Improving health through the social quality approach in 800 communes in Madagascar

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ACRONYMS AND GLOSSARY

APPROPOP/MSH	*Appui aux programmes des populations*-Support for Population Programs/ Management Sciences For Health
CARE	Cooperative and Assistance for Relief Everywhere
CHDC	Communal Health Development Commission
CHV	Community Health Volunteer
COPE	Client-Oriented, Provider-Efficient Services
CRS	Catholic Relief Services
CSB	*Centre de Santé de Base*- Primary Health Care Center
CSC	Community Score Card
CSP	Community Supply Point
DHS	Demographic and Health Surveys
DRV	*Dinika sy Rindran'ny Vehivavy* (a member NGO of the consortium that is responsible for the project's gender promotion efforts)
Fokontany	Administrative denomination of village level in Madagascar
GTZ	*Gesellschaftfür Technische Zusammenarbeit*/ German Agency for Technical Cooperation
INSTAT	*Institut National de la Statistique de Madagascar*/ National Institute of Statistics of Madagascar
KM	*Kaominina Mendrika* or Champion Commune
KM Salama	*Kaominina Mendrika Salama* or Champion Commune for Health
MBB	Marginal Budgeting Bottlenecks
MSI-M	Marie Stopes International - Madagascar
MSIS	Multi-Sector Information Service
PAQ	*Partenariat pour l'Amélioration de la Qualité*- Partnership for Quality Improvement
PSI	Population Services International
SAGE	*Service d'Appui à la Gestion de l'Environnement*
ST	Support Technician
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

Madagascar, an island nation of nearly 22 million people, is one of the poorest countries in the world. The Malagasy population struggles with childhood disease, high maternal mortality and chronic malnutrition which are all exacerbated by the lack of access to clean water and to quality health services. To help empower the Malagasy people to address their own health needs, the USAID/Santenet2 program introduced the social quality approach in 800 communes in Madagascar. The social quality approach is a community-based approach for encouraging service recipients to get involved in the availability, use, and quality of health services. This report, based on Santenet2 project data, correlation analysis, and qualitative data collection, illustrates the implementation process, successes and essential components to the successful implementation of the social quality approach.

The social quality approach is implemented in Madagascar through the Communal Health Development Commissions (CHDC) in each of the 800 communes working in partnership with the community, the community health volunteers (CHVs), and the health center. The social quality approach as implemented in Madagascar has been successful in attaining all four of its key objectives. First, the social quality approach improved local capacity to identify and understand the needs of the community through community meetings held in the *fokontany* by members of the CHDC. Secondly, it improved local capacity to implement local solutions to the identified needs through the development and joint implementation of workplans with one key success being the construction or rehabilitation of 3,552 health huts for CHVs. Third, the approach was able to improve both the perceived and actual quality of community-based health services offered through support to the CHVs, the health supply logistics systems, and other activities. Finally, the social quality approach, through the work of the CHDC, helped increase the use of health services by improving the quality, but also through community mobilization and, in some cases, the establishment of emergency evacuation systems.

In addition to these results, the social quality approach also succeeded in promoting gender equality. In addition to improving women’s expression of their needs and their involvement in decision-making processes, the social quality approach has fostered constructive male engagement in family health.

Essential components that contributed to the successful implementation of the social quality approach in Madagascar are explained in this report. These essential components include the integration of the social quality approach into previously existing structures, the unification of community actors, the promotion of gender equality, the CHDC’s motivation and their own understanding of their assigned role, the ownership and engagement of the social quality approach by local authorities, and the effectiveness of the support and mentoring to the local NGOs and their support technicians (STs).

The social quality approach was designed and implemented in Madagascar to be sustainable since it worked with previously existing structures, it complied with the sociocultural environment, it empowered the CHDC to lead the process, and it mobilized local resources. Despite this, the report presents recommendations for improvements to the social quality approach, further promotion of sustainability of the approach, and recommendations for expansion of the approach.

The end goal of the social quality approach is a healthy Malagasy population. Through the sustainability and the expansion of this approach, this goal can be met. While still in the early phases of implementation, the social quality approach has convinced communities that poor health is not inevitable. Through local governance and community ownership, the social quality approach has created communities that are both expressing and resolving their own health needs and improving the quality of services provided to them.

I. BACKGROUND

A. Health in Madagascar

Madagascar, an island nation of nearly 22 million people, is one of the poorest countries in the world. In 2010, the proportion of Malagasy people living below the poverty line of $1 per day reached 76.5 percent (INSTAT, 2010). Prior to the most recent political crisis, Madagascar was making progress in child health, with under-five mortality dropping from 92/1000 to 72/1000 between 2003-2004 and 2008-2009 (DHS). The percentage of fully immunized children doubled, and infant mortality decreased from 59/1000 to 48/1000. During the same period, modern contraception use increased from 18 to 29 percent (DHS, 2008/9). Despite these successes, maternal mortality and nutrition indicators have remained stagnant. Maternal mortality is 498/100,000, well above the MDG target of 149/100,000. Half of children under five years of age are stunted, indicating chronic malnourishment in this group (DHS, 2008/9). In addition, more than 60 percent of the population does not have access to safe drinking water (DHS, 2008/9).

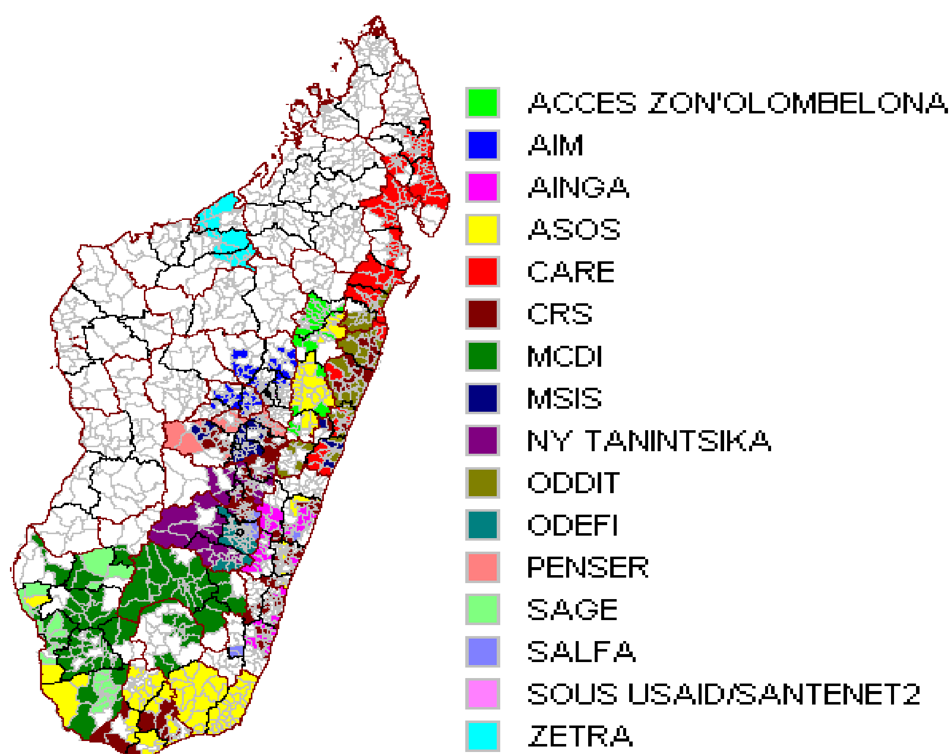
Access to quality health services is a major challenge in Madagascar, where over 80 percent of the population lives in difficult to reach rural locations (World Bank, 2010). The rural population has less information and knowledge about health-seeking behaviors, and they have less access to health services since 54 percent of the rural population lives more than 5 km (or 1 hour's walk) from the nearest primary healthcare center. Due to limited access, the rural population tends to be less informed regarding life-saving behaviors. It also has a higher percentage of early and undesired pregnancies, lower modern contraceptive use, higher malnutrition, fewer parents who seek treatment when children show symptoms of illness, and a lower rate of immunization coverage. As a consequence, the total fertility rate, child mortality rate, maternal mortality rate, and malnutrition rates are higher among the rural population than their urban counterparts (DHS, 2008/2009).

B. Description of the USAID/Santénet2 Project

Santénet2, known locally as *KM Salama*, comprises the fourth phase of a United States Agency for International Development (USAID)-funded community health project. Since 2008, Santénet2 has been implementing integrated community health activities in 800 of 1,566 communes, covering 16 of 22 regions and 72 of 111 districts (see Figure 1).

Santénet2 contributes to the achievement of the USAID Strategic Objective 5 (SO 5): "Increased use of specific health services and products and improvement of practices."

Figure 1: 800 KMs supported by 16 nongovernmental organizations



The Santénet2 conceptual framework has three building blocks: (1) developing and strengthening key community health system components; (2) empowering community participation and accountability in setting and achieving community health goals; and (3) linking the two for at-scale impact to reduce maternal, child, and infant mortality; fertility rate; chronic malnutrition in children under the age of 5; and prevalence of malaria (particularly among children under 5 and pregnant women), as well as to expand access to water, sanitation, and hygiene (WASH) and maintain a low HIV prevalence rate.

To improve the accessibility of outreach health care services, Santénet2 trained over 11,000 CHVs in *fokontany* that are located 5 km or more from the nearest health facility. As a member of the project's consortium, IntraHealth International implemented the training and supervision strategy targeting the CHVs to help them deliver quality integrated maternal and child health services.

Santénet2 worked in partnership with:

- **16** partner NGOs
- **16** regions and **70** districts (pop. **11** million)
- **5,758** *fokontany* located 5 km or more from the nearest primary healthcare center (CSB)
- **800** CHDCs
- **11,413** CHVs
- The leaders of the 800 KMs (Champion Communes), 10 per commune on average
- **1,100** religious leaders
- **1,051** youth leaders
- **400** independent trainers and supervisors
- UNICEF, WHO, World Bank, MSI-M, PSI

Not only did IntraHealth ensure the technical quality of the services being delivered, it also developed an approach aimed at establishing a partnership between the providers and the service beneficiaries to ensure services meet the needs expressed by the population. Since the level of quality delivered by the providers often differs from the quality perceived by the community, several quality improvement processes have been implemented in Madagascar.[1] Through IntraHealth International, the Santénet2 project used the social quality approach to provide a simple vision to quality improvement that was easily accessible to rural populations and ensured its suitability to Madagascar's sociocultural context. Thus, the social quality approach was integrated into the *KM Salama* process.

II. SOCIAL QUALITY

The Santénet2 social quality approach is a community involvement strategy aimed at ensuring the local governance of health services through a democratic and accountable process. It was designed to build skills within the community to enable members of the community to participate in health needs assessments and the development of solutions. This approach was based primarily on IntraHealth's PAQ (*Partenariat pour l'Amélioration de la Qualité*) Approach but was adapted to the local context. It was also inspired by the best practices implemented by Santénet2 as part of the *KM Salama* approach and the World Bank's experience with the community score card (CSC) in 20 communes within the Anosy region. The gender dimension was also integrated into this approach along with these key social accountability principles.

A. Goals and objectives

The end goal of the social quality approach is to ensure that the Malagasy population becomes active beneficiaries of health services so that these services remain available and accessible while meeting their needs. The involvement of community stakeholders in the improvement of health service quality and in the promotion of behavior change should have a positive impact on the health outcomes of each commune. The social quality approach is designed to accomplish two primary goals:

1. Communities in Madagascar are able to express and meet their own health needs.
2. Health services respond to the needs expressed by the community.

The Santénet2 project objectives for the social quality approach are as follows:

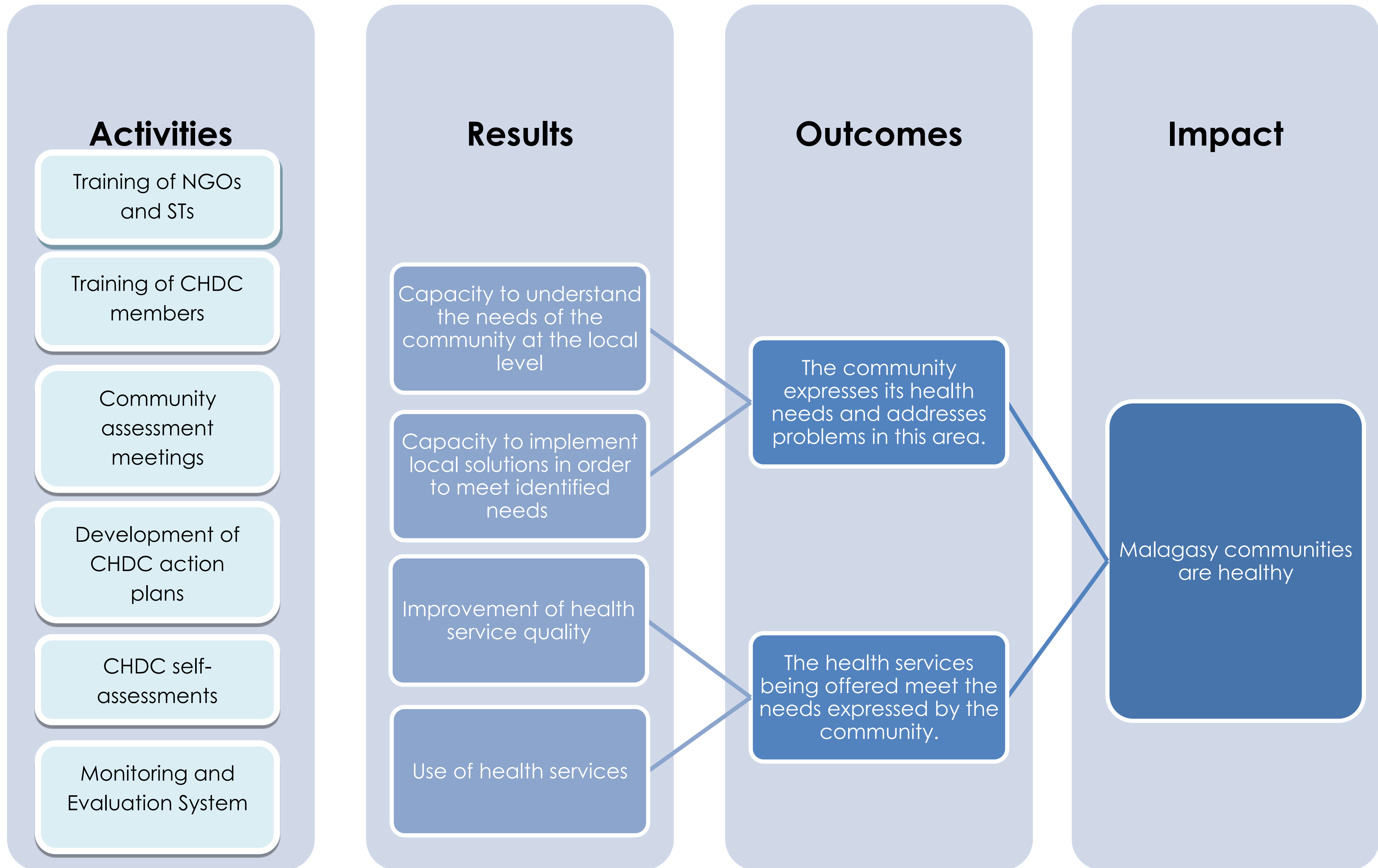
[1] 1992: Client-Oriented, Provider-Efficient (COPE) services supported by the Support for Population Programs/ Management Sciences for Health (APPROPOP/MSH) Project and aimed at improving emergency obstetrical care and family planning services
2005: Marginal Budgeting Bottlenecks (MBB) approach supported by UNICEF and aimed at improving vaccination services
2005: Quality assurance system supported by Santénet2 and implemented in hospitals and primary healthcare centers
2007: Quality competition supported by German Agency for Technical Cooperation GTZ) and implemented in hospitals
2007 and 2008: Community Score Card supported by the World Bank and implemented in primary healthcare centers

1. Improve local capacity to identify and understand the needs of the community
2. Improve local capacity to implement local solutions to the identified needs
3. Improve the quality of the community-based health services being offered
4. Increase the use of quality health services

B. Conceptual Framework

The conceptual framework below illustrates how the social quality interventions implemented through the Santénet2 project were designed to reach the above objectives, and over time, improve community accountability for their health and improve the quality of services offered in their communities.

Figure 2: Social Quality Conceptual Framework



C. Implementation

1. Stakeholders

The main stakeholders involved in the implementation of the *KM Salama* approach as well as their roles in the social quality approach are described below:

- Partner NGOs, through ST and their supervisors, work as facilitators and provide organizational support and leadership.
- The CHDC represents the community, identifies the challenges to address as part of the needs assessment analysis, coordinates the implementation of the social quality approach within the KM Salama approach, mobilizes the community to carry out and monitor the selected activities, addresses the issues encountered during the implementation process and supports the community health volunteers in their duties.
- The technical supervisors2 are members of the CHDC who ensure the technical supervision of the community health volunteers.
- The groups of local facilitators are designated by the CHDC members and ensure the proper implementation of activities at the KM level, delivery of reports, and promote gender equality (two quality facilitators and one gender facilitator in each KM).
- The community supply point (CSP) is identified by the CHDC members and ensures the procurement of social marketing products for the community health volunteers.
- The CHVs raise awareness among the community, ensure the distribution of health products and the management of clients at the community level, refer complicated cases to health centers, and help health facilities actively search for clients who are lost to follow-up.
- The community takes part in all health-related activities, evaluates the quality of health service delivery, expresses its health needs and implements timely actions at the local level.

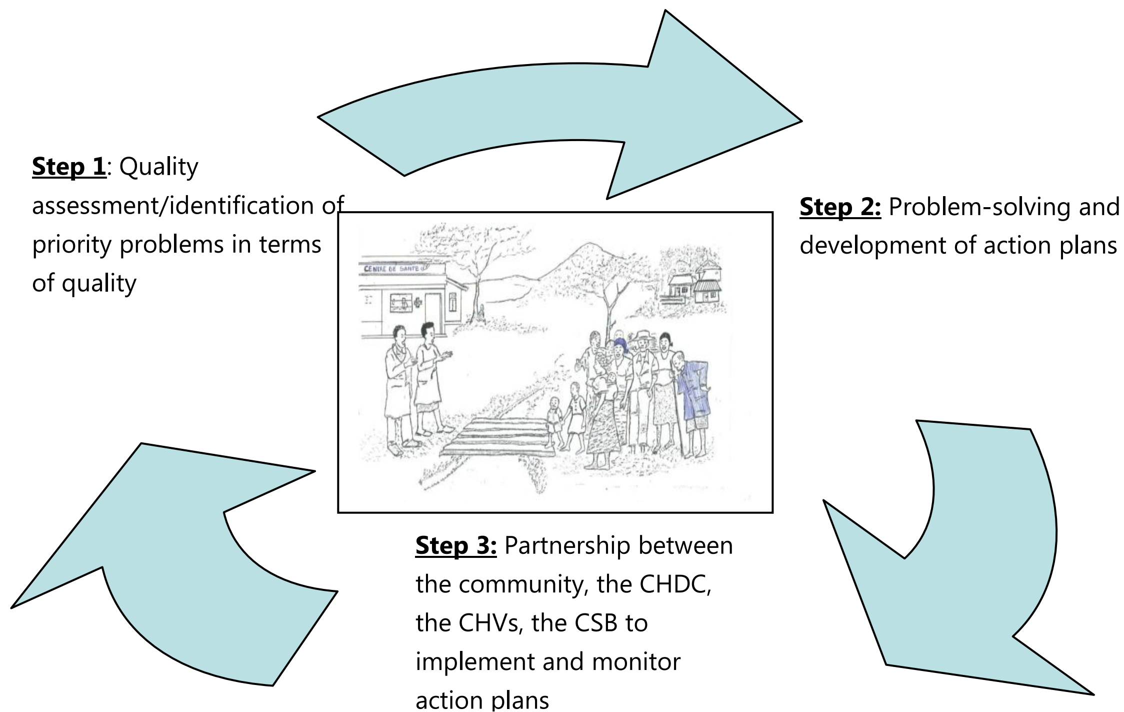
2. Implementation process

USAID/Santénet2 trained and supported 48 NGO supervisors and 156 support technicians. The STs in turn trained 9,562 CHDC members in the 800 targeted communes in order to hold community evaluation meetings as well as self-assessments among CHDC members, and develop simple, relevant and achievable action plans.

The social quality approach is implemented in three stages through a continuous cycle:

[2] The technical supervisors are providers from primary health care centers (CSB).

Figure 3: Steps toward quality improvement



Step 1: Service quality assessment and identification of priority issues related to the quality of health services through community evaluation meetings

The community evaluation meetings are held in each *fokontany* and are facilitated by the head of the *fokontany* (administrative denomination of village level in Madagascar), a leader or the group of facilitators from the CHDC. In other words, the meeting facilitators are local leaders who are neither politicians nor health providers.

The community evaluation meetings proceed as follows:

- The facilitator informs the community of the meeting's objective which is to identify the health needs of the population. The facilitator then informs the participants of their rights in terms of health accessibility, dignity, confidentiality, safety, continuity of care, as well as their right to be informed regarding the services that are available at various levels of the healthcare system.

- The participants then confidentially evaluate their level of satisfaction with available health services and the acceptance of responsibility by men and women in health-related matters.
- This assessment is then followed by a participatory discussion during which various needs and recommendations are discussed.
- The outcomes of the meetings are then reported to the CHDC and will be debated during the CHDC review session.

Step 2: Problem-solving and development of action plans promoting CHDC accountability through self-assessments

The outcomes from the community evaluation meetings are reported to the CHDC in order to identify solutions. Since the members of the CHDC represent the community, they carry out self-assessments to hold themselves accountable to their community. The CHDC self-assessment aims to evaluate the level of satisfaction of CHDC members regarding their own responsibilities, reminding them of their role, and improving decision-making processes. This self-assessment takes place prior to the development of a new community action plan.

Following the self-assessment, the CHDC members identify areas for improvement and discuss the needs expressed by the community in order to implement solutions. Action plans are then drafted in order to determine the timeframe and the individuals in charge of each activity, as well as the resources that need to be allocated.

Two to three self-assessments were carried out each year in the 800 KMs. The CHDC in each commune developed action plans at least every six months.

Step 3: Partnership with the community, the CHDC, the CHVs and the CSB in order to implement and monitor the action plans

The CHDC members share their action plans with the community, mobilize the various stakeholders in order to implement the activities, and monitor the implementation process while addressing potential issues. The NGO support technicians monitor the implementation of activities on a monthly basis and support the CHDC, as needed, to solve problems.

3. Monitoring and evaluation system

User-friendly management tools were developed locally to monitor the various activities and their results:

- The reports of the community evaluation meetings include the name of the *fokontany*, the number of participants (men and women) who are satisfied with the quality of services provided by the CHVs and the CSB, as well as the participants' satisfaction with their level of responsibility in health-related matters, the needs/problems expressed and the recommended solutions.

- The CHDC self-assessment reports include information on the number of satisfied and dissatisfied participants regarding their roles and responsibilities and the functions needing to be strengthened.
- The community action plans include the activities that need to be implemented, as well as expected results, responsible individuals and timeframes.
- The implementation reports compare actual achievements to the expected outcomes included in the action plans.
- The reports developed by the local facilitators are certified by the local authorities and shared with the STs before being submitted to Santénet2.

Throughout the implementation process, the impact of the approach was assessed with a tool called the "quality index". This tool was used to measure the performance of community-based healthcare services by assessing the availability of CHVs in remote *fokontany*, CHVs' skills, available resources, community involvement, and healthcare service use. The quality index was used twice a year in all 800 communes to monitor the various activities.

III. METHODOLOGY

In order to assess the efficiency, the relevance, and the results of the social quality approach as presented in this report, three types of analysis were conducted: quantitative analysis, correlation analysis and qualitative analysis.

A. Quantitative Analysis

All quantitative data in this report were taken from the various databases of regular programmatic data collection. Programmatic indicators were chosen and pulled from the following sources:

- Community assessment reports (See Appendix A)
- CHDC self-assessment reports (See Appendix B)
- CHV monthly activity reports (on Extranet)
- ST reports
- Quality index (See Appendix C)

The data was processed and analyzed in Excel before being audited by the program manager.

B. Correlation Analysis

In addition to presenting regular programmatic data, correlation analysis was conducted with the use of scatter diagrams. A scatter diagram is a graphical technique used to analyze the relationship between two variables. They show whether or not there is correlation between two variables. Correlation refers to the measure of the relationship between two sets of numbers or variables. Two sets of data are plotted on a graph, with the y-axis being used for the variable to be predicted and the x-axis being used for the variable to make the prediction.

In order to better understand the results of the social quality approach, the level of community engagement (based on results from the quality index) and participation in community meetings were plotted on the x-axis with anticipated results on the y-axis. To better understand factors that contribute to the success of the social quality approach, the potential determining factors were plotted on the x-axis with the level of community engagement plotted on the y-axis. In most cases, the scatter diagrams use 800 points as data from all 800 communes are available. However, since not all communes have reported on community meetings, scatter diagrams using the participation of women in the community meetings only have data for 689 of the 800 communes.

There are limitations to this type of analysis. First, the visible slope of the line does not necessarily provide information about the strength of correlation. Second, a direct or strong correlation does not necessarily imply a cause-and-effect relationship, it simply shows a correlation. It is possible that both plotted variables are strongly correlated to a third causal variable. These limitations are considered in the analysis and discussion of the scatter diagrams.

C. Qualitative Data Collection

In order to both verify and better understand some of the correlations pulled from the scatter diagrams and to better understand the determining factors for the successful implementation of the social quality approach, site visits were conducted in four communes. Two communes were chosen from two different regions, one commune designated as successful and another designated as only moderately successful. This designation was based on the level of community engagement (from the quality index), the commune performance score (from the quality index), and the percent of the population of the communes participating in the community meetings. In the region of Haute Matsiatra, the two communes visited were Kirano Firarintsoa and Fiadanana. In the region of Vatovavy Fitovinany, the communes Vatohandrina and Ambohimiarina were visited.

Seven questionnaires (See Appendix D) were elaborated for the following seven targets: the CHDC, the deputy mayor, the head of the CSB, the CHVs, the community supply point, the ST, and the NGO ST supervisor. The CHDC and CHV questionnaires were administered as part of focus group discussions. Interviews with the deputy mayor, the head of the CSB, the CSP and the ST supervisor were conducted. The ST questionnaire was given as a written questionnaire. All questionnaires were written in French, but translated to and administered in Malagasy.

IV. RESULTS

A. The community expresses its health needs and addresses problems

The social quality approach fostered equitable relationships at the local level and helped the community have a better understanding of health service quality, its own health needs, and ways to address them so that community members became active beneficiaries.

1. Local capacity to understand community needs

Nearly one million people took part in the community evaluation meetings, including over 500,000 women. The social quality approach has been successful at increasing the local capacity to understand community needs, including the needs of women. A total of 790 KMs conducted meetings at the *fokontany* level and the average coverage rate of *fokontany* in with meetings held reached 85%. Female participation in these meetings was high, ranging from 44% to 88%.

Social quality has allowed for the needs of the community to be heard. 1,250 people participated in the community assessment meetings compared to only 72 people per commune during the application of the CSC.

The quantitative results from the community evaluation meetings informed the CHDC of the community's level of satisfaction regarding the services provided by the CHVs and the CSBs. The level of satisfaction in both CHV and CSB services are presented in the table below.

Table 1: Community's satisfaction with health services provided in the 800 KMs

Services provided by the CHVs			Services provided by the CSBs		
Case Management	**Medicines**	**Environment**	**Case Management**	**Medicines**	**Environment**
60%	**44%**	**37%**	**56%**	**59%**	**56%**

Source: Reports of community assessment meetings (April 2012 to September 2012)

The participation of clients in these meetings is representative of their need to express themselves and to be listened to. "For the first time in my life, I have been consulted so that people would know if I am satisfied with health care services and what my actual needs are," a 60 year-old woman said in KM Antotohazo, Ankazobe District (Source: NGO report).

The CHDC members were aware of the importance of these meetings since they would help identify community needs. During the focus groups, the CHDC (especially the head of the fokontany) shared their satisfaction with the process. In addition to the community-level problems raised by the community, the meetings helped raise specific issues at the CHDC, commune and CSB levels. The problems that were raised during the meetings included staff absences at the CSB, the need to perform nutritional demonstrations rather than just giving advice, the need to consult with a

midwife at the CSB level rather than with a male physician, and problems related to stockouts for products used by the CHVs.

The CHDC members also insisted on their ability to represent the community. The women were chosen in the community as members of the CHDC "because of their ability to represent women and children at the fokontany level," some female CHDC members from Kirano Firariantsoa said.

The CHDC members also tried to understand the needs expressed by the youth, including in the area of adolescent reproductive health. A total of 1,052 youth leaders participated in the CHDC review sessions. In addition to fostering a better understanding of the community's needs and level of satisfaction, the social quality approach also encouraged the CHDC members to periodically assess their own capacity to understand the community. As a result, 14,546 CHDC members (including 2,245 women) conducted self-assessments in 800 KMs. As indicated in the table below, the CHDC members consider themselves efficient when it comes to supporting community evaluation meetings. However, they need to improve the way the information is transferred back to the community.

Table 2: CHDC self-assessment results regarding their capacity to understand the community in the 800 KMs

Level of satisfaction with information sharing with the community	Level of satisfaction with the support provided to community assessment meetings	General level of satisfaction
59%	71%	65%

Source: CHDC self-assessment reports, April 2012 to September 2012

The CHVs were also satisfied with the community evaluation meetings. "These meetings help us improve the way we deliver services by having a better understanding of the community's needs," a CHV in Vatohandrina said. Another CHV in Ambohimiarina also explained that the community evaluation meetings provide relevant information on their own strengths and weaknesses. The CHVs would also like to get feedback from the CHDC or the head of their fokontany regarding their performance.

Although some providers at the CSB level are weary of the community assessment meetings, most are supportive. Quality improvement activities at the CSB level have shown that there is a real partnership between these primary healthcare centers and the community.

Likewise, the NGOs considered the approach to be relevant. "The meetings gave us the opportunity to evaluate the services provided by the CHVs and to identify problems at the CSB level," an ST in the Haute Matsiatra region said. "Needs are discussed and then integrated into the action plans," said another ST in the Vatovavy Fitovinany region. An NGO supervisor also revealed that the community meetings allowed community members to express needs that they would have kept secret in the past.

2. Capacity to implement local solutions in order to meet pre-identified needs

The social quality approach helps the community meet its health-related needs by using local capacity. Once the community's needs were identified during the evaluation meetings, the CHDC members developed and implemented action plans in order to meet these needs in the 800 KM. A total of 780 KMs (98%) carried out activities in order to improve the quality of services provided by the CHVs, while 741 KMs (93%) conducted quality improvement activities at the CSB level.

These quality improvement activities yielded the following results for CHVs:

- Assignment of regular service hours
- Continuous mentoring of CHVs by technical supervisors
- Organization of income-generating activities in order to strengthen the availability of health products
- Creation of a system to monitor the procurement of health products
- Creation of an emergency referral system from the *fokontany* to the health centers (6,388 *fokontany* in all 800 KMs have a referral system.)
- Construction/rehabilitation of 3,552 health huts
- Implementation of incentives aimed at motivating the CHVs (official recognition, use of fields for crops, t-shirts, payment of transportation fees, increased involvement of CHVs in the CSB's outreach activities).

The quality improvement activities yielded the following results at the CSB level:

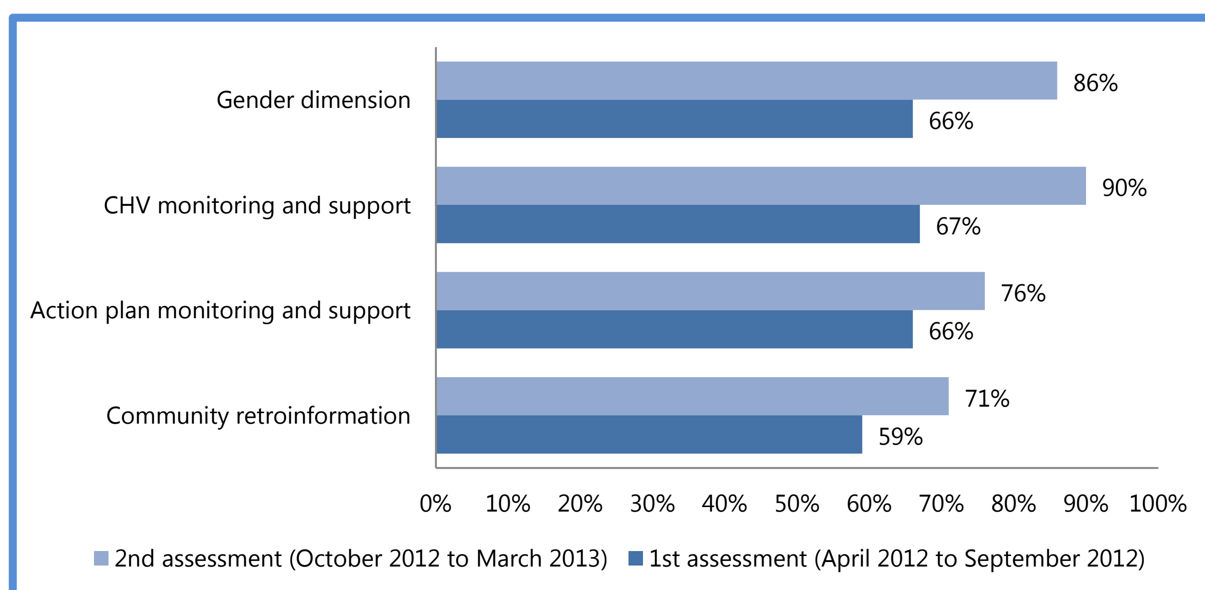
- Assignment of regular service hours
- Development of a plan aimed at informing the community of staff absences
- Increased availability of health products: improved transportation for the purchase of medicine, payment of the salary of the procurement pharmacy manager at the commune level
- Public display of medicine prices
- Construction, rehabilitation and maintenance of the facilities: room for the families, kitchen, waiting room, roof, painting, well, pond, electrical wiring, waste disposal, restrooms, gardens, fence, periodical waste management procedures, etc.

During the focus group sessions, the CHDC explained how they used the action plans to respond to the needs of the community. The CHDC team in Vatohandrina was satisfied with the action plans as they defined both deadlines and the people responsible for each action item. These plans were also easy to use. In Ambohimiarina, the action plan included a dance in each fokontany to raise money for building a health hut for their CHVs. Four of the seven dances had been organized and the health huts were put in place.

The issue of product availability for the CHVs was discussed in all the communes during the site visits. In Ambohimiarina, the CHDC acknowledged that it was part of their role and the CSP expressed her satisfaction with their support. « I am satisfied with the work accomplished by the CHDC members. Early on, the CHDC raised money in order to purchase key commodities. Then, I had the opportunity to work with the CHDC members in order to purchase health products in collaboration with PSI. I was also able to express my needs to the CHDC members so that they could support me on a continuing basis, » she said. In Kirano Firariantsoa, the CHDC had contributed funds for the purchase of stock for the CHVs. Unfortunately, in Vatohandrina, there was a stockout problem primarily due to the CSP. The CHDC had advocated for changes, but felt the problem was really between the mayor and the CSP and thus was somewhat out of their control. They had however tried to address the problem by ensuring the CHVs had supplies from other sources. The CHV continued to work with supplies either from the CSB or from InterAide, a French NGO working in the area.

The satisfaction of the CHDC members in terms of their ability to respond to the community's needs progressively increased as shown in the figure below. This graph shows how the level of satisfaction evolved by comparing the results from the first self-assessment with the second one.

Figure 4: CHDC satisfaction level in terms of their ability to respond to the community's needs in the 800 KMs



Source: Self-assessment reports from the CHDC, April 2012 to March 2013

The graph shows the CHDC's increased satisfaction regarding the promotion of gender equality. Indeed, the social quality approach helped the CHDC members and the community to empower women and men in health-related decision-making processes. At this time, 2/3 of women are accompanied by their husband when they visit the CSB, and nearly half of husbands actively participate in the purchase of food for their children. In addition, over 90% of men are consulted regarding the adoption of an FP method." (Source: Evaluation report on the integration of gender promotion at the KM level, DRV 2013.)

"Before the approach, men were reluctant to use family planning. Now, they are the ones that encourage women to use it." (CHDC, Vatohandrina).

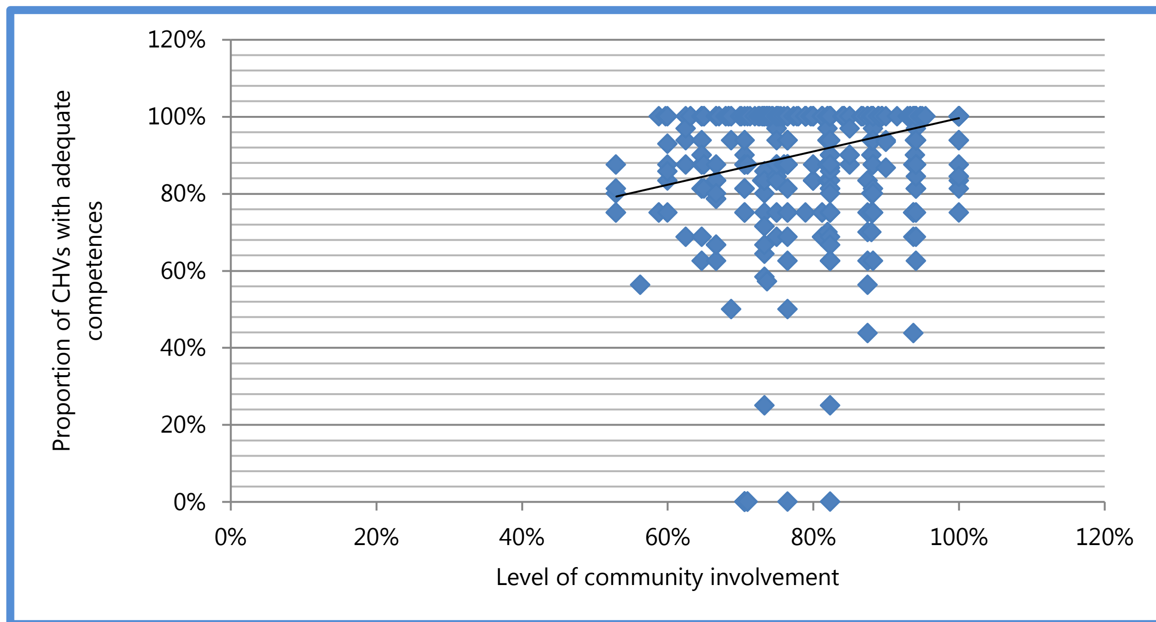
B. Health services offered respond to the needs of the community

The community is more likely to be satisfied with health services when these services are improved based on the community's perception of their quality. The social quality approach contributed to service quality improvement and the increased use of community-based health services.

1. Improvement of health service quality

The more involved the community is, the more competent the community health volunteers become. The CHVs interviewed during the focus group discussions shared their appreciation for the support they received from the CHDC (recognition, solutions to logistics problems). The correlation analysis shows a positive correlation between the level of community involvement in health services and the level of skills displayed by CHVs. The graph below shows that the communes with higher community involvement rates (based on the quality index) seem to have high-performing and more skilled CHVs (based on CHV supervision reports.

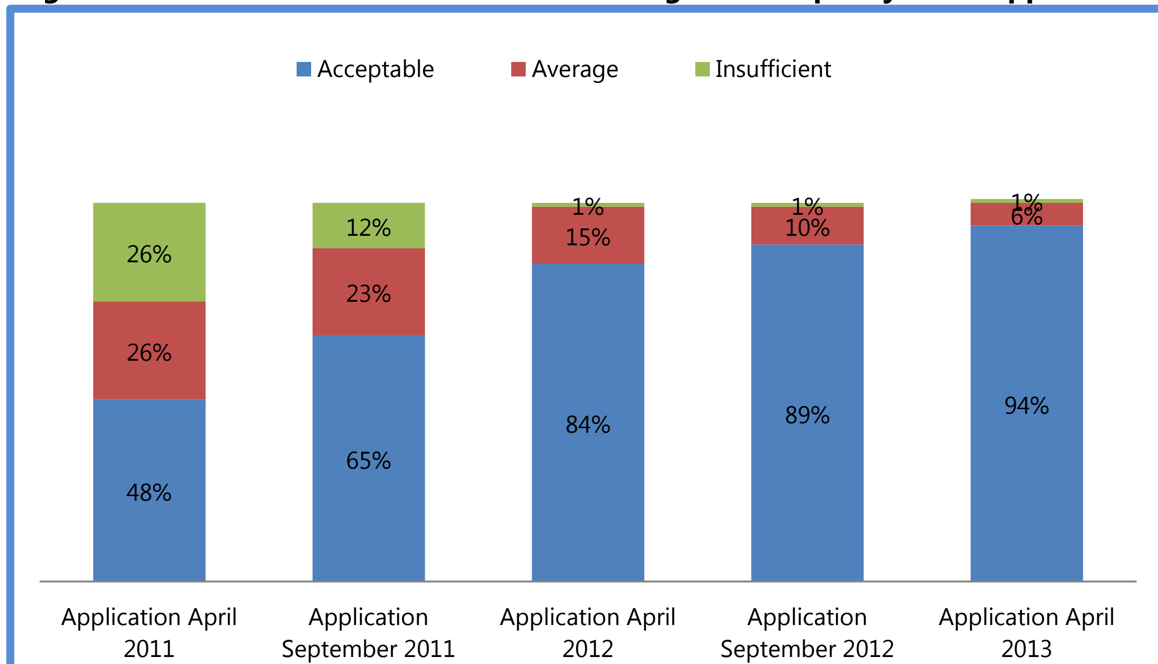
Figure 5: Relationship between community involvement and CHV skills



Source: Quality Index 2012 and CHV supervision reports, 2012

Likewise, the results from the last five applications of the quality index in the 800 targeted KMs also show how community-based health services were improved over time, as shown below.

Figure 6: Evolution in the 800 communes during the five quality index applications

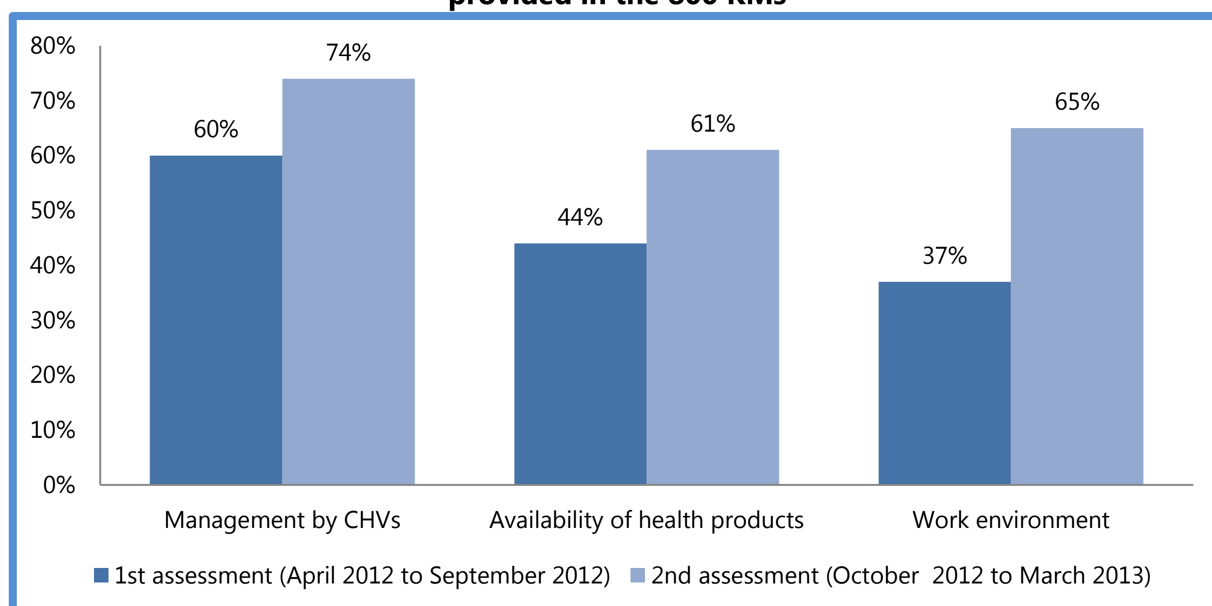


Source: Results from the implementation of the quality index, 2011-2013 fiscal year

As health service quality improved, the community became more satisfied. For services provided by the CHVs, the level of community satisfaction had a relative increase of 24% for patient

management, 39% for medicines and 76% regarding the work environment between the first and second community assessment meetings.

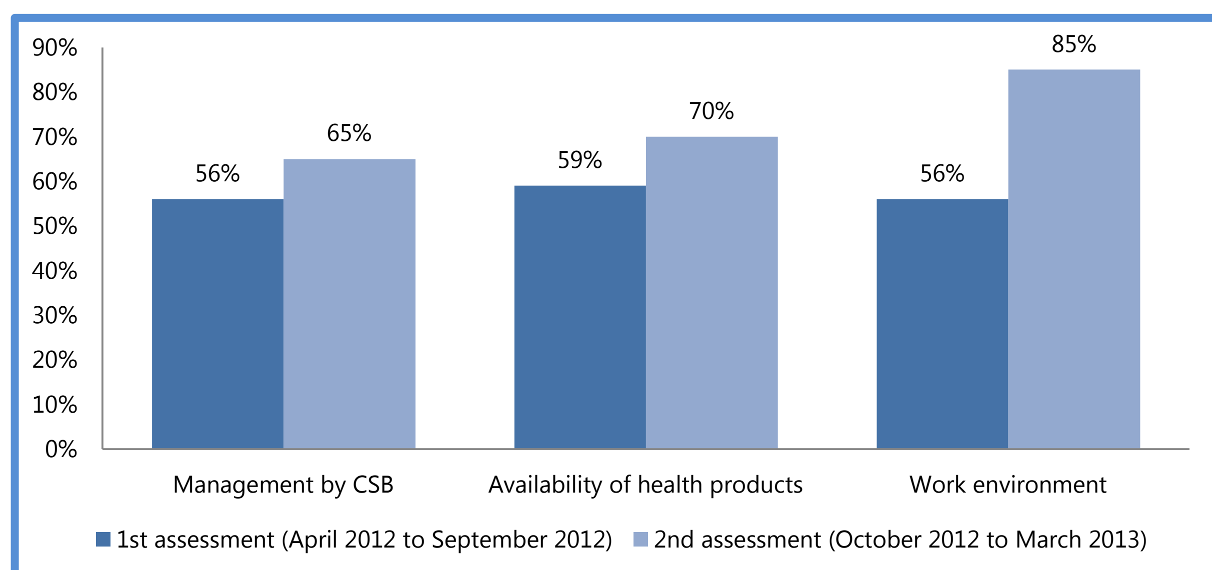
Figure 7: Evolution of community satisfaction regarding CHV services provided in the 800 KMs



Source: Community assessment reports, April 2012 to March 2013

At the CSB level, community satisfaction between the first and second meetings regarding patient management had a relative increase of 16%, with a relative increase of 19% for medicines and 52% for the work environment.

Figure 8: Evolution of community satisfaction regarding services provided by the CSB in the 800 KMs



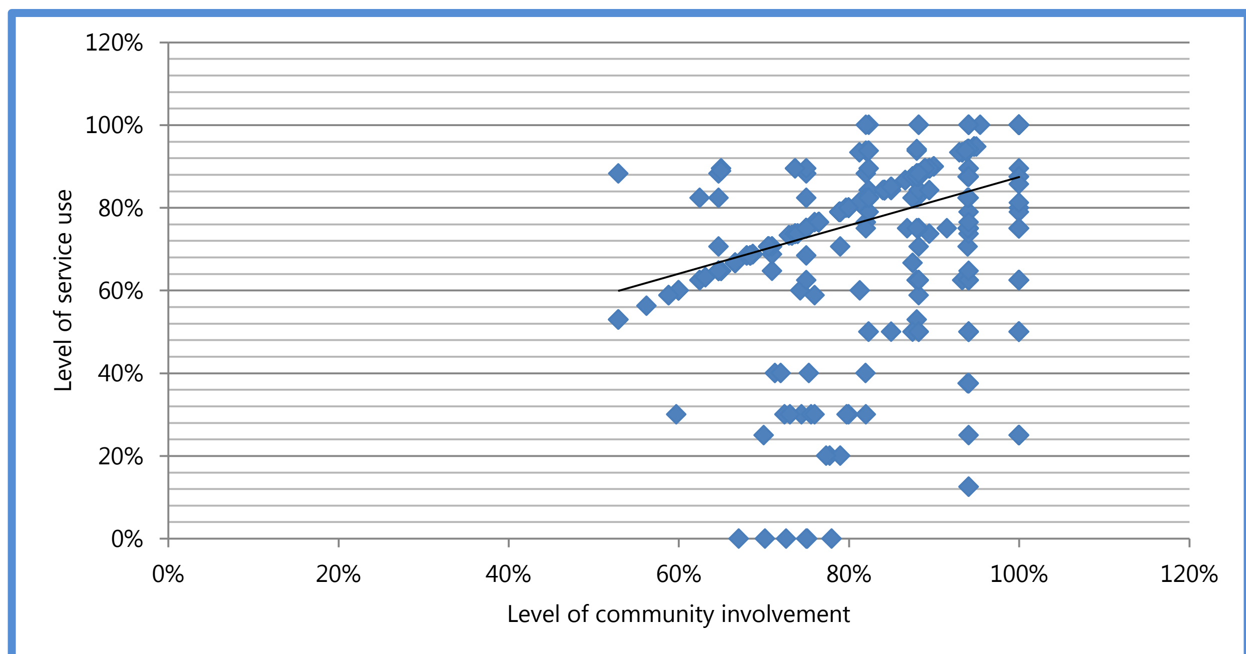
Source: Community evaluation reports, April 2012 to March 2013

The quality of care provided by the CHVs led to a significant change within the community. "We used to take our children to traditional healers. But we were not satisfied with the results. We observed many sudden deaths for no reason. The current results are tangible: The children who are managed by the CHVs have all been healed," some CHDC members from the Vatohandrina commune said.

2. Use of community-based health services

Not only did the social quality approach improve the quality of health services, it also increased their accessibility and their use. As the community got more involved in the way health services were organized, the more people used them. According to the correlation analysis below, there seems to be a relatively strong correlation between the level of community involvement and the use of health services in the commune (based on data from the quality index). While there are outliers on the graph, the majority of communes fall close to the line which illustrates a positive correlation between the two indicators.

Figure 9: Relationship between community involvement and the use of health services



Source: Quality Index, 2012

During focus group discussions, all the CHDC mentioned their role in mobilizing the community to use services. This included formal introductions of CHVs to their communities to ensure awareness of the services they provide, as well as education of the community about the use of family planning, vaccinations, and delivery at health centers.

In order to improve the management of pregnant women, the CHVs were trained to promote the use of iron/folic acid by patients (as part of the national anemia prevention program); refer women to health centers for antenatal consultations (at least four consultations); screen and refer in case of pregnancy complications; and refer pregnant women to the CSB to ensure their delivery would be attended by a qualified provider. The following table shows that between 2011 and 2012 the number of pregnant women being referred for an antenatal consultation had a relative increase of 25%, compared with an 11% increase in the number of women screened and referred for pregnancy complications and a 15% increase for deliveries referred to health centers. Unfortunately, the number of pregnant women receiving iron/folic acid decreased due to a stockout of this product at the country level.

Table 3: Evolution of CHV service use by pregnant women in the 800 KMs

Number of women using specific services	January to December 2011	January to December 2012	Relative increase
Iron/folic acid	14,890	11,888	-20%
Prenatal consultations referred	23,308	29,085	25%
Danger signs referred	673	746	11%
Deliveries referred	9,034	10,387	15%

Source: Monthly activity reports, CHV, Extranet, January 2011 to December 2012

In the domain of family planning, the use of services provided by CHVs increased by 31%. As part of the focus group discussions, most CHDC members emphasized their support for FP. A CHDC member in Vatohandrina even said that he was proud of the changes that occurred in the way family planning services are used and of the significant advances that were made in terms of birth spacing.

Likewise, the use of CHV services for child survival also increased. In the 800 KMs, there was a 38% relative increase in case management targeting children under five suffering from respiratory infections and a 58% increase in malaria case management. As highlighted above, the population no longer consults traditional healers. When a child gets sick, the parents contact the CHVs.

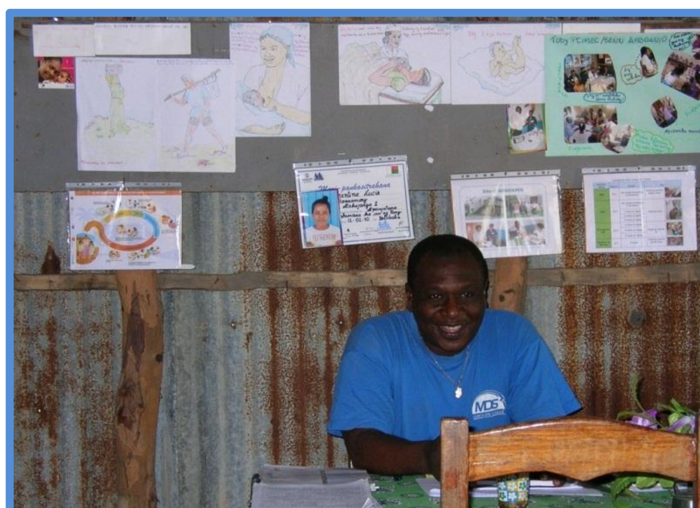
Table 4: Evolution of CHV service use for child survival in the 800 KMs

Number of children under five using specific services	January to December 2011	January to December 2012	Relative increase
Respiratory infections	26,975	37,339	38%
Malaria	64,151	101,569	58%

Source: Monthly activity reports, CHV/Extranet, January 2011 to December 2012

Another important intervention for service use that is supported by the CHDC and the social quality approach is the installation of an emergency evacuation system. The CHDC set up evacuation systems as part of the social quality approach. The community defined the mode of transportation, the distribution of tasks for ensuring evacuation, and, in some cases, created a solidarity fund. Both the CHDC in Kirano Firariantsoa and the CHDC in Ambohimiarina mentioned their role in setting up evacuation systems. In Kirano Firariantsoa, the CHDC talked about their distribution of tasks for ensuring evacuation and their construction of stretchers. In Ambohimiarina, the CHDC mentioned construction of chairs that could be used for evacuation as well as canoes in some of the less accessible *fokontany*. Formalized in all 8000 communes, the emergency evacuation system allowed for the referral of 7,812 individuals, including 3,471 pregnant women, 1,272 newborns and 3,069 others. (Source: Review reports, Fiscal Year 2013, January-April 2013).

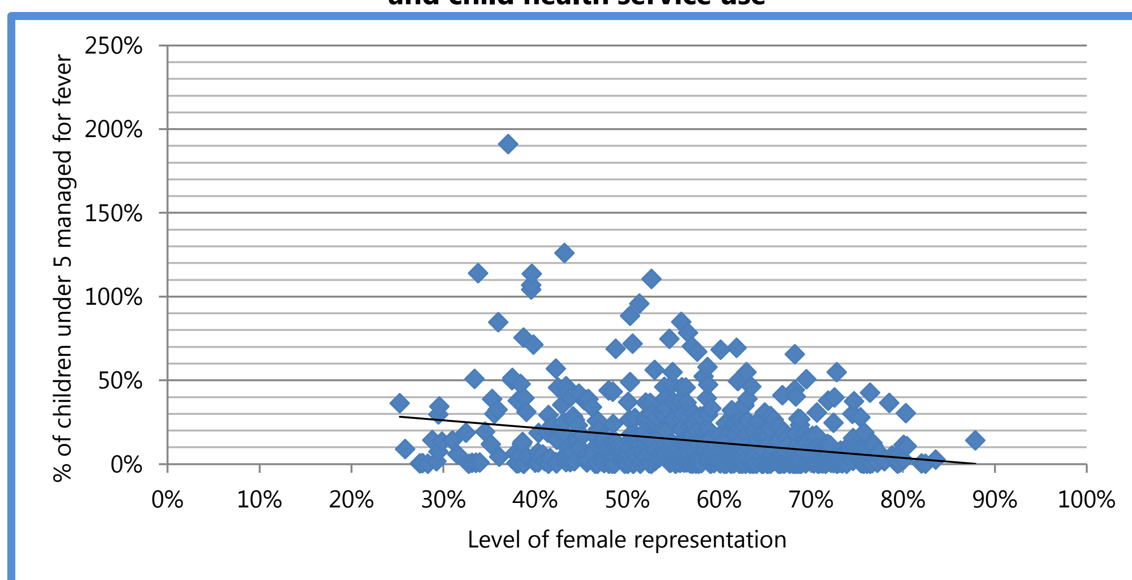
CHVs believe community meetings increase the use of health services. One CHV stated that it promoted continuity of services because clients were happy to be asked about their satisfaction (CHV mother, Kirano). Another CHV stated that the community meetings increase people's trust in their services (CHV mother, Vatohandrina). Correlation analysis reinforced the fact that there was a correlation between the percentage of the population participating in community meetings and the level of health service use.



However, correlation analysis also showed the importance of having male participation in the meetings. The scatter graph below shows the relationship between the participation of women in these meetings and the use of child health services (based on the quality index). There is a clear curve that implies that if female participation is low, service use is low as well. However, if women's participation is extremely high, service use is also low. The curve in this scatter graph seems to imply that community participation needs to include both men and women and that egalitarian

participation (between 40 and 60% women) encourages the best use of health services, particularly for the use of child health services. For the most part, focus group discussions supported this theory because most believe that the decision to seek care is a mutual decision. "Men and women are now discussing health issues, and they are making health decisions together" (CHDC, Vatohandrina). While a small number of people stated that women make the decision to take a child to a CHV, they agreed she would definitely need her husband's permission to go to the CSB if referred.

Figure 10: Relationship between the level of female representation in community meetings and child health service use



Source: Quality Index, 2012

V. ESSENTIAL COMPONENTS FOR SUCCESS

Based on the quantitative project data and the qualitative data collected during site visits, several essential factors were identified as critical to the successful implementation of the social quality approach.

A. Integration of the approach to existing structures

The use of existing structures (CHDC, community meetings and social structures) was a key factor for success in introducing the approach. The approach was integrated into the community's representation framework through the CHDC. The leaders of the fokontany and the various local authorities and members of the civil society were represented in the CHDC which was already the official structure identified as part of Madagascar's national community health policy. Not only did the approach strengthen the relationship between the community and the CHDC by reporting the community's needs to the CHDC members, it also reinforced the accountability of CHDC members toward the community via self-assessments.

Likewise, the social quality approach was based on local capacity. The community evaluation meetings as well as the CHDC self-assessments were conducted by local facilitators. The support technicians who attended the self-assessment meetings during the CHDC review sessions did not attend the community evaluation meetings. No financial incentives were given as part of the community evaluation meetings. In addition, the quality improvement facilitators and the gender facilitators are volunteers who have been designated by the community.

B. Unification of community actors

When the deputy mayor of Kirano Firariantsoa was asked what factors contributed to the success of the approach, he mentioned the partnership between the CHDC and the CHVs and said: "The participation of all stakeholders from the commune like a police force for enforcing activities made this approach a success."

The social quality approach succeeded in unifying community actors to work together. "This approach unifies the community and improves the health environment," a support technician said in Vatohandrina. This unification of actors is reflected in the fact that all actors interviewed pointed out similar successes and the same challenges. The CHDC in Ambohimiarina considered the improved health of the community to be a result of a "trio" of actors – the head of the CSB, the CHVs, and the CHDC. Each actor has a specified role, but they have to work together to engage the community.

C. Promotion of gender equality

The social equality approach is based on the participation of community actors and a representative sample of the community as a whole is expected to participate in the CHDC. The average CHDC is made up of about 20% women but that does vary with some having much more active participation of women and others having very limited participation of women. While not all CHDC have appropriate representation of women, most have ensured that women are represented and given a voice.

One of the roles of the CHDC is to promote men and women taking equal responsibility for the health of their families. They do this by example and by community education. During the last application of the CHDC auto-evaluations, 86% of CHDC members were satisfied with their engagement in promoting equality.

The facilitators of the community meetings encourage the participation of both men and women in the community in order to ensure that all community voices are heard. During focus group discussions, a CHDC member in Fiadanana

stated that “men and women make joint decisions” when their child is sick.

This is not just the case for child health but also for family planning. “Men used to be reluctant to use family planning services. Now, they are the ones encouraging women to use it” (CHDC Vatohandrina). In addition, a member of the CHDC in Kirano Firariantsoa said that the social quality approach had promoted gender equality because family planning is more accepted and with family planning use, women are more available for meetings and other social activities.

D. CHDC motivation

The motivation of the CHDC varied from site to site but was directly correlated with the amount of work and/or advocacy the CHDC reported performing to understand the needs of the community, respond to the needs of the community, and improve the quality of services provided by the CHVs and the CSB. When asked about his/her motivation to participate in the CHDC, a member from Vatohandrina said: “It is our social duty to improve health for everyone. Sustainable development is impossible if the population is not healthy. A country can only thrive if the population is healthy. That’s why we bought into the social quality approach.” This attitude was reflected in their activities including holding community meetings, assisting the CHVs, attempting to intervene in the logistics management issues between the mayor and the CSP, and community mobilization.

Likewise, where CHDC are more active in one aspect of their role, it seems to be based on the motivation behind participating in the social quality approach. The CHDC in Ambohimiarina stated their motivation as the following: “It is difficult for the community to access the CSB, and it can take several hours of transportation to access health services. We now have the opportunity to access outreach health services. Therefore, how could we not be motivated?” Thus, their primary activities revolved around supporting the CHVs in their role, particularly building health huts, working with the CHVs to mobilize the community and having review meetings with the CHVs to support them. An example that is pervasive throughout the communes is that many CHDC have begun to organize review meetings on their own. While the project encouraged quarterly review meetings to review the progress of the action plans and support the CHVs and share feedback from the community, many CHDC started holding monthly review meetings on their own.

E. CHDC understanding of role

Like CHDC motivation, the understanding each CHDC has of their role and the limitations of their role has an impact on the activities they choose to do and the methods they use to address problems in their communities. As mentioned above, the Ambohimiarina CHDC focus their activities on the CHVs. While this seems to be their main motivation, it also reflects how they responded to the question regarding how they saw their role. Based on how engaged they are in supporting the CHVs in their commune, this is not a problem per se, but it did mean that they were less likely to engage in improvements at the health center level since they did not see this as their primary role. This was the case for the CHDC in Fiadanana as well. The CHDC in Fiadanana considered their primary role to be community mobilization for utilization of health services and addressing water and hygiene issues in the community. Thus, they had successfully helped communities build latrines and water pumps, but according to the health center manager, the CHDC rarely communicated with him and had never provided feedback to him on the services provided in the health center.

All CHDC seem to see limitations to their role and/or limitations to the level of authority they have. In theory, the CHDC should supervise the CSP and should have the authority to address problems with the CSP if they occur. Unfortunately, this was not the case. While it was clear that the CSP in Vatohandrina was unable to do his job, the CHDC did not feel like they could do anything to have him replaced. They had talked to the mayor and advocated for a different CSP, but to no avail. Thus, rather than replace the CSP or request that PSI replace the CSP, they began working with another NGO for the provision of CHV supplies. This was the case for Fiadanana as well. The CSP had stopped doing his job, so the CHVs went to the health center to resupply.

F. Ownership by local authorities

Based on the results of the site visits, it is clear that local authorities need to be engaged in the process for the approach to succeed. While the CHDC in Vatohandrina was extremely motivated and active, they had limited power to create change at the commune level. The biggest issues were that the CSB had been closed for almost a year and the CSP was no longer engaged in procuring supplies. The deputy mayor had died and the mayor was not engaged in the social quality approach, so the CHDC work was focused on helping the CHV find alternative sources for stock and other fokontany level interventions.

Likewise, while the majority of the CHDC in Fiadanana did not seem exceptionally motivated to do anything other than address water and hygiene issues, the deputy mayor was both very motivated and had a strong understanding of the social quality approach. The head of the CSB in Fiadanana is also extremely motivated because he believes "community health is a key factor in sustainable development. It is part of my duty to work closely with the CHVs and the commune authorities. I coordinate all CHV activities and carry out monitoring and supervision visits." The combination of the motivation and ownership of the deputy mayor and the motivation and dedication of the head of the CSB resulted in a truly successful commune with high indicators for both community engagement and improved health outcomes.

G. Efficiency of the supervision strategy for STs and NGOs

The last key factor for the success of the social quality approach was the efficiency of the supervision strategy. The NGOs in charge of supervising the support technicians had their skills strengthened through training sessions, implementation guidelines, coordination meetings, and regular communication. This strategy played a key role in the motivation and capacity of the support technicians.

The NGOs then transferred their competences to the local stakeholders through training sessions, facilitation tools and periodical monitoring sessions. The support technicians worked as facilitators so that the various stakeholders could get organized. The motivation and competences of the support technicians led local actors to become more involved.

Of the four STs who were interviewed during site visits, all four seemed motivated to participate in the social quality approach. One related his motivation to the fact that "this approach unifies the community and improves the health environment as a whole" (ST, Vatohandrina). Another stated that the approach "showed how involved the community was in the improvement of health services" (ST, Ambohimairina).

Based on the site visits, ST knowledge and competency to transfer that knowledge is clearly an important factor in the success of the social quality approach. One issue mentioned above is that the Ambohimiarina CHDC defined their role as supporting the CHV activities. This seemed to come mostly from the ST as she tended to focus her responses regarding the results of the social quality approach on the support provided to the CHVs. Most CHDC said their main support was the ST and all expressed appreciation for the trainings they had received from the ST.

One competency issue that came out during the site visits was the STs' ability to negotiate with local authorities. If the ST felt that the mayor or the deputy mayor or the head of the CSB was either the cause of the problem or blocking a solution to a problem, they felt the matter was out of their hands. One issue in Kirano Firariantso was that the head of the CSB was almost never at post, including during the site visit. Neither the ST nor the CHDC felt they had the ability to address the problem.

VI. SUSTAINABILITY OF THE APPROACH

The social quality approach was designed to be sustainable since it empowers the community to take the lead in ensuring their health needs are met and the services in their community are of the quality they desire. While the ST from the NGO has supported the approach through training and supervision of the CHDC, the decisions are being made and the work is being done locally – both at the commune level and the fokontany level.

During the site visits, all community actors were asked about sustainability of their work – both the implementation of the social quality approach through the CHDC and the provision of community health services by the CHV. Without question, all actors, including the CHV themselves, believed the

CHV will continue to provide services and continue to work with the CHDC and the CSB as long as the supply chain for CHV products is maintained. The quality improvement activities will continue to be implemented because the community itself is requesting quality services.

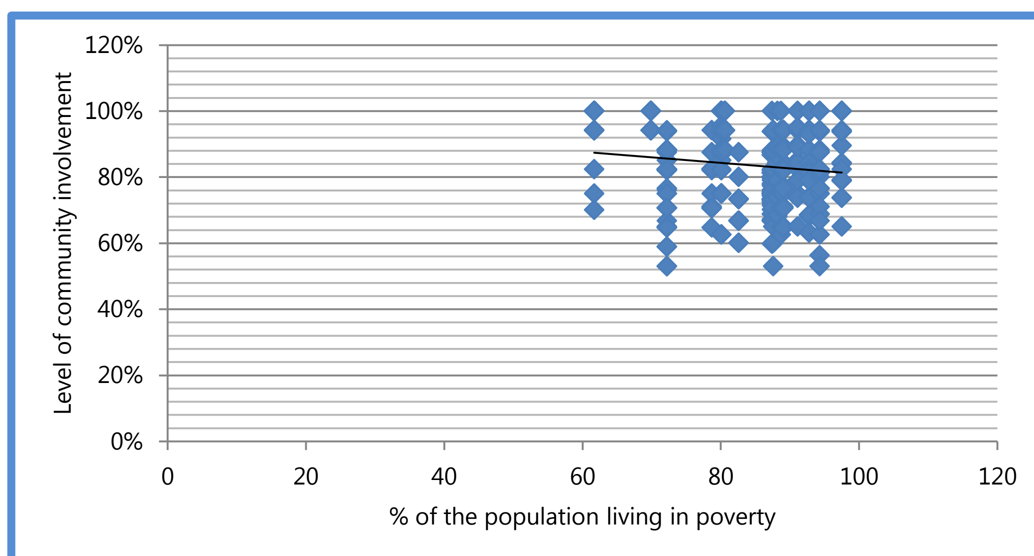
For the most part, the CHDC and local authorities believe the social quality approach will continue through the CHDC. The CHDC assured us they would continue the work because they were motivated and they had action plans to guide them. The deputy mayor from Ambohiamara believed sustainability would not be an issue because they (the CHDC) had been trained and understood the steps to take to continue. As a CHDC member from Kirano Firariantsoa stated: "How could we stop now? We used the approach and observed significant improvements in health service delivery. The approach is now in the hands of the community. We want this approach to keep benefitting the population." They believed all community health work would continue because they would "always try to ensure the availability of health products" and they would "continue strengthening the link between the CHVs, the CHDC and the community."

The social quality approach can be sustained because:

- It supported and linked existing structures at the institutional level.
- It was adapted to the sociocultural context and used the community as a lever for social change.
- It had the CHDC lead the quality improvement process on various technical aspects.
- It succeeded in mobilizing local resources (human, material, financial and time resources).

The scatter graph below compares the level of community involvement with the percentage of the population living in poverty. The fact that there is no real correlation illustrates that no matter what the level of poverty is, the community can overcome this obstacle and take responsibility for its own health.

Figure 11: Relationship between poverty level and the level of community involvement



Source: Quality Index, 2012 and INSTAT, Periodic household survey, 2010

Despite the factors encouraging sustainability, the political instability and the upcoming elections could hinder the sustainability of the approach. In fact, the members of CHDCs could be replaced by these elections. However, according to the deputy mayor in Kirano Firariantsoa, the elections would not prevent the activities from being implemented since the community is already committed to the approach and would hold the CHDC and the newly elected representatives accountable.

VII. RECOMMENDATIONS

1. Based on the success of the social quality approach and the need for local community support to CHVs, the social quality approach should be expanded to all communes where there are active CHVs.

2. Ensure the CHDC has annual refresher training on their role and methods for advocacy to local government authorities.

3. Consider methods for sharing information and experiences between different CHDC. A competition amongst CHDCs to be a regional "Champion CHDC" could be a useful way to motivate the CHDC.

4. Following elections, the CHDC will have to receive training and/or refresher training. Advocacy and an orientation to the social quality approach should be done with all newly elected officials.

5. The CHDC needs representation of women from rural areas. A minimum of 20% of the members of each CHDC should be women.

6. The CHDC or the head of the *fokontany* should try to hold community meetings at a time when both men and women are available to participate and equal participation should be

encouraged. When the community is called, the CHDC should ask attendees to come with their spouses.

7. CHVs and the community should receive an orientation on the role of the CHDC. This will help the community hold the CHDC accountable and ensure a stronger partnership between the CHDC, the CHVs, and the community.

8. PSI should provide the CSP with phones for ordering supplies by SMS and for improving communication between the CSP and PSI to avoid stockouts and facilitate delivery.

9. In order to support and motivate the STs, NGOs should continue to hold regular collaborative information sharing meetings so STs can share successes and get ideas to address specific challenges from fellow STs.

10. STs should also be trained in advocacy and negotiation techniques to better address local authorities.

VIII. CONCLUSION

"Poor health is not inevitable." The communities in the 800 targeted communes of Madagascar proved it. The community can be more than just a simple observer and take responsibility for its own health. It can improve health services by assessing its own needs and by being involved at the local level.

Local health governance should be based on trust in order to strengthen the relationship between the people and the local and technical leaders. Involving beneficiaries of health services and encouraging health providers and decision makers to be attentive to the community's needs has helped Malagasy communities increase the availability and use of quality health services. Any community health system or development project that is not aware of the feedback from its end users cannot succeed in the long run.

IntraHealth International, through Santénet2, shared a simple vision so that the social quality approach would become easily accessible to the rural community while being adapted to the local context. The social quality approach was designed based on existing structures and local capacity. It paid close attention to the community's needs, empowered women, and fostered constructive male involvement in family health and social accountability. The implementation of the approach was based on a simple idea: the problems faced by a population can only be solved if that population can express its needs and be involved in the design of the solution.

The social quality approach yielded tangible and promising results. It helped the community better assess its own needs and to address them by leveraging local capacity. This in turn helped improve the overall quality of health services provided to the community. The community appreciated the approach and its outcomes. For all these reasons, the social quality approach should be advocated for at the policy level and scaled up throughout Madagascar.

IX. APPENDICES

Appendix A: Community assessment report template (in French)
Appendix B: CHDC self-assessment report template (in French)
Appendix C: Quality Index (in French)
Appendix D: Social Quality site visit questionnaires (in French)