USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM

Building Local Sanitation Capabilities for Open Defecation-Free Communities in Madagascar

Mahefa Miaraka Sofia

PROGRAM SUMMARY

The USAID Community Capacity for Health Program—known in Madagascar as Mahefa Miaraka—is a five-year (2016–2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaborative effort among the Ministry of Public Health (MOPH), USAID, and JSI Research & Training Institute, Inc. (JSI). Mahefa Miaraka provides tools and capacity-building training to approximately 10,000 community health volunteers (CHVs) who provide basic maternal health, child health, and family planning services to their local communities. The Program also works with national and local government stakeholders to strengthen the health sector and health policies. Mahefa Miaraka operates in seven regions of Madagascar, covering 4,708 villages with a total population of 6.6 million people, or 28 percent of the country's population.

MAHEFA MIARAKA

- OPERATES IN **7** REGIONS OF MADAGASCAR
- COVERING A TOTAL OF **4,708** VILLAGES
- WITH A TOTAL POPULATION OF **6.6** MILLION PEOPLE
- OR **28** PERCENT OF THE COUNTRY'S TOTAL POPULATION

JSI

OVERVIEW

Approximately two billion people globally lack access to basic sanitation facilities, including a toilet or latrine. This contributes to a situation where more than 600 million people defecate in the open, "for example in street gutters, behind buses, or into open bodies of water."[1] Inadequate sanitation has been estimated to lead to 432,000 diarrheal deaths annually and to increases in the transmission of cholera, diarrhea, hepatitis A, and typhoid.[2] Although the number of people practicing open defecation (OD) globally has declined, Madagascar is one of only a few countries that have seen the rate increase, from 38 percent to 45 percent between 2000 and 2017.[3] Approximately 38 percent of households in Madagascar have a basic toilet. This low level of sanitation, and especially of OD, contribute to the incidence of diarrhea, cholera, and the spread of intestinal parasites, which in turn cause malnutrition. In Madagascar, 42 percent of children under five suffer from stunted growth resulting from chronic or recurrent malnutrition.[4]

Madagascar's Ministry of Water, Sanitation, and Hygiene's (MEAH, *Ministère de l'Eau, de l'Assainissement, et de l'Hygiène*) *Madagasikara Madio 2025* Program aims to eradicate OD and contribute to the global Sustainable Development Goals (SDGs), including goal 6.2: "to ensure access for all, under equitable conditions, to adequate sanitation and hygiene services and end OD, paying particular attention to the needs of women and girls and people in vulnerable situations; by 2030."

The Madagascar Madio 2025[5] Roadmap, launched in 2019, sets objectives for household latrine use and the number of people newly declared to no longer practice OD. To build community capabilities to achieve these objectives, Mahefa Miaraka promoted and implemented the globally-proven Community Led Total Sanitation (CLTS) approach. CLTS is an integrated approach that encourages communities to analyze their sanitation practices with the aim of stimulating collective action to eliminate OD.[6] CLTS was introduced in Madagascar in 2008 and was recommended by the MEAH to eradicate OD and improve access to sanitation in the country.[7]

1 World Health Organization (WHO) (2019). Sanitation: Key Facts. Retrieved March 3, 2021 from: https://www.who.int/news-room/fact-sheets/detail/sanitation.
2 WHO. (2019). Sanitation: Key Facts.
3 The World Bank Data. People Practicing Open Defecation (Madagascar). Retrieved March 3, 2021 from: https://data.worldbank.org/indicator/SH.STA.ODFC.ZS?end=2017&locations=MG&start=2000&view=chart.
4 Institut National de la Statistique (INSTAT) and UNICEF. (2019). Enquête par Grappes à Indicateurs Multiples-MICS Madagascar 2018, Rapport Final. Antananarivo, Madagascar: INSTAT and UNICEF.
5 Madio = Clean
6 MEAH (2016). Guide de Mise en Œuvre de l'Approche 'Assainissement Total Piloté par la Communauté
7 MEAH. (2016). Guide de Mise en Œuvre de l'Approche 'Assainissement Total Piloté par la Communauté

KEY ACTIVITIES

Activity planning with stakeholders and communes. Mahefa Miaraka organized annual orientation workshops for PNSC health committee members, MOPH staff, *fokontany* heads, and CHVs to review results, best practices, and lessons learned to strengthen stakeholder commitment to community health activities. At the commune level, these workshops were followed by a participatory activity planning meeting with stakeholders to develop annual plans that identified and planned for the operationalization of activities needed to achieve the objectives in each commune, (e.g., Bronze, Silver, or Gold targeted level classification according to criteria established with KMSm commune committees).

Supporting stakeholder implementation of planned activities. The Program supported CHVs and health center teams to conduct CLTS activities and provide integrated case management of illness for children under five. CCDS members and *fokontany* COSAN teams supported the CLTS activities, coordinated the implementation of the KMSm process, and mobilized participation in community health-related activities.

- **Community mobilization to end OD.** CHVs, *fokontany* heads, and their teams led several interventions to promote the elimination of OD. They included collective cleaning days where community members swept and worked together to remove trash and to beautify public spaces; community discussions to propose and determine new functions for areas previously used for OD; participatory community monitoring to track household latrine usage; support for household or communal construction of latrines; participatory evaluation of results; and review of criteria needed for the self-proclamation of success in the fight against OD. Mahefa Miaraka also encouraged communities to provide CHV health huts with a latrine and handwashing station as a model for household replication. After communities reviewed their progress and declared that community members no longer practiced OD, the Mahefa Miaraka team, accompanied by a district or communal MEAH team, traveled to the village to verify and certify ODF status.
- **Model and Mentor Families support behavior change to end OD.** CHVs visited each household to educate family members to put into practice the key EFHP (box). In addition to delivering messages, the CHV encouraged the household to undertake and demonstrate key family practices. After mastering the EFHP, families worked with *fokontany* heads to verify their consistent application of the EFHP so that they could be named as "Model Families." CHVs then supported the Model Family members to sponsor and mentor a neighboring family to further encourage the uptake of the EFHP through peer-to-peer support.

Essential family health practices linked to sanitation in the Model and Mentor Families approach:

- **Mass communication to support ODF status.** Mahefa Miaraka produced several radio spots and dramas that were systematically broadcast via local radio stations. Local radio reaches all households and people with access to a radio receiver. CHVs also organized community listening groups to encourage discussion of the messages transmitted.
- **Supervision activities.** Supervision visits were led by health center and *fokontany* heads, and CCDS members, with the participation and organizational support of Mahefa Miaraka teams at the commune, district, and regional levels.

Quarterly progress review of the annual KMSm plan. Implementing actors in each commune met every quarter to discuss their achievements and results as part of the KMSm for each commune's activity plan objectives. To achieve the final objectives for each commune, challenges and implementation delays were reviewed and corrective actions were identified as part of the participatory action plan.

End of activity cycle evaluation. At the end of the predefined period, a final KMSm meeting was held to review the results for each indicator in comparison with the objectives set in the initial participatory action plan. Best practices and lessons learned during the implementation period were also shared, along with a determination of the success or failure of the community implementation. In both cases, stakeholders determined new approaches to continue successful activities or to revise and catch up on any indicators that needed further reinforcement.

Celebrating community success. In the event of a positive evaluation for the commune, the president and members of the CCDS organized a celebration and certification event.

CLTS' objectives and approaches were key components of two Mahefa Miaraka Program initiatives: the Champion Communes for Health (KMSm; Kaominina Mendrika Salamamiabo) and the Model and Mentor Families approach, which promotes essential family health practices (EFHP). As part of the Program's integrated community health and nutrition activities, these initiatives provided sustainable community- and household-led approaches to fight against OD and promote latrine and toilet construction and use.

APPROACH

The KMSm approach provided the foundation for community engagement in the Mahefa Miaraka Program. KMSm has demonstrated the effective operationalization of the National Community Health Policy (PNSC, *Politique Nationale de Santé Communautaire 2017*), the construction and use of latrines, and community engagement to eliminate OD, by working through Community Approach Coordination Committees (CCAC, *Comité de Coordination pour l'Approche Communautaire*) at regional and district levels; the Commune Commission for Health Development (CCDS, *Commission Communale de Développement de la Santé*) at the commune level; and the health committee (COSAN, *comités de santé*) at the *fokontany*[8] level.

KMSm sanitation objectives for each commune:

- During the year each *fokontany* (community) must have at least one new verified open defecation free (ODF) village, and all previous ODF villages maintain their status.
- During the year, there are at least six "improved" latrines newly built and used in each *fokontany*.
- *Fokontany* heads must organize a sanitation or other activity together at the level of the *fokontany*, at least once every quarter.

The Program coordinated activities across these committees at each level and supported stakeholder planning and program review meetings to measure progress for 28 KMSm indicators (related to support for the EFHP), cascade training programs, technical orientation, and joint supervision led by MEAH staff. To promote latrine construction and use, Mahefa Miaraka developed a latrine catalog for *fokontany* heads, which included specifications for the construction of different types of latrines according to local soil and weather conditions. Community leaders and households used the catalog to select the construction techniques that were most appropriate for their location, including the type of local materials and construction approaches.

8 *Fokontany*=village

Promotion of the Model and Mentor Families approach. The Program supported *fokontany* heads and CHVs to encourage families to put into practice **seven key actions targeted for four different life-stage groups**. The groups were:

1. Pregnant women
2. Children ages 0–11 months
3. Children ages 12–23 months
4. Children older than 24 months

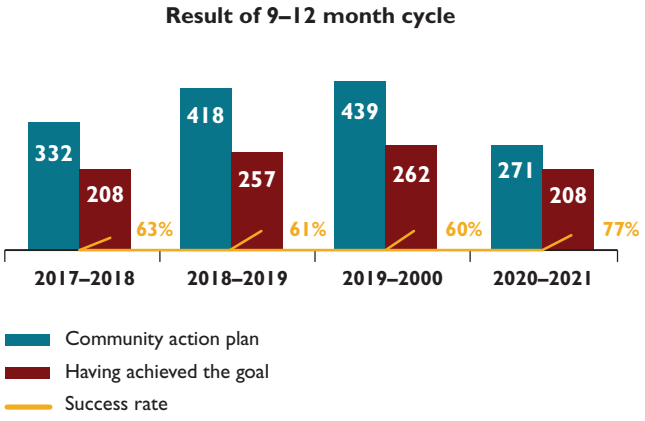
Key actions for families with children older than 24 months included building and using latrines, and handwashing with soap and water (after using the latrine, before preparing meals, and before eating). The Program also supported communities to complete their self-proclamation as ODF and to obtain their certification. Initially, certification was conducted by district and commune MEAH teams and their representatives, which transitioned to a more decentralized community-led process by the end of the Program.

RESULTS

Through the KMSm and the Model and Mentor Families initiatives, Mahefa Miaraka **built local sanitation capabilities and achieved measurable results for improved community health**. For example:

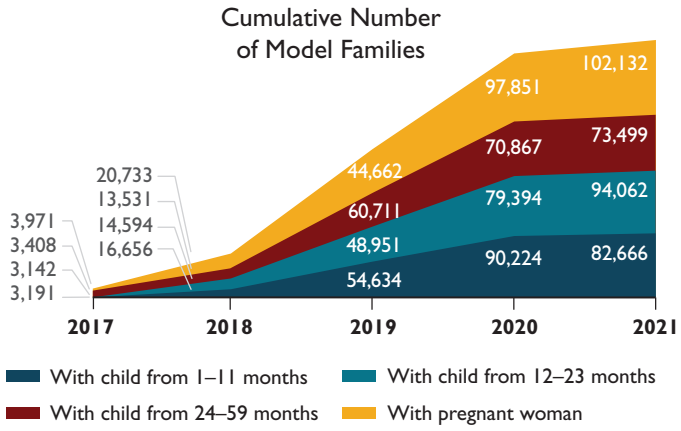
1,460 rounds of participatory KMSm planning in communes were completed and more than 935 of these rounds led to the achievement of objectives set for the 28 KMSm indicators related to EFHP support. As indicated in Figure 1, the KMSm approach began in FY2018.

FIGURE 1. COMMUNES WITH COMPLETED COMMUNITY ACTION PLANS AND THOSE HAVING ACHIEVED KMSM GOALS



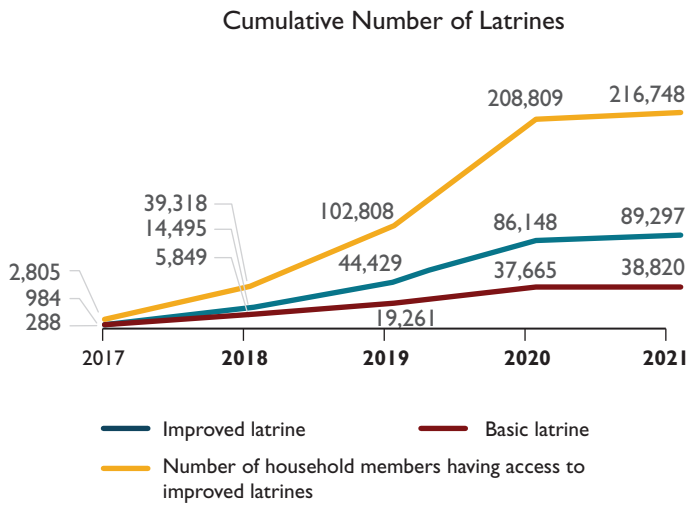
352,359 model families received Program support through their CHVs and *fokontany* heads to encourage families to put into practice the seven key actions targeted for four different life-stage groups. Of those, **181,209 became sponsor families to mentor** neighboring families and to further encourage the uptake of the EFHP through peer-to-peer support.

FIGURE 2. GROWTH OF THE MODEL FAMILY APPROACH



89,279 improved latrines were built, **providing 216,748 people with access** to improved latrines (Figure 3).

FIGURE 3. INCREASED ACCESS TO IMPROVED LATRINES



CHALLENGES

Basic sanitation remains a taboo subject. In some Mahefa Miaraka intervention regions, such as Menabe, Melaky, Sofia, and part of Boeny, discussing the subject of sanitation with family members or between children and adults was still taboo. Prohibition on the use of the same toilet between genders also existed in many areas. The implementation team faced significant challenges in finding ways to overcome these social norms. In collaboration with *fokontany* heads and local leaders (leaders naturels) and starting with small- and medium-sized villages, Program activities led to success in some villages, which was further shared with neighboring villages. The demonstration of positive results helped convince leaders and families in neighboring villages to follow the example of the successful villages.

Climatic hazards and natural disasters (e.g., cyclones, floods, bush fires). The majority of communities use local materials, such as earth mixed with cow dung, bamboo, palm leaves, and ordinary wood, for the construction of latrines. These materials are fragile when faced with fires and the recurrent cyclones and routine flooding during the rainy season. Communities struggle with the repetitive need to rebuild latrines and their own houses every time there is natural damage.

Characteristics of the soil (soft and sandy) require specialized building materials not available locally. In some areas, the community members faced difficulties when digging in the soil for the construction of pits: the soil may be rocky and hard, with boulders; they may face the instability of sandy conditions; or they may need to avoid a shallow water table. In these cases, the construction of latrine pits required specific materials, such as cement and iron, and more advanced tools and techniques.

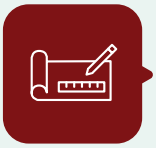
Loss of institutional memory due to changes in local administrations following elections. Several elections were held in Madagascar during the life of the Program, which led to changes in local leadership. Due to these changes, a majority of personnel at each level were replaced, often leading to a break from previous planning and the loss of experience and networks. At times, this resulted in delays and even the abandonment of activities focused on the elimination of OD. Because leaders ensure community mobilization for ODF, their change or absence can lead to risks of relapse of OD in communities.

Urban sanitation remains a challenge in Madagascar, especially in the capitals and large cities of the seven Mahefa Miaraka regions. Small feasible practices, including latrine construction, are not always feasible due to a lack of available land or building rights. Strategies to overcome gaps in sanitation, including land-use challenges to toilet or latrine construction, in urban and peri-urban zones have been piloted and are in the process of scale-up in other countries. However, systemic approaches to fecal sludge management can be costly and are generally quite different from the CLTS approach in more rural and peri-urban zones. In general, the financial capacity to provide public facilities is still weak compared with the needs of the population.

RECOMMENDATIONS

Continue to use and adapt the Mahefa Miaraka latrine catalogue and widely share it with communities to support continued latrine construction. To overcome the challenges that difficult terrains and weather-related damage pose for building latrines, the Program designed a latrine booklet and catalog containing specifications for the construction of different types of latrines. Use of locally available and weather-resistant materials—including bamboo, and recycled and repurposed plastic materials—are described to meet local soil and weather conditions and to support the community in the construction of adequate latrines. The Program also provided education to community members about approaches to building weather-resistant latrines. Following weather-related events, fokontany heads and CHVs have ensured regular follow-up and community mobilization to support household rebuilding efforts, especially after the passage of a cyclone or a flood.

Continue the use of the KMSm and Model and Mentor Families approaches to expand community engagement, increase construction and use of latrines, and reinforce the EFHP.



Develop a sanitation plan for regional and district capital cities. With input from private fecal sludge management companies, innovative urban sanitation partners, including Sanergy and Water and Sanitation for the Urban Poor, this plan can begin to address urban and peri-urban sanitation needs. The plan will provide an updated overview of the urban sanitation landscape, include lessons learned from other countries, and develop an actionable plan to extend community and household latrine access and use. The plan will also include strategies to mobilize communes and budget resources to fund construction of public hygienic toilets and their management through public-private partnerships.

This product is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this product are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.