FINAL PERFORMANCE EVALUATION OF USAID MADAGASCAR MIKOLO PROJECT

December 2017

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DISCLAIMER

The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
This document was submitted by GH Pro to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.
USAID/Madagascar Mikolo Project supports Madagascar’s national policy for the implementation of community-based service delivery, to increase access to and availability of community-based primary health care, especially for women of reproductive age, children under age five, and infants living in remote areas of Madagascar. This evaluation of the Mikolo Project is to: 1) to learn to what extent the project’s goals and objectives have been achieved; and 2) to inform the design of a future community-based health services activity. The evaluation explored if Mikolo will achieve its objectives, how it improved the Government of Madagascar’s use of data for decision-making, and how effective is Mikolo’s management structure. This evaluation utilized qualitative methods (i.e., document review, key informant interviews, focus group discussions and observations), supplemented by a review of existing quantitative data (e.g., project data and Community Health Volunteer (CHV) monthly report data). Working closely with the Madagascar Ministry of Public Health (MOPH), Mikolo has been successful in achieving most of its targeted outcomes in support of community health service delivery. Areas for improvement include training, support, and supervision for CHVs; community engagement for demand creation and healthy practices; and referral systems. Working with local NGOs and MOPH, data quality has improved, but more work is needed to improve the use of these data.
ACKNOWLEDGMENTS

This evaluation would not have been possible without the support, cooperation, and sharing of information and experiences, perceptions, and viewpoints of different stakeholders, who provided vital material for this report’s findings and conclusions. The team wishes to acknowledge a debt of gratitude to all those, including community health workers, districts, and national leaders, U.S. Government implementing partners, and other partners of the Government of Madagascar, who gave generously of their time, and shared their thoughts—at times extensively and with great depth. Special thanks are due to the leadership and staff of the Mikolo Project consortium, including Management Sciences for Health (MSH) and their four consortium partners: Action Socio-sanitaire Organisation Secours (ASOS), Catholic Relief Services (CRS), Institut Technologique de l’Education et du Management (ITEM), and Overseas Strategic Consulting, Ltd (OSC). The data collectors who supported us in the field were indispensable and helped shaped our interpretation of the information we received. The USAID staff who support and oversee Mikolo deserve special mention for their time and sharing of their insights into the role of Mikolo with the evaluation team. In addition, we would like to thank USAID/Madagascar staff, including Azzah Al-Rashid, Raymond Grant, Ramy Razafindralambo, and Andry Rahajarison, for setting a solid direction for the evaluation. Special thanks to Vololontsoa Raharimalala for her excellent work and support to our team from start to finish. We appreciate her responsiveness. And last, but certainly not least, the evaluation team would like to sincerely thank Melinda Pavin for her thorough technical reviews, Crystal Thompson for her administrative support throughout this evaluation, and Laurie Chamberlain, for her guidance with the editing and final production.
## CONTENTS

Abstract ............................................................................................................................................................. iii
Acknowledgments ........................................................................................................................................... iv
Acronyms ......................................................................................................................................................... vii
Executive Summary ......................................................................................................................................... xi

I. Introduction.................................................................................................................................................... 1
   Evaluation Purpose........................................................................................................................................................1
   Evaluation Target Audience........................................................................................................................................1
   Evaluation Questions....................................................................................................................................................1

II. Project Background ..................................................................................................................................... 2

III. Evaluation Methods & Limitations...........................................................................................................4
   Methodology ..................................................................................................................................................................4
   Limitations.......................................................................................................................................................................7

IV. Findings ......................................................................................................................................................... 8
   Question – 1 Is the Mikolo Project likely to achieve its objectives as outlined in the contract sub-results (SR) and the PMP? ................................................................. 8
   Question 2 – Did Mikolo improve the use of data for decision-making by the GOM and within the project? ........................................................................................................... 24
   Question 3 – Strength and weaknesses of Mikolo’s management structures .............................................. 28

V. Conclusions and Recommendations .................................................................................................... 29
   Conclusions ..................................................................................................................................................................29
   Recommendations ......................................................................................................................................................29

Annex I. Scope of Work .............................................................................................................................. 34
Annex II. Evaluation Instruments ............................................................................................................... 57
Annex III. Evaluation Sites ............................................................................................................................ 67
Annex IV. Evaluation Participants............................................................................................................... 68
Annex V. SOW for Community Health Volunteers.............................................................................. 71
Annex VI. Project Achievements to Date ................................................................................................. 72
Annex VII. Mikolo PMP Indicator Data .................................................................................................. 77
Annex VIII. OSC Terms of Reference ...................................................................................................... 84
Annex IX. Recommendations for a Low Literate, More User-Friendly Low Literacy Job Aid.... 85
Annex X. Low Levels of Latrine Use Per Fokontany .............................................................................. 87
Annex XI. References ................................................................................................................................... 88
Annex XII. Disclosure of Any Conflicts of Interest................................................................. 90
Annex XIII. Summary Bios of Evaluation Team Members......................................................... 1

TABLES
Table 1. Selected MCH Service Delivery Results to Date FY 2017 Q3................................. 12
Table 2. Selected FP Results to Date FY2017 Q3 ................................................................. 14
Table 3. Selected Malaria Results to Date FY2017 Q3 ....................................................... 14
Table 4. Community-level Primary Care Results to Date FY2017 Q3 .............................. 16
Table 5. SBCC Results to Date FY 2017 Q3 ...................................................................... 20

FIGURES
Figure 1: RMA Data on Key MCH Indicators................................................................. 13
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ACT</td>
<td>Artemisinin-based combination therapy (malaria)</td>
</tr>
<tr>
<td>AM</td>
<td>Amoron'I Mania</td>
</tr>
<tr>
<td>AMS</td>
<td>Ankohonana Mendrika Salama, or “Champion Healthy Household,”</td>
</tr>
<tr>
<td>ASOS</td>
<td>Action Socio-Sanitaire Organisation Secours (Social and Health Actions Assistance Organization)</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CCDS</td>
<td>Commission Communale de Développement Social (Social Development Communal Commission)</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CGL</td>
<td>Comité de Gestion Logistique (Logistics Management Committee)</td>
</tr>
<tr>
<td>CHH</td>
<td>Community Capacity for Health Project</td>
</tr>
<tr>
<td>CHV</td>
<td>Community Health Volunteer</td>
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<tr>
<td>CHX</td>
<td>Chlorhexidine</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community-Led Total Sanitation</td>
</tr>
<tr>
<td>COSAN</td>
<td>Comité de Santé (Health Committee)</td>
</tr>
<tr>
<td>CPN</td>
<td>Consultation Pre-Natale (Antenatal Care)</td>
</tr>
<tr>
<td>CPR</td>
<td>Comité de Pilotage Régional (Regional Steering Committee)</td>
</tr>
<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>CSB</td>
<td>Centre de Santé de Base (Basic Health Center)</td>
</tr>
<tr>
<td>CSLF</td>
<td>COSAN Savings and Loans Fund</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community-led Total Sanitation</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple Years Protection</td>
</tr>
<tr>
<td>DDS</td>
<td>Direction des Districts Sanitaires (Health Districts Directorate)</td>
</tr>
<tr>
<td>DHIS</td>
<td>District Health Information System</td>
</tr>
<tr>
<td>DHS</td>
<td>District Health Service</td>
</tr>
<tr>
<td>DLP</td>
<td>Direction de la lutte contre le paludisme (Directorate of the Fight Against Malaria)</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depo-Provera (DepoMedroxyProgestosterone Acetate)</td>
</tr>
<tr>
<td>DMT</td>
<td>District Management Team</td>
</tr>
<tr>
<td>DQA</td>
<td>Data Quality Assurance</td>
</tr>
<tr>
<td>DSF</td>
<td>Direction de la Promotion de la Sante Familiale (Directorate of Family Health)</td>
</tr>
<tr>
<td>EIPM</td>
<td>Enquête sur les Indicateurs de Paludisme (Research on Malaria Indicators)</td>
</tr>
</tbody>
</table>
EMAD  Equipe Managériale de District (District Management Team)
EMAR  Equipe Managériale de Région (Regional Management Team)
FAA   Fonds d’Appui à l’Assainissement (Global Sanitation Fund)
FGD   Focus Group Discussion
FKT   Fokontany
FP    Family Planning
FS    Formation Sanitaire
FY    Fiscal Year
FY    Fiscal Year
GESIS Gestion de l’Information Sanitaire, an Access-based database software for routine health management information system (HMIS) data reporting
GH Pro Global Health Program Cycle Improvement Project
GMP   Growth Monitoring and Promotion
GOM   Government of Madagascar
GSF   Global Sanitation Fund, a pooled global fund established by the Water Supply and Sanitation Collaborative Council (WSSCC) (see FAA)
HPN   Health, Population and Nutrition Office
IEC   Information, Education and Communication
IRs   intermediate results
ITEM  Institut de Technologie de l’Education et du Management [Institute of Education and Management Technology]
KII   Key Informant Interview
LOP   Life of the Project
M&E  Monitoring and Evaluation
MAHEFA Madagascar Healthy Family Project
MI    Médecin Inspecteur
ML    Men’s Leader (Homme Leader)
MNCH  Maternal, Newborn, and Child Health
MOPH  Ministry of Public Health
MSH   Management Sciences for Health
MSI   Marie Stopes International
MS/M  Marie Stopes/Madagascar
NGO   Non-Governmental Organization
ODF  Open-Air Defecation Free
ORT  Oral Rehydration Therapy
OSC  Overseas Strategic Consulting, Ltd.
PA  Points d’Approvisionnement [Supply Points]
PASSOBA-SANTE  European Union funded Programme d’Appui aux Services Sociaux de Base - Santé (Basic Social Support Services Program–Health)
PMP  Performance Management Plan
PNLP  Programme National de Lutte contre le Paludisme
PNSC  Plan National de Santé Communautaire
PSI  Population Services International
RDT  Rapid Diagnostic Test
RH  Reproductive Health
RMA  Report of Monthly Activities
SBCC  Social and Behavioral Change Communication
SDSP  Services de district de Santé Publique [District Public Health Services]
SILC  Saving and Internal Lending Community
SR  Sub-Result
SSME  Mother and Child Health Week
ST  Support Technician (see TA)
STA  Support Technician Supervisor
TA  Technicien d’Appui (Support Technician)
TOR  Terms of Reference
TOT  Training of Trainers
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
USG  United States Government
V7V  Vatovavy Fitovinany
VAD  Visite à Domicile (Home Visit)
VAR  Vaccin Anti Rougeole [anti-measles vaccine]
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>WASH</td>
<td>Water, Sanitation, and Hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WL</td>
<td>Women’s Leader</td>
</tr>
<tr>
<td>YPE</td>
<td>Youth Peer Educator</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS
The Mikolo Project evaluation serves a dual purpose: (1) to learn to what extent the project’s objectives and goals—at all result levels—have been achieved; and (2) to inform the design of a future community-based health follow-on activity. The evaluation addresses three key evaluation questions.

1. Is the Mikolo project likely to achieve its objectives as outlined in the contract sub-results and the Performance Management Plan (PMP)?
   Key areas for consideration:
   a) the most and least successful activities implemented by the Project for each sub-result
   b) the contributing factors for successes and shortcomings
2. Did Mikolo improve the use of data for decision-making by the Government of Madagascar (GOM) and within the project? How?
3. Did Mikolo’s management structure allow for effective oversight of project operations? Why or why not?

PROJECT BACKGROUND
The five-year (August 1, 2013 – July 31, 2018) USAID Mikolo Project was designed to support the implementation of the GOM national policy for the implementation of community-based service delivery, the Plan National de Santé Communautaire (PNSC). The project’s goal is to increase access to and availability of community-based primary health care, especially for women of reproductive age, children under age five, and infants living in remote areas of Madagascar. The Project works in eight regions targeting 3,557 rural fokontany/communities, 506 communes, and 43 health districts.

By focusing on communities which are greater than 5 kilometers from the nearest health facility, the project is ensuring that the most underserved target populations are receiving quality integrated health services for women and children under-5 years old. The project has re-established a strong community-based service delivery mechanism through the strengthening of the quality of service delivery of more than 6,500 trained community health volunteers (CHV). Continuum of care in MNCH, FP/RH, malaria, and WASH is provided by CHVs in their villages. The project is implemented by Management Sciences for Health (MSH) with four consortium partners: Action Socio-sanitaire Organisation Secours (ASOS), Catholic Relief Services (CRS), Institut Technologique de l’Education et du Management (ITEM), and Overseas Strategic Consulting, Ltd (OSC).

The Mikolo project has four intermediate results (IRs):

1. Sustainably develop systems, capacity and ownership of local partners
2. Increase the availability and access to primary healthcare services in the project’s target communes
3. Improve the quality of primary health care services at the community level
4. Increase the adoption of healthy behaviors and practices

METHODS

Data Collection
This evaluation utilized multiple methods of data collection to answer the evaluation questions. Information from all sources was triangulated, where possible, as a way to verify and substantiate key
findings. The evaluation team utilized information gleaned from project documents during the desk review, and collected data through key informant interviews (KII), focus group discussions, and observations. Secondary data analysis of CHV monthly report data (RMA) was also conducted. A toolbox of question guides was developed for each method and respondent group.

**Sampling**

The selection of the evaluation sites was done in consultation with USAID. Amoron’I Mania and Vatovavy Fitovinany regions were visited for data collection. Priority was placed on going to highland and coastal areas for both geographic and project implementation variations. Two districts in each region were selected, taking into account accessibility and security. Selection was further restricted to those districts that are not benefiting from the USAID Fararano (nutrition) program. Within each district, one commune was selected, and within each commune two FKTs were selected—one relatively accessible fokontany about 5 km from the nearest CSB while the other, less accessible. In total, eight FKTs from four different communes and four districts within two regions were included in the evaluation.

**Participants**

Purposive sampling was used to select evaluation participants. Individuals or groups of individuals who have first hand, knowledge of the project at central and regional and community levels were identified and selected. All participants who participated provided verbal informed consent.

**Analysis**

Qualitative data were coded with prevalent themes and were cross-checked for verification. Coding moved from the descriptive to the more interpretative and supported the development of data inferences. Qualitative analyses were aided with the use of HyperRESEARCH software. The quantitative RMA data were analyzed using Excel to develop simple cross-tabulation tables with frequencies of services utilized, disaggregated by region and time (year and quarter the service was used). Additionally, annual Mikolo PMP indicator data were reviewed and used to substantiate qualitative findings. Data was then triangulated across the different methods to verify and substantiate the findings.

**Limitations**

Major limitations were:

1. **Generalizability**—Qualitative data from eight districts across two regions; whereas, Mikolo works in 43 health districts across eight regions. This limits the generalizability of the evaluation findings, but we hypothesize that although there is variation across the country, major issues are likely to be present in most project sites.

2. **Data quality**—Quantitative data were from existing data sources, and as such the data quality could not be verified. The team has access to limited RMA data, of which there appeared to be possible inconsistencies. Mikolo PMP indicator data appeared to be reliable, but no data quality assessment was conducted.

**FINDINGS**

**Question 1 – Is the Mikolo project likely to achieve its objectives as outlined in the contract sub-results and the PMP**

**SRI 1 Developing systems, capacities and ownership**
Under SR1 there are three notable achievements during the last three years: 1) fostering an effective partnership with the GOM in project implementation; 2) revitalizing the Social Development Communal Commission (Commission Communale de Développement Social or CCDS); and 3) improving GOM’s capacity to deliver quality health services.

Mikolo has developed and maintained a close and effective collaborative relationship with the Ministry of Public Health (MOPH). This is reflected in interviews with all stakeholders at central and lower levels. Mikolo’s efforts or support to the MOPH can be categorized into several areas at the central level: support to national policy development, national planning for health promotion activities, and capacity building. For example, the project, together with other USAID-funded health partners and the Centers for Disease Control and Prevention (CDC) was instrumental in supporting the MOPH in developing the Plan National de Santé Communautaire (PNSC) guide in 2014, which defines the roles and responsibilities of public sector structures in supporting community health service delivery at the lower levels. The project also works closely with other branches of MOPH, including the Directorates of Family Health and Family Planning. During the project life, Mikolo built capacity of actors on all subject matters related to services and promotion, including family planning, child health, leadership, management, etc. through a cascade training of trainers (TOT) approach from the central level all the way to the commune and community (Fokontany or FKT). The project has been credited with operationalizing a public health structure that had not been operationalized since 2008. The project started involving the health center heads in assessing their performance and providing clinical support to CHVs in FY17.

**SR2 Availability of and access to primary health care services**

The Mikolo Project has also increased the availability and access to primary health care services in project target communes. Achievements reported through project documents show increasing number of services being utilized by beneficiaries; FP utilization continues to increase, even among youths; and stockouts of primary care commodities has decreased. However, there are a number of challenges, namely high opportunity costs for CHVs, infrequent and regular supervision, and an ineffective referral/counter-referral system. Additionally, the project had limited success in introducing new products at the community level.

**SR3 Improve the quality of community-level primary health care services**

Mikolo introduced a series of performance measures to improve quality of community-led primary health care services. In compliance with the PNSP guidance and with the MOPH training strategy, the project added detailed supervisory tools to score CHV performance on a regular basis, introduced in Year 4. Most CHVs are achieving a minimum score of quality. The involvement of the health center heads is a way to both strengthen public health sector capacity and improve its ownership. CHVs are not getting the support needed through NGO supervision visits (supervision sur site) and clinical supervision visits at the Basic Health Centers (Centres Santé de Base or CSB) level were both regular and consistent. The level of resources currently allocated to the partner NGOs does not allow the NGO to hire clinically qualified staff or to carry out monthly supervision due to lack of logistics (e.g., funds, motorcycles, vehicles); the distances to be covered by each Support Technician (Technicien d’Appui or TA) and the numbers of CHVs to be supervised by each TA are also factors.

**SR4 Increase adoption of healthy behaviors and practices**

The most successful SR4 activities are derived from Mikolo’s prioritized integration of Social and Behavioral Change Communication (SBCC) interventions into the GOM health system along with the...
joint development of harmonized SBCC materials and their availability to all implementers. The project involved the MOPH from the early stages of development through validation, as well as engaging other stakeholders in the process. Consensus was generated around some innovative approaches for Madagascar. The most successful adolescent and youth intervention has been the increase in new and returning family planning users associated with the establishment of trained Youth Peer Educators (YPEs).

Insufficient international and local SBCC technical assistance may have hindered timely adjustments to field implementation realities. The NGO TAs were expected to support an excessive number of volunteers (between 45-85 volunteers). However, many fokontany did not have the full complement of three health promoters. In many fokontany the CHVs took on the role of Women’s Leader (WL) or Men’s Leader (ML), effectively reducing the number of health promotion volunteers.

Mikolo SBCC implementation did not make adequate adjustments to two major field implementation challenges arising from rural fokontany socio-cultural realities: 1) the low educational levels, 2) and the persistent social norm of open defecation continue to undermine SBCC effectiveness. Additionally, the Champion Community has had limited success, as people don’t see building latrines as a priority, and they maintain their habits (e.g., open defecation).

**Question 2 – Data use for decision-making by the GOM and within the project**

Mikolo has improved its internal monitoring and evaluation (M&E) system and commenced working with the MOPH on the national health information system. The project has been using the District Health Information System (DHIS)-2 platform since the second quarter of Fiscal Year (FY) 16 for their internal project information system; Mikolo has been sharing project achievements at the district level through the quarterly coordination meetings with partners and EMAR/EMAD. They have started training workshops for district health officials on data quality and utilization. Mikolo carefully tracks malaria data and shares with its partners and the MOPH. These data have been used for planning purposes and to avoid stockouts. Furthermore, Mikolo has notified the PNLP of confirmed malaria cases in six districts. However, there is room for improvement, as Mikolo has not fully used M&E data to prioritize and resolve issues, especially in the area of SBCC at the community level. For example, performance related to Champion Households is weak, and training youth peer leaders as agents of change has become stagnant.

**Question 3 – Mikolo’s management structures**

The Mikolo project is primarily centrally managed from the Antananarivo main office. This management structure facilitated the availability and responsiveness of the project to the GOM, particularly related to activities of health system strengthening. Although Mikolo was effective in working with the GOM, their ‘top down’ management structure (centralized decision-making) had pros and cons. For example, the pros are senior staff provide leadership, vision, and assure consistent programming, and strong relations with GOM. The cons are lower level staff are needed to provide broad coverage to partner NGOs at the district and community levels, and strengthen the supervision and support of the CHVs.

**CONCLUSIONS**

Mikolo has been successful in reaching key health targeted outcomes during the span of four years. The project should be recognized for their efforts to revitalize the CCDS health structures to support
community health service delivery in remote communities (> 5 km from a public health center). They have attentively and persistently adapted intervention activities to changes in the political arena with the re-engagement of the public sector. Working hand-in-hand with the MOPH, the project has been able to capacitate more than half of the project CHVs to provide quality continuum of care ranging from under 5 (U5) care to malaria. In addition to obvious improved outcomes, the project has started to support the development of systems and capacities moving toward sustainability. These efforts to sustain community health service delivery should continue. There are a few potentially promising pilot strategies underway, although there is a need for prioritization to focus on those that will render the outcomes, in addition to considering investments needed to carry out these activities effectively. Investments in CHVs need to continue to ensure that they are not only trained but supervised, supported, and compensated. Future community health service projects need to funnel funds to the lower levels where 90 percent of the work is occurring. The project could focus energies to respond in a more timely manner to issues impeding progress concerning creating demand for services: Champion Community Households, and youth strategies. Better coordination with consortium partners, other partners, and stakeholders on the ground would ultimately benefit CHVs in their work delivering needed health care to communities as well as ensure commodities are available in the public and private supply points. Transition or handover of responsibilities to the MOPH should be done in a phased-out manner with adequate support. Country ownership and effective sustainability of community health service is a process; this project is the first of many phases.

RECOMMENDATIONS
For Future Interventions
CCDS—The transition period is an opportune time to phase out incentives for CCDS members.

SILC—Support working for both the standardization and integration of all SILC schemes in collaboration with partners.

CHV Support—CHVs need to be adequately supervised, motivated, and compensated. This is especially important for “polyvalent” CHVs since their workload is heavier with greater responsibilities.

Referral/Counter-Referral System—Refresher trainings should be carried out for CHVs, NGOs, and CSB heads to remind them of the purposes for the forms and their utilization and routing. NGO TAs can reinforce the message of using the referral/counter-referral forms in consultation with clients during supportive supervision; a low-cost system should be developed where these forms are stored so that they do not get lost.

Project coverage—Should cover the entire commune and district and not parts of them.

SBCC—Invest in a robust participatory, community engagement program that aims to establish sustainable norms for increased service use and healthy practices that maximize the benefits of the community health system; recruit and train more community health promoters and more health promotion group participants; develop more participatory communication activities (songs, skits, narrated mimes) that focus on learning, recalling, discussing, and sharing decision-making information; simplify training manuals and tools.

Champion Households—Adopt Global Sanitation Fund (GSF) Community-Led Total Sanitation; limit the Household Champion criteria to behavior changes that are effective at the household level (excluding latrine use).
M&E—Support the MOPH to simplify tools for community health service to include the continuum of care into fewer than the current 10 tools.

For the 5th year
Transition period—As there may not be sufficient time to accomplish all the activities (tasks) for MOHP that are outlined in CCDS, these should be prioritized, to ensure that respective MOPH personnel have the appropriate skills/capacities to carry out activities, and to provide sufficient follow up and coaching in the interim to allow for learning and timely corrections.

Polyvalent CHVs—Increase community service delivery in the project intervention zone, prioritize completion of the integrated services delivery package training for all CHVs who have not yet received this training.

CHV Supervision—NGOs should monitor the cash deficits (debts) when carrying out the CHV supportive supervision visits and consider negotiating with the CSB heads regarding the use of funds from the “caisse sociale” when appropriate to replenish stock—especially moving forward with the recent GOM decision on universal health care.

Coordination—Convene a Consortium Coordination Meeting to review the Year 5 implementation Work Plan and the draft Close Out Plan process.

Prioritization of Strategies—Review and prioritize the various ongoing pilot activities (mHealth, paire AC, etc.) and draft the case studies. Determine which if any pilot activity is to be brought to scale in Year 5 given the limited time and budget remaining on this contract.
I. INTRODUCTION

EVALUATION PURPOSE
This evaluation serves a dual purpose: (1) to learn to what extent the project’s objectives and goals—at all result levels—have been achieved; and (2) to inform the design of a future community-based health follow-on activity.

This evaluation will assist the Mission in reaching decisions related to:

1. The effectiveness of the current approach to build capacity and ownership of local partners, increase availability of and access to basic health care services, and improve the quality of services and adoption of health behaviors.
2. The type of mechanism(s) the Mission should use in future community and facility-based health activities.
3. The nature and scope of possible future interventions in the sector, based on lessons learned from the current project.

EVALUATION TARGET AUDIENCE
The audience of the evaluation report will be:

1. USAID/Madagascar Mission, primarily the Health Population and Nutrition team, the Program Office, and the USAID/Washington Global Health Bureau.
2. An Executive Summary in French will be provided to the Ministry of Public Health (MOPH). This will inform them about USAID’s support to the community health system to deliver basic services and health commodities and how effective various methods have been.
3. Management Sciences for Health (MSH) and its partners. They will learn about their strengths and weaknesses to enable them to adjust their closeout and sustainability strategy accordingly.

EVALUATION QUESTIONS
This evaluation aims to understand the difference between “espoused theories” and “theories-in-use” in order to improve program effectiveness (Argyris 1982). This involves finding out what people say they do, or how the program/project operates, versus what really happened. This evaluation utilizes qualitative methods that are especially suited for this line of enquiry. For example, interviewing project staff and administrators and analyzing project documents can reveal the espoused theory whereas interviewing frontline staff and directly observing the program reveals the theory-in-use.

The Mikolo project evaluation has three key evaluation questions:

1. Is the Mikolo project likely to achieve its objectives as outlined in the contract sub-results and the Performance Management Plan (PMP)?
   Key areas for consideration:
   c) the most and least successful activities implemented by the Project for each sub-result
   d) the contributing factors for successes and shortcomings
2. Did Mikolo improve the use of data for decision-making by the Government of Madagascar (GOM) and within the project? How?
3. Did Mikolo’s management structure allow for effective oversight of project operations? Why or why not?
II. PROJECT BACKGROUND

The USAID Mikolo Project, a five-year (August 1, 2013 – July 31, 2018) $24,767,490 contract, was initiated during a period of bilateral restrictions with the Government of Madagascar, when USAID only supported a humanitarian strategy in Madagascar. Following successful elections in Madagascar, USAID re-engaged with the GOM, at which time the Mikolo Project also shifted its orientation. The Project has gradually increased working with the public sector since Fiscal Year (FY) 15 as well as the number of regions that varied from six in Year 1 to nine in Year 2 and eight in Year 3.

Mikolo was designed to support the implementation of the GOM national policy for the implementation of community-based service delivery—the Plan National de Santé Communautaire (PNSC). The project’s goal is to increase access to and availability of community-based primary health care, especially for women of reproductive age, children under age five, and infants living in remote areas of Madagascar.

Within the country’s 22 regions, the project works in eight regions (Atsimo Andrefana, Haut Matsiatra, Vatovavy Fitovinany, Amoron’I Mania, Atsinanana, Analamanga, Alaotra Mangoro, and Vakinankaratra), targeting 3,557 rural fokontany [communities] (FKT), 506 communes, and 43 health districts. By focusing on communities which are greater than five kilometers from the nearest health facility, the project is ensuring that the most underserved target populations are receiving quality integrated health services for women and children under five years old. In this connection, the project has re-established a strong community-based service delivery mechanism through the strengthening of the quality of service delivery by more than 6,500 trained community health volunteers (CHV), under the supervision of Basic Health Centers (Centres de Santé de Base or CSBs). In addition, the project aims to improve access, availability, and use of high-impact services, products, and practices for family planning/reproductive health (FP/RH; maternal, newborn, and child health (MNCH); malaria; and water, sanitation, and hygiene (WASH) in target FKT. These major interventions are aligned with the PNSC. USAID/Mikolo is implemented by Management Sciences for Health with four consortium partners: Action Socio-sanitaire Organisation Secours (ASOS), Catholic Relief Services (CRS), Institut Technologique de l’Education et du Management (ITEM), and Overseas Strategic Consulting, Ltd (OSC).

The Mikolo project has four intermediate results (IRs):

1. Sustainably develop systems, capacity, and ownership of local partners
2. Increase the availability and access to primary healthcare services in the project’s target communes
3. Improve the quality of primary health care services at the community level
4. Increase the adoption of healthy behaviors and practices

The main project activities are carried out by trained CHVs to ensure the delivery of the continuum of care. These services and practices include: the delivery of FP services to women of reproductive age, including youth; identification of pregnant women, and promotion of four antenatal care visits at CSB level; provision of chlorhexidine (CHX) to expecting mothers for the prevention of umbilical cord infections, misoprostol for the prevention of postpartum hemorrhage; promotion of safe motherhood by encouraging assisted deliveries at a health facility; identification of newborns in FKT for growth monitoring/nutrition, vaccination, and newborn care; provision of critical case management for the three main killers of the under-five children (malaria, pneumonia, and diarrhea); promotion of healthy families and household champions who exhibit model behavior; promotion of three key WASH behaviors (hand
washing with soap (or cinders), use of latrine, and drinking clean water); and, conducting community surveillance to identify those who have dropped out of the system, especially for vaccinations.

In order to promote integrated development, Mikolo has been working in coordination and collaboration with USAID-financed and non-USAID-financed projects, including Population Services International (PSI), Madagascar Healthy Family Project (MAHEFA), Maternal and Child Survival Program (MCSP), Marie Stopes Madagascar (MS/M), Pivot, Interaide, and Projet d’Appui d’urgence aux Services Essentiels de l’Education, de la Nutrition et de la Santé (PAUSENS).
III. EVALUATION METHODS & LIMITATIONS

METHODOLOGY

Evaluation Design
This evaluation employed qualitative research methods that were supplemented with existing quantitative data (e.g., project data and CHV monthly report data) to evaluate the project performance over the last three and a half years. Given that the mandate of the evaluation is to understand project successes and shortcomings, the data collection approach was inductive to enable the evaluation to delve into complex topics, while obtaining multiple perspectives on Mikolo’s strategies and interventions. The evaluation team conducted a desk review of project related reports/documents throughout the evaluation process. The review provided the necessary information concerning Mikolo’s intended and actual implementation efforts. The team spent approximately three weeks studying background documents and designing the evaluation and its instruments.

The following section highlights the methods and processes to address three questions proposed by USAID.

Data Collection Methods
This evaluation utilized multiple methods of data collection to answer the evaluation questions. Information from all sources was triangulated, where possible, as a way to verify and substantiate key findings. The evaluation team utilized information gleaned from project documents during the desk review, and collected data through key informant interviews (KII), focus group discussions, and observations. Additionally, secondary data analysis of CHV monthly report data (!M) was also conducted.

KIIs provided perspectives of both implementers and stakeholders on Question 1, which addresses the likely Mikolo achievements of the project objectives as outlined in the contract sub-results and the PMP, as well as providing a comparison between the most and least successful project activities. This includes establishing contributing factors for project successes and shortcomings. GOM officials from central and regional levels were interviewed to secure their opinions and perceptions of the project implementation. Project staff, including implementing non-governmental organizations (NGOs) and partners, were interviewed to elicit information to: a) validate and, where possible, verify project approaches, interventions, and achievements as well as their current and potential future technical and strategic appropriateness; b) secure opinions and perceptions of the effectiveness of project implementation; c) obtain first-hand reports on training and supportive supervision and on the data and management systems; d) determine how stakeholders and beneficiaries interact with the project in terms of ownership, partnership, and collaboration; and e) determine how Mikolo has contributed to increased uptake of quality health services and behaviors in rural communities.

In addition, interviews also elicited the perspectives of both implementers and stakeholders on both Question 2, which addresses the extent to which Mikolo improved the use of data for decision-making by the GOM and by the project itself, and Question 3, which addresses the strengths and weakness of the project management structure.

Focus group discussions (FGD) were used to obtain multiple and unique perspectives of community actors and beneficiaries. Group discussions with local health committees were organized to understand how the community health system actually carries out health plans, what supports they provide for
related CHV activities, and how data is being used to inform planning. At the FKT level, CHVs shared their experiences providing integrated health services to their communities; they also discussed issues related to the support and supervision they received in carrying out their work, including data tracking and reporting. Other community actors include women/men/youth groups who reinforce the work of CHVs in health promotion also described their training and volunteer work. FGDs with direct beneficiaries (mothers/women of reproductive age and fathers) provided information related to their experience in accessing health services from CHVs and the health promotion activities in their communities.

Observations were an integral part of fieldwork. Understanding the effect of project interventions entailed visiting FKTs to gain first-hand experience of realities for those receiving the health service as well as those providing them. Likewise, visits were made to the CSB facility in the commune to interview CSB chefs and examine the facility and/or community reports. These observations further validated KII and FGD findings. Observations of households achieving Ankohonana Mendrika Salama [Household Champion of Health] (AMS) status were also conducted to obtain beneficiaries’ perspectives in adopting and maintaining health practices. (See Annex I for evaluation instruments.)

Because the goal of this evaluation is to obtain perspectives of stakeholders, project staff, and service delivery clients and providers/promoters on how activities were carried out, the instruments to guide interviews and discussions were intentionally semi-structured in format. This meant that evaluators had access to a toolbox of questions guiding them in the interviews and discussions but were not restricted in using the questions verbatim or using all the questions. The freedom to adjust the questions and employ probing and clarifying questions is an advantage of the method.

SAMPLING

Sites
The selection of the evaluation sites was done in consultation with USAID. The evaluation team spent 12 days collecting data in the Amoron’I Mania and Vatovavy Fitovinany regions. Priority was placed on going to highland and coastal areas for both geographic and project implementation variations. Two districts in each region were selected, taking into account accessibility and security. Selection was further restricted to those districts that are not benefiting from the USAID Fararano (nutrition) program. Within each district, one commune was selected, and within each commune two FKTs were selected—one relatively accessible fokontany about 5 km from the nearest CSB while the other, less accessible. In total, eight FKTs from four different communes and four districts within two regions were included in the evaluation (See Annex III: sample sites).

Participants
Purposive sampling was used to select evaluation participants. Individuals or groups of individuals were selected who have first-hand knowledge of the project at central and regional (including community) levels. USAID provided a list of key individuals from GOM and other partner organizations for key interviews. Others included NGO implementation grantees, CHVs, other community health promoters, such as youth, women, and men peer leaders as well as beneficiaries. In addition to knowledge and experience, their participation was based on their availability and willingness to participate. All

1 Depending availability in the field, two CHVs from the same FKT were interviewed together.
participants who participated provided verbal informed consent. (See Annex IV for list of evaluation participants).

**In the field**
The evaluation team divided into two to cover the two agreed-upon regions. As Malagasy is the common language at the community level, the majority of data collection activities were done by local consultants. International consultants participated and conducted some KII's in French, particularly those with Mikolo regional staff, NGOs, and public health officials. KII/FGD/observation notes were transcribed/translated into French. Though it was envisioned that transcriptions and translations would occur the same day as data collection, this was not feasible. Most of the 110 transcriptions were done after data collection. Every transcription took on average about three hours.

The two teams conducted analysis throughout the data collection period through daily debriefs in the respective region; the teams also touched based on a regular basis to debrief with each other. Team members used secondary data sources to confirm/confront findings and triangulated reported achievements (numbers/targets reached) with findings in the interviews/FGDs/observations wherever possible. The entire team provided inputs and insights during and after the data collection period.

**Data analysis**
An inductive approach was used in this evaluation—a “bottom-up” approach, done at several levels by going beyond the level of description analysis that addresses the question of “what is going on here?” The analysis identified essential features and provided systematic description of interrelations among them. For example, the evaluation team examined how Mikolo has supported and managed responsive community health services in collaboration and partnership with national and other stakeholders. This and other important questions were examined using this approach. Elements of deductive approach were also present throughout the evaluation period from design to data collection and analysis. In conducting the desk review, the evaluation team formulated “theories” on what's going on or questions that need further clarifications. These questions or theories were proven or validated in the field through various data collection methods.

Analysis of qualitative data was aided by HyperRESEARCH software. This facilitated the management of transcriptions by allowing ease of access to codes or analyses. Themes such as sustainability, ownership, and partnerships were coded or cross-coded to indicate primary or overlapping areas of analysis and complexities. Coding moved from the descriptive to the more interpretative and supported the development of inferences about the data.

RMA data were analyzed using Excel to develop simple cross-tabulation tables with frequencies of services utilized, disaggregated by region and time (year and quarter the service was used).

Additionally, annual Mikolo PMP indicator data were reviewed and used to substantiate qualitative findings.

**Triangulation**
Data were triangulated as a method of verification. Whenever possible, team members worked together in carrying out the interviews, discussions, and observations. These qualitative data were then compared across the various data collectors (evaluation team members) to verify the results and to strengthen the confidence in the findings.

The qualitative data were then triangulated with the quantitative data from the Mikolo PMP indicator data and the RMA quarterly data.
LIMITATIONS

The role of the researcher
Qualitative data is dependent on the “human element” of the evaluators’ skills and understanding of the topic and context, as well as their ability to ask clear questions that illicit information that can be pulled together to answer the evaluation questions. These skills also include the evaluator’s ability to listen and note the information as it is being provided. The evaluation team spent a considerable amount of time in evaluation design and tools development prior to embarking on data collection in the field. During this time, team members had opportunities to familiarize themselves with the evaluation tools and underwent two days of orientation. Though this process was not perfect, team members were ready to conduct the KIIIs and facilitate FGDs with the training/coaching received. Team members’ skills complemented each other to provide critical and creative thinking in conducting the evaluation and interpreting its results.

Generalizability
One of the key purposes of this evaluation was to understand what really went on during project implementation so that findings could be used to effect change for the remaining project life and to inform the design of future community health projects in Madagascar. Due to resource and time constraints, the evaluation was not able to collect data from all Mikolo project sites, nor all stakeholders. A purposive sample was selected based on criteria determined in consultation with USAID. The criteria aimed to select sites and respondents that characterized the full range of Mikolo efforts, and that did not introduce bias. As this was not a randomly selected representational sample, not all findings are generalizable, but the evaluation team is confident that the lessons learned in this evaluation will be useful to Mikolo and USAID.

Data Quality
As noted above, qualitative data collection is dependent on the human element, and as such, can be biased by the data collector, creating a range of reliability and validity across the various data collectors. To better insure the reliability and validity of the qualitative data, everyone involved in data collection (the evaluation team) met for two days to review and orient themselves to all the data collection tools and protocols. This allowed for more uniformity in the use of these tools.

The quantitative data used in this evaluation was existing data. As such, the team was not able to check the quality of the data, from the point of data collection, data transfer, data input, data cleaning, data completeness, data accuracy, etc. The Mikolo PMP indicator data were pulled from existing reports. As these data are routinely reported to USAID, the evaluation team assumed they were accurate and complete.

The team was only able to access five quarters of RMA data from Mikolo project sites, from FY 2016, quarters 1-4, and FY 2017, quarter 2. This was not ideal, as FY 2017 quarter 1 data were missing, and this represented only a little more than one year’s data. Data over a longer period of time would have been much more useful. However, the limited data that were available did provide a picture of services CHV provide, and possibly insights to data quality that may need to be addressed by the project.
IV. FINDINGS

The results in this report are syntheses of individual and group analyses presented with related project information found in documents and existing studies. Results presented indicate observed and noticeable trends or occurrences across both regions. The quotes illustrate the most-often expressed statements or similar findings across the two regions and among several evaluation participant groups (e.g., beneficiaries, Mikolo, and/or partners, etc.). When only one person made an observation, this is explained in the report and/or in footnotes.

QUESTION – 1 IS THE MIKOLO PROJECT LIKELY TO ACHIEVE ITS OBJECTIVES AS OUTLINED IN THE CONTRACT SUB-RESULTS (SR) AND THE PMP?

SRI Sustainability develop systems, capacity, and ownership of local partners

Successes and Challenges
The USAID Mikolo Project key program activities under SRI were developed to improve the systems, capacity, and ownership of local partners to enable them to support quality health promotion and service at the community level. Under SRI there are three notable achievements during the last three years: 1) fostering an effective partnership with the GOM in project implementation; 2) revitalizing the Commission Communale de Développement Social [Social Development Communal Commission] (CCDS); and 3) improving GOM’s capacity to deliver quality health services.

Partnership with the MOPH
With the re-engagement with the public sector, Mikolo changed its project strategies to work directly with the MOPH. The project developed and maintained a close and effective collaborative relationship with the Ministry; this is reflected in interviews with all stakeholders at central and lower levels. Key informants praised Mikolo’s openness and willingness to work with the MOPH every step of the way. As an Equipe Managériale de District [District Management Team] (EMAD) member explains, “Mikolo’s strong points, are their capacity to develop relationships with the local team. The communication channel is very fluid and it’s easy to communicate and discuss with them. The project always asks for our opinion.” Nurturing this partnership—building on trust and encouraging open communication—is a crucial success especially after the re-engagement. A district health office official described the relationship saying that he could call any time if he needed anything. Though all projects require authorization and support from the MOPH to start project implementation in Madagascar, projects operate more efficiently and effectively when there are strong partnerships with the national agencies. This makes work in the field much easier as all government work plans originate from the central level.

Central level
Mikolo’s efforts or support to the MOPH can be categorized into several areas at the central level: support to national policy development, national planning for health promotion activities, and capacity building. Mikolo, together with other USAID-funded health partners and the Centers for Disease and Prevention Control and Prevention (CDC), was instrumental in supporting the MOPH in developing the PNSC guide in 2014, which defines the roles and responsibilities of public sector structures in supporting community health service delivery at the lower levels. The project strategies are completely aligned with the vision the MOPH has for its community health programs as spelled out in the PNSC. Both have the same purpose—to improve access and quality of service to everyone. “The priority of the MOPH and the priority of Mikolo are to improve the quality of care and access to care of the entire
community,” according to the Services de district de Santé Publique [District Public Health Services] (SDSP).

The project also works closely with other branches of MOPH, including the Direction de la Promotion de la Santé [Directorate of health promotion] (DPS) and Direction de la Santé Familiale (DSFa). Mikolo worked with the Ministry of Public Health [Ministère de Santé Publique (MOPH) to update standards and procedures on RH and FP, which entailed compiling working group results and validating the updated document. In addition, the project has been involved in the planning of special health events/days with the respective MOPH branches. For example, as mentioned by regional and district health offices in both evaluation regions, and Mikolo and NGO staff, the project has worked closely with DPS and DSF to organize the workshop on breastfeeding and for the preparation of the Week of Mother and Child Health (SSME) and Vaccin Anti Rougeole [anti-measles vaccine] (VAR).

During its project life, Mikolo built capacity of actors on all subject matters, including family planning, child health, leadership, management, and others, through a cascade training of trainers (TOT) approach from the central level all the way to the commune and community (FKT) levels. This approach not only provided the necessary skills required of people carrying out the front-line work or supporting roles but also built social capacity and institutionalized essential expertise within the public health system.

Regional and lower levels
At the lower level, Mikolo also works closely with the district health office (EMAD) in the following ways. Quarterly coordination meetings occur with the EMAD, partners, and NGOs to share project/partner activities and achievements, and to coordinate activities between all involved in the zone. This is especially important for the districts where there are overlapping projects providing similar services. Though Mikolo promotes the sharing of quarterly project achievement numbers at the district level as data utilization, they are sharing achievements and keeping the district health officials and partners aware of the levels of Mikolo’s activities. Presumably, other partners are doing the same at these meetings; however, at the present time, the availability and the use of community health data is limited and does not routinely flow up to the central level. (See Q2 findings discussion below on data utilization for more detail.)

Whether it is a national or regional health event or campaign, Mikolo at the district level is involved working with the EMAD and its partners in organizing and carrying out the activities in communities. Implicit in the project participation is financial support to the district. Without Mikolo’s contribution EMAD officials could not accompany Mikolo and partners in the communities to support these activities. Mikolo, NGO, and public sector interviewees all agreed that without the project’s financial support the EMAD could not have participated. “Mikolo’s strength is its budget, it allows for different activities and monitoring. So, it’s easy for the EMAD to implement our activities,” said one interviewee.

Representatives from Mikolo regional offices, partner NGOs, and EMAD mentioned that the joint supervision frequently occurs during these national or regional events rather than on a regular or scheduled basis (perhaps due to the unavailability of EMAD). Depending upon the availability of EMAD members, sometimes the CSB heads, the Médecin Inspecteur (MI), or other health officials from the

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2 Mikolo Annual Report FY16
3 Mikolo regional offices; NGOs; SDSP; CSB heads
4 In V7V PIVOT, Marie Stopes, and InterAide; in AM PAUSENS
5 Mikolo regional; NGO
district health office participate in these joint supervision visits. All CSB heads, district health officials, project and NGO staff, said they felt CSB heads do not have the time to conduct these supervisory visits.

**Revitalizing the CCDS**

Another Mikolo success, mentioned by many interviewees from all levels and sites, is the revitalization of the CCDS. The project has been credited with operationalizing a public health structure that had not been operationalized since 2008. The PNSC guide was developed and disseminated in 2014 with the support of the project. The CCDS is considered functional when three criteria are met: 1) it has a municipal decree authorizing the establishment of the CCDS; 2) it has an action plan that is updated every twice a year; and 3) regular meetings are held. As of the third quarter of Fiscal Year (FY) 2017, there are 504 functioning CCDS in the project intervention zones, going from 0 to 504 (99 percent of target). Based on Mikolo’s CCDS meeting notes and interviews with Mikolo and NGO staff, it is difficult to tell how effective the CCDS really is in taking charge of their respective health and development activities. The project is present at every meeting as NGOs are expected to attend and report on discussion and achievements of the action plan. CCDS membership is voluntary as is members’ active participation in carrying planned activities.

For the CCDS to remain functional and useful they have to continue to meet, plan, and organize, and actually do what they said they would do to promote the community health service, including activities related to leveraging local funds, establishing ways for emergency transport, promoting building latrines, promoting hand washing. From interviews, project document review, and communication with the project, it appears that Mikolo has been very supportive technically and financially. In the words of one District Health Official: “Among the advantages that the public sector teams have had are the technical and financial support from Mikolo, support in carrying out health campaigns. The project gives us support not only financially but there are also supports in terms of logistics and manpower.”

It may not be realistic to expect that the CCDS continue to meet if/when the project reduces or stops paying for transport and per diems. CCDS membership, which can be between 10 and 50 members. Due to budget limitations, Mikolo set a range for the number of members (between 12-20) that can be compensated. By compensating just 12-20 members, the project may be discouraging others from participating. However, if more than 12-20 people attend, the group divides the funds so that everyone gets a share.

**Comité de Santé [Health Committee] (COSAN) Commune**

COSAN Commune is another public sector structure that supports community health service delivery. Although the project frequently combines COSAN and CCDS when discussing achievements of the CCDS, they are different groups with different purposes and membership. A Mikolo representative explained CHVs as “the members of COSAN commune [they] meet every month…, and they come to the CSB to hand in their reports every month.” Many informants explained that the main purposes for monthly meetings at the CSB were for the CBS head to: a) collect the Report of Monthly Activities (RMAs), b) make a few announcements, and c) conduct a mini-training on a particular technical area.

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6 Mikolo FY17 Q3 Report
7 CCDS needs to meet at least two times per year; this is the number of times Mikolo compensates members for participation. Some CCDS meet every quarter but the evaluation team did not encounter this frequency in the two regions. The CPR also participates coordinating visits to the regions around these bi-annual meetings.
8 See the PNSC guide for details.
The Project only tracks CCDS activities through the bi-annual meetings mentioned above, not monthly meetings at the CSB. Based on the findings and clarifications, it is unclear the contributions to the community health system and functionality of the COSAN.

Improving GOM’s capacity to deliver quality health services

As mentioned above, Mikolo collaborates with the district health office and other partners as needed to carry out national and regional health events (VAR, SSME, breastfeeding, etc.), which often serve as opportunities to conduct joint supervisory visits. These are important excursions for public health officials as they do not have the time or budget to conduct these visits normally. Officials mentioned their appreciation for being able to see for themselves the activities in the field.

Most recently, second and third quarter FY 2017, CSB heads assumed more responsibility for providing CHV supervision at the CSB, including overseeing the weakest CHVs. This entails evaluating CHVs’ technical performance and providing immediate feedback and opportunity to practice at the CSB. While CSB heads interviewed saw the value of this new strategy to strengthen CHVs capacity, they also explained the challenges of having this extra responsibility as they already have a heavy clinic workload. CSB heads in various locations devised ways to provide this supportive supervision to the number of CHVs in their commune, although a few were still unable to conduct the quarterly CHV performance evaluations. For example, 65 percent of the weakest CHVs were evaluated and supported at the CSB by the CSB head while the remaining 35 percent were evaluated by the NGO Techniciens d’appui [Support Technicians] (TAs) in the region V7V (ASOS staff). How CSB heads carry out the added responsibility of evaluating and strengthening CHV technical/clinical capacity varies widely, with instances of CSB heads evaluating and supporting only one-third to one-half of the CHVs while another spends half a day working with CHVs. As one District Health Official noted, “The CHVs are supposed to be supported technically by the CSBs. But it’s not support like the kind the project provides, because the CSBs cannot monitor the CHVs in their work. They don’t have the time or the resources”.

Although it can be said that this involvement of the public health sector is the first step towards sustainability, it is questionable whether this strategy works in the longer term given the limited bandwidth and limited resources. CSB heads are compensated 5,000 AR per CHV they assess and support. Mikolo is currently piloting a peer CHV support activity with the hope of alleviating the work responsibilities of CSB heads while providing needed CHV support.9

SR2 Availability of and access to primary health care services

Successes and Challenges

The Mikolo Project has increased the availability and access to primary health care services in project target communes. This is demonstrated through the results achieved to date (Table 1)10 that shows the project is in line to meet or exceed their targets on almost all its MCH indicators. The following sections highlight these achievements. This report will rely more on Mikolo project data than RMA data. Figure 1 (detailed in Annex VII) provides RMA data on key primary health care services. It is difficult to interpret these data, as they do not appear to display trends, as the data fluctuate from quarter to quarter (see limitations discussion above in Methods section). In AM region, CSB heads and other MOPH staff credited referrals for: a) a decrease in the number of minor cases, which freed up health care practitioner availability, b) an increase in the number of case referrals for complicated illness, and c)

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9 See Annex V for a job description of a peer CHV.
10 See Annex VI for selected outcome achievements to date, per email communication with Mikolo August 2017.
an increase in deliveries at the CSB. The community health system in AM appears to have improved, evidenced by the increasing number of cases of minor illness for ARI, diarrhea, etc. being treated at community level. CSB heads in Vatovavy Fitovinany did not report the same positive outcomes (increased referrals/services) explicitly; however, they do recognize the hard work of CHVs. They mostly talked about issues and challenges they face in doing the work, mainly data collection/reporting on time.

Table 1. Selected MCH Service Delivery Results to Date FY 2017 Q3

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>LOP Target</th>
<th>Results (start-up thru Q3 FY’17)</th>
<th>% Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.12</td>
<td>Percent of service delivery points (CHVs) that experience a stockout at any time of Artemisinin-based combination therapy (ACT)</td>
<td>10%</td>
<td>9%</td>
<td>110%</td>
</tr>
<tr>
<td>2.14</td>
<td>Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT)</td>
<td>269,413</td>
<td>112,311</td>
<td>42%</td>
</tr>
<tr>
<td>2.15</td>
<td>Number of children with pneumonia taken to appropriate care</td>
<td>269,413</td>
<td>233,741</td>
<td>87%</td>
</tr>
<tr>
<td>2.16</td>
<td>Number of children reached by United States Government (USG)-supported nutrition programs (Number of children under 5 years registered with CHW for Growth Monitoring and Promotion (GMP) activities)</td>
<td>2,272,435</td>
<td>2,146,467</td>
<td>94%</td>
</tr>
<tr>
<td>2.18</td>
<td>Number ANC clients referred and seeking care at the nearest health provider by CHV</td>
<td>72,447</td>
<td>85,591</td>
<td>118%</td>
</tr>
<tr>
<td>2.19</td>
<td>Number cases referred and seeking care at the nearest health provider by CHW for severe illness episodes (CU 5 years)</td>
<td>96,126</td>
<td>86,400</td>
<td>89%</td>
</tr>
<tr>
<td>2.21</td>
<td>Number cases referred and seeking care at the nearest health provider by CHW for neonatal emergencies</td>
<td>3,744</td>
<td>7,965</td>
<td>213%</td>
</tr>
<tr>
<td>2.22</td>
<td>Number cases referred and seeking care at the nearest health provider by CHW for obstetric emergencies</td>
<td>4,213</td>
<td>7,121</td>
<td>169%</td>
</tr>
</tbody>
</table>
Family Planning

Both Mikolo project data (Table 2) and RMA data (Figure 1) show an uptake of family planning services. Mikolo data indicate annual increases in the number of new users and continuing users—although the results are not meeting the PMP targets for these indicators. The LOP Results through June 2017, with three quarters implementation remaining in the contract, show that it is likely Mikolo will not achieve its targets for Couple Years Protection (CYP) (51 percent), New FP Users (49 percent), Continuing FP Users (60 percent), and referrals for LAPMs. However, with a consistent decrease in FP stockouts the project has exceeded their targets. To address stockouts, Mikolo worked with PSI to quickly reduce stockouts for the two most popular FP products—Oral Contraceptives and Depo-Provera (DMPA).11

In interviews with CHVs and discussions with beneficiaries, people share their own experiences or explain that they share the information learned with their family. CHVs and Youth Peer Educators (YPEs) refer clients to the CSB or MS/M. There is an active informal network among both CHVs and YPEs as they talk about referring clients, family members, and friends to FP services in both regions. A youth group member explained how youth seek FP services in her FKT this way: “Women prefer to go to the CHV for FP, but since she can’t provide the service, they go to MS/M. Nevertheless, she doesn’t have any shame because she has the referral slip from the CHV. Plus, it’s the sensitization that prompts young people to go see her [CHV].”

Table 2. Selected FP Results to Date FY2017 Q3

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>LOP Target</th>
<th>Results (start-up thru Q3 FY’17)</th>
<th>% Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Number of new users of FP method</td>
<td>617,421</td>
<td>302,174</td>
<td>49%</td>
</tr>
<tr>
<td>2.4</td>
<td>Number of continuing users of FP method</td>
<td>234,370</td>
<td>141,043</td>
<td>60%</td>
</tr>
<tr>
<td>2.5</td>
<td>Percent of service delivery points (CHVs) that experience a stockout at any time of oral contraception products</td>
<td>15%</td>
<td>6%</td>
<td>160%</td>
</tr>
<tr>
<td>2.6</td>
<td>Percent of service delivery points (CHVs) that experience a stockout at any time of DMPA products</td>
<td>15%</td>
<td>7%</td>
<td>153%</td>
</tr>
<tr>
<td>2.7</td>
<td>Number clients referred and seeking care at the nearest health provider by CHW for LAPMs</td>
<td>49,550</td>
<td>19,916</td>
<td>40%</td>
</tr>
</tbody>
</table>

Malaria

Though Mikolo has been successful in malaria interventions, malaria was not a salient topic of discussion among beneficiaries in the evaluation regions. The project achieved three of its five malaria targets as of Q3 (Table 3). Although, the number of children presenting with fever who were tested has increased since the beginning of the project (FY14), it has decreased over the past two years (Annex VI). This may be partly “due to RDT stock-outs at the district level, which trickle down to the community level” (Mikolo Q3 FY 2017 Report). However, Mikolo indicator data show a decrease in stockouts AT CHV service delivery points from FY 2014 (20 percent) to FY 2017 (7 percent).

Within the Mikolo PMP there are two malaria indicators that ask for the number of children that should be measured in percentages. Indicator 2.10 ‘Number of children with fever in project areas receiving an RDT’ and 2.11 ‘Number of children with RDT positive who received ACT’, assume a numerator and denominator, but only the numerator is reported. Reporting of numbers, in these two cases, only tells you the number of children receiving RDT (2.10), and the number of children who received ACT (2.11). Yet it is assumed that the project and USAID want to know the number of children receiving RDT (numerator) among those who present with a fever (denominator) (2.10), and the number of children who received ACT (numerator) among those with a positive RDT (denominator) (2.11). If these data are available, reporting percentages is more meaningful.

Table 3. Selected Malaria Results to Date FY2017 Q3

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>LOP Target</th>
<th>Results (start-up thru Q3 FY’17)</th>
<th>% Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8</td>
<td>Number of health workers trained in case management with artemisinin-based combination therapy (ACTs)</td>
<td>7,507</td>
<td>7,964</td>
<td>106%</td>
</tr>
<tr>
<td>2.9</td>
<td>Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy)</td>
<td>7,507</td>
<td>7,825</td>
<td>104%</td>
</tr>
<tr>
<td>#</td>
<td>Indicator</td>
<td>LOP Target</td>
<td>Results (start-up thru Q3 FY’17)</td>
<td>% Target Achieved</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>2.10</td>
<td>Number of children with fever in project areas receiving an RDT</td>
<td>429,300</td>
<td>96,991</td>
<td>23%</td>
</tr>
<tr>
<td>2.11</td>
<td>Number of children with RDT positive who received ACT</td>
<td>232,300</td>
<td>174,459</td>
<td>75%</td>
</tr>
<tr>
<td>2.12</td>
<td>Percent of service delivery points (CHVs) that experience a stock-out at any time of ACT</td>
<td>10%</td>
<td>9%</td>
<td>110%</td>
</tr>
</tbody>
</table>

**Flexible payment system**

CHVs in both regions visited reported providing credit to their clients for products. Although this credit system is initiated by the CHVs, not Mikolo, this is a customer service that brings the client back and indicates trust between the CHVs and their clients. However, offering flexible payment works to the disadvantage of the CHVs, as clients do not always pay on time or at all. Meanwhile, CHVs spend more of their personal savings to stock up on commodities. The increased demand for and use of these products validates the health-seeking behaviors by community members and the capacity of the CHVs to successfully treat and/or refer cases to the CSB; however, without adequate cash on hand to maintain supply levels, the CHV will not always have essential products available when most needed. The PSI Points d’approvisionnement [supply points] (PAs) do not extend credit, and the CHV must pay in cash for any purchases.

**CHV Challenges**

**Opportunity Costs for CHVs**

The experiences and challenges of being a CHV in Madagascar (and in other contexts) have been well-recognized and documented. Madagascar, like many low-income countries, relies on CHVs to provide basic primary health care as there is an inadequate number of health professionals, especially in the more rural isolated areas. Madagascar has only 2.9 physicians and 3.2 nurses per 10,000 population, compared to the WHO recommended threshold of 23 doctors, nurses and midwives per 10,000 population. In addition to the ratio of health providers to population, these professionals are unevenly distributed and the number of facilities is inadequate. All this underlines the vital role of these front-line volunteers. CHVs showed frustration, fatigue, or de-motivation when talking about their work; this was perhaps more pronounced in V7V than in AM. A CHV in Lavomanitra said she was miferin’aina or frustrated. “I love this job and I do it with all my heart….On the other hand…I have to earn money and work to satisfy the needs of my family.”

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14 WHO Density of doctors, nurses and midwives in the 49 priority countries (http://www.who.int/hrh/fig_density.pdf?ua=1).

Though it may be an honor to be elected by one’s village to be the CHV, CHVs interviewed in V7V reported challenges, such as fatigue, competing projects in the same community, opportunity costs, and lack of support and supervision. CHVs in FKTs where there are overlapping interventions must contend with competition and/or being CHVs for both projects. This further demotivates CHVs, especially if the other project compensates their CHVs more or provides more frequent supervision/support.16 “Even though I am already trained in the IMCI program, few people came to see me for the treatment of their children because of the existence of the PAUSENS Project, which covered health service costs for mothers and children,” said a CHV in AM.

Most CHVs have other jobs to bring in household income. Many are involved in agriculture, and time becomes a real issue during harvesting seasons. Regional NGO staff noted that CHVs have to balance volunteer work with family responsibilities and other work. The workload for CHVs is greater, requiring them to spend more time with data collection/reporting. Motivating CHVs and retaining them is a complex problem, at the core of and linked with sustainability of community service delivery. At the central level, an MOPH Official said “[t]he MOPH is currently improving the implementation of the PNSC and the issue of motivation of the CHV is being addressed because concerns for the sustainability of the community-based delivery of services are part of this ongoing improvement.” Although CHVs do participate in SILC and CSLF, overall only about 4 percent of SILC/CSLF are CHVs members. 17

CHV Support and Supervision

Mikolo works to support CHVs and has provide ongoing training to CHVs in FP, MNCH, malaria, and other community health topics. They routinely monitor community-level primary care results (Table 4). As of FY17, Quarter 3, Mikolo has achieved over 85 percent of their targets on indicators measuring the percentage of CHVs who achieve minimum quality scores (3.1 and 3.2). They have exceeded their targets for completed monthly activity reports (3.3), and CHVs attending COSAM meetings (3.6).

Table 4. Community-level Primary Care Results to Date FY2017 Q3

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>LOP Target</th>
<th>Results (start-up thru Q3 FY’17)</th>
<th>% Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 - USAID IR 2.1.4</td>
<td>Percent of CHVs achieving minimum quality score for community case management of childhood illnesses</td>
<td>85%</td>
<td>75%</td>
<td>88%</td>
</tr>
<tr>
<td>3.2 - USAID IR 2.1.4</td>
<td>Percent of CHVs achieving minimum quality score for family planning counselling at the community level</td>
<td>85%</td>
<td>73%</td>
<td>86%</td>
</tr>
<tr>
<td>3.3</td>
<td>Percent of monthly activity reports received timely and complete</td>
<td>85%</td>
<td>92%</td>
<td>108%</td>
</tr>
</tbody>
</table>

16 Discussion with PIVOT staff; Mikolo/PIVO CHVs, V7V. PIVOT has big presence with resources to better support their CHVs and those working for them (Mikolo/PIVOT CHVs); CHVs doing both end up abandoning Mikolo work as they get paid monthly from PIVOT. PIVOT/Mikolo CHVs may report achievements/activities done for PIVOT under Mikolo reporting.

17 Numbers of CHVs who are members of SILC is 894, number of CHVs who are members of CSLF 677. Total number of SILC members 34,635; total number of CSLF members 1,056. Thus, $1,571/35,691 = .044$. Mikolo provided up to date numbers of CHV participation in either SILC or CSLF groups via email in September 2017.
CHVs are supposed to be supervised/visited once every two months, according to NGOs and CHV interviews many do not receive visits this frequently. The LOP target for the number of CHVs supervised was set at 7,893, but only 77 percent of this target has been met, and that the mean number of NGO TAs is 2 and should be 4 by this time (Table 4). CHVs need to feel supported/motivated to work. It was reported that they appreciated the visits (on-site supervision) by the TAs because it brought recognition among villagers. This non-financial incentive is important for technical and moral support. “People in the village have more confidence in CHVs when they see them being visited by responsible agents like TA. As a result, the number of people who come to the AC to seek health services increases,” said a CHV in AM.

**Service Delivery Challenges**

**Referral/Counter-Referral System**

The referral and counter-referral system requires more attention to confirm continuum of care activities from the referral initiated at community level to the CSB and the counter-referral back to the community level. The Mikolo Project will not meet their PMP target for Under-5 referrals partially due to the lack of a well-functioning referral and counter-referral tracking system (8.9 percent). The referral and counter-referral system appeared to work better in AM region than V7V. Though in both evaluation regions findings from interviews with CHVs and women/youth peer leaders and group discussions with beneficiaries indicated that some community volunteers do refer women/youth to health services (health center, Marie Stopes, or other CHVs) but this practice is not consistent. In V7V, one CSB head showed the interviewers referral slips from the PIVOT saying that she’s never gotten referral slips from Mikolo CHVs; another said that she throws out the slips because she’s not sure what she should do with them; and another person seemed confused by the question. In AM, CSB heads reported receiving referrals from CHVs and sending back counter referrals. The MOPH RMA does not have a designated indicator for referrals and counter-referrals although an NGO partner reported the CSB instructs CHVs to note the referrals on the back of the form for their information—not necessarily to be entered into the MOPH HMIS.

**Rolling out new products and services**

Mikolo successfully supported the availability of MOPH-approved training materials, provided the logistics and supported staff per diems to train (with the NGO TAs) CHVs in how to properly use these new products, as noted by key informants and Mikolo reports. However, the project had limited success in introducing new products at the community level is (e.g., pregnancy tests, chlorhexidine gel for umbilical cord care, and misoprostol for postpartum hemorrhage). It should be noted that the use of misoprostol was not cited by any of the CHVs or MOPH staff during the interviews at the central,
regional, district or community levels in both regions. A senior staff of a partner USAID project summed it up well revealing the situation with misoprostol:

“Misoprostol and CHX are supposed to be used at the community level and not at health facilities level. In theory, we inform health providers at health facilities level about the use of misoprostol and CHX at the community level. In fact, it is the CSB Head who supervises the health staff at AC at the CSB level who should know and share information about the use of these products at the community level even though they don’t use them at the health facility level. To improve the communication, we have been asking for samples of these products at the PSI-assisted supply points so that we can share them with service providers at the CSB level during training sessions. Unfortunately, this has not been done and the current treatment protocol at health facility’s level recommends the use of Oxytocin (Ocytocide) as the product to be used for the control post-delivery hemorrhage.”

Most discussions related to the roll-out of products/services was limited to discussion on trainings received by CHVs. Also cited was the additional challenge of the cost of the new products, as well as a slow uptake, for example, in accepting to use a gel—rather than liquid isopropyl alcohol previously used—for newborn umbilical cord care. Other issues noted that negatively affected the introduction of the new products include: 1) ad hoc pipeline delays outside of the project’s control (e.g., ORS-Zinc treatment supplied by PSI, and pregnancy tests supplied by the United Nations Population Fund [UNFPA]); and 2) missed opportunities to improve coordination with the local MOPH for the phased roll-out for these products. Each Equipe Managériale de Région [Regional Management Team] (EMAR) and EMAD sets its own schedule of trainings and prioritized activities. This calls for additional efforts by the Mikolo Regional Office and the partner NGO staff to maintain communication and coordinating relationships. This challenge was clearly demonstrated during the shift in providing malaria supplies from the private sector social marketing project’s PAs to the public sector CSB sites during Year 4 of the project.

**SR3: Improve the quality of community-level primary health care services**

*Successes and Challenges*

Mikolo introduced a series of performance measures to improve quality of community-led primary health care services. Starting with rigorous compliance with the PNSP guidance and with the MOPH training strategy, the project added detailed supervisory tools to score CHV performance on a regular basis introducing in Year 2. The involvement of the health center heads is a way to both strengthen public health sector capacity and improve its ownership. CSB heads were trained on how to assess CHVs with the related tools; under this innovative system, the “weakest” CHVs work with the CSB heads with NGO TAs supervising and assessing the stronger CHVs. The idea is that those who need the most clinical/technical support would receive them under the care of the CSB heads. NGOs/Mikolo track individual performance to determine eligibility for additional training and “promotions.”

Mikolo has successfully promoted a Continuous Quality Improvement approach with high levels of awareness at the CHV, NGO TA, and CSB levels of the importance and the use of this rating system. Mikolo staff fully document each performance rating by CHVs, and maintain these records for future

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18 Mikolo Project presentation, NGO (AIM, SAF, ASOS) RT, RSE, TA, Mikolo Regional, Project Quarterly Progress Reports and Annual Reports.
Mikolo uses the performance ratings to determine the CHV’s eligibility for further training and possible promotion.

Efforts to provide targeted support to CHVs through the series of assessments and feedback could work better if NGO supervision (supervision sur site) and clinical supervision at the CSB level were both regular and consistent. As stated above, many interviewees noted that there was need for more supervision and support. The limited number and the frequency of NGO TA visits (mean frequency of activity supervision conducted by NGO partners to CHWs is 50 percent of the LOP Target four visits per year noting improvements in FY 2015 and FY 2016) (Table 4) and clinical supervisions at the CSB by clinical staff also limit the opportunities to support the quality of services particularly when supportive supervision visits are scheduled every two to three months and/or an NGO TA ‘supervises’ two CHVs together at a common location due to lack of funding to support transport. In AM, CHVs reported having to wait for additional training to move to the next level; several community agents reported waiting more than a year to access additional training in service delivery and products, such as Rapid Diagnostic Test (RDTs). Moreover, all CSB chefs discussed challenges to schedules, juggling multiple patient consultations, and other duties, and reported difficulties in having adequate time to evaluate performance and provide technical feedback to CHVs. The way CSB heads work with CHVs to evaluate performance and improve their clinical skills is not uniformly implemented. For example, one might spend half a day providing feedback while the CHVs are at the CSB while others spend minimal time just to do the evaluation.

The level of resources currently allocated to the partner NGOs does not allow the NGO to hire clinically qualified staff or to carry out monthly supervision due to lack of logistics (e.g., funds, motorcycles, vehicles) combined with the distances to be covered by each TA and the numbers of CHVs to be supervised by each TA.19 During field visits, partner NGOs reported recruiting university graduates with varying expertise—not requiring clinical qualifications.

**SR4 Increase adoption of healthy behaviors and practices**

While recognizing that the social and behavior change communication (SBCC) activities undertaken to increase adoption of health behaviors and practices contribute to many PMP indicators, this section discusses the SR4 indicators achieved with three effective implementation quarters remaining before the end of the project. The two indicators on radio spot broadcasts and breastfeeding education have exceeded targets (Table 5 (Annex VI) shows the indicators with their LOP Results as of Q3 FY 2017 and the percentage of the LOP target 261 percent and 102 percent, respectively). However, it is unlikely that the number of trained youth peer educators will surpass the current 51 percent level. The GOM with UNFPA support and Mikolo participation has been revising the youth training manual delaying training of new youth peer leaders and there is insufficient time left in the project for establishing and supporting new sustainable youth groups. It is also unlikely that the latrine use indicator and the related indicators (Household Champions and Commune Champions) will be met given their current status and the limitations of the champion approach (discussed below). In any case, this data needs revision. Even though the Household Champion target requires latrine use, fewer than 30,000 (29,550) people are reported as latrine users although almost 100,000 (96,408) households have been certified as Household Champions.

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19 Mikolo senior staff informed the evaluation team that Mikolo had tried to recruit additional staff for the CSB to address the issue but due to the change in personnel at the MOPH, the idea was rejected. This however does not explain why Mikolo did not provide NGOs to hire clinical assistants to assist in the supervision/assessment, even if this is a short-term solution.
Champions. However, in many project FKT, Mikolo partnered with the Global Sanitation Fund enabling the Project to surpass the Community-led Total Sanitation (CLTS) Open Air Defecation Free (ODF) target, achieving 150 percent of the target.

Table 5. SBCC Results to Date FY 2017 Q3

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Life of Project Target</th>
<th>Total LOP (thru Q3 FY’17)</th>
<th>% Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Number of Communes having the status of Commune Champion</td>
<td>506</td>
<td>307</td>
<td>61%</td>
</tr>
<tr>
<td>4.2</td>
<td>Number of certified Household Champions</td>
<td>254,545</td>
<td>96,408</td>
<td>38%</td>
</tr>
<tr>
<td>4.3</td>
<td>Number of interactive radio spots broadcast</td>
<td>8,622</td>
<td>22,471</td>
<td>261%</td>
</tr>
<tr>
<td>4.4</td>
<td>Number of fokontany achieving ODF status</td>
<td>1800</td>
<td>2,697 (FY2016)</td>
<td>150%</td>
</tr>
<tr>
<td>4.5</td>
<td>Number of people gaining access to an improved sanitation facility [latrine]</td>
<td>No baseline</td>
<td>29,550</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Number of people (peer youth, youth leader) trained in Adolescent Reproductive Health with increased knowledge and skills</td>
<td>Originally 8,096 Revised to 4,940</td>
<td>2,534</td>
<td>51%</td>
</tr>
<tr>
<td>4.7</td>
<td>Number of people reached with education on exclusive breastfeeding</td>
<td>145,496</td>
<td>148,922</td>
<td>102%</td>
</tr>
</tbody>
</table>

Successes and Challenges

GOM Involvement

The most successful behavior change activities (SR4) are derived from Mikolo’s prioritized integration of SBCC interventions into the GOM health system, along with the joint development of harmonized SBCC materials and their availability to all implementers. The Project involved the MOPH from the early stages of development through validation as well as engaging other stakeholders in the process.

“Other ministries, such as the Ministry of Population and the Ministry of Youth and Sports also came on board, through their technicians. The process of developing the strategy was facilitated by the setting of a coalition grouping the Ministry of Health, the USAID Mikolo Project, UNICEF, and PSI, offering a model of cooperation and harmonization.” *Information, Education and Communication (IEC)/BCC Consultant, Mikolo Annual Report FY 2015, p. 69.*

The Mikolo SBCC strategies,20 tools, products, manuals, and the stepdown training system were developed, pretested and validated under the leadership of Government and with inputs from international partners.21 SBCC activities were initiated with formative research that analyzed barriers to

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21 Mikolo Annual Report FY 2015
behavior change for the project’s many health issues. Implementers can access these SBCC products at the Directorate of Health Promotion of the Ministry of Public Health.

Consensus was generated around some innovative approaches for Madagascar. The strategies prioritize the family and the husband’s involvement in health care throughout the life cycle. This gender perspective recognized that it is unrealistic to expect women to resolve the maternal child health, family planning, and water and sanitation issues by themselves. Pictorial materials with Malagasy text were developed in response to the relatively low literacy levels in the rural areas where one-quarter of the women are illiterate. In addition, radio spots were developed for each health topic and aired repeatedly in local dialects on local and national radio to maximize coverage and reinforce the health messages being promoted by the Mikolo community actors.

New Youth FP Users
The most successful adolescent and youth intervention has been the increase in new and returning FP users associated with the establishment of trained YPEs, as described in the USAID Technical Brief on peer education and contraceptive use. Mikolo trained 2,639 YPEs on the following: a) youth and adolescent reproductive health and other issues, b) how to establish and lead a youth group, and c) their data reporting responsibilities. The YPEs created mixed youth groups with 15-25 members resulting in an estimated 39,600 to 66,000 youth group participants. An increase in FP users among the 15-24 age group was noted in the period following the YPE training in July and August 2015. Between the YPE training and Q1, FY 2017, 1,892 youths became new users. Moreover, within the first four months after the YPE training, returning users among youths increased to 7,205 whereas in the 10 preceding months, there were only 6,226 returning users. Youth leaders reported a wide range of FP promotion activities that were confirmed by members of their own groups. For instance, a few female youth group members reported being referred to their CHV including a few who were then referred to Marie Stopes where they obtained implants. Members of another group reported only learning the abstinence only message. Other contributing factors to the youth FP uptake are likely to be latent demand for reproductive health information and safer sex among adolescents and youth.

Technical Support Issues
Low levels of both international and local SBCC technical assistance

Insufficient international and local SBCC technical assistance may have hindered timely adjustments to field implementation realities. Even though OSC is the international partner responsible for SBCC, the only OSC travel reported after the new community health promoters had started working in the field were a “supervisory visit to onboard the new SP4 BCC Lead” in June 2015 and “the 3-week STTA by Dr. Lynn Lawry who “heads OSC’s M&E work” in November 2016. Moreover, initially OSC was to provide support to ASOS; however, that did not materialize (See Annex VIII for OSC’s Terms of

22 USAID-Mikolo, Recherche Formative – Détermination des Obstacles à l’Adoption des Comportements Sains ; Mikolo Annual Report FY 2015
23 Enquête sur les Indicateurs du Paludisme (EIPM) 2013.
At the beginning of the project, the plan was for OSC to support and reinforce ASOS in the area of community mobilization. However, as the project progressed, this form of support and reinforcement was not established.

The NGO TAs were expected to support an excessive number of volunteers (between 45-85 volunteers) depending upon the number of FKT27 and the number of health promoters actually trained. Supervising the new Mikolo health promotion volunteers was added on to the responsibilities of the TAs who already provided field support and evaluation to 30-45 volunteer CHVs. The Mikolo gender and youth strategies called for three volunteer health promoters per FKT: one Women’s Leader (WL), one Men’s Leader (ML) and one YPE. Yet the TAs were the essential support for these volunteer health promoters who only had two or three days prior training in 2015. The Mikolo Gender Specialist affirmed that there were quarterly Refresher Meetings that the CCDS had been asked to fund for sustainability; however, given the extremely heavy workloads of the CSB heads and the TAs, it is unlikely this practice was widespread.

**Limited number and roles for community health promotion volunteers and participants**

Many fokontany did not benefit from the full complement of three health promoters, because many CHVs took on the role of WL or ML, effectively reducing the number of health promotion volunteers. “Since it is difficult to find men and women who can read well enough, the FKT Chief or the CHVs are often designated the ML…. Many of the CHVs also serve as WLs,” according to a Regional Community Mobilization Officer.

“It was difficult to find the type of person who is dynamic and also possesses a spirit of voluntarism because WL/MLs must produce monthly reports of their activities. In order to overcome the lack of qualified persons, the CHVs wanting to become WL/ML were chosen on the basis of their status.” (TA)

Many FKT never had a YPE. During the site visit to V7V, the team went to the FKT where both Mikolo central and the NGO noted there were YPEs. Yet upon arrival, the evaluation team found none. It is possible there had been a YPE, but at the time of our visit this approach was not functioning well. In one FKT, beneficiaries told the FGD facilitator that they have never seen the YPE there before. According to the original PMP, 8,096 youths were to be trained as YPEs but this target was reduced in FY 2015 to 4,940 YPEs, a 39 percent reduction. A Mikolo staff cited budget constraints as the rationale for reducing the PMP target to one YPE per FKT even though this meant that the youth groups were mixed—females and males—aged 15 through 24. Furthermore, only 2,534 YPEs, half of the 2015 reduced target, have been trained to date, which explains why the evaluation team had some difficulty arranging FDGs and KIIs around youth activities. Although the Mikolo Annual Implementation Plan for FY 2017 includes orientations for new or replacement YPEs during the quarterly YPE meetings at the commune level, the evaluation team never heard about any of these planned activities, nor were they reported in the three FY 2017 quarterly reports.

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27 Calculated conservatively as a low of 45 community volunteers in 15 fokontany (30 CHVs + 15 health promoters (1 per fokontany) vs a high of 85 community volunteers in 22 fokontany (45 CHVs + 40 health promoters (2 per fokontany)

28 Email from Mikolo senior staff to the Evaluation Team Leader re: Mikolo indicators and targets, August 23, 2017.

Although the three health promoters each formed groups of 20 people who met monthly for 12 sessions, few people in the FKT, apart from the group members and people in their own households, benefited from their new awareness. The Mikolo reliance on the slow diffusion “tache de huile” approach for its community SBCC activities (see below) explains why many beneficiary FDGs participants reported that they were unaware or only vaguely aware of the volunteer activities.” When the evaluation team visited V7V, they had difficulty locating active leaders and active groups. A Mikolo staff noted the group participants were only tasked with changing behavior in their own households or in their own personal life until FY 2017. In fact, the women’s and men’s groups in Vatovavy-Fitovinany were still focusing on their own families in July 2017.

“Members learn and practice the twelve health lessons themselves.” (Regional Community Mobilization Officer)

“When the topic has been addressed within the group, we begin the second step, which is the home visits. We do not work outside our group. We visit the households of group members. The idea is to speak with the husband on the topics we have treated within the group.” (CHV)

**Inadequate adjustments to rural realities**

Mikolo SBCC implementation failed to make adequate adjustments to two major field implementation challenges arising from rural fokontany socio-cultural realities; 1) the low educational levels, and 2) the persistent social norm of open defecation.

Mikolo formative research omitted to address the reading skills limitations among rural residents. Only one-quarter of rural women have attended some secondary school and fewer than 2 percent have completed secondary school. Almost 75 percent of the FKT population has only attended primary school or has never been to school. The reading barrier is particularly high for health promotion materials because of the relatively difficult scientific and health vocabulary words. Even written in Malagasy, the very large number of multi-syllable health words (for example, complications, malnutrition, meningitis, etc.) undermine the efforts of low literate and non-literate persons to benefit from the written health promotion materials as use of the SMOG Readability Formula for health literacy materials demonstrates. Consequently, many if not most rural parents have difficulty reading the *Health Booklet for Children* and the *Health Booklet for Mothers*. Communication materials that rely on mixing written text with illustrations instead of clearly separating the text on the page unnecessarily oblige low literate audiences to block out the text in order to appreciate the images. Job aids and other health promotion materials need to be formatted and the text simplified to make them more user friendly for audiences with low reading skills (See Annex IX: Recommendations for a Low Literate, More User-Friendly Job Aid).

The YPE manuals assume a higher level of education than has been achieved by a large portion of the YPEs. One 24-year-old YPE showed the interviewer two manuals of over 50 pages each covering health education content difficult for readers during the first years of secondary school. The YPE said that he has never read either manual entirely, but he does occasionally read a page or two. In FY 2015, the difficulties identifying sufficient qualified FKT residents for training as health promoters was an unheeded

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30 EIPM 2013: 29.

warning that the health promotion training manuals and tools needed to be adapted to the low education levels of the target audience.

In the Mikolo communes and FKT lacking a CLTS intervention that addresses every household, CCDS action platforms promoted latrine use to increase the number of Household Champions. The volunteer CHVs and health promoters have been carrying out home visits and each certified Household Champion was asked to invite three other households to join the challenge. These Project volunteers do not use the CLTS approach—achieving social norm change by persisting in publicly shaming and naming households that place everyone at risk of eating excrement as long as some households continue relying on open defecation. The volunteers only target the households with children under-five and women of reproductive age and they do not target all these households during the same period. Instead the Project uses the “approche tache d’huile” [oil drop approach] where the health actions modeled by the community volunteers and the Household Champions are slowly imitated by other community members the way a spot of oil slowly spreads out. This explains why the beneficiary FGDs revealed that many people are unaware of the ongoing Household Champion challenge and fewer than 15 percent of the households are utilizing latrines in some of the FKT.

The expected Household Champion “tache de l’huile” effect appears to have been impeded by the latrine criteria hurdle. Lacking the strong social support for ending open defecation that is generated during CLTS interventions, the number of Household Champions remains very small even where people are complying with most of the maternal and child health criteria. People do not see building latrines as a priority and they have their habits (open defecation) as the FKT president in Ambanifieferana Fokontany explains, “They say that we don’t even succeed in building proper houses for ourselves to live in; then, why should we focus on building latrines?” Furthermore, sustaining latrine use has proved a challenge for Household Champions in both regions.

The underachievement of the Mikolo championship targets reinforces the benefits of the CLTS approach. Mikolo has only achieved 38 percent of the Household Champion target and 61 percent of the Commune Champion target, the latter being largely based on the percentage of household and FKT championships achieved. Moreover, the percentage of households using latrines in the Mikolo sites is actually closer to 15 percent of the total households (See Annex X: a table showing low levels of latrine use per FKT).

QUESTION 2 – DID MIKOLO IMPROVE THE USE OF DATA FOR DECISION-MAKING BY THE GOM AND WITHIN THE PROJECT?

Data Interpretation by the MOPH

Mikolo has improved its internal health information system and commenced working with the MOPH on strengthening the national health information system. Mikolo has been using the District Health Information System (DHIS)-2 platform since Q2 FY 2016 for their internal project information system; the transition commenced in 2015 with the transfer of legacy data from Datawinners to DHIS-2 along with the essential trainings related to data handling in the new system for all staff, including NGOs and Mikolo regional staff.

“The community data sent to the district is compiled in Excel and cannot be used or verified. The Ministry cannot do the data collection and entry; it takes advantage of the existence of project data.

32 Mikolo comments related to Slide 2 of the SBCC Preliminary Evaluation PowerPoint, shared with the project July 2017.
But the issue is that the systems are not the same for the Project and for the Ministry.” (Regional Health Office V7V)

The project community data is submitted in paper form at the commune level health centers for verification by the CSB heads. The district health office does not have sufficient resources (e.g., staff, hardware) to input the community data into its GESIS (Gestion de l'Information Sanitaire) system, resulting in extended backlogs of data entry. Consequently, community health data are not accounted for and used at the district level nor do the data flow to the regional or central level health offices.

“The monthly community reports are there at the district level, nothing is done, it's not working because of personnel constraints. Manakara has 56 CSB with 322 community sites, so the district person responsible for health information has to do 56 CSB reports, of 11 pages and 322 community reports of 4 pages. We don't have the personnel to do this work.” (District Health Office)

“For us, we cannot use and we do not use the compiled data coming from the CSB.” (District Health Office)

In V7V, a CSB head drew a line in the facility report to allow space for CHV FP data. Despite her innovative effort to include community data in facility report, the district health office is unlikely to incorporate and use that information.

Mikolo has been sharing project achievements at the district level through the quarterly coordination meetings with partners and EMAR/EMAD. Mikolo, often with the CPR, presents project updates and results for the purposes of coordination with other projects in the districts.

In August 2017, Mikolo started training workshops for trainers—district health officials—on data utilization and quality. With community data shared by Mikolo and utilization capacity building, the MOPH is poised to start using community data for decision-making.

**Data interpretation by Mikolo**

The most frequently discussed example of data utilization was the use of malaria data. Mikolo carefully tracks malaria data and shares with its partners, PSI and the Programme National de Lutte contre le Paludisme (PNLP), the malaria branch of the MOPH. At the regional level uses Mikolo’s data has been used for planning purposes, and to help avoid stockouts. Also, the PNLP uses it for surveillance.

“There are also exchanges of information at the regional level when special circumstances arise and special measures need to be taken. For example, Mikolo, through its community-level data, informs us on the prevalence of a disease, like malaria.” PSI staff

In Q3 of FY 2017, Mikolo notified the PNLP of confirmed malaria cases in six districts. This alert helped authorities and partners investigate the situation and mobilize resources, including ensuring sufficient ACT/RDT stocks. Mikolo reports that “Beginning in 2014, the Project introduced and customized DHIS-2 database software for routine community data collection, which has contributed to epidemiological surveillance data (including location, demographics, RDT results, and RDT/ACT availability) collected by CHVs. These data are reviewed by project staff monthly; when a surge in malaria cases, or shortages of RDT and/or ACT are observed, the MOPH Direction de la lutte contre le paludisme [Directorate of the Fight Against Malaria] (DLP) is notified. As a result, priority areas can be identified, targeted behavior

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32 Phone interviews with Central Project M&E staff, August 2017.
change communication campaigns can be implemented there, and the data can be used to more accurately forecast supply needs and ensure reliable access to stock” (Mikolo Q3 FY 2017 Report).

A second often-cited example of data utilization by Mikolo and implementing NGOs ASOS, SAF, and AIM concerns data quality check. For example, both NGOs and Mikolo regional staff explained that they examine new FP user data to see if there are extraordinary increases or decreases, especially from the previous months. Sometimes the error is in typing or transcribing from one form to another, other times they have had to dig deeper by asking questions and contacting the TA who would then do his own investigation. If there is a decrease, then the NGO M&E or STA would remind the TA to work with the CHVs on increasing the result in the future.

**Reinforcing national and internal health information systems**

Mikolo invests heavily in its health information system with the goal of producing quality data for decision-making and improving project implementation and effectiveness. At the central office, there are five M&E staff to develop systems, tools, manage, and provide technical support to regional offices, including implementing NGOs. At the lower level, both Mikolo and the implementing NGOs have M&E staff designated to oversee data collection, reporting, and data verification/quality of community-based agents, primarily CHVs (Mikolo staff, NGO staff).

In fact, it can be said that the project spends considerable effort at all levels to ensure high quality data. The data quality culture was apparent to the evaluation team as all project staff, including NGOs and CHVs, talked about data collection/reporting and the roles of each involved in the process. Mikolo senior management and technical staff discussed the importance of tracking data and reporting.

Mikolo’s data quality system comprises the three following assessments.

1. Quality data at the NGO level—Conducted by the STA to detect transcription errors made by TAs from data entry to the DHIS-2 database.

2. Quality data at the CHV level—Conducted by the TA to detect transcription errors made by CHVs from registers to the RMA.

3. Triangulation of #1 and #2—To determine the accuracy of key indicators that are defined by the project. If an error is discovered, a plan is made so that actors are involved at addressing the error at every level, CHV, NGO, and Mikolo central; the regional office sends these adjustment plans to the central office where tracking takes place.

Regarding data quality checks at the CHV level of RMA data, the RMA data do not appear to have been scrutinized uniformly across all service area and across all regions. FP new user data does appear to be more uniform, with a steady increase in users (Figure 1 and Annex X); whereas exclusive breastfeeding and malaria treatment data fluctuate quarter to quarter. Pneumonia treatment data appears to have a steady increase, but then drops drastically in FY16 Q4. These data may be accurate, but they identify areas where data quality assessments may be needed.

There are also efforts to reinforce NGO data quality capacity, and to a lesser extent, the CHVs, on a regular basis through integrated supervision or CPR from the central office.

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34 The RMA data were not verified by the Evaluation Team, so this is an observation based on a review of the limited RMA data reviewed.
“The members of the central M&E team are the focal points for the regional office, so when the M&E central staff go to the field they build capacity and at the same time assess the data quality at the levels of the TA and CHV. The field visit of the M&E team occurs every six months. There is capacity building for TA on data quality, the use of the DHIS2 system, and analysis. Data quality is part of the project’s capacity strengthening efforts for the staff.” (Mikolo Central M&E staff)

During the midterm evaluation, Mikolo also had an opportunity to work with the EMAR/EMAD to review project results, which essentially demonstrated how to read and use data. This exercise also showed the EMAR/EMAD the interconnectedness of data use and quality.

As a health information system is not separate from a larger health system, Mikolo works to support and strengthen the national health information system. For example, in August 2017, the entire central M&E team was in the field for training workshops on data utilization and quality, targeting district health officials who will in turn train the CSB heads. It should be stated here in that in KIs with Mikolo central and regional offices and with central and regional/district MOPH, no one mentioned this training scheduled in August when asked about how Mikolo supports the GOM or MOPH.

**Effectiveness of data interpretation for application**

The example of utilization of malaria data demonstrates the potential and importance for data applications for the project and its partners. Mikolo has utilized data to understand its achievements and progress in terms of targets, internally and with partners including EMAR/EMAD on a quarterly basis. Mikolo and NGOs also rely on dashboards to track (NGO) project implementation; the project also learns and collects ample data through supervisory/field missions, and OR.

“I keep a quarterly tracking chart for each activity and I color it yellow or red depending on the progress of each activity on a quarterly basis. Depending on the color of the activity, I speak with the person involved on the reasons or the next steps.” (Mikolo Central M&E staff)

“During the staff meeting, the M&E manager presents a discrepancy in the data; the M&E team will then carry out the analysis” (Mikolo Central M&E staff)

There is a clear example of Mikolo making changes based on results of report findings. After the DQA reports indicated areas for improvement, the Project re-organized efforts to focus on ensuring better data quality through increasing the number of M&E staff both at the NGO and Mikolo regional offices in FY 2017 (M&E central and regional staff), but had not yet addressed the recommendation from the USAID DQA (2016) to increase the number of supervisions by the NGO TAs of the CHVs. The CPR was also created to provide management, technical, and M&E-related support to NGOs in the same year.

There is room for improvement, as in some cases Mikolo has not fully used M&E data to prioritize and resolve issues. For example, SBCC data show under-performance based on achievement of targets (Table 5, Annex VI), yet by Year Four, it is clear that Champion Households approach is not working well, with only 38 percent of the target met. Also, the stagnant progress of training youth peer leaders as agents of change in their communities is also noticeable at 51 percent. With the various mechanisms in place (e.g. CPR and TA site visits), Mikolo understood the barriers to uptake of Champion Households as well as the challenges of recruiting and retaining youth leaders. Nevertheless, in

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35 USAID 2013 & USAID 2015

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interviews with beneficiaries and implementers (ASOS, OSC, Mikolo), no one talked about changing project activities to improve the low achievements of Champion Households and the youth intervention.

**QUESTION 3 – STRENGTH AND WEAKNESSES OF MIKOLO’S MANAGEMENT STRUCTURES**

The Mikolo project set up its management structure mirroring the MOPH structure at the regional level with the partner NGO present at district/commune level. This structure permitted Mikolo to participate regularly in MOPH activities and to coordinate with other USAID partners and community health actors at all levels. The frequency of project participation and support to the GOM has been evidenced throughout the LOP in the drafting of training curricula; the development of the SBCC strategy, including the gender and youth components; and the revision of the PNSC, as well as in the financial and logistic support (e.g., per diems, printing, workshop venues, travel to international conferences, etc.) provided by Mikolo to support the MOPH at all levels of the healthcare system.

The project staffing structure did not embed any project staff within the EMAR or within the EMAD. Decisions within the project related to activities, changes in scheduling, etc. were made and announced by the Mikolo Antananarivo office. All data were reported up to the central office for review and verification—and shared with the regional offices and the partner NGOs. The CPR visit schedule was decided at central level and findings and subsequent modifications to implementation announced by the central level. This “top down” management, with all decision-making coming from the central level, may have limited the ability of Mikolo to respond more effectively to changes in activity implementation, particularly at lower levels, and instead delayed the response while observations and reports were submitted to central level for decision and action.

The Mikolo management structure facilitated the availability and responsiveness of the project to meet GOM needs, especially related to requests for meetings, logistics support, and representation activities. Although effective in working with the GOM, the Mikolo management structure can be seen as “top heavy.” There are pros and cons of this management structure. Senior staff are needed to insure leadership, vision, consistent programming, and strong relations with GOM; yet lower level staff are needed to get broad coverage to the partner NGOs to support the district and community levels, and strengthen the supervision and support of the CHVs. Given limited resources USAID and Mikolo may want to review the current management structure, as they prioritize future needs and interventions.

Following the re-engagement with the GOM in 2014, many decisions were suddenly and simultaneously needed in order to effectively implement the changes for re-engagement with the GOM following the election results in 2014. The ‘top down’ management structure (centralized decision-making), as well as delays due to multiple contract modifications may have contributed to slowing project momentum.

In Year Four, Mikolo piloted a series of activities (mHealth, paires AC supervisors, etc.) and introduced additional data use and quality improvement activities. Mikolo added regionally based M&E officers and data use training for EMAR, clinical supervision of CHVs by CSB staff, etc., with less than 18 months remaining in the current contract to scale up these activities and with 79 percent of the project budget already expended at end Q3 FY2017 to support any scale up. 37

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37 The USAID Mikolo Project, Overview for the Evaluation Team, Date: June 14, 2017
38 Email correspondence from senior Mikolo staff to the GH Pro Evaluation Team Leader on August 9, 2017.
V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Mikolo has been successful in reaching key health targeted outcomes during the span of four years. The project should be recognized for its efforts to revitalize the CCDS health structures to support community health service delivery in remote communities (> 5 km from a public health center). They have attentively and persistently adapted intervention activities to be aligned with changes in the political arena with the re-engagement of the public sector.

Working hand-in-hand with the MOPH, the project has been able to capacitate more than half of the project CHVs to provide quality continuum of care ranging from under-5 care to malaria. In addition to obvious improved outcomes, the project has started to support the development of systems and capacities moving toward sustainability. These efforts to sustain community health service delivery should continue. There are a few potentially promising strategies, such as mHealth and SILC/CRLF groups, underway though prioritization is needed to focus on those that will render the outcomes while also considering the investments needed to carry out these activities effectively.

Investments in CHVs should continue to ensure that they are not only trained, but supervised, supported, and compensated. Consistent follow-up in the field, recognition/support from their own community as well as monetary incentives for the duration of their work will be key to their retention and overall strong community health service delivery system.

Future community health service projects need to funnel funds to the lower levels where 90 percent of the work is occurring. The project could focus energies to respond in a more timely way to issues impeding progress concerning creating demand for services: Champion Community Households and youth strategies. Better coordination with consortium partners, other partners, and stakeholders on the ground would ultimately benefit CHVs in their work delivering needed health care to communities as well as ensure commodities are available at the public and private supply points. Transition or handover of responsibilities to the MOPH should be done in a phased-out manner with adequate support along the way. Country ownership and effective sustainability of community health service is a process; this project is the first of many phases.

RECOMMENDATIONS

The recommendations below are organized first by those actions/processes that can commence in Year 5 of project implementation, and continued in the follow-on or for other community health projects in Madagascar. The later recommendations are specific to Mikolo for immediate actions with the time remaining in the project life. However, it is recognized that the project directions/actions in the last year of implementation can also inform ways to proceed in the future.

For Future Community Health Interventions

CCDS

The PNSC vision for the CCDS is that “the responsible community takes ownership of the socio-sanitary development efforts of its locality and participates in the actions leading to the well-being of the population in accordance with the objectives of the PNSC.” The rationale for providing incentives for CCDS participation as well as their consequences need to be examined against the backdrop of the national vision for the CCDS.
To encourage country ownership of community initiatives in planning and implementation of supportive actions towards community health development in general, and community health service delivery specifically, the transition period is an opportune time to phase out incentives for CCDS members; Mikolo plans to begin this transfer in the final year of implementation. 39

**Saving and Loans Fund**
Since a platform for SILC-related activities already exists in Madagascar, but needs strengthening, Mikolo should support working for both the standardization and integration of all SILC schemes in collaboration with partners. This can attract investments from the public and private sectors, including banks that are willing to invest in the country’s economy, thus reducing the burden on the local members to come up with the required initial funding for SILC-related activities.

**CHV Support**
As CHVs play an important role in the provision of needed primary healthcare to mothers and children in many communities, their viability and effectiveness rely on establishing functional community health systems at multiple levels. They need to be adequately supervised, motivated, and compensated. This is especially important for multi-skilled (polyvalent) CHVs since their workload is heavier with greater responsibilities. For example, strategies such as providing CHVs with bicycles or compensating them for transportation costs (even if there are no alternatives or they decide to walk) will likely motivate them to continue work especially when there are other life/work constraints and obligations or they receive inconsistent supervision from the NGOs.

At the central level, a workshop convening all agencies/NGOs supporting CHV activities in-country to discuss ongoing issues should be organized. To the extent possible, partners working/supporting CHVs should be involved in these discussions to explore non-financial incentives to motivate CHVs, to continue to affirm CHVs’ role by educating the public health sector and communities, to provide adequate supervision, and to streamline data collection and reporting tools. Consensus-building amongst all partners on strategies related to these issues will help in strengthening community service delivery.

At the lower levels, COSAN Commune, including FKT Presidents, can create demand for community services. These individuals can continually affirm and legitimize CHVs’ role in their respective communities. These actions can be the key to CHV retention. When CHVs feel supported, they are more motivated to carry out their work, especially since CHVs also have opportunity costs for engaging in volunteer work.

The Project has to prioritize the role of the CHV, and identify approached and activities that aim at motivating and retaining CHVs, as well as providing them sustainable supervision and skill acquisition. This must be done in concert with the NGOs and communes with whom they work. Different approaches tested by asking the stakeholders, including the CHVs, to propose low cost interventions that are then piloted for a limited period of time, such as six months. This grass roots approach may generate solutions that Mikolo and its partners have not yet considered.

**Referrals/Counter-Referrals**
The current referral/counter-referral system needs to be strengthened. First, refresher trainings should be carried out for CHVs, NGOs, and CSB heads to refresh them on the purposes of the forms and their

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39 Details found in Mikolo’s “Transférer la capacité et la compétence au Ministère de la Santé publique pour la gestion de la santé communautaire.”
utilization and routing. NGO TAs can reinforce the message of using the referral/counter-referral forms in consultation with clients during supportive supervision. Second, the forms should be redesigned to facilitate their utilization, for example, duplicates in carbon copy. Third, a low-cost system should be developed where these forms are stored so that they do not get lost.

**Project Coverage**
The intervention should cover the entire commune and district, not just parts of them. This was a suggestion/critique that was made by various stakeholders from consortium partners, other partners, and the GOM at central and district levels.

“If you really want to have this continuum of care, all the communes in the district where Mikolo works must be covered. Without this total coverage, there will be no impact.” (Senior Partner Staff).

“This is flawed because there are obvious differences between the neighboring communes where there are project interventions as compared with those that don’t receive assistance. The communes without interventions are those that are still ‘asleep’ in terms of health.” (DSFA)

**SBCC**

**International SBCC Technical Assistance**
Invest in a robust participatory, community engagement program that aims to establish sustainable norms for increased service use and healthy practices that maximize the benefits of the community health system. Recognize that existing rural SBCC programs worldwide will require significant modifications for rural Madagascar populations. Invest in an international technical assistance organization with experience in low literate, low resource community health promotion and youth and adolescent reproductive health.

**Create Demand for Services**
Creating greater demand for services entails recruiting and training more community health promoters and more health promotion group participants. Select the health promotion volunteers as much as possible from existing formal and informal associations/institutions, such as churches and soccer clubs. Creating a wider base of promoters means reaching more and different social networks, hence spreading health practices to exponentially more potential beneficiaries. Lastly, share and promote youth-friendly service practices among all stakeholders and partners, including EMAD, CCDS, NGOs (TAs and STAs), CSB staff, and CHVs.

**Resources for SBCC**
To ensure a quality SBCC intervention, have dedicated health promotion technical assistants to provide on-site technical assistance for field activities (with only 15 percent of time devoted to recording and reporting). Alternatively, reduce the number of FKT supported by TAs and increase their capacity and responsibility for supporting the health promotion volunteers. Plan for staged health promotion training for the multiple health interventions during quarterly or semi-annual two-day workshops. These SBCC investments will maximize the effect of Mikolo and community resources by increasing Mikolo performance and reducing wastage due to under-achieved targets.

**SBCC Materials, Products, Approaches, and Training Tools**

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40 A sampling of existing successful rural SBCC programs available on [www.thehealthcompass.org](http://www.thehealthcompass.org).
Develop more participatory communication activities (songs, skits, narrated mimes, communication body tools) that focus on learning, recalling, discussing and sharing decision-making information. Develop simpler training manuals and tools that model feasible health promotion actions and emphasize practice discussing and sharing decision-making information rather than promoting messages. Institute Motorcycle Cinema\(^1\) as a cost-effective method to reach large audiences in addition to radio. While cognizant of the benefits of the long government validation process, be prepared to modify SBCC interventions and materials as soon as major impediments to success are apparent. This will entail including piloting modifications and developing job aids as preliminary guides along with a very strong, refresher training program.

**Champion Approach**

Adopt Global Sanitation Fund (GSF) Community-Led Total Sanitation approach for increasing latrine use. Limit the Household Champion criteria to behavior changes that are effective at the household level without relying on substantial social pressure, thereby excluding latrine use. Focus the FKT Champion on achievement of Open Defecation Free status. Create two levels of Commune Champions: a) Commune Champions based on a percentage of Household Champions and b) Prime Commune Champions based on both a percentage of Household Champions and a percentage of FKT Champions.

**Monitoring and Evaluation**

**Community Data Tools**

One of the biggest challenges for CHVs is the completion of data collection and reporting tools. Even without the issue of low education attainment by many CHVs, the national data collection and reporting tools should be as simple as possible. This means reducing the number of data collection tools “polyvalent” CHVs have to complete and carry to and from household visits.\(^2\) As part of strengthening the GOM’s Health Information System, the next intervention should support the MOPH to simplify tools for community health service to include the continuum of care into fewer than the current 10 tools.

Additionally, to support and strengthen the government’s M&E systems and processes, the project should conduct a DQA of the RMA data and data system. In doing this assessment data tools can be reviewed, and data quality checked. Also, improved methods of data collection can be explored, such as use of mobile technology (e.g., smartphones).

**For Year 5**

**Strengthening Country Ownership of CCDS**

In recognition of the importance of increased ownership and sustainability of community health service activities towards the end of the project life, Mikolo plans to transfer the management community health service delivery to the MOPH. If the vision is for the CCDS to take responsibility for its own community, then Mikolo has to take a step back by decreasing its presence at meetings either via the NGO\(^3\) and/or the CPR. The project should consider reducing its support while still monitoring CCDS from afar.


\(^2\) See for example, USAID’s DQA reports 2014 and 2016.

\(^3\) The NGOs are required to attend as one of their benchmarks, and are evaluated for financial disbursement.
Following are a few suggestions:

- Prioritize the 13 activities detailed in the CCDS, as it may be challenging to accomplish all these activities (tasks) with the MOHP
- Ensure that respective MOPH personnel have the appropriate skills/capacities to carry out activities
- Provide sufficient follow-up and coaching in the interim to allow for learning and timely corrections

**CHVs**

To increase community service delivery in the project intervention zone, prioritize completion of the integrated services delivery package training for all CHVs who have not yet received this training.

**CHV Supervision**

NGOs should monitor the cash deficits (debts) when carrying out the CHV supportive supervision visits and consider negotiating with the CSB heads regarding the use of funds from the “Caisse Sociale” when appropriate to replenish stock—especially moving forward with the recent GOM decision on universal health care.

**Coordination**

Convene a Consortium Coordination Meeting to review the Year 5 implementation Work Plan and the draft Closeout Plan process.

**Prioritization of Strategies**

Review and prioritize the various ongoing pilot activities (mHealth, paire AC, etc.) and draft the case studies. Determine which, if any, pilot activity is to be brought to scale in Year 5 given the limited time and budget remaining on this contract.
ANNEX I. SCOPE OF WORK

Assignment #: 383 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 03-01-17 (second draft from USAID/Madagascar 4/11/17)
Last update: 5-17-17

INSTRUCTIONS: Complete this template in MS Word to develop a SOW an evaluation, assessment, or other analytic activity. Please be as thorough as possible in completing this SOW. Your GH Pro technical advisor and project management team will assist you in finalizing your SOW. Some of the sections below have been pre-populated with information that is common to most analytic activities. Please review these details and edit as needed to fit the needs of your specific analytic activity. Refer to the USAID How-To Note: Evaluation SOW and the Evaluation SOW: Good Practice Examples when developing your SOW.

I. TITLE: Final Performance Evaluation of USAID Mikolo Project

II. Requester / Client
☐ USAID/Washington
Office/Division: __________________ / __________

☐ USAID Country or Regional Mission
Mission/Division: Madagascar

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV ☐ 3.1.4 PIOET ☐ 3.1.7 FP/RH
☐ 3.1.2 TB ☐ 3.1.5 Other public health threats ☐ 3.1.8 WSSH
☐ 3.1.3 Malaria ☐ 3.1.6 MCH ☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: _____ (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period
Expected Start Date (on or about): June 1, 2017
Anticipated End Date (on or about): October 31, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)
Madagascar
VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

**EVALUATION:**

- □ Performance Evaluation (Check timing of data collection)
  - □ Midterm  □ Endline  □ Other (specify): ______

  *Performance evaluations* encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making.

- □ Impact Evaluation (Check timing(s) of data collection)
  - □ Baseline  □ Midterm  □ Endline  □ Other (specify): ______

  *Impact evaluations* measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

**OTHER ANALYTIC ACTIVITIES**

- □ Assessment
  - Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

- □ Costing and/or Economic Analysis
  - Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

- □ Other Analytic Activity (Specify)

**PEPFAR EVALUATIONS** *(PEPFAR Evaluation Standards of Practice 2014)*

*Note:* If PEPFA-funded, check the box for type of evaluation

- □ Process Evaluation (Check timing of data collection)
  - □ Midterm  □ Endline  □ Other (specify): __________

  *Process Evaluation* focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? *(PEPFAR Evaluation Standards of Practice 2014)*

- □ Outcome Evaluation

  *Outcome Evaluation* determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the
evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

- **Impact Evaluation** (Check timing(s) of data collection)
  - Baseline
  - Midterm
  - Endline
  - Other (specify): __________

  Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

- **Economic Evaluation** (PEPFAR)

  Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

**VIII. BACKGROUND**

If an evaluation, Project/Program being evaluated:

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>USAID Mikolo Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Number:</td>
<td>AID-687-C-13-00001</td>
</tr>
<tr>
<td>Award Dates:</td>
<td>August 2013 – July 2018</td>
</tr>
<tr>
<td>Project Funding:</td>
<td>$ 24,767,490</td>
</tr>
<tr>
<td>Implementing Organization(s):</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>Project AOR:</td>
<td>Andry Rahajarison</td>
</tr>
</tbody>
</table>

Background of project/program/intervention (Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis)

**Health context in Madagascar**

Reducing maternal, infant and child mortality in Madagascar is a critical priority for the international community and the Government of Madagascar (GoM). Although the country has made significant progress to reduce child deaths, maternal mortality has stagnated over the past twenty plus years; at present, 10 women die each day as a result of birth-related complications. In addition, each day, 100 children die from preventable causes, including malaria, which is the third leading cause of death for children.

The 2009 coup d'état plunged the country further into crisis, stalling development and further deteriorating the health system. With financial and political restrictions placed on the GoM during this period, USAID/Madagascar shifted to a humanitarian support strategy and invested nearly $250 million in innovative community health services and systems: scaling-up access to diagnosis and treatment for simple pneumonia, diarrhea, and malaria as well as condoms, and oral and injectable contraceptives. USAID/Madagascar equipped and trained an extended cadre of more than 15,000 community health volunteers (CHV) in 20 of 22 regions covering about 1,200 mostly rural communes...
to expand basic, life-saving services. Today, this system, which USAID now directly supports in 15 regions, provides health services to 9.5 million people or about 64 percent of Madagascar’s rural population.

Following successful elections in December 2013, multi and bi-lateral organizations normalized relations; the USG lifted restrictions in May 2014. The GoM initiated the development of a health sector development strategy, the Plan de Développement du Secteur Santé (PDSS), in January 2014. The plan outlines a five-year strategy to improve health services and outcomes and was launched in mid-2015. Madagascar also launched an action plan in response to the African Union’s Campaign for the Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA). The ambitious plan aims to reduce, by 2019, the maternal mortality ratio from 478 to 300 deaths per 100,000 live births and the neonatal mortality rate from 26 to 17 deaths per 1,000 live births. Furthermore, in June 2014, the GoM committed to redouble its efforts at the Acting on the Call: Ending Preventable Child and Maternal Deaths meeting, which mobilized governments and their partners from 24 priority countries to address maternal and child mortality.

Overview of the USAID Mikolo Project
In July 2013, during the period of bilateral restrictions, Management Sciences for Health (MSH) was awarded the Contract Number AID-687-C-13-00001 for the USAID Mikolo Project. The award is for a total of $24,767,490, running from August 1, 2013 – July 31, 2018. The goal of the project is to increase community-based primary health care service uptake, and the adoption of healthy behaviors among women of reproductive age, children under age five, and infants.

Working in eight of Madagascar’s 22 regions, in 43 Districts, 506 communes and 3,557 fokontany (communities) over the past three years, the Project has re-established a strong community based service delivery mechanism through the strengthening of the quality of service delivery by more than 6,500 community health volunteers (CHV). By focusing on communities which are greater than five kilometers from a nearest health facility, the Mikolo Project is ensuring that the most underserved of Madagascar’s population are receiving quality integrated health services for women and children under five years old. CHVs are the community linchpin in ensuring a strong continuum of care by:

- offering family planning services to women of reproductive age, including youth;
- identifying pregnant women and promoting four antenatal care visits;
- providing chlorhexidine for the prevention of umbilical cord infection, and soon, misoprostol for the prevention of postpartum hemorrhage;
- promoting safe motherhood by delivering at a health facility;
- identifying newborns to promote good nutrition, vaccination, and newborn care;
- providing critical case management for the three main killers of children under five years old (malaria, pneumonia, and diarrhea);
- promoting healthy families and household champions who exhibit model behavior;
- promoting the three key WASH behaviors: hand washing with soap, using a latrine, and drinking clean water;
- conducting community surveillance to identify those who have dropped out of the system, especially for vaccination.

Mikolo also works in coordination with USAID’s integrated community health programs, MAHEFA, and later Community Capacity for Health (CCH), offering similar community-based health services in six other regions, and the Integrated Social Marketing project to expand community distribution of products and services through Mikolo trained CHVs. Four primary intermediate results (IRs) are expected as outcomes of the Mikolo Project:

1. Sustainably develop systems, capacity and ownership of local partners;
2. Increase the availability and access to primary healthcare services in the project’s target communes;
3. Improve the quality of primary healthcare services at the community level; and
4. Increase the adoption of healthy behaviors and practices.

Theory of Change of target project/program/intervention

Strategic or Results Framework for the project/program/intervention (paste framework below)

The USAID/Madagascar Health, Population and Nutrition Office Results Framework presents the development hypothesis. The Mikolo Project contributes under IRs 1 and 2, and to lesser extent, 3 and 4.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Selected rural communes in eight of 22 regions of Madagascar: Atsimo Andrefana, Haut Matsiatra, Vatovavy Fitovinany, Amoron’I Mania, Atsinanana, Analamanga, Alaotra Mangoro, and Vakinankaratra.

IX. SCOPE OF WORK
A. Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)?
Provide the specific reason for this activity, linking it to future decisions to be made by USAID
This evaluation is meant to serve a dual purpose: (1) to learn to what extent the project’s objectives and goals—at all result levels—have been achieved; and (2) to inform the design of a future community-based health follow-on activity.

This evaluation will assist the Mission in reaching decisions related to: (1) the effectiveness of the current approach to build capacity and ownership of local partners, increase availability of, and access to basic health care services, improve the quality of services and adoption of health behaviors; (2) the type of mechanism(s) the Mission should use in future community and facility-based health activities; and (3) the nature and scope of possible future interventions in the sector, based on lessons learned from the current project.

B. **Audience**

Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience of the evaluation report will be:

1. USAID/Madagascar Mission, primarily the HPN team, and the Global Health Bureau.
2. An Executive Summary in French will be provided to the Ministry of Health (MOH). This will inform them about USAID’s support to the community health system to deliver basic services and health commodities and how effective various methods have been.
3. MSH and its partners will learn about their strengths and weaknesses to adjust their close-out and sustainability strategy accordingly.

C. **Applications and use**

How will the findings be used? What future decisions will be made based on these findings?

USAID/Madagascar and the Mikolo project will use the findings to adjust planned activities for year five of the project, including close-out plans and sustainability strategy. Further, USAID/Madagascar will use the evaluation results to inform the design of a follow-on activity. The Mission will also use it in the annual Performance Plan and Report.

D. **Evaluation/Analytic Questions & Matrix**

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID Evaluation Policy recommends one to five evaluation questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.
<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Suggested methods for answering this question</th>
<th>Sampling Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Questions</strong></td>
<td><em>What data sources and data collection and analysis methods will be used to produce the evidence for answering this question?</em></td>
<td></td>
</tr>
<tr>
<td><strong>Sampling Frame</strong></td>
<td>Who is the best source for this information? What is the sampling criteria?</td>
<td></td>
</tr>
</tbody>
</table>
| 1. Is the Mikolo Project likely to achieve its objectives as outlined in the contract sub-results and the Performance Management Plan (PMP)? Provide information on: the most and least successful activities implemented by the Project for each sub-result the contributing factors for successes and shortcomings | ● Desk review of project reports: work plans, annual reports, studies and other reports.  
● Analysis of project data: PMP, CHV reports, etc.  
● Key Informant Interviews (KIIs) with MOH workers at district, regional, and central level  
● KIIs with local non-governmental organizations (NGOs)  
● Focus Group Discussions (FGDs) with CHVs  
● KIIs with Mikolo project staff  
● FGDs with project beneficiaries  
● KIIs with USAID staff | For individual KIIs, recommendations will be made by USAID and MIKOLO staff. For FDGs and group interviews, convenience sampling from the regions/organizations visited is acceptable. |
| 2. Did Mikolo improve the use of data for decision making by the GOM and within the project? How? | ● Desk review of project reports: work plans, annual reports, studies and other reports.  
● Analysis of project data: PMP, CHV reports, etc.  
● KIIs with MOH workers at district, regional, and central level  
● KIIs with local NGOs  
● KIIs with Mikolo project staff | For individual KIIs, recommendations will be made by USAID and MIKOLO staff. For FDGs and group interviews, convenience sampling from the regions/organizations visited is acceptable. |
| 3. Did Mikolo’s management structure allow for effective oversight of project operations? Why or why not? | ● Desk review of project reports: work plans, annual reports, studies and other reports.  
● KIIs with local NGOs  
● FGDs with CHVs  
● KIIs with Mikolo project staff  
● KIIs with USAID staff | For individual KIIs, recommendations will be made by USAID and MIKOLO staff. For FDGs and group interviews, convenience sampling from the regions/organizations visited is acceptable. |
Other Questions [OPTIONAL]
(Note: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

Areas of special consideration under each evaluation question (to be explored as relevant to answering the main evaluation questions):

Q1. Is the Mikolo Project likely to achieve its objectives as outlined in the contract sub-results and PMP? What were the most and least successful activities implemented by the Project for each sub-result? What were the contributing factors for successes and shortcomings?

Areas for consideration:
Objective: Increase community based primary health care service uptake and the adoption of healthy behaviors
- SR1: Sustainably develop systems, capacity, and ownership of local partners
  - Effectiveness of Mikolo to improve the sustainability of the community health system (Comité de Santé “COSAN”, Comité Communal pour le Développement de la Santé “CCDS”, etc.)
  - Ways the program design be adapted to improve sustainability
  - Perceptions of local health stakeholders of Mikolo’s interventions as aligned with their own priorities
  - Mikolo’s efforts to increase the GOM’s ownership of the community health system
  - Ways that Mikolo improved the public health facilities (known as CSBs), commune, and districts’ capacity to deliver quality health services to communities
- SR2: Increase availability of, and access to primary health care services in project target communes
  - Mikolo achievements regarding polyvalent CHVs, and factors that contributed or detracted from these achievements
  - The effectiveness of Mikolo’s process for rolling out new products and services at the community level (i.e.: pregnancy test kit) or communicating changes to CHV operational protocols (i.e.: malaria commodity shift to public sector), and ways it be improved?
- SR3: Improve the quality of community-level primary health care services
  - CHV service quality improvement under the Mikolo project
  - Continued opportunities for improvement
  - Mikolo’s effectiveness regarding strengthening supportive supervision of CHVs
- SR4: Increase adoption of healthy behaviors and practices
  - The effectiveness of mechanisms and interventions employed for increasing demand for health services and products through social behavior change communication (SBCC) activities
  - Effectiveness of Mikolo’s youth-targeted SBCC interventions as conduits to health-seeking and other behavior change

Q2. Did Mikolo improve the use of data for decision making by the GOM and within the project? How?

Areas of consideration:
- Effectiveness of data interpretion for application by the project and GOM
- The extent to which interventions were adapted based on monitoring and evaluation data and revisited to address weaknesses throughout implementation
- Effectiveness of Mikolo at reinforcing national and internal health information systems

Q3. What were the strengths and weaknesses of Mikolo’s management structure?

Areas of consideration:
- Scalability of the management model to a larger project, potentially covering 15 regions
- Best practices and lessons learned regarding the respective roles of the office in Antananarivo, the regional offices, and the local NGO partners
- Effectiveness of the management structure related to oversight of project operations

E. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:

**Document and Data Review** *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Mikolo Contract including Amendments
- Mikolo Annual Workplans
- Mikolo Annual and Quarterly Reports
- Mikolo PMP and indicator results
- Madagascar (South) 2012 MICS ([http://mics.unicef.org/surveys](http://mics.unicef.org/surveys))
- Mikolo Baseline Microfinance Assessment
- Madagascar National Survey (MDG) surveys
- CHV's monthly report data (RMA)
- Outcome monitoring survey (OMS) for Mikolo for FY 2014 and 2015

**Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHV RMA and BCC RMA</td>
<td>Monthly activity reports from CHVs</td>
<td>As needed to answer evaluation questions</td>
</tr>
</tbody>
</table>

**Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

Mikolo stakeholders, counterparts and partners will be interviewed to learn from their perspective the answers to the evaluation questions. Interviewees will include:

- Mikolo staff
- USAID/Madagascar Mikolo management team
- MOH officials: Central level
- Chefs CSB

**Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

- Community health volunteers
- Project beneficiaries (mothers of children under five, women of reproductive age, etc.)
Group Interviews (list categories of groups, and purpose of inquiry)
- MOH officials: Regional level, District level, Commune level, and fokontany level
- Local governance committees (CCDS, COSAN) representatives
- Local NGOs representatives working with Mikolo
- MAHEFA and CCH staff

Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

Survey (describe content of the survey and target responders, and purpose of inquiry)

Facility or Service Assessment/Survey (list type of facility or service of interest, and purpose of inquiry)

Observations (list types of sites or activities to be observed, and purpose of inquiry)
Observe SBCC event if possible - sporting event, community meeting, etc. Identify “calls to action” or other linkages to behavior change. Examine level of engagement of participants and conduct brief interviews to determine if the health messages were passed effectively.

Cost Analysis (list costing factors of interest, and type of costing assessment, if known)
List or describe case and counterfactual

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
</table>

X. HUMAN SUBJECT PROTECTION
The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an internal review board (IRB).** The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request oral or written consent prior to initiating data collection (i.e., interview/discussion/survey)
XI. ANALYTIC PLAN
Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program’s achievements against its objectives and/or targets.
Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.
Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.
Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, OMS, DHS, MICS, HMIS data, etc.) will allow the Evaluation Team to triangulate findings to produce more robust evaluation results.
The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XII. ACTIVITIES
List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include the Mikolo contract, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:
- Review and clarify any questions on the evaluation SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation, the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:
- Evaluation launch, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- In-brief with USAID, as part of the TPM. At the beginning of the TPM, the Evaluation
The Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **Work plan and methodology review briefing.** At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.

- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- **A final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed, these finding may change.)

- **Implementing partner (IP) and Stakeholders’ debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation/Analytic Report** – The Evaluation/Analytic Team, under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit a preliminary **draft evaluation report** (draft1) to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro. USAID has 10 working days to review the draft.
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do revised edits, as needed, and resubmit to GH Pro
5. If there is more than one draft of the Evaluation Report (e.g. a second or third draft), then USAID will have five working days to comment on a revised draft as well as the Evaluation Team.
6. GH Pro will review and reformat the **final Evaluation/Analytic Report**, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and will give a copy to USAID.
8. GH Pro will post the final Evaluation Report and the evaluations’ raw data to the USAID Development Experience Clearinghouse (DEC).

The Evaluation Report **excludes any procurement-sensitive** and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.
Data Submission – All quantitative data will be submitted to GH Pro and USAID in a machine-readable format (CSV or XML). Cleaned datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on the DEC.

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro and USAID.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing</td>
<td>June 1, 2017</td>
</tr>
<tr>
<td>In-brief with USAID</td>
<td>June 12, 2017</td>
</tr>
<tr>
<td>Workplan and methodology review briefing</td>
<td>June 16, 2017</td>
</tr>
<tr>
<td>Workplan (must include questions, methods, timeline, data analysis plan, and instruments)</td>
<td>June 17, 2017</td>
</tr>
<tr>
<td>In-brief with Mikolo project</td>
<td>June 19, 2017</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Out-brief with USAID with Power Point presentation</td>
<td>July 20, 2017</td>
</tr>
<tr>
<td>Findings review workshop with IP and stakeholders with Power Point presentation</td>
<td>July 21, 2017</td>
</tr>
<tr>
<td>Draft report</td>
<td>Submit to GH Pro: August 7, 2017&lt;br&gt;GH Pro submits to USAID: August 11, 2017</td>
</tr>
<tr>
<td>Final report</td>
<td>Submit to GH Pro: September 1, 2017&lt;br&gt;GH Pro submits to USAID: September 7, 2017</td>
</tr>
<tr>
<td>Raw data (cleaned datasets in CSV or XML with data dictionary)</td>
<td>September 1, 2017</td>
</tr>
<tr>
<td>Report Posted to the DEC</td>
<td>October 20, 2017</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review Evaluation Report requiring USAID review and/or approval? __10__ Business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
• Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI), or describing the conflict of interest to the project being evaluated.

Team Qualifications: Please list technical areas of expertise required for this activity:
• List desired qualifications for the team as a whole
• List the key staff needed for this analytic activity and their roles.
• Sample position descriptions are posted on USAID/GH Pro webpage
• Edit as needed GH Pro provided position descriptions

Overall Team requirements:
• Include at least four members.
• Offer an appropriate mix of speakers of English, French and Malagasy, accounting for tasks related to document review, field visits and key stakeholder interviews, and report writing.
• Include senior-level managers with experience leading large, complex USAID-funded projects

The recruitment of local Malagasy evaluators is highly encouraged.

**Team Lead:** This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

**Roles & Responsibilities:** The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

**Qualifications:**
• Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
• Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
• Excellent skills in planning, facilitation, and consensus building
• Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
• Excellent skills in project management
• Excellent organizational skills and ability to keep to a timeline
• Experience working in the region, and experience in Madagascar is desirable
• An advanced degree in public health, evaluation or research or related field
• Proficient in English and French
• Good writing skills, including extensive report writing experience
• Familiarity with USAID and M&E policies and practices
  – Evaluation policies
  – Results frameworks
  – Performance monitoring plans

**Key Staff 1 Title: Evaluation Specialist**
**Roles & Responsibilities:** Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this
evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, and data analysis to report writing.

**Qualifications:**
- At least 10 years of experience in M&E procedures and implementation; USAID M&E experience preferred
- At least five years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English and French
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

**Key Staff 2 Title:** Community Health Specialist

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in community health, and community approaches to primary health care. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

**Qualifications:**
- Medical Degree or Master of Public Health (MPH);
- At least eight years’ experience working on community health activities within primary health and/or health systems strengthening projects; USAID project implementation experience preferred;
- Strong background in strengthening health services at the community level;
- Experience implementing programs to train or mentor community health volunteers and/or primary health providers to introduce new services;
- Demonstrated understanding of community engagement for services, demand creation and prevention;
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders;
- Experience conducting evaluations and/or related research, including development of data collection tools;
Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations
- Proficient in English and French
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

**Key Staff 3**
**Title:** Health Systems Strengthening Specialist

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in health systems strengthening, including engagement with the public sector. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

**Qualifications:**
- At least eight years’ experience in health systems strengthening, including health management information systems or other data for decision making activities; USAID project implementation experience preferred;
- Strong record of successful coordination with public sector counterparts at all levels of the health system: consensus building, joint planning, skills transfer, capacity building, etc.;
- Demonstrated understanding of issues related to data collection, data quality, and use of data for decision making in low-resource contexts;
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders;
- Experience conducting evaluations and/or related research, including development of data collection tools;
- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations;
- Proficient in English and French;
- Good writing skills, specifically technical and evaluation report writing experience;
- Experience in conducting USAID evaluations of health programs/activities.

**Key Staff 4**
**Title:** Social and Behavior Change Communication Specialist

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in social and behavior change communications. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

**Qualifications:**
- At least eight years’ experience in social and behavior change communication for health and WASH; USAID project implementation experience preferred;
- Strong background in designing and/or implementing projects with interpersonal communication components, including training IPC agents;
- Demonstrated understanding of issues related to youth engagement;
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders;
- Experience conducting evaluations and/or related research, including development of data collection tools;
- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations;
- Proficient in English and French;
- Good writing skills, specifically technical and evaluation report writing experience;
- Experience in conducting USAID evaluations of health programs/activities.

**Other Staff Titles with Roles & Responsibilities (include number of individuals needed):**

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Evaluation Logistics /Program Assistant</strong></td>
<td>will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English, French and Malagasy. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.</td>
</tr>
<tr>
<td><strong>Local Evaluators</strong></td>
<td>to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts. The Local Evaluators will have a good command of English, French and Malagasy. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.</td>
</tr>
</tbody>
</table>

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity. Evaluation Team will check with USAID/Madagascar during the in-brief to determine their level of involvement.

- Yes – If yes, specify who:
- Significant Involvement anticipated – If yes, specify who:
- No

**Staffing Level of Effort (LOE) Matrix:**

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- b) Immediately below each staff title enter the anticipated number of people for each titled position.
- c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.
### Level of Effort in days for each Evaluation/Analytic Team member

*(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)*

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation/Analytic Team</th>
<th>Team Lead / Key Staff 1</th>
<th>Key Staff 2, 3 &amp; 4</th>
<th>Local Evaluators</th>
<th>Logistics/Program Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons →</td>
<td></td>
<td>1</td>
<td>2</td>
<td>2-3</td>
<td>1</td>
</tr>
<tr>
<td>1 Launch Briefing</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 HTSOS Training</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Desk review</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Preparation for Team convening in-country</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5 Travel to country</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 In-brief with Mission</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>7 Team Planning Meeting</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8 Work plan and methodology briefing with USAID</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>9 Eval planning deliverables: 1) work plan with timeline analytic protocol (methods, sampling &amp; analytic plan); 2) data collection tools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 In-brief with project</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>11 Data Collection DQA Workshop (protocol orientation/training for all data collectors)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12 Prep / Logistics for Site Visits</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13 Data collection / Site Visits (including travel to sites)</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>14 Data analysis</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>15 Debrief with Mission with prep</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>16 Stakeholder debrief workshop with prep</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>17 Depart country</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Draft report(s)</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>19 GH Pro Report QC Review &amp; Formatting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Submission of draft report(s) to Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 USAID Report Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 USAID manages Stakeholder review (e.g., IP(s), government partners, etc.) and submits any Statement of Difference to GH Pro.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Revise report(s) per USAID comments</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>24 Finalize and submit report to USAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 USAID approves report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Final copy editing and formatting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 508 Compliance editing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Eval Report(s) to the DEC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total LOE per person</td>
<td>53</td>
<td>50</td>
<td>40</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Total LOE</td>
<td>53</td>
<td>50</td>
<td>80-120</td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted  ■ Yes  □ No

**Travel anticipated:** List international and local travel anticipated by what team members.

**Madagascar -** the evaluation team may select from the implementation regions of the project. USAID will recommend two regions. USAID’s preliminary suggestion is that the Team includes at least 3 regions that are geographically diverse Atsimo Andrefana (SW), either Vakinakaratra or Haute Matsiatra (central highlands) and either Vatovavy-fitvinany or Atsinanana (coastal). These can be finalized following in-brief with Mission and with Mikolo.
XV. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

- Visa can be obtained at the airport for a small fee

List recommended/required type of Visa for entry into countries where consultant(s) will work

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tourist</td>
</tr>
<tr>
<td></td>
<td>Business</td>
</tr>
<tr>
<td></td>
<td>No preference</td>
</tr>
</tbody>
</table>

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.

GH Pro can obtain Secret Security Clearances and Facility Access (FA) for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If Electronic Country Clearance (eCC) is required prior to the consultant’s travel, the consultant is also required to complete the High Threat Security Overseas Seminar (HTSOS). HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week Foreign Affairs Counter Threat (FACT) course offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&E to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- USAID Facility Access (FA)
  Specify who will require Facility Access: ____________________________
- Electronic County Clearance (ECC) (International travelers only)
- High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)
- Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
- GH Pro workspace
Specify who will require workspace at GH Pro: _______________________
☐ Travel -other than posting (specify): _______________________
☐ Other (specify): _______________________

XVI. **GH PRO ROLES AND RESPONSIBILITIES**
GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:
- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. **USAID ROLES AND RESPONSIBILITIES**
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USAID</strong> will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
<tr>
<td><strong>Before Field Work</strong></td>
</tr>
</tbody>
</table>
| - **SOW.**  
  - Develop SOW.  
  - Peer Review SOW  
  - Respond to queries about the SOW and/or the assignment at large. |
| - **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates. |
| - **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment. |
| - **Local Consultants.** Assist with identification of potential local consultants, including contact information. |
| - **Site Visit Preparations.** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. |
| - **lodgings and Travel.** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation). |
| **During Field Work** |
| - **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work. |
| - **Meeting Space.** Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel...
Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.

Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

After Field Work

Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

The Evaluation/Analytic Final Report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

− The report must not exceed 30 pages (excluding title page, executive summary, table of contents, acronym list, annexes, tables and maps).

− The structure of the report should follow the Evaluation Report template, including branding found here or here.

− Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.

− For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.


USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

− Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.

− The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.

− Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.

− Evaluation methodology should be explained in detail and sources of information properly identified.

− Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

− Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.

− Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.

− If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.

− If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. Findings should be specific, concise and supported by quantitative and
qualitative information that is reliable, valid and generalizable. It should detail and describe results, effects, constraints, and lessons learned, and provide action-oriented, practical and specific recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. **The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.**

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project [or Program] Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
  - Annex I: Evaluation/Analytic Statement of Work
  - Annex II: Evaluation/Analytic Methods and Limitations (if not described in full in the main body of the evaluation report)
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Persons Interviewed
    - Bibliography of Documents Reviewed
    - Databases
  - Annex V: Statement of Differences (if applicable)
  - Annex VI: Disclosure of Any Conflicts of Interest
  - Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

**The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports**

--------------------------------

The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

--------------------------------

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). For the USAID Open Data policy, the evaluation team will provide machine
readable format for any structured data set collected during the evaluation, including the codebook. The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Name:</th>
<th>Email:</th>
<th>Telephone:</th>
<th>Cell Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raymond Grant</td>
<td><a href="mailto:rgrant@usaid.gov">rgrant@usaid.gov</a></td>
<td>+261 33 44 328 01</td>
<td>+261 34 20 480 07</td>
</tr>
<tr>
<td>Vololontsoa Raharimalala</td>
<td><a href="mailto:vraharimalala@usaid.gov">vraharimalala@usaid.gov</a></td>
<td>+261 33 326 76</td>
<td>+261 033 12 619 03</td>
</tr>
<tr>
<td>Azzah Al-Rashid</td>
<td><a href="mailto:aal-rashid@usaid.gov">aal-rashid@usaid.gov</a></td>
<td>+261 33 44 327 54</td>
<td>+261 34 07 428 22</td>
</tr>
<tr>
<td>Sara A. Miner</td>
<td><a href="mailto:sminer@usaid.gov">sminer@usaid.gov</a></td>
<td>+(261) 33 44 326 86</td>
<td>+(261) 34 07 428 06</td>
</tr>
</tbody>
</table>

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff):

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>USAID Office/Mission</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Cell Phone:</td>
<td></td>
</tr>
</tbody>
</table>

XX. OTHER REFERENCE MATERIALS
Documents and materials needed and/or useful for consultant assignment, that are not listed above

XXI. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)
ANNEX II. EVALUATION INSTRUMENTS

Introduction

Je m’appelle ______________________________. Et mon collègue s’appelle _______________. *(Si vous êtes en train de mener les Discussions Dirigées (FGD)*

Je suis ici (nous sommes ici) pour évaluer le projet financé par l’USAID qui s’appelle Projet Mikolo. Le but du projet c’est d’augmenter l’usage des services de santé à base communautaire, et l’adoption des pratiques de la santé surtout parmi les femmes à l’âge de procréation, les enfants de moins de cinq ans et les nouveaux nés. Nous voudrions déterminer l’efficacité des stratégies mises en œuvre par le projet jusqu’à présent.

*(Pour les partenaires de mise en œuvre et autres)* Si vous voulez bien participer, je vous demanderai de partager vos perspectives et expériences dans la mise en œuvre/collaboration avec le projet.

*(Pour les populations cibles)* Si vous acceptez de participer, je vous demanderai de partager vos perspectives et expériences pour avoir l’accès et recevoir les services de santé fournis dans le cadre du projet.

Les discussions/interview prendront environs une heure de votre temps. Votre participation dans ces études est volontaire. Nous n’allons pas continuer sans votre consentement.

Consentement

Les informations que vous allez fournir seront gardées strictement confidentielles. Votre identité (nom) ne sera pas inscrite sur la fiche ni utilisée dans le formulaire de cette évaluation. Je vais/Nous allons écrire les réponses que vous allez nous donner pour qu’on ne puisse pas les oublier.

*(Pour les Discussions Dirigées (FGD). Pendant les discussions, nous allons noter vos réponses dans nos cahiers, l’on pourra aussi enregistrer les discussions pour qu’on ne puisse pas manquer les détails ou informations importantes, mais ces informations ou enregistrements seront sécurisés de telle manière que personne de l’extérieur n’aura accès à ces informations.*

Votre participation dans les activités de cette évaluation ne pose aucun risque. Vous pouvez refuser de répondre aux questions ou d’arrêter votre participation n’importe quand. Il n’y a pas de risques ou bénéfices individuels pour votre participation dans cet interview ou discussions dirigées, et il n’y aura pas des conséquences négatives si vous décliner de participer. Cependant, les révélations de cette évaluation vont contribuer à l’élaboration des nouvelles interventions pour le niveau communautaire des services de santé à Madagascar.

Pendant le processus d’interview/discussions dirigées, si vous n’êtes pas en mesure d’entendre n’importe quelle question ou sujet, prière de me demander de les répéter. Votre franche participation est très importante pour nous permettre de comprendre les résultats de ce projet. Avez-vous des questions pour moi?

Etes-vous d’accord de participer dans ces discussions? Si vous dites Oui, cela veut dire vous veniez d’accepter de prendre part à ces discussions.
Si vous êtes d'accord, prière de me dire oui.

Prière de m'arrêter et poser des questions ou exprimer vos soucis si vous en avez.

KII - USAID et MSP

Instructions:

Lire l'introduction et obtenir le consentement verbal avant de commencer.

1. Quelles ont été les plus grandes réalisations et forces de Mikolo?
   Si MSP: Est-ce que vous savez que c’est la dernière année du projet Mikolo ?
2. Quelles sont les points forts de Mikolo ?
3. Quelles sont les faiblesses de Mikolo?
   Si MSP, quelles lacunes avez-vous observé dans la façon dont Mikolo appuie la stratégie de santé communautaire du GoM?
4. Quels sont les défis et obstacles auxquels Mikolo a été confronté? Comment ont-ils surmonté ces défis / obstacles?
   Si MSP, Comment le Mikolo a-t-il soutenu la politique nationale de la santé communautaire pour surmonter ces défis / obstacles?
5. Pensez-vous que Mikolo utilise bien les données pour informer sur ses interventions ?
   Si MSP, comment Mikolo s'associe-t-il avec le GoM pour améliorer la collecte et la qualité des données?
6. Avec quelle efficacité Mikolo travaille-t-il avec le GoM concernant l'utilisation des données ?
   Pourriez-vous nous donner un exemple sur l'amélioration d'utilisation des données ?
   Si MSP, qu'est-ce que le MSP voudrait que Mikolo fasse pour améliorer l'utilisation des données aux niveaux central, régional, de district et de la communauté?
7. Pensez-vous que Mikolo est bien dirigé et géré? Pouvez-vous donner un exemple?
8. Si vous étiez en mesure de redéfinir le projet Mikolo, quelles composantes que vous allez conserver et lesquelles vous allez recomposer?

KII Mikolo

Instructions:

Lire l’introduction et obtenir le consentement verbal avant de commencer.

1. Pouvez-vous partager avec moi quelques succès que Mikolo a accomplis au cours de la vie du projet?
2. Comment décririez-vous les collaborations de Mikolo avec les différents partenaires, acteurs et bénéficiaires?
3. Selon vous, comment les stratégies de Mikolo sont-elles alignées avec les stratégies et les politiques du MSP ?
4. Décrivez comment votre organisation travaille avec les partenaires du consortium ? Comment cela se fait avec les autres partenaires de mise en œuvre des activités du projet ?

5. Quels systèmes sont mis en place pour suivre et appuyer la performance les partenaires du consortium/ des ONG de mise en œuvre ?

6. Pouvez-vous expliquer comment votre organisation appuie le système de santé communautaire ?

7. Qu'est-ce que Mikolo a fait pour créer la culture d'utilisation des données au sein de l'organisation et avec les partenaires, y compris le MSP/ le système de santé communautaire ?

8. Quelle année avez-vous décidé d'utiliser DHIS2 ? Pourquoi ?

9. Comment Mikolo s'assure-t-il que les données / informations rapportées sont de haute qualité ?

10. Quelles sont les leçons apprises de la mise en œuvre des activités de Mikolo ? (creuser : le système d'information, appuis aux ONGs, …)

11. Quand le projet prend fin et les ONGs de mise en œuvre ne seront plus là, comment voyez-vous la continuité des activités sur les services de santé communautaire ?

12. Quelles seraient vos suggestions pour améliorer l'avenir du programme de santé communautaire à Madagascar ?

KII des Consortium, Autres Partenaires, et ONG (Agence de mise en œuvre)

Instructions :

Lire l'introduction et obtenir le consentement verbal avant de commencer.

1. Décrivez comment votre organisation travaille avec Mikolo ? Q3

2. Comment décririez-vous les collaborations parmi/entre les différents partenaires et acteurs ? Q3

3. Pouvez-vous expliquer comment votre organisation appuie directement / indirectement le système de santé communautaire ? Dépend de l'organisation : SR1, SR2, SR3, SR4, Q3

4. Parmi vos activités avec Mikolo, quelles sont les activités les plus réussites et les moins réussites ? Qu'est-ce qui a contribué au réussite ou problèmes qui empêchaient la réussite ?

5. Selon vous, dans quelles mesures les stratégies de Mikolo sont-elles alignées avec celles du MSP ? SR1-ownership

6. Que peut-on faire pour s'assurer que les services de santé communautaire se poursuivent après la fin du projet ? SR1, SR2/continued opportunities for improvement

7. Selon vous, quelles seraient vos suggestions pour améliorer l'avenir du programme de santé communautaire à Madagascar ? Dépend de l'organisation

Questions spécifiques pour le consortium

1. De quelle manière Mikolo a-t-il aidé votre organisation/ONG à mener efficacement le travail ?
2. Selon vous, Mikolo a-t-il donné un appui adéquat au système de santé communautaire et aux ONG partenaires ? Pourquoi vous pensez de cette façon ?

3. Pouvez-vous décrire les efforts de coordination qui existent au sein du Consortium ?

4. Quelles sont des leçons apprises de la mise en œuvre des activités de Mikolo ?

5. Qu'est-ce que Mikolo a fait pour créer la culture d'utilisation des données au sein de l'organisation ?

6. Comment Mikolo s'assure-t-il que les données / informations rapportées sont de haute qualité ?

ONG (Agences de mise en œuvre)
Les ONG qui travaillent sur le terrain peuvent répondre à toutes les questions du SOW.

SR1 systems, capacity, ownership for sustainability
- COSAN
- Aligned with local priorities
- Increased GOM ownership
- Any Facility (CSB, commune, district) improvements

SR2 Availability & Access
- Polyvalent
- Rolling out new responsibilities/activities

SR3 Improved Quality
CHVs
Continued opportunities for improvement
Supportive supervision

SR4 SBCC
Increase demand
Youth activities as conduits for health seeking
& healthier behaviors

Lire l'introduction et obtenir le consentement verbal avant de commencer.

1. Veuillez décrire votre rôle et vos responsabilités au sein de cette ONG.

2. Dans votre rôle en tant que TA / STA, comment avez-vous appuyé les services de santé communautaire (AC et / ou CCDS / COSAN) et de la promotion de santé (JPE, FD, HD) ?

3. Quels sont les défis des AC ? Comment peut-on les résoudre ?

4. Quels types d'appui est-ce-que votre ONG a reçu de Mikolo ? SR1, Q3

5. Quelles formations de Mikolo avez-vous reçu et utilisé ? Les quelles étaient les plus utiles/ moins utiles ? Dans chaque formation que vous avez conduit pour les STA/TA/CSB et/ou des acteurs communautaires, quels sujets étaient les plus utiles/ moins utiles ? CREUSER : prestation des services, gestion des produits a vendre, communication pour le changement du comportement, utilisation de RMA, autres ?

6. Comment avez-vous informé et appuyé les acteurs communautaires et la population a propos des changements dans leur travail/ les services offerts ? CREUSER : (introduction du teste de grossesses ; transféré de la gestion et la distribution des produits palus aux gouvernement (2016) ; les services devenus polyvalents ; nouveau critère pour les ménages/fokontany/communes champion ; autres ) SR2 et tous

7. Que faites-vous lorsque vous êtes confronté à un problème de travail ? (CREUSER : Discuter de ces problèmes et leurs solutions.)
8. Comment vous assurez-vous que les données rapportées sont de bonne qualité ? Q2

9. Qu'est qui arrive aux données, aux rapports? (Utilisation des données) ? Q2

10. Sur la base de votre connaissance du projet Mikolo, que pourrait-on faire mieux pour pourvoir les services de santé communautaire de valeur à la population

CREUSER : Est-ce à travers les ONG, Mikolo, système de santé communautaire ? SR1

KII/FGD - EMAR, EMAD, CCDS, COSAN

Instructions: Lire l’introduction et obtenir le consentement verbal avant de commencer.

1. Quelles sont les réalisations de Mikolo relatives à l’offre des services de santé communautaires (i.e., à travers les CHVs ?)

2. Est-ce qu’il y a eu un changement sur la planification et la mise en œuvre des activités après le réengagement du projet avec l’Etat en 2014 ?

3. Quels types d’appuis Mikolo a fourni à votre comité?

4. Est-ce que le modèle de formation en cascade utilisé par Mikolo est-il efficace ? donner des exemples? Est-ce qu’il y a d’autres modèles que vous voulez promouvoir ?

5. Est-ce que l’appui donné vous a aidé à améliorer vos prestations de services ? Si oui, de quelle manière pratique ?

6. Comment décririez-vous la collaboration et la coordination des activités de programme entre Mikolo et le système de santé communautaire. (EMAR/EMAD, CCDS/COSAN)? Qu’en est-il entre Mikolo et les partenaires de mise en œuvre?

7. Décrivez les réunions de concertation du comité: périodicité ? qui sont les participants ?

8. Comment avez-vous réalisé le plan d’action qui a été développé avec le projet ?

9. Selon vous, comment les stratégies de Mikolo sont-elles alignées avec les priorités du MSP?

10. Quels apports (financiers, personnels, produits de santé, etc.) le MSP a-t-il fourni pour compléter les efforts de Mikolo sur les prestations de services de santé au niveau communautaire?

11. Qu’est-ce que Mikolo a fait pour accroître la probabilité de la pérennisation des efforts des services de santé communautaire? (Creuser sur: SILC, Ménages champions, etc.)

12. Quelle a été votre expérience avec la fin du dernier projet USAID (santenet2 ?)! Que se passerait-il après que le projet Mikolo prenne fin ?

13. Quels défis allez-vous connaitre si le projet prendra fin ? Comment vous allez les adresser ?

14. Quelles sont les leçons apprises de votre expérience de collaboration avec le projet Mikolo?

15. Quelles suggestions vous avez pour s’assurer de la réussite et de la pérennisation des activités de santé à base communautaire ?
16. Quelles seraient vos recommandations à l'USAID pour les investissements avenir dans le développement du système de santé à Madagascar ?

**KII Acteurs communautaires (AC / JPE / FD avec HD)**

- Plus réussite/utiles et pourquoi
- Moins réussite/utiles et pourquoi
- Recommandations

**Instructions :**

Lire l’introduction et obtenir le consentement verbal avant de commencer.

1. Combien de temps avez-vous servi comme AC/ JPE/ FD ou HD ? *(Se rappeler de reconnaître la responsabilité de la personne que ça soit quelqu’un qui a travaillé longtemps ou nouvellement recruté.)*

2. Pouvez-vous décrire vos responsabilités (SR/SMI/PECIMEC/PF4/promotion) et vos activités en tant que volontaire communautaire (AC/JPE/HD ou FD) ?
   a. Lesquelles vous a aidé le plus d’améliorer la santé communautaire ? Comment ?
   b. Qu’est ce qui est de plus difficile ? Pourquoi ?
   c. Qu’est-ce que vous feriez pour le rendre plus facile ?
   d. Qu’est-ce que le Projet Mikolo peut faire pour le rendre moins difficile ?

3. Quelles formations avez-vous reçu du projet ? CREUSER : Parmi les choses que vous avez appris :
   a. Lesquelles sont les plus utiles pour vous aider dans votre travail comme volontaire ?
   b. Lesquelles sont les moins utiles ?

   **POUR LES YPE CREUSEZ :** aux sujets de la santé reproductive aux jeunes (délai, condom, PF, CPN, accouchement au CSB) ?

4. Comment avez-vous appris des nouveaux produits ou instructions dans votre travail comme volontaire ? CREUSER : introduction du test de grossesse/Sayana Press/ misoprostol/Chlorhexidine ; transfère de la gestion et la distribution des produits palus aux gouvernements (2016) ; les services des AC devenus polyvalents ; nouveau critère pour les familles champion ; autres ?

5. Êtes-vous confronté à des problèmes/défis dans le cadre de votre travail de volontaire ? Dites-nous comment vous avez résolu ce problème ?
   CREUSER : parler des problèmes et des solutions, par exemple, la distance, la santé intégrée, la supervision, le matériel, l’équipement, outils de travail et tout autre support reçu dans la communauté, et les problèmes de réapprovisionnement *(stock outs)* ?

6. Est-ce que vous référé des gens à un autre AC ou au CSB ? Pourquoi vous référer un client ?
7. Remplissage des Carnets et des Registres et des RMA mensuelles : Pouvez-vous nous montrer vos registres et nous expliquer comment vous les utiliser ? Quels sont les défis en utilisant ces outils ? D'après vous, quel est l'utilité de ses cahiers ?

8. Comment utilisez-vous les Cartes de Santés Enfant et Mère avec les parents ? CREUSER : Quelle méthode utilisez-vous pour faciliter la compréhension des informations dans ces carnets pour les gens qui ne savent pas lire ?

9. Comment vous faites lorsque vous referez les gens au CSB ? Est-ce que vous faites un suivi après la référence ? Si oui, comment vous procédez ?

10. Quels outils avez-vous reçu pour aider votre travail de volontaire et comment vous les avez utilisés ? Y-en-a-t-il des outils que vous n'avez pas utilisés ? Pourquoi ?

11. Comment est-ce que vous encourager les gens d'utiliser les prestations de services ou adopter des pratiques plus saines ?
   CREUSER : visite à domicile [VAD], sensibilisation de FD ou HD, grande réunion ou événement, partage informelle des informations entre famille et amis, causerie avec un FD ou HD, autres ?

12. Pouvez-vous nous décrire ce qu'est un Ankohonana Mendrika Salama (AMS) (Famille Championne) ?
   CREUSER :
   a) Quand avez-vous entendu parler de Famille Championne ?
   b) Est-ce que vous êtes parmi les Familles Championnes ? Depuis quand ?
   c) Veuillez me parler des actions/étapes nécessaires pour devenir une Famille Championne.
   d) Est que certaines actions/étapes sont plus faciles à suivre pour devenir une Famille Championne ? Plus difficiles ?
   e) Quels types d’assistance les familles demandent/reçoivent de l’AC, YPE /FD/HD/membres des groupements ?
   f) Qu’est ce qui marche bien et qu’est ce qui ne marche pas bien en essayant d’accroître le nombre de ménages champions ?
   g) D’après vous, dans quelle mesure l’existence des familles championnes influence des autres familles ?
   h) Quelles sont les nouveaux critères de devenir une famille championne ? Qu’est-ce qu’on est en train de faire pour aider les familles d’accomplir les critères WASH (boire eau propre, lavez les mains, utiliiez un latrine) ?
   i) Que pourrait faire le projet Mikolo pour vous aider à faire en sorte que le plus de ménages deviennent champion ?
   j) Comment le fokontany pourrait-il continuer à aider davantage de familles à adopter des comportements plus sains sans compter sur le soutien de Mikolo et de vous et les autres volontaires ?

13. Comment est-ce que vous travaillez avec le COSAN FKT ?
14. Quels sont les bénéfices des réunions au CSB ?

15. Combien de visites avez-vous reçu du TA dans les derniers trois mois ? Comment est-ce que le TA vous aide lors de sa visite ?

16. Si le projet Mikolo (qui support le travail du TA et votre transport au CSB), quelles activités seriez-vous en mesure de continuer à faire ? Qu’est-ce que vous ne seriez pas en mesure de faire ?

17. Quels sont les avantages d’appartenir à un SILC ?

18. En se basant sur vos expériences avec Mikolo, que suggériez-vous pour accroître la disponibilité et l’accès aux soins pour votre communauté ?

FGD – Bénéficiaires : hommes et femmes / jeunes

Instructions: Lire l’introduction et obtenir le consentement verbal avant de commencer.

1. Qu’est-ce que vous faites quand vous êtes malade / votre enfant est malade/ ou quand vous constatez que vous êtes enceinte/désire PF ? Où allez-vous ? PROBE pour avoir les réponses des personnes qui utilisent les services ainsi que ceux qui n’utilisent pas.

2. Pour ceux d’entre vous qui ont commencé l’utilisation des services des AC, comment est-ce qui vous étiez convaincu de le faire ? PROBE : Si vous n’avez pas utilisé des services des AC, pourquoi pas ?

3. Pour ceux d’entre vous qui pratiquent un nouveau comportement sanitaire (IEBF / WASH), comment est-ce qui vous étiez convaincu de l’essayer ?

4. Où est-ce que les gens comme vous obtiennent des informations sur la santé ?

5. Avez-vous entendu des messages sur la santé à la radio la semaine passée/ le mois passé ? Qu’est ce que vous avez appris ? Est-ce que cela a affecté vos pratiques ?

6. Pouvez-vous nous décrire ce qu’est un ménage champion ?
   a. Quand avez-vous entendu parler de Ménage Champion ?
   b. Est-ce que vous êtes parmi les Ménages champions ? Depuis quand?
   c. Veuillez me parler des actions/étapes nécessaires pour devenir un Ménage champion
   d. Est que certaines actions/étapes sont plus faciles à suivre pour devenir un Ménage champion ?
   e. Est-ce que vous êtes assistée par l’AC/YPE/FD/HD/GROUPEMENT pour suivre ces étapes ? Comment ?
   f. Comment le fokontany pourrait-il continuer à aider davantage de familles à adopter des comportements plus sains ?

7. Quelles sont les raisons qu’ils y a toujours des familles qui ne sont pas devenus Ménage Champion ?
8. Avez-vous entendu dire des nouvelles actions nécessaires pour devenir un ménage champion ? Quand et de qui ? Qu’est-ce que vous en pensez de ces critères ?

9. Comment est-ce que les volontaires convainquent des hommes et des femmes mariés de commencer à utiliser la contraception ? (visite au AC, VAD, CPN, session d’information en groupe, autres). Quelles suggestions pouvez-vous partager pour augmenter l’utilisation des contraceptives ?

10. Comment le Fokontany peut-il s’assurer que les mères et les enfants reçoivent des soins d’urgence en temps opportun ?

11. Comment les FD, HD, Membres de leurs groupements peuvent-ils aider plus de familles à adopter plus rapidement des comportements sains ?
   a. Latrine, *tippy tap* et cendres/savon, eau propre e. PF
   b. Allaitement exclusive jusqu’au 6 mois f. Délai
   c. Soins auprès de l’AC
   d. Soins auprès de le CSB

12. Questions spécifiques par rapport aux jeunes
   a. Qu’est-ce que vous savez des activités des JPE ? CREUSER : Quels comportements est-ce qu’ils promeuvent de la santé reproductives des jeunes dans votre FKY (abstinence/protection avec préservatif/utilisation de la contraception/ visite du CSB pour CPN si enceinte) ?
   b. Quelles activités de JPE ont aidé les jeunes comme vous d’être informé des comportements à risque/d’adopter des comportements plus sains ? Quelles activités ne semblaient pas aider beaucoup à changer les attitudes et le comportement des jeunes.
   c. Quelles activités supplémentaires proposez-vous ?
   d. Est-ce que les jeunes se sentent à l’aise quand ils sont référés aux CSB par les JPE ? Si non, comment les convaincre ?

PAR RAPPORT AUX PLUS JEUNES MOINS DE 16 ANS :

Quelles activités les JPE pourraient-ils mener pour atteindre les plus de jeunes ?

   a. Que pensent les gens de la FKY des activités des JPE pour ces plus jeunes ?
   b. Lesquelles des activités des JPE sont plus efficaces/moins efficaces pour convaincre ces jeunes à adopter des comportements sains ?
   c. Partagez vos suggestions pour augmenter le numéro de ces jeunes qui protègent mieux leur santé reproductives.

13. Que pensez-vous des personnes mariées qui utilisent le PF ? les célibataires ? Pour ceux d’entre vous qui approuvent le PF, qu’est ce qui vous a convaincu?

14. Quelles méthodes de contraception avez-vous entendu parler?
Checklist d’activités d’observations des ACs

Comment l’AC offre les services de santé communautaire intégrée aux femmes à l’âge de procréation?

Veuillez décrire vos observations sur la façon que l’AC offre les services de santé intégrée aux femmes à l’âge de procréation. Notez aussi les interactions entre l’AC et les bénéficiaires.

- Est-ce que ce travail de l’AC était planifié?
- Qui est le bénéficiaire ou les bénéficiaires des services de l’AC ?
- Où dans le FKT?
- Types de services fournis
- Promotion de la santé (sensibilisation)
- Outils de travail utilisé dans le cas échéant
- Références des cas effectuées
- Enregistrement des activités dans le registre de l’AC
- L’AC essaie-t-il de fournir les services intégrés (promotion/soins)?
# ANNEX III. EVALUATION SITES

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<th>REGION</th>
<th>AMORON ‘I MANIA</th>
<th>VATOAVY FITOVINANY</th>
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<td>MANDROSOVELO ANALAMIDITRA MENARANO SAHOFIKA</td>
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## ANNEX IV. EVALUATION PARTICIPANTS

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<tr>
<td>Coordinator/Technical Assistant District/Regional M&amp;E</td>
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<td>Regional Director of Public Health &amp; Ambositra District Public Health Officer</td>
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<td>Fandriana District Public Health Officer</td>
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<td>NGO AIM – 7</td>
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<tr>
<td>Coordinator/ M&amp;E/ Support Technician Supervisors</td>
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<tr>
<td>Support Technician (Jean Baptiste)</td>
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<td>Support Technician (Tahiry and Jean Baptiste)/ Support Technician Supervisor</td>
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<td>CHV (Polyvalent)/WL &amp; CHV (children)</td>
<td>2 KII</td>
</tr>
<tr>
<td>Youth group</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Male youth beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Female youth beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Female parents beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Male parents beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Chief of Fokontany</td>
<td>1 KII</td>
</tr>
<tr>
<td>YPE</td>
<td>1 KII</td>
</tr>
<tr>
<td>Champion family</td>
<td>2 observations</td>
</tr>
<tr>
<td>Tsarasaotra Commune – Iavomanana Fokontany – 3</td>
<td></td>
</tr>
<tr>
<td>2 CHVs (polyvalent)</td>
<td>1 KII</td>
</tr>
<tr>
<td>Champion Family</td>
<td>2 observation</td>
</tr>
<tr>
<td>Fandriana District – Sandrandahy Commune – 2</td>
<td></td>
</tr>
<tr>
<td>CCDS members</td>
<td>1 KII</td>
</tr>
<tr>
<td>CSB Chief</td>
<td>1 KII</td>
</tr>
<tr>
<td>Sandrandahy Commune – Ambanifieferana Fokontany – 7</td>
<td></td>
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<tr>
<td>CHV (Polyvalent)/ WL</td>
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<tr>
<td>CHV (Children)</td>
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</tr>
<tr>
<td>Chief of Fokontany</td>
<td>1 KII</td>
</tr>
<tr>
<td>Champion Family</td>
<td>3 observations</td>
</tr>
<tr>
<td>Sandrandahy Commune – Fokontany Iavomanitra – 9</td>
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<td>SILC Field Agent</td>
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<tr>
<td>CHV (Polyvalent)</td>
<td>2 KII</td>
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<tr>
<td>SILC members</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Male youth beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Female youth beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Female parents beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Male parents beneficiaries</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Champion Family</td>
<td>1 observation</td>
</tr>
</tbody>
</table>
This was not a CF but we wanted to understand why there were no CF in the FKT.

Topic was indoor residual spraying not maternal, child, or FP.

The team tried twice to interview the CSB chief in the commune Ambila. In the end a CSB chief in the next commune was interviewed (still the project intervention zone).

---

<table>
<thead>
<tr>
<th>V7V Region</th>
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<tr>
<td><strong>July 6-17, 2017</strong></td>
<td></td>
</tr>
<tr>
<td>Mikolo – 4</td>
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<tr>
<td>Coordinator</td>
<td>1 KII</td>
</tr>
<tr>
<td>Technical Assistant District</td>
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<tr>
<td>Regional M&amp;E</td>
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<tr>
<td>ASOS consortium SBCC</td>
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<tr>
<td>V7V Regional &amp; Manakara District Health Offices – 4</td>
<td></td>
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<tr>
<td>EMAR</td>
<td>1 KII</td>
</tr>
<tr>
<td>EMAD</td>
<td>1 KII</td>
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<tr>
<td>Technical Assistant - District</td>
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<td>District Data Specialist</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>M&amp;E</td>
<td>1 KII</td>
</tr>
<tr>
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<tr>
<td>Support Technician</td>
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<tr>
<td>Support Technician SILC</td>
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<tr>
<td><strong>NGO SAF – 6</strong></td>
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<td>Coordinator/Technical Lead</td>
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</tr>
<tr>
<td>M&amp;E</td>
<td>1 KII</td>
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<tr>
<td>Support Technician Supervisor</td>
<td>1 KII</td>
</tr>
<tr>
<td>Support Technician</td>
<td>3 KII</td>
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<td>CSB Chief</td>
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<tr>
<td>SP (supply point)</td>
<td>1 KII</td>
</tr>
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<tr>
<td>FKT President</td>
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</tr>
<tr>
<td>CHV</td>
<td>2 KII</td>
</tr>
<tr>
<td>Women’s group</td>
<td>1 FDG</td>
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<tr>
<td>Beneficiaries (Women and men)</td>
<td>1 FGD</td>
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<tr>
<td>Champion Family&lt;sup&gt;44&lt;/sup&gt;</td>
<td>1 observation</td>
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<tr>
<td><strong>Commune Mizilo</strong></td>
<td></td>
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<tr>
<td>Fokontany Analamiditra (District Manakara) – 8</td>
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<tr>
<td>FKT President</td>
<td>1 KII</td>
</tr>
<tr>
<td>CHV</td>
<td>2 KII</td>
</tr>
<tr>
<td>SILC Group</td>
<td>1 FGD</td>
</tr>
<tr>
<td>Champion families</td>
<td>2 observations</td>
</tr>
<tr>
<td>Awareness raising demonstration&lt;sup&gt;45&lt;/sup&gt; &amp; house visit</td>
<td>2 observations</td>
</tr>
<tr>
<td><strong>Commune Ambahatrazo – 1</strong></td>
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</tr>
<tr>
<td>CSB Chief&lt;sup&gt;46&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Ranomafana Commune– Ifanadana District – 5</td>
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<tr>
<td>EMAD</td>
<td>1 KII</td>
</tr>
<tr>
<td>CSB Chief</td>
<td>1 KII</td>
</tr>
<tr>
<td>SP (supply point)</td>
<td>1 KII</td>
</tr>
<tr>
<td>CCDS</td>
<td>1 KII</td>
</tr>
</tbody>
</table>

<sup>44</sup> This was not a CF but we wanted to understand why there were no CF in the FKT.

<sup>45</sup> Topic was indoor residual spraying not maternal, child, or FP.

<sup>46</sup> The team tried twice to interview the CSB chief in the commune Ambila. In the end a CSB chief in the next commune was interviewed (still the project intervention zone).
Since the youth group in the FKT Menarano was not really functional, the team went to another SAF FKT to obtain an understanding of their activities.
ANNEX V. SOW FOR COMMUNITY HEALTH VOLUNTEERS

(In French only)

RESPONSABILITES DES AGENTS COMMUNAUTAIRES (AC)-PAIRS

Mission principale :

- Appuyer le CSB pour la supervision des AC
- Réaliser les responsabilités en tant que simple AC

1. Au niveau des CSB

- Pendant le jour de vaccination : peser les enfants, prendre la mesure du pourtour brachial des enfants en utilisant le MUAC
- Un jour avant la revue mensuelle : nettoyer la boîte des fiches de vaccination mensuelle, nettoyer la boîte des fiches des femmes enceintes avant la réunion mensuelle
- Pendant la revue mensuelle : se charger du secrétariat de la réunion, distribuer aux AC la liste des enfants moins de 5 ans absents pendant la vaccination
- Appui des AC pendant la phase de stage au niveau du CSB : superviser les AC au moins une fois par mois (de l’ordre de 2 AC par semaine)

2. Dans le site des AC

- Faire le total des RMA des AC
- Grouper les commandes en médicaments des AC
- Exercer les activités en tant qu’en AC
- Appuyer et superviser les AC sous sa supervision (1 AC pair doit superviser 12 AC) sur la disponibilité des registres, produits, outils de gestion, propreté, PF
- Convoquer les AC pour la revue mensuelle avec le COSAN

Recapitulation

<table>
<thead>
<tr>
<th>Au CSB</th>
<th>Au site</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 jours/semaine</td>
<td>3 jours/semaine</td>
</tr>
<tr>
<td>2 jours/mois pour la revue mensuelle</td>
<td>Suivi des RMA durant le mois</td>
</tr>
</tbody>
</table>
## ANNEX VI. PROJECT ACHIEVEMENTS TO DATE

<table>
<thead>
<tr>
<th>N°</th>
<th>Indicator</th>
<th>Life of Project Target</th>
<th>FY 14 Results</th>
<th>FY 15 Results</th>
<th>FY 16 Results</th>
<th>FY17 (Q1-Q3)</th>
<th>TOTAL LOP RESULTS</th>
<th>% TARGET ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 - USAID IR 1.3.1</td>
<td>Number of Communes with functioning COSANs</td>
<td>506</td>
<td>307</td>
<td>506</td>
<td>506</td>
<td>504</td>
<td>506</td>
<td>100%</td>
</tr>
<tr>
<td>1.2 - USAID IR 1.3.2</td>
<td>Number of Communes with functioning CCDSs</td>
<td>506</td>
<td>296</td>
<td>506</td>
<td>506</td>
<td>504</td>
<td>506</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Number of people (NGOs, COSAN, CCDS, SILC) trained with increased Leadership and Management knowledge and skills</td>
<td>48,615</td>
<td>7,053</td>
<td>6,349</td>
<td>489</td>
<td>258</td>
<td>14,14</td>
<td>29%</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Number of people (COSAN, CCDS) trained with increased Leadership and Management knowledge and skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.2</td>
<td>Number of people (NGO) trained with increased Leadership and Management knowledge and skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.3</td>
<td>Number of people (TA and supervisor) trained with increased Leadership and Management knowledge and skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.4</td>
<td>Number of people (EMAD) trained with increased Leadership and Management knowledge and skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Number of COSAN savings and loans funds (CSLF) established</td>
<td>-</td>
<td>13</td>
<td>13</td>
<td>42</td>
<td></td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Number of Saving and Internal Lending Community (SILC) established at the community level</td>
<td>2,530</td>
<td>133</td>
<td>562</td>
<td>706</td>
<td>659</td>
<td>2,060</td>
<td>81%</td>
</tr>
<tr>
<td>1.6</td>
<td>Proportion of female participants in USG-assisted programs designed to increase</td>
<td>50%</td>
<td>62%</td>
<td>67%</td>
<td>64%</td>
<td>75%</td>
<td>75%</td>
<td>150%</td>
</tr>
<tr>
<td>Nº</td>
<td>Indicator</td>
<td>Life of Project Target</td>
<td>FY 14 Results</td>
<td>FY 15 Results</td>
<td>FY 16 Results</td>
<td>FY17 (Q1-Q3)</td>
<td>TOTAL LOP RESULTS</td>
<td>% TARGET ACHIEVED</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>1.7</td>
<td>Number of NGOs eligible to receive direct awards made by USAID</td>
<td>4</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>1.8</td>
<td>Number of local NGO awarded grants</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>11</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sub-Result 2: Increase availability of, and access to primary health care services in project target communes

**FPRH**

2.1 - USAID IR 2.1.2 Number of additional USG-assisted community health workers (CHVs) providing Family Planning (FP) information and/or services during this year 7,507 2,203 1,772 1,081 259 5,315 71%

2.2 - USAID IR 2.2.9 Couple Years Protection (CYP) in USG supported programs 626,460 12,329 71,592 125,526 109,428 318,875 51%

2.2 - USAID IR 2.2.11 Number of new users of FP method 617,421 32,677 76,011 108,755 84,731 302,174 49%

2.4 - USAID IR 2.4.1 Number of continuing users of FP method 234,370 66,465 88,300 104,358 141,043 141,043 60%

2.5 - USAID IR 2.4.1 Percent of service delivery points (CHVs) that experience a stock-out at any time of Oral contraception products 15% 16% 11% 12% 6% 6% 160%

2.6 - USAID IR 2.4.1 Percent of service delivery points (CHVs) that experience a stock-out at any time of DMPA products 15% 21% 17% 11% 7% 7% 153%

2.7 Number clients referred and seeking care at the nearest health provider by CHW for LAPMs 49,550 2,344 6,421 6,268 4,883 19,916 40%

**MALARIA**

2.8 - USAID IR 2.1.6 Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) 7,507 2,808 1,009 3,888 259 7,964 106%
<table>
<thead>
<tr>
<th>Nº</th>
<th>Indicator</th>
<th>Life of Project Target</th>
<th>FY 14 Results</th>
<th>FY 15 Results</th>
<th>FY 16 Results</th>
<th>FY17 (Q1-Q3)</th>
<th>TOTAL LOP RESULTS</th>
<th>% TARGET ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.9 - USAID IR 2.1.2</td>
<td>Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy)</td>
<td>7,507</td>
<td>2,808</td>
<td>1,009</td>
<td>3,888</td>
<td>120</td>
<td>7,825</td>
<td>104%</td>
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<tr>
<td>2.10</td>
<td>Number of children with fever in project areas receiving an RDT</td>
<td>429,300</td>
<td>28,341</td>
<td>133,225</td>
<td>129,460</td>
<td>80,427</td>
<td>96,991</td>
<td>23%</td>
</tr>
<tr>
<td>2.11</td>
<td>Number of children with RDT positive who received ACT</td>
<td>232,300</td>
<td>9,166</td>
<td>77,059</td>
<td>45,937</td>
<td>42,297</td>
<td>174,459</td>
<td>75%</td>
</tr>
<tr>
<td>2.12 - USAID IR 2.4.1</td>
<td>Percent of service delivery points (CHVs) that experience a stock-out at any time of ACT</td>
<td>10%</td>
<td>20%</td>
<td>8%</td>
<td>12%</td>
<td>7%</td>
<td>9%</td>
<td>110%</td>
</tr>
<tr>
<td><strong>MNCH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.13 - USAID IR 2.1.2</td>
<td>Number of people trained in child health and nutrition through USG-supported programs</td>
<td>7,507</td>
<td>4,489</td>
<td>1,275</td>
<td>1,493</td>
<td>83</td>
<td>7,340</td>
<td>98%</td>
</tr>
<tr>
<td>2.14 - USAID IR 2.7</td>
<td>Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT)</td>
<td>269,413</td>
<td>8,255</td>
<td>42,515</td>
<td>35,235</td>
<td>26,306</td>
<td>112,311</td>
<td>42%</td>
</tr>
<tr>
<td>2.15 - USAID IR 2.4</td>
<td>Number of children with pneumonia taken to appropriate care</td>
<td>269,413</td>
<td>13,394</td>
<td>68,113</td>
<td>86,180</td>
<td>66,054</td>
<td>233,741</td>
<td>87%</td>
</tr>
<tr>
<td>2.16</td>
<td>Number of children reached by USG-supported nutrition programs (Number of children under 5 years registered with CHW for Growth Monitoring and Promotion (GMP) activities)</td>
<td>2,272,435</td>
<td>29,266</td>
<td>490,092</td>
<td>762,101</td>
<td>765,008</td>
<td>2,146,467</td>
<td>94%</td>
</tr>
<tr>
<td>2.17 - USAID IR 2.6</td>
<td>Number of newborns who received umbilical care through the use of chlorhexidine</td>
<td>[ ]</td>
<td>4,498</td>
<td>3,613</td>
<td>8,111</td>
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<td></td>
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<tr>
<td>2.18</td>
<td>Number ANC clients referred and seeking care at the nearest health provider by CHV</td>
<td>72,447</td>
<td>5,860</td>
<td>16,182</td>
<td>32,240</td>
<td>31,309</td>
<td>85,591</td>
<td>118%</td>
</tr>
<tr>
<td>2.19</td>
<td>Number cases referred and seeking care at the nearest health provider by CHV for severe</td>
<td>98,126</td>
<td>7,714</td>
<td>21,564</td>
<td>44,169</td>
<td>12,953</td>
<td>86,400</td>
<td>89%</td>
</tr>
<tr>
<td>№</td>
<td>Indicator</td>
<td>Life of Project Target</td>
<td>FY 14 Results</td>
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</tr>
<tr>
<td>2.20</td>
<td>Number of CHVs having received refresher training.</td>
<td></td>
<td>2,189</td>
<td>2,328</td>
<td>892</td>
<td>5,409</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.23</td>
<td>Percent of service delivery points (CHVs) that experience a stock-out at any time of ORS/Zinc</td>
<td>15% 49% 11% 11% 4% 4% 173%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.24</td>
<td>Percent of service delivery points (CHVs) that experience a stock-out at any time of Pneumostop©</td>
<td>30% 50% 14% 11% 4% 4% 187%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.21</td>
<td>Number cases referred and seeking care at the nearest health provider by CHW for neonatal emergencies</td>
<td>3,744 833 2,764 3,138 1,230 7,965 213%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.22</td>
<td>Number cases referred and seeking care at the nearest health provider by CHW for obstetric emergencies</td>
<td>4,213 269 5,397 1230 225 7,121 169%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sub-Result 3: Improve the quality of community-level primary health care services**

<p>| 3.1  | Percent of CHVs achieving minimum quality score for community case management of childhood illnesses | 85% 0% 68% 72% 68% 75% 88% |               |               |               |               |                    |                  |
| 3.2  | Percent of CHVs achieving minimum quality score for family planning counselling at the community level | 85% 0% 68% 66% 78% 73% 86% |               |               |               |               |                    |                  |
| 3.3  | Percent of monthly activity reports received timely and complete | 85% 70% 81% 87% 92% 92% 108% |               |               |               |               |                    |                  |
| 3.4  | Number of CHVs supervised at the service delivery sites | 7,893 1,613 3,968 5,636 5,314 6,105 77% |               |               |               |               |                    |                  |
| 3.5  | Mean frequency of activity supervision visits conducted by NGO partners to CHWs | 4 1 3 4 2 2 50% |               |               |               |               |                    |                  |
| 3.6  | Percent of CHVs in project areas attending monthly COSAN meetings out of the total | 80% 71% 75% 89% 103% 103% 129% |               |               |               |               |                    |                  |</p>
<table>
<thead>
<tr>
<th>Nº</th>
<th>Indicator</th>
<th>Life of Project Target</th>
<th>FY 14 Results</th>
<th>FY 15 Results</th>
<th>FY 16 Results</th>
<th>FY17 (Q1-Q3)</th>
<th>TOTAL LOP RESULTS</th>
<th>% TARGET ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of CHVs in the health center catchment area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Number of Communes having the status of Commune Champion</td>
<td>506</td>
<td>-</td>
<td>50</td>
<td>184</td>
<td>73</td>
<td>73</td>
<td>14%</td>
</tr>
<tr>
<td>4.2</td>
<td>Number of certified Household Champions</td>
<td>254,545</td>
<td>-</td>
<td>3,533</td>
<td>40,163</td>
<td>96,408</td>
<td>96,408</td>
<td>38%</td>
</tr>
<tr>
<td>4.3</td>
<td>Number of interactive radio spots broadcast</td>
<td>8,622</td>
<td>1,288</td>
<td>5,813</td>
<td>12,960</td>
<td>2,410</td>
<td>22,471</td>
<td>261%</td>
</tr>
<tr>
<td>4.4</td>
<td>Number of fokontany achieving Open Defecation Free (ODF) status</td>
<td>To Be Determined</td>
<td>-</td>
<td>804</td>
<td>1,893</td>
<td>NA</td>
<td>2,697</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Number of people gaining access to an improved sanitation facility</td>
<td>To Be Determined</td>
<td>8,727</td>
<td>20,823</td>
<td>NA</td>
<td></td>
<td>29,550</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>Number of people (peer youth, youth leader) trained in Adolescent Reproductive Health (ARH) with increased knowledge and skills</td>
<td>4,940</td>
<td>114</td>
<td>1,743</td>
<td>677</td>
<td>0</td>
<td>2,534</td>
<td>51%</td>
</tr>
<tr>
<td>4.7</td>
<td>Number of people reached with education on exclusive breastfeeding</td>
<td>145,496</td>
<td>5,437</td>
<td>73,420</td>
<td>70,065</td>
<td></td>
<td></td>
<td>L</td>
</tr>
</tbody>
</table>

Sub-Result 4: Increase adoption of healthy behaviors and practices
ANNEX VII. MIKOLO PMP INDICATOR DATA

PHC Service by Quarter (FY 2016 Quarters 1-4 & FY 2017 Quarter 2)

Services used in Mikolo Regions
based on RMA data for FY 2016 (Qtrs 1-4) and FY 2017 (Qrt 1)
### Exclusive BF (AME)

<table>
<thead>
<tr>
<th></th>
<th>FY’16 Q1</th>
<th>FY’16 Q2</th>
<th>FY’16 Q3</th>
<th>FY’16 Q4</th>
<th>FY’17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
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<td>750</td>
<td>620</td>
<td>529</td>
<td>1087</td>
<td>1602</td>
</tr>
<tr>
<td>Amoron’i Mania</td>
<td>1121</td>
<td>1105</td>
<td>1172</td>
<td>1104</td>
<td>1333</td>
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<tr>
<td>Analamanga</td>
<td>1933</td>
<td>1556</td>
<td>878</td>
<td>921</td>
<td>1422</td>
</tr>
<tr>
<td>Atsimo Andrefana</td>
<td>2249</td>
<td>2963</td>
<td>2354</td>
<td>2423</td>
<td>3309</td>
</tr>
<tr>
<td>Atsinanana</td>
<td>2583</td>
<td>2215</td>
<td>2129</td>
<td>2632</td>
<td>2486</td>
</tr>
<tr>
<td>Haute Matsiatra</td>
<td>3560</td>
<td>3324</td>
<td>2963</td>
<td>2705</td>
<td>3671</td>
</tr>
<tr>
<td>Vakinankaratra</td>
<td>6190</td>
<td>5056</td>
<td>4242</td>
<td>2552</td>
<td>4275</td>
</tr>
<tr>
<td>Vatovavy Fitovinany</td>
<td>2460</td>
<td>2479</td>
<td>1698</td>
<td>1845</td>
<td>1670</td>
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<tr>
<td><strong>Exclusive BF Total</strong></td>
<td><strong>20846</strong></td>
<td><strong>19318</strong></td>
<td><strong>15965</strong></td>
<td><strong>15269</strong></td>
<td><strong>19768</strong></td>
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</tbody>
</table>
### Malaria Treated by ACT (Paludisme traité par ACT)

<table>
<thead>
<tr>
<th></th>
<th>FY'16 Q1</th>
<th>FY'16 Q2</th>
<th>FY'16 Q3</th>
<th>FY'16 Q4</th>
<th>FY'17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaotra Mangoro</td>
<td>5</td>
<td>27</td>
<td>43</td>
<td>41</td>
<td>367</td>
</tr>
<tr>
<td>Amoron'i Mania</td>
<td>328</td>
<td>230</td>
<td>250</td>
<td>66</td>
<td>182</td>
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<tr>
<td>Analamanga</td>
<td>23</td>
<td>49</td>
<td>66</td>
<td>21</td>
<td>29</td>
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<tr>
<td>Atsimo Andrefana</td>
<td>2927</td>
<td>2793</td>
<td>2694</td>
<td>1984</td>
<td>2917</td>
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<td>Atsinanana</td>
<td>2344</td>
<td>3728</td>
<td>3389</td>
<td>2991</td>
<td>5442</td>
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<tr>
<td>Haute Matsiatra</td>
<td>318</td>
<td>932</td>
<td>595</td>
<td>129</td>
<td>694</td>
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<tr>
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<td>87</td>
<td>206</td>
<td>333</td>
<td>40</td>
<td>52</td>
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<tr>
<td>Vatovavy Fitovinany</td>
<td>4029</td>
<td>6260</td>
<td>5043</td>
<td>3122</td>
<td>6226</td>
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<tr>
<td><strong>Malaria Tx Total</strong></td>
<td><strong>10061</strong></td>
<td><strong>14225</strong></td>
<td><strong>12413</strong></td>
<td><strong>8394</strong></td>
<td><strong>15909</strong></td>
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</table>
### Pneumonia Treatment

<table>
<thead>
<tr>
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<th>FY’16 Q3</th>
<th>FY’16 Q4</th>
<th>FY’17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
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<td>738</td>
<td>870</td>
<td>1022</td>
<td>752</td>
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<td>1490</td>
<td>1999</td>
<td>1192</td>
<td>1590</td>
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<tr>
<td>Analamanga</td>
<td>653</td>
<td>786</td>
<td>1437</td>
<td>555</td>
<td>1353</td>
</tr>
<tr>
<td>Atsimo Andrefana</td>
<td>3215</td>
<td>3280</td>
<td>3856</td>
<td>2217</td>
<td>3074</td>
</tr>
<tr>
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<td>4166</td>
<td>4915</td>
<td>5592</td>
<td>4143</td>
<td>3754</td>
</tr>
<tr>
<td>Haute Matsiatra</td>
<td>2813</td>
<td>4466</td>
<td>5226</td>
<td>3104</td>
<td>3577</td>
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<tr>
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<td>891</td>
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<td>2404</td>
<td>1530</td>
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<tr>
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<td>4741</td>
<td>5114</td>
<td>3673</td>
<td>4321</td>
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<tr>
<td><strong>Pneumonia Tx Total</strong></td>
<td><strong>18468</strong></td>
<td><strong>22059</strong></td>
<td><strong>26650</strong></td>
<td><strong>17166</strong></td>
<td><strong>20988</strong></td>
</tr>
<tr>
<td>ANC (CPN) 1 visit</td>
<td>FY'16 Q1</td>
<td>FY'16 Q2</td>
<td>FY'16 Q3</td>
<td>FY'16 Q4</td>
<td>FY'17 Q2</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Alaotra Mangoro</td>
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<td>207</td>
<td>204</td>
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<td>320</td>
<td>369</td>
<td>332</td>
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<tr>
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<td>145</td>
<td>134</td>
<td>117</td>
<td>185</td>
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<tr>
<td>Atsimo Andrefana</td>
<td>671</td>
<td>857</td>
<td>986</td>
<td>660</td>
<td>848</td>
</tr>
<tr>
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<td>579</td>
<td>612</td>
<td>640</td>
<td>1044</td>
<td>689</td>
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<tr>
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<td>578</td>
<td>741</td>
<td>955</td>
<td>942</td>
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<tr>
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<td>724</td>
<td>668</td>
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<td>561</td>
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<tr>
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<td>781</td>
<td>884</td>
<td>916</td>
<td>1032</td>
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<tr>
<td><strong>ANC-1 Total</strong></td>
<td><strong>3919</strong></td>
<td><strong>4115</strong></td>
<td><strong>4580</strong></td>
<td><strong>4694</strong></td>
<td><strong>4879</strong></td>
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</tbody>
</table>
### ANC (CPN) 4 visits

<table>
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<tr>
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<th>FY'16 Q3</th>
<th>FY'16 Q4</th>
<th>FY'17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaotra Mangoro</td>
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<td>152</td>
<td>145</td>
<td>208</td>
<td>285</td>
</tr>
<tr>
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<td>262</td>
<td>277</td>
<td>312</td>
<td>389</td>
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<tr>
<td>Analamanga</td>
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<td>161</td>
<td>208</td>
<td>142</td>
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<tr>
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<td>670</td>
<td>758</td>
<td>688</td>
<td>826</td>
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<tr>
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<td>397</td>
<td>442</td>
<td>859</td>
<td>671</td>
</tr>
<tr>
<td>Haute Matsiatra</td>
<td>602</td>
<td>543</td>
<td>758</td>
<td>906</td>
<td>1206</td>
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<tr>
<td>Vakinankaratra</td>
<td>607</td>
<td>581</td>
<td>728</td>
<td>450</td>
<td>577</td>
</tr>
<tr>
<td>Vatovavy Fitovinany</td>
<td>691</td>
<td>645</td>
<td>785</td>
<td>767</td>
<td>1037</td>
</tr>
<tr>
<td><strong>ANC-4 Total</strong></td>
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<td><strong>3411</strong></td>
<td><strong>4101</strong></td>
<td><strong>4332</strong></td>
<td><strong>5216</strong></td>
</tr>
</tbody>
</table>
### FP new users

<table>
<thead>
<tr>
<th></th>
<th>FY'16 Q1</th>
<th>FY'16 Q2</th>
<th>FY'16 Q3</th>
<th>FY'16 Q4</th>
<th>FY'17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1374</td>
<td>1200</td>
<td>1567</td>
<td>2985</td>
<td>2508</td>
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<tr>
<td>Amoron'i Mania</td>
<td>4536</td>
<td>1870</td>
<td>1911</td>
<td>2329</td>
<td>2153</td>
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<tr>
<td>Analamanga</td>
<td>1106</td>
<td>1065</td>
<td>1581</td>
<td>1192</td>
<td>1581</td>
</tr>
<tr>
<td>Atsimo Andrefana</td>
<td>2581</td>
<td>2952</td>
<td>3443</td>
<td>3178</td>
<td>2843</td>
</tr>
<tr>
<td>Atsinanana</td>
<td>5212</td>
<td>4871</td>
<td>5152</td>
<td>5986</td>
<td>5439</td>
</tr>
<tr>
<td>Haute Matsiatra</td>
<td>4734</td>
<td>6447</td>
<td>8152</td>
<td>6354</td>
<td>6048</td>
</tr>
<tr>
<td>Vakinankaratra</td>
<td>1304</td>
<td>2650</td>
<td>2086</td>
<td>1734</td>
<td>2077</td>
</tr>
<tr>
<td>Vatovavy Fitovinany</td>
<td>4522</td>
<td>3449</td>
<td>4545</td>
<td>5272</td>
<td>5917</td>
</tr>
<tr>
<td><strong>FP New Users Total</strong></td>
<td><strong>25369</strong></td>
<td><strong>24504</strong></td>
<td><strong>28437</strong></td>
<td><strong>29030</strong></td>
<td><strong>28566</strong></td>
</tr>
</tbody>
</table>
ANNEX VIII. OSC TERMS OF REFERENCE

**OSC** will work closely with ASOS to strengthen the capacity of this local organization to:

- Use advocacy and Behavior Change Communication with an increased focus on adolescent reproductive health and other Project health focus areas.
- Use mass communication (e.g. radio) and other appropriate media such as youth hotlines or traditional approaches.
- Strengthen CHVs’ health messaging, counseling, and sensitization to improve quality and effectiveness.

*mikola Annual Report FY13, p.12.*
ANNEX IX. RECOMMENDATIONS FOR A LOW LITERATE, MORE USER-FRIENDLY LOW LITERACY JOB AID

This Mikolo job aid with Malagasy text (superimposed here with French translations, see Table below) shows Les Advantages des CPN (Advantages of ANC) with interspersed text overpowering the images. Recommended user-friendly formatting for low literate users: Place this composite image on a full page with the text clearly separate from the image at the bottom of the page.

The lower half of the job aid shows, les problèmes causés par le paludisme chez les femmes enceintes [Problems caused by malaria among pregnant women], with text boxes all around an image depicting the outline of a fetus inside a pregnant woman. This scientific image is not familiar to rural women and does not assist the user to recall the problems described in the text. Recommendation: Omit the fetus image. Develop a song accompanied by communication body tools. Prepare a separate job aid (or place on the back of the CPN job aid) with the text of the song and photos or stick drawings of a woman posing for each mnemonic body tool.

Original Mikolo ANC Job Aid

(see table below for French and English translations of Malagasy text)

<table>
<thead>
<tr>
<th>Superimposed French translation from Malagasy</th>
<th>English translation from the French translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>LES CPN AU NIVEAU DES CSB</td>
<td>ANC AT THE HEALTH FACILITY</td>
</tr>
<tr>
<td>LES AVANTAGES DES CPN</td>
<td>THE ADVANTAGES OF ANC</td>
</tr>
<tr>
<td>SUIVI DE LA MERE ET L’ENFANT</td>
<td>1. CARE OF THE MOTHER AND INFANT</td>
</tr>
<tr>
<td>Mesure de poids</td>
<td>Weigh her</td>
</tr>
<tr>
<td>Mesure de ventre</td>
<td>Measure her womb</td>
</tr>
<tr>
<td>Dépistage syphilis</td>
<td>Test for syphilis</td>
</tr>
<tr>
<td>OFFRE DE PROTECTION DE LA SANTE ET RENFORCEMENT DE L’ENERGIE</td>
<td>2. OFFER HEALTH PROTECTION AND ENERGY REINFORCEMENT</td>
</tr>
<tr>
<td>CONSEIL</td>
<td>3. COUNSELING</td>
</tr>
<tr>
<td>CHX</td>
<td>CHX</td>
</tr>
<tr>
<td>Allaitement</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>Nutrition saine</td>
<td>Healthy Nutrition</td>
</tr>
<tr>
<td>Accouchement auprès du CSB</td>
<td>Facility Delivery</td>
</tr>
<tr>
<td>Signes de danger</td>
<td>Danger Signs</td>
</tr>
<tr>
<td>Bulle à droit</td>
<td>Right Bubble</td>
</tr>
<tr>
<td>Faire au moins 4 CPN pendant la période de grossesse</td>
<td>Attend at least 4 ANCs during pregnancy</td>
</tr>
<tr>
<td>Bulle à gauche</td>
<td>Left Bubble</td>
</tr>
<tr>
<td>Accoucher seulement auprès des CSB</td>
<td>Give birth only at the Health Facility</td>
</tr>
<tr>
<td>LES PROBLEMES CAUSES PAR LE PALUDISME POUR LES FEMMES ENCEINTES</td>
<td>PROBLEMS CAUSED BY MALARIA FOR PREGNANT WOMEN</td>
</tr>
<tr>
<td>Étiquettes à gauche</td>
<td>Labels on the Left</td>
</tr>
<tr>
<td>Insuffisance du poids du nouveau ne</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Fausse couche</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>Palu très intense</td>
<td>Severe malaria</td>
</tr>
<tr>
<td>Étiquettes və droit</td>
<td>Labels on the Right</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Naissance prématurée</td>
<td>Premature birth</td>
</tr>
<tr>
<td>Perte de sang pendant l’accouchement</td>
<td>Loss of blood during delivery</td>
</tr>
<tr>
<td>Insuffisance de lait liée à l’insuffisance de sang</td>
<td>Insufficient milk linked to insufficient blood</td>
</tr>
</tbody>
</table>

---

**LES CPN AU NIVEAU DES CSB**

**LES AVANTAGES DES CPN**

1. **SUIVI DE LA SANTÉ DE LA MÈRE ET DE L’ENFANT**
   - Mesure de poids
   - Mesure de ventre
   - Dépistage syphilis

2. **OFFRE DE PROTECTION DE LA SANTÉ ET RENFORCEMENT DE L’ÉNERGIE**

3. **CONSEIL**
   - CHX
   - Allaitement
   - Nutrition saine
   - Accouchement auprès du CSB
   - Signe de danger

---

**LES PROBLÈMES CAUSÉS PAR LE PALUDISME POUR LES FEMMES ENCEINTES**

- Insuffisance de poids du Nouveau-né
- Perte de sang pendant l’accouchement
- Insuffisance de lait liée à l’insuffisance de sang
- Fausse couche
- Palu très intense
- Nausée prénatale
## ANNEX X. LOW LEVELS OF LATRINE USE PER FOKONTANY

Based on the Estimated Percent of All Households Certified as Household Champions Per Fokontany

<table>
<thead>
<tr>
<th>Cumulative Number of Champion Households FY2017 Quarter 3 Report</th>
<th>Number of Mikolo FKT</th>
<th>Average Number of Champion Households per FKT</th>
<th>Percentage of Champion Households per FKT assuming 200 or 300 households per FKT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Number of Champion Households FY2017 Quarter 3 Report</td>
<td>Number of Mikolo FKT</td>
<td>Average Number of Champion Households per FKT</td>
<td>Percentage of Champion Households per FKT assuming 200 or 300 households per FKT</td>
</tr>
<tr>
<td>$a$</td>
<td>$b$</td>
<td>$c = a/b$</td>
<td>200</td>
</tr>
<tr>
<td>96,408</td>
<td>3,577</td>
<td>27</td>
<td>13%</td>
</tr>
</tbody>
</table>
ANNEX XI. REFERENCES

USAID https://www.usaid.gov/madagascar/back-on-the-path-to-democracy

USAID Mikolo Official Project Documents


USAID Technical Briefs prepared by the USAID Mikolo Project

Assuring the Quality of Community-Based Health Services in Madagascar – A New Approach, prepared by the USAID Mikolo Project, March 2017.
Community Volunteers Provide Essential Primary Health Care Services for Madagascar’s Poorest, prepared by the USAID Mikolo Project, March 2017.
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The USAID Mikolo Project. Recherche Formative – Détermination des Obstacles à l’Adoption des Comportements Sains, The USAID Mikolo Project, Madagascar, Mai 2014
----- Feuille de Sensibilisation Association des Femmes Mikolo
----- Takelaka Ampela Mikolo / AMI (Notebook Designed for Women), July 2015.
----- Torolanana Ho An’ny Vehivavy Mpitarika, Fikambanana Ami/Ampela Mikolo (Guide pour les Femmes Leadeurs des Associations des Femmes Mikolo), June 2015.

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-----. Politique Nationale de Santé Communautaire (National Community Health Policy), 2009

Other Bibliographic Sources


ANNEX XII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or 'need to access" Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
   (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure
   by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii)
   is required to be disclosed by law, court order, or other legal process.

ACCEPANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature: ___________________________ Date: 5/15/2017

Name: ANH THU T. HOANG Title: M&E Consultant
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature: ___________________________ Date: May 12, 2017

ANJAMANAMANAMPISOA Jean Clement Local Evaluator

Name: ___________________________ Title: ___________________________

Page 114 of 131
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature: [signature]
Date: [May 16, 2017]

Name: Susan Brockway
Title: ARADEON Social Behavior Change Communication Consultant
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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Signature

Date 06/16/2017

Name RANDRIARISIA PIERRE HARIANA FILI

Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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Signature

Date 17 Mai 2017

Name MAHAZOMORA Julio
Title Mr.
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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[Signature]
[Date]

Name: [Name]
Title: [Title]
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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<td>Joel RAVELSON</td>
<td>Doctor Community Health Specialist</td>
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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature Date

Name Title
ARMAND L. UTSHUDI CONSULTANT

Page 114 of 131
ANNEX XIII. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

Anh Thu Hoang, Team Leader, has extensive experience in M&E, planning & management, communication, capacity building, and community development. She has worked in Haiti, Vietnam, Africa (DRC, Southern Sudan, Ethiopia, Zambia, Gabon) and has broad experience in Madagascar.

Jean Clement Andriamanampisoa, Local Evaluator, has extensive experience in training, communications, and qualitative research.

Susan Aradeon, Social Behavior Change Communication Specialist, served as resident Behavior Change Communication Adviser for Maternal Newborn Child Health, including HIV/AIDS, in Nigeria and Benin during her 20+ years with UKaid, USAID, UNFPA, IPPF and Planned Parenthood Federation of Nigeria. She has carried out field work in most West African and Pacific countries and in South Sudan and Lesotho.

Julio Mahazomora, Local Evaluator, has broad experience in evaluations, impact studies, and data collection.

Sheryl Martin, Community Health Specialist, has worked extensively in Haiti and throughout Africa (including DRC, Guinea, Rwanda, Nigeria, Ethiopia, Chad) on health- and nutrition-related projects, including health information systems and health system strengthening activities. She has a Master’s in Public Health from the Université libre de Bruxelles.

Eliane Ralison, Local Evaluator, has extensive experience in evaluations, designing and analyzing data collection, and rural agriculture in Madagascar.

Armand Utshudi, Health System Strengthening Specialist, has more than 20 years of experience in planning, management and support of USAID- and Global Fund-financed programs in developing countries (including sub-Saharan Africa and Latin America). He served as Team Leader for planning and carrying out USAID-financed midterm and endline evaluations of Child Survival Health Grants programs in DRC, Ethiopia, Mozambique, Niger, Haiti, and Uganda.
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