 2004. The main purposes of the KPC survey were to assess the progressions towards the objectives and to collect information which would influence the orientation of the efforts and strategies of the project during the two remaining years. Indeed, the use of the LQAS methodology made it possible to identify the areas and interventions which need specific attention in the future so that the project can really reach its objectives. In this report, we will show only coverage results of the whole district which would indicate us either the project made a progression or not. The detailed analysis by area and intervention will be the object of a separate report.

I.1. Methodology : The indicators evaluated at the time of this mid term survey are limited to the 18 specific indicators of the project and some secondary indicators which would have direct relation with the activities carried out to date and which could explain of certain findings. Because of time constraints and budget limitation, MCDI did not include in this mid term KPC survey all the rapid CATCH indicators. These indicators will be targeted during the final evaluation. With the LQAS methodology, the survey was conducted into 07 supervision areas corresponding to the 06 responsibility zones of the 06 Field Agents and to a zone of mixed intervention (i.e., a zone of which all the 06 Field Agents intervene without a clear delimitation who among them is the person in charge). Sample size per zone is 19. Recommended by the KPC 2000+ guideline, application of over sampling and parallel sampling methodology was made and increased the number of respondent to more than 142. MCDI developed 04 questionnaires which take into account of the parallel sampling methodology. Each question was administered to mothers with child of less than 02 years old.

I.2. Main findings : In general, project indicators showed a clear increase. Some even exceeded the programmed final objective (at end of the project). Compared to a linear projection of the final objectives, the objectives at this mid term period are almost exceeded. It could affirm that the project is really in the good way to reach its final objectives. Breastfeeding, family planning, diarrhea home case management by ORT, child immunization are the interventions where project results are very encouraging.

However, it should be noted that almost malaria indicators did not move at all, the indicator on malaria prophylaxis during pregnancy even regressed (31% during the baseline of 2002 and 21% during mid term survey 2004). These situations could be explained by the fact that the project did not allocate yet enough effort in malaria intervention. The main reason is that the MOH is currently about to introduce new policies and strategies on this intervention, among those, the introduction of IPT, the community distribution of SP, the free distribution of ITN. MCDI did not want to undertake major activities in this

intervention which could thereafter without utility.

In addition, TT2 indicator for mothers regressed also (of 35% in 2002 to 20% in 2004). This indicator always faced problem to MCDI during the preceding Betsioky CSP where the project was not able to increase its level. The mid term survey showed a regression as what is currently the case. MCDI will undertake an in depth analysis to explore the reasons which underlie this situation.

In regard to the indicators on home case management of childhood illnesses, there is no change on the mother care seeking behavior in the presence of danger signs (ARI/pneumonia, diarrhoea). It is the same case for the recognition of these danger signs. Project effort for next the two years will be focused on these weaknesses mentioned above.

(a) Nutrition and breastfeeding intervention

project Indicators	2002 Baseline	2004 objectives¹	2006 Final obj	2004 mid term KPC
% of children age 0-5 months who are exclusively breastfed	2%	20%	35%	34%
% of mothers who initiate breastfeeding within one hour after giving birth	20%	40%	55%	42%
% of children 12-23 months who receive 5 or more feeds per day (meals and snacks) in addition to breastfeeding	19%	35%	50%	36%

(b) Spacing of Birth (PF)

project Indicators	2002 Baseline	2004 objectives²	2006 Final obj	2004 mid term KPC
% of mothers who are not pregnant, do not want another child in the next two years or are not sure, and are using a modern method of contraception	9%	20%	25%	22%
% of mothers who know the exclusive breastfeeding as a method of child spacing	1%	20%	40%	4%
% of women who can cite at least two ways to reduce the risk of HIV infection	21%	45%	60%	22%

(c) ARI/Pneumonia : The prevalence of ARI/pneumonia increased slightly (70% to 75%)

¹ Projection linéaire du niveau d'objectif pour une période de 02 ans

² Projection linéaire du niveau d'objectif pour une période de 02 ans

project Indicators	2002 Baseline	2004 objectives³	2006 Final obj	2004 mid term KPC
% of mothers of children 0-23 m with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day	11%	30%	45%	19%
% of mothers of children 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek treatment	25%	45%	65%	45%

(d) Diarrhea control intervention : The prevalence of diarrheal diseases increased slightly (61% to 66%)

project Indicators	2002 Baseline	2004 objectives⁴	2006 Final obj	2004 mid term KPC
% of children 0-23 months who had diarrhoea in the past two weeks who were given the same or more than usual amount or more breast-milk during a diarrhoeal episode.	36%	50%	65%	60%
% of children 0-23 months who had diarrhoea in the past two weeks who were given more than the usual amount of fluids during a diarrhoeal episode	34%	50%	65%	58%
% of children 0-23 months who had diarrhoea in the past two weeks who were given the same or more than the usual amount of foods during a diarrhoeal episode	24%	40%	55%	64%
% of children 0-23 months who had diarrhoea in the past two weeks and whose mothers sought advice or treatment for the illness within 24 hours of the first sign of danger	52%	65%	80%	55%
% the percentage of mothers of children 0-23 months who can cite at least two danger signs for diarrhea as a reason to seek advice or treatment at a health facility	33%	50%	65%	45%

(e) Malaria intervention : The prevalence of malaria increased slightly (61% to 66%)

³ Projection linéaire du niveau d'objectif pour une période de 02 ans

⁴ Projection linéaire du niveau d'objectif pour une période de 02 ans

project Indicators	2002 Baseline	2004 objectives⁵	2006 Final obj	2004 mid term KPC
% of children 0-23 months who slept under an insecticide-treated bed net the previous night	3%	15%	20%	7%
% of mothers who took anti-malarial medicine to prevent malaria during pregnancy	31%	60%	80%	21%
% of mothers of children 0-23 months with a febrile episode ending during the last two weeks who gave correct treatment at home	13%	35%	50%	25%

(f) Immunization

project Indicators	2002 Baseline	2004 objectives⁶	2006 Final obj	2004 mid term KPC
% of children 12-23 months who are fully immunized per the vaccination card	30%	45%	60%	52%
% of mothers who receive at least two tetanus toxoid (TT) injections before the birth of their youngest child	35%	50%	65%	20%

J. Evaluation of the IMCI quality of care provided by the health centers

At the end of this fiscal year , MCDI and the EMAD of Toliara II did a HFA focused on the IMCI quality of care provided by the basic health centers in Toliara II district in order (1) to assess the status of the effective clinical IMCI implementation at the CSB level ; (2) to assess the progression compared to the baseline situation ; (3) to assess IMCI technical equipments and the level of coaching of CSBs ; (4) to make recommendations at all levels on how to improve and make efficient the implementation of the clinical IMCI component.

(A) Methodology

To do this, the survey team developed a tool made up of 04 questionnaires for :

- an observation of the health agent during a consultation of sick child that evaluates the case management process compared to the IMCI protocol (process) and evaluates the effective quality of care received by the sick child (impact)
- an inventory of the CSB in order to evaluate the level of their IMCI technical equipment
- an interview of the mothers leaving the consultation that evaluates the health agent quality of communication and client satisfaction
- an interview of the health agent that evaluates the knowledge of the ASB on IMCI, the level of

⁵ Projection linéaire du niveau d'objectif pour une période de 02 ans

⁶ Projection linéaire du niveau d'objectif pour une période de 02 ans

coaching provided to the CSB and the work organization at the CSB level as well as the problems of clinical IMCI implementation.

The survey was carried out with the collaboration of the INSPC and the DPS of Toliara. Under the Coordination of the Project HIS Manager, the survey team was divided into XXX groups each of them composed by XXX interviewer and XXX supervisors. Prior to the survey, all the members of the survey team are already trained in IMCI and have experience of at least XXX years in the clinical IMCI application. They received a training of the investigators and supervisors before the data collection.

The survey itself was led in 22 CSB out of the 33 (66,6%) within the Toliara II District, including 8 CSB1 and 14 CSB2. 103 consultations were observed including 76,7% case of ARI, 80,3% case of fever and 70,9% case of diarrhoea.

(b) Principal findings : In summary, there is a clear improvement of the CSB capacity to provide a higher quality of care to the children. The competence of the ASB was improved, the principle of case management systematization according to IMCI protocol is mastered by the ASB but the quality itself remains to be improved although its clear improvement since the beginning of the project.

1. Use of IMCI protocols by the care providers : The indicators here assess if the ASBs use correctly or not the IMCI protocol while they give care to the child. These indicators do not assess if the child received or not the correct care that he should receive. Indeed, the ASBs can follow the protocol correctly but may not be correct in its evaluation or its classification or its treatment.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of outpatient children who received a correct management of his illness according to the IMCI protocol	0%	27%

Comment : A correct case management according to the IMCI protocol is defined as a correct evaluation, classification and a treatment according to the IMCI protocol.

Indicator	Baseline Dec. 2002	HFA Aog 2004
Integrated Evaluation Index (average) ⁷		8,1/10

Comment : We can conclude that ASBs master very well the systematization of the evaluation. As an indication, indicators bellow confirm improvements of the ASBs capacity on managing the stage of evaluation of the IMCI protocol :

- (a) % of children that the 03 general danger signs were checked increased by 13% to 48,5% between the baseline and the MTE ;
- (b) % of children that the 03 symptoms were checked systematically increased by 59,3% to 71,8%

⁷ L'Index d'Evaluation Intégrée évalue la systématisation de l'évaluation de l'enfant malade. 10 tâches doivent être exécutées systématiquement pour pouvoir affirmer que l'évaluation est correcte vis-à-vis du protocole PCIME. Ces tâches sont : la recherche des 03 signes généraux de danger, la recherche systématique des trois symptômes (diarrhée, IRA, paludisme), la recherche d'une paleur palmaire, la vérification du statut vaccinal et de vitamine A, la pesée et la comparaison du poids avec la courbe de croissance. L'IEI est la moyenne des tâches exécutées.

(c) % of children that the immunization status was checked systematically increased by 50% to 99%. These figures show a clear improvement of the stage ‘evaluation’ of the sick child.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of children with cough or difficult breathing correctly classified according to the IMCI algorithm	20,8	82,2
% of children with diarrhoea correctly classified according to the IMCI algorithm	-	53,4
% of children with fever correctly classified according to the IMCI algorithm	12,7	75,5

Comment : These indicators show us that in general the ASB follow algorithm PCIME to classify the diseases of the child. The reason for which the use of the algorithm is not respected for the classification of the diarrhoea was the routine practice of the ASB for this pathology.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of children whose treatments prescribed for the principal symptoms correspond to those of IMCI algorithm		80,4%
% of the mothers who receive a counseling during the consultation of his sick child		100%

Comment : The ASBs follow very well the IMCI algorithm to treat the sick child.

2. The quality of care received by the children : Here, the indicators assess if the child receive or not a correct care i.e. a management of his illness according to what he should receive for the precise case. The confirmation is based on the appreciation of the surveyor.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of ARI/pneumonia cases whose evaluation is correct	0%	5,8%
% of diarrhoea cases whose evaluation is correct	0%	9,5%
% of fever cases whose evaluation is correct	0%	7,8%

Comment : Although the ASBs use correctly the IMCI protocol for the evaluation, their evaluation is not correct in more than 90% of the cases. This would suppose that neither classification nor the treatment would not be correct for these 03 principal symptoms in more than 90% of the cases. The project will allow efforts to rectify this problem during the two next years of the project. However, the indicators below show a clear quality management improvement in the field of the immunization catch up, the vitamin A supplementation, the nutrition evaluation (weight compared to the growth monitoring card) and the deworming component of clinical IMCI.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of children who need vaccine and who leave the CSB after having received all the vaccines they need the day of the visit	25,9%	50%
% of children who need vitamin A and who leave the CSB after	80%	88,9%

having received the dose of vitamin A they need the day of the visit		
% of children who need a deworming and who leave the CSB after having received the dose of mebendazole they need the day of the visit	73,7%	86,8%
% of children whose weight was compared with the growth monitoring curve	59,3%	73,8%
% of children whose evaluation of the nutritional state and anemia is correct.	0%	26,2%

3. IMCI technical equipment : Although the improvement of IMCI technical equipment of the CSBs, the current status remains under the acceptable norms and requires more efforts so that the CSBs can provide adequately services with acceptable quality.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of CSB with at least one ASB trained in IMCI	10%	100%
% of CSB with at least 80% of IMCI equipment and material available	10,5%	63,6%
% of CSBs with at least 80% of IMCI oral drugs available		45,5%
% of CSBs with at least 80% of IMCI injectable drugs available		59,1%
% of CSBs whose the 6 vaccine antigens are available the day of the survey	38,9%	45,4%

4. The quality of the communication provided by the ASBs : is evaluated compared to the quality of the messages provided and the mothers capacity to repeat them. We can note that the ASBs focus especially on the messages of drugs administration and forsake the other capital messages of which the follow-up of danger signs which must require an immediate return to the health center, increase of the amount of liquid and continued feeding of sick child. These messages have to be reinforced in both CSB and Community level.

Indicator	Baseline Dec. 2002	HFA Aog 2004
% of ASBs which give at least 02 correct messages on the oral treatments administration at home	5,6%	100%
% of mothers able to describe correctly how to give the oral treatments at home (each drug prescribed)		74,7%
% of mothers correctly advised on at least 03 danger signs to be detected for an immediate return to the CSB	3,7%	15,6%
% of mothers advised to give more liquids than usually and to continue to feed the child for the period of the disease	59,3%	38,2%

(c). General conclusion and recommendations: The process on providing IMCI care and the IMCI technical equipment in the CSBs show a clear improvement and become acceptable. The effort of MCDI must now be dedicated on the improvement of quality itself through efforts of closer follow up and training to the ASBs. The type of approach used in the SSD of Betioky Sud for the reinforcement of capacity of their ASBs through practical training courses during the monthly reviews finds its utility

here.

K. Workplan FY 2005

FY 2005 Activities	Scheduling	Duration / Frequency	Responsible entity
1. Improvement of Quality of Care			
1.1. Training of care providers			
Train the second care providers of Toliara II on clinical IMCI (25 BHAs)	Nov 04	6 days	RAQS, MOH central, DPS
Train the care providers of Toliara II on NEA (25 BHAs)	April 05	5 d	RAQS
Train 39 BHAs on the prevention and management of the non complicated malaria case	June 2005	5 d	RAQS, DPS
Retrain 7 BHAs on BFHI and to set up the BFHI in 6 BHCs (one BHCs per month)	As of Jan 05	Whole year	RAQS
Retrain 60 BHAs in EPI (during monthly review sessions)	April 05	9 d	CAQS, Res PEV
1.2. Reinforcement the Health System			
Reinforce the supply of Antibiotic, quinine, Vitamin A and oil in the BHAs (support to the routing, the planning of orders, inventory control)	Whole year	Quarterly	RAQS
Complete PCIME Kit in all the BHCs (To equip out of thermometer, scales ... according to the needs after inventory)	March 05	30 d	RAQS
Reinforce the maintenance of refrigerators	Semestriel	15 d x 2d	RAQS
1.3. Reinforcement of the community-based care providers			
Update the CBD training modules (FP and chloroquine, ITNs)	Dec 04	15 d	Raqs
Identify the 164 remaining CBD for Toliara II	Oct 04 – Mar 05		AT, ASB
Train 164 CDBs on the diseases prevention, childhood illnesses case management and community-based distribution activities and management	Marc-May 05	5 d per session	AT
Train the 06 Facilitators of the project (Field Agents) on community based Safe motherhood activities.	Jan 05	5 d	Raqs, DAR
Train the Traditional Birth Attendants of Toliara on the prevention and case management of the mother and child health, including the FP promotion	Dec 04	3 d per session	Raqs
2. BCC and Social Mobilization			
2.1. Reinforcement of the capacity of the Community Health Volunteers			
Update the FP training module for VCSs (workshop)	Nov 04	3d	RAQS
Train the 06 project Facilitators on the FP Promotion	Dec 04	3d	AQS
Train the VCSs of Toliara II on the FP promotion	As of Jan 05	3d per session	AT, Res PF
Train the new VCS of Betioky (01 new health sector) on the FP Promotion	Dec 04	3 d	DAR, Vemima

FY 2005 Activities	Scheduling	Duration / Frequency	Responsible entity
Retrain the VCS on management of Sick Child and the prevention of diseases	Bi annually	2d per session integrating follow-up	AT, ASB
Train the VCS of the 4 health Sectors of Betioky on the child diseases case management (C/HH IMCI)	Dec 04 – April 05	5j per medical sectors	DAR, Vemima
Retrain the VCS of BTK on the VISA approach	Whole year	Accompanied with a follow-up	Vemima, DAR
Set up 5 Support Groups in each of the 3 health sectors in collaboration with the NGO Mampifofoha	Jan-Sept 05		Mampifofoha, AT
2.2. Implementation of the child-to-community approach (IPI - SPE)			
Train 21 teachers of primary schools of Bezaha on the CTC approach	Oct 04	5d	Cisco, DAR
Retrain 10 teachers of primary schools in Beavofoha on the CTC approach and reenergize the CTC activities of Beavofoha	Jan 05	5d	Cisco, DAR, RSBM, DGEFS
2.3. Celebration of the acquired achievements			
Hold a health festival in at least 50% of the health sectors (target the weakest medical sectors according to the LQAS result)	April-Sept 05	7d in each site	AT, ASB, Vemima, DAR
Hold 2 festivals CTC "Ecole Flambeaux" Voahary Salama (Bezaha and Beavofoha)	June 05	7d	Cisco, DAR
2.4. Development and production of BCC materials			
Produce an educational radio program per month on the 06 interventions of the project and broadcast them in 02 local stations by using the listening groups based system	Whole year	Monthly	AT, ALT
Produce and broadcast 60 radio spots of each on the malaria, the FP, Immunization, the breast-feeding and nutrition promotion, the home based case management of childhood illnesses (5 of each per month)	Whole year		AT, ALT
Up date messages and BCC supports related to the project intervention, especially on FP and TT immunization (workshop)	Jan 05		AT, R IEC, RAQS
Supply the VCS, CSB, DBC with BCC materials	Whole		Admin
3. Follow-up and evaluation			
Supervise the VCSs and CDBs in the two health districts	Whole year	Quarterly	AT, ASB, Vemima, DAR

FY 2005 Activities	Scheduling	Duration / Frequency	Responsible entity
Follow-up 31 CTC schools	Whole year	Twice a month	Cisco, DAR
Evaluate and Monitor the CTC in the 31 implementation schools	May-June 05		Cisco, DAR
Support EMAD in the supervision of the BHCs and BHAs	Whole year	Quarterly	RAQS, EMAD
Develop a supervision tool for VISA Approach	Oct 04	15 d	RSE
Update the supervision tools on FP for BHCs	Dec 04	15 d	RAQS
Conduct the mid term evaluation	January 05	1 month	Consultant, HO, the whole team
Finalize the KPC survey report	Nov 04		RSE
Finalize the HFA survey report	Nov 04		RSE
4. Reinforcement of the staff capacity			
Reinforce the facilitators' linguistic capacity through a French course	Dec04 – June 05	30d	Training Establishment
Train Facilitators in data processing	Marc 05	15d	Training Establishment
Train facilitators and all persons in charge of BCC and community activities within the project and SSD in social development and program management	May 05	10 d	Medical Health Institute of Tana
Develop and implement a management plan for transfer of Community activities in Betioky to the NGO Vemima	Whole year		RSE, CP, ONG
Institutionalize VCSs groups by transforming them into associations and by advocating for their integration in the flow chart of the communes	Whole year		Vemima et Mampifoha
5. Program management			
Hold monthly technical meeting	Monthly		Technical staff
Hold a quarterly meeting of planning with extended staff	Quarterly		
Quarterly activity report	Quarterly		
Annual report	Annual		
Financial statement	Monthly		
6. Mutual health insurance company (To be developed after discussions with SantéNet Project)			

Annexe : Benchmark

Objectives	Benchmark programmés	Realization to date	
PCM			
1) Increase from 11 % to 45% the % of mothers of children 0-23 months with fast/difficult breathing during the last two weeks who sought treatment from a health facility by the end of the day	- 06 FA recruited and trained in FDF and in supervision of VCS including management of ARI/pneumonia	06 AT were trained on the complete training scale except the FP	
	- ARI/pneumonia curriculum for CHVs developed	Curriculum and training modules for VCS were developed and available	
	- Trainees identified	11 trainers on clinical IMCI identified and trained	
	- 420 CHVs in place	445 VCS in place and trained on ARI/Pneumonia according to HH-C IMCI	
	- 420 CHVs trained in ARI		
	- 60 ASB trained in FDF and in supervision of VCS in relation to management of ARI/pneumonia according to IMCI protocol	55 ASB were trained on the ARI /Pneumonia case management according to IMCI protocol	
	- 80% of VCS retrained in ARI/pneumonia on quarterly basis	More than 80 % were retrained in IRA/Pneumonia	
	2) Increase from 25% to 65% the % of mothers of children 0-23 months who can identify at least two danger signs of pneumonia that indicate the need to seek treatment	- Supervision tools for C-IMCI adapted and available at all levels (VCS, ASB etc.)	YES
		- 80% of VCS supervised on quarterly basis	More than 80 % of VCS were supervised
		- Education messages on ARI/pneumonia adapted	YES
- BCC support of ARI/pneumonia adapted, developed, and made available at all levels (VCS, ASB, CIS, Schools, NGOs, DAR)		YES	
- Festivals held annually in each health sector		Festivals were held in 24/29 health sectors in Toliara II and in 21/21 in Betioky Sud	
3) Increase from 0% to 60% the % of clinical staff who will correctly use IMCI protocols.		- 50 Schools implement the child-to-child approach	NA : These activities were transferred under the responsibility of the NGO Aide et Action. However, MCDI implemented the Child to Community Approach in the frame of integrated Health Population and Environment program initiative in collaboration with Voahary Salama (29 schools)
	- 50 teachers of elementary school trained in child-to-child approach and in management of ARI		
	- 80% of schools implementing CTC program supervised on quarterly basis by the CISCO on the implementation of the AEPE		
	- A team of 6 trainers (DPS, MCDI, SSD) retrained in C-IMCI	11 trainers on IMCI were identified and trained	
	- 60 ASB trained in C-IMCI in accordance with the C-IMCI protocol	55 ASB were trained in clinical and community IMCI	
	- C-IMCI training modules for ASB adapted and made available for use	YES	
	- The C-IMCI flowchart made available to all the CSB	YES	

Objectives	Benchmark programmés	Realization to date
	- Consultation forms for C-IMCI implementation regularly made available at the level of the 28 CSB	YES
	- Procurement of antibiotics for the CSB carried out every quarter	More than 80% of CSBs have an adequate stock of oral antibiotics and 63% of CSBs have an adequate stock of injectable antibiotics (HFA oriented IMCI Survey 2004)
	- 28 CSB equipped with functioning refrigerators	16/33 CSB equipped with functioning refrigerators. Other funding agencies will equip the other CSB. (Cresan)
	- 28 CSB regularly supplied with kerosene, and spare parts	100% of the CSB with refrigerators did not experience any stock out of kerosene during the last 06 months. None of them has an adequate stock of spare parts.
	- C-IMCI supervision tools for CSB adapted	Realized
	- Members of the EMAD trained on the C-IMCI supervision tool, on planning and supervision technique	11 EMAD members trained in IMCI supervision
	- 80% of the CSB are regularly supervised in accordance to supervision guidelines	50% of CSB were supervised according to the supervision guidelines in the last 12 months
	- The quality of ARI/pneumonia case management evaluated annually by the HFA	An IMCI quality of care survey was carried out in October 2004.
	- At least 60% of the CSB equipped with C-IMCI kit including (01 watch to check on the frequency of respiration, ORT kit to control dehydration, infant scale, thermometer, and case management card)	100% of the CSB are equipped with IMCI kit
Malaria		
1) Increase from 3% to 20% the % of children 0-23 months who slept under an insecticide-treated bed net the previous night	<ul style="list-style-type: none"> - 184 DBC trained on the community-based sales of ITNs, re-impregnation, and social marketing of ITNs - 184 DBC regularly supplied with ITNs, and the re-impregnation kit through PSI private channels - 50% of CSB regularly supplied with ITNs in accordance with the PFU channel - Social groups formed in 25% of the health sector to facilitate the acquisition of ITNs by the rural populations 	A political change to a free distribution of ITN is imminent. In fact, for the moment any of the 20 DBC sell ITN at the community level.
2) Increase from 13% to 50% the % of mothers of	- VCS, DBC, ONG, & CSB equipped in BCC support to promote malaria prevention through the use of ITNs	Realised

Objectives	Benchmark programmés	Realization to date
children 0-23 months with a febrile episode ending during the last two weeks who gave correct treatment at home	- Radio programs on IEC/BCC for malaria prepared & broadcasted regularly	A broadcasted program education based on the listening group approach is implemented with the collaboration of ALT/Projet Radio. The program is broadcasted twice a week.
	- 8 radio communication agents trained in the light against malaria, and on the development of educational programs on malaria control	11 radio animators and 06 field agents trained on malaria prevention and control, on malaria educational program development.
3) Increase from 31% to 80% the percent of mothers who took anti-malarial medicine to prevent malaria during pregnancy	- 60 spots & 60 radio programs broadcasted on malaria control and the promotion of ITNs	More than 60 spots and radio programs on malaria developed.
	- 420 VCS, 184 DBC, 4 NGOs, DAR & AT trained on the prevention & on home-based case management of malaria	445VCS, 20 DBC, 2 local NGOs, 02 staff member of the Rural Animation Service (DAR) and 06 Field Agents were trained on malaria prevention and home-based case management according to the community IMCI protocol.
4) Increase from 0% to 75% the % of CBDs with no stock out of anti-malarial medicines during the preceding 6 months.	- 60 ASB, 06 FA, DAR, 4 ONG trained in FDF on the prevention and the home-based case management of malaria, supervision of malaria case management intervention and the utilization of ITNs	21 ASBs, 06 Field Agents, 02 NGOs and 02 DAR trained on malaria prevention and home based management TOT
	- Malaria supervision tool adapted, developed, and accessible at all levels (VCS, DBC, ASB etc.)	Developed by WHO
	- 80% of VCS & DBC supervised quarterly	More than 80% VCS were supervised in a quarterly basis. N/A for the DBC
	- 80% of VCS, & DBC retrained on the prevention & malaria case management	100% of trained VCS received retraining on malaria prevention and case management
	- 50 schools implement the child-to-child approach	NA : Activities transferred to the NGO Aide et Action
	- 50 teachers trained in the child-to-child approach to support and promote malaria control	
	- 80% of schools implementing CTC program supervised quarterly by the CISCO on the implementation of AEPE	
	- Messages on malaria control and promotion of the ITNs adapted	
		Realized

Objectives	Benchmark programmés	Realization to date
	- BCC support for malaria control & promotion of ITNs adapted, developed, and accessible at all levels (VCS, ASB, CIS, Schools, NGOs, DAR)	Realized
	- Contests for social mobilization to promote the use of ITNs launched every six months in all the health sectors.	Not Realized
	- 60 ASB retrained every six months on case management and prevention of malaria in pregnant women	21 ASB were retrained in prevention and treatment of malaria in pregnant women
	- training module of malaria in pregnant women adapted	N/A : waiting for the new MOH policy on IPT and artemisinin
	- Procurement of antimalarial drugs for the CSB carried out every quarter	Chloroquine is available in 95% of CSBs, SP in 81% and injectable quinine in 59% of CSB (Survey PCIME 04)
	- 60 ASB retrained on the PFU	Realized by SSD
	- The DBC module on chloroquine adapted	Realized
	- 184 DBC trained in management of chloroquine, the direction for use & the algorithm for malaria treatment for the DBC	20 DBCs of chloroquine were trained and functioning.
	- 80% of DBC supervised quarterly on the community distribution	N/A
	- Management tools for the DBC developed	Realized
	- Procurement of chloroquine for the DBC carried out every quarter	Realized
	- 60 ASB trained in MCM in accordance with the C-IMCI	445 VCS in place and trained on MCM according to community IMCI protocol
	- Training modules for MCM for ASB adapted & made available for use	N/A
Diarrhée		
1) Increase from 34% to 65% the percent of children 0-23 months who had diarrhoea in the past two weeks who were given more than the usual amount of fluids during a diarrhoeal episode	- Training module in prevention and home-based care of diarrhoea adapted	Realized
	- 420 VCS, 06 FAs, 04 NGOs, DAR trained in diarrhoeal diseases prevention, including hygiene and home-based management of diarrhoea	445 VCS, 2 local NGOs, 02 DAR and 06 field agents were trained in diarrhea prevention and home case-management according to the community IMCI protocol.
	- 184 trained in preparation of ORS, community-based sale of ORS, the diagnosis of dehydration, & oral rehydration	N/A : MOH policy is the promotion of the use of home based available fluid. DBC are not yet involved in the CDD.
	- 420 VCS & 184 DBC retrained in home-based case management and prevention of diarrhoea	402 VCS retrained. DBC : N/A

Objectives	Benchmark programmés	Realization to date
2) Increase from 24% to 55% the percent of children 0-23 months who had diarrhoea in the past two weeks who were given the same or more than the usual amount of foods during a diarrhoeal episode	- BCC materials and messages on diarrhoeal control and prevention adapted & made available for use at all levels (CHV, DBC, AS, NGO, ISC)	Realized
	- 80% of teachers of primary schools trained in AEPE, supervised quarterly by the CISCO	NA : Activities transferred to the NGO Aide et Action
	- 50 schools implement the child-to-child approach for diarrhoeal control	
	- Supervision tool for the AEPE developed	
	- Number of ORS sold per year	N/A
	- 28 support groups established to promote the fight against diarrhoea, promote breastfeeding, and promotion of vaccination.	On the way : 5 support groups in place in a health sector.
3) Increase from 36% to 65% the % of children 0-23 months who had diarrhoea in the past two weeks who were given the same or more than usual amount or more breast-milk during a diarrhoeal	- 80% of villages have a local committee on Cholera to avert cholera epidemics	N/A: The project did not allocate any effort for this activity that is supposed under the responsibility of local authorities.
	- CIS working in collaboration with the community for the implementation of diarrhoea prevention activities that include hygiene, water and sanitation, including the building and utilization of latrines.	Activities Canceled
	- 4 NGOs trained in the mentoring approach, and planning of child survival interventions,	02 NGO (Vemima and Mampifo) were trained
	- 60 spots et 60 radio programs on diarrhoea prepared and disseminated regularly	More than 60 CDD spots and radio programs were developed

Objectives	Benchmark programmés	Realization to date
<p>episode.</p> <p>4) Increase from 52% to 80% the % of children 0-23 months who had diarrhoea in the past two weeks and whose mothers sought advice or treatment for the illness within 24 hours of the first sign of danger</p> <p>5) Increase from 33% to 65% the percentage of mothers of children 0-23 months who can cite at least two danger signs for diarrhea as a reason to seek advice or treatment at a health facility</p>	<p>- BCC materials and messages on diarrhoeal control, prevention and treatment seeking adapted & made available for use at all levels (CHV, DBC, AS, NGO, ISC)</p>	<p>On the way</p>
Immunization		
<p>1) Increase from 30% to 60% the % of children 12-23 months who are fully immunized per the vaccination card</p>	<p>- A team of 6 trainers (OPS, MCDI, SSD) retrained on the EPI related activities</p>	<p>11 trainers were trained in EPI national policy and guidelines</p>
	<p>- 60 ASB trained in the new EPI strategies that include (vaccination within the context of C-IMCI, utilization of multiple doses vaccine vials, and Vitarnin A supplementation)</p>	<p>60 ASB were trained in EPI national policy and guidelines</p>
	<p>- 60 ASB retrained on the rationale of the EPI national policy</p>	<p>60 ASB were retrained on EPI national policy and guidelines</p>
<p>2) Increase from 34% to 65% the percent of mothers who receive at least two tetanus toxoid (TT)</p>	<p>- Security stock of spare parts (wicks, & chimney for the refrigerators available in the SSD warehouses)</p>	<p>Not realized</p>
	<p>- Regular re-supply in kerosene for refrigerators established with EMAD</p>	<p>Realized</p>
	<p>- SSD EPI manager, and 60 ASB trained in maintenance of cold chain</p>	<p>Realized</p>

Objectives	Benchmark programmés	Realization to date
injections before the birth of their youngest child	- At least 80% of CSB equipped with refrigerators are functional	100% of CSB equipped with refrigerators are functional
	- The SSD warehouse with refrigerators is functional and is maintained	Realised
3) Reduce from 21 % to 10% or less the % of children 12-23 months who default between DPT and DPT3 doses	- 420 VCS trained in the promotion of EPI, BCC circuits, & VISA approach,	433 VCS were trained in EPI promotion
	- 60% of the VCS apply the VISA approach to vaccination	28% of VCS apply the VISA approach for the EPI promotion
	- EPI training module for VCS developed	Realized
	- Messages & BCC materials on vaccination adapted & made available at all levels of the health system.	Realized
	- Mass media used in the promotion of EPI	Realized : educational program on radio based on the listening in group system implemented in collaboration with ALT Radio
	- Recording system to follow up on the drop-outs of children to be immunized is elaborated	Realized
	- 420 VCS trained in the tracking of drop-out cases in the community - 80% of VCS are supervised quarterly on EPI related activities	Realized
	- HFA realized annually to evaluate the quality of service delivery and the need for ID-service training under the EPI for ASB	Realized
	- 80% of CSB including the cold chain system is supervised	50% of CSB received a supervision visit including the cold chain system
	- Supervision tool for the CSB is developed	Realized
	- 60 ASB retrained in management of vaccines	60 ASB retrained in vaccines management
-Vaccines are supplied to the 28 BHCs every quarter	XXX% of CSB have a stock of vaccines	
Breastfeeding		
1) Increase from 2% to 35% the percent of children age 0-5, months who are exclusively breastfed	- A team of 6 trainers (DPS, MCDI, SSD) retrained on the Essential nutritional package & utilization of the modules	11 trainers are trained in Essential Nutrition Package TOT
	- 60 ASB trained in the Essential nutritional package	60 ASBs are trained in Essential Nutrition Package
2) Increase from 24% to 55% the percent of mothers who	- Baby friendly hospital initiative approach implemented in the 28 CSB	7 ASB trained in BFHI. 1/28 CSB of Toliara, 2/2CHD of Betioky Sud, 3/21 CSB of Betioky implement IHAB.
	- 60 ASB retrained in essential nutritional package including BF /CF /feeding during illness	60 ASB retrained in Essential Nutrition Package

Objectives	Benchmark programmés	Realization to date
initiate breastfeeding within one hour after giving birth 3) Increase from 19% to 50% the percent of children 12-23 months who receive 5 or more feeds per day (meals and snacks) in addition to breastfeeding	- Channels to re-supply the CSB facilities with Vitamin A established project with the EMAD and with the PFU arrangement	Realized
	- Procurement & re-supply of Vitamin A for the 28 CSB carried out on quarterly basis	68% of CSB did not experience any vitamin A stock out during the last 06 months
	- 420 VCS trained in the promotion of breastfeeding	445 functioning, trained and promote BF and Essential Nutrition Package
	- 60% of VCS apply the VISA approach on breastfeeding	402/445 were trained in VISA and apply this approach on BFP
	- Training modules on breastfeeding and AEN for the VCS developed	Realized
	- Messages & BCC materials on breastfeeding adapted and made available at all levels	Realized
	- Mass media used in the promotion of breastfeeding	Realized. MCDI in collaboration with ALT Radio implemented an broadcasted educational program based on the listening group approach.
	- 80% of the VCS are quarterly supervised on breastfeeding related activities	More than 80% of VCS were supervised
	- HFA realized annually to evaluate the quality of service delivery (counseling in AEN and breastfeeding by the ASB)	Realized
	- Supervision tool for the CSB on breastfeeding, including supervision project of the BFHI	On the way
	- Supervision tools include qualitative analysis of the EBF developed	Realized
	- 420 CSV trained, equipped with Salter scales for surveillance and growth monitoring	Not Realized
	- 28 CSB practice surveillance for growth monitoring of sick and healthy children	Realized
PF		
1) Increase from 9% to 25% the % of mothers who are not pregnant, do not want another child in the next two years or are not sure, and are using a modern	- 28 CSB adequately equipped with medical equipment and supplies for Family Planning	28/28 CSB in Toliara II and 21/21 CSB in Betioky are appropriately equipped with FP materials and equipments
	- 420 VCS trained in promotion of FP, BCC techniques, VISA approach,	Not Realized
	- 60% of VCS apply the approach VISA on FP	Not Realized
	- Training module in FP for the VCS developed	All the modules are available

Objectives	Benchmark programmés	Realization to date
method of contraception	- Messages & BCC materials on FP adapted and made available at all levels of the system	Realized
	- Mass media used to promote FP	Realized
2) Increase from 21 % to 60% the % of women who can cite at least two ways to reduce the risk of HIV infection	- Recording system that is developed for community-Level activities is established to track dropouts from the FP program	Not Realized
	- 420 VCS trained on the follow up of those who drop out of the program at the community level	Not Realized
3) Increase from 0% to 75% the % of CBDs that have no stock outs of condoms during the last six months	- 80% of the VCS are supervised quarterly in FP related activities	Not Realized
	- 60 ASB retrained on PFU, supply and drug management	Not Realized
	- 28 CSB re-supplied quarterly with contraceptives in accordance with the established PFU system	XXX% of CSB did not experience have any contraceptives stock out these last 06 months
4) Increase from 1% to 40% the % of mothers who know the exclusive breastfeeding as a method of child spacing	- District Pharmacies have appropriate stock of contraceptives	Phagedis in Toliara and in Betioky without any contraceptives stock out in the last 06 months.
	- A team of 6 trainers (OPS, MCDI, SSD) retrained on birth spacing	YES
	- 60 ASB trained & retrained on the four family planning methods according to national policy for FP	XXX ASB were trained in PF
	- 28 CSB providing birth spacing services to the target population	Yes
	- HFA realized annually to evaluate the quality of FP services being provided by the ASB	no
	- Supervision tools for the CSB on FP are developed	YES
	- Mass media used to promote FP	YES