COMMUNITY INVOLVEMENT IN MATERNAL AND CHILD HEALTH IN MADAGASCAR

Example from immunization
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Community Involvement in Maternal and Child Health in Madagascar (example from immunization)

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Acronyms

ACT  Artemisinin-based combination therapy (for malaria)
AIDS  Acquired Immune Deficiency Syndrome
BASICS  Basic Support for Institutionalizing Child Survival
BHC  Basic Health Center
CC  Champion Community (*Kaominina Mendrika* in Malagasy)
DQS  Data Quality Self-Assessment
DHS  Demographic and Health Survey
EPI  Expanded Program on Immunization
FANOME  Financing for Sustained Provision of Medicines
FP  Family Planning
HC  Health Committee
HIV  Human immunodeficiency virus
HSSPDP  Health Sector and Social Protection Development Plan
ICS  Immunization Coverage Survey
IEC  Information, Education and Communication
JICA  Japan International Coordination Agency
JSI R&T  John Snow, Inc Research and Training
LDI  Landscape Development Initiatives
LLIN  Long lasting insecticide-treated net
MAP  Madagascar Action Plan
MAR  Monthly Activity Report
MCHW  Maternal and Child Health Week
MGHC  Madagascar Green Healthy Community
MDG  Millennium Development Goals
MICET  Madagascar Institute for Conservation of Tropical Eco-systems
MLM  Mid-level management
MOH/FP  Ministry of Health and Family Planning
NGO  Non-governmental organization
PMTCT  Prevention of mother-to-child transmission (of HIV)
RED  Reaching Every District
SAF/FJKM  Development Project/ Church of Jesus Christ in Madagascar
STI  Sexually transmitted infection
USAID  U.S. Agency for International Development
WHO  World Health Organization
I. Context

The Government of Madagascar is committed to reaching the Millennium Development Goals (MDGs), as indicated in its five year Madagascar Action Plan (MAP) to reduce maternal and infant/child mortality.

According to the Demographic and Health Survey (DHS) figures, between the 1997 and 2003-2004 DHS, the rates of Malagasy maternal and infant mortality have dropped: infant mortality has gone from 96 per 1,000 live births in 1997 to 58 per thousand in 2004 and child mortality from 159 per 1,000 children under 5 years of age in 1997 to 94 in 2004. The maternal mortality rate for every 100,000 live births has dropped from 488 in 1997 to 469 in 2004. Immunization coverage rose from 61% for DPT3 (DHS 2003-2004) to 82% (2008 National Madagascar Immunization Coverage Survey).

Despite these improvements, Madagascar still struggles to reach the MDGs by 2015, which include reducing: infant mortality to 30 per 1,000 live births, child mortality to 54 per 1,000 under fives and maternal mortality to 127 per 100,000 live births. For immunization, Madagascar’s goals are to achieve an immunization coverage rate of at least 84% for all antigens, maintain the DPT1 to DPT3 drop-out rate below 10%, and ensure immunization outreach services to at least 50% of the population who live more than 10 kilometers away from a Basic Health Center (BHC).

District performance is constrained by irregular operation of BHCs in certain districts, unavailability of needed resources, insufficient staff and low competency levels of some health staff, and weak program management and information and reporting systems. Poor logistics, insufficient funding and limited outreach also make it difficult to reach remote populations far from BHCs with needed interventions, notably for maternal and child health. To address this, the Madagascar national health policy has emphasized the importance of maternal and child survival. It calls for involving the communes and the fokontany in steps towards rapid and sustainable development that directly benefit the local population. In addition to improving traditional health services, biannual Maternal and Child Health Weeks (MCHW) have been implemented since October 2006 to reinforce integration and comprehensive care. Since 2002, the Ministry of Health and Family Planning (MOH/FP) and its immunization program (EPI) - with the support of USAID, WHO, UNICEF and JICA – is also reinforcing the immunization system through implementation of the “Reaching Every District” (RED) approach (see box) for strengthening immunization and integrated services at district level.

II. Integrating interventions

Continuing the various approaches implemented in Madagascar, the MOH/FP and its health units have implemented the principle of a “health continuum,” as shown in Figure 1.

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1 an administrative subdivision that represents a collection of villages under a locally appointed fokontany leader
The aim of Madagascar’s integrated strategy is to inform the population about and motivate people to use the variety of maternal and child health services and to train and support health staff to reliably provide these services. Community mobilization is a focus within the commune to empower people to carry out ‘small, feasible actions’ (resulting in improved behaviors that benefit people’s social, economic and cultural development) and to focus the attention of health professionals on the quality of services that they offer to communities. The goal is to improve and increase the use of complementary preventive and curative health services to reduce maternal and child morbidity and mortality in Madagascar and optimize coordination and use of resources.

III. Kaominina Mendrikaa Salama (Champion Community) and Integration

The Kaominina Mendrikaa (or Champion Community) approach began in 1999 to mobilize and link communities and services and improve health goals (see timeline). The Champion Community (CC) approach is being rolled out throughout the country to cover the 1750 communes, 2493 BHCs, 111 districts in 22 regions through support from the government, World Bank and partners.

3.1 The Principal Strategies

A combination of strategies has been implemented:

- Strengthening the organization and provision of health services and health teams’ managerial capacity;
- Involving the community in planning health activities at the district and BHC levels;
- Reaching the target populations through fixed, outreach or mobile strategies, including implementation of the RED approach;
- Using health data collected on a monthly basis for corrective action and reinforcing epidemiological monitoring;
- Ensuring availability and use of health program management tools;
- Improving immunization services;
- Ensuring availability of products, equipment, and staff at all levels;
- Distribution of resources equitably (refrigerators, means of transportation for outreach or mobile strategies);
- Training and supervision;
- Integrating and expanding availability of joint maternal-child health interventions: integrated outreach through routine services and bi-annual MCH Weeks;
- Identifying gaps in reaching target populations and improving their access to and utilization of health services.

**GENERAL HEALTH GOAL**

To reinforce the Maternal and Child Survival Program and improve key indicators.

**SPECIFIC GOALS**

- Increase immunization coverage to at least 90% for all antigens
- Mobilize and empower communes to improve the health of the households, mothers and children
- Develop management skills, e.g. regional and district EPI staff’s Mid-Level Management (MLM) training
- Promote family planning among couples
- Encourage pregnant women to go for prenatal care
- Complete the child’s basic immunizations before his/her first birthday and ensure that a vitamin A supplements are given to children 6-59 months, and deworming for children 12-59 months
- Protect children below five years of age and pregnant women against malaria
- Improve eating habits of pregnant and lactating women;
- Encourage mothers to practice exclusive breastfeeding for infants 0-6 months
- Improve complementary feeding for children 6-24 months
- Improve people’s knowledge of

**TIMELINE**:

**Kaominina Mendrika (Champion Communities)**

1999 : The Jereo Salama Isika-Linkages/USAID project begins the Champion Community (CC) program at the MOHFP’s request to promote community mobilization and achieve specific health goals in its intervention districts.

1999-2003 : Jereo Salama Isika-Linkages/USAID implements CC in 33 communes within the provinces of Antananarivo and Fianarantsoa. The USAID-funded BASICS II project also provides technical assistance.

2003 : The Voahary Salama organization adapts the CC initiative to integrate Health, Population and Environment.

2003-2004 : With financing by the MGHC Project and JSI R&T, NGOs working with forest preservation, (LDI, SAF/FJKM, MICET and ASOS), developed a community mobilization program, adding health activities to agricultural development and environmental protection. This approach was implemented in 17 villages in vulnerable biodiversity zones along the forest corridor.

2004 : Santénet/USAID project adapts the CC model at commune level and for national scale up.

2005-2006 : The MOHFP and Santénet/USAID extend CC in 81 communes within the provinces of Antananarivo, Toliary, Fianarantsoa and Toamasina. Other ministries decide to adopt the approach. The community health insurance model is also piloted.


2007-2008 : SantéNet/USAID concentrates and extends Kaominina Mendrika Salama to 303 communes through community health agreements that encourage collaboration between public services and the community to improve MCH. BASICS II and IMMUNIZATIONbasics also provide MCH technical assistance.

3.2 Structure at BHC and community level

The BHC is the structural unit closest to the community and is established through health sector and commune or mayoral agreement. The head of the BHC (either a doctor or professional nurse) is under the direction of the head of District Health Services. Community and health sector collaboration ensures the functioning of the BHC.

3.2.1 BHC and health and management committees

The Head of the BHC is the main person in charge of the BHC’s health care services. She or he is part of the BHC health staff team as well as an advisor to the management committee. With the management committee, the BHC Head ensures the availability of medicines and products (by requesting vaccines and medicines, conducting in-patient consultation and manning the front desk). The BHC Head supervises staff, ensures use of management tools, and completes and sends monthly activity reports to the head of the District Health Services.

The health committee (HC) is the reference point for planning, developing, and monitoring health care programs at the community and/or commune level. Each BHC must have a HC, which can consist of local leaders, NGO representatives, community mobilizers, and the head of the BHC. If a commune has more than one BHC, the group of health committees within the sector constitutes the commune’s HC. If the commune does not have a BHC, the HC within the larger health sector serves as the commune’s health committee.

The management committee is the BHC’s working management structure, in which representatives from the commune, the community, and the health sector must be represented. This committee is specifically responsible for managing medicine and the use of resources generated by FANOME (a mutual credit, cost recovery system for medicines, involving financial participation by users).

3.2.2 Community role

Community involvement is perceived as empowerment and appropriation, with the following norms having developed over time:

- Making each household responsible for decision-making relating to the family's well-being. Thanks to intensive and continued outreach conducted through the CC approach, individuals and households make decisions based on information from a variety of sources, including BHC staff, community mobilizers, village coordinators, teachers, fokontany leaders, etc.
- **Increasing women’s roles in decision-making within the household.** Men are now more conscientious of the economic interests of good health for the family and the role of women in this, thanks to improved care, preventive behavior and family planning. They encourage their spouses to take part in decision-making concerning the household’s health.

- **Effective collaboration between the commune’s different officials.** The CC approach strengthened collaboration between officials within the different development sectors in the commune. This methodology has enabled officials to better understand the links and complementarities between the health sector and other development sectors and then to establish common goals and solutions.

- **Reinforcing public-private partnership.** The implementation of the CC approach with NGO support enabled collaboration and partnership between decentralized and regional government structures and non-governmental partners. The use of social links and contacts between the administrative officials (the mayor’s office and the fokontany chiefs), the health officials (health workers, community coordinators) and the population have established trust and lifted certain social barriers that had hampered open and transparent dialogue on health services and preventive and curative needs.

- **Special consideration for the poor:** The basis of FANOME is “mutual credit for health,” or a solidarity or equity fund to facilitate the poor’s access to treatment.

### IV. Operationalizing the Integration Package

The under-use of services offered at BHCs can be explained, in part, by people’s lack of information on risk or illness detection and prevention, as well as cultural behavior of seeking treatment at health centers as a last resort. It is also due to households’ inability to get to the BHC, or missed opportunities by facilities to provide a fuller range of appropriate services when mothers and children are present.

The CC approach implements many different interventions (in all or nearly all of the fokontany) to promote the adoption of healthy behaviors and increase demand for certain products and health services, while improving their availability, access and quality. (Refer back to Figure 1 for the health interventions that are integrated.)

A National Committee for Child Survival, which coordinates the various interventions, meets at least three times a year to review indicators and exchange experiences among members. Various initiatives, including the CC approach, RED and a community health insurance mechanism\(^2\) are discussed. The experiences have shown that it is just as essential to engage the public administration and technical services at regional and district levels to support community level involvement as it is to involve and empower individuals, community volunteers and communities. Involvement of the environment, health,

\(^2\) These three strategies have all looked at ways in which a series of preventive services can be provided to mother-child pairs at the community level. The integrated approach allows for synergy among partnering services and the social coordinators responsible for mobilization during the implementation. As the CC approach, RED, and the community health insurance mechanism have been piloted and adapted for scale-up; supervision, monitoring and evaluation have been carried out by management teams on a periodic basis, and findings fed into an overall integrated strategy for improving community involvement in health.
economic development, good governance and education sectors has also been necessary to enable tangible, long-lasting achievements based on the available resources.

4.1 Setting up a sustainable community structure for health

The Government of Madagascar, through the MOH/FP, has adopted a policy of intensified and long-lasting development that links local populations with health services. The integrated approach for community interventions allows the commune to create its own communal development plan, with activities chosen and co-managed by the commune.

4.1.1 Health committees - meetings and joint planning

To improve health and resolve problems, it is essential to engage the public administration and regional and district services, as well as individuals, community volunteers, local NGOs and communities.

Health committees and their social mobilization sub-committees exist at each level of the health pyramid, with an increased number of volunteer community mobilizers (at a minimum 2 per fokontany) to reach 90% of target groups with advocacy and IEC support. The fokontany chiefs, along with the HC coordinators and BHC staff, are key leaders within the committee. Nutrition workers and other community influences (e.g. religious organizations, traditional leaders, Scouts, Red Cross, NGO’s, associations, and teachers) also participate, with a particular role in IEC and advocacy to promote health and development with communities that are not accessing the BHCs.

The HC establishes goals to improve key health indicators for its community in a defined period of time. The key indicators for improving maternal and child health, the approach’s implementation process, as well as the roles and responsibilities of the different actors at the commune level are presented in a simplified and illustrative way in a technical implementation guide. The methodology behind establishing goals is also described in the guide.

Essential Communication Tools Package for a BHC

The integrated approach incorporates a range of IEC support and managerial tools intended for:

- beneficiaries (maternal and child health cards, Gazety health magazine, immunization certificate for complete vaccination),
- community coordinators (counseling cards to advocate with communities, invitation cards to encourage visits to services)
- health workers (registers, advertising flags for vaccination session days, job aids, management tools) and trainers (reference guide).

The MOH/FP coordinates this support with partners, including a Communication and Health Mobilization Committee to assist with standardizing support and messages. A workshop in 1997, organized with assistance from the USAID/BASICS project, brought together many of the Ministry’s supervising technical experts and private partners working in the health sector to standardize messages and support mechanisms on maternal and child health.

4.1.2 Channels for transmitting messages

Community partners, such as local authorities, community health workers, local NGO’s and nearby radio stations are involved in increasing and sustaining public awareness.
Community health workers have been given outreach and marketing kits to support interpersonal communication activities. These kits consist of standardized, tested IEC support materials with different presentations, such as television and social marketing products and articles. Distributed at the community level, these products both increase access to health information and motivate volunteers. Social marketing tools promote the health interventions within the commune. A mass media outreach kit, including various audio materials for radio, supports the mobilization and outreach activities and reinforces the key messages diffused locally.

Mass media (radio and TV), cultural events, door-to-door, evidence of health achievement, and communication through community services (e.g. street salesmen, carnivals and information in schools, churches, fokontany offices, etc.) are all strategies to inform and reach out to the community, particularly to encourage people to take advantage of available services. Invitation cards are also given out by mobilizers as an outreach tool to invite community members to the BHC for services (e.g. for target populations eligible for immunization and reproductive health).

4.1.3 Sustainability of services

The CC approach encourages the appropriation of health activities by local authorities: e.g. integrating these activities into the communal development plan on a larger scale. The CC process is supervised and evaluated by the development and health sectors to monitor service performance in their communities. Champion Communities and individuals contributing to the achievements are also thanked, valued and awarded on many occasions (e.g. at public festivals).

The BHC offers the population a minimum package of interventions (refer to Figure 1), which vary according to what is prioritized by each region or district and what is agreed upon with the HC. Within the CC approach, other goals (e.g. for improved sanitation or environment indicators) may also be incorporated.

BHCs also support public-private partnerships as a way to address community health problems and link private services with the health indicators being tracked.

4.2 Quality of Service

The Madagascar Action Plan (MAP) specifies the government’s commitment to “ensure the quality of service provided to all.” In supporting the MAP, the Health Sector and Social Protection Development Plan (HSSPDP) has integrated “innovative financial modalities in order to offer quality services and to increase their use with the most disadvantaged population by means of mechanisms such as community health insurance, social security or Equity Funds.” Some technical and financial supports are provided to the MOH/FP to improve quality, including exploring how to improve health worker skills and address infra-structure

**Key Components for Quality of Service:**

- Community health care and equity funds,
- Reinforcing the integrated health system and logistics system (FP, malaria, nutrition, STI/AIDS, EPI, MCH),
- Management Information Systems (MIS) – monitoring and evaluation,
- Organizational and institutional development,
- Policy, norms and procedures,
- Initial and continued training, capacity building and supervision for health care workers,
- Planning for measuring and improving training impact and adapting strategies to needs and gaps.
and program needs to improve service delivery.

4.2.1 Using data to make effective decisions

BHC managers utilize the information system to collect, analyze and disseminate routine health data to all levels of the health system. The BHCs’ Monthly Activity Report (MAR) is the main health tracking form at the base level. In 1998, the data management system was reformed within the national health policy to establish data management for BHC and district staff to improve their decision-making and planning. A culture of data use for decision-making is being implemented throughout the government. In the health sector, this culture incorporates program management at all levels of the health system as well as community program management:

- The BHC team holds periodic internal meetings to discuss and analyze management and health indicators and address issues related to use and accessibility of services.
- The BHC and health committee organize meetings at the commune level to discuss community health indicators and analyze gaps, causes, and possible solutions.

<table>
<thead>
<tr>
<th>Key data for decision-making needs for the BHC and community:</th>
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<tbody>
<tr>
<td>• Standardization of denominators used at different levels</td>
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<tr>
<td>• Periodic updating of data from the monthly activity report</td>
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<tr>
<td>• Determining the target population and the drop-out rate for each key intervention</td>
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<tr>
<td>• Measuring intervention coverage (and analysis on its adequacy, effectiveness and completeness)</td>
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<tr>
<td>• Displaying data in the form of graphs/diagrams/tables</td>
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<tr>
<td>• Obligatory measuring of wastage rates/ratio of vaccine and commodity losses</td>
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<tr>
<td>• Promptness and completion of reports</td>
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<tr>
<td>• Measuring performance and corrective measures</td>
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<tr>
<td>• Supervisor’s support in organizational improvement</td>
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</table>

The goal of these meetings is to recommend solutions and improve action plans and their implementation, including:

1. Choosing between the most appropriate and cost-effective measures to bridge performance gaps and identify available resources to support the success for each intervention.
2. Strengthening the ability of service providers in the relevant technical areas, including training and supervision.
3. Implementing joint monitoring and evaluation with the community to review
progress, proceed with required modifications, evaluate the interventions’ impact and recognize and reward the contributors.

The CC approach and the incorporation of RED within the districts are opportunities to get health and commune leaders to meet regularly and use the data that are generated on a daily basis for managing their BHC and linking services and communities around focused interventions and indicators.

4.2.2 Development of Competencies for Program Officials

A national health policy, including norms and standards that incorporate the Champion Community approach, was developed to improve system quality and increase coverage.

“Ensuring the administering of quality health services to all” is a priority in the MAP. Mid-level management training of regional and district officials has been implemented to improve performance and the quality of services in public health care training. Refresher training, integrated supervision, and the CC approach are integral parts of the national health policy’s implementation.

4.3 Community Health Insurance

Community health insurance in Madagascar is a community financial system for health care that began as an community initiative to confront financial barriers to primary and hospital health care access. Members establish common funds through an association to share the cost burden.

An Example of Community Health Insurance: Haute Matsiatra

The region of Haute Matsiatra has a coverage rate of 100% for community health insurance in all its communes.

The principal results observed include:

- An average membership rate to community health plans of 15% (fluctuating between 10% and 80% of the target population in various communes);
- External consultations at the BHC level increased by 39% during the period covered;
- Prescriptions at the community managed pharmacy increased by 40% during the period covered;
- 57% of the number of external consultations during the covered period were community health insurance members;
- Mobilization of important financial resources for the community to underwrite health insurance.

Source: SantéNet 2008

The goal of the community health insurance is to increase the population’s access to health care services and improve workers’ competencies, given limited resources for national health care. The process begins with advocacy with the administrative and local regional authorities and outreach to the population on the importance of insurance against disease and how to address periodic insufficiency of household income (e.g. during planting or pre-harvest seasons). It also is a means of addressing medical costs – for example, for pharmaceuticals.

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3 An analysis of Madagascar’s national health care account in 2006 showed that 70% of household health costs were used to purchase of pharmaceutical goods.
Over the last three years, the implementation of 150 private community health insurance programs has been supported in seven regions: Haute Matsiatra, Vatovavy Fitovinany, Amoron’i Mania, Atsimo Atsinanana, Ihorombe, Atsinanana and Itasy.

V. Perspectives on Sustainability

The following factors have been important for sustaining the Champion Community approach for health in Madagascar:

• Improving accessibility of preventive and curative care services.

• Reviving and maintaining the population’s interest in health and social matters in the commune through municipal and communal meetings and through mobilization in the public interest, such as leveraging funds for the health center, constructing latrines in each fokontany, and restorating rural roads.

• Developing policies and standards, methodologies, and capacity building and monitoring tools: e.g. the national community health policy; the reference guide on the CC approach; certification instructions to become a CC; road map documents for FP, STI’s, child health, and service management; standards for IEC and human resources; and an integrated supervisory matrix.

• Establishing agreed-upon performance goals for a BHC’s minimum activity package (see box on “Champion Community Health Goals”) with the involvement of district officials, service providers and community representatives.

• Training facilitators and providers on the use of job and IEC tools and conducting regular supervision and evaluation (see immunization example, section VI).

• Ensuring continuing and increased financing for health, including the community’s contribution through their involvement with the HC and MC as well as expansion of community health insurance.
### Champion Community Health Goals

Various health goals have been outlined by the MOH/FP for communities to choose from in order to become a champion community. These include:

**Improving maternal health:**
- Increasing the number of individuals using family planning
- Increasing the number of pregnant women coming in for prenatal consultations
- Increasing the number of pregnant women getting immunized against tetanus
- Increasing the number of pregnant women receiving supplements in iron and folic acid
- Increasing the number of households with at least one long-lasting treated mosquito net

**Improving child health:**
- Increasing the number of children less than one year of age immunized against diphtheria, tetanus, whooping cough, hepatitis B, Hib and polio
- Increasing the number of children 6-59 months having received vitamin A supplements
- Increasing the number of children 12-59 months who have received preventive deworming medication

**Increasing knowledge:**
- Outreach to the population on sexually transmitted infections and HIV/AIDS
- Outreach to the population on nutrition for pregnant and breastfeeding women
- Outreach to the population on exclusive breastfeeding
- Outreach to the population on complementary child nutrition
- Outreach to the population on water, hygiene and cleanliness

**Improving the access of services:**
- Ensure product availability
- Improve the use of data as the basis for decisions
- Ensure the availability of work tools
- Intensify active research

Following are examples of some of the standard health activities that Champion Communities have undertaken:

- Counseling and services on family planning and screening tests for HIV/AIDS in health facilities and fixed sites (routine)
- Immunization against tetanus and prenatal care for pregnant women (routine);
- Preventative treatment against malaria for pregnant women starting from the 4th month of pregnancy in the high-risk zones (routine)
- Vitamin A supplements for children between 6 and 59 months and for women who have recently given birth (routine and MCH Weeks)
- Deworming with Mebendazole for children between 12 and 59 months and pregnant women (starting from the 4th month of pregnancy) (routine and MCH Weeks)
- Distribution of mosquito nets treated with insecticide (LLINs) for children between 0-59 months (campaigns)
- Promotion of exclusive breastfeeding and post-natal consultation (routine)
Motivating volunteer workers and communities

Volunteers serve as an important link between services and communities. They also have other responsibilities and work, however, that limit their availability to volunteer. As the CC approach has rolled out, there has been on average approximately 30% attrition of volunteers due to other commitments.

Various ways have been applied to motivate volunteers, considering the services that they provide: training, social recognition, involvement in planning, using a self-recruiting system, badges, distributing social marketing products, enabling them to add responsibilities to their job descriptions, and/or occasionally granting commodities (e.g. caps, communication materials, bags or binders). Monetary incentives have not been a significant part of the champion community approach.

Certification and Compensation for Deserving Communes. The communes that are successful in achieving their objectives are certified as champion communities by the MOH/FP. The main benefit for the commune is health improvement for its population. The certification and acknowledgement by the central authorities also offers additional motivation for the efforts as well as to continue to improve the health system’s performance at the base level.

VI. Results (example from immunization):

In order to strengthen the performance of immunization activities, a combination of the various initiatives has been implemented, including the CC approach, the RED approach, and supplementary immunization activities (e.g. a polio eradication campaign in 2005, maternal and neonatal tetanus campaigns in 2006 and 2007, a measles campaign in 2007), as well as integrated strategies for the MCH Weeks twice a year since 2006.

- Immunization for children between 0 and 11 months for all antigens defined in the policy (routine).

Outside of health, the Champion Community approach has also involved other sectors, such as:

a. The Ministry of Education: percentage of children who have passed the first level examination in elementary school; the ratio between girls and boys in class
b. The Ministry of Environment: to battle against burning of fields and forest, as well as using the percentage of surface of land burned as an indicator by contrast to the prior year; water and sanitation improvement
c. Ministry of Finance
d. Ministry of Decentralization and Good Governance
e. Ministry of Agriculture: for improved farming and rice cultivation practices

The HCAs at the commune and community levels are involved in establishing goals, creating strategies and activities to reach these goals, implementation and monitoring and evaluation.

Following a joint evaluation with exterior evaluators, when the fixed goals for a sector have been reached, the committee awards the commune “a star.” Two stars for two sectors and the commune can also win a sum of money to support the sectors that have reached these goals.
The integrated approaches (designed to reach the MDGs) encourage participation of all departments in the health sector - including immunization, reproductive health, neonatal and child survival - to improve health coverage. This also enables sharing of resources.

The HC at each level of the system operationalizes the plan, including immunization. Fokontany and district data are rapidly reviewed to select the weaker-performing indicators. Advocacy with local authorities is conducted to involve them in implementation and reorientation of base health and immunization activities at each corresponding level -- through opportunities such as local social events (regional/district fairs, celebrating national and international events) and/or by soliciting their assistance in organizing immunization service delivery. It is an effective coordinating mechanism with partners through regular meetings, joint activity planning, and collective monitoring and evaluation of interventions. In immunization, for example, performance improvement and indicator tracking follow a standardized set of components (see box).

The implementation of all of these components requires specific planning, management by the appropriate department within the health sector, as well as the mobilization and coordinated use of resources – material, human, community and financial.

Since 2004, the following activities by the MOH/EPI and partners have contributed to improving service delivery and community linkages:

- Training of 20 immunization officials in 22 regions - with their district officials – on the use of the immunization data management tool. Training district officials in Mid-Level

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**Five components for immunization performance improvement and quality of services**

1. *Procurement and vaccine quality*
   a. Assessing the need for vaccines
   b. Procurement of vaccines
   c. Monitoring and using vaccines
   d. Immunization safety

2. *Logistics*
   a. Vaccines, equipment and other materials: stock management
   b. Cold chain
   c. Transportation
   d. Maintenance
   e. Waste disposal

3. *Service Delivery*
   a. Broken vial policy
   b. VVM : Vaccine vial monitor
   c. Fixed and outreach site schedule
   d. Immunization strategies and activities

4. *Surveillance*
   a. Measuring incidence/disease prevalence
   b. Lab tests
   c. Registering and reporting

5. *Advocacy and communication*
   a. Political and media advocacy
   b. IEC/immunization
   c. Interpersonal communication
   d. Social mobilization; community participation
   e. Inter-sectoral collaboration

6. *Measure and evaluation*
   a. Administrative reports
   b. Immunization coverage
   c. Studies
Management (MLM/EPI) (101), Data Quality Self-Assessment (DQS) (101), data management (170), supervisors (19), initial training specialists (31), and 2 fokontany workers.

- Holding a DQS in districts in 21 regions. Conducting a vaccine management assessment in 54 BHCs and 18 districts in 6 regions.

- Facilitated program management through permanent availability of management tools for standardized data, EPI logistics, and monthly immunization tracking and reporting.

- Active use of maternal and child health cards and the tickler file system to identify and track the target population, with community mobilizers, to come for immunization and health services.

- Integrated supervision by regional and district health teams.

**Use of monitoring data in immunization**

For the past three years, the monthly activity report has shown encouraging results – including improved reliability, completeness and promptness of reporting -- for the various services offered, particularly immunization. Monitoring data (using the scorecard, MAR, computerized management data tools, monitoring and DQS) enable district health officials to improve program management and respond to performance indicators, including:

- Updating and analyzing data at all levels
- Analyzing, estimating and planning cold chain needs and maintenance
- Estimating vaccine needs and understanding the stock situation
- Planning program activities, including outreach with communities, based on results

The Champion Community approach has contributed to the reduction of barriers between service providers and communities and has facilitated implementation of health services. Institutionalizing technical and social mobilization committees at all levels has strengthened the approach’s synergy. Most of the BHCs are now familiar with the CC and community approaches and are organizing themselves with their community and mobilization workers. Use of health services is increasing; in the case of immunization, DPT3 coverage has risen from 61% (DHS 2003-2004) to 82% (national immunization coverage survey 2008). In 2004, only seven districts had reported immunizing more than 80% of children less than 1 year with DPT3. In 2006 and 2007, this had increased to 83 districts (see Graph 1).

**Graph 1 : DPT3 Immunization Coverage at the District Level between 2002 – 2007 (n = 111 districts)**
In addition to the coverage increases, the drop-out rate between DPT1 and DPT3 (Graph 2) has also reportedly declined in districts where interventions, notably the CC approach, have been implemented. These results can, in part, be attributed to the improved linkage of health workers and communities in the intervention zones.

**Graph 2: Drop-Out Rate between DTP1 and DTP3 (2002 – 2007)**

Implementing the standardized RED approach has also contributed to the improvement of coverage. From 2005 – 2007 (Graph 3), RED has been implemented in all 22 regions and 101 districts, with further extension to the remaining districts in 2008.

**Graph 3: Implementation of RED in districts from 2002-2007 (n = 111 districts)**
VII. Conclusion

Health is a key aspect of development, as a healthy population is more productive and more likely to take responsibility for its own welfare. Improving health hinges on an integrated approach that encompasses maternal and child health and delivery of good quality health care services.

Community and health system collaboration is needed in an engaged and systematic way that ensures integration and the notion of coordinated preventive and curative care for all target populations. In Madagascar, the engagement of health teams and communities, and the standardization of services around a Minimum Activity Package at all levels is assisting with achievement of the target goal – to lower the mortality rates for women and children. The community plays a significant and predominant role in support for and participation in the health program for routine services and campaigns.

The health achievements in Madagascar, including support for the CC approach, have been possible through the strong political will of the MOH/FP and concerted efforts by technical and financial partners at all levels, including the communities themselves. The government has fully assumed its role in integrating the maternal and child health program within the health system and has established a performance-based management culture with community involvement. This involvement will be increasingly reinforced as the “Madagascar Community Health Policy” is formally established and rolled out.

Improving maternal and child health is a key aspect of winning the battle against poverty. Through continuing attention and support to the adoption of healthy behaviors and linking communities to quality health services, Madagascar is working to improve and sustain the health and lives of its people.
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