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Midterm Evaluation

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GLOSSARY and ACRONYM LIST

ADRA	Adventist Development and Relief Agency
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASAP	<i>Ankohonana Salama</i> Project (“Healthy Family Project”; the acronym <i>ASA</i> means “work” in Malagasy)
BCC	Behavior Change and Communication
BPP	Birth Preparedness Plan
C-IMCI	Community-IMCI
<i>Carnet de santé</i>	Health booklet for immunization records, clinic visits, etc.
CASC	Commune-based health management committee
CDD	Control of Diarrheal Disease
CHA	Community Health Agent
CHD	Referral Hospital at the District Level
COPE	Client-Oriented, Provider Efficient
COSAN	Health compliance committee at the level of the <i>fokontany</i>
CRS	Catholic Relief Services
CS	Child Survival
CSB	A community health center with no doctor, and only basic services (CSB I) or with a doctor, and more extensive services (CSB II)
CSHGP	Child Survival and Health Grants Program
CSSA	Child Survival Sustainability Approach
CSTS+	Child Survival Technical Support Plus
CtC	Child-to-Child
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus vaccine
EOP	End of Project
FGD	Focus Group Discussion
<i>Fokontany</i>	Administrative unit presiding over several villages, but smaller than the level of the commune; sub-commune
FP	Family Planning
GAINT	<i>Groupe d’Action Intersectorielle en Nutrition de Toamasina</i> (Toamasina Region Intersectoral Nutrition Coordination Group)
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health/Management Information System
HQ	Headquarters
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ITN	Insecticide-Treated Net

KPC	Knowledge/Practice/Coverage (Survey)
LMIS	Logistics Management Information System
LQAS	Lot Quality Assurance Sampling
MCDI	Medical Care Development International (INGO)
M&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MoH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
OTJ	On-the-Job (Training)
PaluStop	Pediatric, pre-packed anti-malarial of correct single treatment
PM	Project Manager
PHN	Population, Health and Nutrition
PRA	Participatory Rural Appraisal
PSI	Population Services International
PVO	Private Voluntary Organization
SEECALINE	<i>Surveillance et Éducation des Écoles et des Communautés en matière d'Alimentation et de Nutrition Élargie</i> (A food distribution project funded by the World Bank to improve nutrition inside schools and communities)
SSD	District Health System
STI	Sexually Transmitted Infection
Stratégie Avancée	MoH's outreach strategy to reach remote areas w/ immunization services
Tamatave	Name for Toamasina under colonialism; still commonly used
TBA	Traditional Birth Attendant
TCSP	Toamasina Child Survival Project (Oct 1998-March 2003)
TIPs	Trial of Improved Practices (approach to promotion of improved nutrition)
TMM I	Toamasina I or the town of Toamasina
TMM II	Toamasina II District
ToT	Training of Trainers
TRMs	Technical Reference Materials
USAID	United States Agency for International Development
VISA 5/5	Innovative, school-based vaccination promotion campaign
VVT	Vavatenina District
WRA	Women of Reproductive Age (15-49 years)

1.0 Executive Summary

The ANKOHONANA SALAMA PROJECT is a four year project designed to improve the health of children under five and women of reproductive age in 269 villages, of 27 communes in the two districts of Toamasina II and Vavatenina, Toamasina Province, Madagascar. The two districts are extremely poor and populations depend largely upon subsistence slash-and-burn agriculture. Limited means of transport, minimal communications infrastructure and isolation are predominant in many villages and contribute to ongoing poverty and poor health indicators. The project's three primary results-based objectives are:

- Improved community- and facility-based Integrated Management of Childhood Illnesses
- Improved community-based maternal and newborn care/child spacing and
- Increased capacity building for Toamasina II and Vavatenina District Health Systems

Project activities began their start-up from December 2003 (with the hiring of the Project Manager) to July 2004 (with the final approval of the Detailed Implementation Plan - DIP). After the approval of the DIP, the program began fully implementing activities in July 2004. This evaluation reviews the results of 23 months of concerted implementation.

To date, the main accomplishments of the project have been:

- Increased ITN use for children < 24 months
- Increased number of births of children < 24 months that were attended by a trained health person
- Improved care-seeking behaviors for ARI
- Increased use of modern contraceptive methods
- DPT drop-outs reduced

Overall progress is positive. Of the 20 indicators on which the project collected data during February 2006, 15 showed progress (in both VVT and TMM II) towards the end of project targets; seven of these showed progress of more than 20% points from the baseline and five of the indicators (primarily knowledge based, except for ITN use) had even surpassed their EOP targets. For example, the percentage of mothers of children aged 0-2 years who sought medical attention for cough with rapid breathing in the same or next day rose from 30% to 76% in TMM II and from 43 to 64% for VVT and the percentage of mothers using a modern family planning method increased from 19% to 90.5% in TMM II and from 13% to 77% in VVT; these figures exceed the targets set for the end of the project.

An additional three of the 20 indicators showed progress in one of the two districts and of the five indicators that showed negative progress or progress in only one of the districts, some of these indicators were set excessively high (if not for both, for at least

one of the two districts, for example, baseline immunization rates were 29 for TMM II and 33 for VVT, but targets for full immunization were set at 80%.

Of the thirteen CATCH (Core Assessment Tool on Child Health) indicators, four of them have shown progress towards the end of project targets. For example, the percentage of children aged 0-2 years who slept under an ITN the previous night has increased from the baseline of 39% to 77% for TMM II and from 4% to 67% for VVT. ASAP has also been able to raise the percentage of births attended by skilled personnel to 60% and 68% for TMM II and VVT respectively, tripling the percentages at baseline and thus making a significant contribution not only to the project goals but to the national Millennium Development Goals. Apart from the quantitative indicators, observation and field visits indicate that the improved partnership between the health centers and TBAs/CHAs, the community trust in the program staff, and project training methods appear to be strengths of the program.

Among the indicators that showed a decline, the breast feeding, immunization, and increased fluids and breastfeeding during diarrheal episodes indicators are the most puzzling and will need further examination, as they indicate a significant decrease in the exclusive breast feeding (for both districts), immunization coverage rates for VVT, and appropriate treatment during diarrhea for both districts. According to the Project Manager, since there appear to have been inconsistencies with some of the questions asked, the February LQAS survey is presently being repeated. Some of the data presented here may be replaced or updated with figures that the project considers to be more reliable in September.

Areas in need of further attention include: the reinforcement of the COSAN (community level health committees) and clarity of their roles; familiarity with, buy-in to, and implementation of the phase-out program; improved use of IMCI and COPE; mechanisms for continuity of activities, including supervision and refresher training of and for the TBAs and CHAs (in collaboration with CSBs); and the use of data at the community level. These areas have been discussed with ADRA staff, and they are already preparing a plan to implement recommendations. It must be noted that 2005/6 were extremely difficult years because of factors beyond ADRA's control, but which have had an impact on project implementation. These include the cyclone, inundations caused by the cyclone, and Dengue and Chikungunya epidemics. Another major challenge continually faced by the project is the sheer remoteness of many of the communities; some are only accessible with a three-day walk; others often have bridges and roads washed out and thus are only accessible by taking a pirogue (if available).

At ASAP staff, SSD/CSB, CHA, TBA and household levels, ADRA and partners have successfully built capacity in a variety of areas; some of the effects of these efforts are that TBAs now feel that mothers and CSB staff value their contributions; CSB staff have improved their capacity to diagnose and treat childhood illnesses, to communicate with, manage, supervise, and train others- this has resulted in increased numbers of women coming to the clinics for services; CHAs have increased their capacity to provide quality community outreach and counseling services and to collect data at the household level;

and mothers capacity building efforts have resulted in increases in appropriate care-seeking.

Project staffs are acutely aware of the need for sustainability, but there are serious institutional barriers hampering their efforts. A detailed sustainability plan was elaborated in the Detailed Implementation Plan and project staff have developed and implemented some elements of a phase-out plan; however, at the same time the local health systems are understaffed and seriously under funded, making it difficult to effect a transfer of responsibilities. The general community, despite a willingness to work toward project goals, also has extremely limited resources. On average, in the 269 villages where the project has activities, 74% of the households live below the poverty line (DHS- Madagascar 2003-2004).

Conclusions and recommendations that follow from this evaluation are included in section E of this report. Among the main recommendations are the following:

- Investigate immediately the indicators with midterm values that show deterioration of the public health system, such as those on immunization for VVT and on Vitamin A (for TMM II); also those on breastfeeding, complementary feeding, and increasing breastfeeding and fluids during diarrhea;
- Measure project progress towards sustainability indicators in each dimension and work together with SSD/CSBs to identify ways to accelerate progress;
- Refine and implement the phase-over plan, including: 1) reinforcement of the COSAN and CASC to help build capacity (through application of new skills) in resource development and diversification; 2) mobilizing local authorities- mayors, etc., to actively engage themselves in addressing challenges and to play major roles in the sustainability/phase-over plan;
- Facilitate cross-visits of COSAN/CASC members involved with successful community health projects to other nearby communities;
- Define and address barriers to consistent application of IMCI protocols;
- Support the CSB heads from those clinics where COPE has been applied in conducting cross-visits or in hosting COPE refresher sessions;
- Help CSBs transition to a system in which they have full responsibility for implementing regular monthly meetings, providing facilitative supervision, and providing on-going support via sustainable technical reinforcement and refresher training to the CHAs and TBAs;
- Increase direct involvement of SSDs in the collection and analysis of project/CSB related data;
- Identify positive deviant “EBF moms” and help these mothers form support groups to promote EBF;
- Conduct a listeners’ survey to further investigate the utility and cost-effectiveness of the radio component;
- Facilitate CHAs and TBAs reporting on the perceived impact of each type of behavior change activity conducted;
- Facilitate CHAs and TBAs in the formulation of associations in order to ensure continued ITN re-supply and sales at EOP; and

- Consider revising the EOP targets to make them more in-line with what the SSD feels is realistic for the remaining project period

The evaluation team held a debriefing meeting in the field on July 20th. ADRA has already begun to respond to some of the recommendations that were shared at that time. For example, ADRA has begun the process of revising the work plan for the next fifteen months. The revised annual work plan and the monitoring and evaluation plan, subject to final approval from USAID, will be completed in September and submitted shortly thereafter. The process for this work plan revision will be:

- Internal project staff discussion (already begun),
- Dissemination of the midterm evaluation to stakeholders,
- Consultative meetings with stakeholders to get feedback and suggested changes for the next fifteen months (planned for mid-August),
- Strategy meetings with the SSDs and CSBs in project sites (September),
- Incorporation of feedback from USAID Washington (October),
- Work with villagers, the COSAN and CASC health committees to discuss the development of village planning and a project action plan which will be reflected in the revised work plan (first quarter of FY 2007).

2.0 Assessment of Results and Impact of the Program

Summary Chart of Results

Indicator	Baseline		Midterm		EOP Target	
	TMM II	VVT	TMM II	VVT	TMM II	VVT
% of children under 2 who slept under an ITN last night (net verified by observation) (CATCH)	39%	4%	76.8%	67.4%	60%	60%
% of children <24 mos with a febrile episode within the last 2 weeks treated with an anti-malarial drug within 48 hours after the fever began	41%	34%	43.2%	50.4%	55%	55%
% of children <24 mos with a febrile episode within the last 2 weeks who completed the correct dosage of anti-malarial treatment if given	n/a	n/a	n/a	n/a	50%	50%
% Pregnant women who slept under an ITN	n/a	1%	n/a	n/a	60 %	60%
% Mothers of children who slept <24 mos who took malaria chemoprophylaxis during their last pregnancy	49%	68%	68.4%	73.7%	75	75
% children aged 12-23 months fully immunized (CATCH)	29%	33%	35.8%	17.9%	80%	80%
% difference between DPT1 and DPT3 doses (drop-out rate) before age 12 months	19%	25%	0	0	10%	10%
% children under 2 who were breastfed within an hour of birth	52%	49%	54.7%	62.1%	70%	70%
% of infants <6 months being exclusively breastfed (CATCH)	46%	54%	36.8%	18.9%	65%	65%
% children 6-9 mos being introduced to appropriate weaning foods (CATCH)	46%	58%	n/a	n/a	75%	75%
% children 12-23 mos who received a vitamin A capsule in the last 6 months	60%	21%	46.6%	27.4%	70%	70%
Among children < 24 mos who had diarrhea in the last 2 weeks, increase % who...	TMM	VVT	TMM	VVT	TMM	VVT
Were treated with an appropriate ORT	19%	22%	28.4%	35.8%	50%	50%
...received increased fluids during their diarrheal episodes	74%	51%	38.9%	54.7%	75 %	75%
...received continued breastfeeding/ feeding during diarrheal episodes	56%	54%	42.1%	27.4%	70%	70%
% mothers of children< 24 mos who report that they wash their hands with soap before food preparation and feeding children and after defecating and cleaning a child who has defecated	10%	16%	n/a	n/a	60%	60%
% mothers of children< 24 mos who know that rapid breathing is the principle danger sign of ARI	2%	9%	48.4%	38.9%	40%	40%
% mothers of children < 24 mos who seek medical attention for cough with rapid breathing in the same or next day	30%	43%	75.8%	64.2%	50%	50%
% mothers who received at least two TT injections before the birth of the youngest child< 24 mos of age (CATCH)	13%	34%	40%	47.4%	50%	50%
% mothers who received at least 30 iron/folate capsules during their last pregnancy	n/a	n/a	25.3%	28.4%	45%	45%
% births of children < 24 months that were attended by a trained health person (CATCH)	21%	22%	60%	67.5%	40%	40%
% non-pregnant mothers who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing (CATCH)	19%	13%	90.5%	76.8%	35%	35%
% mothers of children < 24 mos who can name at least 2 methods of preventing STI/HIV/AIDS (CATCH)	25%	12%	85.3%	73.7%	60%	60%

3.0 Assessment of Progress Made Toward Achievement of Program Objectives

3.1 Technical Approach

3.1.1 A. Brief Overview

This four year child survival grant is being implemented in the district of Tamatave II (TMM II) and the neighboring district of Vavatenina (VVT). Both districts are in Toamasina Province, which is located in the central east coast region of Madagascar. ASAP, is a follow-on of activities established by the Tamatave Child Survival Project (TCSP) in Tamatave II, from 1998 to 2003. The province lies approximately 6 hours east of Antananarivo, the national capital. Program activities are focused on the 27 communes, and are targeted to the 269 villages in the neediest sub-districts. The main components of the project are: IMCI 60% and MNC/CS 40%. The population target is 163,070.

The project's three primary results-based objectives are:

1. Improved community- and facility-based Integrated Management of Childhood Illnesses
2. Improved community-based maternal and newborn care/child spacing and
3. Increased capacity building for Tamatave II and Vavatenina District Health Systems

The principle results of this project are:

- Increased ITN use for children < 24 months
- Increased number of births of children < 24 months that were attended by a trained health person
- Improved care-seeking behaviors for ARI
- DPT drop-outs reduced



3.1.2 Progress Report by Intervention Area

a. Malaria

Activities in Support of the Intervention Area

The key activities in this intervention area center on promoting the use of ITNs by women of reproductive age and children under five and improving the technical skills of CHAs, TBAs and CSB personnel to prevent, treat, and refer malaria cases appropriately. Specific activities include:

- Capacity building of CHAs and CSB staff
- Promotion of ITNs and distribution of anti-malarials
- Community sensitization by CHAs
- Development of IEC print materials and dissemination of radio broadcasts
- Promotion of IPT
- Mobile community sensitization

Progress toward Benchmarks and Intermediate Results

Up until June, 2006, progress regarding capacity building of CHAs and CSB staff in malaria prevention and treatment, ITN promotion, and distribution of anti-malarials has gone in accordance with the established DIP. In collaboration with PSI, the project has provided training to 10 ASAP technical project staff and 50 SSD/CSB staff from the two districts (19 from Vavatenina and 31 from Tamatave II) in Community Social Marketing of PSI products, focusing primarily on ITN use. All of the 500 CHAs recruited have gone through an integrated training module which included *Malaria Prevention and Treatment*. The topics discussed were: definition, causative agent, transmission methods, prevention measures, (including the use of ITNs), danger signs, anti-malarials with correct dosage for children under 24 months, and the use of prophylactic methods for pregnant women. In addition, the project trained all 50 CSB heads from VVT and TMM II in IMCI, including malaria.

As of July 2006, approximately 16,000 total ITNs have been distributed to 40 CSBs for resale by the CHAs to families within their jurisdiction; this represents 80% of the total ITNs the project had planned to distribute according to their work plan (the overall target is 20,000). During the final quarter of FY06, the project plans to continue efforts to keep pace with the increasing demand for private sector ITNs; however, recently, there has been an issue regarding availability of stock from PSI and to a lesser extent, the project providing orders well enough in advance. The project has already begun to address the issue of providing orders in advance; its ability to continue to distribute the quantities in demand will strongly depend on the future capability of PSI to continue to fill orders in a timely fashion.

In October 2005, anti-malarials were first distributed by the MOH to the districts, and then from the districts to the CSBs. Distribution by CHAs began a few months later after negotiations with the SSD personnel. Since then, the CHAs have distributed

approximately 2,310 blisters (150mg/tablet) and 1,440 blisters (75mg/tablet) free of charge (based on estimates of the numbers of blister packs given to CSBs under the ASAP program for free distribution by the CHAs). CHAs also provide follow-up by visiting the mothers to whom they have received the blister packs; this ensures that mothers comply with the full dose of treatment. Progress to date in this area is approximately 75% on target according to the DIP and the project is planning to scale up in this area as they enter their final year.

Community sensitization by CHAs has been conducted according to schedule: approximately 40 malaria community awareness raising sessions have been conducted in the project area; Roll Back Malaria days were conducted in VVT and TMM II; and bearing in mind the number of CHAs (500), thousands of home visits were carried out by them in the two districts to discuss malaria prevention and care-seeking. The project has developed and distributed a simple illustrated brochure with relevant key messages in Malagasy. CHAs use the brochure as an aide memoire, to reinforce key messages, especially when conducting home visits and engaging in informal awareness-raising. To date, CHAs have distributed the brochure to more than 5 households. In accordance with the project work plan, project-sponsored local radio programs on malaria have been broadcast twice weekly to complement the community sensitization being conducted by CHAs during the same period on the same topic. Approximately 30 radio programs providing key malaria prevention and care-seeking messages have been disseminated on three local FM radio stations, Radio Mazava and Radio Alpha in VVT and Radio Voanio in TMM. CHAs have conducted hundreds of listeners groups on malaria in which they have mobilized households to listen to the stations during the radio broadcast and facilitated discussions on malaria related issues.

Promotion of IPT-

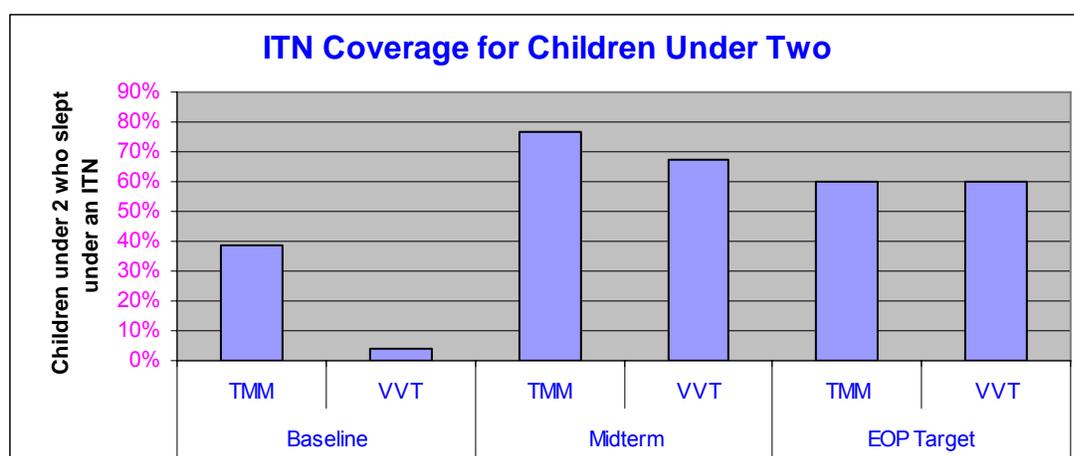
PSI, in partnership with the MOH, began to support the introduction of IPT for pregnant women in early 2005. According to the operations research study conducted by ASAP (see Annex G) in selected CSBs within the two districts, more than 80% of pregnant women visiting CSBs for ANC entered the IPT program and by the time the research was conducted, 57% of them had returned for the second dose of IPT. More importantly, to date, there have not been any side effects reported due to the introduction of IPT. Due to this success, the MOH is exploring introducing IPT for children.

In 2005, ASAP initiated the mobile community sensitization program whereby staffs go out for two to three days at least once a month to sensitize people by moving from community to community. To date, staffs have conducted 40 such mobile visits and as a result of this approach, more than 60 communities have been visited with a total of 5,000 adult men and women receiving key health messages. The activity enabled ASAP to work closely with the PSI mobile team. During their tour, the staff conducts house to house visits, pays a courtesy call to the local leaders, conducts focus group discussions, facilitates question and answer sessions, holds video viewings, and distributes printed materials. While this activity was not specifically planned in the DIP, it came about through joint team planning and by learning from other partners, such as

PSI. The CHAs and CSBs play a major role in the program. CSBs give messages and CHAs and TBAs present role plays or creative sketches, including skits, poems songs and traditional dances.

Effectiveness of the Interventions

Indicator	Baseline		Midterm		EOP Targets	
	TMM	VVT	TMM	VVT	TMM	VVT
% of children under 2 who slept under an ITN last night	39%	4%	76.8%	67.4%	60%	60%
% of children <24 mos with a febrile episode within the last 2 weeks treated with an anti-malarial drug within 48 hours after the fever began	41%	34%	43.2%	50.4%	55%	55%
% Mothers of children who slept <24 mos who took malaria chemoprophylaxis during their last pregnancy	49%	68%	68.4%	73.7%	50%	50%



According to the above chart, the project has surpassed its EOP target of 60% coverage for children under 2 who slept under an ITN the previous night for both districts. While MTE (Feb 2006) results show impressive progress for this rapid CATCH indicator, another indicator which project staff feel is also extremely important shows less progress to-date especially for TMM II, that of the percentage of children under 2 with a febrile episode who were treated with an anti-malarial drug within 48 hours after the fever began (41% at baseline and 43.2% at MTE). This may be due to the fact that 1) less emphasis has been placed on care-seeking message dissemination and related behavioral change strategies, and 2) CSB heads have not been uniformly applying IMCI protocols in their treatment of children under five. In terms of IPT, the project has made good progress towards its EOP targets in both districts, (68.4/85 for TMM II and 73.7/85 for VVT) thus indicating the effectiveness of their approach.

The substantial increase in net use for children under two and results from the qualitative research clearly indicate that 1) the messages being promoted in this project are being heard, understood and being put into practice; and 2) barriers to behavior change are beginning to be broken down. During the focus group discussions (FGDs) and in-depth interviews, CHAs, TBAs, and mothers were all able to correctly recite the key messages regarding ITN use for malaria prevention. Interviews with mothers coming to the health center also indicated that some mothers had understood the importance of bringing their baby to the clinic at the first signs of fever. Discussions with PSI staff and heads of CSBs indicate that since CHAs have been increasing the distribution network of ITNs, demand for nets has increased significantly. According to the PSI representative in Tamatave, "CHAs are ensuring that ITNs reach remote areas where PSI distributors have not been traditionally been able to reach."

The high quality of technical training by PSI was mentioned as one of the reasons for key malaria message retention by project staff and CHAs. In addition, many of the CHAs interviewed mentioned the utility of the Malagasy-language brochure in helping them transmit key messages to their target households.

While reports from organized listeners groups have indicated that malaria is the favorite topic of those who have listened to the radio programs, it is not clear what the real impact of this intervention has been on behavior change. Very few of the mothers we interviewed had heard the broadcasts (partly due to limited radio access in many remote areas). It is also not clear if the project's decision to add a third radio station has resulted in a significant increase in listener-ship and/or behavior change. The project staff have decided to conduct a listeners survey to further investigate the utility of this project component.

Training of CSB staff appears to have had a significant impact on increasing the IMCI related knowledge levels of most CSB staff; however, while technical knowledge levels have been raised and skills have been acquired (as demonstrated through the majority of correctly answered IMCI related questions), widespread application of technical skills to diagnose and treat malaria using IMCI algorithms has not been consistent. In the majority of cases, CSB heads mentioned heavy caseloads as being the number one reason for not uniformly applying the IMCI protocols; in addition some alluded to the impracticality of the IMCI forms and not possessing sufficient forms or the algorithms. In most cases, CSB staff were convinced of the benefits of using the protocol and the majority of the CSB staff mentioned better results when algorithms were used.

While IPT is not widely known by the CHAs and TBAs (only a few of those interviewed provided a complete response to the question regarding malaria prevention during pregnancy). However, it is probable that rates have increased because of the increase in the percentage of women coming to the health centers for ANC (during which they would be counseled for and if during the appropriate period, be given IPT).

Changes in technical approach outlined in DIP and rationale

No changes from the DIP.

Special outcomes, unexpected successes or constraints

Despite free net distribution, during ANC visits at the CSBs, the PSI nets that CHAs sell continue to be in high-demand. This is probably due to the community outreach that the CHAs have been engaged in and according to several of the heads of the CSBs, the quality of the PSI nets. This being said, the team was surprised to learn that only a third of the CHAs we spoke with were actually selling the ITNs. We finally came to understand that several of the CHAs have no money to acquire the nets from the CSBs. Therefore, since some are able to negotiate with their prospective customers, they are the only ones who are involved in selling nets. The project team is currently exploring new strategies that can involve more CHAs in acquiring the ITNs. An additional challenge, according to discussions with project staff, is that some CSB heads have been less proactive in ensuring that the CHAs receive the nets, preferring instead in some cases, to sell the nets themselves in order to gain the small revenue. Also, individual interviews with some of the new CSB heads indicated that there was a lack of clarity as to how the net should be re-supplied to the CHAs. Also, discussions with project staff have indicated that some distribution bottlenecks have occurred as well; for example, sometimes the regional PSI office runs out of ITNs preventing ASAP staff from delivering them during their site visits. PSI staff have suggested that ADRA order stock in advance and if possible, provide for a one month advance order to be distributed to the CHAs, after which they can reimburse themselves for the money owed to PSI. The project reports that this has been implemented, but PSI is still experiencing stock-outs.

Follow up and Next Steps

To keep pace with the continuing demand for socially marketed nets, ADRA needs to continue to reinforce their work with the CSBs to first, determine if they understand the role of the CHAs in selling nets; second, to help reduce the barriers preventing some of the CSB heads from supporting the CHAs in this activity; and third, ensure that CSB heads understand exactly how to reorder stock. As mentioned above, ADRA needs to work to continue to improve the net distribution by ensuring that bottlenecks in their end of the distribution chain do not reoccur. While ADRA has little control over the stock-outs experienced by PSI, they have already begun to implement the new system whereby a one month advance order can be made and distributed to the CHAs.

As part of the transition plan, ADRA staff should continue working with the TBAs, and encourage others not yet involved, to help in the sales of ITNs since many of them are located in areas where women have limited access to health facilities. To ensure that distribution mechanisms are smoothly transitioned away from ADRA staff and appropriately to PSI prior to the end of the project, staff need to facilitate CHAs and TBAs in the formulation of associations who can be supplied directly by PSI.

ADRA staff also need to continue working with the CHAs and TBAs to encourage women to come at the appropriate times for ANC visits. During these promotional sessions, CHAs and TBAs need to inform mothers of their right to and the importance of receiving IPT during the appropriate trimesters of their pregnancy.

Most significant in terms of achieving target results in the area of improved care-seeking and treatment for malaria, project staff need to 1) intensify efforts via the CHAs and TBAs to encourage mothers to bring their baby in to the CSB during a febrile episode, to strengthen the community-based distribution of anti-malarials, to help mothers reduce barriers to providing their child with complete doses of anti-malarials, and 2) work closely with the CSB heads to reduce barriers to consistent use of IMCI protocols. Project staff may consider on-the-job refresher training in IMCI protocol use, redistributing some of the training materials, such as the algorithms and IMCI case forms, and working with some of the CSB heads who have been more successful in applying the protocols to learn how these positive deviants are managing and inviting them to participate in on-the-job cross visit/training sessions.

To determine the impact of the radio messages on behavior change amongst the target population, the project should conduct a listeners' survey to further investigate the utility and cost-effectiveness of this project component. The survey should focus on whether the programs have resulted in real changes in the community.

As another important element of the phase out strategy, the mobile community sensitization strategy needs to be gradually transitioned to local stakeholders, especially the CHAs and CSB heads.

b. Immunization

Activities in Support of the Intervention Area

- Capacity building of CHAs and CSB staff
- Community sensitization by CHAs
- Development of IEC print materials and dissemination of radio broadcasts
- Visa 5/5 Child to child approach
- Mobile community sensitization

Progress toward Benchmarks and Intermediate Results

In terms of capacity building, ADRA has trained all 500 CHAs in immunizations. An additional 293 TBAs have received training in the importance of referring pregnant women and mothers of newborns to the health center for vaccinations as part of their overall training curriculum. The project has also provided training in immunizations to all 50 CSB staff from the two districts as part of their training in IMCI. This activity has been completed in accordance with the DIP. The project plans to conduct follow up, on-the-job, refresher training with the CSBs during the final period.

In the area of community sensitization, the project is on track and CHAs continue to conduct home visits, community awareness raising sessions, and radio discussion groups around the topic of immunizations. The CHAs have conducted thousands of home visits, approximately 40 community sessions, and 35 discussions on radio programs regarding immunizations. As is the case with malaria, ADRA has also developed and distributed, via the CHAs, approximately 6000 copies of an illustrated brochure on immunizations for low-literate audiences. These brochures have helped CHAs to transmit the key messages to pregnant women and mothers of U5s regarding the importance of following the complete vaccination cycle before the child's first birthday. As mentioned under malaria, the project has also utilized the mobile community sensitization approach to provide important vaccination information and to dispel myths regarding vaccinations. Approximately 60 communities have been reached by the project staff in collaboration with CHAs using this strategy to promote vaccinations.

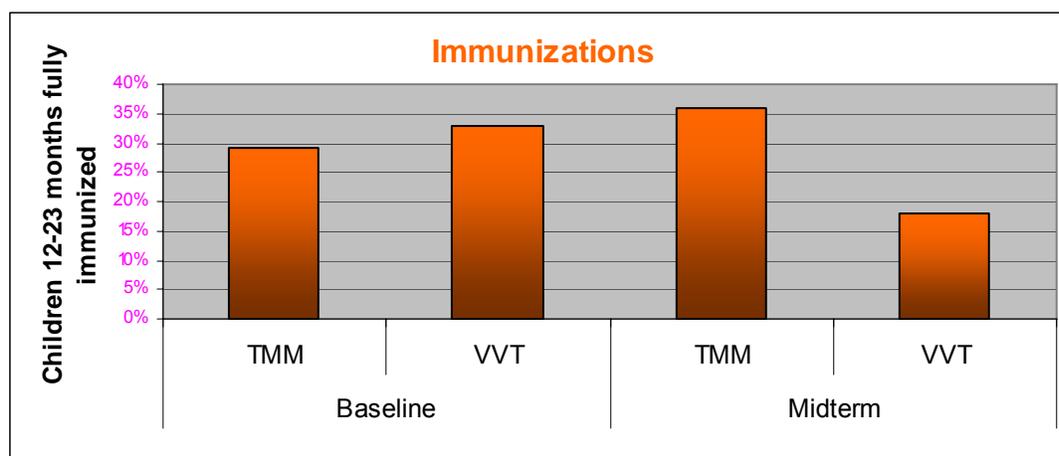
According to the DIP, ASAP planned to assist the MOH in nine vaccination related campaigns during the LOP: anti-polio, EPI/vitamin A, and anti-measles campaigns. To date, ASAP staffs have actively participated in one major national campaign conducted by the MOH. The project has often facilitated transport and provided technical assistance for the other local immunization campaigns (approximately 3-4 each year). This activity appears to be on track. According to the January-March 2006 quarterly report, the project has assured maintenance of the cold chain through monthly distribution of kerosene for refrigerators. However, according to discussions with one of the District Medical Officers at the SSD in TMM II, the MOH has had challenges in assuring the cold chain during the project period; this appears to be primarily due to delayed budget allocations from the MOH and constraints from UNICEF for purchases of petrol and kerosene.

The visa 5/5 approach entailed identifying areas which were doing particularly poorly with respect to vaccination coverage. Area schools were identified and teachers were trained on communication techniques; next, teachers transmitted the key messages to their students who attempted to identify vaccination drop-outs. Project staff developed a follow-up system, based on a five-card system which ensures that mothers bring their children in for all five vaccinations and that once the complete cycle had been received, the child responsible for referring the mother receives credit.

Since the approach was first implemented in 2005, the project has trained 57 teachers and more than 1800 students from 57 schools. During the third quarter alone, 171 children were vaccinated under the visa 5/5 program. To date, over 374 children have been responsible for bringing in over 277 children for vaccination.

Effectiveness of the Interventions

INDICATOR	Baseline		Midterm		EOP Targets	
	TMM	VVT	TMM	VVT	TMM	VVT
% children aged 12-23 months fully immunized	29%	33%	35.8%	17.9%	80%	80%
% difference between DPT1 and DPT3 doses (drop-out rate) before age 12 months	19%	25%	0.0	0.0	10%	10%



As the above chart shows, the data on vaccination coverage, especially for VVT, is of serious concern; they may indicate flawed data or an actual drop in coverage (for VVT) and the situation should be further analyzed. The very slight increase for TMM II is also of concern, and if the data are accurate, indicates that project staff will need to make a concerted effort to substantially increase rates within the remaining project period. Per project Manager's note, one significant issue is the way the SSD understand the coverage area of a particular area. For instance, at the end of every year immunization coverage is 0 and this will increase as the months go by. The project is looking into this issue.

Project staff have already begun to re-analyze this data and because of their concerns, have included the immunization questions in the LQAS survey currently being redone (results should be available in September 2006). They have also offered the following as possible rationale:

- the survey was conducted prior to a vaccination campaign when rates typically increase significantly;
- inconsistent cold chain maintenance due to delays in MOH budget allocation for purchasing petrol may have also played a role in these low rates;
- it is also possible that the rates are correct and a result of the fact that the CSBs did not carry out the EPI program due to the MOH failing to provide funds for the activity;

However, even though vaccination coverage rates appear quite low, in terms of technical knowledge, training appears to have contributed effectively to increasing CHAs and CSB knowledge of the key messages related to immunizations as demonstrated by the fact that all CSB heads, CHAs and TBAs were able to provide accurate key messages regarding immunizations. Several of the TBAs interviewed mentioned that one of their key roles was to refer pregnant women and new mothers to the health centers for vaccinations.

Despite the survey results, many of the CSB heads, as well as the District Medical Officer for Vavatenina, mentioned that they have noticed a continuous increase in the number of women who bring their children to the clinic for immunization. During individual interviews, some of the CSB heads confirmed the important role played by the TBAs and CHAs; others, specifically highlighted the utility of the Visa 5/5 program in identifying drop-outs and encouraging mothers to bring in their under fives to complete their vaccinations.

The project's experience has shown that children have been effective in convincing mothers in their own and nearby villages to completely vaccinate their children. Informal discussions with children aged 10 – 13 years involved in the program indicated that even though incentives will no longer be provided after the program ends, these children intend to continue disseminating health related messages and promote complete vaccination in their daily interactions.

Changes in technical approach outlined in DIP and rationale

No changes.

Special outcomes, unexpected successes or constraints

Please refer to the analysis of vaccination coverage above.

Follow up and Next Steps

However promising the work of visa 5/5 children appears, it does not seem to be sufficient in raising vaccination coverage levels to those targeted by the project.

If there is no simple reason for the apparent drop in coverage, then the evaluation team feels that these two indicators need to be re-checked (as planned) against the results from the August LQAS (to be available in September). In addition, ADRA is in the process of completing the following steps: 1) assess quality of data; 2) identify issues/problems with data collection (verification, validation techniques); 3) identify if the problem is in data entry or analysis; and 4) develop a comprehensive plan to address issues of data quality if this is the explanation (such as utilizing the updated information from the August survey). If ADRA staff arrive at the conclusion that there is indeed a significant drop in vaccination coverage for VVT, then they need to coordinate with the

SSDs and CSBs to discuss the most appropriate interventions to reverse the declining trend.

As mentioned under malaria above, to determine the impact of the radio messages on behavior change amongst the target population, the project should conduct a listeners' survey to further investigate the utility and cost-effectiveness of this project component. The survey should focus on whether the programs have resulted in real changes in the community.

Also as mentioned above, the mobile community sensitization strategy needs to be gradually transitioned to local stakeholders, especially the CHAs and CSB heads.

c. Nutrition and Breastfeeding

Activities in Support of the Intervention Area

- Capacity building of CHAs and CSB staff
- Community sensitization by CHAs
- Development of IEC print materials and dissemination of radio broadcasts
- Nutrition Days/Community Fairs
- Vitamin A Distribution Campaigns
- Cooking demonstrations
- Mobile community sensitization

Progress toward Benchmarks and Intermediate Results

As part of its capacity building approach, the project has trained all 500 CHAs in key messages on exclusive breastfeeding, including the importance of colostrum, and promoting the use of nutritious foods, such as green leafy vegetables and yellow fruits for Vitamin A and other nutrients.

CHAs have utilized this knowledge to disseminate nutrition related messages (again, with the assistance of a set of counseling cards and an illustrated brochure of key messages for low-literate audiences) to thousands of households of women with U5s during home visits, and additional community members during more than 40 community sensitization sessions and mobile community sensitization visits. In addition, through its local radio stations, ASAP has broadcast approximately 30 radio messages discussing key messages on nutrition. ADRA has also recorded a CD including a theme song on nutrition; it is played during ASAP's radio broadcasting sessions and during mobile community mobilization visits. The project is exploring the feasibility of reproducing copies of the CD for increased distribution.

The project has also trained 50 heads of CSBs in VVT and TMM II in essential nutrition actions which has enabled them to provide improved nutrition counseling during growth monitoring sessions. These activities are in line with the DIP.

ASAP and the SSDs have sponsored 5 nutrition days or festivals, 3 in VVT and 2 in TMM II, in which national, provincial, and regional nutrition officers have collaborated to reinforce nutrition messages. Approximately 2,500 individuals have been present at each of these events. According to the DIP, each CSB would plan and coordinate either a local or regional (in collaboration with the SSD) nutrition day at least once per year. Progress to date on this activity is on target.

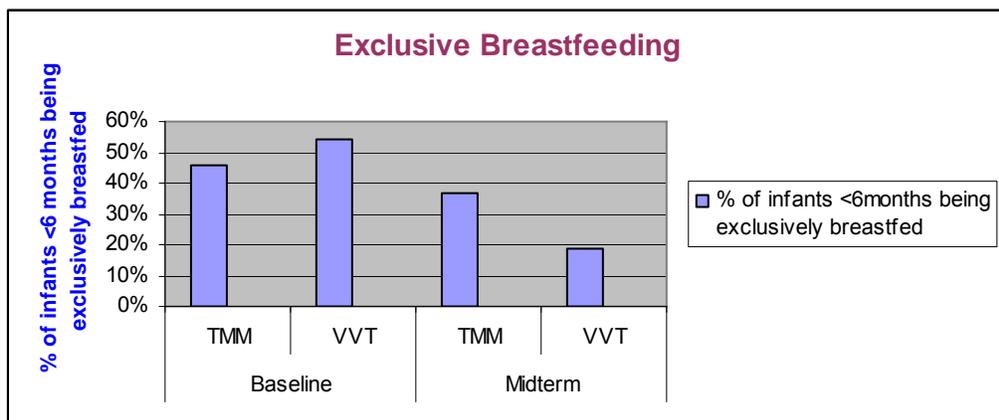
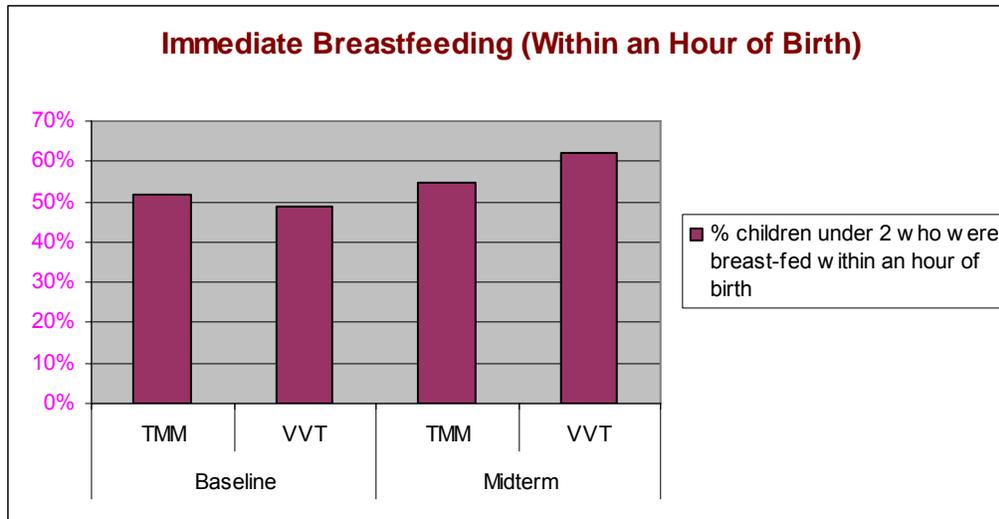
According to the DIP, the project would strengthen SSD planning and capacity to ensure a consistent supply of Vitamin A in all CSBs; in addition, the project would reinforce the MOH Vitamin A distribution campaigns, and ensure that at least one Vitamin A focused nutrition day would be held at the local or regional level at least once per year.

In the DIP, maximizing opportunities to coordinate with other partners working in nutrition was also planned as well as participating in GAIN meetings. To date, the project staffs have participated in meetings and have jointly planned activities maximizing synergies for improving nutrition in the region.

Discussions with project staff indicate that one activity which the project has not been able to fully realize (in accordance with the DIP) has been cooking demonstrations conducted by the CHAs using locally available nutrient dense foods at local market places.

Effectiveness of the Interventions

INDICATORS	Baseline		Midterm		EOP Targets	
	TMM	VVT	TMM	VVT	TMM	VVT
% children under 2 who were breastfed within an hour of birth	52%	49%	54.7%	62.1%	70%	70%
% of infants <6months being exclusively breastfed	46%	54%	36.8%	18.9%	65%	65%
% children 6-9 months being introduced to appropriate weaning foods	46%	58%	n/a	n/a	75%	75%
% children 24 months still being breastfed	56%	62%	n/a	n/a	75%	75%
% children 12-23 months who received a vitamin A capsule in the last 6 months	60%	21%	46.6%	27.4%	70%	70%
% caretakers who fed vitamin A rich foods to their children 6-23 months within the last 24 hours	17%	14%	n/a	n/a	40%	40%



While the indicator for “children under 2 who were breastfed within an hour of birth” for VVT has increased from 49 to 62.1%, progress on this same indicator for TMM II has been very slow (only a 2.7% increase). It is also quite alarming that EBF has actually dropped (from 46 to 36.8% in TMM II and even more significantly from 54% to 18.9% in VVT). According to the above chart, the data on breastfeeding is, not only perplexing, but also, if accurate, is of serious concern; again, data may be flawed or there may have been an actual drop in coverage for EBF for both VVT and TMM II) and the situation should be further analyzed.

The very slight increase in immediate breastfeeding for TMM II is also of concern, and if the data are accurate, indicates that project staff will need to make a concerted effort to substantially increase rates within the remaining project period.

The data on percentage of children receiving Vitamin A within the last six months is also quite alarming, only in VVT was there a slight increase from the baseline of 21% to 27.4% at midterm. TMM II’s data shows a steep drop from 60% at baseline to 46.6% at mid-term which may again indicate flawed data.

Project staffs have already begun to re-analyze these data. They are re-entering all the raw data into SPSS to make sure there is no mechanical reason for the unusual findings. In addition, since staffs have indicated that the interviewers may not have presented the question correctly, the project has decided that it would be more accurate to use the data being collected in the current LQAS, (available in September).

Despite the fact that progress towards indicators remains low for EBF and low for immediate breastfeeding (for TMM II), nearly all CHAs and TBAs were able to answer questions regarding EBF and immediate breastfeeding correctly. While this may show that the training has been effective in increasing the knowledge levels of these individuals, the transmission of these messages and other promotional activities regarding breastfeeding with community members may have been limited. Only about 1/3 of the CHAs and TBAs in VVT and TMM II mentioned breastfeeding promotion as part of their responsibilities and regular activities. Also, mothers interviewed in both districts were more likely to mention the CHA's activities regarding malaria prevention, vaccination, diarrheal disease prevention and treatment, rather than breastfeeding. It is not clear to what extent the radio program has been effective in encouraging women to adopt positive behaviors in breastfeeding/nutrition; of the few mothers who had heard the radio programs, only one had heard a breastfeeding message, and that one was related to the importance of colostrums.

Since the project was unable to collect complete data on complementary feeding, it is unclear how effective program interventions have been in this area. Again, staffs have indicated that the interviewers may not have presented the question correctly, thus the project has decided that it would be more accurate to use the data being collected in the current LQAS, (available in September). The project plans to include this updated information in their next annual report.

Changes in technical approach outlined in DIP and rationale

No changes.

Special outcomes, unexpected successes or constraints

Nothing to report.

Follow up and Next Steps

If there is no simple reason for the apparent drop in coverage, then the evaluation team agrees with the project team that these indicators need to be re-sampled and the data re-entered into SPSS and analyzed again. ADRA is in the process of completing the following steps: 1) assess quality of data; 2) identify issues/problems with data collection (verification, validation techniques); 3) identify if the problem is in data entry or analysis; and 4) develop a comprehensive plan to address issues of data quality if this is the explanation. If after comparison with the data available in September, ADRA staff arrive at the conclusion that the data is accurate, they need to coordinate with the SSDs

and CSBs to discuss the most appropriate interventions to reverse the declining trend in EBF and increase progress towards achieving targets in immediate breast feeding.

Project staff, CSB heads, CHAs and TBAs should discuss how to focus their efforts on not only reinforcing the messages regarding immediate and exclusive breast feeding, but also consider identifying successful positive deviant “EBF moms” and helping these mothers form mothers’ support groups to help other moms become successful EBF moms. Through support groups and one-on-one counseling, CHAs and TBAs can help mothers identify and reinforce positive motivators while breaking down barriers to EBF. In addition, ADRA staff and CSB heads should reflect on what has been done differently in VVT in terms of immediate breast feeding and attempt to replicate this in TMM II.

To contribute towards the project’s overall efforts in sustainability, the project staff need to work with the SSDs to help them to gradually take responsibility for holding nutrition days; this includes working with the MOH partners to advocate for budget allocations to be assigned for this activity.

As mentioned under malaria and immunizations above, to determine the impact of the radio messages on behavior change amongst the target population, the project should conduct a listeners’ survey to further investigate the utility and cost-effectiveness of this project component. The survey should focus on whether the programs have resulted in real changes in the community.

Also as mentioned above, the mobile community sensitization strategy needs to be gradually transitioned to local stakeholders, especially the CHAs and CSB heads.

d. Control of Diarrheal Diseases

Activities in Support of the Intervention Area

- Capacity building of CHAs and CSB staff
- Community sensitization by CHAs
- Development of IEC print materials and dissemination of radio broadcasts
- Mobile community sensitization

Progress toward Benchmarks and Intermediate Results

As part of its capacity building approach, the project has trained all 500 CHAs in key messages on diarrheal disease prevention and treatment. Training topics have included home-based ORT, continued feeding and liquids during diarrheal episodes, danger signs, and prevention, including hand washing, latrines, hygiene, etc.

CHAs have utilized this knowledge to disseminate diarrheal disease related messages (again, with the assistance of a set of counseling cards and an illustrated brochure of key messages for low-literate audiences) to approximately 6000 households during home visits, and hundreds of additional community members during community

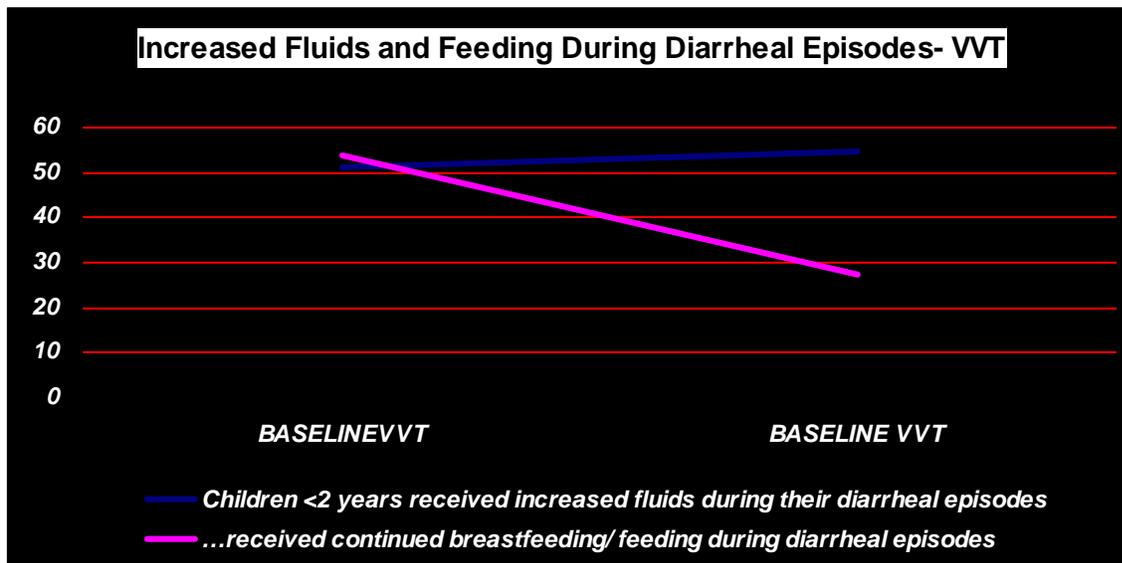
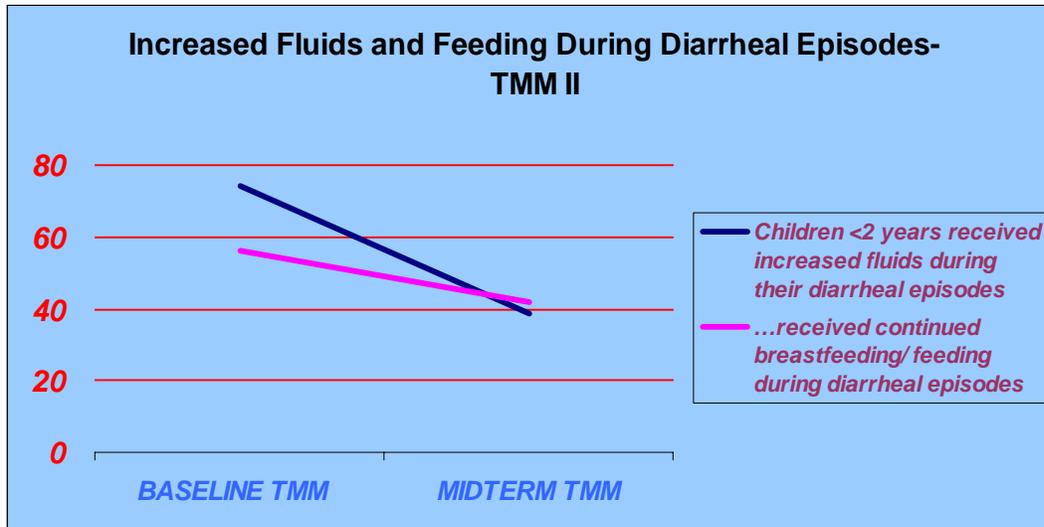
sensitization sessions and mobile community sensitization visits. In addition, through its local radio stations, ASAP has broadcast approximately 30 radio programs/spots discussing key messages on diarrheal disease.

The project has also trained 50 heads of CSBs in VVT and TMM II in counseling and treatment of diarrheal disease as part of its IMCI training. These activities are in line with the DIP.

The DIP also refers to promotion of home treatment with a cereal-based ORT, promotion of water treatment using SurEau, and performing PRAs to assess potable water sources in coordination with the CASCs. To date, ASAP is approximately 60% on target with these activities.

Effectiveness of the Interventions

Indicator	Baseline		Midterm		EOP targets	
	TMM	VVT	TMM	VVT	TMM	VVT
Among children < 24 mos who had diarrhea in the last 2 weeks, increase % who...						
Were treated with an appropriate ORT	19%	22%	28.4%	35.8%	50%	50%
...received increased fluids during their diarrheal episodes	74%	51%	38.9%	54.7%	75%	75%
...received continued breastfeeding/ feeding during diarrheal episodes	56%	54%	42.1%	27.4%	70%	70%
% mothers of children < 24 mos who report that they wash their hands with soap before food preparation and feeding children and after defecating and cleaning a child who has defecated	10	16	na	na	60%	60%



While the mid-term results show only a slight increase in ORT use for both TMM II and VVT (19-28.4% and 22-35.8% respectively), the training seems to have been effective in ensuring the accuracy of ORT-related messages transmitted by CHAs. Individual and group discussions with CHAs indicated high knowledge of how to prepare home-based ORT, the importance of hand washing and food hygiene to prevent diarrhea; nearly all of the CHA's interviewed answered these related questions correctly and completely.

In addition, community sensitization and home visits may also have effectively contributed to the gradual increase in ORT use. The messages regarding correct ORT preparation seem to have been appropriately transmitted from CHAs to mothers as

evidenced by the fact that when asked what the CHAs had taught them, nearly half of the mothers interviewed cited the correct recipe for preparing home-based ORT.

On the other hand, the drop in rates of continued breastfeeding during diarrheal episodes for TMM II and VVT is alarming and leads one again, to question the validity of these data. The steep decline in the rates of children who received increased fluids for TMM II is even more disconcerting. This, accompanied by the slight increase in rates for VVT for the same indicator, has convinced the project to re-analyze these data. They are re-entering all the raw data into SPSS to make sure there is no mechanical reason for the unusual findings and will follow the same steps as listed above under Immunization and Nutrition and Breastfeeding.

While the project appears to have placed significant importance on teaching mothers how to prevent diarrhea and how to correctly prepare and use home-based ORT, other messages that are also important for home-based diarrheal disease treatment, such as increased breastfeeding and increased fluids and complementary foods may have gotten lost.

Changes in technical approach outlined in DIP and rationale

No changes.

Special outcomes, unexpected successes or constraints

Nothing to report.

Follow up and Next Steps

As suggested above, if there is no logical reason for the apparent drop in coverage, then these indicators need to be re-sampled and the data re-entered into SPSS and analyzed again. ADRA is in the process of completing the following steps: 1) assess quality of data; 2) identify issues/problems with data collection (verification, validation techniques); 3) identify if the problem is in data entry or analysis; and 4) develop a comprehensive plan to address issues of data quality if this is the explanation. If once results have been analyzed from the August data collection, ADRA staff arrive at the conclusion that the data is accurate, they need to coordinate with the SSDs and CSBs to discuss the most appropriate interventions to reverse the declining trend and increase progress towards achieving targets in this increasing breast feeding and fluids during diarrheal episodes.

If exclusive breast feeding rates are indeed falling as indicated in the data under the Nutrition section, and the project's data verification efforts indicate that the diarrheal disease data is also accurate, then project staff and the CSBs should consider focusing promotional efforts on the linkages between EBF and reducing the incidence of diarrheal disease (only one of the CHAs interviewed mentioned EBF as a way to prevent diarrheal disease). This could be accomplished by, as suggested under the

Nutrition section above, helping positive deviant mothers to form BF support groups in which they can provide one-on-one counseling, thus addressing the most significant barriers to behavior change in this area.

Also, the project and its SSD counterparts need to advocate with the MOH for approval of zinc use to reduce diarrheal disease, the severity and frequency of episodes. Currently zinc is not available in any of the project intervention areas; however, ASAP is studying potential avenues/opportunities for its approval.

e. Acute Respiratory Infection

Activities in Support of the Intervention Area

- Capacity building of CHAs and CSB staff
- Community sensitization by CHAs
- Development of IEC print materials and dissemination of radio broadcasts
- Mobile community sensitization

Progress toward Benchmarks and Intermediate Results

As part of its capacity building approach, the project has trained all 500 CHAs in key messages on ARI. Training topics included danger signs and promotion of early detection and treatment for children.

CHAs have utilized this knowledge to disseminate ARI related messages (again, with the assistance of a set of counseling cards and an illustrated brochure of key messages for low-literate audiences) to thousands of households during home visits, and several hundred additional community members during community sensitization sessions and mobile community sensitization visits. In addition, through its local radio stations, ASAP has broadcast approximately 30 radio programs/spots discussing key messages on danger signs for pulmonary case management.

The project has also trained 50 heads of CSBs in VVT and TMM II in counseling and treatment of pulmonary case management as part of its IMCI training. These activities are in line with the DIP.

According to the DIP, ASAP also planned to ensure the timely and consistent transport of medications for the CSB with improved ordering and LMIS functions. To date, the project has assisted the SSD in the distribution of medication when needed. No problems have been reported to date with respect to ordering or LMIS functions.

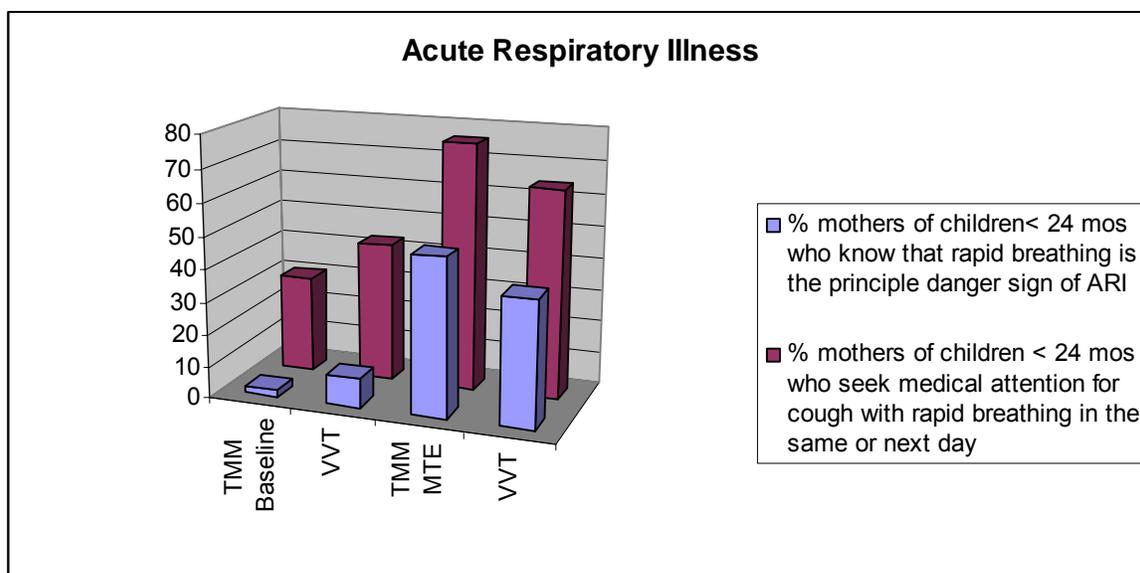
The DIP also indicated that CHAs would work closely with the CSBs in preparing lists of the mothers with children <24 months, making home visits to these mothers to promote C-IMCI, and working with these mothers to ensure that they knew the ARI danger signs requiring them to seek care for the child, as well as referring them to the CSBs when their child presented these signs. ASAP is addressing these activities by gradually

transferring the management of CHAs and TBAs activities to the CSB heads. Most of the CSBs heads have been conducting monthly strategic meetings with CHAs during which time they carry out such activities. ASAP has provided more of a supervisory role for this activity.

An additional activity identified in the DIP was to promote awareness of ARI danger signs during community health promotion days. The project staff, CHAs, and CSB heads successfully coordinated and facilitated community health promotion days since the beginning of the project; the target population was reached with messages regarding ARI danger signs during these events.

Effectiveness of the Interventions

	Baseline		Midterm %		EOP Targets	
	TMM	VVT	TMM	VVT	TMM	VVT
% mothers of children < 24 mos who know that rapid breathing is the principle danger sign of ARI	2%	9%	48.4	38.9	40%	40%
% mothers of children < 24 mos who seek medical attention for cough with rapid breathing in the same or next day	30%	43%	75.8	64.2	50%	50%



According to the data, the project’s interventions have been quite effective in increasing the percentage of mothers who know that rapid breathing is the principle danger sign of ARI in both districts. Even more important is the increase in subsequent related care-seeking behaviors; the percentage of mothers who sought medical attention for cough with rapid breathing in the same or next day rose from 30 to 75.8% in TMM II and from

43 to 64.2% in VVT. Values for this indicator in both TMM II and VVT have surpassed the EOP targets.

Changes in technical approach outlined in DIP and rationale

No changes.

Special outcomes, unexpected successes or constraints

Nothing to report.

Follow up and Next Steps

The ADRA team and their counterparts at the CSB and SSD should reflect on what has made this aspect of the program so successful and continue to replicate and reinforce these interventions.

f. Maternal Newborn Care/Child Spacing

Activities in Support of the Intervention Area

- Capacity building of CHAs, TBAs, and CSB staff
- Community sensitization by CHAs and TBAs
- Development of IEC print materials and dissemination of radio broadcasts
- TBAs' activities
- Mbile community sensitization

Progress toward Benchmarks and Intermediate Results

The project's efforts to achieve targets in the area of maternal/newborn care and child spacing focused on: 1) capacity building of CSB skilled providers, training and endorsement of TBAs, training of CHAs, 2) improving linkages between the health system and the community, and 3) CHA and TBA community outreach focusing on promotion of antenatal and post-partum care, while integrating family planning, nutrition, and malaria issues. 293 TBAs have been trained in Safe Motherhood, focusing on the "three cleans" (clean hands, clean place, and clean equipment) and on the "ten commandments of TBAs" (a list of do's and don't for promoting safe deliveries, referrals to health facilities, and appropriate post-natal care). Upon completing their training, the TBAs received a tool box containing a complete set of counseling cards to help them with their community outreach activities. Each trained TBA also received a safe delivery kit filled with the necessities for ensuring that births were conducted in the most sanitary conditions possible. 293 birthing kits provided by the MOH were distributed. While exact numbers are still being totaled by ASAP, project staff and CSB heads agreed that the training and provision of safe birth kits enabled the TBAs to assist with numerous safe deliveries.

Also, all 500 CHAs were trained in Safe Motherhood, in FP methods, and in the syndromic approach to STIs and HIV/AIDS counseling. To help facilitate improvements in service delivery, CSB heads from VVT and from TMM II were also trained in COPE, Safe Motherhood, Safe Delivery/BEOC, FP, STI/HIV/AIDS diagnosis, counseling and treatment. In addition, CSB staff have been trained in IEC/BCC methods and SSD AIDS coordinators have participated in BCC TOT workshops. According to the Project Manager, these training activities are all on target in accordance with the DIP.

During home visits and community outreach, TBAs and CHAs have utilized the key messages and new skills acquired during the training to promote the importance of ANC, clean deliveries, health center referral, and post partum care. CHAs and TBAs have implemented these community-level activities in collaboration with CSB staff and have utilized a set of counseling cards and an illustrated brochure developed for low-literate audiences to reinforce key messages on maternal and newborn care, including family planning, malaria, and nutrition.

To date, the CHAs and TBAs have disseminated related messages to thousands of households, to hundreds of additional community members during community sensitization sessions and mobile community sensitization visits. In addition, through its local radio stations, ASAP has broadcast approximately 40 radio programs/spots discussing key messages on maternal and newborn care. These activities are in accordance with the DIP.

Project staff have conducted approximately 150 follow-up monitoring/supervision visits for all trained TBAs and CHAs, and for 30% of the CSB staff. Through these visits project staff have helped the CHAs, TBAs, and CSB staff find ways to better apply their skills, to address challenges related to their daily activities, and especially for the CHAs and TBAs, to improve reporting methods.

While the DIP stipulates that COPE would be carried out at CSB and hospital levels, to date only 30 % of all CSBs have conducted COPE sessions even though nearly all CSB and SSD staff have been trained in the approach to improving client satisfaction with quality of services. This is partly due to the policy of the MOH that there is a need of every CSB visited for introduction of the method.

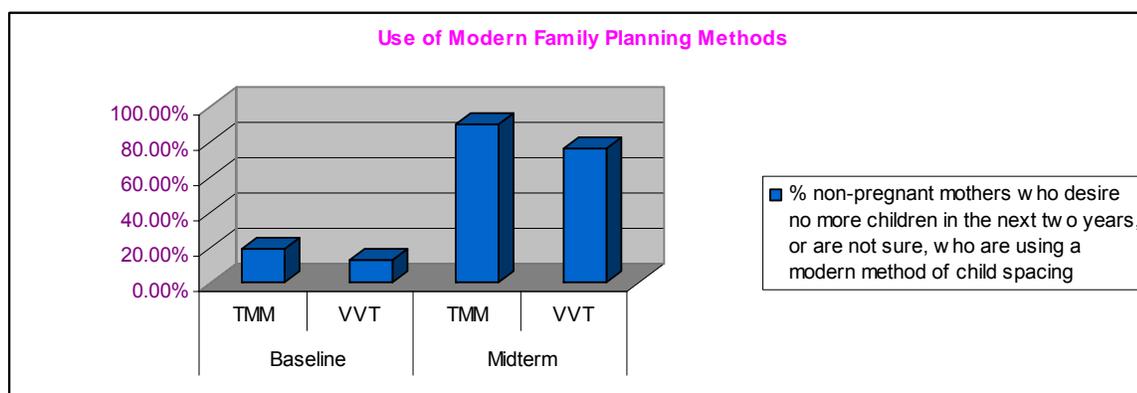
On the supply side, the TBA and CHA activities were complemented by the provision of essential maternity equipment at the health center and hospital levels.

Two key activities described in the DIP were 1) the promotion of birth preparedness plans (BPP) and 2) the involvement of heads of households, CASC/COSAN and *tangalamenas* in strategic plans to support pregnant women, such as transportation schemes, maternal waiting houses, or quality of care activities. In reference to the BPPs, while the CHAs and TBAs were trained in this as part of their Safe Motherhood training, they encountered challenges in fully implementing this activity. Project staff felt this was largely due to cultural norms/superstitions which dictate that preparing for a

birth may bring bad luck to the parents and have a negative effect on the outcome of that birth.

Other activities planned in the DIP included: CHAs and TBAs' promotion of micronutrients for pregnant and post-partum women; contraceptive distribution via the CHAs, assistance with monitoring stock ordering and re-supplying to ensure the CHAs have adequate and consistent supply of contraceptives; and working with the CSBs to conduct a health promotion day promoting reproductive health and to hold World AIDS Day events. ASAP also planned to conduct TOT training for mayors as representatives of their local HIV/AIDS committees and to increase awareness of HIV/AIDS /STIs amongst *Tangalamena*, CASC, COSAN, CVA. The training activities have been conducted according to schedule and an additional follow-up workshop has been organized for the month of September. The other activities, such as assisting the CHAs with monitoring and re-supplying of contraceptives and conducting a reproductive health day have been accomplished.

Effectiveness of the Interventions



As indicated by the substantial increases in the majority of MNC related indicators from baseline to mid-term, several of the MNC interventions appear to have been effective. Impressive strides have been made in percentages of births attended by a trained person, contraceptive use, and knowledge of prevention of STI/HIV/AIDS. These last two have met or surpassed EOP targets. However, greater focus needs to be placed on areas in which progress has been more gradual (steady yet, less significant), such as TT immunizations, and iron distribution, and on those areas in which challenges still remain, making it not only difficult to carry out activities, but also to track actual progress, such as with the emergency preparedness plans and transportation schemes.

During individual interviews, without exception CSB heads applauded the linkages between the TBAs and their clinics; they highlighted the contributions made by the TBAs to improvements in MNC. These CSB heads emphasized the important role in encouraging mothers to come into the health centers that was being successfully fulfilled by both TBAs and CHAs. They described concrete increases in the numbers of women attending ANC visits, deliveries at the clinics, and family planning users. In the

case of Anjahambe, for example, after 7 TBAs from the area were trained in Safe Motherhood, the increase in the number of women delivering at the CSB was 7% greater for just the three-month period following the training (i.e. 35 women delivered at the CSB between October-December 2005) than it had been over the entire previous 9 months (i.e. 30 women delivered at the CSB between January-September 2005).

Besides capacity-building of TBAs and CHAs, follow-up visits and informal facilitative supervision have been instrumental in ensuring progress in improving MNC. Most of the CHAs and TBAs interviewed mentioned that support from the project staff had helped them carry out their responsibilities. CSB staff, CHAs, and TBAs, with only a couple of exceptions, all knew the project team members by first names and had received regular follow-up visits- most had received their last visit within the two-three week period prior to the mid-term evaluation.

According to those interviewed, the TBAs have made concrete changes in their approach to deliveries. All of those trained mentioned that they are now cutting the cord with a clean razor (rather than with hair); they are wrapping and drying the baby (rather than bathing the baby); and they are no longer massaging the mother's uterine area.

In terms of improvements in quality of care at the service delivery level, of the four CSB staff that cited having received training in COPE, two had directly applied the process at their CSBs. In these CSBs, the CSB heads had witnessed real changes, such as the night guardian greeting women with interest, warmth and respect ("he used to be kind of lazy") and improved sanitation precautions (such as safe disposal of sharps). Unfortunately, other CSB staff have felt that lacked support for carrying out the process (i.e. either an outside facilitator was necessary or they stated they did not have the appropriate documents).

While staff members have met with challenges in accurately tracking these totals, informal discussions indicate that the maternal waiting houses which have been constructed by several of the communities have been extremely effective in encouraging women to deliver at the CSBs. In a few communes, such as Amabatoaranana, the community members have been able to mobilize themselves to contribute to the construction of as many as ten maternity waiting houses. These efforts have been so successful that many CSB heads have asked the project to help facilitate the construction of these waiting houses in their communes. In the Malagasy tradition, family members must accompany a woman and stay with her at the health facility until she is ready to go home and since many of the CSBs have traditionally been unequipped to host these family members, women have been less inclined to deliver at the CSBs.

Changes in technical approach outlined in DIP and rationale

No changes.

Special outcomes, unexpected successes or constraints

Perhaps one of the most important achievements of the project is the improvement in the relationship between the traditional health sector and the modern health service delivery system. CSB staff say that the TBAs and CHAs are located in very remote areas and they have been primarily responsible for many more women coming to the CSBs for ANC and deliveries. Some CSB heads are so complementary that they say “the TBAs and CHAs are extending our work into the community; they are helping us do a better job.” This is quite a change of heart from what staff had been hearing from some MOH officials during the project’s first few years, that it was a waste of time to train the TBAs, that they should be phased out and not made partners in the project. It is clear that the relationship between the TBAs and the CSBs has metamorphosed from one of enemies to mutual partners in improving community health.

The TBAs’ self-esteem and desire to continue working in partnership with the CSBs has been raised in the two regions. Several of those interviewed commented that they have been more highly valued by the community after participating in the training. As an indication of the success of the training and positive peer pressure, as we conducted interviews in several communities of VVT and TMM II, we were approached by TBAs requesting to be trained. In one case, five TBAs waited nearly 4 hours (the staff person was conducting interviews in an adjacent community and unaware of their arrival) to speak with the staff member regarding training opportunities. The project staff have agreed to adjust their program activities in order to train 80-100 more TBAs who would be recommended by the CSBs or community leaders. They have already begun discussions with the MOH to order more kits to distribute to the new TBAs who will be reintegrated into the health system.

Follow up and Next Steps

Project staff, in collaboration with SSD/CSB staff, CHAs, and TBAs, need to identify and implement activities which will focus directly on increasing rates of complete TT immunizations and seizing opportunities for iron distribution. They are currently in discussions with their MOH partners to explore the most appropriate ideas for this. Project partners also need to reinforce key related messages at the community level. Regarding emergency preparedness plans, transportation schemes, and construction of maternity waiting houses, staff members have begun to improve their data collection in this area. Once accurate data has been collected, staff should decide whether the barriers to implementing behavior change regarding BPP are so significant as to make the potential benefits of intensifying efforts within the remaining project period, futile. Regarding transportation schemes and the construction of maternity waiting houses, the project staff should conduct an informal survey to determine the impact of these two efforts on increasing CSB births in the communities in question. If the impact has been substantial, then ASAP may want to consider facilitating cross-visits of those COSAN/CASC members involved with these projects to other nearby communities.

Reporting continues to be a challenge for non-literate TBAs, and thus the project staff have developed and are piloting a new pictorial system of reporting using a cloth diagram with pockets representing different types of activities. The TBA will place small pebbles in the pockets to keep track of the number of home visits, community group discussions, assisted births, etc. As soon as the pilot phase has been completed, if the results are positive, ASAP should introduce this method into all communities where TBAs have been trained.

Another major challenge has been to ensure that the TBAs have a mechanism for re-supplying the contents of their birthing kits. Those who can afford it, purchase stock through the local pharmacies and others encourage the mothers to purchase the birthing kit contents (this is problematic since some items, such as gloves, are often not available at the pharmacies). Still many more say that most of the time they cannot afford to purchase the supplies and that some mothers also do not have this possibility; therefore, they must do the best they can with what they have. As part of their transition plan, the ASAP needs to work with the COSAN and the CASC to determine how these two mechanisms might assist in setting up a revolving fund for purchasing the supplies when mothers and TBAs are unable to. Since the TBAs also mentioned that they would like to have some additional incentives to continue their activities, the project may want to consider involving TBAs in some additional small income-generating projects.

Project staff and CSB heads need to continue encouraging and supporting TBAs in their efforts to train other TBAs in adjacent villages who have not yet been trained by the project. ASAP staff also need to work with CSB heads and COSAN members to develop a concrete transition plan for ensuring that refresher training continues for TBAs after the project ends.

CSB heads from those clinics where COPE has been applied need to be supported in conducting cross-visits or in hosting COPE refresher sessions at their own clinics whereby those who have yet to apply the process will participate and sign mentoring contracts which encourage them to conduct COPE sessions in their own facilities within a specific time period.

As previously mentioned, CHAs and TBAs recognize the value of the follow-up support and facilitative supervision afforded them by the project staff, and in some cases, together with the CSB heads. During interviews, TBAs and CHAs alike asked that CSBs continue to support them after the project ends. This support needs to be fully transitioned over to the CSB so that the successfully evolving partnership between the CSBs and the TBAs/CHAs continues to be nurtured and flourishes.

4.0 TOOLS OR APPROACHES, OPERATIONS RESEARCH OR SPECIAL STUDIES

In September 2005, a detailed proposal and protocol for operations research was conducted by a local consultant and the project team. The objective of the operations research was to evaluate the acceptability/adherence to IPT for malaria prevention in pregnant women. The study was implemented in 9 CSBs in the project area. Out of the 1873 women who had visited CSBs for ANC, the study revealed that 84% had received the first dose of SP while 57% returned for the second dose. Results of the study indicated that women who came to the clinic for their first ANC visit did so primarily because they wanted to receive the free ITN (which would be given to them after having received their first dose of SP - if they were confirmed to be in their second trimester with fetal movement).

Project staff utilized the results to generate reflection, discussion, and decision-making: 1) amongst MOH partners to consider advocating for a policy change: free ITNs should be linked to confirmation of receipt of the second dose of SP instead of the first; 2) ensure that the social marketing of ITNs does not conflict with the Safe Motherhood program; and 3) improve coordination between the Reproductive Health division and the Malaria Control division of the MOH to contribute to the achievement of mutual objectives. The lessons learned from the Operations Research were shared with SSDs concerned and was also presented to partners during a RBM meeting called by USAID local mission. Please see Annex G for a complete report of the OR study.

4.1 *Cross-Cutting Approaches*

4.1.2 **Community Mobilization**

All community health workers have been trained and are active in the two project districts of TMM II and VVT. These include 293 TBAs and 500 CHAs (some CHAs are also TBAs so the total for each adds up to more than the total number of health workers). Through home visits, health fairs, radio listeners groups, and mobile community sensitization activities, the CHAs and TBAs have played a major role in mobilizing women to come to the health facilities for ANC, to bring in their babies for vaccination, to use family planning, to sleep under ITNs, and to deliver their babies at the health centers, amongst other improved practices. As previously mentioned, CHAs and TBAs have been documenting these activities through a simple monthly or bi-monthly (in the case where the volunteer lives more than 4 hours away from a CSB) report. Through the visa 5/5 program, ASAP has mobilized school teachers and school-aged children to identify and encourage mothers to bring their babies to the CSBs for vaccination. As mentioned above in the *section f. Maternal/Newborn Care and Birth Spacing*, in a few communes, such as Amabatoaranana, the community members have been able to mobilize themselves to contribute to the construction of ten maternity waiting houses. During the period of construction, the WFP had promised to work with ASAP in the food for work program (which subsequently did not materialize). It appears that the villagers may have constructed these houses because they were hoping to get paid in cash or in kind. While project staff are disappointed that WFP did not follow-through on its commitment, the communities appear to be happy to have this completed

to serve patients coming to CSBs. These efforts have been so successful that many CSB heads have asked the project to help facilitate the construction of these waiting houses in their communes.

As previously mentioned, the TBAs and CHAs have formed important links with the CSBs. The community has responded to the new linkages by placing more trust in the system as a whole, including valuing the CHA/TBA contributions, while changing their attitude towards the health center and its ability to provide quality and caring services. They have responded by increasing attendance at ANC sessions, by bringing their babies for vaccinations, by coming to the clinic for deliveries and for family planning, etc. These attitude changes leading to improved care seeking practices should not be underestimated.

In terms of community capacity, in a few cases, the CSBs have begun to take an active role in supervising these community health workers. Of the CHAs who work in collaboration with the 17 CSBs in VVT and the 35 CSBs in TMM II, meet regularly (monthly or bi-monthly) with health center staff. Of the CSB heads interviewed who are active in the follow-up supervision meetings held with the CHAs and TBAs referred to specific ways that the management, supervision, and communication skills and techniques they had learned during ASAP training had helped them with these meetings and in improving relations with their own staff). While some of the CSB heads clearly have taken an active role in supervision of community health workers, others we spoke with mentioned heavy case load and other challenges preventing them from taking a more active role. These CSB heads appeared to rely primarily on ASAP staff to provide support to the CHAs and TBAs in their catchment areas. To further contribute to the sustainability of project results, the project will need to transition away from the current system in which many of the CSB heads rely on ASAP staff visits to hold follow-up support and supervision meetings to one in which they have full responsibility for implementing regular monthly meetings and providing deliberate facilitative supervision and on-going support to the CHAs and TBAs.

During interviews and focus group discussions, it was clear that both CHAs and TBAs had developed important cohesive sub-groups; perhaps because of the training, or the opportunities for mutual support, they had become a close knit group of peers. As previously mentioned, the project plans to encourage these close-knit groups to form TBA/CHA associations in order to continue to sell ITNs and be directly supplied by PSI. This should help them continue to develop community capacity beyond the EOP.

COSAN members from CSBs in VVT and TMM II have been trained in PRA and have used these skills to their activities. This also reflects significant improvements in community capacity and provides the project a good foundation to build upon for transitioning to the phase-over plan. It is apparent, however, that the project will need to work closely and intensively with the CSBs and the local leaders during the final project period to adequately reinforce the COSAN in certain communities where the members have not been active stakeholders in the project.

Project staffs have used these mobilization activities to refine program plans with respect to community-level data collection. As earlier mentioned, some TBAs with limited literacy skills have had difficulties in completing their reports on a regular basis. Thus, the project staffs have designed a cloth pictorial chart which they are pilot-testing in a few communities prior to distributing it and training all the TBAs in its use. Staffs feel that these pictorial charts will help the TBAs and other community level volunteers to further increase the community's capacity to monitor and improve its health status.

In January 2006, the project zone, and the entire Tamatave province (which is a year-round Malaria endemic region), fell victim to both Dengue and Chikungunya epidemics. These debilitating diseases not only limited the community's ability to mobilize around project activities, but also meant that numerous activities were stalled due to nearly 80% of the project staff contracting one of the diseases (Chikungunya has no known prophylaxis). Some staffs were hospitalized and others had to be evacuated to the capital for appropriate treatment.

Competing community priorities has been another factor in the political and socio-ecological environment which has affected staff's ability to fully mobilize the community. For example, within certain areas of the project site, ADRA overlaps with other organizations involved in non-MCH related development activities. Most (all?) of these organizations, including CARE, CRS, Secaline/World Bank, and others, offer a higher per diem for training, etc. and thus, when community members (often community volunteers are engaged in volunteer activity with more than one organization) are faced with the choice of participating in an ADRA sponsored training or other event organized by another group, they logically choose to engage in the activities of the organization which provides them a higher per diem. While the project has presented this issue on numerous occasions to ADRA Madagascar country office managers, per diem has been standardized for all projects throughout the organization. In discussions with country office staff, the evaluation team leader was informed that change would not be possible since the ADRA board would need to approve such a change and that they were unlikely to do so.

4.1.3 Communication for BC

Using community mobilization and sensitization activities as the primary channel for behavior change communication has proven an effective strategy for transmitting the majority of the project's key messages, especially malaria, ARI related, vaccination, and maternal and neonatal care messages, including FP and STI/HIV. This strategy focused on home visits and the use of a one-on-one counseling approach via CHAs and TBAs and was complemented by the use of radio programs, spots, and listeners groups. In addition, CSB staff, project staff and community members have reinforced some of the key messages through occasional health fairs and community demonstrations.

One of the ways in which the project is addressing some of the barriers is through the home visits/counseling sessions in which TBAs and CHAs help mothers to work out the issues preventing them from engaging in positive health behaviors. Another way is by

providing increased access to some of the health products, such as ITNs and pre-packaged malaria treatment. Also, TBAs and/or CHAs accompany women to the health centers to help them overcome the fear of being mistreated. However, as mentioned earlier, the project needs to focus greater attention on further defining and addressing barriers to some of the behaviors that have not yet been widely adopted (vaccination, breast feeding, BPP, transportation schemes, etc.) Barrier analyses to determine the most significant barriers and motivators might be useful for this purpose.

These same methods of engaging in communication for behavior change (especially door to door visits and listeners groups) have provided opportunities for ASAP to teach skills, negotiate changes and influence social and behavioral norms. Examples of new skills that appear to have been effectively transferred are: the preparations of home-based ORS. The work of the TBAs, and CHAs in combination with efforts of the Visa 5/5 school children have also contributed to increasing the community's belief in the importance/necessity of complete vaccination and births conducted by trained skilled personnel with safe birth kits- gradually transforming these concepts into community norms. Radio listeners groups, other one-on-one communication sessions, along with increased ITN access, are also helping to transform the use of ITNs by pregnant women and other family members into a community norm. It will however be essential for the project to increase and strategically direct its efforts to transform community norms in areas that have not seen sufficient progress, such as BPPs and breastfeeding.

The project was strategic in deciding to utilize the excellent existing materials (counseling cards for TBAs and CHAs and the Safe Motherhood flip chart for the TBAs) which had been developed by national programs, in collaboration with PVO partners and supported by AID funding. These materials are currently being used by a number of organizations working in MCH in Madagascar and they contain technically up to date messages. ASAP also used training materials/curriculum and handouts that were provided through the MOH. Prior to their use, key messages were critically reviewed for their level of technical appropriateness and compliance with international standards (TRMs), priority, and relevance to local conditions.

The fact that both the flip chart and the series of counseling cards were in Malagasy was also an advantage for the program and the community. To complement these health worker materials, the project made a significant investment in the production and distribution of take-home culturally-appropriate, illustrated IEC print materials with limited text (for low-literate audiences) on key messages in the local dialect. According to project records, each of a series of 7 illustrated brochures was distributed primarily to mothers and care takers of U5s in the project area. A CD with key messages on the project's intervention areas was also produced and distributed. While each of these brochures contains technically correct messages, the nutrition/breast feeding brochure could have been more complete by including messages reinforcing the fact that EBF helps prevent diarrhea.

While these materials are technically accurate and culturally appropriate, it is not clear as to whether ASAP partners are exploiting all the possible "teachable moments"; for

example, discussions with the CSB staff revealed that they do not have IEC materials to distribute to clients, and half of those interviewed indicated the need for materials on STIs to use with clients. Also, long waits prior to being seen by the provider are quite common, but no one appears to be taking advantage of these moments when mothers are a captive audience. The project needs to explore whether CHAs and TBAs can utilize these ideal opportunities to provide small group health info and skills-building sessions. They may even be able to identify positive deviants during these sessions and recruit them to form mother's peer support groups (for EBF, for example). They also need to distribute copies of the IEC brochures to the health centers and engage the CHAs in monitoring their distribution and re-supply. The project should consider printing a large quantity of the materials a portion of which would then remain with the SSDs for distribution to the CSBs and with the COSAN members for distribution to the CHAs and TBAs after the EOP.

The mid-term review did not note any specific tools that are being used to capture impact of behavior change materials and interventions. Thus there is not yet a sufficient body of data on the effects of the behavior change interventions. The project could benefit from a simple inventory form indicating which materials were currently being used/available/need re-supply with the CHAs, TBAs and at the CSBs. Also, field technicians, CSB staff and others involved in supervision should add a column to their monthly reports to include distribution numbers per target group member and perceived and demonstrated benefit/impact of each type of IEC/BCC material and intervention. CHAs and TBAs should also be reporting on their perceived impact of each type of behavior change activity conducted; this could be done in an informal way during regular follow-up support meetings at the health centers, but would contribute to an increased tendency towards reflection regarding the quality (and outcome or impact) and not the quantity of their BCC activities. A general limitation of the project is that the data available to project staff is not used for program review in a systematic manner and this holds true for the behavior change activities as well.

While the project did not develop the child-to-child approach, their adaptation of the approach, the Visa 5/5 approach which trains school children to identify and visit mothers of infants who have not completed their full cycle of vaccinations has been innovative. The strategy appears to have been successful at least in the communities where it is being used; as earlier mentioned, since the start of the program.

4.1.4 Capacity Building

ADRA Capacity Building

On page 130 of the DIP, brief reference is made to organizational capacity assessments for the ASAP team and that staff will be encouraged to write their own action plans for self-improvement. No further details are provided regarding project plans to conduct an organizational capacity assessment, or establish capacity building objectives, nor organizational assessment tools that might be used to assess capacity of ADRA staff.

Mention is made that as part of the COPE strategy, all staff (SSD, SSD, and ADRA) would undergo annual performance evaluations and self-assessments, but tools are not identified. It would have been beneficial for the organization to identify an organizational capacity assessment tool to help them identify high priority areas needing strengthening, establish an organizational action plan based on capacity building objectives, and implement that plan to improve capacity at the organizational level.

Nonetheless, individual interviews with 12 of the 13 key staff members clearly demonstrated numerous areas in which capacity had been built and new skills were being constantly applied.

In terms of their utility in helping them improve the way they perform their duties, staff referred most frequently to the training and skills building in Management/MBO approach, Integrated Supervision, and Training of Trainers Techniques. Staff also mentioned that the training in IMCI protocols, team building, COPE and IEC/BCC had helped them improve systems and approaches. For example, several staff mentioned increasing their capacity to manage their own teams, lead a meeting, plan an activity, and better organize and manage their internal work load. Some had even changed their management style and way of communicating, "I have changed the way I give feedback; I was aggressive before, but now I speak better with my colleagues;" and "I no longer follow my team so closely, no micro-management." Still others had gained valuable lessons from the Training of Trainers; they mentioned learning how to communicate through appropriate non-verbal language and understanding the way people learn; several colleagues mentioned using the TOT techniques not only during the planning and facilitation of training sessions (for CSB staff, CHAs and TBAs), but also during regular meetings with the SSD/CSB staff. Other staff referred to the many ways they had applied skills learned during the supervision and IMCI training. "I have used the supervision skills to develop and use an integrated outline/checklist for jointly monitoring performance and improving supervision together with the SSD staff at the CSB level." Two additional staff described how the IMCI training had been instrumental in enabling them to not only develop appropriate materials (the brochures and key message memory/job aides), but also to provide better follow-up for the community health workers.

According to the PM, the staff also benefited greatly from LQAS training provided by MCDI. He also felt that his own capacity had been increased substantially by participating in the training; in particular, he was able to motivate the team to utilize the methodology and provide quality follow-up on their sampling techniques for the mid-term survey. While there appeared to be a few kinks in the system, for example, staff had noticed that some of the questions may have been asked in a leading manner (such as the question on essential moments for hand washing), for the most part these appeared to be issues that staff had identified during data analysis and were making plans to address. The PM, himself, mentioned that although he had participated in several useful trainings, including LQAS, Project Design & Monitoring & Evaluation, and Management, he and his team could benefit from him receiving refresher training in the

following areas: 1) Advanced Management, 2) Advanced Monitoring and Evaluation, and 3) Finance, especially budgeting.

The skills and new techniques that staff have acquired and regularly apply in their project and team management, implementation, monitoring and evaluation thanks to these multiple training opportunities indicate that organizational capacity has been strengthened in these areas. This is especially true since ADRA country program managers have indicated their plans to make every attempt to transfer appropriately qualified individuals to other projects with position vacancies at the EOP, therefore, transferring good skills and approaches to other parts of the organization.

Other indications that organizational capacity has been built are:

- Improved understanding and use of data and indicators for child survival
- ASAP was the first ADRA project (and amongst the first CS projects in general) to incorporate and learn from its application of the CSSA framework- ADRA's entire project was designed according to the three dimensions of the framework; this learning has been transferred to ADRA projects around the world
- Improved ability to apply lessons learned and recommendations from one CS project to the next (ADRA appropriately applied the recommendations from the final evaluation of their previously funded TCSP project in developing their DIP for ASAP)

ADRA has also taken advantage of the networking and staff development opportunities associated with the child survival program. Headquarters staff regularly participate in the fall and spring CORE meetings, as well as the Mini-University. They have also tapped the expertise available through Child Survival Technical Support Plus on issues such as LQAS, use of standard indicators, and sustainability.

Strengthening of Local Partner Organizations and Health Facilities

At the district and commune levels, the MOH SSD and the CSB staff have been the main participants of capacity building activities. Their roles and responsibilities, such as providing regular supervision to the CSB staff on the part of the SSD management and delivering health services to the community on the part of the CSB staff have not changed since these were described in the DIP. Also, PSI was identified as a major partner for the malaria prevention and treatment interventions of the project; their role as trainers and suppliers of ITNs and pre-packaged malaria blister packs has not changed since this partnership was articulated in the DIP. While no capacity assessment was conducted with PSI staff (they have been the facilitators of capacity building rather than recipients), it should be noted that discussions with PSI staff indicated their satisfaction in having also learned a great deal from the ASAP staff. In particular, the PSI representative interviewed mentioned having increased his own understanding of the many challenges and constraints of the field work that the ASAP

staff engage in. His appreciation of the realities of the field was fine-tuned thanks to the interaction he had had with ADRA staff.

For TMM II, the project used results from the BASICS Health Facilities Assessment (HFA) conducted at CSBs in February 2003; this included a questionnaire for health personnel and an inventory of materials and medicines. These tools were appropriate and effective, though since the DIP was written in mid-2004, the results may have been somewhat outdated. In addition to the HFA at the CSB level, the DIP also explained that SSD and CSB staff would undergo performance evaluations and self-assessments as part of the COPE strategy.

The baseline HFA for both districts indicated common weaknesses, such as lack of sufficient equipment/supplies, poor overall condition of the CSBs, no transportation nor adequate communication system, no access to clean water, no electricity, etc. No staff needs assessments were described in the DIP for VVT. In TMM II, when asked to identify the major challenges in adequately performing their job, 67% of CSB health agents mentioned a lack of drugs and equipment, 42% said a lack of supervision, and 21% identified the lack of training. However, the HFA also showed that within the previous 12 months, a substantial percentage of the CSB staff in TMM II had received training in the following:

IMCI- 63%, IEC- 63%, management- 54%, FP 54%, BF, Immunization, Nutrition, and Cold Chain Monitoring (71-75%).

This being said, training and capacity building was universally cited at all levels of the qualitative research process, as one of the strengths of this project. At the MOH SSD level, colleagues acknowledged the utility and continuous application of skills gained during training in computer programs (such as SPSS, GESIS), training of trainers, supervision, and management. In Toamasina II, SSD colleagues mentioned the supervision checklist and management tools as being particularly useful for their supervision visits and planning of activities. In VVT, colleagues mentioned applying new training techniques, such as planning a training session, public speaking, and preparing appropriate training materials. At the SSD level, the MTE team concluded that information is being analyzed and used for decision making more frequently; not only did SSD staff mention their use of the computer skills in transferring data into useable formats, but in one case, an SSD staff spoke of her desires to increase vaccination rates and appropriately used the current wall charts she herself had prepared which compared data from previous and current months to targets.

At the CSB level, as earlier mentioned, the MTE team learned that some CSB heads increased their capacity largely due to the training and follow-up provided by the ADRA technicians. For some, capacity improvements were evident in the use of COPE (most had never used the process prior to the project); for others, in the application of the IMCI protocol when diagnosing and treating U5s, and still others had increased their ability and enthusiasm for conducting follow-up, supervision of CHAs. Due to time limitations, the team was unsuccessful in observing any examples of the use of IMCI

protocols in action; however, the team members surmised according to CSB heads' responses to the relevant IMCI interview questions, that many had made substantial increases in knowledge and comfort levels in dealing with the protocols.

While for many staff, these health facilities and health worker performance strengthening activities appear to have been appropriate and in many cases, have had a positive impact on improving the quality of health service delivery, for some CSB heads, the capacity building activities were not as effective as they could have been and these staff could benefit from furthering strengthening activities based on an assessment of barriers to behavior change. Some of these have been discussed in previous section and are the same in which other CSB staff interviewed have shown effective capacity improvements: standardized IMCI application, COPE roll-out, and supportive supervision. . In addition, though CSB staff had been trained in proposal development, none of them had developed any proposals; this had had a direct impact on their inability to identify funding sources for improving some of the structural aspects of the CSBs, construction of maternity waiting houses, solar panels for electricity, etc.

Some of the challenges staff might encounter in further building the capacities of its primary partners at the SSD and CSB levels are:

- Limited time to identify and address barriers to CSB staff using skills learned from COPE, IMCI, Proposal Development
- Limited availability of Positive Deviants (from CSBs having applied the skills) to participate in cross-visits or co-facilitate on-the-job training
- High turn-over of SSD key staff (investments in capacity strengthening activities may be lost to the project site)
- Limited supervision for the CSBs due to the shortage of personnel to effect supervision visits (SSD staff are only able to complete about 2 visits per CSB annually)
- Challenge of SSD staff completing joint activities with ADRA, such as joint supervision visits due to lack of planning and imposition of activities by national level MOH supervisors
- Heavy work load and limited incentives/motivation (without project per diem) for CSB heads to effectively take on their role of on-going capacity-builder for CHAs and TBAs
- Sustainability issues in terms of how to keep the community partners/CHAs motivated once the per diem and other incentives are no longer provided after EOP (especially if CSB heads do not continue to provide refresher training as a motivation)

Please see relevant Section above for a complete discussion of the linkages between the health facilities and the communities.

Strengthening Health Worker Performance

As previously mentioned the project's strategy to strengthening the performance of health workers was primarily directed at training in IMCI, IEC/BCC, Supervision, and COPE. This was followed up by supervision/supportive site visits by the project staff, sometimes jointly with SSD staff to help strengthen these skills and address challenges. The project staff used a supervision checklist for these visits; this appeared to be an effective way of assessing performance, acknowledging particular strengths and discussing areas for further strengthening in the short term. The project also used the COPE methodology to assess health worker performance and in particular, client satisfaction with health worker performance. ASAP staff helped to facilitate some of the COPE sessions at the CSBs, in others, CSB staff completed these assessments. In those CSBs where COPE was used, it has proven an effective, low-cost tool for measuring change in the program time frame. As earlier mentioned, in one CSB the COPE assessment results were used to improve the infection control procedures and in another, they helped staff to improve their attitude towards clients. When gaps in performance standards and actual performance have been identified the ASAP technicians have generally increased the amount of time spent visiting these CSBs. During the final project period, the program plans to 1) increase and improve joint supervision visits to help SSD staff identify and resolve gaps; and 2) intensify the use of the COPE tool with the help of other CSB heads who have been successful in using the tool.

Training

ASAP contained a heavy training component and a substantial part of the training was conducted according to the DIP. While a large proportion of the training strategy consisted of training of SSD and CSB staff, the primary focus for training was on equipping the CHAs and TBAs with the key messages and skills necessary to effectively work with mothers and other care takers to promote and negotiate behavior change in key intervention areas. All of the training was done by PSI, and/or ADRA staff, in collaboration with national level MOH and local district partners. Training was largely decentralized at the district level, leaving district teams of ADRA and MOH staff (and oftentimes, national level MOH colleagues who had been invited) to adapt training content and programs as needed. This approach meant the project could be very responsive to locally identified needs.

Because national level MOH staffs were often involved as members of the teams of facilitators, the project was able to ensure that training materials and approaches were in line with national level standards. In addition, for the majority of the training, the project staff (most of whom had been trained in Training of Trainers sessions) ensured that trainers applied adult education methodologies. However, while the project supported an adult education approach and teaching methods were included in the training of trainers' sessions, the many of the training materials focused more on technical content than on specific training approaches with each trainer preparing their themes for presentation as they felt appropriate.

Staff at many levels commented on the quality of the PSI training on social marketing, including ITNs and malaria treatment; this seems to have been quite effective.

Please see the above section on Capacity Building for details on evidence that the training has resulted in new ways of doing things. As mentioned in this same section, to ensure that health workers continue to maintain and improve their skills, the project will need to focus greater attention on ensuring that SSD and CSB (especially during regularly scheduled follow-on meetings) offer an opportunity for systematic and sustainable technical reinforcement and refresher training to the CHAs and TBAs. ADRA staff also need to ensure that they maximize the cost-effectiveness of training opportunities during the final period of the project. For example, if one person or two individuals need refresher training in a certain area, say IMCI, then every attempt should be made to identify a peer colleague who is competent and willing to provide on the job training with support from ADRA and/or SSD staff members. Ultimately, these SSD and CSB colleagues should begin to identify their colleagues who can mentor them in certain areas thus providing better opportunities for sustainability of refresher training once ADRA leaves.

The approach of focusing on one topic during a certain period, for message reinforcement, such as vaccinations or EBF/nutrition should be continued by the SSDs/CSBs. In addition, the project may want to consider promoting the “mini-module” approach to regular technical refresher updates during monthly follow-up meetings at the CSBs; staff should take the opportunity to assess its effectiveness during the final project period.

4.1.5 Sustainability Strategy

While the majority of the project staff were unable to describe the project’s sustainability strategy, many of them had a number of ideas reflecting elements of a phase-over plan that would need to be accomplished during the final project period. A couple of the staff members referred to the important role that the COSAN would need to play in first being reinforced and mentored/supported to gradually take on more and more of the responsibilities at the community level. As mentioned above, the training of COSAN members in several communities has laid a broad foundation on which the ASAP staff will be able to further build to effectively transfer the project responsibilities at community level. Capacity building in supervision and refresher training techniques for SSD and CSB staff will need to be intensified to ensure that they are able to effectively assume these responsibilities. Please see Annex for an outline of the phase over plan to work with COSAN committee members.

However, in addition to the phase over plan mentioned by some staff, according to the DIP this project has a well developed sustainability strategy which considers all aspects of the sustainability triangle¹ (Dimension I: individual health status/behaviors and health services; Dimension II: organizational capacity and organizational viability; and Dimension III: community capacity and socio-ecological environment). Each activity

¹ Sarriot, Eric: “Child Survival Sustainability Assessment” Core / CSTS document, September, 2002.

included in the project logframe has been categorized as part of Dimension I, II, or III. During the DIP workshop, staff identified the following existing and additional indicators in each dimension as elements that they would track on the star diagram, also referred to as the dashboard. These indicators included:

Dimension I:

- Rate of renewal for drug prescriptions in comparison to number of consultations
- % of infants treated by a trained health staff
- % of deliveries by a trained attendant
- Rate of mothers satisfied with CSB services

Dimension II:

- % of CSBs with at least 2 health care agents
- % of CSBs who offer at least 6 different types of health care services
- % of CSBs who have less than 2 days of irregular absence per month
- % of CSBs who send their monthly report of activities
- % of CSBs who possess a means of communication
- % of CSBs who have at least 4 sources of financial support
- % of CSBs who are within the norms (defined by MOH)
- Frequency of coordination meeting at the level of the BSD

Dimension III:

- % of trained TBAs who sterilize their instruments
- % of trained TBAs who turn in their reports to the CSB
- Rate of vaccination with DTCHB III
- Rate of outpatient consultations
- Rate of activity reports turned in by the community partners in comparison with the number of partners
- Number of local Emergency Assistance committees trained and active in disaster mitigation and reduction of the potential impact of cyclones

According to the DIP, plans were to monitor indicators at least once a year. To-date, the project has been able to monitor and chart progress towards achieving target indicators once.

In terms of building financial sustainability, as previously mentioned several CSB heads were trained in proposal development; however, they have not yet been able to develop proposals (many claim this is due to their heavy workload). One of the SSD staff interviewed suggested that the SSD might be able to identify other MOH budget allocations that were not being fully expensed, such as the HIV/AIDS budget to include some of the relevant activities in that allocation from the national level. On the community level, it is evident that COSAN and CASC members will need to be creative in brainstorming ways to provide financial support to ensure that the gains from the

project are not lost, but continue in the right direction. As discussed earlier, TBAs and CHAs are willing to continue working after the EOP, but have requested that the project set up assurances for their refresher training and if possible provide some incentives; these might be in the form of small revenues from the sales of ITNs and other socially marketed products, or income generating projects. The project will need to work closely with the CSBs and the community during the next six months to focus on expanding and prioritizing the most feasible of these possibilities for alternative funding sources.

5.0 Program Management

This project appears to be well managed:

- A relatively effective staffing structure while keeping staffing costs within the realm of replicability
- Solid financial management with appropriate budget allocations and low spending rates
- A commitment to improving the partnership between ADRA and their MOH SSD partners.

There were a couple of issues with financial management and human resources that seem to be exacerbated by the bureaucratic structure of the organization, a temporary lack of support from senior management and limited child survival expertise at the ADRA country office, the work load of the financial manager, among other issues.

5.1 Planning

District MOH partners as well as the majority of the ASAP staff were involved in developing the DIP and it seems to have been quite participatory at the time. However, with high staff turnover, due primarily to the frequent turn-over/reassignment of MOH staff, only one of the individuals interviewed from the MOH (SSD VVT) had been involved in these project planning exercises. That being said, all the individuals interviewed, including the PSI representative, MOH partners, and project staff knew the project objectives and their own responsibilities vis a vis the project. ASAP staff members all had copies of the DIP and used them to prepare their quarterly activities plans. Partially due to the high turn-over, but also due to previous copies being misplaced, neither of the two SSD Medical Directors were able to locate copies of the DIP, nor of project objectives or the M & E plan. Project staff have already made arrangements to reproduce and distribute copies of the work plan, sustainability plan, and other key elements of the DIP for project partners.

Please see individual sections on interventions for an assessment of which areas of the DIP work plan are on track.

Staff routinely use program monitoring data for planning and revising program activities during quarterly planning meetings.

5.2 Staff Training

Staff generally felt their training had provided them with the tools they needed to effectively fulfill their responsibilities. Please see above ADRA capacity building section for further details on how staff training has been effective in providing staff with improved methods for performing on the job.

As part of each employee's MBOs, staff identify areas in which they need improvement to better perform their job. During the employee performance review conducted every six months, a follow-up assessment is supposed to be conducted to determine how the employee has utilized the training, how the employee's performance has changed (if any) in the skill area, and if s/he requires other types of training. This has proven to be an effective process in guiding the project manager in selection of the appropriate staff to include in training opportunities and in providing additional support where necessary.

While adequate resources appear to have been dedicated to this line item, the project could increase its spending in this area during the final project period. Staff have identified the following as areas in which they could benefit from additional training:

- Computer programs, especially EPI, SPSS, GESIS, advanced excel and ACCESS data base,
- IEC/CCC ,
- Management,
- M & E,
- Training of Trainers
- Budgeting, and
- English

5.3 Supervision and Support

In general, field staff felt the level of supervision and support was appropriate, although some of them had suggestions for ways in which it could be improved. These suggestions have been shared with the PM who has agreed to incorporate them into his supervision/support process. Individuals appreciated his advice, supportiveness, accessibility, and open style of leadership of the PM. His methods include 1) encouraging each staff member to develop his/her quarterly work plan, 2) discussing the work plan with the staff member, and 3) providing suggestions as to how the plan could be improved upon, and 4) discussing progress updates at weekly or bi-weekly staff meetings. According to his own assessment, he has gone from being somewhat of a micro-manager to a more hands-off type of manager; indeed, some staff confirmed their appreciation of the changes made in the PM's leadership and supervisory style since the team-building exercises. Comments during staff interviews indicated that he has made progress in improving his leadership style (with both staff and SSD colleagues), but that some staff feel that he could be more open to team members' ideas.

In contrast, the PM indicated that while the situation had greatly improved over the past 6 months, he felt that there had been times during the project's first few years when he received little to no supervisory support from managers in Antananarivo. During a large part of this time, the ADRA had no one point person supporting the health projects in its field offices.

While the number of supervisory visits from the PM to the field and from ASAP technicians to the field appear to be both regular and relatively frequent, a couple of staff mentioned that they feel overwhelmed with the workload, this is especially true in VVT where communities are extremely dispersed and field staff have to travel significant distances. During the final project period, ADRA might consider adding additional part-time staff to help bolster current activities, but especially focusing on the sustainability plan and the steps which need to be implemented to ensure a smooth transition period.

5.4 Human Resource and Staff Management

All twelve staff members interviewed, with one exception (she is supervised by the Finance Officer in the country office) had received their performance evaluations within the last six months and appropriately on schedule. Staff are managed according to their MBOs which provides the opportunity for both the employee and the supervisor to comment on the employee's performance. ADRA's field offices have not yet implemented a system of peer evaluations or of upward feedback, whereby employees are encouraged to provide feedback on the quality of the supervision they receive; however, many individuals interviewed stated their belief in the overall organizational benefits in implementing such a process.

Throughout the project, there has been a problem with relatively high turnover; as mentioned by a former staff member who now works for a partner PVO, "ADRA needs to find a way of motivating their staff better- they have changed the M & E person three times since the start of the project. In fact, several staff stated that they perceived ADRA salaries to be lower than the majority of similar organizations operating in the region. While staff morale appears to be high, some staff mentioned a feeling of limited appreciation at the country office level for the hazards and challenges of working in the most remote areas of the country. For example, some colleagues described the insufficient per diem for travel to remote areas of the project; others recommended that ADRA's per diem system should be revisited to ensure that it is more in-line with other organizations such as CARE and CRS.

A general feeling of job insecurity was expressed by many of the staff who suggested that ADRA provide some type of verbal commitment to help staff who qualify for other positions after the EOP to fill those vacancies and to encourage others to start looking for positions so that by the end of the project they will have lined something up either with ADRA or another organization. The MTE team leader wholeheartedly agrees with this suggestion and has encouraged senior management staff at the ADRA county office to follow-up as soon as possible.

Key personnel policies appear to be in place, however the Finance Assistant discussed the need for training in HR policies and procedures since she has recently had some of these responsibilities transferred to her. All staff interviewed had received a job description.

5.5 Financial Management / Administration

Financial management for the project appears to be effective and provides an appropriate balance between controlling for misappropriation and facilitating program activities. The project's financial assistant takes responsibility for all large payments such as for training and per diems. The essential financial information was available for management and spending was appropriate. Reports were timely, with enough detail for the PM to make spending decisions. The budget was also monitored by the Silver Springs ADRA office. Savings on initial staff salaries, due to delays in hiring project staff and other events have contributed to a low burn-rate, however the PM feels that these funds will be appropriately utilized to strengthen the areas related to the phase over plan and to implement several of the recommendations provided by the MTE team.

When planning takes place according to schedule, three months in advance, and no changes are required in terms of financial allocations, the system seems to work well. Quarterly budgets are submitted to the country office who then releases the funds according to the activities planned. However, the finance assistant, the PM, and other project staff commented on the slow and unwieldy procedure required for releasing funds for previously unscheduled activities. Discussions with the Finance Officer at the country office in Antananarivo indicated that some of the delays were related to the fact that project staff oftentimes prepared budgets incorrectly. One suggestion provided to the Finance Officer was that she works more closely with the project on these issues. Previously she helped them prepare their quarterly budgets by working with them on site and this was quite helpful.

The Finance Assistant also mentioned the need to improve coordination of work and to be clear regarding what procedures should be followed; there is some concern that application of certain financial and/or HR procedures is not standardized across the organization.

5.6 Logistics

In terms of logistics issues which have impacted the DIP, one of the most concerning issues is that of the limited access to functional computers for ASAP staff. Partially due to the high humidity in the region, but also due to the poor quality of some of the equipment (some of the computers were old models that were inherited from other ADRA projects), computers are constantly breaking down and currently staff are unable to fully carry out their responsibilities (such as prompt report writing) due to the shortage of computers. During the MTE period, the team noticed that nine staff were sharing three computers. Some staff admitted having had to bring work to the internet cafes on Sundays in order to get it completed by the deadlines.

Another logistics related issue is that of providing transportation to the MOH to ensure that kerosene arrives at the CSBs to maintain the cold chain. On the one hand, this appears to have helped the MOH to improve the quality of service delivery at the CSBs, while on the other hand, it appears to have established a dependency relationship.

Now, instead of purchasing their kerosene with MOH budget allocations, while the project helps to deliver it, the SSDs are asking the project to purchase the kerosene as well.

The procurement of cars from ADRA's other projects had enabled the project to avoid having to develop an alternative funding strategy and these vehicles have been instrumental in helping the project staff implement their activities. On the other hand, the distribution of donated items, which included requested and non-requested items (such as baby clothes and new mother's gift packs) caused a temporary delay in moving forward on some project activities in VVT. Because the VVT SSD head was not in agreement with some of the items, she originally refused to sign the letter of receipt. This could have been avoided if the contents of the shipment (which was known by ADRA staff) had been thoroughly discussed with her prior to their unveiling. It should be noted, however, that the total of goods donated to the SSD and CSBs included such items (that have helped the staff better perform their jobs) as computers, office equipment, salter scales. Through these donations, however, the project positively influenced the quality, particularly of safe motherhood services, at both the health center and hospital levels: The project provided equipment and supplies based on their review of essential equipment needs for maternal health.

The project is anticipating the following logistics challenges: a push from the SSD to turn over all project vehicles and computer equipment to them at the EOP; increased requests on behalf of the SSD to be supplied with per diem and other incentives in order to participate in intensified activities, such as the increased joint supervision opportunities.

5.7 Health Management Information System

The project made a significant investment in the establishment and use of a community based information system. As a result, while it served project management, the information system served more as a capacity building intervention. Forms were developed, people were trained, and analysis and use of the data were emphasized during meetings and supervision at multiple levels. While the community component has been strengthened through monthly or bi-monthly reports completed by the CSBs and TBAs, these reports are still being submitted to the project staff. Within the next two quarters, project staff need to focus on convincing the CSB heads that it is their responsibility to compile the reports, analyze their data, integrate them into the health center data collection system, and make decisions and support CHA/TBA efforts based on their results. The cloth chart to be piloted within the next few months, should provide staff with an alternative for non-literate individuals to also participate in this community HIS. Data collected includes information on births, deaths, vaccination, numbers of home visits, community IEC discussions, brochures distributed.

5.8 Technical Support

During the DIP process, this project benefited from excellent technical support provided by Mr. Karl Blanchett, the Director of Handicapped International, UK. In addition, it had regular technical support from the ADRA headquarters in Silver Springs, although, the backstop for this position changed three times since the start of the program. A technical support person visited the project over the first 2.5 years. PSI has been providing technical support in training and follow-up assistance for the malaria component and the MOH has helped the project by providing training, IEC materials and facilitators to help implement training.

The project also drew on local resources from other ADRA projects for support, such as the nearby ADRA family planning project. Finally, the project hired an external evaluator to conduct this midterm evaluation.

5.9 Collaboration with USAID Mission

According to the HPN Team Leader, ADRA maintains excellent relations with the USAID Mission. This has been greatly enhanced by the addition (14 months ago) to the ADRA Antananarivo team of the Program Coordinator who has a health background. To the extent possible, the Project Manager keeps the USAID Mission abreast of its activities through attendance at periodic PVO meetings (held quarterly or every 6 months). USAID Mission staff have also made frequent trips to visit the project site, approximately three per year and the Mission is currently planning a joint supervision visit with ADRA country office staff to help follow-up on the recommendations made during the MTE.

During the design of the project, ADRA collaborated fully with the USAID Mission. In order to maximize health results and get critical mass, the Mission's strategy has been to group projects to work more closely together. The Mission felt that the project's strengths were its informational sharing, especially key messages and training. The Mission also commended ADRA for their successful work in malaria with the public and private sector and made special mention of the way the project has been able to link field agents with the government health services.

Nonetheless, ADRA could improve its dissemination of information and story telling to enable other PVO's to learn from its successes and challenges.

6.0 Selected Additional Information for 2006 Evaluation Cycle

6.1. Contribution to Scaling:

- Building from the experience of the previous TCSP (Cycle 14), ASAP activities followed strategic network through partnerships to reach beneficiaries from districts, communes, up to the village levels.
- The project also strengthened district leadership for both MOH and Government as follows:
 - ASAP strengthened the MOH through capacity building in various areas including administration, computer skills, management and other technical aspects.
 - ASAP strengthened the Government through providing training to selected local authority representatives from the entire 17 communes composing the two districts; to be trained in Rapid Rural Appraisal techniques for proper decision making. The training enabled them to manage the health of their respective communities in such a way that they can carry out proven intervention at scale.
- The project built capacity among all agencies as ADRA and its partners worked in a collaborative manner. ASAP carried out interventions in a complimentary manner rather than competitively. As a result, ADRA and its partners developed a mutually beneficial capacity building. Best practices emphasized during capacity building were collaboration thus minimizing or eliminating completely the overlapping of activities.
- ASAP made sure to always make use of existing information to raise awareness among beneficiaries. Thus, no reinvention of wheels
- The project included other successful approaches, to scaling up at a large scale by introducing a Mobile Strategy for Community Mobilization. ASAP in collaboration with MOH successfully developed 5 new IEC printed leaflets for every IMCI components, which have been distributed to beneficiaries and could be used by other stakeholders in the country.

6.2. Civil Society Development:

- Although capacity building is mentioned above in contribution to scale among MOH and district authorities, it has most notably been increased by the development and training of village and commune health committees. The committees themselves (through training from ADRA) mobilized and sensitized the community to take ownership of their improved health. In addition, ADRA trained and worked closely with the district health posts to increase capacity and effect change. In this way, community members and more importantly pregnant mothers and children visited more frequently health posts and clinics. District levels of health ministry appeared to be more willing to work with local staff in order to create linkages and support at the village level.

- Training of community leaders, linkages with health facilities, capacity building and overall improvement of health within communities contributed greatly to civil society development. Empowered CHAs and TBAs work together to mobilize their respective communities to raise awareness and break barriers to development.
- ADRA must be commended for their work in educating communities on family planning practices even to the remotest community in its assigned districts. This has had a positive impact on the way in which the communities view family planning and take ownership through their culture and development. The joint intervention of ADRA and MOH enable TBAs to come out of their hiding and to openly go through training and now are working with health personnel in a healthy relationship. Community trusts more health services providers and both are becoming partners in development. TBAs trust health workers who in their turn assist TBAs in empowering them and supervising them. They feel more secured that ASAP is now receiving more requests for additional number of TBAs who are pleading for a training seminar to be organized for them too.

6.3. Equity

- One of the best qualities of this ADRA CS program is its inherent equity throughout. Equity is seen among CHAs whose ratio between men and women is almost 1:1. On the other hand, males TBAs are also significantly represented in some communities. Hence, no one is excluded from the program. Unlike the old belief that village people will not accept a male TBA to assist them during delivery, more and more women express more trust in male TBAs. It is believed that male TBAs better provide satisfying services, since they are more understandable and are stronger than their female counterpart.
- Although the interventions are targeted at women in reproductive age and children less than 5 years, this program has positively affected all community members. However, ADRA has also taken time to care for mothers and children at risk. Mothers with malnourished children are encouraged by other mothers in the community to join training program in order to learn ways in which to better feed their child/children and create healthier families. The poorest of women are able to access quality health care without an increased burden to the family.

7.0 Conclusions and Recommendations

The recommendations below are organized according to the three sections of the report: technical approaches, cross-cutting issues and program management. These recommendations are designed to stimulate ADRA and the ASA Project into taking action and addressing the issues coming from the midterm evaluation. If ASAP has already identified next steps and actions in their work plan for certain areas, then the evaluation team did not make further recommendations.

7.1 Recommendations for Technical Areas

7.1.1 Malaria

- Work with the CSBs to: 1) determine if they understand the role of the CHAs in selling nets; 2) help reduce the barriers preventing some of the CSB heads from supporting the CHAs in this activity; 3) ensure that CSB heads understand exactly how to reorder stock;
- Improve ITN distribution by ensuring that bottlenecks in the distribution chain do not reoccur. They should order stock in advance and if possible, provide for a one month advance order to be distributed to the CHAs, rather than depending on PSI's stock on an order to order basis;
- Continue working with and recruit additional TBAs to sell ITNs since many of them are located in areas where women have limited access to health facilities.
- Facilitate CHAs and TBAs in the formulation of associations which can be supplied directly by PSI after EOP;
- Continue to work with CHAs and TBAs to encourage them to focus their messages so that women come at the appropriate times for ANC visits. During these promotional sessions, CHAs and TBAs need to inform mothers of their right to and the importance of receiving IPT during the 2nd and 3rd trimesters of their pregnancy;
- Intensify efforts via the CHAs and TBAs to encourage mothers to bring their baby in to the CSB during a febrile episode, to strengthen the community-based distribution of anti-malarials, to help mothers reduce barriers to providing their child with complete doses of anti-malarials; and
- Define and address barriers to consistent IMCI use (see Capacity Building below);

7.1.2 Immunization

- Investigate immediately the CATCH indicators with mid-term values that show deterioration of the public health system, such as the immunization indicator for VVT; one significant issue is the way the SSD understand the coverage area of a particular area. For instance, at the end of every year immunization area is 0 and this will increase as the months go by. The project is looking into this issue.
- If ADRA staff come to the conclusion that there is indeed a significant drop in vaccination coverage for VVT, then they need to coordinate with the SSDs and CSBs to discuss the most appropriate interventions to reverse the declining trend and increase progress towards achieving targets;

7.1.3 Nutrition and Breastfeeding

- Investigate immediately the declining indicators regarding breastfeeding, complementary feeding, Vitamin A (for TMM II), and increasing breastfeeding and fluids during diarrheal episodes;

- If ADRA staff come to the conclusion that there is indeed a significant drop in these indicators, they should discuss with the SSDs and CSBs the most appropriate interventions to reverse the declining trends and increase progress towards achieving targets;
- Project staff, CSB heads, CHAs and TBAs should discuss how to focus their efforts on not only reinforcing the messages regarding immediate and exclusive breast feeding, but also consider identifying successful positive deviant “EBF moms” and helping these mothers form mothers’ support groups to help other moms become successful EBF moms;
- CHAs and TBAs should increase focus on one-on-one counseling during their home visits to help mothers identify and reinforce positive motivators while breaking down barriers to EBF;
- In addition, ADRA staff and CSB heads should reflect on what has been done differently in VVT in terms of immediate breastfeeding and attempt to replicate this in TMM II;
- Work with the SSDs to help them to gradually take responsibility for holding nutrition days; this includes working with the MOH partners to advocate for budget allocations to be assigned for this activity;

7.1.4 Control of Diarrheal Disease

- Investigate immediately the declining indicators regarding diarrheal disease;
- If ADRA staff conclude that the data is accurate, they should discuss with the SSDs and CSBs, the most appropriate interventions to reverse the declining trend and increase progress towards achieving targets;
- Focus promotional efforts on the linkages between EBF and reducing the incidence of diarrheal disease (only one of the CHAs interviewed mentioned EBF as a way to prevent diarrheal disease). This could be accomplished by, as suggested under the Nutrition section above, helping positive deviant mothers to form BF support groups in which they can provide one-on-one counseling, thus addressing the most significant barriers to behavior change in this area;
- ASAP and its SSD counterparts need to advocate with the MOH for approval of zinc use to reduce diarrheal disease, the severity and frequency of episodes. Currently zinc is not available in any of the project intervention areas; however, ASAP is studying potential avenues/opportunities for its approval.

7.1.5 Acute Respiratory Infections

- ADRA and SSD/CSB colleagues should reflect on what has made this aspect of the program so successful and continue to replicate and reinforce these interventions;

7.1.6 Maternal and Newborn Care

- Project staff need to collaborate with SSD/CSB staff, CHAs, and TBAs to identify and implement activities which will focus directly on increasing rates of complete TT immunizations and seizing opportunities for iron distribution
- Project partners also need to reinforce key related messages at the community level;
- Regarding emergency preparedness plans, transportation schemes, and construction of maternity waiting houses, staff have begun to improve their data collection in this area;
- Once accurate data has been collected, staff should decide whether the barriers to implementing behavior change regarding BPP are so significant as to make the potential benefits of intensifying efforts within the remaining project period, non cost-effective;
- Regarding transportation schemes and the construction of maternity waiting houses, the project staff should conduct an informal survey to determine the impact of these two efforts on increasing CSB births in the communities in question. If the impact has been substantial, then ASAP may want to consider facilitating cross-visits of those COSAN/CASC members involved with these projects to other nearby communities;
- Reporting continues to be a challenge for non-literate TBAs, and thus the project staff have developed and are piloting a new pictorial system of reporting using a cloth diagram with pockets representing different types of activities. The TBA will place small pebbles in the pockets to keep track of the number of home visits, community group discussions, assisted births, etc. As soon as the pilot phase has been completed, if the results are positive, ASAP should accelerate introduction of this method into all communities where TBAs have been trained;
- ASAP needs to work with the COSAN and the CASC to determine how these two mechanisms might assist in setting up a revolving fund for purchasing the birthing kit supplies when mothers and TBAs are unable to. Since the TBAs also mentioned that they would like to have some additional incentives to continue their activities, the project may want to consider involving TBAs in the manufacture and sale of clean delivery kits as a way to: 1) provide a sustainable small incentive for the TBAs; 2) help them continue to utilize birthing kits which contain the necessary items; 3) continue providing a concrete intervention for safe deliveries and a sensitization tool for behavior change. Health centers could purchase the supplies for the TBAs using money generated from sales; any remaining money could be used for small income-generating projects for the TBAs;
- Project staff and CSB heads need to continue encouraging and supporting TBAs in their efforts to train other TBAs in adjacent villages who have not yet been trained by the project. ASAP staff also need to work with CSB heads and COSAN members to develop a concrete transition plan for ensuring that refresher training continues for TBAs after the project ends.

7.2 Recommendations for Cross-cutting Areas

Community Mobilization

- To further contribute to the sustainability of project results, the project will need to transition away from the current system in which many of the CSB heads rely on ASAP staff visits to hold follow-up support and supervision meetings to one in which the CSBs have full responsibility for implementing regular monthly meetings and providing deliberate facilitative supervision and on-going support to the CHAs and TBAs;
- Project staff and SSD/CSB colleagues need to hold a planning meeting to discuss how the mobile community sensitization strategy will be gradually transitioned to local stakeholders as part of the phase out strategy;
- Work closely and intensively with the CSBs and the local leaders to adequately reinforce the COSAN in certain communities where the members have not been active stakeholders in the project;

Communication for Behavior Change

- Increase efforts and strategically direct activities to transform community norms in areas that have not seen sufficient progress, such as BPPs and breastfeeding, etc.
- Conduct a listeners' survey to further investigate the utility and cost-effectiveness of this project component. The survey should focus on whether the radio programs have contributed towards concrete changes in the community;
- Explore whether CHAs and TBAs can better seize "teachable moments" to provide small group health informational and skills-building sessions. These CHAs and TBAs should explore identification of positive deviants during these sessions and recruit them to form mother's peer support groups (for EBF, for example).
- Distribute copies of the IEC brochures to the health centers and engage the CHAs in monitoring their distribution and re-supply. The project should consider printing a large quantity of the materials, a portion of which would then remain with the SSDs for distribution to the CSBs and with the COSAN members for distribution to the CHAs;
- Develop, distribute and orient colleagues in the use of a simple inventory form indicating which materials are currently being used/available/need re-supply with the CHAs, TBAs and at the CSBs;
- Field technicians, CSB staff and others involved in supervision should add a column to their monthly reports to include distribution numbers of IEC materials per target group member and perceived and demonstrated benefit/impact of each type of IEC/BCC material and intervention.
- CHAs and TBAs should report on the perceived impact of each type of behavior change activity conducted; this could be done in an informal way during regular follow-up support meetings at the health centers, but would contribute to an

increased tendency towards reflection regarding the quality (and outcome or impact) and not the quantity of their BCC activities;

Capacity Building Approach

- Work closely with the CSB heads to reduce barriers to consistent use of IMCI protocols. Project staff may consider on-the-job refresher training in IMCI protocol use, redistributing some of the training materials, such as the algorithms and IMCI case forms, and working with some of the CSB heads who have been more successful in applying the protocols to learn how these positive deviants are managing and inviting them to participate in on-the-job cross visit/training sessions;
- Support the CSB heads from those clinics where COPE has been applied in conducting cross-visits or in hosting COPE refresher sessions at their own clinics whereby those who have yet to apply the process will participate and sign mentoring contracts which encourage them to conduct COPE sessions in their own facilities within a specific time period;
- Continue to collaborate with the CSB heads to ensure that the support provided to TBAs and CHAs is fully transitioned over to the CSB heads so that the successfully evolving partnership between the CSBs and the TBAs/CHAs continues to flourish;
- Focus greater attention on ensuring that SSD and CSB (especially during regularly scheduled follow-on meetings) offer an opportunity for systematic and sustainable technical reinforcement and refresher training to the CHAs and TBAs.
- Take measures to ensure the cost-effectiveness of training opportunities during the final period of the project. For example, if one person or two individuals need refresher training in a certain area, say IMCI, then every attempt should be made to identify a peer colleague who is competent and willing to provide on the job training with support from ADRA and/or SSD staff members. Ultimately, these SSD and CSB colleagues should begin to identify their colleagues who can mentor them in certain areas, thus providing better opportunities for sustainability of refresher training at EOP;
- The approach of focusing on one topic during a certain period, for message reinforcement, such as vaccinations or EBF/nutrition should be continued by the SSDs/CSBs;
- Consider promoting the “mini-module” approach to regular technical refresher updates during monthly follow-up meetings at the CSBs; staff should take the opportunity to assess its effectiveness during the final project period;
- Provide English language courses to both SSD staff and project staff;

Sustainability Strategy

- Measure project progress towards sustainability indicators in each dimension and work together with SSD/CSBs to identify ways to increase progress, if necessary;
- Refine and implement phase-over plan with COSAN;

- Hold creative strategy session with COSAN and CASC members to brainstorm resource development strategies; develop and implement an action plan to provide financial support to ensure that the gains from the project continue in the right direction; consider helping COSAN and CASC committees identify students to work in collaboration with trained CSB heads on proposal development;
- Identify alternate sources of funding for non-AID related needs and put CSB heads in touch with these resources; encourage them to develop and submit simple concept papers for the highest priority needs, such as solar panels, water projects, etc.

7.3 Recommendations for Program Management

- For those indicators which were set unrealistically high at the time of the DIP, ASAP should, in collaboration with their SSD colleagues, consider revising the EOP targets to make them more in-line with what the SSD feels is realistic for the remaining project period;
- Consider purchasing additional computers for the final period of the project; make sure that future project design (for all ADRA projects) includes sufficient line item amounts for re-purchase of computers if the project location is in a humid area;
- ADRA country office staff and the ASAP team should strategize and identify new ways to motivate staff during the final project period; (suggestions: provide English lessons, increase training and capacity-building opportunities, especially according to the requests made for additional project-related training- see Annex on Compilation of Responses -Staff Interviews, provide rain/cold weather gear, such as rain jackets and rain boots for those who make site visits);
- As soon as possible, representatives from the Country Office should present possibilities for staff who are open to transfer to another project at EOP; this should be communicated directly and expediently with ASAP staff;
- ADRA Country Office managers should consider revisiting the per diem and salary scales for ADRA project staff to determine how they now compare to other organizations' scales and if it is possible to raise these to be on the same par with other similar PVOs operating in the same project areas;
- Work with the finance team at the Country Office and ASAP Finance Assistant to streamline financial mechanisms (especially regarding the expedient release of budget allocations for activities which may be planned or changed after the quarterly planning report has been submitted); provide additional on-site assistance from the Country Office to the project team for budget procedures so that staff are more adept at submitting correct and timely budgets;
- Provide HR training and an orientation on current HR policies for the Finance Assistant; also ensure that she receives additional training in computer programs for HR administration so that she can effectively respond to her newly assigned additional roles; ensure that the Country Office Finance Officer provides the performance review (well overdue) for the Finance Assistant before the end of August;

7.4 Recommendations for MOH Collaboration

CSB Level:

- Work with the CSB to develop and implement a realistic plan for reinforcing the viability of the COSAN & CASC in each of the project's target villages; finalize and implement the plan for phase-over of certain project aspects to the COSAN and CASC;
- Determine if in some communes the CASC committee members can advocate for funds from the Commune/Mayoral level to contribute to occasional incentives for the CHA/TBAs;
- Explore with the CASC and COSAN their role in helping the CHAs and TBAs to develop health related income generating activities as a way to continue their motivation in health activities;
- Strategize with CSB heads (who are particularly dynamic) ways to encourage other CSB heads to own the compilation and analysis for decision-making of CHA & TBA reports;
- Use role model CSB heads to motivate others (COPE, IMCI, etc.)

SSD Level:

- Hold a joint planning meeting to determine best approaches for:
 - Continuing to expand the partnership vision;
 - Improving the joint team spirit (team building session with the SSD)
 - Strengthening efforts to integrate planning of joint supervision and other activities (development of joint activities calendar);
 - Mobilizing local authorities- mayors, etc., to convince them to actively engage themselves in overcoming challenges, (consider reflecting on and replicating positive experiences such as joint advocacy efforts w/ mayors from VVT)
 - Increase direct involvement of SSDs in the collection and analysis of project/CSB related data
- Distribute copies of the work plan, sustainability plan, M & E plan, and other key elements of the DIP to SSD team; provide copies of most recent annual and quarterly reports and continue to provide copies of key future planning and reporting documents (in French, if available);
- Develop a list of needed items to improve quality of CSB service delivery (vacuum extractor, toase scale, neonatal aspirator, laboratory supplies, etc.) and submit to ADRA HQ to determine if an additional donation can be made;
- Provide SSDs with reports of technical activities within 2-4 week period; include spending amounts on each training activity so that SSDs can include in their MOH PTA (Annual work plan) reports
- Increase investment (time and financial support) in M & E (work with SSD to determine the shape this additional investment should take)

- Follow-up on the SSD wish list (presented during the July 20th debriefing meeting) being transparent early-on regarding which items the project may be able to transfer to the SSD, such as computer equipment;
- Plan and conduct a joint annual recreation day to celebrate successes; engage in regular joint mixers, such as sports events and continue to participate in monthly clean-up the area day (ensure that both SSD and ASAP staff are in complete agreement on the dates for these events);

Central MOH Level:

- Invite some of the central Maternal and Child Health team members who have not been to the project site, to visit the project (Drs. Bako and Clarisse); provide them with several months of advance notice;
- Provide suggestions to MOH as to how the MOH collaborate better with ASAP;
- Provide relevant information to Dr. Olga, Dr. Gertrude, and other MOH team members who were involved in the training of TBAs as to the follow-up for TBAs- including the impact of their activities (i.e. their progress on referrals, clean births, how well they remember the danger signs);
- If additional TA is needed from the MOH, ASAP needs to submit the request 2-3 months in advance

7.5 Recommendations for Mission/PVO Collaboration

- ADRA should explore opportunities to improve its dissemination of information and success story telling to enable other PVO's to learn from its successes and challenges; they should focus on ways to share their successes in working with the public sector and in improving linkages between field agents and health centers;

8.0 Results Highlight

The project's three primary results-based objectives are:

- Improved community- and facility-based Integrated Management of Childhood Illnesses
- Improved community-based maternal and newborn care/child spacing and
- Increased capacity building for Tamatave II and VVT District Health Systems

The principle results of this project are:

- Increased ITN use for children < 24 months
- Increased number of births of children < 24 months that were attended by a trained health person
- Improved care-seeking behaviors for ARI
- DPT drop-outs reduced
- Increased use of modern contraceptive methods

9.0 Response to Findings by PVO and Action Plan

Evaluation Follow-up Form					
Project Title / Agreement Number		Child Survival Project			
Country		Madagascar			
Date of Evaluation		July, 2006			
Nº	Evaluation Recommendation	Action to respond to the recommendation	Expected Results of the action	Date when the action will be implemented	Responsible person for implementing the action
IMCI	a) Technical Areas : <i>Malaria</i>				
1	Work with the CSBs to: 1) determine if they understand the role of the CHAs in selling nets; 2) help reduce the barriers preventing some of the CSB heads from supporting the CHAs in this activity; 3) ensure that CSB heads understand exactly how to reorder stock;	ASAP's field technical staff will re-emphasise the main purpose of social marketing program and differentiate the role of the CHAs in relation to CSBs. At the same time he will address item number 2 and 3. This will happen during ASAP/SSD/CSP monthly or bi-monthly meeting	<ul style="list-style-type: none"> - CHA role in nets selling has been differentiated and is clear to CSB heads. - Ties between CHAs and CSB heads are strengthened - CSB heads know well how to make orders. 	Periodic review with SSD/CSB <ul style="list-style-type: none"> - Nov 10 and 11, 2006 for VVT - Nov 6 and 7 for TMM II 	Fredo
2	Improve ITN distribution by ensuring that bottlenecks in the distribution chain do not reoccur. They should order stock in advance and if possible, provide for a one month advance order to be distributed to the CHAs, rather than depending on PSI's stock on an order to order basis;	ASAP will negotiate with PSI and come up with a regular schedule every quarter to avoid stock out. Occasionally there are country-wide stockouts of ITNs, ADRA will try to build a buffer against these stockouts, but occasionally they cannot be avoided.	Schedule for Nets orders is available	October 2006	Fredo
3	Continue working with and recruit additional TBAs to sell ITNs since many of them are located in areas where women have limited access to health facilities.	Depending on training budget, ASAP plans additional 100 TBAs and in relation to that, ASAP is ordering more kits and working material for TBAs. The project considers also working with COSAN members who are basically located in every village	<ul style="list-style-type: none"> - At least 100 new TBAs recruited and trained - TBAs are part of social marketing of nets 		Gerard

4	Facilitate CHAs and TBAs in the formulation of associations which can be supplied directly by PSI after EOP;	ASAP is scaling up the step taken of creating village (Fonkotany) Associations composed of COSAN, CHAs and TBAs. These will be introduced to PSI for further collaboration beyond EOP.	At least 50 community associations are created and are functional and well documented.	From October 2006 to March 2007	Fredo
5	Continue to work with CHAs and TBAs to encourage them to focus their messages so that women come at the appropriate times for ANC visits. During these promotional sessions, CHAs and TBAs need to inform mothers of their right to and the importance of receiving IPT during the 2 nd and 3 rd trimesters of their pregnancy;	ASAP will emphasize the issue of encouragement to women for ANC visits and their right to IPT during refresher courses during the following year.	ANC and IPT themes are part of every community sensitization and monthly broad casting programs. The same themes are part of refresher curriculum.	October 2006 onward ...	Ladyslas
6	Intensify efforts via the CHAs and TBAs to encourage mothers to bring their baby in to the CSB during a febrile episode, to strengthen the community-based distribution of anti-malarials, to help mothers reduce barriers to providing their child with complete doses of anti-malarials; and	ASAP will continue its radio broad casting program including the importance of early treatment for children with febrile episode. Also, this issue will be emphasized during refresher courses. ASAP will also discuss with SSD and CSBs regarding pre-packed anti-malarials community distribution	Increased number of mothers with children < 24 months who visit CSB during a febrile episode. CHAs distribute actively the anti-malarial tablets in their respective villages	Beginning December 2006	Raymond
7	Define and address barriers to consistent IMCI use (see Capacity Building below)	During radio program, ASAP will also discuss some of the identified barriers and possible ways to address them. Such topic will also be ASAP's Top priority during community fairs through "Community Dialogue" (CD) or in French language "Dialogue Communautaire"(DC)	- CHAs take the lead during open dialogue in the community. - Open forums are regularly held in the communities where barriers are discussed and solution to overcome are discussed together with community members	August 2006	Raymond
	<i>b) Technical Areas : Immunization</i>				
8	Investigate immediately the CATCH indicators with mid-term values that show deterioration of the public health system, such as the	Introduce Rapid Result Initiative (RRI) in Immunization mostly within areas identified as low in immunization coverage such as VVT commune. ASAP plans to motivate more schools	EPI program realized in many areas of VVT More school children involved in visa 5/5 More children are immunized	Starting November 2006	Tantely

	that there is indeed a significant drop in these indicators, they should discuss with the SSDs and CSBs the most appropriate interventions to reverse the declining trends and increase progress towards achieving targets;		complementary feeding and vitamin A distribution Increased rate of mothers giving more fluid during diarrheal episodes		
12	Project staff, CSB heads, CHAs and TBAs should discuss how to focus their efforts on not only reinforcing the messages regarding immediate and exclusive breast feeding, but also consider identifying successful positive deviant "EBF moms" and helping these mothers form mothers' support groups to help other moms become successful EBF moms;	The issue of positive deviance was discussed during the MTE exit meeting and will be our focus during every other joint meeting held with government and community partners. ASAP is also introducing the Appreciative Inquiry in its strategic planning with SSD/CSBs not only in EBF but also in other areas of intervention.	<ul style="list-style-type: none"> - Spots with positive deviant available - Concept well understood by community health workers, including CSB heads, TBAs/CHAs 	End of October 2006	Sylvain
13	CHAs and TBAs should increase focus on one-on-one counseling during their home visits to help mothers identify and reinforce positive motivators while breaking down barriers to EBF;	Items like the previous points to be underlined during CSB/TBAs refresher courses.	- Availability of spots targeting barriers to EBF	Beginning October 2006	Sylvain
14	In addition, ADRA staff and CSB heads should reflect on what has been done differently in VVT in terms of immediate breastfeeding and attempt to replicate this in TMM II;	ASAP proposes an exchange visit between SSDs, which will serve as a learning experience from each one another. This will be the second time during the life of ASAP. ASAP will also increase collaboration with other USAID funded CS programs such as MCDI in south of Madagascar for exchange of the best practices. We will also explore possibilities for possible exchange visit with MCDI.	<ul style="list-style-type: none"> - One exchange visit has taken place - Good practices learned are implemented in TMM II 	Septemebr 2006	Lila
15	Work with the SSDs to help them to gradually take responsibility for holding nutrition days; this includes working with the MOH partners to	Since this is an activity which SSD has been doing through other nutrition partners under a group known locally as Group d'Action Inter-sectorielle en Nutrition de Toamasina, ((GAIN(T))	Close work relationship between MOH partners and other stakeholders in nutrition in planning and organizing community fairs on nutrition	October 2006 April 2007 May 2007 June 2007	Raymond

	advocate for budget allocations to be assigned for this activity;	or "Toamasina Intersectoral Nutrition Coordination Group"			
	d) Technical Areas : <i>Control of Diarrheal Disease</i>				
16	Investigate immediately the declining indicators regarding diarrheal disease;	The same issue as mentioned in item '10' above	Increased coverage rate of breastfeeding, complementary feeding and vitamin A distribution Increased rate of mothers giving more fluid during diarrheal episodes	Starting November 2006 onward.	Parfait
17	If ADRA staff conclude that the data is accurate, they should discuss with the SSDs and CSBs, the most appropriate interventions to reverse the declining trend and increase progress towards achieving targets;	The same issue as mentioned in item '10' above	Increased coverage rate of breastfeeding, complementary feeding and vitamin A distribution Increased rate of mothers giving more fluid during diarrheal episodes	Starting November 2006 onward.	Parfait
18	Focus promotional efforts on the linkages between EBF and reducing the incidence of diarrheal disease (only one of the CHAs interviewed mentioned EBF as a way to prevent diarrheal disease). This could be accomplished by, as suggested under the Nutrition section above, helping positive deviant mothers to form BF support groups in which they can provide one-on-one counselling, thus addressing the most significant barriers to behaviour change in this area;	The linkage between EBF and diarrhia will be discussed during refresher courses of the community partners (CHAs and COSAN). As mentioned above on nutrition indicator, Diarrhoea will also discussed during radio programs	Mothers know the linkage between EBF and diarrhoea to the extent of preferring to exclusively breastfeed to avoid diarrhoea. Women give more fluid during	Starting November 2006 onward.	Raymond
19	ASAP and its SSD counterparts need to advocate with the MOH for approval of zinc use to reduce diarrhoeal disease, the severity and frequency of episodes. Currently zinc is not available in any of the project intervention areas;	ASAP will negotiate with the MOH and the USAID local mission for possibilities to include MMII and VVT in Zinc Project.	Reduced diarrhoea cases within the two districts	Starting January 2007 onward.	Mitch

	however, ASAP is studying potential avenues/opportunities for its approval.				
	e) Technical Areas: <i>Acute Respiratory Infections</i>				
20	ADRA and SSD/CSB colleagues should reflect on what has made this aspect of the program so successful and continue to replicate and reinforce these interventions;	Recommendation well taken.	Maintained high coverage of mothers who know danger signs for Acute Respiratory Infections	On going monitoring	Parfait
MNC	Technical Areas : <i>Maternal and Newborn Care</i>				
21	Project staff need to collaborate with SSD/CSB staff, CHAs, and TBAs to identify and implement activities which will focus directly on increasing rates of complete TT immunizations and seizing opportunities for iron distribution.	<ul style="list-style-type: none"> - ASAP will increase the search of the drop outs from ANC program through the CHAs and TBAs - Involve CHAs in all EPI (both local and national campaigns) - Reward best CHAs for better performance. 	<ul style="list-style-type: none"> - Increased number of ANC - CHAs are have become an integral part of EPI 	Beginning October 2006, onward	Ladyslas
22	Project partners also need to reinforce key related messages at the community level;	Creation of new /convincing radio spots involving local authorities and key opinion leaders.	Availability of new convincing spots involving opinion leaders	First week of October 2006	Sylvain
23	Regarding emergency preparedness plans, transportation schemes, staff have begun to improve their data collection in this area.	Strengthen community structures (COSAN/CASC) to be more functional in terms of creation of a functional plan for emergency transport	<ul style="list-style-type: none"> - COSAN/CASC are functional - 80 % of the communities have a emergency preparedness plan. 	Mid October 2006	Jean de Dieu
24	Once accurate data has been collected, staff should decide whether the barriers to implementing behaviour change regarding BPP are so significant as to make the potential benefits of intensifying efforts within the remaining project period, non cost-effective.	Organize a staff capacity building seminar in monitoring and evaluation process (survey method, data analysis, data interpretation, communication of results and decision making)	<ul style="list-style-type: none"> - ASAP staff are capable of collecting valid and quality data - Data is well analyzed interpreted and communicated to stakeholders 	January 2007	Parfait & Country Office M&E Coordinator
25	Regarding transportation schemes and the	Budget cross-visits between COSAN/CASC to neighbouring	<ul style="list-style-type: none"> - Raised awareness between 	Starting from November 2006	Sylvain

	<p>construction of maternity waiting houses, the project staff should conduct an informal survey to determine the impact of these two efforts on increasing CSB births in the communities in question. If the impact has been substantial, then ASAP may want to consider facilitating cross-visits of those COSAN/CASC members involved with these projects to other nearby communities;</p>	<p>communities to learn or share their experience.</p>	<p>COSAN from different communities.</p> <ul style="list-style-type: none"> - A common understanding on the impact of waiting house at CSB level 		
26	<p>Reporting continues to be a challenge for non-literate TBAs, and thus the project staff has developed and are piloting a new pictorial system of reporting using a cloth diagram with pockets representing different types of activities. The TBA will place small pebbles in the pockets to keep track of the number of home visits, community group discussions, assisted births, etc. As soon as the pilot phase has been completed, if the results are positive, ASAP should accelerate introduction of this method into all communities where TBAs have been trained;</p>	<p>Complete the distribution of the new pictorial reporting system.</p>	<ul style="list-style-type: none"> - Increased percentage of TBA monthly reports - Improved relationship between CSBs and TBAs 	<p>Starting October 2006 for 3 months.</p>	Lila
27	<p>Project staff and CSB heads need to continue encouraging and supporting TBAs in their efforts to train other TBAs in adjacent villages who have not yet been trained by the project. ASAP staff also need to work with CSB heads and COSAN members to develop a concrete transition plan for</p>	<p>Almost a hundred additional TBAs will be recruited and trained to join the 293 existing ones. Also as mentioned above, ASAP will surely work with CSB heads and COSAN members to put up a plan for continuity beyond the project life.</p>	<ul style="list-style-type: none"> - Improved relationship with local communities - Increased capacity building in the community leading to self-governance. 	<p>Starting for January 2007 onward</p>	Ladyslas

	ensuring that refresher training continues for TBAs after the project ends.				
	2. CROSS-CUTTING AREAS				
	a)Community Mobilization				
28	To further contribute to the sustainability of project results, the project will need to transition away from the current system in which many of the CSB heads rely on ASAP staff visits to hold follow-up support and supervision meetings to one in which the CSBs have full responsibility for implementing regular monthly meetings and providing deliberate facilitative supervision and on-going support to the CHAs and TBAs;	ASAP will discuss with SSD administration in order to sell the idea of project ownership. First of all CSBs need to appreciate the greater help brought about by the existence of CHAs/TBAs, then only they can better supervise/work with them	<ul style="list-style-type: none"> - SSD/CSB and local authorities take the lead in implementing project activities - CSBs appreciate the important role of CHAs as partners in development. - CSBs are delighted to supervise the work of CHAs/TBAs 	Starting January to March 2007 November 2006	Lila
29	Project staff and SSD/CSB colleagues need to hold a planning meeting to discuss how the mobile community sensitisation strategy will be gradually transitioned to local stakeholders as part of the phase out strategy;	Same as above	<ul style="list-style-type: none"> - Joint planning with CSB/SSD - CSB/SSD plan themselves their activities and implement them with out difficulties 	November, February and May 2007	Lila
30	Work closely and intensively with the CSBs and the local leaders to adequately reinforce the COSAN in certain communities where the members have not been active stakeholders in the project;	ASAP will meet with SSD to plan courtesy call to several communities for the purpose of reviving and involving local leaders to take community lives in their hands.	<ul style="list-style-type: none"> - COSAN committee members are functional and recognize their role and responsibilities - Local authorities and health institutions work closely with COSAN 	Starting September 2006	Sylvain
	b) Communication for Behaviour Change				
31	Increase efforts and strategically direct activities to transform community norms in areas that have not	The best strategy proposed by the team is negotiation with key persons (local opinion leaders like government representatives,	Opinion leaders participate actively in every organized fair to raise community awareness	Starting October 2006	Ladyslas

	seen sufficient progress, such as BPPs and breastfeeding, etc.	community leaders religious authorities),... to participate in every activity			
32	Conduct a listeners' survey to further investigate the utility and cost-effectiveness of this project component. The survey should focus on whether the radio programs have contributed towards concrete changes in the community;	Identify a qualified consultant and conduct a study on radio listening habits and understanding.	<ul style="list-style-type: none"> - Result of the study available and well documented. - Impact of radio messages appreciated 	Starting January – March 2007	Ladyslas
33	Explore whether CHAs and TBAs can better seize “teachable moments” to provide small group health informational and skills-building sessions. These CHAs and TBAs should explore identification of positive deviants during these sessions and recruit them to form mother's peer support groups (for EBF, for example).	Emphasize the new approach during monthly meetings with SSD/CSBs and refresher courses	<ul style="list-style-type: none"> - Functional womens'groups - Regular exchange of experience - Easy communication between community and health centers 	Starting from October 2006 onward.	Sylvain
34	Distribute copies of the IEC brochures to the health centers and engage the CHAs in monitoring their distribution and re-supply. The project should consider printing a large quantity of the materials, a portion of which would then remain with the SSDs for distribution to the CSBs and with the COSAN members for distribution to the CHAs;	Set a side budget for the printing of the additional IEC material	IEC printed materials are available at the level of SSD/CSBs	End of March, 2007	Sylvain
35	Develop, distribute and orient colleagues in the use of a simple inventory form indicating which materials are currently being used/available/need re-supply with the CHAs, TBAs and at the CSBs;	Well noted. Currently, this activity is being done by project Field technicians during supervision time.	An inventory form is available at the level of CSBs	End of January, 2007	Lila
36	Field technicians, CSB staff and others	Discuss possibilities of adding a column on the	A new report form with an additional column is	End of October 2006	Raymond

	involved in supervision should add a column to their monthly reports to include distribution numbers of IEC materials per target group member and perceived and demonstrated benefit/impact of each type of IEC/BCC material and intervention.	monthly report number of IEC distributed keeping in mind the assessment of benefit/impact if at all for each type of IEC/BCC material.	available to CSB heads and is being used by CHAs		
37	CHAs and TBAs should report on the perceived impact of each type of behaviour change activity conducted; this could be done in an informal way during regular follow-up support meetings at the health centers, but would contribute to an increased tendency towards reflection regarding the quality (and outcome or impact) and not the quantity of their BCC activities;	This is in line with the above approach. ASAP will reinforce the discussion during supervision period	Formal discussion held during supervision visits and periodic refresher courses	On going starting September 2006	Raymond
	c) Capacity Building Approach				
39	Work closely with the CSB heads to reduce barriers to consistent use of IMCI protocols. Project staff may consider on-the-job refresher training in IMCI protocol use, redistributing some of the training materials, such as the algorithms and IMCI case forms, and working with some of the CSB heads who have been more successful in applying the protocols to learn how these positive deviants are managing and inviting them to participate in on-the-job cross visit/training sessions;	<ul style="list-style-type: none"> - Plan an exchange visit under the same framework - Conduct an on-job refresher trainings in IMCI - Algorithm distribute to needing CSB heads 	<ul style="list-style-type: none"> - Documented exchange visit - CSBs follow protocol for improved services. - Improved performance among CSB staffs. 	<p>March 2007</p> <p>November 2006 February 2007 and May</p>	Sylvain
40	Support the CSB heads from those clinics where COPE	Engage in discussion with SSD ways to introduce COPE in all	CSBs are able to assess their performance and to decide for improving of	December 06, February, April, and June 2007	Sylvain

	has been applied in conducting cross-visits or in hosting COPE refresher sessions at their own clinics whereby those who have yet to apply the process will participate and sign mentoring contracts which encourage them to conduct COPE sessions in their own facilities within a specific time period;	CSBs through cross-visits and supervision	service provision		
41	Continue to collaborate with the CSB heads to ensure that the support provided to TBAs and CHAs is fully transitioned over to the CSB heads so that the successfully evolving partnership between the CSBs and the TBAs/CHAs continues to flourish;	Encourage CSBs to organize more supervised monthly meetings of CHAs/TBAs and COSAN	Refresher courses are organized and held by CSBs, COSAN are coordinated/supported and supervised by CSBs	October 2006 January 2007	Raymond Jean de Dieu
42	Focus greater attention on ensuring that SSD and CSB (especially during regularly scheduled follow-on meetings) offer an opportunity for systematic and sustainable technical reinforcement and refresher training to the CHAs and TBAs.	Same approach as above. Encourage CSBs to organize more supervised monthly meetings of CHAs/TBAs and COSAN	Strategically planned activities for refresher of CHAs extended to all CSBs	Ongoing activity	Ladyslas
43	Take measures to ensure the cost-effectiveness of training opportunities during the final period of the project. For example, if one person or two individuals need refresher training in a certain area, say IMCI, then every attempt should be made to identify a peer colleague who is competent and willing to provide on the job training with support from ADRA and/or SSD staff members. Ultimately, these	Strengthen ability of CSBs and support them in preparing and conducting refresher training for CHAs/TBAs		Starting September 2006	

	SSD and CSB colleagues should begin to identify their colleagues who can mentor them in certain areas, thus providing better opportunities for sustainability of refresher training at EOP;				
44	The approach of focusing on one topic during a certain period, for message reinforcement, such as vaccinations or EBF/nutrition should be continued by the SSDs/CSBs;	This approach will be encouraged as the project "transfers ownership."	Messages easily retained and remembered	On going	Ladyslas
45	Consider promoting the "mini-module" approach to regular technical refresher updates during monthly follow-up meetings at the CSBs; staff should take the opportunity to assess its effectiveness during the final project period;	This approach will be encouraged as the project "transfers ownership."	A mini-module for regular training/refresher is available	December 2006	Sylvain
46	Provide English language courses to both SSD staff and project staff;	Set aside a time table and budget for training	Improved English communication of ASAP / SSD personnel	January – March 2007	Lila
	d) Sustainability Strategy				
47	Measure project progress towards sustainability indicators in each dimension and work together with SSD/CSBs to identify ways to increase progress, if necessary;	<ul style="list-style-type: none"> - Refresh ASAP staffs on sustainability (Ruth / Dina from ADRA HQ) - Organize and hold a sustainability strategic meeting with stakeholders - Courtesy call to Authorities for negotiation on ways to sustain the changed behavior - Emphasize the role and responsibility of CASC and COSAN 	<ul style="list-style-type: none"> - Clear understanding of sustainability indicators among project staffs - Stakeholders and ADRA appreciate working together - Local authorities find solutions for the health of their communities - COSAN more involved in the health of the respective communities 	<p>February 2007</p> <p>Starting from October 2006</p> <p>Starting from October 2006</p> <p>Starting from October 2006</p>	Lila
48	Refine and implement phase-over plan with COSAN;	Plan and meet with districts and communal authorities to hand over their support and supervision	Districts and communal authorities are fully in charge of the work of COSAN	October –November 2006	Jean de Dieu

49	Hold creative strategy session with COSAN and CASC members to brainstorm resource development strategies; develop and implement an action plan to provide financial support to ensure that the gains from the project continue in the right direction; consider helping COSAN and CASC committees identify students to work in collaboration with trained CSB heads on proposal development;	Conduct more studies and develop new strategies to solve community problems according to priority.	CASC / COSAN remain functional	Starting October 2006 onward	Jean de Dieu
50	Identify alternate sources of funding for non-AID related needs and put CSB heads in touch with these resources; encourage them to develop and submit simple concept papers for the highest priority needs, such as solar panels, water projects, etc.	Encourage trained CSBs to conceive and write proposals for funding purposes.	CSBs make proposals for funding purposes	Starting December 2006	Ladyslas
	3. Recommendations for Program Management				
51	For those indicators which were set unrealistically high at the time of the DIP, ASAP should, in collaboration with their SSD colleagues, consider revising the EOP targets to make them more in-line with what the SSD feels is realistic for the remaining project period;	Recommendation well taken. ASAP will organize a meeting with SSDs representatives to discuss indicators. The result will be presented to USAID for approval.	Realistic and attainable objectives are agreed upon.	October 2006	Parfait
52	Consider purchasing additional computers for the final period of the project; make sure that future project design (for all ADRA projects) includes sufficient line item amounts for re-purchase of computers if the project location is in a humid area;	<ul style="list-style-type: none"> - The budget line for this equipment is spent, excepting a budget modification, no additional computers can be purchased for this project. - Repair the one desktop, which is out of order to make it 	All project staff currently have access to computers at the office to complete their respective tasks. Bottlenecks do happen, but are rare. It is not necessary for each staff member to have his/her own computer.	Starting October 2006	Josué

		functional.			
53	ADRA country office staff and the ASAP team should strategize and identify new ways to motivate staff during the final project period; (suggestions: provide English lessons, increase training and capacity-building opportunities, especially according to the requests made for additional project-related training- see Annex X- Compilation of Responses -Staff Interviews, provide rain/cold weather gear, such as rain jackets and rain boots for those who make site visits);	<ul style="list-style-type: none"> - Plan and budget for at least a 3 months Basic English course. - Consider providing more training according to the need of every particular staff as indicated in Annex X. - As per ADRA Madagascar policy, appropriate staff members will receive an "outfitting allowance" depending on their job description. 	<ul style="list-style-type: none"> - Staff are motivated - Improved competence among project staff - Improved performance 	December 2006	Rivo
54	As soon as possible, representatives from the Country Office should present possibilities for staff who are open to transfer to another project at EOP; this should be communicated directly and expediently with ASAP staff;	This has been completed.	Job security and settled mind	Done	Mitch
55	ADRA Country Office managers should consider revisiting the per diem and salary scales for ADRA project staff to determine how they now compare to other organizations' scales and if it is possible to raise these to be on the same par with other similar PVOs operating in the same project areas;	<ul style="list-style-type: none"> - ADRA Madagascar is committed to reviewing its rate of per diem applied within project site visits. - ADRA's salary grid has been revised and was implemented on Oct. 1, 2006 	<p>Revised "in region" per diem policy</p> <p>New/revised salary grid</p>	<p>December 2006</p> <p>Done</p>	<p>Hery</p> <p>Hery</p>
56	Work with the finance team at the Country Office and ASAP Finance Assistant to streamline financial mechanisms (especially regarding the expedient release of budget allocations for	<ul style="list-style-type: none"> - Financial administrator will make sure ASAP's quarterly budget is done in their presence (on project site) - Assure that documented 	<p>Reasonable budget are proposed</p> <p>Budget approved on time</p>	November 2006– January 2007	Lalaina

	activities which may be planned or changed after the quarterly planning report has been submitted); provide additional on-site assistance from the Country Office to the project team for budget procedures so that staff are more adept at submitting correct and timely budgets;	<p>budget approval is received within two weeks after plan and budget meeting</p> <ul style="list-style-type: none"> - Empower ASAP's financial assistant and allow her a limited power to sign checks of approved budgets up to a certain specific amount. - Invite ASAP's financial backstop or country office financial administrator to empower project staff on appropriate use and allocation/reallocation of line budgets (Bob/Hery) 	<p>No longer delay in planned/ approved activity</p> <p>Easy and appropriate allocation and reallocation of budgets</p>		
57	Provide HR training and an orientation on current HR policies for the Finance Assistant; also ensure that she receives additional training in computer programs for HR administration so that she can effectively respond to her newly assigned additional roles; ensure that the Country Office Finance Officer provides the performance review (well overdue) for the Finance Assistant before the end of August;	Recommendation well taken	<p>ASAP's Financial Assistant competent with computer program in HR administration</p> <p>Performance evaluation has been done</p>	<p>Complete</p> <p>Complete</p>	Lalaina
	4. Recommendations for MOH Collaboration				
58	<p>CSB Level:</p> <p>Work with the CSB to develop and implement a realistic plan for reinforcing the viability of the COSAN & CASC in each of the project's target villages; finalize and implement the plan</p>	ASAP will make sure CSBs understand their role in COSAN/CASC viability for sustainability of project activities during monthly or quarterly meetings with SSD/CSBs	CSB heads take the lead in project interventions supervising COSAN/CHA/TBA	February 2007 onward	Jean de Dieu

	for phase-over of certain project aspects to the COSAN and CASC;				
59	Determine if in some communes the CASC committee members can advocate for funds from the Commune/Mayoral level to contribute to occasional incentives for the CHA/TBAs;	ASAP will discuss the issue with mayors of communes during their monthly meetings during which they both will explore possibilities of supporting CHAs/TBAs	Local authorities have motivation strategies in place.	February 2007 onward	Jean de Dieu
60	Explore with the CASC and COSAN their role in helping the CHAs and TBAs to develop health related income generating activities as a way to continue their motivation in health activities;	ASAP plans to emphasize the role of COSAN committees as well as individual members in keeping CHAs and TBAs viable.	Viable/functional CASC/COSAN	February 2007 onward	Jean de Dieu
61	Strategize with CSB heads (who are particularly dynamic) ways to encourage other CSB heads to own the compilation and analysis for decision-making of CHA & TBA reports;	Consult with selected dynamic CSB to study together ways to arrive at the decision to compile and use of CHAs' report	CSB heads make use of community reported data, collected by CHAs and TBAs	January, 2007 onward	Lila
	Use role model CSB heads to motivate others (COPE, IMCI, etc.)	Encourage cross visits among CSBs performing and non-performing.	There is a cross visit between CSBs	March, 2007 onward	Parfait
	<u>SSD Level:</u> Hold a joint planning meeting to determine best approaches for:				
62	Continuing to expand the partnership vision;	Recommendation well taken	Sustainable strong partnership between stakeholders	Starting from August, 2006	Parfait
63	Improving the joint team spirit (team building session with the SSD)	Organize and hold social activities together with SSD	Healthy working relationship	Starting December, 2006 onward	Lila
64	Strengthening efforts to integrate planning of joint supervision and other activities (development of joint activities calendar);	Coordinate joint meetings for feedbacks and future plans.	Improved performance	Starting October, 2006 onward	Parfait
65	Mobilizing local authorities- mayors, etc., to convince them to actively engage themselves in overcoming	Plan more attendance to mayors' monthly meetings to learn and share experiences, particularly to disseminate survey	Increased team spirit among stakeholders	Starting October, 2006	Sylvain

	challenges, (consider reflecting on and replicating positive experiences such as joint advocacy efforts w/ mayors from VVT)	results and success stories.			
66	Increase direct involvement of SSDs in the collection and analysis of project/CSB related data	ASAP will involve selected CSBs in data collection and analysis during the next LQAS surveys	Appropriation of survey results.	March, 2007	Parfait
67	Distribute copies of the work plan, sustainability plan, M & E plan, and other key elements of the DIP to SSD team; provide copies of most recent annual and quarterly reports and continue to provide copies of key future planning and reporting documents (in French, if available);	Reports are done in English since the recipient is USAID. Annual reports will be shared, but quarterly reports are internal documents.	Improved communication leading to greater cooperation between ASAP and SSD	Starting October, 2006	Parfait
68	Develop a list of needed items to improve quality of CSB service delivery (vacuum extractor, toase scale, neonatal aspirator, laboratory supplies, etc.) and submit to ADRA HQ to determine if an additional donation can be made;	If a container is coming over from the US, non-exhaustable supplies will be requested according to CSB need.	Improved quality of services at CSB level	November, 2006	Rivo
69	Provide SSDs with reports of technical activities within 2-4 week period; include spending amounts on each training activity so that SSDs can include in their MOH PTA (Annual work plan) reports	Recommendation well taken	Improved communication and greater understanding of the project > Healthy Cooperation	October, 2006	Parfait
70	Increase investment (time and financial support) in M & E (work with SSD to determine the shape this additional investment should take)	Every effort will be made to accommodate this recommendation within existing budget lines.	Increased monitoring and achieved objectives	Starting November, 2006	Parfait
71	Follow-up on the SSD wish list (presented during the July 20 th debriefing meeting) being transparent early-on regarding which items the project may be able to transfer to the	ASAP will encourage and accept the wish list from by SSD and will study which equipment /material could be passed on to SSD at the close of the Project.	Selected material equipment to be donated are ready	November, 2006	Rivo

	SSD, such as computer equipment;				
72	Plan and conduct a joint annual recreation day to celebrate successes; engage in regular joint mixers, such as sports events and continue to participate in monthly clean-up the area day (ensure that both SSD and ASAP staff are in complete agreement on the dates for these events);	An annual event will be planned where the annual report will be shared with the SSD staff. Following the meeting, a lunch or similar event can occur.	Strong team spirit build between SSD and ASAP	April, 2007	Lila
73	<u>Central MOH Level:</u> Invite some of the central Maternal and Child Health team members who have not been to the project site, to visit the project (Drs. Bako and Clarisse); provide them with several months of advance notice;	Such visit, also including USAID staff, and members of UNICEF is being planned.	<ul style="list-style-type: none"> - Better picture, greater understanding of field activities. - Increased support of project activities 	Between January – March, 2007	Josué
74	Provide suggestions to the MOH as to how the MOH can collaborate better with ASAP;	ASAP will plan an open forum for discussion	Mutual collaboration between ASAP and MOH	February, 2007	Josué
75	Provide relevant information to Dr. Olga, Dr. Gertrude, and other MOH team members who were involved in the training of TBAs as to the follow-up for TBAs- including the impact of their activities (i.e. their progress on referrals, clean births, how well they remember the danger signs);	ASAP will compile appropriate information, which will be forwarded to Dr Olga and team members.	<ul style="list-style-type: none"> - Information compiled and forwarded to MOH - Greater understanding and - Appreciation of project accomplishment 	November, 2006	Gerard
76	If additional TA is needed from the MOH, ASAP needs to submit the request 2-3 months in advance	Recommendation well taken	Improved performance	Starting October, 2006	Parfait
	5. Recommendations for Mission/PVO Collaboration				
77	ADRA should explore opportunities to improve its dissemination of	<ul style="list-style-type: none"> - ASAP will refresh its staff on information dissemination process 	<p>Every report contains a success story</p> <p>Shared experience and good practices learned</p>	Starting September, 2006	Parfait

	<p>information and success story telling to enable other PVO's to learn from its successes and challenges; they should focus on ways to share their successes in working with the public sector and in improving linkages between field agents and health centers;</p>	<ul style="list-style-type: none"> - ASAP will share success stories - ASAP will strengthen the working relationship between health centers and field agents for appropriate supervision 			
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APPENDICES

Appendix 10.1:

SCOPE OF WORK FOR MID-TERM EVALUATION

**ADRA MADAGASCAR CHILD SURVIVAL PROJECT XVIII
GHS-A-00-03-00008**

July 2006

**EVALAUTION DEPARTMENT
INTERNAL CONTROL AND COMPLIANCE BUREAU
12501 OLD COLUMBIA PIKE
SILVER SRPING, MD 20904**

SCOPE OF WORK FOR MID-TERM EVALUATION
ADRA MADAGASCAR CHILD SURVIVAL PROJECT XVIII
GHS-A-00-03-00008

July 2006

I. INTRODUCTION

In August 2003, the Adventist Development and Relief Agency (ADRA) and United States Agency for International Development (USAID) signed a Cooperative Agreement for the ANKOHONANA SALAMA Child Survival (CS) project.² With a total funding of \$1,498,673, the project is under implementation. It is expected that project implementation will be completed in September 2007.

The project is located in Toamasina II (TMM II) District and Vavatenina, the district bordering the northwest “corner” of the current project area. Both are in Toamasina Province, in the central east coast region of Madagascar. The following sections describe the scope of work for the mid-term evaluation (MTE) of this project being scheduled for July 2006.

II. THE PURPOSE OF EVALUATION

The primary purpose of the mid-term evaluation is to assist ADRA in assessing the project’s effectiveness and efficiency. It also aims at identifying lessons learnt, best practices and innovative ways that would eventually help attain the ultimate success of the Child Survival Project. By carrying out the mid-term evaluation, ADRA will comply with the requirement of the Cooperative Agreement under section A.5.2.c.

² ANKOHONANA means family, and SALAMA means healthy. ASA means “work” in Malagasy. Thus, the new project will be the ASA Project (ASAP).

Furthermore, the mid-term evaluation of the project is expected to present objective assessment to enable informed management decision making on future direction and improve project performance. By identifying what is working well and what is not; the mid term evaluation will layout areas that need further monitoring and action; and recommend means of ensuring the achievement of the goals and objectives. The mid-term evaluation provides an opportunity for the project management team to examine the project's performance more closely, learn community views on sustainability of the project activities, and familiarize partners, key local health and development professionals with the evaluation outcomes.

III. PROGRAM GOALS AND OBJECTIVES

Project Goal: Improved health for children under five and women of reproductive age in Toamasina II and Vavatenina Districts, Toamasina Province, eastern Madagascar.

Results Based Objectives:

- Community-based IMCI
- Improved prevention and treatment of malaria among children <24 months & pregnant women.
- Increased complete immunization coverage for children < 1 year of age.
- Improved nutritional status of children <5 years of age.
- Improved home management and care seeking for children with diarrhea.
- Improved treatment of respiratory illnesses among children <24 months.
- Community-based Maternal and Newborn Care/Child Spacing
- *Maternal and Newborn Care*
- Improved maternal health care during pregnancy and delivery.
- Child Spacing and STI/HIV/AIDS prevention

- Increased use of modern methods of contraception.
- Capacity Building for Toamasina II and Vavatenina SSD/CSBs
- Improved management capacity for TMM II and VVT SSDs.
- Improved quality of service provided at all levels of the health system.

Major Strategies

Integrated community-based capacity-building approach: This strategy includes: a) continuing to provide skills and management training for CSB agents in both community- and facility-based IMCI, and the addition of a maternal and newborn care (MNC) component with BEOC training; b) C-IMCI training for all community health agents (CHA) and literate TBAs; and c) comprehensive MNC training for TBAs.

Strengthening linkages between traditional and formal health care systems: The second strategy includes: a) working with the SSDs (District Health Systems) to strengthen the CSB agents' capacity to supervise TBAs and CHAs; b) the development of an MCH referral system involving community and clinical levels; and c) integration with community-based structures (CASC and COSAN).

Collaborative capacity-building for maximum sustainability: The final strategy builds upon the previous TCSP project by: a) ensuring capacity has been built, and progressively handing over responsibilities to the TMM II SSD; b) a concomitant increase in responsibilities and capacity building interventions in VVT, based on lessons learned in TMM II; c) the continuation of the Appreciative Inquiry approach to management and capacity building in both districts.

Local Partners: The ASAP's primary local partners will be the SSDs (district health systems) for TMM II and VVT. The second important and related partners are the CSBs (community health clinics). The SSDs are responsible for

managing and overseeing the provision of health care services provided by the CSBs. ADRA will also collaborate with Population Services International, linking to provide insecticide-treated nets and other important health promotion items for community-based distribution via community health agents and traditional birth attendants.

IV. EVALUATION METHODOLOGY AND ACTIVITIES

A. Evaluation Methodology

The process of the mid-term evaluation is conceived in terms of its social-political setting. In view of this, the evaluating team should realize that the final interpretation cannot totally be free from the social and political climate of the time and the personal biases of the evaluator (s). Therefore, the evaluating team is expected to be unduly astute with its written presentation as this involves the lives of many whose welfare could be affected either positively or negatively. The team is reminded that we are social beings and as such, every assessment takes place in a given cultural, socio-economic and political context. Consequently, there may be ideas that do not make sense outside such an environment. Furthermore, this evaluation takes place in the context of two organizational cultures, ADRA and USAID. The evaluating team should keep in mind that it is undertaking a major responsibility in its attempt to make a cross-cultural references and analyses. The mid-term evaluation team will ensure that all relevant partners and stakeholders actively participate in order to ensure high quality, credibility and effectiveness of the exercise.

In line with the USAID CSHGP Guidelines, the independent consultant (Evaluation Team Leader) will take the primary responsibility for the design of the evaluation methodology. This will comprise the process of sampling, determining appropriate sample size as well site selection, development of the evaluation tool (s), and scheduling detailed time table for data and information collection.

A beneficial evaluation is a result of reliable data collection, analysis, interpretation and reporting. Collection methods may include a combination of primary sources from interviewing partners and stakeholders, general observations, and gathering information from secondary sources including the project's monitoring and reporting system. In the preparation of the final report, the mid-term evaluation team is expected to provide the reader with accurate sources of its information and conclusions. All evaluation statements must be backed by existing data and information. When this is not the case, the team is required to state its rationale for its observations and conclusions. In the event that some of the questions do not apply, the team may explain the reason (s).

B. Evaluation Activities

The evaluation activities will be implemented in accordance with the USAID CSHGP guidelines for the mid-term evaluation. All USAID funded CS projects are required to respond to the sustainability questions and issues outlined in the CSHGP Guidelines. In addition, the evaluation takes into consideration ADRA's interest in its capacity building for its CS project.

Following these guidelines and taking the program objectives, the evaluation team is expected to carry out the following activities:

First, referring to the DIP, the evaluation team will provide an external objective perspective on project's progress toward the targets and outcomes stated in the DIP as well as the potential for reaching stated objectives. The team will review project activities, processes, outputs, results and sufficiency as well as relevance of interventions (strategies) in respect of changes in health knowledge and practices of target beneficiaries. It will also look at the extent to which the recommendations set forth in the baseline survey report have been implemented.

Secondly, the evaluation team will assess whether the project is being carried out in a competent and efficient manner. This activity will encompass an examination of the technical and organizational aspects, funding allocations and resource utilization with particular emphasis on resource-activity and resource-site mix.

Thirdly, the team will also identify constraints and problems encountered so far and priorities for future actions. Furthermore, the team will identify any need for further training and technical assistance, examine the effectiveness of community participation, review the project's sustainability strategy and evaluate the adequacy of technical backstopping by ADRA/International. The team leader will identify and document lessons learnt and "best" practices on all aspects of the project's implementation.

Finally, when necessary, the team should recommend a course of action that will promote the highest quality performance for the remaining life of the project. The team leader will prepare the mid-term evaluation report for submission to ADRA/International and USAID. He/She will provide ADRA two original print-outs and electronically copies in two CDs).

V. CITIZENS PRIVACY

A. General Use of Data

ADRA/HQ considers it unethical for any member of the evaluation team to use information gathered from *unsuspecting citizens* during the evaluation assignment for anything other than the evaluation under study. Should viable reason present itself for using the information obtained for other purposes, then, ADRA/International must be consulted and prior permission secured. This must be adhered to, especially when the material is of a controversial nature and exclusively involves the private lives of the target population.

B. Distribution of the Evaluation Document

The ultimate responsibility for gathering and disseminating information from all of its regional offices around the world lies within ADRA/International. Therefore, ADRA/International expects the evaluation team, particularly hired consultant, to turnover to ADRA/International all the data and other information that were used as the basis of the team's final inferences. It is ADRA's position that no evaluation is final until it is: 1) presented to ADRA International, 2) both the consultants and ADRA International have discussed the contents in an open manner and 3) clear understandings of all conclusions and any differing views are reached between the consultant and ADRA/International as reflected in the final document.

ADRA International does not edit or change in any form or fashion the final report of the evaluation team without the Team's consent. In the event the evaluation team and ADRA remain to have a difference of opinion regarding the final report of the evaluation, ADRA distributes the document intact but will attach a letter to the report stating its own position.

VI. COMPOSITION OF THE EVALUATION TEAM

The mid term evaluation will be conducted by an Independent Consultant (Team Leader) who will be joined by Assistant Director for Evaluation at ADRA/International, ADRA Madagascar's CS Director, a community representative, a MOH representative and, if possible, local USAID Mission representative at various stages as appropriate. The team leader is expected to have a strong background in child and maternal health.

VII. DELIVERABLES

In accordance with the calendar of evaluation activities, the independent consultant will be responsible for writing and submitting the following deliverables to ADRA/International in two hard copies and electronically (CDs):

1. Draft mid-term evaluation report
2. Final mid-term evaluation report

VIII. BUDGET FOR EVALUATION

The detailed budget for the mid-term evaluation of this project will be attached to this SOW.

IX. CALENDAR OF EVALUATION ACTIVITIES

Travel to Madagascar	July 9
Draft evaluation framework by Team Leader	July 10
Meeting with ADRA/Madagascar, MOH & USAID	July 11
Evaluation visit to project sites and field office	July 12- 21
Writing of the draft MTE Report	July 23 - 26
Review of the evaluation findings with staff	July 26
Submission of draft report to ADRA International	July 30
Review of the draft document by ADRA/I	August 4
Feedback to Consultant by ADRA/I	August 6
Final MTE Report submitted to USAID	August 15

X. REPORT FORMAT

The Mid-Term Evaluation Document will be written using the following outline (*see section II of the "USAID MTE Guidelines" for more details*):

Title Page.

The title page will state the name and project number, names and titles of consultants, and date and name of the document.

List of Acronyms.

Unusual or obscure acronyms should be identified at the beginning of the report.

Executive Summary.

The executive summary synthesis should be no more than two pages in length and will include: background of project, evaluation methodology, accomplishments and impact of the project, concerns and recommendations.

Table of Contents.

The table of contents should outline each major topic section, appendices, figures, maps, tables, etc.

Body of the evaluation.

The body of the evaluation report will include the following in sequential order:

Introduction and background.

The introduction and background will include at a minimum: justification for awarding grant, goals and objectives of the grant, implementation methods, and the purpose of the evaluation.

Evaluation Methodology.

The evaluation methodology will include at a minimum: description of data collection and evaluation sites selection processes.

Discussion and Analysis (Sections IIB, C and D of "USAID MTE Guidelines").

This is where the findings are clearly stated and discussed in detail. All the recommendations and the summary of the evaluation are based on this section of the document. See sections

Supplementary Issues and Questions.

This section will address in sequence the supplementary issues and questions outlined in this Scope of Work.

Conclusions and Recommendations.

This section presents the main conclusions based on this mid-term evaluation. It should outline the recommendations for ADRA, USAID, the project staff and collaborating partners for the remaining life of the program.

Results Highlight

One page “results highlight” If appropriate, provide a one-page description of some element of the program, with supporting data, that would make a good stand-alone communication piece for the PVO or USAID to distribute or to post on the Office Web Page.

Appendices.

The appendices included will be at the discretion of the evaluation team. However, the appendices must include the scope of work, itinerary for the evaluation visit, list of individuals interviewed/surveyed during the evaluation, surveys and interviewers' questionnaires, references cited and maps (*see also section on Attachments of the USAID MTE Guidelines*). Additional appendices such as case studies, etc. may be included as determined appropriate by the evaluation team.

Appendix 10.2:**EVALUATION TEAM MEMBERS & THEIR TITLES**

Dr. Josué Mpayamaguru - Project Director
Razafimahefa, Sylvain Noel, Coordinator VVT
Norosoa Fanjaniaina Ralantoharilolona, Translator/Interpreter
Christophe - Health Technician, VISA 5/5
Francois – Teacher & COSAN member
Andriatsimbarison, Lila Anica, Coordinator MIS
Linda Morales – Consultant, MTE Team Leader
Dawit Habtemariam – Assistant Director for Evaluation, ADRA International

Appendix 10.3: EVALUATION ASSESSMENT METHODOLOGY

The evaluation methodology included document review, in-depth interviews with ADRA staff and partners in the field, focus group discussions, data review and analysis on eight of the 13 CATCH indicators for which the project collected data, consultation with other private sector partners working in the field, and discussions with both the MOH national level health team and members of the USAID health team. In addition, the team leader drew on her own prior experience and expertise; she has 20 years of experience working in public health and two and a half years of experience working in Madagascar.

ADRA International Evaluation Department provided copies of the necessary documentation of the project for review by the consultant. Prior to beginning the field discussions, the evaluation team leader met with the USAID team leader and six members of the national MOH team to discern any special issues which might need to be addressed. Next, the team leader and Dr. Josue Mapayamaguro, the ASAP Project Director, jointly determined the evaluation sites and drafted the evaluation instruments. A cross-section of communities was agreed upon, providing a representative sample of 4-5 villages in each district; these included Anjahambe, Maromitety, Ampasimazava, Marfinaritra and VVT town for VVT district and Ampasamadinika, Ambohibonara, Ambalabe, and Ampasimbe Onibe for Toamasina II; these communities were chosen by random selection. Due to the limits of time, certain communities were eliminated from the selection- note that the most distant communities require several hours by four wheel drive vehicle, followed by 3-4 days of walking in difficult terrain. The team agreed upon seven cohorts for the individual interviews: private sector partners, MOH partners at the district level, MOH partners at the community health center level, ADRA staff, mothers of children under five, trained TBAs, and trained CHAs. Because of the numbers of both CHAs and TBAs the evaluation team came across in VVT, they decided to conduct some of these as focus groups. In addition, the evaluation team planned to interview at least 2 representatives from COSAN, CASC, and COGE (three different types of health committees); however in VVT, the team was not able to locate more than one representative for both the CASC and COGE. The interviews and focus groups were conducted during the field visit between July 7th and July 18th, 2006.

Team members for the field work included the team leader, the Project Manager, a representative from the community (a COSAN health committee member), the Coordinator for VVT, the Visa 5/5 Coordinator, and a translator whose primary role was to assist the team leader with translation from Malagasy to French and visa-versa, and to aid in taking notes. A member of the district MOH team had been requested to participate by both the team leader and the Project Director; however, due to other scheduling conflicts, he was not available. The methodology for the field work included the following: the team leader individually interviewed the district level health personnel, the heads of the

community health centers, and the project staff. The translator assisted with note-taking for all but the staff interviews. In the communities, the members of the interview team conducted individual interviews and focus groups in teams of two, whereby one person in each team had not been affiliated with the project prior to the evaluation. The team members encountered various challenges in conducting the interviews and focus groups. For example, one health center director was interrupted three times during the interview due to a series of maternal emergencies at the adjacent hospital; other team members had to change their route towards a target community twice due to impassable roads (the MTE was conducted during the rainy season and the area is prone to flooding).

At the end of the field visit, a half-day debriefing was held with ADRA staff and the project's private and public sector partners in Toamasina. In addition, the MTE team leader debriefed with both the ADRA Madagascar Program Coordinator and representatives from the USAID Madagascar health team in Antananarivo.

**Appendix 10.4:
TABLE OF TYPES AND TOTALS OF INTERVIEWEES**

TABLEAU – EFFECTIFS DES ENQUETES

* Some of the individuals are both CHAs or ATs and members of CVAs or both CSB heads and members of the CASC

	TMM II	VVT	TOTAL
Meres	6	7	13
AT s	4	23*	27
COSAN (communauté)	3	2	5
CASC (commune)	2*	1	3
CSB	2*	2 1 CHD	5
COGE	2	1	3
CVA (CHA)	3/4*	13*	20
Staff du Projet			12
Rep. Des ONG locales PSI, SanteNet	2		2
Médecin Inspecteur + Adjoint Tech. (SSD)	1 MI 1 ADJ Tech	1 MI	3
Enfants VISA		5	5
USAID			1
MinSanPF- Antananarivo			6
TOTALS	30	55	101*

**Appendix 10.5:
LIST OF PEOPLE INTERVIEWED AND CONTACTED/MATERIALS
REVIEWED**

**Wendy Benazerga, HPN Team Leader, USAID
Dr. Benjamin, USAID**

**Dr. Bako, ralainirina@wanadoo.mg
MCH
MinSanPF**

**Dr. Clarisse, minsandse@wanadoo.mg
Head IMCI
MinSan PF- Tana**

**Dr. Rakotoarison Rachel, Tel 032 02 13103
SSR, MSR
MinSanPF- Tana**

**Dr. Rabemanantsoa, Olga, Tel 032 04 12997
Chef de Division MSR du SSRMSR
MinSanPF- Tana**

**Dr. Gertrude Raharinanana, Tel 032 07 559 27
Responsable PF
MinSanPF- Tana**

Partenaires – Societe Civil/NGOs

**SanteNetDr. Pamaka, Camille Gonzague, Tel 53 348 80/033 02 001 42
CGZ@santenet.mg
Coordinateur Regional de Programme SanteNet Toamasina**

**PSI, Mr. Andriaherinosy Solofo Robson (Hery) Tel 20 53 300 76, 032
07 576 82
hery@psi.mg
Coordinateur Provincial PSI Tamatave**

Partenaires- Secteur Public

**Dr. Zara Hassanaly Patrick, Tel 53 92853, 032 04 737 34
Chef – SSD Toamasina II**

**Dr. Rabearison, Frederic, Tel 032 02 828 39
Adjoint Technique, SSD Toamasina II**

Dr. Sebastian, Medecin Inspecteur- Vavatenina

Dr. Jeny & Mr. Marcelin, CSB Marometety - VVT

Dr. Randriambelontsoa Frederic, Chef du CHD- VVT

Dr. Edouard, Chef CSB VVT

Dr. Nirina, Chef CSB, TMM II

Project Staff :

Dr. Mpayamaguru, Josue, Project Manager
Razafimahefa, Sylvain Noel, Coordinator VVT
Andriatsimbarison, Lila Anica, Coordinator MIS
Ralahiroarisoa, Christophe, Health Technician, VISA 5/5
Andriamihanta, Gerard, Health Technician, TBA
Raymond, Coordinator IMCI
Jean de Dieu, Coordinator COSAN
Nasinto, Jean Parfait, Coordinator M & E
Fredo, Coordinator, Marketing
Rasamimanana Tsiry, Admin
Lalaina, Finance, Admin. & HR
Andriamitantsoa, Edmond, Health Technician, CHAs

Community Health Agents/CVA members

Matrones/TBAs

Mothers

Documents Reviewed:

ASAP CS Proposal
ASAP DIP 2004
Annual reports: 2003-04, 2004-05
Quarterly report: FY 06 Qtr 1 & 2
Results tables – February 06 LQAS
Operations Research Report

**Appendix 10.6:
QUESTIONNAIRES IN ENGLISH, FRENCH AND MALAGASY****Questionnaire for mothers**

Is there a midwife in your village? A traditional birth attendant?

If yes, what are their names? _____

What is it that they do? _____

What is your impression concerning the work of the midwives? _____

Have you received a visit from a midwife? Yes No
When? _____ What did they do? _____

Did he/she give you something? If yes, what?

Did he/she use any other types of tools?
_____ Illustrative cards
_____ Brochures
_____ Other

What do you think of the care (technique and quality) given by the CSBs?

How might they improve?

Where was your baby born?

Have you understood the radio messages?

On what? _____

What were the main messages? _____

Have you already met an ADRA team member?

If yes, when?

What was the reason for their visit?

What happened during the visit?

Did you find the visit useful? Why? How?

Questionnaires des Meres

Est-ce qu'il y a un partenaire communautaire dans votre village ? Accoucheuse Traditionnelle ?

Si oui, comment s'appellent-ils/elles ? _____

Qu'est-ce qu'elles/ils font ? _____

Quelle est votre impression concernat le travail du partenaire communautaire ? _____

Est-ce que vous avez reçu une visite d'un partenaire communautaire ? Oui
Non

Quand ? _____ Qu'est-ce qu'elle/il a fait ? _____

Est-ce qu'elle/il vous a donne qq ch ? Si oui, quoi ? _____

Est-ce qu'elle/il a utilise autres types des outils ?

_____ Cartes illustrees
_____ Brochures
_____ Autres

Que pensez vous des soins (technique & qualitative) du CSB ?

Comment faut-il les ameliorer ?

Ou est-ce que vous avez mis au monde votre bebe ?
Avez vu entendu des messages a la radio ?

Sur
quoi ? _____

Quels etaient les messages
principaux _____

Avez-vous deja rencontre qq'un de l'equipe ADRA ?

Si oui, quand ?

Quelle était la raison de sa visite?

Qu'est-ce qui s'est passe pendant la visite?

Est-ce que vous avez trouve la visite utile ? Pourquoi ? Comment ?

Fanontaniana hoan'ny Reny

Misy PC ve na mpiara-miasa amin'ny mpiara-belona ao amin'ny tanàna misy
anao? Renin-jaza ?

Raha Eny , Iza avy no
anarany ? _____

Inona avy no ataon'izy
ireo? _____

Ahoana no mba fijerinao ny asa ataon'izy
ireo? _____

Efa nitsidika anareo ve ireo mpanampy ny mpiara-belona ireo (PC)? ENY
TSIA

Oviana? _____ Inona no zavatra
nataony? _____

Nanome zavatra anareo ve izy ireo? Efa nampianatra zavatra anareo ve izy?
Raha ENY,
Inona? _____

Nampiasa fitaovana hafa ve izy?

_____ Karatra misy kisarisary

_____ Gazety kely

_____ Hafa

Ahoana ny fijerinareo ny fikarakaràna ara-teknika sy ara-kalitao omen'ny CSB?

Ahoana ny fomba anatsaràna izany?

Taiza ianao no niteraka ny zanakao?

Efa naheno ny hafatra tamin'ny alalan'ny RADIO nataon'ny ADRA ve ianao?

Momban'ny

inona? _____

Inona avy no votoatin'izany hafatra izany

Efa nahita ny ekipan'ny ADRA ve ianao?

Raha ENY, oviana?

Inona no anton'ny fitsidihana nataony?

Inona avy no zava-niseho nandritran'ny fitsidihana nataony?

Tena ilaina ve ny fitsidihana nataony araka ny fahitanao azy? Nahoana? Amin'ny fomba ahoana

Questionnaire for Midwife's/ATs/Nurses

Introduction: Hello. My name is _____ and I am a Min/San/ADRA team member, I am here for a small talk on evaluation of the ADRA project. This little chat will allow us to see how the activities of this project have developed in the area in which you have worked. You may be assured that the information you provide will be confidential.

How many years have you worked as a renin- jaza/AT/Nurse? _____

Have you had any training? YES NO

In what subjects?

- _____ Maternity without risk
 _____ PRA
 _____ Emergency transportation system for pregnant women
 _____ OTHERS _____

Do you need any further training? YES NO

If yes, in what? _____

What is your work as a midwife/TBA?

- _____ Assist with deliveries
 _____ Visit pregnant women
 _____ Promotion of exclusive breast-feeding by women
 _____ Visit women after delivery
 _____ Encourage pregnant women to have ANC
 _____ Encourage women to deliver at the local clinic
 _____ Promote FP methods
 _____ Sale of mosquito nets
 _____ Other _____

Do you know the technical agent of ADRA? YES NO

What is their name? _____

Have you collaborated with him/her? YES NO

In what way have you collaborated? On what have you collaborated?

- _____ FP promotion
 _____ Visiting new mothers and/or newborns
 _____ Promoting exclusive breast-feeding by mothers
 _____ Other _____

When was the last time that you saw an ADRA technician?

In what situation did you see them? _____

Are you satisfied with their collaboration?

Suggestions to improve partnership? _____

Who supported you in your work? _____

When was the last supervision check by X _____

What was the discussion topic during your visit? _____

Have you had periodic meetings? YES NO

With what frequency?

____ every month ____ every two months ____ every three months

Do you fill out work reports? YES NO

With what frequency?

____ every month ____ every two months ____ every three months

(Ask to see the reports)

Have you received a box? YES NO

Can you show it to me?

Check the contents by asking what should be in the kit (illustrated cards and brochures)

Does the box contain what it should have? YES NO

If not, what is missing? _____

(AT) Have you received a birthing kit?

Check the contents by asking what should be in the kit. (Cotton, ...)

What is the process for restocking the kit?

What would you like to help you work better? _____

Do you have the intention to continue your activity after the end of the project?

Suggestions for the sustainability of the activities?

Questionnaire de Partenaire Communautaire/ ATs/Matrone

Introduction : Bonjour. Mon nom est _____ et je suis membre d'une équipe du Min/San/ADRA, je suis ici pour un petit entretien dans le cadre d'une évaluation du projet –ADRA. Cette petite causerie nous permettra de voir comment s'étaient déroulées les activités de ce projet dans la zone que tu as fait des interventions. Sois assuré que ce seront confidentielles les informations que tu vas nous fournir.

Combien des années avez-vous travaillé comme renin- jaza/AT/matrone ?

Est-ce que vous avez été formés ? OUI NON

Dans quels sujets ?

_____ Maternité sans Risques

_____ PRA

_____ Système de transport en cas d'urgence pour les femmes enceintes

_____ AUTRES _____

Avez-vous besoin d'autres formations ? Oui Non

Si oui, en quoi ?

Quel est votre travail comme matrone/partenaire communautaire ?

_____ assister aux accouchements

_____ visiter les femmes enceintes

_____ Promotion d'allaitement maternel exclusif

_____ visite des femmes après l'accouchement

_____ referer /inciter les femmes enceintes aux consultations prénatales

_____ referer/inciter les femmes a accoucher au CSB

_____ Promotion de la PF

_____ Vendre les moustiquaires

_____ autres

Est-ce que vous connaissez l' Agent Technique d'ADRA ? OUI NON

Quel est son nom ? _____

Avez-vous collaboré avec elle/lui? OUI NON

Quel type de collaboration ? Sur quoi vous avez collaboré ?

_____ Promotion de PF

_____ visite des nouvelles mères/nouveaux-nés

Promotion d' allaitement maternel exclusif
 Autre

Quelle était la dernière fois que vous avez vu un technicien d'ADRA ?

Dans quel contexte vous l'avez vu ? _____

Etes vous satisfait avec sa collaboration ?

Suggestions pour améliorer partenariat? _____

Qui vous a donné l'appui dans votre travail _____

Quand est-ce que vous avez eu la dernière visite de supervision de X _____

Quelle était votre sujet de discussion pendant cette visite _____

Avez vous des réunions périodiques ? Oui Non

Quelle est la fréquence ? _____ chaque mois _____ tous les 2 mois
 _____ tous les 3 mois

Est-ce que vous remplissez des rapports de travail ? Oui Non

Quelle est la fréquence ? _____ chaque mois _____ tous les 2 mois
 _____ tous les 3 mois

(Demander de voir les rapports)

Avez –vous reçu une boîte (trousse ou cartable) ? OUI NON

Est-ce que vous pouvez me la montrer ?

Vérifier le contenu en demandant qu'est-ce qu'il y a dans la boîte. (Cartes illustrées, brochures)

Est-ce que la boîte contient tout ce qu'il faut? OUI NON

Si non, qu'est-ce qui manque ? _____

(AT) Avez-vous reçu un kit d'accouchement (birthing kit) ?

Vérifier le contenu en demandant qu'est-ce que **doit être** dans le kit. (Coton, ...)

Qu'est-ce qu'il faut faire pour renouveler le stock ? (Quel est le processus?)

Qu'aimeriez vous avoir pour mieux travailler ?

Avez-vous l'intention de continuer vos activités après la fin du projet ?

Suggestions pour la pérennisation des activités ?

COSAN or CASC or CVA

Questions 1- ?? (on top)

+ the following:

What activities did you do after your training? _____

What is the responsibility/duty of the members of COSAN / CASC / CVA?

Do you have the intention to continue your activities after the end of the project?
Why? How?

Suggestions for the perpetuation of the activities?

Has this project had an impact on the community?

What kind of impact? _____

What do you wish the ASAP would do in your community? _____

COSAN ou CASC ou CVA

Questions 1- ?? (en haut)

+ les suivantes :

Quelles sont les activités que vous avez faites après la formation ?

Quelle est la responsabilité/devoir du membre COSAN / CASC / CVA ?

Avez-vous l'intention de continuer vos activités après la fin du projet ?
Pourquoi ? Comment ?

Suggestions pour la pérennisation des activités ?

Est-ce le projet a eu un impact dans votre communauté ?
Lequel ? _____

Qu'est-ce que vous souhaiteriez que l'ASAP fasse dans la
communauté ? _____

TECHNICAL QUESTIONS (ONLY FOR CVAs OR PCs)

Vaccination

20. At what age is the measles vaccine administered?

9 months other (incorrect)

21. When does an infant complete their vaccination regime?

When the infant has received 1 dose of BCG, 3 doses of DPT and Polio, and 1 dose of measles

other (incorrect)

Nutrition

22. What is the protocol for Vitamin A administration?

Start at 6 months, then every 4 months until 7 years of age.

Other (incorrect)

23. What is the correct dose of Vitamin A in an infant below the age of 1?

100,000 units (or 3 drops) other (incorrect)

24. What is exclusive breastfeeding?

6 months breastfeeding without any other complementary feeding (liquid or dry food)

other (incorrect)

25. Why should mother practice exclusive breastfeeding?

to prevent diarrhea other _____

26. When you see that the weight of the infant is in the yellow range, what do you do? Correct

counsel the mother on the weight of the child and the correct nutrition

refer the infant

other (incorrect)

ARI

27. What are the signs of ARI that you know?

correct : incorrect :

dyspnea

cough

intercostal retraction

respiratory difficulty

fever

___ other (incorrect)

28. Cite at least 3 danger signs tht necessitate the referral of an infant to a health center.

correct : incorrect :

- ___ Inability to drink
- ___ No oral intake
- ___ Refusal to breastfeed (younger than 6 months)
- ___ Fever
- ___ Profuse diarrhea
- ___ Convulsion
- ___ Lethargy or unconsciousness
- ___ Vomiting after every oral intake
- ___ Other (incorrect)

Diarrhea

29. Cite 4 ways to prevent diarrhea.

- ___ Exclusive breastfeeding
- ___ Hand washing
- ___ Water treatment
- ___ Food hygiene (wash/treat fruits, vegetables, legumes; cook meat well done, keep food covered)
- ___ Other (incorrect)

30. When is it necessary to wash your hands, in order to prevent diarrhea?

correct : incorrect :

- ___ Before eating
- ___ After using the restroom
- ___ After having changed a soiled diaper
- ___ Before preparing food
- ___ Other (incorrect)

31. Tell us how to prepare the ORS?

correct

- ___ Mix 3 bottles PET (bottles of cola) clean water & 1 envelope of ORS
- ___ Others (incorrect)

Maternal care

32. Cite 3 danger signs in pregnancy. correct : incorrect :

- ___ intense headache
- ___ visual problems
- ___ lower leg edema
- ___ epigastric pain

- hemorrhage
 other (incorrect)

33. What is the minimum amount of antenatal visits necessary during pregnancy?

correct : incorrect :

- 3
 others (incorrect)

34. When should healthcare workers make post natal visits?

correct : incorrect :

- During the first three days
 Others (incorrect)

35. Citez Cite 3 tasks to be accomplished during the postnatal visit

correct : incorrect :

- administer vitamin A to the mother
 counsel the mother _____
 check-list filling up (visit form)
 others (incorrect) _____

Birth Spacing

36. Cite 2 avantages to birth spacing. correct : incorrect :

- mothers health
 infants health
 economical for the family
 allows the number of children that one desires.
 other (incorrect)

37. What is the most important thing to do before the administration of a birth spacing method?

correct : incorrect :

- Counselling
 Other (incorrect)

38. What should be done in the face of a potential FP client that has multiple partners and would like to use the pill as a FP method?

correct : incorrect :

- advise the use of condoms with another method (double method)
 other (incorrect)

HIV/AIDS/STD

39. Cite 2 signs / symptoms of a sexually transmitted disease.

correct : incorrect :

- discharge
 - itching
 - pelvic pain
 - genital lesions
 - burning on urination
 - others _____
-

40. Cite 3 ways to prevent HIV/AIDS ?

Correct: incorrect :

- condom
- fidelity
- abstinence
- other (incorrect)

41. What is the difference between an STD and HIV/AIDS?

Correct : incorrect :

- STDs can be treated
- HIV/AIDS is incurable
- other (incorrect)

Malaria

42. What is the best way to prevent malaria?

- sleep in mosquito netting
- other (incorrect)

43. What other methods are there to prevent malaria?

- removing mosquito shelters
- keeping your surroundings clean
- using the mosquito nets
- use of insecticides
- others _____

43. Who are the target groups for malaria prevention?

- pregnant women
- infants younger than 5 years
- other (incorrect)

44. What is the advice concerning pregnant women on malaria prevention?

- IPT prevention (Intermittant Presumptive Treatment)
- other (incorrect)

QUESTIONS TECHNIQUES (UNIQUEMENT POUR LES CVA OU PCs)

Vaccination

20. A quel age on administre le vaccin anti-rougeoleux?
 9 mois autre (incorrecte)
21. Quand est-ce qu'un enfant est complètement vacciné ?
 Quand l'enfant a reçu 1 dose de BCG, 3 doses de DPT et de Polio, et 1 dose de Rougeole
 autre (incorrecte)

Nutrition

22. Quel est le protocole d'administration de Vitamine A ?
 Commence a 6 mois, et puis tous les 4 mois jusqu'a sept ans
 autre (incorrecte)
23. Quelle est la dose correcte pour la Vitamine A d'un enfant moins d'un an ?
 100,000 unités (ou 3 gouttes) autre (incorrecte)
24. Qu'est-ce que c'est l'allaitement maternel exclusif ?
 6 mois d'allaiter sans donner rien d'autre (ni des liquides, ni des aliments)
 autre (incorrecte)
25. Pourquoi les mères doivent pratiquer l'allaitement maternel exclusif ?
 prévenir la diarrhée autre
-
26. Des que vous voyez le poids d'un enfant dans le jaune fonce, que faites vous? Correct
 conseiller la mère sur le poids de l'enfant et l'alimentation correcte
 referez l'enfant
 autre (incorrecte)

IRA

27. Quels sont les signes d'IRA que vous connaissez ? correct : incorrect
- dyspnée
 toux
 tirage intercostale
 difficultés respiratoires
 fièvre

___ autre (incorrecte)

28. Citez au moins 3 signes de danger qui exigent la référence de l'enfant au centre de santé

correct : incorrect :

___ incapable de boire

___ Ne mange pas

___ Ne veut pas être allaité (moins de 6 mois)

___ Fièvre

___ Diarrhée profuse

___ Convulsion

___ léthargique ou inconscient

___ vomit tous ce qu'il consomme

___ autre (incorrecte)

Diarrhée

29. Citer 4 moyens de prévention de la diarrhée ? incorrect correct

___ Allaitement maternel exclusif

___ Laver les mains

___ Traitement de l'eau

___ Hygiène alimentaire (laver/traiter les fruits, crudités, légumes ; faire cuire la viande, couvrir les aliments etc)

___ autre (incorrecte)

30. Quand est-ce qu'il faut se laver les mains pour prévenir la diarrhée ?

correct : incorrect :

___ Avant de manger

___ Après la toilette

___ Après avoir nettoyé un enfant qui a fait la caca

___ Avant de préparer a mangé

___ autre (incorrecte)

31. Dites- nous comment préparer la SRO ?

correct ___ Mélanger 3 bouteilles PET (bouteilles de kola) d'eau propre & 1 sachet de SRO

___ Autres (incorrecte)

Soins Maternels

32. Citez 3 signes de danger durant la grossesse ? correct : incorrect :

___ céphalée intense

___ troubles visuelles

___ œdème des membres inférieurs

___ douleur épigastriques

hémorragie
 autre (incorrecte)

33. Quel est le nombre minimum des visites prénatales qu'une femme doit faire durant sa grossesse ?

correct : incorrect :

3
 autres (incorrecte)

34. Dans quelle intervalle les agents de santé/AT/ doivent réaliser ses visites post-natales ?

correct : incorrect :

dans les 3 premiers jours
 autres (incorrecte)

35. Citez 3 taches à accomplir lors d'une visite post-natale ? denominator

correct : incorrect :

administration de vitamine A à la mère
 conseils à la mère _____
 remplissage de check-list (formulaire de visite)
 autres
 (incorrecte) _____

Espacement des Naissances

36. Citez 2 avantages de l'espacement de naissance. correct : incorrect :

santé de la mère
 santé des enfants
 économie pour la famille
 permet d'avoir le nombre des enfants que l'on désire
 autre (incorrecte)

37. Quelle est la tache la plus importante a exécuté avant l'administration d'une méthode de l'espacement des naissances ?

correct : incorrect :

Counselling
 autre (incorrecte)

38. Qu'est-ce qu'il faut faire face a une cliente potentielle PF qui a des partenaires multiples qui voudraient utiliser la pilule comme méthode PF ?

correct : incorrect :

utilisez les condoms avec une autre méthode (double méthode)
 autre (incorrecte)

VIH/SIDA/IST

39. Citez 2 symptômes /signes d'une infection sexuellement transmissible ?

correct : incorrect :

leucorrhée (perte vaginale, écoulement urétral)

prurit

douleur au bas ventre

lésions génitales

brûlure mictionnelle

autres _____

40. Citez 3 moyens de prévention de VIH/SIDA ?

Correct: incorrect :

condom

fidélité

abstinence

autre (incorrecte)

41. Quelle est la différence entre une IST et VIH/SIDA ?

Correct : incorrect :

IST peuvent être traités

VIH/SIDA est incurable

autre (incorrecte)

Paludisme

42. Quelle est la meilleure prévention sur le paludisme ?

dormir dans une moustiquaire

autre (incorrecte)

43. Y a-t-il d'autres méthodes pour prévenir le paludisme ?

éloigner les gîtes

nettoyer l'environnement

utilisation des anti-moustiquaires

utilisation d'insecticides

autres _____

43. Qui sont les groupes cibles pour la prévention du paludisme ?

femmes enceintes

enfants moins de 5 ans

autres (incorrecte)

44. Qu'est-ce qui est conseillé pour les femmes enceintes pour prévenir le paludisme ?

_____ Prevention TPI (Traitement Presumptif Intermitant)
 _____ autre (incorrecte)

Fanontaniana ho an'ny PC(Mpiara-miasa amin'ny mpiara-belona)/ Ny renin-jaza

Teny Fampidirana: Miarahaba anareo. _____ no anarako ary anisan'ny miara-miasa amin'ny Min/Fahasalamana/ADRA aho, hanao dinidinika kely ny amin'ny fanombatombanana ny foto-drafitr'asa- ADRA no ho ahatongavako eto. Ahafahantsika mahita ireo hetsika ataon'ity tetik'asa ity ao amin'ny faritra iasanao ny resadresaka ho ataontsika. Aza matahotra fa mijanona ho tsiambaratelo ny vaovao homena.

Firy taona izay no naha-renin-jaza anao? _____

Nahazo fiofanana ve ianareo?

Momban'ny inona ilay fiofanana?

_____ Fiterahana tsy mitera-doza (MSR)

_____ PRA

_____ Fomba fitaterana ny reny bevohoka raha sendra ny vonjy taitra.

_____ Hafa _____

Mila fanofanana hafa ve ianareo? Eny Tsia

Raha Eny, Amin'ny lafiny inona?

Inona no asanareo amin'ny maha-renin-jaza / Mpiara-miasa amin'ny mpiara-belona?
 Anareo

_____ Manampy amin'ny fampiterahana

_____ Mitsidika ny vehivavy bevohoka

_____ Fanentanana ny fampinonoana ny zaza amin'ny nonon-dreny irery ihany.

_____ Mitsidika ny reny avy niteraka

_____ Manentana ny vehivavy bevohoka hanao fisafoana mialohan'ny ahaterahana

_____ Manentana ny vehivavy mba hiteraka any amin'ny CSB

_____ Mamporisika ny Fandrindram-piterahana(PF)

_____ Mivarotra lay

_____ Hafa _____

Fantatrao ve ny tompon'andraikitra ara-teknikan'ny ADRA? ENY TSIA

Iza no anarany? _____

Efa naira-niasa taminy ve ianao? ENY TSIA

Fiaraha-miasa toy ny inona ? Tamin'ny inona no niarahanareo niasa ?

_____ Fanentanana ny fandrindram-piterahana(PF)
 _____ Fitsidihana ny reny vao avy teraka /ny zaza vao teraka
 _____ Fanentanana ny fampinonoana ny zaza amin'ny nonon-dreny irery ihany
 _____ Hafa _____

Oviana no nifankahitanareo farany tamin'ny teknisianan'ny ADRA?

Tamin'ny resaka inona no nahitanareo azy?

Afa-po ve ianareo tamin'ny fiarahana niasa taminy?

Toro-hevitra vitsivitsy mba hanatsarana ny fiaraha-miasa?

Iza no nanohana anao tamin'ny asanao? _____

Oviana no fotoana farany nanaovan'ny _____ fitsidihana fanaraha-maso anao?

Momban'ny inona ny ady hevitra nataonareo tamin'io fitsidihana io? _____

Manao fivoriana ara-potoana ve ianareo? ENY TSIA

Impiry ? _____ Isam-bolana _____ Isaky ny roa volana _____ Isaky ny telovolana

Mameno tatitra momban'ny asa vita ve ianareo? Eny Tsia

Impiry? _____ Isam-bolana _____ Isaky ny roa volana _____ Isan-telovolana

(Jereo ny tatitra)

Efa nahazo boaty (na trousse na kitapo) ve ianareo? ENY TSIA

Azonareo aseho ahy ve izany?

Hamarino izay ao anatin'ny ary anontanio miaraka amin'izay hoe: Inona ny ao anatin'ilay boaty.

(Karatra vitsivitsy misy kisarisary, gazety kely vitsivitsy)

Ao anatin'ilay boaty avokoa ve izay ilaina rehetra? ENY TSIA

Raha TSIA, inona no banga? _____

(Renin-jaza) Nahazo kojakoja momban'ny fampiterahana ve ianareo?

Hamarino ny ao anatiny ary anontanio hoe: Inona avy no tokony ao anatin'ilay fitaovana.(Vovò,...)

Inona no tokony hatao mba hanavaozana ny entana ao amin'ny trano fitehirizana? (Inona ny dingana atao?)

Inona no tianao hananana mba ahafahanao miasa tsara?

_____ Mbola maniry ny hanohy ny hetsika rehetra ve ianao na dia aorian'ny fahataperan'ny tetik'asa aza?

Manomeza toro-hevitra vitsivitsy ho fanohizana hatrany ny hetsika rehetra

COSAN na CASC na CVA

Inona avy ny hetsika nataonareo taorian'ny fanofanana? _____

Inona no andraikitra sy adidin'ny mambra ao amin'ny COSAN/CASC/CVA?

Mbola te-hanohy ireo hetsika ireo ve ianareo na dia aorian'ny fahataperan'ity tetik'asa ity aza? Nahoana? Amin'ny fomba ahoana?

Manomeza toro-hevitra vitsivitsy mba ho fanohizana hatrany ny hetsika rehetra?

Nisy akony teo amin'ny mpiara-belona taminao ve ilay tetik'asa?

Inona? _____

Inona no mba irinao ho ataon'ny ASAP eo amin'ny fiaraha-monina misy anao? _____

FANONTANIANA ARA-TEKNIKA (ho an'ny CVA na PC irery ihany)

Fanaovam-baksiny

20- Atao amin'ny zaza firy taona ny vaksiny miady amin'ny kitrotro?
_____ 9 volana _____ hafa(diso)

21- Oviana ny zaza iray no atao hoe vita vaksiny tanteraka?

_____ Rehefa nahazo fatra 1 tamin'ny BCG, fatra 3 tamin'ny DPT sy Polio ary fatra iray tamin'ny vaksiny miady amin'ny kitroto.

_____ Hafa (diso)

Fampisakafoanana

22- Ahoana no fomba fampiasa ny Vitamina A?

_____ Manomboka ny fahaenimbolana, avy eo isaky ny 4 volana mandram-pahatongan'ny faha-7 taona

_____ Hafa (Diso)

23- Inona no fatra marina momban'ny Vitamina A hoan'ny zaza latsaky ny 1taona?

_____ Intelo mitete _____ hafa (diso)

24- Inona no atao hoe fampinonoan-dreny irery ihany?

_____ Mampinono mandritran'ny 6 volana ary tsy misy zavatra hafa ankoatrany (na rano hafa na sakafo hafa)

_____ Hafa(diso)

25- Nahoana ny reny no tokony hampihatra ny fampinonoan-dreny irery ih any io?

_____ Mba hisorohana ny fivalanana _____ hafa _____

26- Raha vao hita ao amin'ny faritra mavobe ny lanjan'ilay zaza , inona no ataonareo?

_____ Mampahafantatra ilay reny ny amin'ny lanjan'ilay zaza sy ny fampisakafoanana azy amin'ny tokony ho izy.

_____ Mampahafantatra ny tompon'andraikitra ny amin'ilay zaza

_____ Hafa(incorrecte)

IRA(Infection Respiratoire Aigue) Aretina mafy ao amin'ny taovam-pisefoana

27- Inona avy no famantarana ahitana ny IRA fantatrao? Marina Diso

_____ hasemporana miaro fanaintainana

_____ Kohaka

_____ fahasarotana eo amin'ny fisefoana

_____ tazo

_____ hafa(Diso)

28- Mitanisà farafahakeliny famantarana 3 ny amin'ny loza izay tsy maintsy itondrana ny zaza any amin'ny tobim-pahasalamana. Marina: Diso:

_____ Tsy afaka misotro rano

_____ Malain-komana

_____ Tsy tia nono (latsaky ny 6 volana)

_____ Tazo

_____ Mivalana be loatra

- Malemy ny hozatra
 Tsy mahatsiaro tena
 Mandoa
 Hafa(diso)

Fivalanana

29- Mitanisa fomba 4 isorohana ny fivalanana? Diso Marina

- Fampinonoan-dreny irery ihany
 Manasa tanana
 Fampiasana SUR EAU
 Fahadiovan'ny sakafo (manasa/ mikarakara manokana ny voankazo, ny legioma, masahana tsara ny hena, manarona tsara ny sakafo...)
 Hafa (diso)

30- Rehefa inona no tokony hanasa tanana mba hisorohana ny fivalanana?

Marina:

Diso:

- Alohan'ny sakafo
 Aorian'ny fanaovana ny WC
 Rehefa avy manasa zaza avy nanao maloto
 Alohan'ny fikarakarana ny fisakafoanana
 Hafa (diso)

31- Lazao anay ny fomba fikarakarana ny SRO?

Marina afangaroy ny rano madio 3 tavoahangy (tavoahangy cola) ary asio SRO 1 fonosana

hafa (diso)

Ny fitsaboana ny reny

32- Milazà famantarana 3 mampidi-doza mandritran'ny vohoka. Marina:

Diso:

- Aretin'andoha mafy
 Tsy mahita
 Fivontosan'ny tongotra
 Fanaintainan'ny faritra ambonin'ny kibo
 Fahaverezan-drà
 Hafa (diso)

33- Tokony ipiry farafahakeliny ny fisafoana ataon'ny reny bevohoka?

Marina:

Diso:

- 3
 hafa (diso)

34- Ao anatin'ny fe-potoana inona no tokony hanaovan'ny tompon'andraiki-pahasalamana/Renin-jaza ny fizaham-pahasalamana aorian'ny fahaterahana?

Marina:

Diso:

_____ Ao anatin'ny 3 andro voalohany
 _____ Hafa (diso)

35- Milazà asa 3 tsy maintsy atao rehefa manao fizaham-pahasalamana aorian'ny fahaterahana?

Marina:

Diso:

_____ Fanomezana vitamina A ho an'ilay reny

_____ Fanoroana hevitra an'ilay reny _____

_____ Famenoana ny taratasy momban'ny fizaham-pahasalamana natao

_____ Hafa(diso)

Fanelanelanana ny fiterahana

36- Milazà tombontsoa 2 azo avy amin'ny fanelanelanana ny fiterahana. Marina:

Diso:

_____ Ny fahasalaman'ny reny

_____ Ny fahasalaman'ny zaza

_____ Fitsitsiana vola hoan'ny fianakaviana

_____ Fananana ny isan'ny zanaka araka ny iriana

_____ Hafa(diso)

37- Inona no asa tena mavesa-danja indrindra ilaina atao mialohan'ny fampiasana ny fomba fanelanelanana ny fiterahana ?

Marina:

Diso:

_____ Fanoroan-kevitra

_____ Hafa(Diso)

VIH/SIDA/IST

39- Milazà famantarana 2 ahalalàna ny IST na fery eo amin'ny taovam-pananahana izay mamindra.

Marina:

Diso:

_____ Tsiranoka mivoaka amin'ny fivaviana na koa amin'ny filahiana

_____ Ny hidihidy

_____ Manaintaina eo amin'ny tapany ambanin'ny kibo

_____ Fery eo amin'ny taovam-pananahana

_____ Mavaivay rehefa mivalan-drano

_____ Hafa _____

40- Milazà fomba 3 hisorohana ny VIH/SIDA.

Marina:

Diso:

_____ Ny fimailo

_____ Ny fanajana ny vady

_____ Ny tsy fanaovana firaisana ara-nofa

_____ Hafa (diso)

41- Inona no maha-samy hafa ny IST,VIH / SIDA?

Marina: _____ Diso: _____

_____ Azo tsaboina ny IST

_____ Tsy azo tsaboina ny VIH/SIDA

_____ Hafa (diso)

Ny Tazomoka

42- Inona no fisorohana tsara indrindra amin'ny tazomoka?

_____ Matory ao anaty lay

_____ Hafa (Diso)

43- Misy fomba hafa ve hisorohana ny tazomoka?

_____ Manalavitra ny lobolobo

_____ Manadio ny tontolo manodidina

_____ Mampiasa ody moka

_____ Mampiasa fanafody moka

_____ Hafa _____

43- Iza avy ny sokajin'olona voakasiky ny fisorohana ny tazomoka?

_____ Ny reny bevohoka

_____ Ireo zaza latsaky ny 5taona

_____ Hafa (diso)

44- Inona no toro-hevitra hoan'ny reny bevohoka?

_____ Ny Fomba fisorohana TPI (Traitement Presumtif Intermittent)

_____ Hafa(diso)

Questionnaire for the CSB Staff

Post _____ Supervisor _____

How many years have you worked as a X (nurse, SF, doctor) in the CSB ?

Did you have training? YES NO

On what subjects?

_____ C-IMCI

_____ Integrated Supervision

_____ Management/Gestion/MBOs

_____ COPE

_____ Project

_____ Formation de formateurs

_____ Immunization, maintenance of the cold chain

_____ Nutrition

_____ Diarrheal illnesses

_____ Management of ARI/pneumonia cases

_____ Maternité sans Risque

_____ Birth spacing

_____ HIV/AIDS/STDs

_____ IEC/CCC

_____ PRA

_____ Transport system for pregnant women in emergencies

_____ Movable strategy of Community Sensibilization

Others _____

Did you do something different before the classes?

Si oui, what? _____

Do you need more classes? YES NO

If yes, on what?

What is your job as a worker of the CSB?

_____ assist with deliveries

_____ visit pregnant women

_____ promotion of exclusive breastfeeding

_____ visit women after delivery

_____ promotion of FP

_____ Distributor of mosquito nets

_____ supervise the TBAs and the midwives

_____ Applying COPE

_____ others _____

Do you know the Technical Agent of ADRA? YES NO

What is their name? _____

Have you collaborated with them? YES NO

What type of collaboration? On what have you collaborated?

_____ Promotion of FP

_____ Visiting new mothers and newborns

_____ Promotion of exclusive breastfeeding

_____ Other _____

When was the last time that you saw the Technical Agent of ADRA?

In what context did you see them? _____

Are you satisfied with their collaboration?

Suggestions for improvement? _____

Who has supported you in your work? _____

When was the last supervisory visit that you received by X _____

What did you discuss during this visit? _____

Do you have periodic meetings? Yes No

With what frequency?

_____ every month _____ every two months _____ every three months

Do you fill out work reports? Yes No

With what frequency?

_____ every month _____ every two months _____ every three months

(Ask to see the reports)

Do you make supervision visits? YES NO

If YES, to whom?

When was the last supervisión visit? _____

What did you discuss? _____

Did you use audio-visual support? YES NO

Questionnaire de Staff du CSB

Poste __ Chef _____

Combien d' années avez-vous travaillé comme X (infirmiere, SF, Medecin) a CSB ? _____

Est-ce que vous avez été forme ? OUI NON

Dans quels sujets ?

_____ PCIME

_____ Supervision Integree

_____ Management/Gestion/MBOs

_____ COPE

_____ Montage de projet

_____ Formation de formateurs

_____ Immunisation, maintenance de chaine froide

_____ Nutrition

_____ Maladies Diarrheiques

_____ Management des cas d'IRA/pneumonie

_____ Maternité sans Risque

_____ Espacement de naissance

_____ VIH/SIDA/ITS

_____ IEC/CCC

_____ PRA

_____ Systeme de transport en cas d'urgence pour les femmes enceintes

_____ Stratégie Mobile de Sensibilisation Communautaire

Autres _____

Est-ce que vous avez fait qqch differentes apres la formation ?

Si oui, lesquelles? _____

Avez-vous besoin d'autres formations ? Oui Non

Si oui, en quoi ?

Quel est votre travail comme agent au CSB ?

_____ assister aux accouchements

_____ visiter aux femmes enceintes

_____ Promotion d'allaitement maternel exclusif

_____ visite des femmes après l'accouchement

_____ Promotion de la PF

_____ Distribuer les moustiquaires

_____ Superviser les AT et les PC

_____ Appliquer le COPE

_____ autres _____

Est-ce que vous connaissez l' Agent Technique d'ADRA ? OUI NON

Quel est son nom ? _____

Avez-vous collaboré avec elle/lui ? OUI NON

Quel type de collaboration ? Sur quoi vous avez collabore ?

- Promotion de PF
 visite des nouvelles mères/nés
 Promotion d' allaitement maternel exclusif
 Autre

Quelle était la dernière fois que vous avez vu l'Agent Technique d'ADRA ?

Dans quel contexte vous l'avez vu ? _____

Etes vous satisfait avec sa collaboration ?

Suggestions pour l'améliorer ? _____

Qui vous a donné d'appui dans votre travail _____

Quand était la dernière visite de supervision que vous avez reçu de X _____

Qu'est-ce que vous avez discuté pendant cette visite _____

Avez vous des réunions périodiques ? Oui Non

Avec quelle fréquence ? _____ chaque mois _____ tous les 2 mois
 _____ tous les 3 mois

Remplissez -vous des rapports de travail ? Oui Non

Avec quelle fréquence ? _____ chaque mois _____ tous les 2 mois
 _____ tous les 3 mois

(Demander de voir les rapports)

Faites-vous des visites de supervision ? OUI NON

Si OUI à qui ?

Quand était la dernière visite de supervision ? _____

Qu'est -ce que vous avez discuter ? _____

Utilisez des supports audio –visuel ? OUI NON

Est-ce que vous pouvez me les montrer ?

*Vérifier le contenu en demandant qu'est-ce qu'ils **doit avoir** dans le CSB.
(Cartes illustrees, brochures)*

Contient-elle la boite tout le contenu qu'il faut? OUI NON

Sinon, qu'est-ce qui manque ?

Avez-vous reçu un kit d'accouchement (birthing kit) ?

*Vérifier le contenu en demandant que **doit être** dans le kit. (Coton, ...)*

Qu'est-ce qu'il faut faire pour renouveler le stock ? (Quel est le processus?)

Qu'aimeriez vous avoir pour mieux travailler ?

Suggestions pour la perennisation des activites ?

Questions 1- ?? (en haut)

+ les suivantes :

Quelles sont les activites que vous avez faites apres la formation ?

Quelle est la responsabilite/devoir de COSAN / CASC / CVA
membre ? _____

Suggestions pour la perennisation des activites ?

Est-ce le projet a eu un impact dans votre communaute ?

Lequel ? _____

Qu'est-ce que vous souhaiteriez que l' ASAP fasse dans la
communaute ? _____

TECHNICAL QUESTIONS

Were you trained in C-IMCI? If so when? _____ by whom? _____

What were the main topics?

What did the C-IMCI protocol say regarding what needs to be done to treat a child?

Can you always use the C-IMCI? Yes Non Why not

When was the last time you followed the protocol?

Please describe the case _____

What are the 5 illnesses associated with the protocol?

What are the advantages of following the protocol?

What are the medicines you need to implement the methodology?

___ ORS

___ Vaccines

___ Antibiotics

___ Anti-malarial

___ Other _____

Have you experienced supply shortages these last 3 months? _____

Can you give me three questions medical staff should ask each mother who brings her sick child?

Vaccination

20. At what age should the measles shot be dispensed?

9 months other (incorrect)

21. At what time is a child fully vaccinated?

When the child received 1 dose of BCG, 3 doses of DPT and Polio and one dose of measles

Other (incorrect)

Nutrition

22. What is the protocol to dispense vitamin A?

starts at 6 months and then every 4 months until 7 years old

Other (incorrect)

23. what is the correct dose for A vitamin for a child who is less than a year old?

100,000 units (or 3 drops) Other (incorrect)

24. What is exclusive breast feeding?

6 months of breast feeding without any other additives (no liquids or food)

Other (incorrect)

25. Why should mothers practice exclusive breast feeding?

Prevent diarrhea other

26. As soon as you notice that a child's weight is in the dark yellow zone what do you do?

Give counseling to the mother on how to properly feed her child

Refer the child

Other

ARI

27. What ARI signs do you know?

Dyspnea

Cough

Intercostals problems

Respiratory difficulties

Fever

Other (incorrect)

28. List at least 3 signs of danger that require the child to be sent to the health center.

Correct - incorrect

impossibility to drink

doesn't eat

refuses breast feeding

- fever
- important diarrhea
- convulsions
- lethargy or coma
- vomit all he takes
- Other (incorrect)

Diarrhea

29. list 4 means to prevent diarrhea

Correct – incorrect

- exclusive breast feeding
- wash hands
- treat water
- food hygiene (wash fruits, salad and vegetables, cook meat, cover food etc)
- Other (incorrect)

30. When should we wash our hands to prevent diarrhea?

- Before eating
- After going to the bathroom
- After cleaning a child who pooped
- Other (incorrect)

31. Tell us how to prepare ORS

Correct ___ mix 3 bottles PET (kola bottles) of clean water with one packet of ORS

- Other (incorrect)

Maternal care

32. List 3 signs of danger during pregnancy.

Correct – incorrect

- Strong headaches
- Vision troubles
- Lower limbs edema
- Stomach pain
- bleeding
- Other (incorrect)

33. What is the minimum prenatal visits a woman should have during her pregnancy?

Correct - incorrect

- 3
- Other (incorrect)

34. How often should medical staff give these post-natal visits?

Correct – incorrect

- The first 3 days
- Other (incorrect)

35. List 3 task that should be accomplished during a post-natal visit?

Correct – incorrect

- give vitamin A to the mother
 - Counseling to the mother
 - fill the visit check list
 - Other (incorrect)
- (incorrect) _____

Family planning

36. List 2 advantages to the family planning

- Mother's health
- Children's health
- Family budget
- enables to have the number of children we want
- Other (incorrect)

37. What is the most important thing to do before giving a family planning method?

- Counseling
- Other (incorrect)

38. What should be done for a woman with multiple partners looking to use the pill for family planning?

- use condoms on top of another method
- Other (incorrect)

STI/HIV/AIDS

39. List 2 symptoms of a sexually transmissible infection

- Leucorrhoea (vaginal/urethral secretion)
- Pruritus
- Womb pain
- Micturitional burning
- Other (incorrect)

40. List 3 ways to prevent STI/HIV/AIDS

- Condom
- Faithfulness
- Abstinence
- Other (incorrect)

41. what's the difference between a Sexually Transmissible Infection and SIDA/AIDS?

- STI can be treated
- SHIV/AIDS in not curable
- Other (incorrect)

QUESTIONS TECHNIQUES

Avez- vous ete forme en PCIME ? si oui, quand ? _____ Par qui _____

Quels etaient les points principaux ?

Qu'est-ce que le protocole PCIME a dit sur ce qu'il faut faire pour traiter un enfant ?

Pouvez –vous toujours utilise le PCIME ? Oui Non Pourquoi pas ? _____

Quand etait la derniere fois que vous avez suivi le protocole ?

SVP, decrivez le cas _____

Quelles sont les 5 maladies associees avec le protocole ?

Quels sont les avantages lorsqu'on suit le protocole ?

Quels sont les medicaments qu'il vous faut pour appliquer la methodologie.

- SRO
- vaccines
- antibiotiques
- anti-malarial
- autres _____

Pendant ces derniers 3 mois, avez vous experimente une rupture de stock ? _____

Pouvez-vous nous dire 3 questions que le personnel de sante doit poser a chaque mere qui emmene son enfant pour etre traite ?

Vaccination

20. A quel age on administre le vaccin anti-rougeole ?

9 mois autre (incorrecte)

21. Quand est-ce qu'un enfant est complètement vaccine ?

Quand l'enfant a reçu 1 dose de BCG, 3 doses de DPT et de Polio, et 1 dose de Rougeole

autre (incorrecte)

Nutrition

22. Quel est le protocole d'administration de Vitamine A ?

Commence a 6 mois, et puis tous les 4 mois jusqu'a sept ans

autre (incorrecte)

23. Quelle est la dose correcte pour la Vitamin A d'un enfant mois d'un an ?

100,000 unités (ou 3 gouttes) autre (incorrecte)

24. Qu'est-ce que c'est l'allaitement maternel exclusif ?

6 mois d' allaitement sans donner d'autres additifs (ni des liquides, ni des aliments)

autre (incorrecte)

25. Pourquoi les mères doivent pratiquer l'allaitement maternel exclusif ?

prévenir la diarrhée autre

26. Des que vous voyez le poids d'un enfant dans le jaune fonce, que faite vous?

Correct

conseiller la mère sur le poids de l'enfant et l'alimentation correcte

referez l'enfant

autre (incorrecte)

IRA

27. Quels sont les signes d'IRA que vous connaissez ? correct : incorrect

dyspnée

toux

tirage intercostale

difficultés respiratoires

- fièvre
 autre (incorrecte)

28. Citez au moins 3 signes de danger qui exigent la référence de l'enfant au centre de santé

correct : incorrect :

- incapable de boire
 Ne mange pas
 Ne veut pas être allaité (moins de 6 mois)
 Fièvre
 Diarrhée profuse
 Convulsion
 léthargique ou inconscient
 vomit tout ce qu'il a consommé
 autre (incorrecte)

Diarrhée

29. Citer 4 moyens de prévention de la diarrhée ? incorrect correct

- Allaitement maternel exclusif
 Laver les mains
 Traitement de l'eau
 Hygiène alimentaire (laver/traiter les fruits, crudités, légumes ; faire cuire la viande, couvrir les aliments etc)
 autre (incorrecte)

30. Quand est-ce qu'il faut se laver les mains pour prévenir la diarrhée ?

correct : incorrect :

- Avant de manger
 Après la toilette
 Après avoir nettoyé un enfant qui a fait caca
 Avant de manger
 autre (incorrecte)

31. Dites nous comment préparer la SRO ?

correct Mélanger 3 bouteilles PET (bouteilles de kola) d'eau propre & 1 sachet de SRO

Autres (incorrecte)

Soins Maternels

32. Citez 3 signes de danger durant la grossesse ? correct : incorrect :

- céphalée intense
 troubles visuelles
 odème des membres inférieurs
 douleur épigastriques

hémorragie
 autre (incorrecte)

33. Quel est le nombre minimum des visites prénatales qu'une femme doit faire durant sa grossesse ?

correct : incorrect :

3
 autres (incorrecte)

34. Dans quelle intervalle les agents de sante/AT/ doivent réaliser ses visites post-natales ?

correct : incorrect :

dans les 3 premiers jours
 autres (incorrecte)

35. Citez 3 taches à accomplir lors d'une visite post-natale ? denominator

correct : incorrect :

administration de vitamine A a la mère
 conseils a la mère _____
 remplissage de check-list (formulaire de visite)
 autres
 (incorrecte) _____

Espacement des Naissances

36. Citez 2 avantages de l'espacement de naissance. correct : incorrect :

santé de la mère
 santé des enfants
 économie pour la famille
 permet d'avoir le nombre des enfants que l'on désire
 autre (incorrecte)

37. Quelle est la tache la plus importante a exécuter avant l'administration d'une méthode de l'espacement des naissances ?

correct : incorrect :

Counselling
 autre (incorrecte)

38. Qu'est-ce qu'il faut faire face a une cliente potentielle du PF qui a des partenaires multiples qui voudraient utiliser la pilule comme méthode PF ?

correct : incorrect :

utilisez les condoms en plus d'une autre méthode (double méthode)
 autre (incorrecte)

VIH/SIDA/IST

39. Citez 2 symptômes /signes d'une infection sexuellement transmissibles ?

correct : incorrect :

leucorrhée (perte vaginale, écoulement urétral)

prurit

douleur au bas ventre

lésions génitales

brûlure mictionnelle

autres _____

40. Citez 3 moyens de prévention de VIH/SIDA ?

Correct: incorrect :

condom

fidélité

abstinence

autre (incorrecte)

41. Quelle est la différence entre une IST et VIH/SIDA ?

Correct : incorrect :

IST peuvent être traités

VIH/SIDA est incurable

autre (incorrecte)

Fanontaniana hoan'ny mpiasan'ny CSB

Teny fampidirana : Teny Fampidirana: Miarahaba anareo. _____no anarako ary anisan'ny miara-miasa amin'ny Min/Fahasalamana/ADRA aho, hanao dinidinika kely ny amin'ny fanombatombanana ny tetik'asa- ADRA no ho ahatongavako eto. Ahafahantsika mahita ireo hetsika ataon'ity tetik'asa ity ao amin'ny faritra iasanao ny resadresaka ho ataontsika. Aza matahotra fa mijanona ho tsiambaratelo ny vaovao homenareo.

Asa _____

Firy taona no niasanao amin'ny maha _____ anao (mpitsabo mpanampy, mpampivelona, dokotera) tato amin'ny CSB?

_____ Efa nahazo fiofanana ve ianao? ENY TSIA

Tamin'ny sehatra inona?

PCIME

Fitantanana(Management/Gestion/MBOs)

COPE

Famoronana tolo-kevitra

Fanamafisana ny hery fiarovana, fikarakaràna sy fitehirizana ny vaksiny(vata fampangatsiahana)

Fampisakafoanana

Aretim-pivalanana
 Fitantanana ny amin'ny IRA/ aretim-pisefoana
 Fiterahana ieren-doza
 Fanelanelanana ny fiterahana
 VIH/SIDA/ITS
 IEC/CCC
 Hafa _____

Nanao zavatra hafa ve ianareo taorian'ny fanofanana?
 Raha ENY, inona avy? _____

Mbola mila fanofanana hafa ve ianao? Eny Tsia
 Raha ENY, amin'ny lafiny inona?

Inona no asa ataonao amin'ny maha-mpiasan'ny CSB anao?
 Manampy amin'ny fampiterahana
 Manao fizaham-pahasalamana ny reny bevohoka
 Manao fanentanana ny amin'ny fampinonoan-dreny ireny ihany
 Mizaha ny reny aorian'ny fahaterahany
 Manao fanentanana ny amin'ny fandrindram-piterahana(PF)
 Mizara lay
 Manara-maso ny AT sy ny PC
 Mampihatra ny COPE
 Hafa _____

Efa nanome fitaovana hafa ny CSB ve ny tetik'asa ADRA? ENY TSIA
 Raha ENY , Inona avy ?
 Fitaovam-piasana
 Fitaovana ilaina ao amin'ny birao.

Mahafantatra teknisiana ao amin'ny ADRA ve ianao? ENY TSIA
 Iza no anarany? _____

Efa niara-niasa taminy ve ianao? ENY TSIA

Fiaraha-miasa toy ny inona ? Tamin'ny inona no niarahanareo niasa ?
 Fanentanana ny fandrindram-piterahana (PF)
 Fizahana ny reny vao avy teraka/ zaza vao teraka
 Fanentanana ny fampinonoan-dreny ireny ihany
 Hafa _____

Oviana no fotoana nahitanao farany ny teknisianan'ny ADRA? _____

Oviana no nifankahitanareo farany tamin'ny teknisianan'ny ADRA?

Tamin'ny resaka inona no nahitanareo azy?

Afa-po ve ianareo tamin'ny fiarahana niasa taminy?

Toro-hevitra vitsivitsy mba hanatsaràna ny fiaraha-miasa?

Iza no nanohana anao tamin'ny asanao? _____

Oviana no fotoana farany nanaovan'ny _____ fitsidihana fanaraha-maso anao?

Momban'ny inona ny ady hevitra nataonareo tamin'io fitsidihana io? _____

Manao fivoriana ara-potoana ve ianareo? ENY TSIA

Impiry ? _____ Isam-bolana _____ Isaky ny roa volana _____ Isaky ny telovolana

Mameno tatitra momban'ny asa vita ve ianareo? Eny Tsia

Impiry? _____ Isam-bolana _____ Isaky ny roa volana _____ Isan-telovolana

(Angataho Jerena ny tatitra)

Efa nanao fitsidihana fanaraha-maso ve ianao? ENY TSIA

Raha ENY , tany amin'iza?

Oviana ny fitsidihana fanaraha-maso farany? _____

Momban'ny inona ny ady hevitra
nataonareo? _____

Nampiasa fitaovana haino aman-jery ve ianareo? ENY TSIA

Azonareo aseho ahy ve izany?

Hamarino izay ao anatin'ny ary anontanio miaraka amin'izay hoe: Inona ny ao anatin'ilay boaty.

(Karatra vitsivitsy misy kisarisary, gazety kely vitsivitsy)

Ao anatin'ilay boaty avokoa ve izay ilaina rehetra? ENY TSIA

Raha TSIA, inona no banga? _____

Inona no tokony hatao mba hanavaozana ny entana ao amin'ny trano fitehirizana? (Inona ny dingana atao?)

Inona no tianao hananana mba ahafahanao miasa tsara?

Manomeza toro-hevitra vitivitsy ho fanohizana hatrany ny hetsika rehetra.

Inona avy ny hetsika nataonareo taorian'ny fanofanana na ahoana ny fomba nitrandrahanao ny fahaiza-manao vaovao mba hanatsaràna ny fomba fiasanareo?

Inona no andraikitra/ adidin'ny mambran'ny COSAN/ CASC/ CVA /COGE? _____

Ny toro-hevitrareo ho fanohizana hatrany ny hetsika rehetra.

Nisy akony teo amin'ny mpiara-belona taminao ve ilay tetik'asa?

Inona? _____

Inona no mba irinao ho ataon'ny ASAP eo amin'ny fiaraha-monina misy anao? _____

FANONTANIANA ARA-TEKNIKA

Efa nomena fiofanana ny amin'ny PCIME ve ianareo? Raha ENY , oviana? _____ Iza no nanofana _____

Inona avy ny votoatiny?

Inona no fomba arahina araka ny lazain' ny PCIME ny amin'ny tokony hatao mba hitsaboana ny zaza?

Mbola azonareo ampiasaina foana ve ny PCIME? ENY TSIA
Raha TSIA, nahoana? _____

Oviana ny fotoana farany nanarahanareo ny fomba tokony arahina?

Azafady, mba tanisao kely ny momba izany

Inona avy ireo aretina 5 mifandray amin'io fomba io?

Inona avy no tombontsoa azo rehefa arahina io fomba io?

Inona avy ireo fanafody ilaina mba ampiharana io fomba io?

_____ SRO
 _____ Vaksiny
 _____ Antibiotika
 _____ Fanafody miady amin'ny tazomoka
 _____ Hafa _____

Nandritran'izay 3 volana farany izay, efa nisy fotoana nahalany ny tahirim-panafodinareo ve? _____

Afaka milaza fanontaniana 3 izay tokony apetraky ny mpiasan'ny fahasalamana amin'ny reny tsirairay izay mitondra ny zanany hotsaboina ve ianareo?

Fanaovam-baksiny

20- Atao amin'ny zaza firy taona ny vaksiny miady amin'ny kitroto?
 _____ 9 volana _____ hafa(diso)

21- Oviana ny zaza iray no atao hoe vita vaksiny tanteraka?
 _____ Rehefa nahazo fatra 1 tamin'ny BCG, fatra 3 tamin'ny DPT sy Polio ary fatra iray tamin'ny vaksiny miady amin'ny kitroto.
 _____ Hafa (diso)

Fampisakafoanana

20- Atao amin'ny zaza firy taona ny vaksiny miady amin'ny kitroto?
 _____ 9 volana _____ hafa(diso)

21- Oviana ny zaza iray no atao hoe vita vaksiny tanteraka?
 _____ Rehefa nahazo fatra 1 tamin'ny BCG, fatra 3 tamin'ny DPT sy Polio ary fatra iray tamin'ny vaksiny miady amin'ny kitroto.
 _____ Hafa (diso)

Fampisakafoanana

22- Ahoana no fomba fampiasa ny Vitamina A?
 _____ Manomboka ny fahaenimbolana, avy eo isaky ny 4 volana mandram-pahatongan'ny faha-7 taona
 _____ Hafa (Diso)

23- Inona no fatra marina momban'ny Vitamina A hoan'ny zaza latsaky ny 1taona?
 _____ Intelo mitete _____ hafa (diso)

24- Inona no atao hoe fampinonoan-dreny irery ihany?

_____ Mampinono mandritran'ny 6 volana ary tsy misy zavatra hafa ankoatrany (na rano hafa na sakafo hafa)

_____ Hafa(diso)

25- Nahoana ny reny no tokony hampihatra ny fampinonoan-dreny irery ih any io?

_____ Mba hisorohana ny fivalanana _____ hafa

26- Raha vao tafiditra ao amin'ny faritra mavobe ny lanjan'ilay zaza , inona no ataonareo?

_____ Mampahafantatra ilay reny ny amin'ny lanjan'ilay zaza sy ny fampisakafoanana azy amin'ny tokony ho izy.

_____ Mampahafantatra ny tompon'andraikitra ny amin'ilay zaza

_____ Hafa(incorrecte)

IRA(Infection Respiratoire Aigue) Aretina mafy ao amin'ny taovam-pisefoana

27- Inona avy no famantarana ahalalàna ny IRA fantatrao? Marina: Diso:

_____ hasemporana miaro fanaintainana

_____ Kohaka

_____ fahaserotana eo amin'ny fisefoana

_____ tazo

_____ hafa(Diso)

28- Mitanisà farafahakeliny famantarana 3 ny amin'ny loza izay tsy maintsy itondrana ny zaza any amin'ny tobim-pahasalamana. Marina: Diso:

_____ Tsy afaka misotro rano

_____ Malain-komana

_____ Tsy tia nono (latsaky ny 6 volana)

_____ Tazo

_____ Mivalana be loatra

_____ Malemy ny hozatra

_____ Tsy mahatsiaro tena

_____ Mandoa

_____ Hafa(diso)

Fivalanana

29- Mitanisa fomba 4 isorohana ny fivalanana? Diso Marina

_____ Fampinonoan-dreny irery ihany

_____ Manasa tanana

_____ Fampiasana SUR EAU

_____ Fahadiovan'ny sakafo (manasa/ mikarakara manokana ny voankazo, ny legioma, masahana tsara ny hena, manarona tsara ny sakafo...)

_____ Hafa (diso)

30- Rehefa inona no tokony hanasana tanana mba hisorohana ny fivalanana?

Marina:

Diso:

_____ Alohan'ny sakafo

_____ Aorian'ny fanaovana ny WC

_____ Rehefa avy manasa zaza avy nanao maloto

_____ Alohan'ny fikarakarana ny fisakafoanana

_____ Hafa (diso)

31- Lazao anay ny fomba fikarakarana ny SRO?

Marina _____ afangaroy ny rano madio 3 tavoahangy (tavoahangy cola) ary asio SRO 1 fonosana

_____ hafa (diso)

Ny fitsaboana ny reny

32- Milazà famantarana 3 mampidi-doza mandritran'ny vohoka. Marina:

Diso:

_____ Aretin'andoha mafy

_____ Tsy mahita

_____ Fivontosan'ny tongotra

_____ Fanaintainan'ny faritra ambonin'ny kibo

_____ Fahaverezan-drà

_____ Hafa (diso)

33- Tokony impiry farafahakeliny ny fisahoana ataon'ny reny bevohoka?

Marina:

Diso:

_____ 3

_____ hafa (diso)

34- Ao anatin'ny fe-potoana inona no tokony hanaovan'ny tompon'andraiki-pahasalamana/Renin-jaza ny fizaham-pahasalamana aorian'ny fahaterahana?

Marina:

Diso:

_____ Ao anatin'ny 3 andro voalohany

_____ Hafa (diso)

35- Milazà asa 3 tsy maintsy atao rehefa manao fizaham-pahasalamana aorian'ny fahaterahana?

Marina:

Diso:

_____ Fanomezana vitamina A ho an'ilay reny

_____ Fanoroana hevitra an'ilay reny _____

_____ Famenonana ny taratasy momban'ny fizaham-pahasalamana natao

_____ Hafa(diso)

Fanelanelanana ny fiterahana

36- Milazà tombontsoa 2 azo avy amin'ny fanelanelanana ny fiterahana. Marina:

Diso:

- _____ Ny fahasalaman'ny reny
 _____ Ny fahasalaman'ny zaza
 _____ Vola tsara tantana hoan'ny fianakaviana
 _____ Fananana ny isan'ny zanaka araka ny iriana
 _____ Hafa(diso)

37- Inona no asa tena mavesa-danja indrindra ilaina atao mialohan'ny fampiasàna ny fomba fanelanelanana ny fiterahana ?

Marina: _____ Diso: _____

_____ Fanoroan-kevitra

VIH/SIDA/IST

39- Milazà famantarana 2 ahalalàna ny IST na ny fery eo amin'ny taovam-pananahana izay mamindra.

Marina: _____ Diso: _____

- _____ Tsiranoka mivoaka amin'ny fivaviana na koa amin'ny filahiana
 _____ Ny hidihidy
 _____ Manaintaina eo amin'ny tapany ambanin'ny kibo
 _____ Fery eo amin'ny taovam-pananahana
 _____ Mavaivay rehefa mivalan-drano
 _____ Hafa _____

40- Milazà fomba 3 hisorohana ny VIH/SIDA.

Marina: _____ Diso: _____

- _____ Ny fimailo
 _____ Ny fanajàna ny vady
 _____ Ny tsy fanaovana firaisana ara-nofo
 _____ Hafa (diso)

41- Inona no maha-samy hafa ny IST,VIH / SIDA?

Marina: _____ Diso: _____

- _____ Azo tsaboina ny IST
 _____ Tsy azo tsaboina ny VIH/SIDA
 _____ Hafa (diso)

Ny Tazomoka

42- Inona no fisorohana tsara indrindra amin'ny tazomoka?

- _____ Matory ao anaty lay
 _____ Hafa (Diso)

43- Misy fomba hafa ve hisorohana ny tazomoka?

- Manalavitra ny lobolobo
- Manadio ny tontolo manodidina
- Mampiasa ody moka
- Mampiasa fanafody moka
- Hafa _____

43- Iza avy ireo sokajin'olona voakasiky ny fisorohana ny tazomoka?

- Ny reny bevohoka
- Ireo zaza latsaky ny 5taona
- Hafa (diso)

44- Inona no toro-hevitra hoan'ny reny bevohoka?

- Ny Fomba fisorohana TPI (Traitement Presumtif Intermittent)
- Hafa(diso)

Interview of Responsible Regional NGO – TMT II

1. How can you describe your main roles and responsibilities within the ASA project? How has your role changed since it was described in the DIP.
2. In your experience, what are the main achievements/strengths of the project?
3. Why ?
4. What are the areas of the project to be improved?
5. Why?
6. What are your suggestions to improve those areas?
7. Have you participated in the preparation of the activities scheduled, if yes, how many times ?
8. In regards to the training of PSI, how have you found the implementation of those activities? How many persons have been trained by PSI?
9. Comparing the role ADRA staff has played what are some suggestions to help improve ADRA's participation in the organization and delivery of the training?
10. Have you monitored the participants to ensure they are using their newly acquired skills? How often?
11. What behaviors have you observed ?
12. What are the main problems that have arisen, and that have been solved?
13. What are the main problems that have not been solved until now?
14. Why?
15. In relation to the distribution of ITNs, what are the problems that you have found?
16. As compared to the distribution of l'ody tazomoka/chloroquine ?
17. What are the strengths of the relationship between ADRA and your organization?
18. What needs to be improved?
19. Why?
20. How?
21. In relation to the activities implemented by ADRA among the communities, what do you think are the results?

22. What needs to be improved?
23. **What do you think are the obstacles and challenges to be overcome to ensure the sustainability of the interventions?
24. What are the plans to ensure that the community partners can continue selling the ITNs (at the same price) after the end of the project?
25. Has the project been able to reinforce your skills?
26. To what extent? What are the skills that you would like the project to reinforce?
27. Did the project make an analysis of skills where you participated?
28. What changes in organizational capacity has occurred since the beginning of the project or as a result of the project intervention?
29. What do you think is the sustainability plan and/or the success of the project as compared with the phaseout plan?

Interview of the Medicine Inspector – TMT II

Ask Josue what has been the role of the Inspector and adapt the following questions.

30. In a few words please mention the main responsibilities of the Medicine Inspector within the ASA project?
31. Have you participated in the planning of activities? To what level? When?
32. Do you have a copy of the DIP? Project objectives? M&E plan? Other planning documents ?
33. What do you think are the main objectives of the project?
34. In your experience, what are the main achievements/strengths of the project?
35. Why ?
36. What are the areas to be improved?
37. Why?
38. What are your suggestions to improve those areas?
39. Has the project been able to reinforce your skills ?

40. To what extent? What are the skills that you would like the project to reinforce?
41. What do you think is the sustainability plan and/or the success of the project as compared with the phaseout plan?
42. Have the activities to reinforce personnel capacity of the Health Institutions been effective and appropriate?
43. What are the tools used by the project for the HFA ?
44. Are they appropriate and effective ?
45. What are the links between the institutions and the community?
46. What have been the approaches used by the project to ensure sustainability?
47. Has the Medicine Inspector provided his advice on the schedule of activities? (Quarterly?) How many times?
48. Is the schedule of activities included within the operational plan of the province ?
49. To what extent is the project data used for decision-making ?
50. Could you give me an example of that ?
51. Has the Medicine Inspector provided his advice to the curriculum for the training of SSD personnel and the session plans?
52. Could you remember the training of Feb. 05, how it was organized?
53. Has the Medicine Inspector organized the meetings with the person responsible for the institutions within the project intervention area to discuss questions related to the good implementation of activities of this project ? How often?
54. Has the Medicine Inspector supervised field activities ? How often?
55. What are the main problems encountered that have been solved?
56. What are the main problems that have not been solved until now?
57. Why?
58. Have you participated in the preparation of the project budget?
59. If no, why ?
60. If yes, have the needs of the Medicine Inspector as related to the activities to be implemented in the operational plan been addressed ?

61. If not, why ?
62. **Has the Medicine Inspector been satisfied with the support of the project for the improvement of the relationship between SSD and project personnel? If not, why?
63. Within the project, has the Medicine Inspector received logistic and financial support?
64. If no, why?
65. If yes, has this support been used within the project?
66. If no, why?
67. In the project document has provision been made to implement :.... Why has this never been implemented ?
68. Has the Medicine Inspector regularly received the annual report?
69. If yes, has he made the relevant comments and suggestions? On what issues?
70. If the Medicine Inspector has not received the reports, has he requested them?
71. If no, why?
72. If the Medicine Inspector should have written a monthly report, has he done that?
73. If yes, how many times?
74. If not, why?
75. Has the Medicine Inspector ensured that the storage Depot has enough stock to supply the institutions in medicines, vaccinations, folic acid, vitamin A, FP supplies etc?
76. If no, why?
77. Has the Medicine Inspector ensured the implementation of control mechanisms in order that each employee arrive on time and works his full shift according to MOH regulations?
78. Has any measures been implemented against any employees who haven't met the requirements of the work regulations ?
79. Have any provisions been made to continue field activities after the end of the project ?
80. If yes, which ones/
81. If not, why?

82. **What do you think are the obstacles and challenges to be overcome to ensure the sustainability of the interventions?

Interview du Resp. regional ONG – TmT II

1. En quelques mots pouvez-vous mentionner vos principaux rôles et responsabilités dans le cadre du Projet ASA ? Est-ce que cela a changé depuis ce qui était écrit dans le DIP ?
2. A votre avis, quels sont les accomplissements principaux/points forts du projet ?
3. Pourquoi ?
4. Quels sont les points à améliorer ?
5. Pourquoi ?
6. Quelles sont vos suggestions pour améliorer ces points ?
7. Avez-vous participé dans l'élaboration du calendrier des activités ? si oui, combien de fois ?
8. En ce qui concerne les formations menées par PSI, comment avez-vous trouvé le déroulement de ces activités ? Combien de personnes ont été formées par PSI ?
9. Vis-à-vis du rôle que le staff de l'ADRA a joué, quelles sont vos suggestions pour améliorer leur prestation/participation dans l'organisation/démarche de la formation ?
10. Avez-vous fait un suivi pour appuyer les participants dans l'application de leurs nouvelles habiletés/acquis ? combien de fois ? à quelle fréquence ?
11. Quels sont les atouts que vous avez pu observer ?
12. Quels sont les principaux problèmes soulevés et qui ont été résolus ?
13. Quels sont les principaux problèmes relevés et qui n'ont pas été résolus jusqu'au présent ?
14. Pourquoi ?
15. Par rapport à la distribution des ITN, quelles sont les difficultés que vous avez rencontrées ?
16. Vis-à-vis la distribution de l'ody tazomoka/chloroquine ?

17. Vis-à-vis la relation entre ADRA et votre organisation, quels sont les points forts ?
18. A améliorer ?
19. Pourquoi ?
20. Comment ?
21. Concernant les activités menées par ADRA dans les communautés, que pensez-vous sont les atouts ?
22. A améliorer ?
23. **Quels sont d'après vous les obstacles à surmonter et les défis à relever afin d'assurer la pérennité des interventions ?
24. Quels sont les plans pour assurer que les partenaires communautaires puissent continuer à vendre des ITN (au même prix) après la fin du projet ?
25. Est-ce que le projet a pu renforcer vos capacités ?
26. Dans quelle mesure ? Quelles sont les capacités que vous aimeriez que le projet vous renforce ?
27. Est-ce qu'il y a eu une analyse de capacités dans laquelle vous avez participé ?
28. Quels sont les changements de votre capacité organisationnelle que vous constatez depuis le début/grâce aux interventions du projet ?
29. A votre avis, quel est le plan de pérennisation et/ou le progrès du projet par rapport à son plan de « phase out » ?

Interview du Médecin Inspecteur – TmT II

Demander à Josue quels rôles ont été joués par le MI & adapter les questions suivantes :

30. En peu de mots pouvez-vous mentionner les principales responsabilités du Médecin Inspecteur dans le cadre du Projet ASA ?
31. Avez-vous participé dans le planning des activités ? A quel niveau ? Moment ?
32. Avez-vous une copie du DIP ? Objectifs du projet, plan de M & E ? Autres documents du planning ?
33. A votre avis, quels sont les objectifs principaux du projet ?

34. Quels sont les achèvements principaux/points forts du projet ?
35. Pourquoi ?
36. Quels sont les points à améliorer ?
37. Pourquoi ?
38. Quelles sont vos suggestions pour améliorer ces points ?
39. Est-ce que le projet a pu renforcer vos capacités ?
40. Dans quelle mesure ? Quelles sont les capacités que vous aimeriez que le projet vous renforce ?
41. A votre avis, quel est le plan de pérennisation et/ou le progrès du projet par rapport à son plan de « phase out » ?
42. Est-ce que les activités pour renforcer les capacités du personnel des institutions sanitaires sont-elles appropriées et effectives ?
43. Quels sont les outils utilisés par le projet pour le HFA ?
44. Sont-ils appropriés et effectives ?
45. Quels sont les liens entre les institutions et la communauté ?
46. Quels sont les approches utilisées par le projet pour assurer la pérennisation ?
47. Le Médecin Inspecteur a-t-il eu à donner son avis sur le calendrier des activités (trimestriel ?) ? si oui, combien de fois ?
48. Est-ce le calendrier des activités est inséré dans le plan opérationnel de la province ?
49. A quel point, les données du projet sont-elles utilisées pour la prise des décisions ?
50. Pourriez-vous donner un exemple de ceci ?
51. Le Médecin Inspecteur a-t-il eu à donner son avis sur les curricula de formation du personnel de SSD et les plans de session ?
52. Pourriez-vous raconter comment cela a été organisé la formation de Feb. 05
53. Le MEDECIN INSPECTEUR a-t-il organisé des rencontres avec les responsables des institutions dans la zone d'intervention du projet afin de discuter des questions relatives à la bonne marche des activités dans le cadre du dit projet? Quelle fréquence?

54. Le MEDECIN INSPECTEUR a-t-il supervise les activites de terrain ? combien de fois ? a quelle frequence?
55. Quels sont les principaux problemes souleves et qui ont ete resolus ?
56. Quels sont les principaux problemes releves et qui n'ont ete resolus jusqu'a date?
57. Pourquoi ?
58. -Est-ce que vous avez participe a l'elaboration du budget du projet?
59. Si non , pourquoi ?
60. Si oui , est-ce que les besoins du MEDECIN INSPECTEUR en ce qui concerne les activites a realiser dans son plan operationnel ont ete adresses ?
61. Si non , pourquoi ?
62. **Est-ce que le MEDECIN INSPECTEUR est satisfait de l'apport du projet pour l'amelioration de la relation entre les SSD et le personnel du projet ? si non , pourquoi ?
63. Est-ce que dans le cadre du projet , le MEDECIN INSPECTEUR a recu un appui logistique et financier ?
64. Si non , pourquoi ?
65. Si oui, est-ce que cet apport a ete utilise dans le cadre du projet?
66. Si non pourquoi ?
67. Dans le document du projet il etait prevu la mise en place d'.....Pourquoi celui-ci n'a jamais ete mis en place ?
68. Est-ce que le MEDECIN INSPECTEUR a regulierement recu les rapports annuels du rapport ?
69. Si oui , est-ce qu'il a eu a faire des remarques pertinentes et des suggestions ; et sur quel point ?
70. Si le MEDECIN INSPECTEUR n'a pas recu de rapports , est-ce qu'il les a reclames ?
71. Si non , pourquoi ?
72. Si le MEDECIN INSPECTEUR devrait rediger un rapport mensuel , est-ce que cela a ete fait?
73. Si oui , combien de fois ?

74. Si non , pourquoi ?
75. Est-ce que le MEDECIN INSPECTEUR via le depot peripherique a toujours dispose d'un stock suffisant pour approvisionner les institutions en intrants et en medicaments (vaccin, fer folate , vitA , Methodes de PF)?
76. Si non, pourquoi ?
77. Est-ce que le MEDECIN INSPECTEUR est assurée de la mise en place des mecanismes de controle afin que chaque employe soit a l'heure au travail et fournissent aussi la quantite d'heures de travail suivant le reglement du Ministere ?
78. Est-ce que des mesures ont ete prises contre les employes n'ayant pas respecte les reglements du travail ?
79. Est-ce que des dispositions ont été prises pour la continuité des activités de terrain après l'expiration du projet ?
80. Si oui , lesquelles ?
81. Si non , pourquoi ?
82. **Quels sont d'apres vous les obstacles a surmonter et les défis a relever afin d'assurer la perenite des interventions ?

Questionnaire for ADRA - ASAP Staff

Introduction: Hello, I would like to have a talk with you on the topic of an ADRA project evaluation. This little chat will allow us to see how the activities of this project have developed in the area in which you work. I can assure you that any information you provide will be confidential.

Position: _____

Have you received a description of this position? YES NO

How many years have you worked with ADRA _____, with ASAP _____?

__ 1 day - 2 weeks __ 1 - 3 months __ 13 months - 2 years __ >2 years (ADRA)

__ 1 day - 2 weeks __ 1 - 3 months __ 13 months - 2 years __ >2 years (ASAP)

In a few words, what are your responsibilities in regards to the project? 7/7

Do you feel comfortable doing these tasks? YES NO

Why? _____

Did the project equip you with tools to do your work better?

Which tools?

_____ Motorcycle _____ did it function well?

_____ Reference material

_____ Office supplies (computer, etc.)

Do you have all the necessary tools with which to do your job? YES NO

What tools do you need? _____

Did you see a copy of the DIP? YES NO The plan of Monitoring and Evaluation?

What are the objectives of the projects? _____

Have you had classes? YES NO

If yes, in what subjects?

_____ C-IMCI

_____ Information

_____ Management/Gestion/MBOs

_____ COPE

_____ Team building

_____ Immunization

_____ Nutrition

_____ Diarrheal illnesses

_____ Management of ARI/pneumonia cases

Maternity without risk
 Birth spacing
 HIV/AIDS/STDs
 IEC/BCC
 Mobile Strategy for Community sensibilization
 Others _____

Recycling YES NO

What topics? _____

What classes on the topic have you received?

How have you used the classes that you received?

Giving classes to others
 To do better in my duties
 Others _____

Do you need any other classes? YES NO

On what subjects? _____

Have you collaborated with midwives/TBAs/Healthcare center workers/
others _____?

What type of collaboration? On what have you collaborated?

Activity planning
 Activity execution, vaccination day, etc.
 New mother/newborn visits
 Supervisión of visits
 Movable strategy of community sensibilization
 Other _____

When was the last supervisión visit that you made? _____
 ___ 1-2 weeks ago ___ more than 2 weeks ___ a month ago ___ other _____

What problems were raised? _____

How did you resolve them? _____

Do you have the support of the administration to assure your responsibilities?
YES NO

How do you view the assistance given by the Director? _____

Suggestions for improvement:

Have you received a performance evaluation? Yes No When?

Do you feel comfortable giving feedback on the quality of your supervision?
YES NO

How do you view ADRA in general? _____

What are your suggestions on improving the project to augment the field results?

What is the transfer/perpetuation plan of the project?

What are your suggestions to improve work conditions so that the objectives may be attained?

Is there anything else that you would like to say? _____

Questionnaire du Staff d'ADRA- ASAP

Introduction : Bonjour, j'aimerais mener un court entretien avec vous dans le cadre d'une évaluation du projet –ADRA . Cette petite causerie nous permettra de voir comment s'étaient déroulées les activités de ce projet dans la zone où tu travailles. Sois assuré que ce seront confidentielles les informations que tu vas nous fournir.

Poste : _____ Avez-vous reçu une description de cette poste ? OUI NON

Combien d'années avez-vous travaillé avec ADRA _____ avec ASAP?

____ 1jr -2 semaines ____ 1- 3 mois ____ 13 mois- 2ans ____ + de 2ans (ADRA)
____ 1jr -2 semaines ____ 1- 3 mois ____ 13 mois- 2ans ____ + de 2ans (ASAP)

En quelques mots, quelles sont vos responsabilités vis-à-vis du projet ? 7/7

Sentez-vous à l'aise de réaliser ces tâches ? Oui NON

Pourquoi ? _____

Est-ce que le projet vous a équipé des outils pour mieux faire votre travail ?
Quoi ?

_____moto _____qui fonctionne bien ?
 _____matériel de référence
 _____fournitures de bureau (ordinateur, etc.)

Est-ce que vous avez tous les outils pour pouvoir réaliser votre travail ? OUI
 NON

Quels sont les outils dont vous en avez besoin ? _____

Est-ce que vous avez vu une copie de DIP ? OUI NON Du plan de Suivi
 & Eval _____

Quels sont les objectifs du projets ? _____

Est-ce que vous avez été forme ? OUI NON

Si oui, dans quels sujets ?

_____PCIME
 _____Informatique
 _____Management/Gestion/MBOs
 _____COPE
 _____Team building
 _____Immunisation
 _____Nutrition
 _____Maladies Diarrhéiques
 _____Management des cas d'IRA/pneumonie
 _____Maternité sans Risque
 _____Espacement de naissance
 _____VIH/SIDA/ITS
 _____IEC/CCC
 _____Stratégie Mobile de Sensibilisation Communautaire
 Autres _____

Recyclage Oui Non

Quels thèmes ? _____

Quelles formations sur le cas avez-vous
 reçu ? _____

Comment avez vous utilisé la formation que vous avez reçu ?

_____ Former des autres
 _____ Mieux faire mes responsabilités
 _____ Autres

Avez-vous besoin d'autres types de formation ? OUI NON

Quels sujets? _____

Avez-vous collaboré avec les partenaires communautaires/ATs/agents de CSB/PSI/autres _____ ?

Quelle type de collaboration ? Sur quoi vous avez collabore ?

- Planning des activités
- Exécution des activités, journée de vaccination, etc.
- Visite des nouvelles mères/nés
- Visite de supervision
- Stratégie Mobile de Sensibilisation Communautaire
- Autre

Quand était la dernière visite de supervision que vous avez fait?

_____ 1-2 dernières semaines _____ il y a plus de 2 semaines _____ il y a un mois _____ autre _____

Quels problèmes ont été soulevés ? _____

Comment vous l'avez résolu ? _____

Est-ce que vous avez l'appui de l'administration pour assurer vos responsabilités ? OUI NON

Comment voyez vous l'assistance du Directeur ? _____

Suggestions pour l'amélioration

Est-ce que vous avez reçu une évaluation de performance ? Oui Non
Quand ?

Sentez vous à l'aise de donner une retro alimentation (**feedback**) sur la qualité de votre supervision ? Oui Non

Comment vous voyez ADRA en général ? _____

Quelles sont vos suggestions pour améliorer le projet pour augmenter les résultats sur terrain ?

Quel est le plan de transfert /pérennisation du projet ?

Quelles sont vos suggestions pour améliorer les conditions du travail pour atteindre les objectifs ?

Est-ce qu'il y a qq'ch d'autres que vous aimeriez nous dire ?

**Appendix 10.7:
PHASE – OVER PLAN FOR COSAN**

**TRANSFER PLAN
Proposed Plan of Responsibilities for COSAN
(Developed by Jean de Dieu)**

Activity	Resp.	Date	Commentaries
1) Attend the next reunion of CSB leaders with SSD	Didi/ Sylvain	08/06	1st CSB meeting – TMT II 2nd CSB meeting– VVT - Preparatory activities: make a draft of the plan of transfer; solicit feedback from other colleagues, solicit the agreement of the SSD
2) Attend the next periodic meeting of Mayors that follows the CSB meeting.	Didi/ Holy/ Josué	09/06	1st Mayors meeting – TMT II 2e Mayors meeting – VVT (last Friday of the month)
3) Attend the organization of COSAN meetings	Didi/ Holy	10/06	Work in close collaboration with the leaders of the CSB & the mayors of each community to create an appropriate canvas: - reminder of the vision - perpetuation objectives - technique reminder if needed - clarify and differentiate member profiles and the roles of COSAN, midwives, and nurses. - elaboration of a transfer plan - reinforcement of the importance filling out reports - transfer of responsibility for compilation to the CSB - ideas for facilitating the key points in the reports
4) Follow the development of COSAN meetings	Didi/ Sylvain/	10/06- 07/07	Between 2-3 colleagues among the staff of ASAP, would it be possible to attend the majority of the COSAN meetings?

PLAN DU TRANSFERT
Proposition du Plan de Responsabilisation des COSAN
(Développé par Jean de Dieu)

Activité	Resp.	Date	Commentaires
1) Assister la prochaine réunion de Chefs CSB aux SSD	Didi/ Sylvain	08/06	1ere réunion CSB – TMT II 2eme réunion CSB – VVT - Activités préparatrices: faire un brouillon de l'agenda au sujet d'un plan de transfert, solliciter du feedback des autres collègues, solliciter l'accord du SSD
2) Assister prochaine réunion périodique des Maires qui suit les réunions CSB	Didi/ Holy/ Josué	09/06	1e réunion Maires – TMT II 2e réunion Maires – VVT (dernier vendredi du mois)
3) Assister à l'organisation des réunions des COSAN	Didi/ Holy	10/06	Travailler en étroite collaboration avec les chefs CSB & les maires de chaque commune pour élaborer un canevas approprié : - rappel de la vision - objectifs de pérennisation - rappel technique si besoin - clarifier et différencier les profils de membres et les rôles des COSAN, PC, Matrones - élaboration du plan de transfert -renforcement de l'importance de remplissage des rapports - transfert de responsabilité pour compilation au CSB -idées pour faciliter la tache (un/e jeune qui veut de l'expérience peut illustrer/écrire les rapports ?)
4) Suivre le déroulement des Réunions des COSAN	Didi/ Sylvain/	10/06- 07/07	Entre 2-3 collègues parmi le staff de l'ASAP, il serait possible de assister le plupart des réunions des COSAN ??

Appendix 10.8:**COMPILATION SHEETS FROM INTERVIEWS & FGDs**

Questionnaires of Mothers - VVT

Is there a community health agent in your village? A traditional birth attendant? 5
CHA- 6TBA

And if so, what are they called? PC Known: 4; PC Unknown: 1
AT Known: 5; AT unknown: 1

What is it that they do?

- Weigh the children : 1/7
- Give vitamins: 1/7
- Give trainings : 1/7
- Encourage or take the mothers to the CSB/ Hospital : 4/7
- Give counseling on infant health : 1/7
- Vaccination campaign : 2/7
- Raise awareness on maternal health (malaria, diarrhea..) : 1/7
- nutrition : 1/7

What is your impression concerning the work of your community health agent?

- NR: 4/7
- GOOD: 2/7
- SATISFIED: 1/7

Did you receive a visit from a community agent? Yes (5/7), No (1/7), NR (1/7)

When? 2-4 weeks: 1/7
+ 4 weeks: 4/7
NR: 1/7

What is it that he/she did?

- ORS: 2/7
- Distributed vitamins, palustop: 2/7
- Nutrition (sensitization): 1/7
- Hygiene: 2/7
- Fight against AIDS: 1/7
- NR: 3/7

Does he/she use other types of tools?

- Illustrated cards: 1/7
- Brochures: 1/7

What do you think of the care (technical & qualitative) of the CSB?

- Well done: 4/7
- Progress: 1/7
- Satisfied: 2/7

How should they be improved?

- I would like that the project reach my village, the Ambodimanga bus reaches here and is far enough from home
- Give hospitalized patients meals
- Give free medications
- To make sanitations by poster in the zones that can not be reached by Radio Masada and Alpha

Where did you have your baby (delivered)?

- CSB : 1/7
- Hospital : 1/7
- Matron (midwife) : 4/7
- NR : 1/7

Have you understood the radio messages from ADRA? YES (5/7), NO (2/7)

On what? - Infant and maternal health: 1/7

- Vaccination: 1/7
- Antenatal care: 1/7
- Mosquito nets/malaria: 3/7
- Diarrhea: 1/7
- ARI: 1/7
- Nutrition: 1/7
- NR: 1/7

What is the principal message? _____

Have you already met an ADRA team member? YES (4/7), NO (3 /7)

If yes, when?

- Last year: 1
- In the past 5 months : 1
- I forget : 3

What was the reason for the visit? FP: 1, NR: 3

What is the main reason for the visit?

- Communication with the villagers, promotion of mosquito nets, supervisory visits on hygiene, donation of a meal after the ligation of tubes (with MARIE STOPES)

Did you find the visit useful? Why? How?

YES (4/7); Reasons:

- The children are in good health
- ADRA donates what the children have to eat when they are malnourished and that decreases the infant mortality rate
- Increases my knowledge of health

NO (3 /7):

- The ASAP did not visit me again, but I just encountered them in Vavatenina
- NR

Compilation -Questionnaires of the Mothers of TMT II

Is there a midwife in your village? A traditional birth attendant? YES

If yes, what is her/his name? PC Known: 4/5; PC unknown: 1/5

AT Known: 2/5; AT Unknown: 3/5

What do they do ?

- Weigh the children : 4 /5
- Give vitamins : 1/5
- hygiene : 1 /5
- Encourage pregnant women to deliver at the CSB/hospital: 2 /5
- Give counseling over child health : 1/5
- Vaccination campaign : 1/5
- sensibilisent la sante maternelle (paludisme, diarrhea...) : 2/5
- nutrition : 1/5
- ANC : 2/5
- FP : 1/5

What is your impression concerning the work of your community midwife ?

- NR : 2/5
- Satisfactory: 2 /5
- Interesting : 2/5

Did you receive a visit from the community midwife ? Yes (4/5) , No (1/5)

When ? 2-4 weeks : 1/5

+ 4 weeks : 1/5

Today :1/5

Before yesterday :1/5

NR : 1/5

What is it that she did ?

- Distribution of vitamin A:1/5
- Distribution of palustop :1/5
- nutrition (sensitation) : 1/5

- hygiene : 1/5
- construction of latrines : 1/5
- De-parasitation: 1/5
- FP : 1 /5
- NR : 1/5

Does he/she use other types of tools?

- Illustrated cards : 0/5
- Brochures : 0/5
- Sheet to monitor growth : 2/5
- Fabric/felt : 1/5

What do you think of the care (technical and qualitative) of the CSB ?

- Well done : 1/5
- Very satisfied : 1/5
- Very interesting : 1/5
- NR : 2/5

How should it be improved?

- It is necessary to increase the number of personnel of the project so that we don't wait so long for vaccination
- We need frequent visits

Where did you have your baby delivered?

- Hospital : 1/5
- Matron (midwife) : 4/5

Have you understood the radio messages from ADRA? YES (2/5), NO (3/5)

On what? - infant and maternal health : 1/5

- Vaccination : 1/5
- Prenatal visits : 1/5

What is the principal message ? _____

Have you already met an ADRA team member? YES (1/5), NO (4/5)

If yes, when?

- June 2006 : 1/5

What was the reason for the visit? FP : 1/5, STI/AIDS : 1/5

What was the main reason for the visit?

- Preparation of ORS
- Water treatment (Sur Eau)

Did you find the visit useful? Why? How?

YES (3/5) ;

Reasons :

- We know now how one treats water, about ORS, hygiene for the family, one is well informed on the health plan.
- We now use mosquito net and Palustop, we now have a refuse pit, our environment becomes clean, there is collaboration between the mothers, the CSB, and ADRA; there is also a change of behavior.
- The children are in good health, no malaria, the newborn are vaccinated, we can make ORS when there is diarrhea, and the children are looked after by the doctor of the CSB.

NO (2 /5) :

Reasons : NR

COMPILATION OF RESULTS: Midwife – VVT**Manpower : 13**

- 1- Years working as a midwife :
 - 1 year : 2/13
 - 2 years : 11/ 13
- 2- Trained : 12/13
NR : 1/13
- 3- Topics of trainings :
 - MSR : 13/13
 - STI/AIDS
 - Vaccine
 - Hygiene, nutrition
 - Malaria, diarrhea
 - ARI
 - Maternal breastfeeding
 - FP
 - ORS
 - ARI
- 4- Worked as a midwife :
 - ANC (sensibilisation)
 - Birth delivery at CSB
 - FP
 - AIDS (fight)
 - Hygiene (sensibilisation)
 - Distribution of folders
 - Visits pregnant women
 - Attends birth deliveries
 - Visits women ante natally
 - Promotion of breastfeeding
 - Vaccine
 - ARI

- Nutrition
- 5- Do you know the ADRA Technical Agent?
 - YES : 10/13
 - NR : 3/13

Their Names : Sylvain, Edmond, Raymond, Gérard, Christophe, Fredo

- 6- Do you collaborate with them :
 - YES : 13/13
- 7- Type of collaboration :
 - Promotion of FP
 - Visits to new mothers and newborns
 - Promotion of breastfeeding
 - Distribution of folders
 - Visits to households
 - Use of T-shirts,caps, luggage, penis models
- 8- Last encounter with the ADRA technicians :
 - 23 May 2006 (1/13)
 - 06 May, 12 June 2006 (9/13)
 - 23 June 2006 (1/13)
 - 29 June , 30 June 2006 (1/13)
 - NR (1/13)
- 9- Context of the encounter:
 - Breasfeeding
 - Filling up of work reports
 - Festival
 - Put back to level
 - Follow-up of matron
- 10-Collaboration :
 - Satisfactory : 12/13
 - NR : 1/13
- 11-Suggestions for improvement :
 - Encourage the family to listen to the radio at 6 pm in the evening
 - Re-stock the kit (alcohol, scissors)
 - Put back to level
 - Increase the length of training
 - Do more of the sensibilisations together with ADRA technicians
- 12-Who supported you in your work?
 - NR (13/13)
- 13-Last visit of supervision :
 - 11 June 06 (2/13)
 - 12 June 06 (9/13)
 - 23 June 06 (1/13)
 - 30 June 06 (1/13)
- 14-Topic of discussion :
 - New strategies for home visits

- FP, malaria, diarrhea, nutrition, STI/AIDS
 - Put back reports on time
 - Nutrition
- 15-Periodic meetings :
- Every month : 11/13
 - Every 3 months : 1/13
 - NR : 1/13
- 16-Filling out the work reports
- YES (12 /13)
 - NR (1/13)
- 17-Frequency :
- Every month : 12/13
 - NR : 1/13
- 18-Reception of briefcase or portafolio :
- YES : 2/13
 - NO: 8/13
 - NR : 3/13
- 19-Contents of the box :
- Leaflets, card counsels, training modules, newspaper, illustrated cards, pamphlets, brochures
 - Brushes for nails, blades, scissors, gloves, alcohol
 - Illustrated cards, leaflets, brochures
- 20-Does the box contain all that is necessary?
- YES : 3/13
 - NO : 8/ 13 (c'est seulement le flip chart qui manque)
 - NR : 2/13
- 21-Receipt of the birthing kit: Only for midwife's
- 22-Method of restocking the kit :
- Buy at the pharmacy
 - We want ADRA to buy them
- 23-In order to work better :
- We want ADRA to supply us with medications 2/13
 - We want a balance, scissors, gloves, and compresses 1/13
 - We want a little compensation (8/13)
- 24-Intention to continue the activities after the endo of the project :
- YES : 12/13
 - NR : 1/13
- 25-Suggestions for the perpetuation :
- Encourage the people to continue the good results
 - Continue the sensitisation of mothers and pregnant women
 - Organize periodic community sensibilisation with the contribution of ADRA technicians
- 26-Impacts :
- Declaration of elevated births
 - Motivation for FP and vaccination

- Thirst to learn the counsels relating to health
- Donation of mosquito nets
- The people are in good health
- ANC at the CSB for pregnant women
- Vaccination supplements for up to 11 months for babies
- Reduction in infant and maternal mortality rates
- Increase in the intellectual level of the mothers
- Sensibilisation of familles
- Protection against disease
- Receipts of medications and mosquito nets
- Reduction in malaria
- Hand washing by the midwives before delivery of the pregnant women
-

27-QUESTION REPONSES : Questions that are well answered

Questionnaires des Meres - VVT

Est-ce qu'il y a un partenaire communautaire dans votre village ? Accoucheuse Traditionnelle ? 5PC- 6AT

Si oui, comment s'appellent-ils/elles ? PC Connus : 4 ; PC inconnus : 1
AT Connues : 5 ; AT inconnues : 1

Qu'est-ce qu'elles/ils font ?

- pesent les enfants : 1/7
- donnent des vitamines : 1/7
- donnent des formations : 1/7
- incitent/emmenent les meres au CSB/ Hopital : 4/7
- donnent des conseils sur la sante infantile : 1/7
- campagne de vaccination : 2/7
- sensibilisent la sante maternelle (paludisme, diarrhee...) : 1/7
- nutrition : 1/7

Quelle est votre impression concernant le travail du partenaire communautaire ?

- NR : 4/7
- BON : 2/7
- SATISFAISANT : 1/7

Est-ce que vous avez reçu une visite d'un partenaire communautaire ? Oui (5/7) , Non (1/7), NR (1/7)

Quand ? 2-4 semaines : 1/7
+ 4 semaines : 4/7
NR : 1/7

Qu'est-ce qu'elle/il fait ?

- SRO : 2/7
- distribution des vitamines, palustop : 2/7
- nutrition (sensibilisation) : 1/7
- hygiène : 2/7
- Lutte contre le SIDA : 1/7
- NR : 3/7

Est-ce qu'elle/il a utilisé autres types d'outils ?

- Cartes illustrées : 1/7
- Brochures : 1/7

Que pensez-vous des soins (techniques & qualitatives) du CSB ?

- Bien faits : 4/7
- Progres : 1/7
- Satisfaisants : 2/7

Comment faut-il les améliorer ?

- Je veux que le projet atteigne mon village à Ambodimanga car ici c'est assez loin de chez moi
- Donner de repas aux malades hospitalisés
- Donner des médicaments gratuitement
- Faire des sensibilisations par affiche dans les zones qu'on ne peut pas capter la Radio Mazava et Alpha

Où est-ce que vous avez mis au monde (accouché) votre bébé ?

- CSB : 1/7
- Hopital : 1/7
- Matrone : 4/7
- NR : 1/7

Avez-vous entendu des messages à la radio de la part d'ADRA ? OUI (5/7), NON (2/7)

Sur quoi ? - Santé infantile et maternelle : 1/7

- Vaccination : 1/7
- Visites prénatales : 1/7
- Moustiquaires /paludisme: 3/7
- Diarrhée : 1/7
- IRA : 1/7
- Nutrition : 1/7
- NR : 1/7

Quels étaient les messages principaux _____

Avez-vous déjà rencontré qq'un de l'équipe d'ADRA ? OUI (4/7), NON (3/7)

Si oui, quand ?

- L'année dernière : 1
- 5 mois passés : 1
- Oublié : 3

Quelle était la raison de sa visite? PF : 1, NR : 3

Qu'est-ce qui s'est passé pendant la visite?

- Communication avec les villageois, promotion sur les moustiquaires, visite de supervision sur l'hygiène, donation du thé et de repas après la ligature de trompe (avec MARIE STOPES)

Est-ce que vous avez trouvé la visite utile ? Pourquoi ? Comment ?

OUI (4/7) ; Raisons :

- Les enfants sont en bonne santé
- L'ADRA donne de quoi à manger aux enfants malnourris et cela diminue le taux de mortalité infantile
- Augmente ma connaissance sur le plan sanitaire

NON (3 /7) :

- L'ASAP ne m'a pas encore visité mais je l'ai juste rencontré à Vavatenina
- NR

Compilation -Questionnaires des Mères à TMT II

Est-ce qu'il y a un partenaire communautaire dans votre village ? Accoucheuse Traditionnelle ? OUI

Si oui, comment s'appellent-ils/elles ? PC Connus : 4/5 ; PC inconnus : 1/5

AT Connues : 2/5 ; AT inconnues : 3/5

Qu'est-ce qu'elles/ils font ?

- pesent les enfants : 4 /5
- donnent des vitamines : 1/5
- hygiène : 1 /5
- incitent/emmenent les mères au CSB/ Hôpital : 2 /5
- donnent des conseils sur la santé infantile : 1/5
- campagne de vaccination : 1/5
- sensibilisent la santé maternelle (paludisme, diarrhée...) : 2/5
- nutrition : 1/5
- CPN : 2/5
- PF : 1/5

Quelle est votre impression concernant le travail du partenaire communautaire ?

- NR : 2/5

- SATISFAISANT : 2 /5
- INTERESSANT : 2/5

Est-ce que vous avez reçu une visite d'un partenaire communautaire ? Oui (4/5) , Non (1/5)

- Quand ?
- 2-4 semaines : 1/5
 - + 4 semaines : 1/5
 - Aujourd`hui :1/5
 - Avant Hier :1/5
 - NR : 1/5

Qu'est-ce qu'elle/il fait ?

- distribution des vitaminesA :1/5
- palustop :1 /5
- nutrition (sensibilisation) : 1/5
- hygiene : 1/5
- construction des latrines : 1/5
- deparasitage: 1/5
- PF : 1 /5
- NR : 1/5

Est-ce qu'elle/il a utilise autres types d'outils ?

- Cartes illustrees : 0/5
- Brochures : 0/5
- Fiche de suivi de croissance : 2/5
- Tissu : 1/5

Que pensez vous des soins (techniques & qualitatives) du CSB ?

- Bien faits : 1/5
- Tres satisfaisants : 1/5
- Tres interessants : 1/5
- NR : 2/5

Comment faut-il les améliorer ?

- Il faut augmenter le nombre des Personnels du projet pour ne pas attendre longtemps pour la vaccination
- Besoin des visites frequentes

Où est-ce que vous avez mis au monde (accouché) votre bébé ?

- Hopital : 1/5
- Matrone : 4/5

Avez vu entendu des messages à la radio de la part d'ADRA ? OUI (2/5), NON (3/5)

- Sur quoi ?
- Sante infantile et maternelle : 1/5
 - Vaccination : 1/5
 - Visites prenatales : 1/5

Quels étaient les messages principaux

Avez-vous déjà rencontré qq'un de l'équipe d' ADRA ? OUI (1/5), NON (4/5)

Si oui, quand ?

- Juin 2006 : 1/5

Quelle était la raison de sa visite? PF : 1/5, IST/SIDA : 1/5

Qu'est-ce qui s'est passé pendant la visite?

- Préparation de SRO
- Traitement D'eau (Sur Eau)

Est-ce que vous avez trouvé la visite utile ? Pourquoi ? Comment ?

OUI (3/5) ;

Raisons :

- Nous connaissons maintenant comment on traite l'eau, SRO, l'hygiène de la famille, on est bien informé sur le plan sanitaire.
- Nous utilisons maintenant de moustiquaire et Palustop, nous avons une fosse à ordures, notre environnement devient propre, il y a des collaborations entre les mères et le CSB et l'ADRA ; il y a aussi un changement de comportement.
- Les enfants sont en bonne santé, pas de paludisme, les nouveaux sont vaccinés, nous pouvons faire le SRO quand il y a présence de la diarrhée, les enfants sont soignés par le médecin du CSB

NON (2 /5) :

Raisons : NR

COMPILATION DES RESULTATS PC – VVT

Effectifs : 13

28-Année de travail comme PC :

- 1 an : 2/13
- 2 ans : 11/ 13

29-Formés : 12/13

NR : 1/13

30-Sujets de formation :

- MSR : 13/13
- IST/SIDA
- Vaccin
- Hygiène, nutrition
- Paludisme, Diarrhée
- IRA

- Allaitement Maternel
- PF
- SRO
- IRA

31-Travaux comme PC :

- CPN (sensibilisation)
- Accouchement au CSB
- PF
- SIDA (lutte)
- Hygiène (sensibilisation)
- Distribution des dépliants
- Visite des femmes enceintes
- Assister aux accouchements
- Visite des femmes après l'accouchement
- Allaitement maternel (promotion)
- Vaccin
- IRA
- Nutrition

32-Connaissez-vous l' Agent Technique de l'ADRA ?

- OUI : 10/13
- NR : 3/13

Leur nom : Sylvain, Edmond, Raymond, Gérard, Christophe, Fredo

33-Collaboration avec eux :

- OUI : 13/13

34-Type de collaboration :

- Promotion du PF
- Visites des nouvelles mères/ nouveaux nés
- Promotion de l'allaitement maternel
- Distribution des dépliants
- Visites des ménages ensemble
- Utilisation des T-shirts,casquettes, malles, penis models

35-Dernière rencontre avec les techniciens de l'ADRA :

- 23 Mai 2006 (1/13)
- 06 Mai, 12 Juin 2006 (9/13)
- 23 Juin 2006 (1/13)
- 29 Juin , 30 Juin 2006 (1/13)
- NR (1/13)

36-Contexte de la rencontre :

- Allaitement maternel
- Remplissage de rapports de travail
- Festival
- Remise à niveau
- Suivi de matrones

37-Collaboration :

- Satisfait : 12/13
 - NR : 1/13
- 38-Suggestions d'amélioration :
- Inciter la famille d'écouter la radio à 18h du soir
 - Dotation de balance et kit (alcool, ciseaux)
 - Remise à niveau fréquente
 - Augmenter la durée de formation
 - Faire davantage des sensibilisations ensemble avec les techniciens de l'ADRA
- 39- Qui vous a donné l'appui dans votre travail ?
- NR (13/13)
- 40-Dernière visite de supervision :
- 11 Juin 06 (2/13)
 - 12 Juin 06 (9/13)
 - 23 Juin 06 (1/13)
 - 30 Juin 06 (1/13)
- 41-Sujet de discussion :
- Nouvelles stratégies pour la visite à domicile
 - PF, paludisme, diarrhée, nutrition, IST/SIDA
 - Remise des rapports à temps
 - Nutrition
- 42-Réunions périodiques :
- Chaque mois : 11/13
 - Tous les 3 mois : 1/13
 - NR : 1/13
- 43-Remplissage des rapports de travail
- OUI (12 /13)
 - NR (1/13)
- 44-Fréquence :
- Chaque mois : 12/13
 - NR : 1/13
- 45-Réception de trousse ou cartable :
- OUI : 2/13
 - NON : 8/13
 - NR : 3/13
- 46-Contenu de la boîte :
- Dépliants, cartes conseils, module de formation, gazette, cartes illustrées, brochures
 - Brosse à ongle, lame, ciseaux, gants, alcool
 - Cartes illustrées, dépliants, brochures
- 47-Est-ce que la boîte contient tout ce qu'il faut ?
- OUI : 3/13
 - NON : 8/ 13 (c'est seulement le flip chart qui manque)
 - NR : 2/13
- 48-Réception de kit d'accouchement : Seulement pour les matrones
- 49-Mode de renouvellement du stock :

- Achat à la pharmacie
- Nous voulons qu'ADRA les achète

50-Pour mieux travailler :

- Nous voulons qu'ADRA nous approvisionne des médicaments 2/13
- Nous voulons de balance, ciseaux, gants, compresses 1/13
- Nous voulons un peu d'indemnité (8/13)

51-Intention de continuer les activités même après la fin du projet :

- OUI : 12/13
- NR : 1/13

52-Suggestions pour la pérennisation :

- Encourager les gens de continuer les résultats
- Continuer la sensibilisation des mères et femmes enceintes
- Organiser périodiquement de sensibilisation communautaire avec la contribution des techniciens de l'ADRA

53-Impacts :

- Déclaration de naissance élevée
- Motivation pour le PF et vaccination
- Soif d'apprendre les conseils relatifs à la santé
- Donation des moustiquaires
- Les gens sont en bonne santé
- CPN au CSB pour les femmes enceintes
- Vaccination complète jusqu'à 11 mois pour les bébés
- Diminution des taux de mortalité infantile et maternel
- Augmentation du niveau intellectuel des mères
- Sensibilisation des familles
- Protection contre les maladies
- Réception des médicaments et moustiquaires
- Diminution de paludisme
- Lavage des mains pour les matrones avant de faire accoucher les femmes enceintes
-

27- QUESTION REPONSES : les questions sont presque bien répondues

Questionnaires of midwives – TMT II

Effective: 3 midwives

- 1- Years of work as a midwife:
 - 3 years
 - 2- Schooled: YES (2/3), NR (1/3)
 - 3- Subjects of classes:
 - MSR (3/3)
 - Malaria, diarrhea, AIDS, CPN, child growth
 - Transportation system (emergency) (1/3)
 - ORS, ARI (2/3)
 - Vaccination
 - Exclusive breastfeeding (1/3)
 - 4- Need of more classes?
 - YES (2/3)
 - NR (1/3)
 - 5- Need of classes in: concerned about handing over AIDS
 - 6- Work as midwife:
 - Visit pregnant women: 1/2
 - Visit women after delivery: 1/2
 - Sale of mosquito nets : 1/2
 - Others: increase awareness of malaria, ADD, and immunization with the head of the CSB
- Technical agents of ADRA:
YES: 3/2
Names: Dr Holy, Edmond, Gérard, Dr Josué, Joeline
- 7- Collaboration:
 - YES: 3/3
 - 8- Type of collaboration:
 - maternal health, infant health, filling out of reports, monthly meeting
 - 9- Last meetings with the ADRA technician:
 - June 29 and 30, 2006
 - June 08, 2006
 - June 2006
 Topic of the meeting:
 - Monthly meeting, FP (increase awareness)
 - New instructions for good workers
 - 10- Satisfied (collaboration)? YES (1/3), NR (2/3)
 - 11- Suggestions for the improvement of the partnership:
 - Classes on a uniform level on AIDS and ARI
 - Need more mosquito nets to sell

- 12- Impacts:
- People come more frequently to the CSB.
 - Women begin to use the mosquito nets, whereby there is a decrease in malaria
- 13- Who has supported you in your work? NR (1/3), an ADRA technician (2/3)
- 14- Last supervision visit:
- June 2006 (2/3)
 - May 2006 (1/3)
- 15- Discussion topics: NR (3/3)
- 16- Periodic meetings: YES (3/3)
- 17- Frequency:
- Every month (2/3), Once a year
- 18- Filling out the activity report: YES (3/3)
Notice: Some times, it is difficult for the midwives to fill out the work reports and that necessitates a decrease in level
- Frequency: - Monthly (2/2)
- 19- Have you received a briefcase or portfolio?
- YES (2/3)
 - NR (1/3)
- 20- Does the box contain all that is necessary? YES (3/3)
- 21- Receipt of birthing kit: YES (1/3), NR (2/3)
- 22- Stocking renewal method
- Purchase from pharmacy
- 23- What would you like to have in order to improve your work?
- the 5 different folders
- 24- Intention to continue activities after the end of the project:
YES (3/3)
- 25- Suggestions for the perpetuation of activities:
- a. Regular classes, organized meetings between the CSB and midwives.
- 26- 1 COSAN, 0 CASC, 1 CVA

Technical questions: The midwives need a decrease to level in the technical classes.

Questionnaires des PC– TMT II

Effectifs : 3PC

- 1- Année de travail comme PC :
 - 3 ans
- 2- Formés : OUI (2/3), NR (1/3)
- 3- Sujets de formation :
 - MSR (3/3)
 - Palu,diarrhée, ,SIDA,CPN, croissance de l'enfant
 - Système de transport (urgence) (1/3)
 - SRO, IRA (2/3)
 - Vaccination
 - Allaitement maternel exclusif (1/3)
- 4- Besoin d'autres formations ?
 - OUI (2/3)
 - NR (1/3)
- 5- Besoin de formation en : remise a niveau concernant le SIDA
- 6- Travail comme PC :
 - Visiter les femmes enceintes : 1/2
 - Visiter les femmes après l'accouchement : 1/2
 - Vendre des moustiquaires : 1/2
 - Autres : Sensibilisation de paludisme, diarrhée, vaccination (avec le chef CSB)
- Agents techniques de l'ADRA :
 - OUI : 3/2
 - Noms : Dr Holy, Edmond, Gérard, Dr Josué, Joeline
- 7- Collaboration :
 - OUI : 3/3
- 8- Type de collaboration :
 - Santé maternelle, santé infantile, remplissage de rapports, réunion mensuelle
- 9- Dernières rencontres avec le technicien de l'ADRA : - 29 Juin 2006 et 30 Juin 2006
 - 08 Juin 2006
 - Juin 2006
 Sujet de la rencontre :
 - Réunion mensuelle, PF (sensibilisation)
 - Nouvelles instructions pour les bons travailleurs
- 10- Satisfait (collaboration)? OUI (1/3), NR (2/3)
- 11- Suggestions pour l'amélioration du partenariat :
 - Formation et remise à niveau régulier sur le SIDA, IRA
 - Besoin en moustiquaires à vendre

- 12- Impacts :
- Les gens viennent plus fréquemment au CSB
 - Les femmes commencent à utiliser des moustiquaires, d'où diminution de paludisme
- 13- Qui vous a donné l'appui dans votre travail ? NR (1/3), technicien de l'ADRA (2/3)
- 14- Dernière visite de supervision :
- Juin 2006 (2/3)
 - Mai 2006 (1/3)
- 15- Sujets de discussion : NR (3/3)
- 16- Réunions périodiques : OUI (3/3)
- 17- Fréquence :
- Chaque mois (2/3), 1 fois par an
- 18- Remplissage de rapport d'activité : OUI (3/3)
Remarque : Quelques fois, il est difficile aux PC de remplir les rapports de travail et cela nécessite une remise à niveau
Fréquence : - Chaque mois (2/2)
- 21- Avez-vous reçu une trousse ou cartable ?
- OUI (2/3)
 - NR (1/3)
- 22- Est-ce que la boîte contient tout ce qu'il faut ? OUI (3/3)
- 21- Réception du Kit d'accouchement : OUI (1/3), NR (2/3)
- 22- Mode de renouvellement du stock :
- Achat a la pharmacie
- 23- Qu'aimeriez-vous avoir pour mieux travailler ?
- les 5 différents dépliants
- 24- Intention de continuer les activités après la fin du projet :
OUI (3/3)
- 27-Suggestions pour la pérennisation des activités :
- a. Formations régulières, réunions organisées entre les CSB et les PCs
- 28- 1 COSAN, 0 CASC, 1 CVA

Questions techniques: Les PC ont besoin de remise à niveau sur les formations techniques

Questionnaire of AT- VVT

Name of matrons of VVT : 18

- 1- Years of experience :
 - 10- 15years :
 - 15-30 years :9/18
 - + de 30 years :1/18
 - NR : 8/18

- 2- 11 trained, 7 trained
- 3- MSR, breastfeeding
- 4- Do you have need for more training? NR
- 5- Changes after training :
 - No herb tea massage
 - No bath for newborn
 - Refer mother and baby for vaccinations
 - Encourage women to deliver at the CSB
 - Encourage women to notify when birthing
- 6- What is your work as a matron ?
 - To attend the childbirth
 - Promotion of exclusive breastfeeding (up to 6 months)
 - Promotion of FP
 - Encourage pregnant women to use ANC
 - Encourage pregnant women to deliver at the CSB
 - Vaccination
 - Accompany the pregnant woman to CSB for delivery
- 7- ADRA Technicians : Dr Sylvain, Gérard, Christophe, Edmond
- 8- Yes(1/2questionnaire),NO(1/2 questionnaire)
 - Promotion of FP
 - Visit newborns/mothers
 - Promotion of exclusive breastfeeding
 - Meeting for vaccination promotion
- 9- Last visit of the ADRA technician :
 - 13 June 2006 : Vaccination Festival
 - 30 June 2006 : At the stage of VVT

- 10- In which context? Reponse(1/2 questionnaire)
 - FP, Vaccination, MSR
- 11- Satisfied : yes
- 12- Suggestions :
 - Wish a little more motivation (mosquito nets, drapes, birthing kits)
 - Wish for more training
 - Wish to have more equipment so that I can do my work better
- 13- What do you think gave you support in your work ? :(1/2 questionnaire) : PC
- 14- Last supervision visit (1/2 questionnaire) Response:

- 30 June 2006
- 08 July 2006 (with the wise woman)
- 15- Subject discussed : Reponse (1/2 questionnaire)
 - FP
 - Care of newborn
 - Exclusive breastfeeding
- 16- Periodic meetings :
 - Frequency : every month (1/2)
 - All three months(1/2)
- 17- Work reports ? yes
 - Frequency : every month (1/2)
 - When the matron passes by
- 18- Reception of the bags :
 - yes (for the forms)
 - With all the necessary items
 - Missing items : gloves (1/2 questionnaire)
- 19- Process for renewing the stock (bags) :
 - Purchase in pharmacy except for gloves (not available)
- 20- What would you like to have to make your work better?
 - A little premium to be motivated
- 21- Do you want the activities to continue after the end of the project : yes(2/2)
- 22- Suggestions to make the activities annual :
 - Matrons to continue all awareness trainings (CPN)
 - We would like the CSB to continue its supervision
- 23- CASC or COSAN or CVA : No (2/2)
- 24- Changes after the trainings :
 - Before : Washing of the newborn
 - After :
 - Cleanse the body with a wet cloth
 - Progress on the mode of childbirth(1/2)
 - CPN after the visit from Dr. Sylvain
 - Distribution of free mosquito nets to pregnant women
 - After the training, the mothers have a lot more consideration for us.
- 25- Their wish for the work of the ASAP project in the community (1/2):
Visit and supervise regularly

TECHNICAL QUESTIONS (matrons)

General remarks Remarque générale : The matrons could answer all the questionnaires correctly

Questionnaire des AT- VVT

Nombre des matrones de VVT : 18

- 26- Années d'expérience :
- 10- 15ans :
 - 15-30 ans :9/18
 - + de 30 ans :1/18
 - NR : 8/18
- 27- 11 formées, 7 formées
- 28- MSR, allaitement
- 29- Avez – vous besoin d'autres formations? NR
- 30- Des changements apres la formation :
- Pas de massage ni de tisane
 - Pas de bain pour le nouveau né
 - Référer le bébé et la femme enceinte pour la vaccination
 - Inciter les femmes d'accoucher au CSB
 - Inciter les femmes à faire la déclaration de naissance
- 31- Quel est votre travail en tant que matrone ?
- Assister aux accouchement
 - Promotion d'allaitement maternel exclusif (jusqu'à 6 mois)
 - Promotion du PF
 - Inciter les femmes enceintes aux APN
 - Inciter les femmes à accoucher au CSB
 - Vaccination
 - Accompagner les femmes enceintes pour accoucher au CSB
- 32- Techniciens de l'ADRA : Dr Sylvain, Gérard, Christophe, Edmond
- 33- OUI(1/2questionnaire),NON(1/2 questionnaire)
- Promotion du PF
 - Visites des nouveaux nés/ mères
 - Promotion de l'allaitement maternel exclusif
 - Réunion de la promotion de vaccination
- 34- Dernière visite du technicien de l'ADRA :
- 13 Juin 2006 : Festival de vaccination
 - 30 Juin 2006 : Au Stade de VVT
- 35- Dans quel contexte ? Réponse(1/2 questionnaire)
- PF, Vaccination, MSR
- 36- Satisfait : OUI
- 37- Suggestions :
- souhaitent un peu plus de motivation (moustiquaires,draps,kit d'accouchements)
 - souhaitent plus de formations
 - souhaitent avoir plus d'équipements pour mieux travailler
- 38- Qui vous a donné d' appui dans votre travail ? Réponse :(1/2 questionnaire) : PC

- 39- Dernière visite de supervision : Réponse (1/2 questionnaire)
 - 30 Juin 2006
 - 08 Juillet 2006 (avec la sage femme)
- 40- Sujet de discussion : Réponse (1/2 questionnaire)
 - PF
 - Soins des nouveaux nés
 - Allaitement maternel exclusif
- 41- Réunions périodiques :
 - Fréquence : - Chaque mois(1/2)
 - Tous les 3 mois(1/2)
- 42- Rapports de travail ? OUI
 - Fréquence : - Chaque mois (1/2)
 - A chaque passage des matrones
- 43- Reception de trousse ou cartable :
 - OUI (pour les formées)
 - Avec tout le nécessaire
 - Article manquant : Gants (1/2 questionnaire)
- 44- Processus de renouvellement du stock :
 - Achat en pharmacie sauf pour les gants (non disponibles)
- 45- Qu'aimeriez vous avoir pour mieux travailler ?
 - Un peu de prime pour être plus motivées
- 46- Vouloir continuer les activités après la fin du projet : OUI (2/2)
- 47- Suggestions de pérennisation des activités :
 - Des matrones prêtes à continuer toutes sensibilisations (CPN)
 - Nous aimerions que le CSB continue sa supervision
- 48- CASC ou COSAN ou CVA : NON (2/2)
- 49- Changements après la formation :
 - Avant : Lavage du nouveau né
 - Après :
 - Essuyage du corps avec un tissu mouillé
 - Progrès sur le mode d'accouchement(1/2)
 - CPN après le passage du Dr Sylvain
 - Distribution gratuite des moustiquaires à des femmes enceintes
 - Après la formation les mères nous attribuent plus de considérations.
- 50- Leur souhait sur le travail de l'ASAP dans la communauté (1/2) : Visite de supervision régulière

QUESTIONS TECHNIQUES(matrones)

Remarque générale : Les matrones ont pu répondre correctement à toutes les questionnaires

Questionnaires for midwife's – TMT II

- 1- Years of experience: 12 years/ 21 years
- 2- Have you had classes? YES (2/3), NR (1/3)
- 3- Classes: MSR, ANC, post delivery visits, immunization, no massages, referral to the CSB for difficult deliveries, transportation system for pregnant women in case of emergencies.
- 4- Need for other classes? YES (1/3), NR (2/3)
- 5- Your work as a matron:
 - Assist in deliveries (3/3)
 - Visiting women before and after delivery (3/3)
 - Encourage the women to deliver at the CSB (3/3)
 - Immunization, hygiene (1/3)
 - FP (3/3)
- 6- Do you know the technical agent of ADRA? YES (3/3)
- 7- Their names (2/3 response), NR (1/3): Gérard, Joel, Dr Holy, Dr Josue
- 8- Collaboration with them: YES (3/3)
- 9- Type of collaboration: FP, classes, meetings, immunization (awareness)
- 10- Last encounter with the ADRA technician: 1 month ago (2/3), end of June (1/3)
- 11- Context of the meeting: Filling out of the report card
- 12- Collaboration: satisfactory (3/3)
- 13- Suggestions for improving the partnership:
 - Need of kiranyl (plastic shoes) and torch for the night
 - Continuity of the partnership to give councils
- 14- Impact of the project on the community:
 - Many people use the mosquito nets, hence the decrease in malaria
 - Infants are vaccinated
 - Infants have birth certificates
 - The risks during delivery have diminished thanks to the CSB
- 15- Last supervision visit: 1 month before (2/3), June (1/3)
- 16- Discussion subjects (2/3), NR (1/3): Activity report, immunization
- 17- Periodic meetings: YES (1/3), NO (1/3), NR (1/3)
- 18- Frequency: every month
- 19- Filling out of work reports: YES (1/3), NO (2/3)
 - Frequencies:
 - Every Saturday (1/3)
 - After every activity (1/3)
 - Every month (1/3)
- 20- Receipt of a briefcase or portfolio: YES (1/3), NO (2/3)
- 21- Contents of the box: illustrated charts, booklets, box with image, small newspaper, council chart, notebooks, report cards
- 22- The box contains everything that it needs: YES (1/3), NR (2/3)
- 23- What is it missing? NR (3/3)
- 24- Receipt of birthing kit: NO (1/3), NR (2/3)

- 25- Mode of renewal of stock: NR (2/3)
 - Ask the mother to buy the needed elements of the kit before the delivery.
- 26- What would you like to have to improve your work: alcohol, birthing kit.
- 27- Intention to continue the activities after the end of the project: YES (3/3)
- 28- Suggestions for the perpetuation of the project: NR (1/3)
 - Continuity of the collaboration with the CSB/SSD and the COSAN to help us.

Compilation -Questionnaires for Mothers - VVT

Is there a midwife in your village? TBA? 5 midwives - 6 TBA

If yes, what are their names? Known midwives: 4 ; Unknown midwives: 1
 Known TBAs: 5 ; Unknown TBAs: 1

What do they do?

- Weigh the children: 1/7
- Give vitamins: 1/7
- Give classes: 1/7
- Take/advise the mothers to go to the CSB/hospital: 4/7
- Give advice on child health: 1/7
- Vaccination campaign: 2/7
- Increase maternal health awareness (malaria, ADD...) : 1/7
- Nutrition: 1/7

What is your impression of the work of the midwives?

- NR: 4/7
- GOOD: 2/7
- SATISFACTORY: 1/7

Have you received a visit from the midwife? Yes (5/7), No (1/7), NR (1/7)

When? 2-4 weeks: 1/7

+ 4 weeks: 4/7

NR: 1/7

What does he/she do?

- ORS: 2/7
- Distribution of vitamins, palustop: 2/7
- Nutrition (awareness): 1/7
- Hygiene: 2/7
- Fight against AIDS: 1/7
- NR: 3/7

Has he/she used another type of tool?

- Illustration charts: 1/7

- Brochures: 1/7

What do you think of the care (technique & quality) of the CSB ?

- Well done: 4/7
- Progress: 1/7
- Satisfactory: 2/7

How can it improve?

- I want the project to come to my village in Ambodimanga because here, it is too far from my home.
- By giving meals to hospitalized patients
- By giving free medications
- Do awareness campaigns by poster in the areas that do not receive Radio Mazava and Alpha

Where did you have your baby?

- CSB: 1/7
- Hospital: 1/7
- Matron: 4/7
- NR: 1/7

Did you understand the radio messages from ADRA? YES (5/7), NO (2/7)

On what? - Infant and maternal health: 1/7

- Vaccination: 1/7
- Antenatal care: 1/7
- Mosquito nets/Malaria: 3/7
- ADD: 1/7
- ARI: 1/7
- Nutrition: 1/7
- NR: 1/7

What were the principal messages? _____

Have you encountered an ADRA team member? YES (4/7), NO (3/7)

If yes, when?

- Last year: 1
- 5 months ago: 1
- I don't remember: 3

What was the reason for their visit? FP: 1, NR: 3

What happened during the visit?

- Communication with the villagers, promotion on the mosquito nets, supervision visit on hygiene, complimentary tea and meal after the ligation of the fallopian tubes (with MARIE STOPES)

Did you find the visit useful? Why? How?

YES (4/7) ; Reason:

- The children are healthy
- ADRA donated food for malnourished infants, hence the infant mortality rate diminished
- My knowledge of the sanitation plan has increased

NO (3/7):

- The ASAP has not visited me again but I encountered them at Vavatenina
- NR

Questionnaires des matrones – TMT II

- 29- Années d'expérience : 12 ans/ 21ans
- 30- Formée ? OUI (2/3), NR (1/3)
- 31- Formation : MSR, CPN, visite après l'accouchement, vaccination, pas de massage, reference au CSB en cas d'accouchement difficile, systeme de transport en cas d'urgence pour les femmes enceintes
- 32- Besoin d'autres formations ? OUI (1/3), NR (2/3)
- 33- Vos travaux en tant que matrone :
- Assistent les accouchements (3/3)
 - Visitent les femmes enceintes/ après l'accouchement (3/3)
 - Incitent les femmes à accoucher au CSB (3/3)
 - Vaccination, hygiene (1/3)
 - PF (3/3)
- 34- Connaissez-vous les agents techniques de l'ADRA? OUI (3/3)
- 35- Leur nom (2/3 reponse), NR (1/3) : Gérard, Joel, Dr Holy, Dr Josue
- 36- Collaboration avec eux : OUI (3/3)
- 37- Type de collaboration : PF, formation, reunion, vaccin (sensibilisation)
- 38- Dernière rencontre avec le technicien de l'ADRA : 1mois passe (2/3), fin Juin (1/3)
- 39- Contexte de la rencontre : Remplissage de la fiche du rapport
- 40- Collaboration : satisfaisant (3/3)
- 41- Suggestions d'amélioration du partenariat :
- Besoin en kiranyl (chaussures plastiques)et torche pour la nuit
 - Continuïte du partenariat pour se donner des conseils
- 42- Impacts du projet sur la communaute:
- Beaucoup de gens utilisent les moustiquaires, d'où diminution de paludisme
 - Les enfants sont vaccinés
 - Les enfants ont de copies de naissance

- Les risques pendant l'accouchement diminuent grâce au CSB
- 43- Dernière visite de supervision : 1 mois avant (2/3), Juin (1/3)
- 44- Sujet de discussion (2/3), NR (1/3): Rapport d'activité, vaccination
- 45- Réunions périodiques : OUI (1/3), NON (1/3), NR (1/3)
- 46- -Fréquence : Chaque mois
- 47- Remplissage des rapports de travail : OUI (1/3), NON (2/3)
Fréquences :
 - Chaque Samedi de la semaine (1/3)
 - Apres chaque activite (1/3)
 - Chaque mois (1/3)
- 48- Reception de trousse ou cartable : OUI (1/3), NON (2/3)
- 49- Contenu de la boîte : cartes illustrées, brochures, boîte à image, petit journal, carte conseil, cahiers, fiches de rapport
- 50- La boîte contient tout ce qu'il faut : OUI (1/3), NR (2/3)
- 51- Qu'est ce qui manque ? NR (3/3)
- 52- Reception du kit d'accouchement : NON (1/3), NR (2/3)
- 53- Mode de renouvellement du stock : NR (2/3)
 - Demander a la mere d'acheter les elements utiles du kit avant l'accouchement
- 54- Qu'aimeriez vous avoir pour mieux travailler : alcool, impermeable, kit d'accouchement
- 55- Intention de continuer les activités après la fin du projet : OUI (3/3)
- 56- Suggestions de pérennisation du projet : NR (1/3)
 - Continuite de collaboration avec le CSB/SSD et COSAN pour nous aider

Compilation -Questionnaires des Meres - VVT

Est-ce qu'il y a un partenaire communautaire dans votre village ? Accoucheuse Traditionnelle ? 5PC- 6AT

Si oui, comment s'appellent-ils/elles ? PC Connus : 4 ; PC inconnus : 1
AT Connues : 5 ; AT inconnues : 1

Qu'est-ce qu'elles/ils font ?

- pesent les enfants : 1/7
- donnent des vitamines : 1/7
- donnent des formations : 1/7
- incitent/emmenent les meres au CSB/ Hopital : 4/7
- donnent des conseils sur la sante infantile : 1/7
- campagne de vaccination : 2/7
- sensibilisent la sante maternelle (paludisme, diarrhee...) : 1/7
- nutrition : 1/7

Quelle est votre impression concernant le travail du partenaire communautaire ?

- NR : 4/7
- BON : 2/7

- SATISFAISANT : 1/7

Est-ce que vous avez reçu une visite d'un partenaire communautaire ? Oui (5/7) , Non (1/7), NR (1/7)

Quand ? 2-4 semaines : 1/7
 + 4 semaines : 4/7
 NR : 1/7

Qu'est-ce qu'elle/il fait ?

- SRO : 2/7
- distribution des vitamines, palustop : 2/7
- nutrition (sensibilisation) : 1/7
- hygiène : 2/7
- Lutte contre le SIDA : 1/7
- NR : 3/7

Est-ce qu'elle/il a utilisé autres types d'outils ?

- Cartes illustrées : 1/7
- Brochures : 1/7

Que pensez vous des soins (techniques & qualitatives) du CSB ?

- Bien faits : 4/7
- Progres : 1/7
- Satisfaisants : 2/7

Comment faut-il les améliorer ?

- Je veux que le projet atteigne mon village a Ambodimanga car ici c'est assez loin de chez moi
- Donner de repas aux malades hospitalisés
- Donner des médicaments gratuitement
- Faire des sensibilisations par affiche dans les zones qu'on ne peut pas capter la Radio Mazava et Alpha

Où est-ce que vous avez mis au monde (accouché) votre bébé ?

- CSB : 1/7
- Hopital : 1/7
- Matrone : 4/7
- NR : 1/7

Avez-vous entendu des messages à la radio de la part d'ADRA ? OUI (5/7), NON (2/7)

Sur quoi ? - Santé infantile et maternelle : 1/7
 - Vaccination : 1/7
 - Visites prénatales : 1/7

- Moustiquaires /paludisme: 3/7
- Diarrhee : 1/7
- IRA : 1/7
- Nutrition : 1/7
- NR : 1/7

Quels étaient les messages principaux _____

Avez-vous déjà rencontré qq'un de l'équipe d' ADRA ? OUI (4/7), NON (3 /7)

Si oui, quand ?

- L'année dernière : 1
- 5 mois passés : 1
- Oublié : 3

Quelle était la raison de sa visite? PF : 1, NR : 3

Qu'est-ce qui s'est passé pendant la visite?

- Communication avec les villageois, promotion sur les moustiquaires, visite de supervision sur l'hygiène, donation du thé et de repas après la ligature de trompe (avec MARIE STOPES)

Est-ce que vous avez trouvé la visite utile ? Pourquoi ? Comment ?

OUI (4/7) ; Raisons :

- Les enfants sont en bonne santé
- L'ADRA donne de quoi à manger aux enfants malnourris et cela diminue le taux de mortalité infantile
- Augmente ma connaissance sur le plan sanitaire

NON (3 /7) :

- L'ASAP ne m'a pas encore visité mais je l'ai juste rencontré à Vavatenina
- NR

Questionnaires for Mothers in TMT II

Is there a midwife in your village? TBA? YES

If yes, what are their names? Known midwives: 4/5 ; Unknown midwives: 1/5
Known TBAs: 2/5 ; Unknown TBAs: 3/5

What do they do?

- Weigh children: 4 /5
- Give vitamins: 1/5
- Hygiene : 1 /5
- Take/advise the mothers to go to the CSB/hospital: 2/5
- Give advice on infant health: 1/5
- Vaccination campaign: 1/5
- Provide awareness on maternal health (malaria, ADD...) : 2/5
- Nutrition: 1/5
- ANC: 2/5
- FP: 1/5

What is your impression on the work of the midwives?

- NR: 2/5
- SATISFACTORY: 2/5
- INTERESTING: 2/5

Have you received a visit from a midwife? Yes (4/5), No (1/5)

When? 2-4 weeks: 1/5
+ 4 weeks: 1/5
Today: 1/5
Yesterday: 1/5
NR: 1/5

What does he/she do?

- Distribute vitamin A: 1/5
- Palustop:1 /5
- Nutrition (awareness): 1/5
- Hygiene: 1/5
- Construction of latrines: 1/5
- Deparasitization: 1/5
- FP: 1 /5
- NR : 1/5

Did he/she use another type of tool?

- Illustrative charts: 0/5
- Brochures: 0/5
- Growth sheet monitoring: 2/5

- Fabric : 1/5

What do you think of the care (technique & quality) of the CSB ?

- Well done: 1/5
- Very satisfactory: 1/5
- Very interesting: 1/5
- NR: 2/5

How may it improve?

- It is necessary to increase the number of personnel on the project in order to wait less time for vaccination
- More frequent visits

Where did you have your baby?

- Hospital: 1/5
- Matron: 4/5

Did you understand the radio messages fro ADRA? YES (2/5), NO (3/5)

On what? - Maternal and infant health: 1/5

- Vaccination: 1/5
- Antenatal care: 1/5

What were the main messages? _____

Have you already encountered an ADRA team member? YES (1/5), NO (4/5)

If yes, when?

- June 2006: 1/5

What was the reason for their visit? FP: 1/5, STDs/AIDS: 1/5

What happened during the visit?

- Preparation de ORS
- Water treatment (On what)

Did you find the visit useful? Why? How?

YES (3/5);

Reasons:

- We now know about water treatment, ORS, family hygiene, and are well informed on the sanitary plan.
- We now use mosquito netting and Palustop, we have a garbage dump, our environment is cleaner, there is cooperation between mothers, the CSB, and ADRA, and there is a behavior change.
- Children are in good health, without malaria, newborns are vaccinated, we can administer ORS when there is ADD, and the infants are cared for by doctors from the CSB.

NO (2/5):

Reasons: NR

Questionnaires des Meres à TMT II

Est-ce qu'il y a un partenaire communautaire dans votre village ? Accoucheuse Traditionnelle ? OUI

Si oui, comment s'appellent-ils/elles ? PC Connus : 4/5 ; PC inconnus : 1/5
AT Connues : 2/5 ; AT inconnues : 3/5

Qu'est-ce qu'elles/ils font ?

- pesent les enfants : 4 /5
- donnent des vitamines : 1/5
- hygiene : 1 /5
- incitent/emmenent les meres au CSB/ Hopital : 2 /5
- donnent des conseils sur la sante infantile : 1/5
- campagne de vaccination : 1/5
- sensibilisent la sante maternelle (paludisme, diarrhee...) : 2/5
- nutrition : 1/5
- CPN : 2/5
- PF : 1/5

Quelle est votre impression concernant le travail du partenaire communautaire ?

- NR : 2/5
- SATISFAISANT : 2 /5
- INTERESSANT : 2/5

Est-ce que vous avez reçu une visite d'un partenaire communautaire ? Oui (4/5) , Non (1/5)

Quand ? 2-4 semaines : 1/5
+ 4 semaines : 1/5
Aujourd`hui :1/5
Avant Hier :1/5
NR : 1/5

Qu'est-ce qu'elle/il fait ?

- distribution des vitaminesA :1/5
- palustop :1 /5
- nutrition (sensibilisation) : 1/5
- hygiene : 1/5
- construction des latrines : 1/5
- deparasitage: 1/5
- PF : 1 /5
- NR : 1/5

Est-ce qu'elle/il a utilise autres types d'outils ?

- Cartes illustrees : 0/5
- Brochures : 0/5
- Fiche de suivi de croissance : 2/5
- Tissu : 1/5

Que pensez vous des soins (techniques & qualitatives) du CSB ?

- Bien faits : 1/5
- Tres satisfaisants : 1/5
- Tres interessants : 1/5
- NR : 2/5

Comment faut-il les améliorer ?

- Il faut augmenter le nombre des Personnels du projet pour ne pas attendre longtemps pour la vaccination
- Besoin des visites frequentes

Où est-ce que vous avez mis au monde (accouché) votre bébé ?

- Hopital : 1/5
- Matrone : 4/5

Avez vu entendu des messages à la radio de la part d'ADRA ? OUI (2/5), NON (3/5)

Sur quoi ? - Sante infantile et maternelle : 1/5
 - Vaccination : 1/5
 - Visites prenatales : 1/5

Quels étaient les messages principaux

Avez-vous déjà rencontré qq'un de l'équipe d'ADRA ? OUI (1/5), NON (4/5)

Si oui, quand ?

- Juin 2006 : 1/5

Quelle était la raison de sa visite? PF : 1/5, IST/SIDA : 1/5

Qu'est-ce qui s'est passe pendant la visite?

- Preparation de SRO
- Traitement D'eau (Sur Eau)

Est-ce que vous avez trouvé la visite utile ? Pourquoi ? Comment ?

OUI (3/5) ;

Raisons :

- Nous connaissons maintenant comment on traite l'eau, SRO, l'hygiene de la famille, on est bien informé sur le plan sanitaire.
- Nous utilisons maintenant de moustiquaire et Palustop, nous avons une fosse a ordure, notre environnement devient propre, il y a des collaboration entre les meres et le CSB et l'ADRA ; il y a aussi un changement de comportement.

- Les enfants sont en bonne sante, pas de paludisme, les nouveau sont vaccinés, nous pouvons faire le SRO quand il y a presence de la diarrhee, les enfants sont soignes par le medecin du CSB

NON (2 /5) :

Raisons : NR

Compilation of the Results -VVT & TMT II Questionnaire for the Staff of the CSB

Positions: Head of CHD (VVT), Head of CSB Maromitety (VVT), Head of CSB Anjahambe (VVT), Head of CSB Ampasamadinika (Tmt II), Head of CSB Ambodibonara_____

How many years have you worked as X (nurse, SF, Doctor) in the CSB?

Have you had classes? YES (4) NO

In what subjects?

5 C-IMCI

1 Integral supervision

4 Management/Gestion/MBOs

4 COPE

4 Project mounting

2 Training of trainers

1 Social marketing

2 Maternity without risk

1 Nutrition

3 Birth spacing

_____ HIV/IADS/STDs

2 IEC/CCC

_____ FDF

_____ PRA

_____ Emergency transport systems for pregnant women

_____ Mobile strategy for community awareness

Others _____

Did you do anything differently before your training/classes?

If yes, what? __3 people from VVT conducted training (TBAs & PCs, COSAN) _____

VVT

- 1) IMCI- I've integrated the protocols into my consultations for U5s; makes it easier to diagnose & gives better results but I can't use it b/c I don't have any more IMCI forms (the algorithm are also buried underneath a stack of reference materials)
- 2) Staff Management – "I now ask for their opinion- the paramedical staff- I know that they have a lot more experience than I do" I'm not as difficult (stern) as I used to be
- 3) Supervision – I haven't used the checklist yet, when we tried it during the training it was too long, not practical
- 4) COPE- I haven't applied it b/c I don't have the documents (manual) and b/c we don't have an external facilitator; no per diems to pay them; this

- should come from Tmt II – “Sylvain is aware of this” (??) (1); we applied COPE here & even the guardian has changed his attitude/way of greeting people (before he was a bit lazy) (1)
- 5) Project development- I haven't yet applied these skills b/c of my heavy workload (1); this has helped me in preparing my PTA and with the RRI
 - 6) IEC/CCC- I have changed the way I conduct awareness raising, e.g. before we would tell them everything we had in our heads, now we think of “PAFI” (petite chose, mais grande importance) – one subject at a time; I also notice that more women come to the CSBs either for vaccination or for PNC (2) our communication is different (before women were fearful of coming to the CSB)
 - 7) I have learned many additional skills, but do not have the opportunity to use them here (at VVT CHD; i.e. they are not w/in my responsibilities, such as holding meetings)
 - 8) FP: Found solutions to our problems; increased FP coverage
 - 9) Nutrition: women are coming to the CSB more often; infants' weights have increased and the rate of malnourished children has dropped; fewer cases of diarrhea
 - 10) The FDF have changed my way of speaking toward my colleagues

Do you need anymore training? Yes No

If yes, in what?

Remise a niveau en Management (VVT CHD)

Vaccination & IMCI (CSB- nurse has Maromitety) (LM's opinion based on fact that ¾ of IMCI-related responses were incorrect)

What is your job as a worker of the CSB?

Assist in deliveries

Visit pregnant women

Promotion of exclusive breastfeeding

Visit women after delivery

Promotion of FP

Distribution of mosquito netting

Supervisión of the TBAs and the midwives

Applying COPE

Other

Do you know the ADRA Technical Agent? 5/5 YES NO

What is their name?

5/5

Have you worked with them? 5/5 YES NO

What type of collaboration? On what have you collaborated?

FP promotion

- visiting new mothers/newborns
 Promotion of exclusive breastfeeding
 Other

Assumption of responsibility of the allowances during the periodic review; To provide the mosquito nets PSI, Day Health; Tmt II: provide refresher training; joint supervision

When was the last time that you saw the ADRA Technical Agent? ___ every 2 months ___ (1), Friday, June 30, in the last month (4), 2 weeks ago

In what context did you see them? ___ delivery of mosquito net; program planning; supervision of midwife activities, discussion with the TBAs _____

Are you satisfied with that collaboration? yes (5)

Suggestions for improvement?

- 1) Ask what the CHD needs before delivering supplies (many items are not useful, collecting dust) Vacuum Extractor, Neonatal aspirator, Oxygen, Laboratory supplies, & Scale/height measure _____
- 2) Donation of food (milk) to infants;
- 3) Teach the moms how to cook local foods (like CRS, Mother's Groups cooking demonstrations of local products.
- 4) Give the CPs, TBAs and COSAN members some additional motivation (t-shirts, per diem)

- 1) Project should not forget the health agents (training, materials, motivation, etc.)
- 2) We need copies of the training reports to supervise the PC & TBAs in the new skills
- 3) The assumption of responsibility is not according to the standards of the SSD.
- 4) Close the gap between the time when the order is placed & when the ITNs are delivered "people consider the products of PSI (mosquito nets) better because the fabric is finer, the nets are free, and they can always buy them from the project. Sales are going well !
- 5) Increase # of contacts by project staff with PCs & TBAs (people feel motivated with just your visit)

When was the last supervisión visit that you received from X _____
 -one visit a month ago by DRS/Chef SMS_(VVT CHD); Mai (CSB Marometety);
 1.5 months ago, 1 1 week ago , _____

What did you discuss during this last visit _____
 questions only ; check vitamin supply, ask about problems/provide solutions;
 discussed condition of the building & low # of women giving birth at the CSB,
 discussion about our fridge which broke down _____

Do you have periodic meetings? YES, No

With what frequency? _____1___ every month _3___ every two months
 ___every 3 months

Do you fill out your work reports ? 3 YES No

He sends the PC reports directly to the SSD w/o compiling them first

With what frequency ? 3___every month _____ every 2 months ___every
 3 months

(Ask to see the reports)

Do you make supervisory visits ? YES (-2 w/ PCs) NO (1) will start supervising
 PCs & TBAs from Aug

If yes, to whom ? PCs (1)

When was the last supervision visit ? ___2 months ago _____

What did you discuss ? _____bandaging the umbilical
 cord _____

Did you use audio visual aids ? YES 1counsel cards , NO 2 would like to
 have on STIs/AIDS, 1 would like to have brochures

Would you be able to show them to me ?

*Check the content and ask what they must have in the CSB. (Illustrated Charts,
 brochures)*

What would you like to have to make your work better ? Electricity, computer
 (CSB Ambodibonara)

Suggestions for the sustainability of the activity?

- 1) The Heads of the CSB should ensure that everyone works together (local authorities, Tangalamena)
- 2) The trained PCs should be called upon to continue vaccination-health campaigns (rather than train new ones)

3) The CSB can assure the per diem (depending on the Min/San/PF)

Problem- ADRA gives them materials & its not sure if they will continue working for the project_(need to make sure that those trained & with materials continue to work for the community)_____

--COSAN need to take the PC under their responsibility after the project (thus we need to include in the phase-out plan a way to reinforce the viability of the COSAN)

- 1) Give them training in agricultural methods (give them seeds)
- 2) Need to study the sustainability issue w/ the CASC (LM suggestion: can the CASC advocate for funds from the Commune level/Mayor to contribute to occasional incentives for the PC & TBAs? Or establish some additional health related income-generating activities to motivate them to continue activities)

Si COSAN /CASC ou CVA :

What is the responsibility/duty of the COSAN / CASC / CVA/ COGE, member ? _____

Suggestions for the sustainability of the activities?

Has the project had an impact on your community? What kind?

- 1) the PCs and their "awareness-building"
- 2) women are now bringing their children for vaccination, thus; increase of the vaccination rate ,women are coming for PNC thanks to the PC's work
- 3) people know about health;
- 4) the TBAs w/o training are coming to ask for training (& waiting)
- 5) Many children own their birth certificate

People come more often for FP; nutrition improved, along with better vaccination coverage rates (40->46%); problem: great distance from homes & CSB (some even walk more than 5 hours)

Strengths of the project:

- 1) work in-depth with the community
- 2) regularly supervise their staff
- 3) provide tools, book, counseling cards, etc.
- 4) training

The PC & TBAs are very useful; they have helped us increase the # of PreNC & the % of women who give birth at the CSB

Compilation des Resultats -VVT & Tmt II

Questionnaire de Staff du CSB

Postes : Chef CHD (VVT), Chef CSB Maromitety (VVT), Chef CSB Anjahambe (VVT), Chef – CSB Ampasamadinika (Tmt II), Chef CSB Ambodibonara_____

Combien d' années avez-vous travaillé comme X (infirmière, SF, Medecin) au CSB ? _____

Est-ce que vous avez été forme ? OUI (4) NON

Dans quels sujets ?

5 PCIME

1 Supervision Intégrée

4 Management/Gestion/MBOs

4 COPE

4 Montage de projet

2 Formation de formateurs

1 Marketing Social

2 Maternité sans Risque

1 Nutrition

3 Espacement de naissance

_____VIH/SIDA/ITS

2 IEC/CCC

_____FDF

_____PRA

_____Système de transport en cas d'urgence pour les femmes enceintes

_____Stratégie Mobile de Sensibilisation Communautaire

Autres _____

Est-ce que vous avez fait qqch differentes apres la formation ?

Si oui, lesquelles?_3_ people from VVT conducted training (TBAs & PCs, COSAN)_____

VVT

11)IMCI- I've integrated the protocols into my consultations for U5s; makes it easier to diagnose & gives better results but I can't use it b/c I don't have any more IMCI forms (the algorithm are also buried underneath a stack of reference materials)

12)Staff Management – "I now ask for their opinion- the paramedical staff- I know that they have a lot more experience than I do" I'm not as difficult (stern) as I used to be

13)Supervision – I haven't used the checklist yet, when we tried it during the training it was too long, not practical

14)COPE- I haven't applied it b/c I don't have the documents (manual) and b/c we don't have an external facilitator; no per diems to pay them; this

- should come from Tmt II – “Sylvain is aware of this” (??) (1); we applied COPE here & even the guardian has changed his attitude/way of greeting people (before he was a bit lazy) (1)
- 15) Project development- I haven't yet applied these skills b/c of my heavy workload (1); this has helped me in preparing my PTA and with the RRI
- 16) IEC/CCC- I have changed the way I conduct awareness raising, e.g. before we would tell them everything we had in our heads, now we think of “PAFI” (petite chose, mais grande importance) – one subject at a time; I also notice that more women come to the CSBs either for vaccination or for PNC (2) our communication is different (before women were fearful of coming to the CSB)
- 17) I have learned many additional skills, but do not have the opportunity to use them here (at VVT CHD; i.e. they are not w/in my responsibilities, such as holding meetings)
- 18) FP: Found solutions to our problems; increased FP coverage
- 19) Nutrition: women are coming to the CSB more often; infants' weights have increased and the rate of malnourished children has dropped; fewer cases of diarrhea
- 20) The FDF have changed my way of speaking toward my colleagues

Avez-vous besoin d'autres formations ? Oui Non

Si oui, en quoi ?

Remise a niveau en Management (VVT CHD)

Vaccination & IMCI (CSB- Infirmier a Maromitety) (LM's opinion based on fact that ¾ of IMCI-related responses were incorrect)

Quel est votre travail comme agent au CSB ?

- assister aux accouchements
- visiter aux femmes enceintes
- Promotion d'allaitement maternel exclusif
- visite des femmes après l'accouchement
- Promotion de la PF
- Distribuer les moustiquaires
- Superviser les AT et les PC
- Appliquer le COPE
- autres

Est-ce que vous connaissez l' Agent Technique d'ADRA ? 5/5 OUI NON

Quel est son nom ?

5/5

Avez-vous collaboré avec elle/lui ? 5/5 OUI NON

Quel type de collaboration ? Sur quoi vous avez collabore ?

- ___ Promotion de PF
- ___ visite des nouvelles mères/nés
- ___ Promotion d' allaitement maternel exclusif
- 1 ___ Autre

Prise en charge des indemnités pdant la revue periodique ; Fournir les moustiquaires PSI, Journee Sante ; Tmt II : provide refresher training ; joint supervision _____

Quelle était la dernière fois que vous avez vu l'Agent Technique d'ADRA ?
 __ tous les 2 mois_(1), vendredi 30 juin, dans le dernier mois (4), 2 semaines passées _____

Dans quel contexte vous l'avez vu ?_ livraison des moustiquaires ; planification d'un programme ; supervise PC activities, discussion avec les ATs _____

Etes vous satisfait avec sa collaboration ? oui (5)

Suggestions pour l'améliorer ?_

- 1) Ask what the CHD needs before delivering supplies (many items are not useful, collecting dust) Vacuum Extractor, Neonatal aspirator, Oxygen, Laboratory supplies, & Scale/height measure _____
- 1) donner des aliments (du lait) aux enfants; 2) teach the moms how to cook local foods (like CRS, Mother's Groups cooking demonstrations of local products.
- 3) Give the CPs, TBAs and COSAN members some additional motivation (t-shirts, per diem)
- 6) Project should not forget the health agents (training, materials, motivation, etc.)
- 7) We need copies of the training reports to supervise the PC & TBAs in the new skills
- 8) La prise en charge n'est pas selon les normes (per diems grilles de SSD)
- 9) Close the gap between the time when the order is placed & when the ITNs are delivered "les gens considèrent les produits de PSI (les moustiquaires) meilleurs car le tissu est plus fin; même s'elles reçoivent les moustiquaires gratuites, elles pleurent toujours pour acheter les moustiquaires du projet" sales are going well !
- 10) Increase # of contacts by project staff with PCs & TBAs (people feel motivated with just your visit)

Quand etait la dernière visite de supervision que vous avez reçu de X_

-one visit a month ago by DRS/Chef SMS_(VVT CHD); Mai (CSB Marometety);
1.5 months ago, 1 week ago , _____

Qu'est-ce que vous avez discute pendant cette visite_
questions only ; check vitamin supply, ask about problems/provide solutions;
discussed condition of the building & low # of women giving birth at the CSB,
discussion about our fridge which broke down _____

Avez vous des reunions periodiques ? Oui Non

Avec quelle frequence ? _____1___ chaque mois _3___ tous les 2 mois
____tous les 3 mois

Remplissez -vous des rapports de travail ? 3 Oui Non

He sends the PC reports directly to the SSD w/o compiling them first

Avec quelle frequence ? 3___ chaque mois _____ tous les 2 mois
____tous les 3 mois

(Demander de voir les rapports)

Faites-vous des visites de supervision ? OUI (-2 w/ PCs) NON (1) will start
supervising PCs & TBAs from Aug

Si OUI a qui ? PCs (1)

Quand etait la derniere visite de supervision ? ___2 months ago_____

Qu'est -ce que vous avez discuter ? _____bandaging the umbilical
cord _____

Utilisez des supports audio -visuel ? OUI 1counsel cards , NON 2 would
like to have on STIs/AIDS, 1 would like to have brochures

Est-ce que vous pouvez me les montrer ?

*Vérifier le contenu en demandant qu'est-ce qu'ils **doit avoir** dans le CSB.
(Cartes illustrees, brochures)*

Qu'aimeriez vous avoir pour mieux travailler ? Electricity, computer (CSB
Ambodibonara)

Suggestions pour la perennisation des activite?

- 4) The Chefs CSB should ensure that everyone works together (local
authorities, Tangalamena)

- 5) The trained PCs should be called upon to continue vaccination-health campaigns (rather than train new ones)
- 6) The CSB can assure the per diem (depending on the Min/San/PF)

Problem- ADRA gives them materials & its not sure if they will continue working for the project_(need to make sure that those trained & with materials continue to work for the community)_____

--COSAN need to take the PC under their responsibility after the project (thus we need to include in the phase-out plan a way to reinforce the viability of the COSAN)

- 3) Give them training in agricultural methods (give them seeds)
- 4) Need to study the sustainability issue w/ the CASC (LM suggestion: can the CASC advocate for funds from the Commune level/Mayor to contribute to occasional incentives for the PC & TBAs? Or establish some additional health related income-generating activities to motivate them to continue activities)

Si COSAN /CASC ou CVA :

Quelle est la responsabilite/devoir de COSAN / CASC / CVA/ COGE, membre ? _____

Suggestions pour la perennisation des activites ?

A-t-il eu un impact dans votre communaute le projet? Lesquels ?

- 1) the PCs and their "awareness-building"
- 2) women are now bringing their children for vaccination, thus; increase of the vaccination rate ,women are coming for PNC thanks to the PC's work
- 3) people know about health;
- 4) the TBAs w/o training are coming to ask for training (& waiting)
- 5) Many children own their birth certificate

People come more often for FP; nutrition improved, along with better vaccination coverage rates (40->46%); problem: great distance from homes & CSB (some even walk more than 5 hours)

Strengths of the project:

- 5) work in-depth with the community
- 6) regularly supervise their staff
- 7) provide tools, book, counseling cards, etc.
- 8) training

The PC & TBAs are very useful; they have helped us increase the # of PreNC & the % of women who give birth at the CSB

TECHNICAL QUESTIONS

- 1 – VVT ville - CHD – understood & accurate
- 1- VVT – CSB - needs refresher training (Maromitety)
- 1- VVT CSB- understood & accurate (Anjahambe)
- 1- Tmt II – CSB- understood & accurate (problem is time & case load- “with 50 patients waiting...)

Were you trained in C-IMCI? If yes, when ?_____ By whom_____

What were the main points ?

What did the C-IMCI protocol say regarding what needs to be done to treat a child?

Can you always use the C-IMCI? Yes No Why not ?_____

When was the last time you followed the protocol?

1 today

Please describe the case

What are the 5 illnesses associated with the protocol?

What are the advantages of following the protocol?

What are the medicines you need to implement the methodology.

- ___ ORS
- ___ vaccines
- ___ antibiotics
- ___ anti-malarial
- ___ others_____

Have you experienced supply shortages these last 3 months?

- fever
 other (incorrect)

28. List at least 3 signs of danger that require the child to be sent to the Health Center : correct : incorrect :

- inability to drink
 doesn't eat
 refuses breastfeeding
 fever
 profuse diarrhea
 Convulsion
 lethargy or coma
 vomiting
 other (incorrect)

Diarrhea

29. List 4 ways to prevent diarrhea

- Exclusive breastfeeding
 handwashing
 water treatment
 food hygiene (wash fruits/salads and vegetables ; cook meats ; cover food, etc.)
 other (incorrect)

30. When should we wash our hands to prevent diarrhea ?

- correct : incorrect :
 before eating
 after going to the bathroom
 after cleaning a child who has soiled
 before eating
 other (incorrect)

31. Tell us how to prepare ORS?

- correct Mix 3 bottles of PET (cola bottles) of clean water with one packet of ORS
 other (incorrect)

Maternal care

32. List 3 signs of danger during pregnancy

- intense headache
 vision problems
 lower limb edema
 stomach pain
 bleeding

___ other (incorrect)

33. What is the minimum antenatal visits a woman should have during her pregnancy?

correct : incorrect :

_____ 3

_____ other (incorrect)

34 How often should medical staff give post-natal visits ?

correct : incorrect :

_____ in the first 3 days

_____ other (incorrect)

35. List 3 tasks that should be accomplished during a post-natal visit :

correct : incorrect :

___ give vitamin A to the mother

___ counsel the mother

___ fill out the visit check list

___ other(incorrect)

Birth Spacing

36. List 2 advantages to birth spacing

___ mother's health

___ children's health

___ family budget

___ enables you to have the number of children you want

___ other(incorrect)

37. What is the most important thing to do before giving a FP method?

correct : incorrect :

___ Counselling

___ other (incorrect)

38 What should be done for a woman with multiple partners looking to use the pill for FP?

correct : incorrect :

_____ use condoms along with another method

_____ other (incorrect)

STI/HIV/AIDS

39. List 2 symptoms of a sexually transmitted infection

correct : incorrect :

___ discharge (vaginal secretion, urethral secretion)

___ itching

___ pelvic pain

genital lesions
 burning on urination
 others _____

40. List 3 ways to prevent HIV/AIDS

Correct: incorrect :

condom
 fidelity
 abstinence
 other (incorrect)

41 What is the difference between STI and HIV/AIDS

Correct : incorrect :

STI can be treated
 HIV/AIDS is incurable
 other (incorrecte)

QUESTIONS TECHNIQUES

1 – VVT ville - CHD – understood & accurate

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Avez- vous ete forme en PCIME ? si oui, quand ? _____ Par qui _____

Quels etaient les points principaux ?

Qu'est-ce que le protocole PCIME a dit sur ce qu'il faut faire pour traiter un enfant ?

Pouvez –vous toujours utilise le PCIME ? Oui Non Pourquoi pas ? _____

Quand etait la derniere fois que vous avez suivi le protocole ?

1 today

SVP, decrivez le

cas _____

Quelles sont les 5 maladies associees avec le protocole ?

Quels sont les avantages lorsqu'on suit le protocole ?

Quels sont les médicaments qu'il vous faut pour appliquer la methodologie.

SRO
 vaccines
 antibiotiques
 anti-malarial
 autres _____

Pendant ces derniers 3 mois, avez vous experimente une rupture de stock ? _____

Pouvez-vous nous dire 3 questions que le personnel de sante doit poser a chaque mere qui emmene son enfant pour etre traite ?

Vaccination

20. A quel age on administre le vaccin anti-rougeole ?

9 mois autre (incorrecte)

21. Quand est-ce qu'un enfant est complètement vaccine ?

Quand l'enfant a reçu 1 dose de BCG, 3 doses de DPT et de Polio, et 1 dose de Rougeole

autre (incorrecte)

Nutrition

22. Quel est le protocole d'administration de Vitamine A ?

Commence a 6 mois, et puis tous les 4 mois jusqu'a sept ans

autre (incorrecte)

23. Quelle est la dose correcte pour la Vitamin A d'un enfant mois d'un an ?

100,000 unités (ou 3 gouttes) autre (incorrecte)

24. Qu'est-ce que c'est l'allaitement maternel exclusif ?

6 mois d'allaitement sans donner d'autres additifs (ni des liquides, ni des aliments)

autre (incorrecte)

25. Pourquoi les mères doivent pratiquer l'allaitement maternel exclusif ?

_____ prévenir la diarrhée _____ autre

26. Des que vous voyez le poids d'un enfant dans le jaune fonce, que faite vous?

Correct

_____ conseiller la mère sur le poids de l'enfant et l'alimentation correcte

_____ referez l'enfant

_____ autre (incorrecte)

IRA

27. Quels sont les signes d'IRA que vous connaissez ? correct : incorrect

_____ dyspnée

_____ toux

_____ tirage intercostale

_____ difficultés respiratoires

_____ fièvre

_____ autre (incorrecte)

28. Citez au moins 3 signes de danger qui exigent la référence de l'enfant au centre de santé

correct : incorrect :

_____ incapable de boire

_____ Ne mange pas

_____ Ne veut pas être allaité (moins de 6 mois)

_____ Fièvre

_____ Diarrhée profuse

_____ Convulsion

_____ léthargique ou inconscient

_____ vomit tous ce qu'il a consommé

_____ autre (incorrecte)

Diarrhée

29. Citer 4 moyens de prévention de la diarrhée ? incorrect correct

_____ Allaitement maternel exclusif

_____ Laver les mains

_____ Traitement de l'eau

_____ Hygiène alimentaire (laver/traiter les fruits, crudités, légumes ; faire cuire la viande, couvrir les aliments etc)

_____ autre (incorrecte)

30. Quand est-ce qu'il faut se laver les mains pour prévenir la diarrhée ?

correct : incorrect :

_____ Avant de manger

_____ Après la toilette

- Après avoir nettoye un enfant qui a fait caca
 Avant de mangér
 autre (incorrecte)

31. Dites nous comment préparer la SRO ?

correct Mélanger 3 bouteilles PET (bouteilles de kola) d'eau propre & 1 sachet de SRO

Autres (incorrecte)

Soins Maternels

32. Citez 3 signes de danger durant la grossesse ? correct : incorrect :

- céphalée intense
 troubles visuelles
 odeme des membres inférieurs
 douleur épigastriques
 hémorragie
 autre (incorrecte)

33. Quel est le nombre minimum des visites prenatales qu'une femme doit faire durant sa grossesse ?

correct : incorrect :

- 3
 autres (incorrecte)

34. Dans quelle intervalle les agents de sante/AT/ doivent réaliser ses visites post-natales ?

- correct : incorrect :
 dans les 3 premiers jours
 autres (incorrecte)

35. Citez 3 taches à accomplir lors d'une visite post-natale ? denominator

correct : incorrect :

- administration de vitamine A a la mère
 conseils a la mère _____
 remplissage de check-list (formulaire de visite)
 autres
 (incorrecte) _____

Espacement des Naissances

36. Citez 2 avantages de l'espacement de naissance. correct : incorrect :

- santé de la mère
 santé des enfants
 économie pour la famille

___ permet d'avoir le nombre des enfants que l'on désire
 ___ autre (incorrecte)

37. Quelle est la tache la plus importante a exécuter avant l'administration d'une méthode de l'espacement des naissances ?

correct : incorrect :

___ Counselling
 ___ autre (incorrecte)

38. Qu'est-ce qu'il faut faire face a une cliente potentielle du PF qui a des partenaires multiples qui voudraient utiliser la pilule comme méthode PF ?

correct : incorrect :

___ utilisez les condoms en plus d'une autre méthode (double méthode)
 ___ autre (incorrecte)

VIH/SIDA/IST

39. Citez 2 symptômes /signes d'une infection sexuellement transmissibles ?

correct : incorrect :

___ leucorrhée (perte vaginale, écoulement urétral)
 ___ prurit
 ___ douleur au bas ventre
 ___ lésions génitales
 ___ brûlure mictionnelle
 ___ autres _____

40. Citez 3 moyens de prévention de VIH/SIDA ?

Correct: incorrect :

___ condom
 ___ fidélité
 ___ abstinence
 ___ autre (incorrecte)

41. Quelle est la différence entre une IST et VIH/SIDA ?

Correct : incorrect :

___ IST peuvent être traités
 ___ VIH/SIDA est incurable
 ___ autre (incorrecte)

Questionnaire of Staff of ADRA- ASAP

Introduction : Hello, I would like to have a short talk with you concerning the ADRA project. This little chat will allow us to see how the activities of this project are developing in the area where you work. We assure you that all the information you provide will be confidential.

Position: _____ Have you received a job description ?
YES NO

11/11

How many years have you worked with ADRA_____ with ASAP?

1__1day -2 weeks _1__1 - 3 months __3__13 months – 2 years __6_ > 2years
(ADRA) (5yr 1 p)

1__1day -2 weeks _1__1 - 3 months __3__13 months – 2 years __6_ > 2years
(ASAP)

In a few words, explain what your responsibilities are concerning the project ?

11/11

Do you feel at ease with your duties? 8/11 Yes 3/11 Yes, but... NO

Why?

___Yes, (1) i know everybody, the midwives are colleagues of mine

___Yes, I've already worked with a similar project (2)

___Yes, (1) the whole team is very united, they help me alot, I feel at home

___Yes, but.... Its not very clear (c'est un défi) (1) ;

___Yes, but....insufficient personnel (to represent the project in all the activities of the area)

___Yes, but....at the beginning there were strained relations between SSD & PC (its a little better now, but can continue to improve); PCs of CARE, ASOS, Secaline, etc. have greater remuneration than us (cause of problems)

Does the project you work in need tools to improve your work? What tools?

___X___ car/moto _____ that works well?

___X___reference material

___X___office furniture (computer, etc.)

Do you have all the tools needed to do your job? 4/ YES 6/11 yes, but... 1
NO

What are the tools that you need?_

A. (3p)_computers (3 computers are shared amongst about 9 staff) (humidity has been a huge issue w/ computers breaking down ; one staff mentioned that all of his important files were saved on one of the computers that is now non-functional)_

B. need internet connection in VVT (but it's not w/in our control- Min TelCom)_____

C. Remise a niveau en 1) management, 2) suivi & évaluation, 3) Finance (budgeting)_____

D. Traitement statistique : logiciel EPI, SPSS, GESIS

E. Reference documents in human resources; logiciel- gestion du personnel

F. Protection against the rain and cold for people who leave by motorcycle, boots

Do you have a copy of the DIP ? 11/11 YES NO Of the follow-up plan

What are the objectives of the project?__11/11_____

Have you been trained? 5/7 YES 2/7 NO

If yes, in what subjects?

__6__ C-IMCI

__3__ Information

__9__ Management/Gestion/MBOs

__4__ COPE

__5__ Team building

__4__ Maternity without risk

__2__ Marketing/Vente DBC

_____ HIV/AIDS/STIs

__3__ IEC/CCC

__2__ MARP/PRA

__7__ T of T

Others_ (1) Suivi & Eval., (1) PDME, (3) LQAS, (1) PDM (CSTS)_ (4)

Integral supervision_____

Recyclage 2/11 Yes No

What topics?_____

What on the job training have you received?__ (4) informatics (partage des collègues) ; (1) PAF, SEPO (succès, échecs, potentiel, obstacles)_____

How have you used the training that you received?

__7__ Training of others (PC & ATs & COSAN et autres collègues) (en MARP, CIP)

__9__ I can better carry out my responsibilities

_____ Others (1) I have improved my work system after training in supervision (élabore un canevas qui a intégré SR, PCIME ; (3) management & integral supervision: I know how to make a plan (2), direct 1 meeting; management of subordinates, organization of internal work; (1) after the training of trainers, I have improved the communication method- I have improved the nonverbal communication, i offer a helping hand; (4) team management 1) I have chngaged the way to give feedback- I was aggresive before;(2) I speak better with others, understand better the training of others; I tell them the advantages of each activity (1) I have changed my management style, I don't follow them as closely as before, I often remember the advice of managers, I thank my team more; LQAS : I motivated the team to use it & to manage it ; (1) elaboration of documents in C-IMCI – work guides for midwives; I use the technique of T for T in the periodic meetings with SSD ; (1) supervision, I use when we make supervision visits with the SSD, Assist in May with 4 CSB ; (1) training of COSAN in the reporting system (MARP) ; T for T in the training of midwives/TBAs; Management: preparation of activities, collaboration with the teams; C-IMCI-use when I do the followup of TBAs – they ask me how to use the cards

Do you need another type of training? (10) YES NO

What subjects? _(1) Nutrition, MSR, (2) IEC/CCC ; (1) management (II), M & E, Budgeting (2) T of T (1 de base, 1 moyen), Maternal and Infant health; (1) coaching, planification, (3) english IEC/CCC- especially how to assemble a video clip and how to make a radio program,_(4) Informatics (1- logiciel SPSS ; 1- Excel Avance ; 1- Access) ; (1) supervision (1) human resources; (1) french__

Have you collaborated with midwives/TBAs/Healthcare center workers/PSI/others ___10/11_____ ?
« They are like my work colleagues»

What type of collaboration ? On what have you collaborated?

- ___4_ Activity planning
- ___3_ Activity execution, immunization, journal, etc.
- ___1_ Visits to new mothers/newborns
- ___5_ Followup visits (periodic meeting of SSD-VVT with the midwives (1) ; with the TBAs)
- ___4_ Community awareness (ensemble avec PSI & Peace Corps)
- ___2_ Mobile strategy for community awareness (causerie avec les femmes)
- ___(4)___ Other _Report preparation(2) ; Provisioning(1) ;Followup of radio listener groups(1)__(1) meetings_____

When was the last supervision visit that you made?

___7___ 1-2 weeks ago ___1___ its been more than 2 weeks _____ its been 1 month_____ other _____

What problems have been solved ?__A. Put in place an emergency plan (pregnant women), rappel de MARP ; B. pérennisation – rapports de PC tant qu'ils sont des volontaires ; il sont trop loin pour le remplir chaque mois, d'autre n'ont pas de radio (2); C. manque de moustiquaire- rupture de stock ; D. suivi des PC & FGD sur le paludisme : les filles veulent encore acheter (7 personnes et une moustiquaires gratuites) ; E. Règlements/10 commandements des AT ; rappel sur les messages des CPN, etc.- problème de jalousie entres les AT non-formés et les formés ; autre problème sur le remplissage des rapports- ; F. elle n'aime pas être suivi de près ; G. quelques familles ne sont pas sérieux ; quelques PC sont occupes avec le travail du champs donc ils oublient le remplissage des rapports ; les responsables CSB sont absentes souvent_____

Comment vous l'avez résolu ?_A. Elaborer un rapport (COSAN), Enregistrement des naissances de matrones non-formées, collaboration- mêmes s'elles ne sont pas formées, nous avons simplifier les modules/formats de rapport ; C. Il fallait rembourser les gens (rupture de stock des ITNs) , PC doit faire leur rapport a temps, ADRA doit assurer en stock disponible ; s'il y a un problème de paiement, on ne peut pas délivrer donc le procédure n'est pas fiable, besoin de chercher un meilleur système ; B. félicite, compense des nouveaux commence (pas forme) ; on essaye de voir avec l'UNICEF ; E. il a encourager les AT formées a former les non-formées ; les a informe sur le système de rapportage avec le tissu ; il a demander les dates probables d'accouchements et rendu visites aux femmes pour observer si les « 3 propres » ont été respecte ; F. j'ai réduit l'intensité de ma supervision et elle est plus performante ; G. il explique les avantages de l'action pour que le PC l'explique mieux a la famille ; il décide de faire une remise a niveau tout les 3 mois _____

Est-ce que vous avez l'appui de l'administration pour assurer vos responsabilités ? 11/11 OUI NON

Comment voyez vous l'assistance du Directeur ?_utile , nous écoute, donne des conseils_(2) ; il dirige bien, m'appuie (il m'explique pourquoi il faut changer mon planning) ; il prend l'avis des autres (1) ; toujours disponible (1) ; après le team building ça marche (1)_____

Suggestions pour l'amélioration _1) ne pas limiter les activités (période sur le terrain, etc.) monter le budget de COPE mais au dernier moment pris par autre chose ; 2)_façon de voir différent sur la façon de travail (e.g. partir dans 3 lieux différents, ils aimeraient se libérer de la quantité dans l'endroit la plus proche ; il se sent presse de partir très vite au lieu de prendre son temps a améliorer les relations humaines ; tenir en considération plus les conseils techniques_(1) faut respecter toujours l'hierarchie/protocole (les gens de l'état se place toujours plus élevés que les ONGs ; ça va mieux maintenant ; continuer a inciter les responsables avant de prendre décisions ; (1) on doit nous donner plus de

considération pour prévoir l'avenir- stabilité ; ex. trouver 1 autre projet, donner des formations pour le développement professionnel du staff _____

Est-ce que vous avez reçu une évaluation de performance ? 11/12 Oui Non
Quand ?

Dans les normes (11) 2x pendant cette année (2); mai 06 (2) ; mars (3) ; tous les 6 mois (1) ;

Sentez vous à l'aise de donner une retro alimentation sur la qualité de votre supervision ? Oui 9 ((1) oui, il est ouvert) Non 3 (1-il est un peu sensible, donc je le fais d'une façon indirecte ; le feedback, c'est dans un seul sens (1) ; j'ai trouvé que les idées ne sont pas bien reçues la 1^e fois, mais quand je reviens pour expliquer, il m'écoute (1))

Comment vous voyez ADRA en général ?__

1) améliorer la situation des ordinateurs (empêche de terminer ses rapport, doit travailler dans les café internet parfois) ; 2) procédures (point de vue technique & logistique, cela ne dépend pas de lui), doit donner plus de considération pour le personnel (activités sont trop charges- parfois on est obligé de travailler le dimanche pour pouvoir finir)__(1) Mieux traiter le personnel ; (2) pas rémunération adéquate, standardiser les indemnités; (3) sécurité du travail - contrats sont trop courts ; il faut les dire verbalement qu'il faut chercher du travail ; nous terminons le 07 et qu'est-ce qu'on fait ? (1) L'ADRA est dynamique ; (1) amélioration dans la coordination de travail, bien préciser les procédures à suivre (standardiser l'application des procédures) ; (1) Premier financier est à Tana et le projet est ici : quand il y a des imprévus, il faut attendre beaucoup pour l'argent ;

Quelles sont vos suggestions pour améliorer le projet pour augmenter les résultats sur terrain ?

(2) faire un suivi plus proche et plus souvent aux PC et AT dans leur travail ; (1) Aider avec développement du staff, donner du crédit pour l'achat des matériel informatique

Se concerter plus dans la planification & partager ensemble, continuer à améliorer les relations humaines avec les partenaires (avant c'est plus comme nous étions le bailleur de fonds pas le partenaire) ; (1) le temps qu'on fait des animation en brousse n'est pas suffisant- 59 écoles par exemple- il vaut mieux de ne pas limiter la durée de la mission ; les enfants, institutrices veulent qu'ADRA rendre visite plus souvent ; (1) renforcer la collaboration entre CSB/Communauté pour les faire fréquenter (les PC/AT) les CSB & non les staff du projet ADRA ; (1) si nous allons loin, nous avons besoin d'un avance de ADRA central mais les frais de mission sont bloqué, pas pratique ; (1) problème de centralisation surtout pour le budget (il y a des moments quand on ne peut même pas commencer les activités)_____

Quel est le plan de transfert /pérennisation du projet ?

Dans l'ensemble les staffs ne sont pas au courant d'un plan spécifique mais les idées sont présentées : 1) cfr au plan de transfert (COSAN- Didi)- 1) renforcer le MARP au niveau de COSAN ; 2) les maires (CASC) sont déjà formes ; 3) ils vont élaborer les objectifs ; 4) réunion de planification (pendant réunions périodiques) ; SSD introduction d'un travail (changement d'attitude, Agents de santé & PC (les faire apprendre petit a petit) ; (2) les chefs CSB vont consolider les rapports des PC, transfert des compétences- on entend souvent « le projet ADRA », je ne trouve pas les mots de les expliquer adéquatement que c'est leur responsabilité/projet ; (1) les enfants continueront a sensibiliser les mères mais cela sera difficile a assurer la continuité car il n'y auront pas de motivations ; (1) aider les CSB en matériel de sensibilisation (dépliants, IEC) ; (1) nous disons toujours que c'est leur projet que nous ne serons pas la dans l'avenir ; (1) Les AT doivent inciter les autres et améliorer les relations entre CSB & AT (qu'elles n'ont plus peur mais sentent appuyé par eux

Quelles sont vos suggestions pour améliorer les conditions du travail pour atteindre les objectifs ?

(1) Difficulté de l'analphabétisme rend difficile le travail de rapport ; (1) Motivation pour les PC (les t-shirts sont bien fatigués), CSB (changer l'attitude de quelque uns que c'est l'affaire d'ADRA), les staff de l'ADRA (per diem de voyage est largement insuffisant et pas standardise avec les autres ONGs; situation des insuffisance des ordinateurs (3); (1) faire une réunion toutes les fin d'années fiscales avec tous les partenaires pour voir ensemble ou on est ; se féliciter les gens ; (1) responsabilisation des AT & PC d'abord et le suivi des CSB par les SSD ; (1) procurer des petits outils pour les AT (système de réapprovisionnement) ; (1) donner motivation au personnel- les indemnités au présent sont très bas pour les personnel et les PC ; considérations du staff de logement et transport ; planning- mieux planifier avec les SSD (cela a alourdit mon travail) ; (1) au retour de missions, il faut faire son rapport mais nous n'avons pas assez d'équipements informatiques ; (1) éclaircissement dans les procédures entre ADRA Tana et le projet (on est vraiment coincide)

Atout : 1) ADRA travaille dans les endroits tres loin (approche communautaire) – visa 5/5, les achevements de COSAN (construction des latrines et des bâtiments- waiting house) ; l'équipe est tres solidaire ; dynamique (3), les gens disent que l'équipe est grave (contagieuse) ; le projet a eu des effets palpables (vaccination, femmes qui accouchent aux CSB) ; (3) équipe travaille bien, sont vraiment dévoué ; les techniciens sont dynamiques et performant, on s'entend bien (ex. aux moments des festivals, tout le monde s'entre aide ; tous les employés font des sacrifices pour le projet (travaille dans les conditions défavorables) (1) le projet a servi a la communauté ;

Impact : ADRA est devenu connu, USAID aussi ; la communauté aime acquérir des connaissances et les appliquer ; utilisation des moustiquaires (3) ; augmentation des femmes -> CPN ; vaccination (visa 5/5) ; bcp de changement

de comportement de gens, fréquentation des CSB ; ADRA a bcp aide les PC & villageois ; utilisation des latrines ; PF

Est-ce qu'il y a qq'ch d'autres que vous aimeriez nous dire ? ___ Dans l'avenir, il faut mieux choisir les participants des formations (SSD) ; la majorité de gens du SSD était déjà forme par l'autre projet en informatique ; d'autres qui ont eu besoin n'ont pas été forme ; d'autres ont été forme dans les acquis qu'ils n'auront pas l'occasion d'utiliser (ex. l'administration SSD en F d F)___ ; (1) les chefs CSB ne sont pas content (ils se plaignent toujours sur la prise en charge pas dans les normes) ; (1) histoire de grains de café qui tombent sur le caca (facteurs qui motivent les gens de construire et utiliser les latrines)

Appendix 10.9

INTERVIEW NOTES USAID, MOH, NGOs

Wendy Benazerga, HPN Team Leader USAID

Collaboration w/ the USAID mission

Excellent, has been greatly enhanced by having Mitch on staff – only within last 14 months; nice to have someone in Tana.

Peter is also a great CD, he is open and transparent.

Approximately 3 times/year, a mission staff person has visited the project

How complementing Mission goals?

Contributing completely to Mission goals; during the design they tried to create mechanisms to draw in CS and Title II. During design of SanteNet, we forced them to link up with other activities (like the ADRA project?) This made a huge difference in terms of getting a critical mass by grouping the partners more together (CS project near SanteNet). This created better sharing and cross-learning between the projects (SanteNet is funding part of ADRA's Title II project)

Strengths: information sharing, especially messages and training. Doing a good job in malaria interventions, especially as a model for working with the public and private sector. This interaction has been a learning experience for SanteNet. During a meeting at USAID b/t malaria partners, ADRA shared the results of their malaria interventions and high net use. Also good partnerships.

Suggestions:

Could improve upon their dissemination of information and telling the story: CS project made huge success working with public sector; made link w field agents and health center- part of it is the longevity, it takes time

Min San

Dr. Bako & Clarisse

Close collaboration with ADRA (especially subordinates); collaborated on training, technical support materials (documents), training in FP, IEC, provision of curriculum, brochures; also gave to the CSB approximately 200 birthing kits. More contact w/ Dr Gertrude, very close contact b/t her & Med Inspecteur

Clarisse has never visited the project & does not know what it is about. However she knows Josue well, occasionally she sees him at meetings (IMCI meeting in Tana). They provided the project with an IEC kit (counseling cards & training curriculum for IMCI). She mentioned his involvement with validating the algorithms.

They would like to be more involved with the project

Suggestions: Improve the collaboration outside of partners' meetings; they never had a conversation one-on-one; technical support during the training; they would like an invitation to visit the project (plenty of notice). Bako:: she prefers that the collaboration remains decentralized; ADRA has followed the hierarchical process of the ministry. Dr. Josue has been in contract direct with Dr. Gertrude, Dr. Olga.

They would like to have ADRA's suggestions as to how to improve the relationship/collaboration with the MinSanPF.

Details on Collaboration

Gave assistance for the Safe Motherhood, TOT and for the training of the TBAs (2 in each district) (Feb 05). They provided IEC materials such as the flip chart for the TBAs, and FP brochures. After the TOT, they facilitated the sessions together (split themselves into 2 teams). They did not do follow-up after the training. Small problems with the organization of the logistics, could be b/c the ADRA staff person was new.

Dr. Josue asked for TA with training in supervision, but the request arrived too late. Suggestion –they would like to be informed 2-3 months ahead so they can plan accordingly.

The collaboration b/t DRS, SSD, & CSB was not in harmony b/c of the proposition of the dates (Feb 05) they were not ready or available. The Med Inspecteur was only informed at the last minute/

Suggestion:

- ADRA's work plan should be inserted into the district plan (they should do them at the same time)
- they would like to receive the information regarding the activities of the women TBAs who were trained
- are they doing the referrals? What happened to the system they set up with the coupons? What is the impact? Do they remember the danger signs? Are they assisting with proper, clean births?

Great deal of collaboration with Dr. Gaby and with SSD. Before the MI complained of the collaboration (05) b/c they (the project) had short circuited the district. She spoke to Gaby about this & thinks that it's been addressed.

During the training in FP IV, 2 reps from the DR and none from the SSD?

Asked for addition training in SIG, but the Min staff were not available

Appui IEC- training> of MinSanFP

Improve coordination: should be first with SSD, then DR, lastly the Min San central

Dr. Camille Pamaka- SanteNet

Knows the objective of the project- improve MCH & sees ADRA's role as 1) capacity building of the SSD in order to improve overall results

Wasn't involved in project planning but used to work for the previous ADRA project as the IMCI Coordinator (99-01)

Santenet's role: provide technical & financial assistance to other partners (work w/ ADRA, ASOS, CARE, MATEZA, SAF /FJKM, ERI)

SanteNet has no direct collaboration w/ the project, except for the fact that some of the ADRA communes are KM (Moramanga)

Their partner (SAF/FJKM) benefited from informal capacity building in the field in IEC/BCC

Dr. Hery (PSI)

Knows objectives & PSI's role as partner, collaborating through 1) training ADRA staff & partners in marketing; and 2) supplying of the ITNs; Dr. Hery wasn't involved in original project planning b/c he's only been in Tmt since June 05; contacted Josue immediately on arrival; they receive some GFATM funds

Dr. Camille (SanteNet)

Greatest strengths:

- ❖ fact that ADRA is working in VVT as one of the most important strengths of the project (not many partners working there)
- ❖ ADRA is strict about procedures, respects discipline (ex. Prayer before beginning work), has an appropriate style for its leadership (interesting that this was also mentioned as a point to improve upon- see below)
- ❖ Has a youthful technical staff who can easily access isolated communes; they are from the region, know the dialect & the culture
- ❖ Has experts/experienced staff in M & E
- ❖ Fact that their office is located at the SSD office for TmT II
- ❖ Capacity to transfer the messages

Dr. Hery

- ❖ Penetration into the remote rural areas by PC's trained by ADRA (enables PSI's messages re: malaria prevention to infiltrate even the most distant areas); we have a partner – relief team -who has taken on the responsibility of reaching some of the most distant areas
- ❖ Appreciates the fact that ADRA always includes them when ADRA receives a visit (US, Tana, etc.) whether it's an evaluation or other type of visit; they are very open; we share frequently; also Josue & I get along well

- ❖ Learned how some project staff, PCs & TBAs work in extremely difficult conditions (to sell the products/moustiquaires) (i.e. some travel for hours, even days; they are required to cross waterways in pirogues to arrive at project site)- this has motivated us to give the best of ourselves

Achievements (Dr. Camille):

- Donated equipment at the CSB
- Trained the CHA, CSB clinicians,
- Use of local radio for message dissemination
- Work with non-literate populations

Suggestions for Improvement (Camille)

- "ADRA needs to find a way of motivating their staff better- they changed the M & E person three times since the start of the project.
- The PM is very involved with his own team, but he needs to have more of a vision of partnership with the DRS (head of the MI), Medecin Inspecteur
- ADRA needs to be more flexible with public partners (ex. Field trip to celebrate the new appointment of the Dr. fell on a Sat.; they could have sent someone else (not Adventist) from the project as a rep.

Dr. Hery

- Extend the project into other impoverished adjacent areas (Fenerive Est & Foulpointe are caught in the middle)
- Difficult for us to make our orders accurately (6 mos. In advance) when we never know if ADRA will need 2,500 ITNs or 5,000. If ADRA can advance from their own funds a month's worth of stock, then reimburse themselves from the revenue from the sales, that would help us
- Sometimes the PCs come to us directly at the PSI office & ask for resupply of the ITNs (we refer them back to the project)
- Continue to reinforce existing & create new synergies b/t our projects
-

Suggestions regarding Sustainability

Dr. Camille:

- Team spirit/ attitude of overcoming challenges is important (how to mobilize local authorities- Mayors, etc.)
- Phase-out plan is essential; it should be specific & show the gradual exchange of responsibilities from the project staff to the health facilities/community (100, 80, 60)- they need to learn to manage for themselves, but we need to help them at each step so they have the tools to "own the project"

Dr. Hery:

- Ensure that the PCs take on the ownership/management of activities- they can group themselves into an **association** in order to continue selling the ITNs for a price that provides them some revenue (this is easy to do if they go to the mayor & follow the standard procedures at the commune level)

Appendix 10.10: DEBRIEFING GUIDE

**Projet ASAP
MinSan/PF/USAID/ADRA
Jeudi 20 juillet 06**

Heure	Activité	Responsable/s
9h	Accueil/ Bienvenue	Josué
9h15	Brise Glace – présentation des participants et de l'équipe	Linda
9h45	Objectif de l'évaluation & limites	Linda
9h50	Types et nombre des intervenants, Sites des entretiens	Christophe / Fanja
10h	Résultats principaux	Linda/Sylvain/Parfait/Lila/Raymond/Gérard
10h30	Recommandations	Linda
10h40	Discussion / Questions & Réponses	Josué
11h	Clôture	Josué

Appendix 10.11

Résultats Principaux

Evaluation à Mi Parcours - Projet ASAP, Madagascar

MinSanPF, USAID, ADRA

A. Points Forts/Impact du Projet

1) Renforcement des capacités (qualité et efficacité, suivi)

- a. SSD- F de F, Management/Gestion d'équipe, Supervision, Informatique
- b. CSB- PCIME, F d F, COPE, IEC/CCC, Management
- c. Matrones- MSR, CPN, AME
- d. PC- MSR, IST/SIDA, Vaccination, Nutrition (VVT) ; MSR, IRA, Diarrhée/SRO, Palu, SIDA (Tmt II)
- e. Suivi régulier (appui/soutien des PC et AT)

2) Changement de comportement

- a. SSD/CSB – planification et supervision des activités (utilisation du canevas) ; application de nouvelles techniques de formation, communication/traitement/gestion de l'équipe et des clients- qualité de soins ; prise en charge des enfants utilisant le PCIME
- b. Matrones/PC (confiance et valeur de soi- «après la formation, les mères nous valorisent/respectent») adoption des pratiques positives : accouchement au CSB, essuyer du corps avec un tissu, AME immédiate, référer la femme et l'enfant -> vaccin, faire la déclaration de naissance, ne font plus de massage ni de tisane
- c. Mères –n'ont plus peur des CSB ; meilleure utilisation de PF et des moustiquaires; augmentation de visites CPN ; emmener leur enfants aux CSB ; moins des maladies et de dépenses...

3) Résultat palpables

- a. plus des CPN ; SSD – VVT accouchement dans les centres de 20% ->28%); copies de naissances ; plus d'enfants vaccines

4) Liens/Relations entre CSB & Matrones et PC

- a. Chefs CSB considèrent les matrones et PC comme extension du CSB (« ils nous aident à mieux faire notre travail dans la communauté »)
- b. Les AT & PC veulent être supervisé/appuyé par les CSB
- c. Plus de problèmes avec les copies naissances (le Maire)

5) Qualité de l'équipe/travail dans les zones enclavées

- a. 3h.-3jr. de marche, ponts détruits ; bien connus et vus, connaissent la région, coutumes, peuple, dialecte ; responsable, dévoué, et prennent l'initiative

B. Points à Améliorer

- 1) Renforcement de la Vision de Partenariat avec SSD – Planning et préparation des rapports des activités ensemble (calendrier), flexibilité, plus de partage des données du projet, continuation d'amélioration des relations humaines par le biais d'activités en dehors de travail : Ex. jours récréatifs, matchs sportifs, et nettoyage environnemental
- 2) Plan de transfert concret et bien connu
 - a. Supervision des CSB, des PC (que les CSB prend la relève)
 - b. Remise a niveau
- 3) Renforcement de l'utilisation de PCIME (alléger les facteurs bloquantes)
- 4) Renforcement des ventes de moustiquaires (a étudier – 7/20)
- 5) Couverture de messages de radio ? Quel est l'impact des messages sur le changement de comportement ? (a étudier - 6/13)
- 6) Motivation de propre staff (conditions de travail- per diem, bottes de pluie, ordinateurs, remise a niveau, sécurité dans l'avenir)
- 7) Mécanismes financiers- trouver un moyen de diminuer l'attente entre sollicitude d'approbation des fonds et l'obtention des fonds d'ADRA Tana

C. Suggestions/Recommandations

- ADRA & SSD devront renforcer leurs efforts/maximiser les occasions à intégrer le planning et supervision des activités pendant la dernière période du projet. Ceci pourrait rendre plus efficace le transfert des responsabilités et l'appartenance des interventions du projet par les membres de la communauté; il pourrait contribuer aussi à la réplication et pérennisation des résultats positifs.
- Continuer à chercher des opportunités à améliorer les synergies entre les activités du SSD & du ASAP
- Continuer à renforcer et intensifier l'investissement en Suivi et Valorisation
- Chercher des occasions pour maximiser le coût efficacité de formations et remises a niveau (s'il y a 1 seule personne qui a besoin d'être formé dans un tel sujet, chercher une façon de le faire sur le tas, appuyer/*empower* les collègues dans le transfert de connaissances/compétences aux pairs)
- Revoir les activités afin qu'elles soient visées sur le cadre de changement de comportement au niveau de ménages (mettre l'accent sur les facteurs bloquants et motivants et diminuer les campagnes de sensibilisation accentués sur l'augmentation de connaissances) pour atteindre et dépasser les résultats ciblés (couverture de vaccination, VISA 5/5, etc.) ex. Etude sur le coût efficacité du programme radial (étude d'audience)

- Journée d'action sur la pérennisation et préparation d'un plan réaliste d'action:
 - a. Cultiver un esprit d'équipe communautaire et surtout parmi les autorités locales par rapport à la continuation des améliorations en santé; encourager une attitude de surmonter les défis ensemble (l'union donne la force)
 - b. Plan d'action : Préciser les étapes à suivre, les responsables, les périodes de démarche, prévoir les outils nécessaires à chaque étape afin que les responsabilités du projet soient transférées graduellement aux institutions sanitaires et à la communauté
 - c. Renforcement de viabilité de COSAN pour s'assurer d'une transition progressive sur le volet d'appui/supervision des PC et AT -> "nous aimerions que les CSB continuent à nous superviser"
 - d. Impliquer/responsabiliser les Chefs CSB dans la remise à niveau continu (ex. IEC/CC & PF pour les AT & PC); Utilisation des Déviants Positifs (exemples/modèles) pour motiver leurs pairs (Dr. Nirina- CSB Ampasimadinika- supervision des PC/AT, Dr. Edouard – CSB Anjahambe pour COPE, etc.)
 - e. Impliquer/responsabiliser les Chefs CSB dans les rapports du PC : la compilation et l'analyse pour la prise de décisions
 - f. Explorer les possibilités à assumer les dépenses prioritaires des activités à continuer après Sept 07- ex. budget de VIH/SIDA
 - g. Réfléchir sur comment les SSD/CSB peuvent persuader les autres membres de COSAN à adresser la question de comment continuer à motiver les PC et les AT après le projet (ex. motivation potentielle: remise à niveau, moustiquaires, draps, kit, contenu de kit, encadrement en méthodes cultivatrices, activités génératrices de revenu)
 - h. Mobilisation des Maires et d'autres autorités locales : explorer si le CASC pour faire du plaidoyer auprès du Maire pour un appui financier de la Commune (contributions occasionnelles pour couvrir remise à niveau motivant pour les PC & AT)
 - i. Inciter et faciliter les PCs et AT à créer des associations pour pouvoir continuer à vendre les moustiquaires SupraNet après le projet

PAFI et MAFI (SSD & CSB)

Envoyer documents : DIP, Algorithmes, COPE, brochures, flip charts (STI)

Fiche de PCIME- CSB Maromitety

Rapports de Formation et d'Activités

Somme totale de budget dépensé pour les formations pour inclure dans le PTA (SSD VVT) – requiert par le MinSanPF

Cours d'anglais

Transport des équipements aux CSB par ADRA (lits, etc.) – si planning fait à temps

Sollicitude des équipements:

Vacuum Extractor (CHD- VVT, CSB- Tmt II)
Aspirateur Néonatal
Équipement de Laboratoire
Toase
Outils informatiques (à étudier)

PAFI et MAFI (Staff de l'ADRA)

Achat des bottes, protection contre pluie
Journées récréatives ensemble avec les SSD

GAFI MEDC

(Grande Action Faisable Importante Mais En Dehors du Control du projet)

Standardisation des prises en charge avec les normes des autres ONGs
Achat du pétrole pour la chaîne froide (ADRA peut continuer la distribution mais ne pas acheter)
Voitures (Tmt II)
Staff (VVT)
Bâtiments nouveaux (SSD – VVT)
Oxygène (VVT)
Electricité/Panneaux solaires (CSB – Ampasimadinika, CSB Ambodimaharo)
Formation en Echographie, Pédiatrie, MSP, Médecine Traditionnelle, etc. (CHD- VVT)
Adduction d'eau (VVT Maromitety)
Salles pour les accompagnateurs
Ajouter des sites (entre les 2 régions)

Child Survival and Health Grants Program Project Summary

Oct-30-2006

**Adventist Development Relief Agency
(Madagascar)****General Project Information:**

Cooperative Agreement Number: GHS-A-00-03-00008-00
Project Grant Cycle: 19
Project Dates: (9/30/2003 - 9/29/2007)
Project Type: Standard

ADRA Headquarters Technical Backstop: Dina Madrid
Field Program Manager: Mpayamaguru Josué
Midterm Evaluator: Linda Morales
Final Evaluator:
USAID Mission Contact:

Field Program Manager Information:

Name: Mpayamaguru Josué
Address: ASA Child Survival project
Toamasina , , 501
Phone: (261)
Fax: (261) 20-53-30667
E-mail: director.cs@adra.mg

Alternate Field Contact:

Name: Dr. Gaby RAKOTONDRABE
Address: Lot 22 Boulevard Ponthiau
TAMATAVE 501 ,
Phone:
Fax:
E-mail: director.ff@adra.mg

Funding Information:

USAID Funding:(US \$): \$1,498,673 **PVO match:(US \$)** \$675,943

KPC survey indicated a TT2+ coverage rate of only 31% (n=300)

All

Project Information:**Description:****Project Goal:**

Improved health for children under five and women of reproductive age in Toamasina II and Vavatenina Districts, Toamasina Province, eastern Madagascar.

Interventions are in the areas of malaria, immunization, control of diarrheal disease, nutrition, ARIs, community-based Maternal and Newborn Care, Child Spacing and STI/HIV/AIDS; and capacity building.

The strategies include:

- a) continuing to provide skills and management training for CSB agents in both community- and facility-based IMCI, and the addition of a maternal and newborn care (MNC) component with BEOC training;
- b) C-IMCI training for all community health agents (CHA) and literate TBAs; and
- c) comprehensive MNC training for TBAs
- d) working with the SSDs (District Health Systems) to strengthen the CSB agents' capacity to supervise TBAs and CHAs;
- e) the development of an MCH referral system involving community and clinical levels;
- f) integration with community-based structures (CASC and COSAN); and
- g) the continuation of the Appreciative Inquiry approach to management and capacity building in both districts.

Location:

The ASA Project will continue to work in Toamasina II (TMM II) District, and will also expand to include Vavatenina (VVT) the district bordering the northwest "corner" of Toamasina II district. Both districts are in Toamasina Province, in the central east coast region of Madagascar.

Project Partners	Partner Type	Subgrant Amount
Population Services International (PSI)	Collaborating Partner	
District Health Systems (SSDs)	Collaborating Partner	
Community Health Clinics (CSBs)	Collaborating Partner	

Project Sub Areas:

Tamatave II
Vavatenina

General Strategies Planned:

Social Marketing
Strengthen Decentralized Health System
Information System Technologies

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Organizational Capacity Assessment with Local Partners
 Organizational Capacity Assessment for your own PVO
 Participatory Rapid Appraisal
 Lot Quality Assurance Sampling
 Appreciative Inquiry-based Strategy
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
 Mass Media
 Interpersonal Communication
 Peer Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	(None Selected)	Traditional Healers	Dist. Health System Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:**Immunizations (15 %)**

- (IMCI Integration)
- (CHW Training)
- Polio
- Classic 6 Vaccines
- Vitamin A
- Cold Chain Strengthening
- Mobilization
- Measles Campaigns

Nutrition (15 %)

- (IMCI Integration)
- (CHW Training)
- Comp. Feed. from 6 mos.
- Growth Monitoring
- Maternal Nutrition

Pneumonia Case Management (5 %)

- (IMCI Integration)
- (CHW Training)

Control of Diarrheal Diseases (10 %)

- (IMCI Integration)
- (CHW Training)
- Water/Sanitation
- Hand Washing
- Feeding/Breastfeeding
- Care Seeking
- POU Treatment of water

Malaria (15 %)

- (IMCI Integration)
- (CHW Training)
- Training in Malaria CM
- Adequate Supply of Malarial Drug
- Antenatal Prevention Treatment
- ITN (Bednets)
- Community Treatment of Malaria

Maternal & Newborn Care (25 %)

- (CHW Training)

Child Spacing (15 %)

- (CHW Training)
- Child Spacing Promotion
- (IMCI Integration)
- (CHW Training)
- (CHW Training)
- (CHW Training)

Target Beneficiaries:

	Tamatave II	Vavatenina	Total Beneficiaries
Infants < 12 months:	7,814	12,659	20,273
Children 12-23 months:	7,814	12,659	20,273
Children 0-23 months:	15,228	25,318	40,546
Children 24-59 months:	22,340	37,976	60,316
Children 0-59 months:	38,068	63,294	101,362
Women 15-49 years:	50,778	38,959	90,735
Population of Target Area:	230,717	383,599	614,316

Rapid Catch Indicators:

LQAS sampling methodology was used for this survey				
UNDERWEIGHT CHILDREN				
Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)				
Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age				
Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	57	95	60.0%	18.4
Vavatenina	50	95	52.6%	17.7
BIRTH SPACING				
Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child				
Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth (Rapid CATCH Question 10)				
Denominator: Number of children age 0-23 months in the survey who have an older sibling				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	86	95	90.5%	20.0
Vavatenina	73	95	76.8%	19.6
DELIVERY ASSISTANCE				
Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel				
Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D				
Denominator: Number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	57	95	60.0%	18.4
Vavatenina	64	95	67.4%	19.0
MATERNALITY				
Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child				
Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9				
Denominator: Number of mothers of children age 0-23 months in the survey Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9				
Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	38	95	40.0%	16.1
Vavatenina	45	95	47.4%	17.1
EXCLUSIVE BREASTFEEDING				
Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24				

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	35	95	36.8%	15.6
Vavatenina	18	95	18.9%	11.8

COMPLEMENTARY FEEDING
Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13
Denominator: Number of infants age 6-9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	16	95	16.8%	11.2
Vavatenina	10	95	10.5%	9.0

FULL VACCINATION
Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)
Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	35	95	36.8%	15.6
Vavatenina	17	95	17.9%	11.5

MEASLES
Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16
Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	60	95	63.2%	18.7
Vavatenina	68	95	71.6%	19.3

BEDNETS
Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19
Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	73	95	76.8%	19.6
Vavatenina	64	95	67.4%	19.0

DANGER SIGNS
Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20
Denominator: Number of mothers of children age 0-23 months in the survey

Tamatave II	46	95	48.4%	17.2
Vavatenina	37	95	38.9%	15.9

SICK CHILD

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	37	95	38.9%	15.9
Vavatenina	52	95	54.7%	17.9

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	60	95	63.2%	18.7
Vavatenina	62	95	65.3%	18.9

HANDWASHING

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/wash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II	68	95	71.6%	19.3
Vavatenina	45	95	47.4%	17.1

TB TREATMENT SUCCESS RATE

Description -- Percentage of new smear positive cases who were successfully treated

Numerator: Number of new smear positive cases who were cured plus the number of new smear positive cases who completed treatment

Denominator: Total number of new smear positive cases registered

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Tamatave II			%	
Vavatenina			%	