The Champion Communes Approach

Improving communities' capacity to manage health activities

Background

Access to health care for rural populations in developing countries is limited. In Madagascar, over 35 percent of the population lives more than 10 km away from a health facility. Additionally, less than 32 percent of the population has access to outpatient health services at health facilities. The closure of many *Centres de Santé de Base* (CSB) between 2008 and 2012 further exacerbated this situation[1]. In rural areas, it is often the role of local leaders, including community health volunteers (CHVs), to provide basic health services.

MAHEFA Context

MAHEFA builds the capacity of this important cadre to carry out program activities and meet community health needs for services including but not limited to antenatal care (ANC), newborn and child health, nutrition, family planning, and water sanitation and hygiene (WASH). In 2009, the Ministry of Public Health (MOH) developed the National Community Health Policy. The policy stated that interventions including CHVs had the greatest potential for improving access of health services to populations in the most isolated parts of the country.

Since the mid- 1990's, the *Kaominina Mendrika Salama* (KMS) approach has been a tool to address a variety of public health challenges. The approach encourages community members to create goals for improved community health, identify activities that contribute to the goals, track progress, and support all local actors to work together to achieve the goals.

The MAHEFA Approach

MAHEFA used the existing KMS approach and modified it to create *Kaominina Mendrika miabo Salama* (KMSm) or Champion Communes Reaching Higher. The program added the term *miabo*, which means to reach higher. The letter "m" was chosen in order to express a community's desire to never be limited to health targets and objectives it has reached, but to constantly work towards an improved quality of life. MAHEFA's modified KMSm approach was designed to match the integrated nature of the community health services offered by the program's trained CHVs.

The MAHEFA's KMSm approach involves continuous cycles of four steps each. When all four steps are completed, one KMSm cycle is completed and another cycle begins. With each new cycle, the community's health targets and objectives are established based on achievements of the previous cycle. As shown in Figure 1, the period required to complete the steps in a KMSm cycle vary and depend on the community's progress towards their targets (indicators) and objectives.

Key Activities

1. Redesigned KMSm approach and modified tools. The MAHEFA team reviewed the existing KMS model in Madagascar and adapted it to fit into the program's community health activities. It redesigned the tools required to implement activities under each KMSm component.

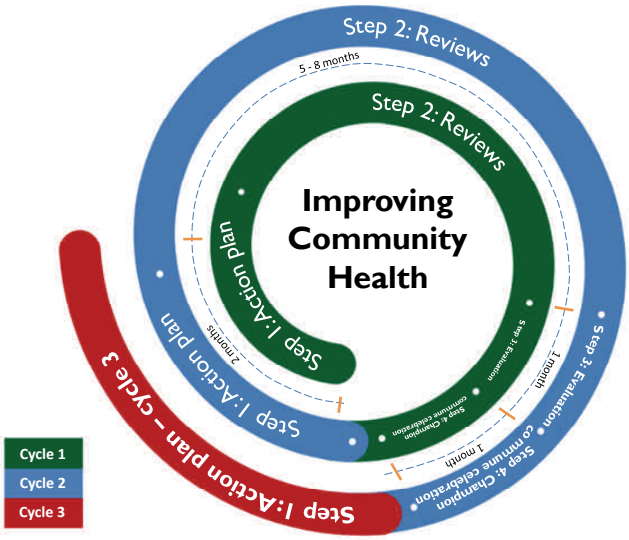
2. Trained MAHEFA and NGO teams on KMSm approach. Before rolling out the KMSm activities, MAHEFA conducted a workshop for its staff and implementing partners to discuss the approach, implementation process and tools.

3. Implemented the KMSm approach at the community level. The KMSm cycle was rolled out by the community, one cycle at a time as shown in Figure 1. Each cycle of the KMSm was conducted in four main steps as below.

KMSm Step 1: a. Held a half-day meeting to introduce the KMSm concept to get buy-in from community leaders. Meeting participants included four members from the CCDS (*Commissions Communales de Développement de la Santé* or commune-level

1. *World Health Organization 2014*

Figure 1. MAHEFA's KMSm Model



health development committees), four religious leaders, COSAN members (*Comités de Santé* or local health committee) and other community members.

b. Held a training for COSAN members on the KMSm approach including process and tools. After obtaining buy-in from the community leaders, MAHEFA held a three-day training for the COSANs to develop ownership and skills to carry out activities

c. Assisted the CCDS and COSAN to develop a health plan. Through a two-day participatory planning workshop, participants of the workshop, CCDS members, a representative of each COSAN from all *fokontany* (collection of villages), all CHVs in the *commune*, and community members from each *fokontany,* discussed health challenges in their community and developed action plans for how the *communes* would achieve eleven health targets (see health targets for KMSm in Box 1).

d. Signed the tripartite agreement between the *commune*, the *fokontany* and the MAHEFA program to commit to the action plan developed above. This was the last activity of the first step of KMSm.

KMSm step 2: Conducted a series of review sessions to monitor KMSm progress against targets. All the participants that attended the annual planning meeting held a day-long workshop every three months to review targets and monitor progress. The workshop served as a forum to give feedback to CHVs on the quality of their services. MAHEFA trained the community leaders to use the KMSm evaluation forms to determine their achievement rates. Some *communes* achieved their targets after two review sessions and did not need to hold a third review session. However, a few *communes* did not reach their goals after the third review session and organized a fourth review session.

KMSm step 3: Held a one day evaluation meeting to determine if the goals outlined in the action plan were achieved. Participants who attended the initial planning workshop attended this evaluation meeting. The evaluation was conducted by scoring each target and compiling those scores to produce a percentage that reflected total progress towards completion of a KMSm cycle. Each cycle had a minimum percentage required in order for a *commune* to be declared a Champion *Commune* for that year. A *commune* had to achieve 60 percent completion of its goals to pass the first cycle, 70 percent to pass the second, 80 percent to pass the third and 85 percent to pass the fourth.

KMSm step 4: The *commune* organized a celebration after they completed a cycle of KMSm, as evidenced in the evaluation above.

4. Began a new cycle of KMSm. After the celebration, the champion commune began its next KMSm immediately and repeated the same four steps as described earlier. As the health conditions are improved or changed, the *commune* may decide to modify or add health targets when they start the next cycle.

Box 1. Eleven KMSm Indicators

1. Number of pregnant women referred for (antenatal care) ANC
2. Number of new users of family planning with CHVs
3. Number of children under 5 (CU5) with diarrhea but without dehydration received SRO or Zinc with CHV
4. Number of CU5 with pneumonia treated with Pneumostop or Cotrim with CHV
5. Number of CU5 with fever tested by rapid diagnostic test (RDT) by CHV
6. Number of CU5 tested positive by RDT who received treatment within 24 hours of fever
7. Number of people received key messages on handwashing with soap
8. Number of hygienic latrines
9. Number of *fokontany* received open free defecation certification
10. Number of children under 2 weighed every month at CHV *toby*
11. Number of *toby* that offer integrated services and having permanent *toby* or health hut with Tippy Tap stand, Hygienic latrine and disposal pit.

Results

By the end of February 2016, all 279 MAHEFA *communes* completed their third KMSm cycle, which meant that all *communes* in the program areas had achieved at least 80 percent of their health targets. Out of all the *communes* in the MAHEFA program, 131 of them completed their 4th KMSm cycle which meant that they achieved 85 percent of their health targets. To increase participation and commitment of *communes* in KMSm activities, MAHEFA developed a KMSm facilitation manual in Malagasy and trained CCDS members on how to conduct KMSm activities. Figure 2 shows the number of CCDS trained on KMSm activities from 2011 to 2016.

Figure 2. Number of CCDS members trained to conduct KMSm activities in MAHEFA program areas (2011-2016)

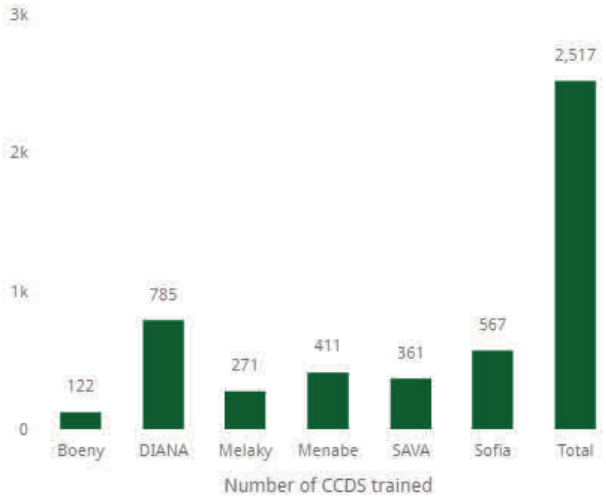


Table 1 presents health progress as evidenced by selected KMSm health indicators. While the progress is found in all indicators in the table below, the two largest increases in health achievements between the two KMSm cycles are latrines (nine times) and CU2 weighed by CHV (7.8 times).

Challenges

The concept of the KMSm approach was new to all communes in the MAHEFA program areas. Therefore it took time for communities to understand its importance and develop ownership of the process. As a result, in the first years, the communities relied heavily on MAHEFA program staff to remind them of KMSm activities and monitor their progress. Without frequent reminders, local actors did not conduct regular activities to progress towards the goals outlined in the *commune* action plans. Delays in implementation impacted success of the KMSm approach.

The KMSm indicators focused more on services from CHVs instead of a community's overall performance. Communities were responsible for only three of the eleven KMSm indicators but CHVs were responsible for eight of the eleven. As a result, communities were not encouraged to take more responsibility in moving their *communes* to achieve KMSm targets.

Table 1. Progress on KMSm indicators between cycle 1 and 4

Selected KMSm indicators	Average achievements in cycle #1	Average achievements in cycle #4	Increase from cycle #1 to #4
Pregnant women who went for ANC #4 at CSB	12,085	29,568	2.4
New users of family planning	33,086	54,939	1.7
Children under two years (CU2) weighed every month by CHV	7,749	60,421	7.8
Number of improved latrines built	3,488	31,659	9.1

As with any activity that promotes community ownership, the KMSm approach required modifications and adjustments to match each of the commune's unique contexts. Each approach had to be tailored to address the dynamics between the local leaders and the program team. This resulted in frequent changes in the KMSm approach and tools in the first couple of years of the program. This caused confusion among partners (the MAHEFA team, the NGO team and community leaders) and at times, hindered programmatic progress.

Linked to the above, this was the first time that the MAHEFA team implemented the KMSm approach in the program areas. At the same time as rolling the KMSm activities out, the MAHEFA team needed to train the NGO field staff that were

directly responsible to conduct the KMSm activities with the community leaders. This simultaneous implementation of activities caused confusion.

Lessons Learned and Recommendations

Train the implementing teams, program staff and NGO partners on KMSm concepts, procedures and tools before beginning activities at the community level. It is important to adapt tools for the environment in which the tools are being used. The implementing team should have a strong understanding of the KMSm cycles and tools to ensure smooth implementation at the community-level.

Provide multiple sessions and training workshops to community leaders. Allow this process to happen over time; explain to local leaders that there will be a gradual transfer of all KMSm responsibilities to them. By ensuring these two conditions are met, the likelihood of successful implementation of the KMSm approach at the community level will be higher. Community leaders will be committed to commune action plans and have the skill set required to carry out the various activities under the four KMSm cycles.

Balance the KMSm indicators to be both on CHV services and *commune* performance. More balanced indicators would encourage shared responsibility between service providers and users to commit to the goals of the action plan and monitor those indicators on a regular basis.

Link the KMSm plan to the commune's own health development plan. This can serve as a way to encourage more commitment and ownership form the commune to adopt the KMSm action plan as an important tool to advance their own health development plan.

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment, Community Radio Listening Groups, Community Score Card Approach, Chlorhexidine 7.1%/ Misoprostol, Champion Communes Approach, Community Health Volunteer Mobility, Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

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