



## Fiscal Year 2006 Portfolio Review Strategic Objective 05 Use of Selected Health Services and Products Improved and Increased



**This year it is about the youth...**

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**Office of Health, Population, and Nutrition USAID Madagascar  
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## **USAID/HPN Madagascar supports the 2007-2012 Madagascar Action Plan**

### **Commitment Five**

#### **Health, Family Planning, and the fight against HIV/AIDS**

“We will work to ensure that all of our people are healthy and can contribute productively to the development of the nation and lead long fruitful lives. The problems of malnutrition and malaria will be brought to a halt. HIV and AIDS will not advance any further; safe drinking water will become accessible; and, through education and the provision of health services the average size of the Malagasy Family will be reduced.”

*-President of the Republic of Madagascar Marc Ravalomanana*

## Acronyms

ACT	Artemisin-based combination therapy
ADRA	Adventist Development and Relief Agency
AISC	National Avian Influenza Steering Committee
DHS	Demographic Health Survey
CI	Conservation International
ENA	Essential Nutrition Actions
FY	Fiscal Year
GOM	Governmental of Madagascar
HPN	Health Population Nutrition Office
HIP	Hygiene Improvement Project
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide treated bednet
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
KM	Kominina Mendrika
LQAS	Lot Quality Assurance Sampling
MAP	Madagascar Action Plan
MOHFP	Ministry of Health and Family Planning
MOP	Malaria Operational Plan
PLeROC	Religious Leaders HIV platform
PSI	Population Services International
RBM	Roll Back Malaria
RCO	Regional Contracting Officer
SO5	Strategic Objective 5
STI	Sexually Transmitted Infections
SWAp	Health Sector Wide Approach
USG	United States Government
USP	US Pharmacopeia
USPSC	United States Personal Service Contractor
VCT	Voluntary Counseling and testing
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WWF	World Wildlife Fund for Nature



# USAID/Madagascar Health Population Nutrition Fiscal Year (FY) 2006 Performance Review

## 1. USAID Health Program Introduction

Despite recent improvements in child mortality rates, total fertility rate and other key health indicators, Madagascar still faces major health challenges which threaten social and economic development. Health service quality is substantially below standard and basic medicines and supplies are regularly in short supply. Public and non-governmental sector capacity to plan effectively and manage health programs is weak, particularly in the areas of financial and administrative management, and the use of data for program planning and monitoring. National health infrastructure, information and commodity management and logistics systems are extremely weak, and much remains to be done at central and regional levels to ensure sustainable health financing. The Government of Madagascar (GOM) recognizes that improvements in health, nutrition, and food security are critical components for rapid and sustainable economic development and have included specific health and food security objectives in the Madagascar Action Plan (MAP).

USAID/Madagascar's Health, Population, and Nutrition (HPN) program is advancing community health and food security priorities established under Madagascar's MAP by promoting reproductive, maternal, and childhood health; intensifying essential nutrition activities; and reducing infectious diseases (especially malaria). HPN's integrated program uses state of the art approaches, mobilizing communities to action, engaging the private and non-governmental sectors to partner with the public sector, promoting positive behavior change with innovative interventions. With USAID support, the government and partners are increasing demand, quality, and availability of high-impact health services and products in the public and private sectors.



## 2. FY06 Health Population Nutrition Performance Overview

Fiscal Year (FY) 06 was an expansion year for the HPN. At the Commune level, HPN extended its geographic reach, intensified its community behavior change interventions, scaled up innovative interventions, and improved access to health services and commodities. At the National level, HPN strengthened contraceptive security, reinforced the commodity and information health systems, and took on a leadership role to improve the quality of services, and policies and standards in maternal/child and reproductive health, and malaria. The HPN team reinforced its partnerships to enhance the impact of United States Government (USG) investments by leveraging support and assuring program alignment with the GOM and Ministry of Health and Family Planning (MOHFP). The results of HPN efforts are visibly demonstrated in the improvements in indicators in health element areas. HPN met and in many cases exceeded targets for FY06.

HPN results are confirmed through a cost effective monitoring and evaluation tool using Lot Quality Assurance Sampling methodology (LQAS). The survey was carried out in 146 communes, reflecting a cross section of all HPN commune level interventions (SanteNet, child survival grants, Title II, Voahary Salama, etc) and captures the national level support to systems and the PSI social marketing and behavior change activities. The survey was conducted both at the household and the clinic levels. This information allows HPN to obtain outcome results and to re-orient the program as needed. The results of the 06 LQAS clearly show that the HPN program is on track.

The following paragraphs provide select highlights of HPN achievements at the commune and national levels, and in reinforced partnerships. Section 3 provides specific results by Element.

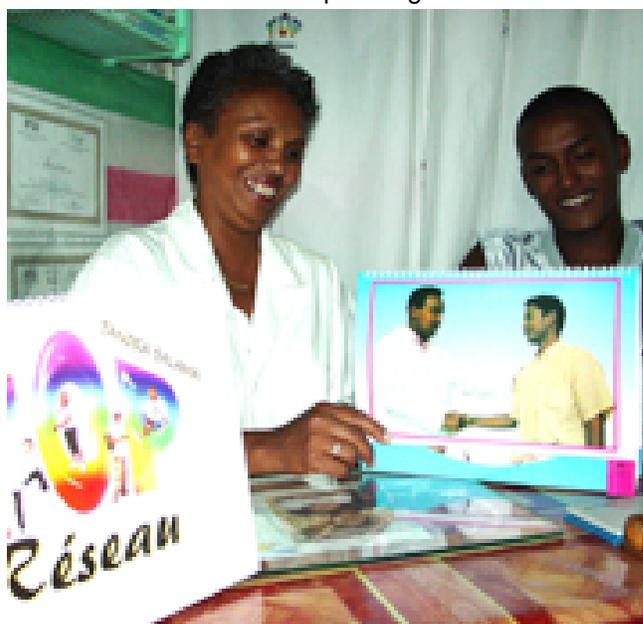
### **Commune Level**

HPN expanded its successful community empowerment, mobilization, and behavior change approach called Kominina Mendrika (KM) or Champion Commune with 189 communes achieving their health objectives this year. HPN trained 1820 volunteer local community based health agents who are actively working in these communes. The KM approach engages communal leaders and stakeholders in identifying health objectives, and breaking these down into doable actions with measurable results. As the Commune leaders commit to these actions, and measure the results, their capacity is strengthened. They begin to include their local health information in their communal development plans and take on ownership for the health and well being of the population. (Annex 1). As a result, the recent LQAS survey in these communes showed a net improvement in the key program element indicators in rural areas: Contraceptive prevalence was 22% while the national target is 20%; exclusive breastfeeding was 88% up from 65% in 2004; and vaccination coverage is 66% in champion communes while the national average is much lower. In FY 07, the 189 Communes will set new objectives, and HPN will extend the approach to an additional 180 new communes.

During this fiscal year, HPN took a number of its innovative behavior change approaches to scale. For example, based on the promising results from the Ankoay scouts initiative, HPN and the National AIDS Control Program expanded this approach to include Ankoay Sports, Ankoay College and the Ankoay Red Card (Annex 2). Over 48% of the 165 scout troupes have achieved 'Ankoay' status, and over 2,040 youth have been trained in life skills and prevention. This innovative approach uses existing groups and provides them with an essential package of training, education tools, and behavior change tools. Much like the KM approach, these innovations like Ankoay, employ doable actions with measurable results. (Annex 3). The National AIDS Control Program has taken full ownership of the all the Ankoay initiatives and have included these in the National HIV Strategic Plan 2006-2012 and will fund national scale up through the World Bank Multi-sector AIDS Program.

HPN's highly successful comprehensive targeted reproductive health program for youth, TOP Réseau was expanded to two additional cities. Top Réseau is an all-inclusive program including a franchised network of private sector service providers offering youth friendly services, peer educators who reach at-risk youth through interpersonal communication, and multiple mass media channels with key prevention messages. HPN's innovative behavior change interventions such as Ankoay and Top Réseau are showing real results. A recent behavior survey showed that the percentage of youth age 15-19 who reported being not yet sexually active increased from 64.6% in 2003 to 79.5% in 2006.

HPN continued to improve access to health especially for the poorest of the poor and remote rural populations. HPN introduced local health insurance schemes in 61 communes, making it possible for rural people to access funds for critical health care and medications. HPN's work with conservation partners, WCS, CI WWF has extended family planning services to communes in areas of high biodiversity. The vast network of over 1800 community health agents, assure the availability of contraceptives and life saving commodities such as insecticide treated nets, and malaria treatment for children at the household level. HPN's efforts to ensure that commodities are consistently available in the health centers has paid off, with a significant decrease in stock-outs of depo provera from 14% in 2004 to 4% in 2006 in USAID supported communes.



### **National Level**

With HPN support, the GOM made dramatic strides in assuring long term contraceptive security. Using evidence based family planning data; the partners developed a 7 year contraceptive needs and procurement plan. The GOM has committed to the procurement of over \$300,000 contraceptives in 2007, over \$1 million in 2008, and supporting and leveraging for the funding gaps in the out years. By introducing simple and easy to use tracking tools, HPN improved national ability to gather and use information on health commodity use and stocks available. This information has lead to declines in stock-outs of vaccines and other essential drugs.

HPN provided strong leadership in the improvement of quality of family planning services. Knowing that a number of internationally recognized best practices, such as the use of the pregnancy checklist to determine if a woman is medically eligible for contraceptives, could dramatically improve the quality of services offered, HPN led the introduction in Madagascar. HPN supported a national assessment on best practices and facilitated the incorporation of these practices in the revision of the national norms and procedures. Over the next fiscal year, these practices will be piloted in 9 health districts. HPN is also supporting operational research on one of the best practices—the use of community based agents to provide injectable contraceptives to women who choose that method. Only one other African country, Uganda, has piloted this practice thus far.

Another important national level achievement this year was in the area of child health. HPN supported the development and validation of the National child health policy that will guide implementation of more effective interventions to save children's lives at the household and clinic levels. The policy includes the adoption of community-based use of zinc for diarrhea and cotrimoxazole for childhood pneumonia to appropriately treat these deadly diseases that, with malaria are the top three killers of children in Madagascar. The roll-out of these new treatment therapies at the community level has already begun and will be taken to national scale in the next fiscal year. Madagascar will be the first African country to accomplish this.

HPN supported important national progress in the area of Malaria. Trained providers and availability of drugs for Intermittent Preventative Therapy for pregnant women was expanded from a pilot activity in a dozen centers to cover all the community health centers in the stable malarial zones. The promotion of insecticide treated nets through community-based networks was substantially expanded, with more than twice the number distributed as anticipated from the annual target. Finally HPN supported a three day national workshop to develop a practical, doable one-year plan for the transition from chloroquine treatment to Artemesian -based combined therapy. Based on the national program progress, Madagascar was nominated to become a Presidential Malaria Initiative Country next year, with substantial increases in funding.

### **Partnerships**

HPN focused efforts to reinforce key partnerships to improve cooperation, leverage funding, and assure better alignment of activities. These partnerships are based on mutually understood objectives, complementary areas of expertise, and collaboration to produce greater results.



The Roll Back Malaria (RBM) partnership was one of the main focal points for improving relations during this year. With GOM and HPN efforts, the RBM partnership began to work effectively together developing critical operational plans such as the plan to transition from chloroquine to Artemisinin combined therapy at both clinic and community levels.

HPN's partnership work has also paid off through substantial leveraging of funds in support of key Ministry of Health and Family Planning programs such as the contraceptive security committee that engaged the World Bank in \$800,000 of support for the procurement of Implanon and other contraceptives. Another important example of synergistic partnering is the work that HPN, Unicef and the MOHFP are engaged in to launch the use of zinc and cotrimoxazole to treat diarrhea and pneumonia among children at the household level. Following the collaboratively established plan, USAID and Unicef are providing complementary expertise and products for the program.

Most important, HPN has been an active participant with other partners, the GOM, civil society and the private sector in the process to establish a Health Sector Wide Approach (SWAp). Partnership is a key element of the SWAp process. Coordination and alignment of all financial and technical resources, including GOM as well as from the development partners, is one of the ultimate goals of the Sector-Wide Approach. The successful adoption of the Sector Wide Approach is expected to yield a number of development benefits, starting from stronger country ownership and leadership to greater focus on results. In addition, the SWAp process will encourage and foster coordinated and open policy dialogue for the entire sector, more rational resource allocation based on priorities, and facilitate scaling-up of benefits to entire sector. It will also enhance sector-wide accountability with common fiduciary standards, and strengthen the country's capacity, systems & institutions. (Annex 4)

### **3. Program Accomplishments**

#### Element 1.1 HIV/AIDS

HPN's HIV/AIDS technical assistance focuses on sharply targeted behavior change interventions; reducing STI prevalence through increased health seeking behaviors; improving availability and quality of STI services and products; expanding condom promotion and behavior change communication; strengthening capacity at the national and local levels; enhancing public/private partnerships; and improving surveillance and data collection and use. HPN interventions are having real impact. For example the syphilis rate among STI patients dropped from nearly 15% in 1996 to 6.82% in 2005 (Annex 5). Recent surveys also show that HPN behavior change interventions are achieving demonstrable results. PSI' 2006 behavior TRAC survey showed that males reporting condom use with their last non-regular partner was 51.6%, while the 2004 national average was only 13.1% (DHS). The TRAC survey also demonstrated that HPN abstinence interventions are having impact with the youth; 15-18 years olds delaying sexual intercourse increased from 64.6% in 2003 to 79.5% in 2006. The following are among the key results achieved this year in this element.

- The HPN scouting initiative, Ankoay, was expanded to 165 scout troops and also sports teams and high-school clubs. In ten months, more than 2,400 scouts have been trained in participatory activities developing skills such as decision-making, goal-setting and effective communication. Ankoay's expansion also targeted young people in rural areas. About 144 soccer teams, representing about 31,000 players are directly involved in the Ankoay Sports approach. HPN also launched the Ankoay Red Card initiative, a behavior change tool to empowering young girls to



say “no” and avoid risky sexual situations. Four Red Card spots were produced and aired in major public and private TV stations. In the first month, more than 10,000 ten to twelve years old girls were trained in the use of red cards. Following the training and the spots, the demand was so great that the National AIDS Prevention committee will print one million cards.

- HPN continues to expand programs to increase preventive and care-seeking behaviors among youth and increasing access to high-quality, affordable and youth-friendly counseling and treatment services. The successful Top Reseau program was extended to two additional cities this year, Antsirabe and Morondava. Over 64,376 clients received quality counseling and reproductive health services at Top Reseau clinics this past year, a 45% increase from last year. HPN also launched voluntary counseling and testing (VCT) services in selected Top Reseau clinics.
- Through its targeted interventions with the most at risk populations, HPN sold and distributed 9,601,848 condoms exceeding 2006 targets and 300,255 clients received quality treatment for gonorrhea and Chlamydia, an increase of 74% from 2005.
- HPN expanded efforts of faith-based groups engaged in STI/HIV prevention through the platform of religious leaders and faith-based organizations (PLeROC). With HPN support, PLeROC, trained 143 faith-based trainers on STI/HIV prevention and psychosocial support in six provinces. These trainers will in turn train all other members of the faith based groups that are members of PLeROC.

### Element 1.3 Malaria

Malaria is one of the primary causes of childhood death in Madagascar. To address this crucial maternal, child and public health concern, HPN supports policy development, commodity management, drug quality assurance, and training at the national level, and at the community level, HPN mobilizes the people to action, provides outreach education; and distribution of life-saving commodities. HPN interventions are showing a positive impact, and saving lives. HPN malaria activities are on track and exceeding targets. In HPN intervention zones, LQAS data shows over 51.2% of respondents report having insecticide treated bednets (ITNs), higher than the national average of 39% in 2004. Community and care-giver education activities are also showing excellent results with 93.4% of respondent giving an



appropriate treatment for a child with fever, which is attributed to HPN’s successful prepackaged malaria treatment, distributed through the Community-based distribution agents and the education and behavior change campaigns. The following highlight some important results achieved during the past year:

- HPN’s strong social marketing program and the vast network of community-based health agents augmented access of remote rural populations to life-saving commodities. Over 801,102 ITNs and 3,451,025 prepackaged malaria treatments were sold and distributed in FY 2006. In communes where CARE works, the percentage of households with a bed net increased from 59% in FY04 to 97.4%.
- HPN’s program improved access to effective malaria treatment for pregnant women. Over 2,144 health facilities, 92 out of 111 districts are implementing the intermittent preventive treatment (IPT) for pregnant women. Currently over 2.8 million women of reproductive health age in stable transmission zones have access to malaria in pregnancy services and over 4.1 million have access to health facilities with trained providers with focused antenatal care and support materials.

- HPN assistance to Madagascar's drug agency helped to establish a quality pharmacovigilance system (to alert providers and clients of drug reactions and bad quality medications) making it one of the only Sub-Saharan African countries to achieve this. During a national seminar, the system was validated and fifty three health staff from private and public sectors and regions were trained as trainers on pharmacovigilance. Four mini-labs to test drug quality have been distributed to Fianarantsoa, Tamatave, Mahajanga and Toliara. HPN worked with the Ministry of Health and Family Planning to plan and improve the Indoor Residual Spraying (IRS) campaign for this year. HPN conducted an environmental impact assessment and a Memorandum of Understanding with the GOM in preparation for the next FY support for the campaign.

#### Element 1.4 Avian Influenza

HPN is working actively with the Government of Madagascar on Avian Influenza prevention and preparedness, including provision of technical advice to the National Avian Influenza Steering Committee (AISC), donor coordination, and working with the World Health Organization (WHO) and other donors to leverage resources. In this past year, the USAID participated in Mission Emergency Action Committee meetings to assess the potential impact of an AI outbreak on the U.S. Mission, as well as to improve communication between U.S. Agencies. The following are key achievements:

- HPN, with other members of the AISC, finalized the Government of Madagascar's Avian Influenza preparedness plan, with U.S. Mission assistance. The Ministry of Agriculture and Animal Husbandry and Ministry of Health and Family Planning drafted the Government of Madagascar decree to formalize the Avian Influenza Steering Committee and its procedures.
- HPN helped the GOM in preparing AI emergency response and pandemic prevention with particular emphasis on wildlife and domestic fowl surveillance and virus containment.
- HPN worked with the GOM to design an AI preparedness table top exercise, which included five 'real' scenarios. The simulation exercise was designed to test AI response plans, identify bottlenecks in the prevention and preparedness system, and clarify roles and responsibilities at all levels. The exercise effectively improved emergency planning efforts.

#### Element 1.6 Maternal and Child Health

HPN's innovative and strategic efforts to improve child health are showing results in the overall national decline in child mortality. HPN works at the central and community level to increase vaccination coverage, expand Essential Nutrition Actions (ENA), and improve early detection and treatment of childhood diseases through the integrated management of childhood illnesses (IMCI). USAID's community-based support for child health is paying off. The LQAS survey shows that in HPN intervention zones, rates of infants exclusively breastfed were 86.7% compared to the national average in 2004 of 48.8% and rates of children 12-23 months old that are completely vaccinated is 65.5% in USAID supported communes compared to the 2004 national rate of 53%. This same survey showed that 80.3 % of children aged 6-59 months received two doses of Vitamin A. The following are key achievements in this element:

- HPN and partners worked with the GOM to organize and launch the twice-yearly National Mother and Child Health Week. The National Mother and Child Health Weeks will mobilize communities to visit their local health center for critical services, and will help to group campaign efforts during these weeks. The US Ambassador, who gave opening remarks during the launch, stressed that this innovative approach will increase cost efficiencies and will bring about positive health impacts for Malagasy women and children.



- HPN supported the development of community-based treatment and implementation protocols for zinc for diarrhea and cotrimoxazole to manage Acute Respiratory Infection cases. With USAID support, community-based agents have been trained, job-aids developed, and zinc and cotrimoxazole interventions were launched in 12 districts.
- USAID's Title II child health and nutrition programs are showing good results in immunization, diarrheal prevention, and nutrition including the use of locally grown food and knowledge to address malnutrition. During FY '06 ADRA worked to promote and monitor the nutritional status of 18, 065 children exceeding targets by 70%.

#### Element 1.7: Family Planning and Reproductive Health

HPN's family planning program includes a full range of support at the national, service delivery and community levels. At the community level, HPN is increasing demand for and access to family planning services and products through community based distribution and community education. At the national level, HPN is strengthening the public sector commodity management and distribution system, improving the quality of services, focusing on competency-based approaches in pre-service training institutions and revising norms, standards and guidelines. Substantial progress has been made in family planning. LQAS data in HPN rural intervention zones shows contraceptive prevalence rates of 20.7% compared to the national contraceptive prevalence rate of 16% in rural areas.

- Madagascar was chosen by USAID Washington as a focus country for family planning and to serve as the sub-Saharan African model for 'repositioning' Family Planning.
- With HPN support, the MOHFP increased the number of health centers providing family planning in the public sector from 80% in 2005 to 89% in 2006.
- With HPN support, the MOHFP developed a national communication strategy and family planning media campaign along with an innovative clinic and community level communication package including an invitation card for potential users.
- HPN support to strengthen the contraceptive logistic and management system is showing excellent results. This year only 4% of health centers in USAID districts reporting a stock out in contraceptives down from 14% in 2004.
- HPN social marketing program is increasing access to family planning services and products in the private sector. During FY06, HPN sold 1,772,946 cycles of oral contraceptives and 643,061 doses of injectable contraceptives, an increase of over 28% and 18% respectively from last year sales.

#### Element 1.8: Clean Water and Sanitation Services



Diarrheal diseases are the primary causes of mortality and morbidity among children under five in Madagascar and clean water, hygiene practices and sanitation are critical to reduce diarrhea and is a National priority. HPN's water and sanitation program focuses on increasing the synergies among partners working in this area, improving access to potable water at point of use and scaling up important behaviors to improve hygiene. To enhance synergies, HPN brought together stakeholders to collaborate in "at scale" effort to reduce the incidence of diarrheal disease and facilitate cross-sectoral collaboration on water-related interventions. At the community level, HPN is expanding access to potable water with simple, affordable treatment solutions, increasing access to clean water, promoting important, doable behaviors to improve hygiene and sanitation, and improving local water management capacity. HPN Water Hygiene and sanitation activities are beginning to show positive results. HPN treated over 894 million liters of Drinking Water Treated with One or More USG-supported Proven Methods for Point-of-use Disinfection. In HPN intervention zones, 67.4% of the rural population has access to safe water much higher as compared to the national average of 23% in 2004 (DHS).

The following are highlights of HPN achievements in this element:

- Madagascar is one of the 5 Hygiene Improvement Project (HIP) focus countries. Through this initiative, HPN supported the Government's hygiene improvement behavior change strategy and compiled a catalogue of behavior change approaches and materials, of water, sanitation and hygiene products used and available in Madagascar.
- *Sûr'Eau Vaovao* provides up to 2 months of clean water for a family of six for approximately \$0.15. From October 2005 to September 2006, over 662,450 bottles were sold, an increase of 10% from 2005, providing 894 million liters of potable water.
- HPN, through launched the innovative *Sekoly Sûr'Eau* initiative in 10 schools. *Sekoly Sûr'Eau* combines the provision of water infrastructure (construction of latrines, washing stations, and water fountains) with the behavior change components through training the *Sekoly Sûr'Eau* student committee in water, sanitation, and hygiene outreach messages. Each *Sekoly Sûr'Eau* receives 3 Jerri cans and 10 bottles of *Sûr'Eau* to launch the outreach activities.
- USAID's Title II child health and nutrition programs were very active in water and sanitation in FY 06. ADRA rehabilitated seven hundred and sixty six hectares of irrigation systems, representing 121% of the target for FY '06 and installed 13 dams into new or rehabilitated irrigation systems. CARE assisted 18 communities to complete infrastructure-related action plan elements and built 10 school latrines, 3 hand pumps, 4 drainage / sewer systems, and 1 gravity-flow water system



#### 4. Management Issues and Actions

**Issue: The Mission must jump-start the Presidential Malaria Initiative to be fully operational at the beginning of FY08.**

##### ***Background***

Madagascar has been nominated to receive additional US Government assistance through the Presidential Malaria Initiative that will support Madagascar's National Malaria program and the Government of Madagascar's on-going efforts in Malaria control. While the budgets for the different countries are not yet final, the Madagascar PMI support could be from \$ 17 to \$20 million per year until 2010.

The initiative will work in close partnership with the government, national and international non-governmental organizations, private sector, and other donors including the Global Fund. With the Government of Madagascar, and other partners, the PMI interventions will include scaling up artemisinin combined therapy to treat malaria; indoor residual spraying in the central highlands, south and west of the country; broad distribution of insecticide treated nets through a variety of channels; and intermittent preventive treatment of pregnant women. The initiative will strengthen National Malaria Control Program, reinforce the Roll Back Malaria Partnership, support private, non-governmental and public sector agencies, and facilitate complementary approaches between and among other Donor programs such as Global Fund, WHO, World Bank, Unicef and others in the fight against malaria.

The countries chosen for PMI will be announced at a high level White House Summit on December 14<sup>th</sup>. Given that the initiative has not yet been publicly announced, HPN action has been limited to the following:

- The US Ambassador and Health Team Leader discussed PMI with Minister Robinson, who expressed his Government's willingness to participate in this important initiative. HPN drafted and sent a cable confirming the GOM interest.
- HPN contacted and received some guidance from USAID/Washington on next steps to prepare for PMI. Additional technical, programmatic and outreach publicity guidance will be forthcoming from Washington this week (November 29<sup>th</sup>).

##### ***Issue/discussion points***

Madagascar will only have three years to achieve the same as the two earlier groups of PMI countries that began in FY 06 and 07 respectively. PMI will be a highly visible program, needing strong Front Office guidance. The Global Health Office is strongly encouraging this new group of eight countries to jump-start the initiative during this fiscal year so that by early FY 08 the program is operational. HPN FY 07 budget has some additional funding in Infectious Diseases that are to be used for this purpose. HPN would like guidance and support from FO on key actions to jump-start the program:

##### ***Additional Actions Required:***

- Staffing the "PMI office" Attached is a Generic staffing pattern for PMI countries. (Annex 6) HPN recommends hiring some of the PMI staff with FY 07 funding. The FSN program assistant support staff will be essential to have on board early. HPN recommends developing support staff solicitation and posting it by early January. Ideally, the support staff could be hired by mid-February. This way the support staff could assist in the organization and logistic support for the two PMI assessment and planning teams. The Senior FSN staff could be put 100% on Malaria by April or May.

The timeline for the solicitations for the two US positions, United States Personal Service Contractor (USPSC), CDC will need to be considered so that they can be in place as early in the new fiscal year as possible. The Team leader plans to recuse herself from the USPSC discussions and decisions.

- Preparation for the needs assessment and the Malaria Operational Plan for FY08 These two actions will include large international teams and will be time and energy intensive. HPN has requested that Madagascar be placed on the top of the list for the assessment with the hope that this will take place in February with the Malaria Operational Plan (MOP) to be completed in April or May. Staff from PDA, Controllers and Contract offices may need to be available for parts of these activities. The Mission will also need to consider how to best utilize existing procurements both to

jump-start activities, to assure smooth transition, and achieve rapid results for PMI. It may be important to have the Regional Contracting Officer (RCO) present during the MOP. HPN will need to take these activities into consideration in planning other TDYs and especially for HPN transition planning. (see next issue).

- PMI will require substantial outreach and public relations as well as on going dialogue with donors and the GOM.

HPN will appreciate Front Office assistance in the public relations aspects. The Team Leader and Public Health Specialist will assure on-going dialogue with donors and GOM.

### **Issue: Transition Plan**

FY 08 will be the end of SO5 and the current SOAg. According to our understanding of guidance from Washington, HPN would be required to complete a new bi-lateral agreement with the government, program design and have new mechanisms (with targets) in place by September 07. This is not realistic, especially given the level of effort required to plan and jump-start PMI. HPN has developed a draft transition plan (Annex 7). There are still many questions that need to be answered with the new foreign assistance framework. For example, what form will the new agreement with the Government take? Since the programs can not be extended past the current SOAg, what is the solution? What is the horizon for USAID/HPN planning and how does this interface with the MSP? What guidance do we follow for developing a USAID strategic plan? What form will the Title II program take and with what timeframe? To adequately address these unknowns and to assure a bridge to the new bi-lateral mechanism some of our current programs should be extended at least two years.

### **Progress/Actions Taken:**

- Reviewed current portfolio to evaluate where programming gaps may occur and how to address them.
- Discussed possible a possible design team (time frame July?) with Global Health backstop team.

### **Additional Actions Required:**

- HPN would like to request the RCO to come early next year to review and extend current procurements.
- Need to have an internal Mission discussion on Title II.
- Need to develop new strategy and implementing mechanism.

### **Issue: indicators**

The "indicators" as currently articulated in the Operational Plan (OPs) are very different from our current program indicators and (thus) our implementing partners and their subs targets. HPN has been tracking results that demonstrate actual behavior change or are at an outcome level (for example % of infants exclusively breast fed) while the vast majority of health indicators in the op are now at an output level (e.g. - number of people trained in nutrition). It will be very challenging for us to set output targets and pull back from our outcome reporting. The vast majority of these new indicators do not evaluate the outcomes of our interventions nor will they provide adequate information to tell us if we are on track to achieve our results. For example the number of people trained is such a low output indicator that we will not be able to determine if the trained people are providing better quality services, or if people are using those services. The same applies for people reached with messages. This is a low level output indicator. It will tell us only how many people have seen/heard messages. However, we also need to know if people are changing behaviors because of those messages. When using an indicator without denominators, it is also very difficult to show the measure of the intervention. They may show some trend but generally they are not at all useful if there are changes in denominators

**Progress/Actions Taken:**

- HPN/Madagascar has established a useful and cost-effective monitoring system that provide necessary data on implementing partners and document annually the key indicators required to track HPN performance at the household and service delivery levels in the areas of child, maternal, and reproductive health. We are confident that this system and the indicators collected show impact and progress of USG interventions and allows HPN to monitor the quality of services delivered; identify under-performing activities, and offer recommendations to overcome identified challenges. This system will not allow for numbers but will allow for percentages based on analysis of the sample population.
- HPN is working to review and choose relevant indicators for this year's OPS.

**Additional Actions Required:**

- HPN must work with implementing partners to adapt the current technical elements of activities and regroup them to reflect the program areas, elements, and indicators for future years.

**5. FY'08 projected funding and corresponding "strategic realignment" needs**

Additional population funding in the FY2007 would enable USAID to expand support to cross-sectoral synergies through investments in family Planning and continue support of innovative approaches such as the sub-Saharan regional Family Planning online sharing tool and extra mile initiative reaching the most remote. Additional funding will allow USAID to adequately provide contraceptives to meet the upward demand for modern methods provided solely by USAID to the public sector. Beyond this, increasing HIV/AIDS funding will enable USAID to expand innovative HIV prevention activities targeting youth with Abstinence, Be faithful, and Delay onset of sexual behavior messages, such as the Ankoay Red Card' campaign, made possible by the success of the Ankoay Scout, School and Sport programs.

**6. FY'08 procurement transition issues**

Please see issue number 2

**7. Gaps between current program structure and DFA indicator requirements; plan for closing any gaps identified**

Annex 8 Crosswalk

**8. FY'07 Procurement Plans**

Annex 9

## 9. Summary indicator table

Indicator	Definition	Baseline	Target (2006)	Actual (2006)	Target (2007)	Target (2008)
Vitamin A	Proportion of children aged 6-59 months who received a high dose (100,000 IU) of Vitamin A supplementation in the last six months	National:* 48.5%	TBD	65.5% USAID zones	TBD	TBD
Exclusive Breastfeeding	Proportion of infants under 6 months who are being exclusively breastfed. Exclusive breastfeeding is the practice of giving only breast milk to the infant, with no other solid or liquids, including water.	67%national 68% USAID zones	70% national 73% USAID zones	86.7% USAID zones	70% national 74%USAID zones	70% national 75% USAID zones
DPT3 coverage	Proportion of children aged 12-23 months who received the full series of immunizations for Diphtheria, Pertussis, Tetanus before age 12 months Unit of measure: Percentage	61.3% 2003-2004 DHS national	66% national 76% USAID zones	76.2% USAID zones	68% national 78% USAID zones	70% national 80% USAID zones
Contraceptive prevalence rate	Proportion of women in union age 15-49 who are using (or partner using) a modern method of contraception. Modern methods include oral contraceptives, injectables, implants, male condoms, IUD, male and female sterilization, vaginal foaming tablets Unit of measure: Percentage	18% 2003 DHS	21% USAID zones	22.7% USAID zones	23.5%USAID zones	25%USAID zones
Percentage of public health centers in selected areas reporting one stock-out of injectable contraceptives (Depo-Provera) in the last 12 months	A stock out is when a product is not available at a given health center  Numerator: Number of health centers in USAID districts with one stock out of Depo-Provera in the last 12 months Denominator: Total number of public health centers in USAID intervention districts	2004: 14% USAID zones	10% USAID zones	4% USAID zones	8% USAID zones	6% USAID zones
The number of condoms sold nationwide through the social marketing system	The number of condoms sold nationwide through the social marketing system	1996: 1,051,000	8,470,000	9,601,848	10,000,000	10,248,000
Oral Contraceptive Sales	The number of oral contraceptives sold nationwide through the social marketing system	2003: 952,940	1,342,000	1,772,946	1,449,360	1,565,309
Injectable contraceptive sales	The number of injectable contraceptives sold nationwide through the social marketing system	2003: 346,454	435,000	643,061	470,448	508,084
Sales of treated mosquito nets	The number of treated mosquito nets sold nationwide through the social marketing system	2002: 110,680	400,000	801,102	440,000	485,000
Safe water treatment solution sales	The number of Safe water treatment solution sales sold nationwide through the social marketing system	2003: 428,524	700,000	662,450	770,000	847,000
Individuals reached through community outreach that promotes HIV/AIDS through Abstinence and/or being faithful	Number of individuals reached through community outreach (anokay and PSI peer educators) that promotes HIV/AIDS through Abstinence and/or being faithful	2005: 344,333	750,000	1,014,710	1,000,000	1,000,000
clients attending Top Reseau	Number of clients attending Top Reseau, a network of high quality youth-friendly services, mass media, and interpersonal educators.	2004: 20,600	36,449	64,376	40,095	44,105

## **ANNEXES**

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**ANNEX 10: Success Stories**

## **ANNEX 1: *Kôminina Mendrika* brief**

### ***The Champion Community Approach***

The Government of Madagascar is currently implementing a rapid and sustainable development policy that is in line with the national Poverty Reduction Strategy Paper (PRSP) that aims at directly benefiting local communities. At the community level, innovative partnerships between the public and private sectors are being formed to carry out important efforts in community mobilization.

One example of a dynamic public-private partnership is the Champion Community approach which is used to mobilize community leaders, groups and individuals in a community that will lead to positive social, economic, and cultural development.

#### ***1.1 The Champion Community Approach is a platform for all sectors of development***

The Champion Community Approach seeks to integrate four key development sectors to improve community well-being: 1) environmental protection, 2) health improvement, 3) economic development, and 4) good governance.

Development sectors are completely interdependent and need to be integrated to produce the best possible synergy while promoting rapid and sustainable development. The development of the rural economy, for example, is highly dependent on the availability and sound management of human and natural resources. In turn, the population needs to be healthy to be productive and natural resources rely on rational management to ensure availability and quality. At the same time, good governance in a community ensures commitment to and investment in natural resource management and health services.

The Champion Community Approach serves as a platform for the integration of these crucial development sectors. It calls for close collaboration between local and international partners and stakeholders to reach as many communities as possible throughout Madagascar.



#### **Mobilizing all actors in the community**

Finding solutions to development challenges in a community requires the engagement of all key actors. The Champion Community Approach seeks to mobilize all community actors to achieve common goals and common objectives. An ACTOR is an individual or a group of individuals that voluntarily commits itself to carry out actions for achieving pre-defined objectives to become a Champion Community.

#### ***Achieving common development objectives in the community***

Champion Community actions are defined through a participatory process which establishes development objectives and corresponding indicators, based on needs identified by the community and on the analysis of data available at the community level. The set of objectives and indicators that serve as Champion Commune criteria are negotiated directly with the community by local partners. These must be specific, realistic, and achievable. The key is to define OBJECTIVES that require a significant but also reasonable level of effort from the community.

### **Changing behaviors through Important-Doable-Actions**

The approach is based on important-doable-actions with tangible and measurable results which foster sustainable behavioral change. An ACTION is any form of participation by an individual or a group that facilitates, supports or promotes the achievement of the predefined objectives.

*A community becomes a Champion Community when it demonstrates that it has achieved the predefined objectives by implementing important, doable and measurable actions.*

### **Implementation cycle of the Champion Community Approach**

The approach is implemented through a 10-step cycle with a variable timeframe based on the development sector:

- Step 1: Introduction of the approach in the community and definition of the indicators and objectives
- Step 2: Signature of the commitment contract with the community
- Step 3: Training of community-based agents and launch of community-based activities
- Step 4: Monitoring of activities round 1
- Step 5: Supervision and technical/organizational support round 1
- Step 6: Monitoring of activities round 2
- Step 7: Supervision and technical/organizational support round 2
- Step 8: Monitoring of activities round 3
- Step 9: Evaluation of community performance against their predefined objectives
- Step 10: Festival to award Champion Community status and prize (if they meet their objectives)

#### **1.2 Champion Community's four-star system encourages multi-sectoral development**



At the end of this implementation cycle, the Community is awarded the Champion Community status if it has achieved the objectives in the development sectors targeted during the cycle. This earns it the status of “One-Star Champion Community.” The community can then continue or expand its activities to a different sector, using the same approach to define objectives relative to the sector. Upon realizing these objectives, the community may continue its activities and earn stars from the remaining sectors, eventually becoming a “Four-Star Champion Community”. Each star is given a specific color to represent the corresponding development sector: green for environmental protection, blue for health improvement, gold for economic development, and white for good governance

#### **1.3 The Champion Community Approach tools**

Three toolkits are available to implementing partners for community-based activities:

- **The Marketing kit:** includes print materials that increase visibility of the approach in the community, to motivate community-based agents and to facilitate the approach's implementation.
- **The Mass Media Communication kit:** includes audio materials like songs, fables, sketches and promotional spots targeting local radio to support community mobilization and awareness-raising activities and to reinforce key messages.
- **The Interpersonal Communication kit:** includes materials to assist trainers and community-based agents to facilitate introductory activities, negotiate objectives with local communities, conduct training sessions, awareness-raising campaigns, behavior change communication activities and monitoring and evaluation activities.

## ANNEX 2: Ankoay Red Card Brief



Sitraka at an *Ankoay* festival

### YOUTH TRANSFORMATION IN MADAGASCAR The Ankoay Programs and the Red Card Campaign

Sitraka, a cheerful 21 year-old who lives in a modest home on the outskirts of Tana, has been involved in scouting since she was young. When she first heard of the *Ankoay* program a year ago, all she knew was that it was named after the a Malagasy eagle that represents honor and independence – and that it had something to do with preventing AIDS.

As she began working through the first of the twenty-five activities in the *Ankoay* book with her scout troop, she thought, “this is a cool thing to do on Sunday afternoons.” She had fun acting out the skits –and was particularly adept at playing outraged at a cheating boyfriend. Volunteering to act this sketch out at a local festival, she found herself nervous but proud on stage before her parents and peers.

As the weeks went on, Sitraka found herself behind a megaphone talking about *Ankoay* at all sorts of events. In private, she started talking to her friends about relationships, about STIs and HIV, and about the risks they face in their own lives. Last week, Sitraka’s scout troop was officially named *Ankoay*, as 60 troops have now been across Madagascar.



A scout troop becomes *Ankoay*



A friend of Sitraka’s participates in the Red Card training

In a new initiative called the ‘Red Card’ campaign, made possible by the success of the Ankoay Scout, School and Sport programs, girls are given red cards and encouraged to use them to say ‘stop’ in risky situations, and to start conversations about normally taboo subjects.

Sitraka recently participated in a Red Card training. Towards the end of the session, she decided to speak up. “You know, I’ve actually already used the red card - with my boyfriend one night...” she was stopped short by an explosion of giggles rifling through the younger participants. “Hey...it worked!” she cut in, redirecting her peers’ attention. “He understood, and now we both know where we stand.” The other girls glanced at each other, and then back at her. “I hope you try it, too.”

When Sitraka was asked to act in the new ‘Red Card’ TV spots, she jumped at the occasion. She plays a girl who is asking for advice about how to use the red card in different situations. But, to be sure, it was Sitraka herself who was giving the others advice between takes.

Four Red card TV spots were aired on three Malagasy TV stations during the month of October. The spots created a huge “buzz” around town. One indication is that the national AIDS hotline receives 70 – 80 call a day requesting Red cards. Trainings are taking place around the country. The National AIDS Prevention committee has requested that the Health Communication Partnership, which assisted with the red card launch submit a grant request to print one million cards. Now that’s scale!



## ANNEX 3: Ankoay scouting Brief

### The “Ankoay” AIDS Prevention Movement in Madagascar Youth Talent Beats AIDS

## Background

Data from the 2003 Demographic Health Survey indicate that Malagasy youth are among the groups with the highest rates of HIV infection. Two age groups are particularly at risk:

- 1.64% of youth under 15 years old are HIV positive
- 1.35% of youth 15-19 years old are HIV positive

In early 2005, recognizing that effective youth programs represented an important gap in the overall prevention strategy, the CNLS Executive Secretary requested that the Health Communication Partnership (HCP) collaborate on the design of an innovative AIDS prevention program. After consulting close to twenty HIV/AIDS youth prevention models, HCP proposed what would come to be called the “Ankoay” model, which refines and builds on the best life skills approaches and incorporates dozens of lessons learned internationally.



*Ankoay* is the Malagasy name for the indigenous fish eagle, which symbolizes leadership and independence. The overall goal of the “Ankoay” model is to inspire youth groups (scouts, sports teams and secondary schools) to meet a series of goals and to be certified as community leaders in the fight against AIDS. Due to the overall popularity and active community support scouting enjoys in Madagascar, the “Ankoay” program was first launched in April 2005 by the Malagasy National Scouting Federation.

#### Diverse appeal

The “Ankoay” kit sets forth a series of specific goals for youth clubs and employs a broad range of active learning techniques. In addition to activities designed to build life skills, the kit promotes reflection and peer counseling with a close friend through the use of a “Youth Passport.” The Youth Passport has proven to be an effective tool in helping youth connect with their personal values and stand up to peer pressure. Skits and role-plays are also an integral part of the kit’s educational approach. These highly participatory activities add life, humor and context to the messages by allowing youth to emotionally “feel” and to see how “typical” situations, such as resisting peer pressure to drink or have sex, are negotiated. Role plays offer youth an opportunity to work through common, yet challenging scenarios and “experience” the negative consequences of high-risk situations in a safe environment.



## Innovations

The "Ankoay" model brings several innovations to youth AIDS prevention efforts.

- **Certification:** this is an important source of motivation for youth. Youth, indeed, everyone, like to see the end point of their efforts. To date, each time a scout troop has been certified as "Ankoay," neighboring troops have responded to the challenge by strengthening their efforts.
- **Focus on group dynamics:** although individuals earn badges and bracelets when they complete certain activities, it is only the group itself that can earn the distinction of being "Ankoay."
- **Emphasis on Community Outreach:** recognizing that a change in social norms must precede a significant drop in the HIV incidence rate, the "Ankoay" program encourages young people to engage their parents, peers, and communities in their learning process. This vital component of the program seeks to transform an average youth group into a frontline leader in AIDS prevention.
- **Mass Media:** the CNLS plans to transform the "Ankoay" program into a youth movement by using mass media to brand excellence and unite and drive activities.
- **Red Card:** young women receive a "red card" that can be used in a broad range of situations, from signaling a simple "time out" to forcefully telling a guy to "back off."

## Scaling up

In March of 2006, the CNLS launched the Ankoay-College program in secondary schools. Two months later, Ankoay-Sport was launched among sports teams. As of September, 2006 the following youth groups have been trained:

- |                     |     |
|---------------------|-----|
| • Scout troupes     | 161 |
| • Secondary schools | 180 |
| • Sports teams      | 148 |

<b>TOTAL</b>	<b>489</b>
--------------	------------



By the end of 2006, this total will jump to **1000**. CNLS, which fully backs the rapid expansion of "Ankoay," has encouraged the submission of funding requests to the PMPS. To date, the Ministry of Education, the Ministry of Youth Sports and Culture and the Scouting Federation have submitted a total of **10** requests. **4** have received funding, **6** will be approved once the PMPS II program is operational.

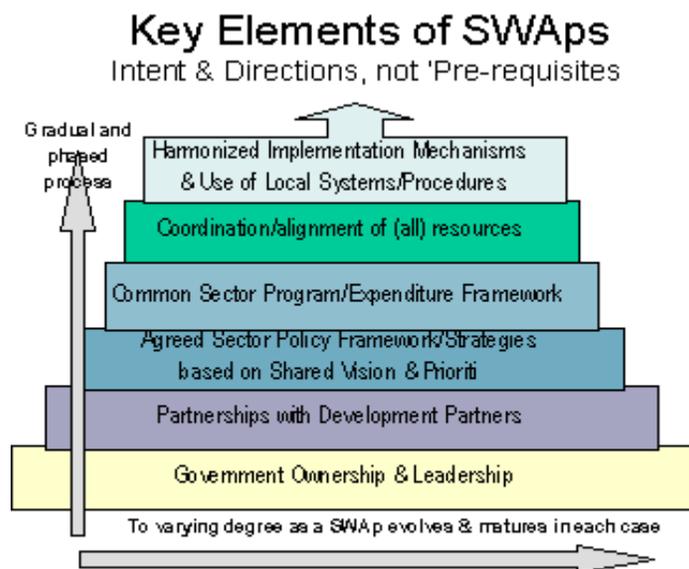
## ANNEX 4: SWAp

### BOX: What is a Sector Wide Approach?

**Sector-Wide Approach (SWAp)** is an *approach* to support a locally owned program for a coherent sector in a comprehensive and coordinated manner, moving toward use of country systems. A SWAp typically encompasses an entire sector (e.g. education) or a major sub-sector (e.g. primary education). Over the years, however, a number of variations have emerged where SWAp principles were applied to a program or a thematic area/initiative.

As an approach, a SWAp embodies a *process* that is guided by a set of principles and progresses over time from the starting point of government leadership towards increased harmonization of implementation mechanisms and use of country systems. There are no strict pre-requisites that must be met in order for an approach to be called a SWAp. Rather, the SWAp is characterized more importantly by the intention and the direction of intervention over time.

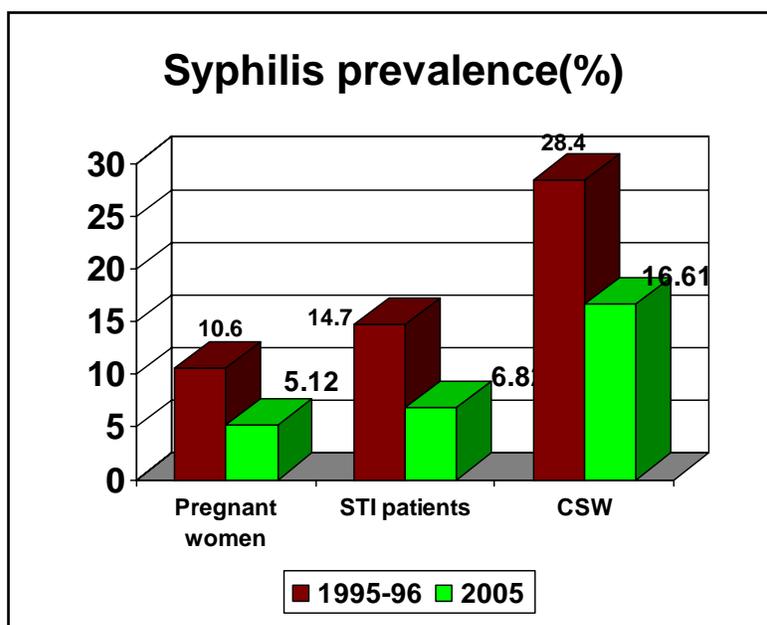
**SWAp are characterized by:** sustained, country-led partnership among development partners and key stakeholders in support of country-owned sector policies and strategies. SWAp promote increasing reliance on country systems and procedures, and employ a common framework for planning, implementation, expenditure, and M&E.



**Expected Development Benefits of SWAp include:** (i) Stronger country ownership & leadership; (ii) Coordinated & open policy dialogue for entire sector; (iii) More rational resource allocation based on priority; (iv) Scaling-up of benefits to entire sector; (v) Sector-wide accountability with common fiduciary and environmental/social safeguard standards; (vi) Strengthening of country's capacity, systems & institutions at a feasible pace and phasing; (vii) Reduced duplicative reporting & transactions; and (viii) Greater focus on results

*Source: World Bank internal documents (edited text)*

# Syphilis prevalence



## **ANNEX 6: PMI Generic staffing pattern**

### **STAFFING AND ADMINISTRATION**

Two new health professionals will be hired to oversee the PMI in Madagascar, one representing CDC and one representing USAID. In addition, two or more Foreign Service Nationals will be hired to support the PMI team. All PMI staff members will be part of a single inter-agency team led by the USAID Mission Director or his/her designee in country. The PMI team will share responsibility for development and implementation of PMI strategies and work plans, coordination with national authorities, managing collaborating agencies and supervising day-to-day activities. Candidates for these positions will be evaluated and/or interviewed jointly by USAID and CDC, and both agencies will be involved in hiring decisions, with the final decision made by the individual agency.

It is envisioned that these two PMI professional staff will work together to oversee all technical and administrative aspects of the PMI in Madagascar, including finalizing details of the project design, implementing malaria prevention and treatment activities, monitoring and evaluation of outcomes and impact, and reporting of results. Both staff members will report to the USAID Mission Director or his/her designee. The CDC staff person will be supervised by CDC, both technically and administratively. All technical activities will be undertaken in close coordination with the MOHFP and other national and international partners, including the WHO, UNICEF, the GFATM, World Bank and the private sector.

Locally-hired staff to support PMI activities either in Ministries or in USAID will be approved by the USAID Mission Director. Because of the need to adhere to specific country policies and USAID accounting regulations, any transfer of PMI funds directly to Ministries or host governments will need to be approved by the USAID Mission Director and Controller.

**ANNEX 7: Transition Plan**

<b>Implementing Partner</b>	<b>October 2008 September 2009</b>	<b>October 2009 September 2010</b>	<b>October 2010 September 2011</b>
<b><u>Bilateral</u></b>			
Development of New Bilaterals			
Sante Net			
PSI			
<b><u>Field Support</u></b>			
Central Contraceptive Procurement			
Extra Mile Initiative			
FHI Depo Study & Best Practices			
HIP			
HCP			
Basics			
US Pharmacopeia			

## ANNEX 8: Cross Walk Matrix

Investing in People						
Program Element:	Program Area 1: Health					
	HIV/AIDS	Malaria	Avian Influenza	Maternal and Child Health	Family Planning and Reproductive health	Water Supply and Sanitation
<b><u>Bilateral</u></b>						
Sante Net	X	X		X	X	X
PSI	X	X		X	X	X
<b><u>Field Support</u></b>						
Central Contraceptive Procurement					X	
Extra Mile Initiative					X	
FHI Depo Study & Best Practices					X	
HIP				X		X
HCP	X			X	X	
Basics				X		
RTI		X				
US Pharmacopeia		X				
LAYERS/Fanta	X	X		X	X	X
Title II		x		x	x	x

Investing in People							
Program Element:	Program Area 1: Health						
	HIV/AIDS						
<u>Bilateral</u>	1.1 Abstinence/ be faithful	1.5 Condoms and other prevention	1.9 Counseling and testing	1.12 Lab infrastructure	1.13 Policy analysis and systems	1.14 Host country strategic info	1.15 Program design and learning
Sante Net	X	X	X		X	X	X
PSI	X	X	X		X		X
<u>Field Support</u>							
Central Contraceptive Procurement		X					
HCP	X	X					
CDC/Consultant				x		x	

Program Element:	Malaria								
<u>Bilateral</u>	3.1 Treatment with ACT	3.2 ITNS	3.3 IRS	3.4 IPT	3.5 Epidemic preparedness and response	3.7 Health Governance and Finance	3.8 Antimicrobial resistance	3.9 Host country strategic info	3.10 Program design and learning
Sante Net	X	X		X		X	X	X	X
PSI	X	X					X		X
<u>Field Support</u>									
US Pharmacopeia	x			X			X		X
RTI			X		X				
Title II	x	x		x	x				x

Program Element:	Maternal and child health									
<u>Bilateral</u>	6.1 Birth preparedness and maternity services	6.3 Newborn care and treatment	6.4 Immunization including polio	6.5 Maternal and young child nutrition	6.6 Treatment of illness	6.7 Household level wat,san, hygien,	6.8 Health Governance and Finance	6.9 Antimicrobial resistance	6.10 Host country strategic info	6.11 Program design and learning
Sante Net	X	X	X	X	X	X			X	X
PSI					X	X		X	X	X
<u>Field Support</u>										
HIP						X				
BASICS			X	X	X			X	X	X
HCP	X			X	X	?				
Title II	X	X	X	X	X	X				X

Program Element:	Family Planning and Reproductive health					
<u>Bilateral</u>	7.1 Service Delivery	7.2 Communication	7.3 Policy analysis and systems	7.4 Health Governance and Finance	7.5 Host country strategic info	7.6 Program design and learning
SanteNet	X	X	X	X	X	X
PSI	X	X	X			X
<u>Field Support</u>						
Central Contraceptive Procurement			X (commodities)			
Extra Mile Initiative	X	X				
FHI Depo Study & Best Practices	X	X	X			X
HCP	X	X				X
Title II	X	X				X

Program Element:	Water Supply and Sanitation					
<u>Bilateral</u>	8.1 Safe water access	8.2 Basic sanitation	8.3 Water and Sanitation Policy and governance	8.4 Water resource productivity	8.7 Host country strategic info	8.8 Program design and learning
Sante Net			X			X
PSI			X		X	X
<u>Field Support</u>						
HIP	X	X	X		X	X
Title 2	X	X	X	X		

**ANNEX 9: SO5 FINANCIAL TABLES**

## Annex 10 Success Stories

# SUCCESS STORY

## Health insurance plans keep families healthy all year long

### Affordable Insurance Improves Health

Every year, most of Madagascar's population, especially in rural areas, goes through a lean period. When the rice harvests have been consumed and the next harvest is yet to come, households spend a large part of their savings to purchase food. They have very little, if any, money left for other expenses, including health care. The government has been looking for a way to reduce economic barriers to accessing health care, especially during the season when families have little cash.

In 2005, with the support from USAID, five community-based health insurance schemes, known locally as *mutuelles*, were piloted in five counties in Madagascar. Members make an annual contribution in cash or in crops. In exchange, they are entitled to receive health care throughout the year, including the lean season. As a result, these counties saw access to health care services significantly improve and preventive health activities increase.

The results have been positive. In one county, the mortality rate for children under four averaged 15 percent in 2003 and 2004. With the advent of *mutuelles* in 2005, the rate dropped dramatically to 5 percent. The insurance contributed to this decrease by requiring members to immunize their children, and allowing parents to bring their children to health facilities for treatment at the very onset of signs of illness.

In the five pilot counties, visits to health care facilities during the traditionally lean season increased between 40 percent and 140 percent. In addition, thanks to the program, the rate of immunization shots in the county exceeded the national average by 60 percent.

In addition to improving overall health in the counties, the programs have proven to government bodies that *mutuelles* contribute significantly toward better health and — in the long run — less poverty. As a result, Madagascar's health ministry plans to set up 73 additional *mutuelles* in the southeastern province of Fianarantsoa with help from USAID.



These women in the community of Ambalamahasoa, Madagascar are all members of a health insurance scheme. They are bringing their children to get immunized at the local health center.

Photo: USAID

**In 2005, USAID helped pilot five community-based health insurance schemes in five counties in Madagascar.**

# SUCCESS STORY

## Community-based sales of bednets improve health and economy

### Bednets Go Beyond Malaria Prevention

Lalaina works in Sahambavy, a village in the Fianarantsoa province of southeastern Madagascar. In October 2005, she took a big step: she became a certified community-based health education and distribution agent for a USAID program that supports community-based development. After successfully completing five days of technical training, she joined the ranks of Madagascar's 1,685 trained health agents.

Community-based distribution agents bring critical health education and products, like anti-malaria bednets and water treatment kits, into areas where these items are hard to find. Once agents complete the training, USAID gives them a start-up stock of health products. When Lalaina finished her training, she received a start-up kit of priority health products for free: five malaria-preventing bednets, 20 packages of malaria drugs, 10 packets of oral contraceptives, a box of condoms, and five water-treatment kits. She sold the products at a price that is affordable, yet allows her to make a small profit. With the start-up stock, she created a revolving fund for purchasing more products. The training she received gave her the skills and knowledge to manage her fund carefully.

Four weeks after returning to Sahambavy, she had already bought and sold 83 bednets, 43 packets of oral contraceptives, and a host of other products. With a profit of 50 cents per bednet and the knowledge that she is helping her community, Lalaina is motivated to go the extra mile to bring life-saving products to families that need them. So not only has Lalaina directly improved the health of mothers and children in her community, she made \$44.41 for herself and her family in one month, in a country where nearly half of the population lives on less than \$1 per day.

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As demand for health products increases in her community, Lalaina is confident she will continue having customers. Her income will steadily increase and she will continue to grow a successful small business. Through the development of her small enterprise, she improves her family's standard of living and inspires others to do the same, showing the true spirit of leadership — and building a real foundation for development.



Lalaina, a certified community-based distribution agent, sells bednets in Sahambavy in the Fianarantsoa Province of Madagascar. Photo Credit: USAID

**“I am happy to get training and to help prevent malaria in my village while growing a small business,” said Lalaina, a certified community-based distribution agent working in Sahambavy in Madagascar’s south-eastern Fianarantsoa Province.**

## SUCCESS STORY

### Youth Fight AIDS in Madagascar

**USAID funded program is transforming Malagasy youth into leaders in the fight against AIDS**

Madagascar has been less affected by HIV/AIDS than many of its neighbors, but recent data suggests the epidemic could spread and the Malagasy youth are at particular risk. In a 2003 HIV survey among girls under 15, 1.64 percent were found to be HIV-positive. Multiple sexual partners among youth is common with 72 percent of young people 15-24 in one mining region reporting to have more than two partners in 12 months.

In cooperation with the President's Emergency Plan for AIDS Relief, USAID is funding an initiative to curb this trend. Known as the Ankoay or eagle initiative, the program educates youth about HIV/AIDS, and teaches them how to become community leaders in HIV/AIDS prevention by promoting behaviors such as abstinence. To encourage participation among young people, the initiative has groups compete as teams to earn the distinction of Ankoay status. The teams are required to complete a series of life skill exercises, a peer education program, and community outreach activities.

The Ankoay initiative incorporates a diverse mix of educational methods, which speak to a variety of learning styles and personality types. To successfully complete the program, youth groups work through twenty highly participatory activities, developing skills such as decision-making, goal-setting, and effective communication. One of these activities is designed to promote individual reflection - the "Youth Passport" includes a role play kit containing scenarios of typical situations youth encounter. As youth act out the dramas included in the booklet, they connect emotionally to vital issues in a safe environment. Once a youth group reaches Ankoay status, it assumes a role of community leadership in the fight against AIDS and celebrates its success with a festival. Media broadcast the news around the country, generating enthusiasm for the program.

The program was designed for youth between the ages of 15 and 18. Originally launched in 2005 through the federation of Malagasy scout troops, the program has expanded to include other youth groups, sports teams, and schools. The Ankoay project is now considered a HIV youth prevention model by Madagascar's National AIDS Committee.



Malagasy Youth are participating in a USAID funded program where they are involved in community outreach to help fight against HIV. Similar to the "scout" system in the US, the youth groups are required to participate in certain activities before reaching "Ankoay" (eagle) status.

Photo Credit: Santénet

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