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THE USAID MIKOLO PROJECT

FIVE YEARS OF HEALTH IMPACT, 10 STORIES OF SUCCESS

Photo MSH/Samy Rakotoniaina

FOREWORD

We are pleased to share this booklet that summarizes 10 of the best stories we've collected from the field. These narratives are a legacy to Madagascar's health system and for future public health interventions in the country. They show how USAID transforms lives by working hand in hand with the Ministry of Public Health to strengthen community resilience and to enhance the quality of primary health care services in rural communities. These are the stories of individuals, of unsung heroes, that have gone above and beyond what is called for in their normal day-to-day lives to have an even greater impact on the health of their communities. These are the faces that have catalyzed community health into a foundational platform upon which the entire health system can be built to achieve the Ministry of Health's goals of reducing maternal and child morbidity and mortality nationwide.

These individuals were instrumental in the USAID Mikolo Project's success in increasing access to and availability of community-based primary health care, especially for women of reproductive age, children under age five, and infants living in remote areas in Madagascar. Implemented by Management Sciences for Health (MSH), with partners Action Socio-sanitaire Organisation Secours, Catholic Relief Services, Institut Technologique de l'Education et du Management, Dimagi, and Overseas Strategic Consulting, Ltd., the project was aligned with Madagascar's national community health policy and specifically focused on reproductive health; family planning; maternal, newborn, and child health; and malaria prevention and care. The five-year project directly served an estimated 4.6 million people who live more than five kilometers from a health facility among 506 communes in 42 districts within 8 regions of Madagascar.

The USAID Mikolo Project supported the Ministry of Public Health by training and supporting 7,591 community health volunteers (CHVs) and mobilizing communities to strengthen the continuum of care. The community-based delivery of the service package offered by CHVs is endorsed by the World Health Organization and has been shown to be an effective way to address shortages of human resources without compromising the quality of care.

This booklet will tell you the stories of community-based savings and loans groups that brought accessible financial solutions to thousands of households; the tales of frontline community health volunteers who saved many lives in remote villages; and the chronicles of mothers and babies who benefited from our innovative approaches. We all want a stronger health system in Madagascar, and we truly hope that this booklet will inspire you to make this goal a reality.

John D. Yanulis
Chief of Party

ACKNOWLEDGEMENT

Samy Rakotoniaina, Aishling Thurow, and Alison Baggen contributed to this booklet.

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COMMUNITY HEALTH WORKER PROMOTES EXCLUSIVE BREASTFEEDING BY EXAMPLE

Half of children under the age of five in Madagascar are chronically malnourished: 24% suffer from moderate malnutrition and 26% from severe malnutrition, according to the 2012-2013 Millennium Development Goal Survey. Children in rural areas suffer disproportionately because they are often cut off from resources and information, and are typically far from health centers that support family health. Community health volunteers (CHVs) like Grancie Cicie help close the gap.

Cicie serves the village of Ambodilahoaty, located 21 km from the nearest health center, in eastern Vatomandry District. She has a four-month-old boy and is known for her determination in promoting healthy living in the community through her work as a CHV with the USAID Mikolo Project.

USAID Mikolo works with the Ministry of Public Health to improve maternal and child health in Madagascar through the adoption of healthy behaviors, which can lead to improved child nutrition and growth. It is clinically proven that breast milk is the best form of nutrition for infants during the first six months of life and it helps fortify a child's immune system long-term. Unfortunately, rates of exclusive breastfeeding for children six months and under have dropped steadily over the past 10 years to about 41% (2016), according to the Ministry of Public Health.

Leading by example has proven to be an effective strategy in rural communities like Ambodilahoaty. Since the birth of her child, Cicie has been breastfeeding in public and instructing mothers about the nutrition benefits of the practice. Her child is healthy and is growing fast. Others have started to understand the importance of exclusive breastfeeding, either because they have witnessed Cicie's practice or heard about it through word of mouth, a powerful tool in rural areas.

Cicie admits it can be difficult to convince mothers about the importance of breastfeeding because of traditional cultural practices. "Often when I talk about proper nutrition for children, mothers still add rice, cassava, or soup into the child's diet, which they believe is more satisfying," she said.

However, Cicie perseveres and has already begun to see more women exclusively breastfeeding for the first six months. Currently, 20 women participate in educational sessions she gives each week and, based on results so far, she knows this trend of sharing with and learning from each other will grow. Cicie plans to work more with community leaders to achieve a broader and more sustainable impact in the commune.

Photo **MSH/Sanny Rakotoniaina**

Photo Alison Baggen

CHANGING THE DIALOGUE TO ADDRESS FAMILY PLANNING

"In the past, the abortion rate in our village was very high among young girls. This motivated me to take action to reduce deaths and improve the quality of life here for all. I talk to both women and men about the benefits—both for health and quality of life—that can be provided through family planning and using contraceptives. This way I can convince families to make necessary changes."

- Manasoa Avelin, CHV, Vohipeno District

In certain parts of Madagascar, traditional cultural beliefs still forbid women from seeking any kind of treatment from male health service providers. However, in the village of Mahanoro in southeastern Vohipeno District, one man is challenging this norm and is making a difference.

Manasoa Avelin, 41, began working as a CHV in 2009 and is driven to improve his community by reducing childhood diseases, teaching parents about caring for the health of their families, and improving family planning—something Avelin considers particularly important.

He said he has already seen a drop in the number of pregnant girls in the community and an increase in families interested in family planning.

As a trusted member of the community, Avelin conducts home visits, provides information at large gatherings, and accepts people seeking treatment or advice into his home at all hours. He not only serves his small village of Mahanoro but neighboring villages as well, where the CHVs are not as well-versed on family planning. Avelin's first health hut was on the edge of the village, but after discussions with the community the residents built him one that was more central so he could better serve them.

Avelin's name and skills are well-known in the whole commune of Andemaka, with one family planning client living 10 km away. As of February 2018 he had 34 family planning users (32 taking Depo Provera and 2 taking the pill). If any of his clients are interested in a family planning method he cannot provide, such as an implant or intra-uterine device, vasectomy, or tubal ligation, he brings them directly to the community health center. Avelin works closely with the health center and encourages villagers to attend other health education sessions there.

Avelin has not only been recognized by his community, but also by the USAID Mikolo Project for his outstanding achievement in health as well as for his leadership in his Savings and Loans Community group. He taught members to utilize the community fund to pay for medicine or hospital visits if needed. In 2015, many people in his community were struggling financially and often bought medicine on credit from Avelin. He continued to supply his stock, eventually going into debt himself. In response, during local campaigns such as bed net or vitamin distributions, the community, including its leader, gave Avelin and his family food and basic resources so he could continue his work.

Avelin also focuses on improving himself as a well-rounded resource for the community, including work with a nongovernmental organization that teaches new farming and agriculture techniques to youth. He enjoys teaching other CHVs who look to him for guidance, as well as gaining new information and training from the doctor at the local health center or from projects such as USAID Mikolo.

COMMUNITY HEALTH VOLUNTEERS ON THE FRONTLINE OF MALARIA PREVENTION

Madagascar experienced a surge in malaria cases in 2015, particularly in the southwestern regions, despite the Ministry of Public Health's efforts to combat the disease. Interventions such as insecticide-treated bednet distributions and indoor spraying proved insufficient to deal with malaria in rural areas.

As a result, the Government of Madagascar decided to boost community involvement in prevention efforts. Simultaneously, the National Community Health Policy of Madagascar was updated to focus on institutionalizing CHVs as the foundation of the country's health program, including its fight against malaria.

Fanamamy Retsilaky is among the most active CHVs involved in this effort. He lives in Amboboka in southwest Tulear II District and benefited from malaria training and follow-up courses provided by the USAID Mikolo Project in the integrated management of childhood illnesses between 2014 and 2016. He regularly sees children with fevers at his health hut where he conducts malaria rapid diagnostic tests. Between 2014 and 2017, Retsilaky tested over 2,100 fever cases, with 1,672 confirmed cases of simple malaria, which were treated with artemisinin combination therapy (ACT). Between January and March 2017 alone, 52 out of 62 children he tested were positive for malaria and were treated with ACT.

CHVs like Retsilaky play a crucial role in the fight against malaria. Many villages are surrounded by rice fields and become almost inaccessible during the rainy season from November to April.

"I often have stock-outs of ACT and have to get to the health center (over 15 km away) to get more," said Retsilaky. "Parents usually go to the traditional healer first. A sick child from another village was brought to me, although I sent him directly to the health center he died because the parents had used traditional medicine at first and waited too long to come to me."

Retsilaky works hard to raise awareness in his community about the importance of prompt treatment when symptoms present, along with personal protection, such as consistent and proper use of bednets.

"People in my village trust me because of my dedication to our community, whether seen through my educational sessions or by word of mouth from those I have treated," he said.

His work has been bolstered by technical training and advice from USAID Mikolo. The project and the Ministry of Public Health's malaria control department continue to work together to strengthen epidemiological surveillance at the community level as well as enforce seasonal prevention and treatment campaigns in malaria-endemic areas.

Photo **Andritiana Tsarafiavy**

Photo **Alison Baggen**

VOLUNTEER PROVES TO BE A RESOURCEFUL ADVOCATE FOR WOMEN IN COMMUNITY

The village of Masiakakoho in southeast Madagascar lies eight kilometers from the nearest health center. Not only is it far away, but it used to have regular medicine stock-outs due to lack of buyers, and those who did want to purchase medicine did so at pharmacies without consulting a health professional, often wasting money or even worsening their medical condition. Children often died of preventable diseases, especially malaria, as well as diarrheal diseases, and pneumonia.

"The health center is far and people here were not used to going when they needed to. I wanted community members to realize the awful health conditions we were in, and that we needed a change," said Solange Hélène, a 27-year-old mother of two, who has been trying to improve development in Masiakakoho and further her own knowledge so she can be a better resource for her neighbors.

The USAID Mikolo Project trained Hélène in 2015 as a women's group leader. She was among 120 women in 111 villages trained on leadership, gender equality, and key health messages to serve as leaders of women's groups around the country.

Hélène was elected president of a Village Savings and Loans Association in 2013. USAID Mikolo facilitates such groups, which are known as Savings and Internal Lending Communities (SILCs). She used the SILC platform—the group now has 25 members—to start sensitizing and mobilizing the community members on healthy living and the importance of utilizing the local health center.

Although she lacked formal health worker training, she sought out new information, helped weigh babies and track their nutrition status, instructed parents to take their children to the health center for vaccines and when they were sick, encouraged women to complete antenatal care and give birth at the health center, and helped the village president and local CHV treat sick children. In addition, Hélène joined a beekeeping association in Manakara and encouraged others in her group to do the same so they could earn money with a local honey exporter and improve their living conditions.

Hélène became a trained USAID Mikolo CHV in 2016 and began treating children. She still holds monthly meetings with her women's group during which they discuss health topics, such as family planning, clean water, and vaccines. Her SILC group meets weekly, and the members continue to improve their savings and self-sufficiency.

Hélène wants to continue to seek opportunities to learn and gain experience, whether from coworkers, health professionals, or projects like USAID Mikolo. There has already been a huge drop in child mortality in her community as well as a visible shift in how community members view the health center and how to protect their family's health. Hélène has demonstrated to her groups and her entire community that women have the power to change the world around them.

A WOMAN LEADS HER COMMUNITY TO BUILDING BETTER HEALTH CARE

The village of Amboafandra in southeast Vohipeno District struggled with many of the same challenges as other villages in rural Madagascar. The nearest health center was far away—more than 17 km—and simple diseases or infections claimed too many lives, while women gave birth under poor conditions, threatening their lives and those of their infants. In one year, five mothers and six newborns had died due to complications during delivery.

Finally, the members of a local women's group, *Ampela Mikolo*, decided in October 2015 to take action. Led by Barbera Georgette, a 60-year-old CHV who was trained through the USAID Mikolo Project, the 20-member group decided to build a local health center. The members had already received training through USAID Mikolo on community health messaging, leadership, gender equality, and promoting healthy behavior change so they had the confidence and knowledge to take on this particular challenge.

After meeting with and mobilizing community members over a period of several months, the group received commitment from the men and women of the village to construct the clinic, knowing that since everyone would reap the benefits, everyone needed to participate. Community members purchased most of the materials themselves.

The initiative impressed others in the area and they wanted to help: the Vohipeno District medical inspector donated a birthing table and a bed, the village king provided structural wood beams, the local quarry supplied rocks for the foundation, two Italian health workers living in a nearby village donated tiles for the delivery room and patio roofing to protect patients from the sun and rain, and the local Peace Corps volunteer gave furniture and other supplies. The USAID Mikolo Project, in addition to providing support, training, and encouragement, gave a bicycle to the health center to be used to pick up vaccines because the clinic still lacked a refrigerator.

After six months, at the end of 2016, the clinic was complete. It provided enough space for overnight patients, a delivery room, a consultation room, and a pharmacy. It also had a latrine.

Georgette and her team asked the medical inspector for a health care worker. A midwife began working at the health center, initially for free because the district could not pay her, and then community members chipped in to pay to stock the pharmacy.

Community members are thrilled to have their own health center with a trusted health provider. Parents bring in their children for vaccines, people of all ages come in for all types of treatment, and most important to Georgette, all women now complete their antenatal care visits and give birth at the health center. No more children die of preventable diseases, and no more pregnant women die as a result of being too far from a health center.

Now Georgette and her fellow CHV, Marie Therese, along with their women's group, look to the future and what else can be accomplished. Georgette hopes for construction of a well that can provide clean water for the health center and a sturdier roof, made of tin.

Photo **MSH/Samy Rakotoniaina**

Photo **MSH/Samy Rakotoniaina**

A SAVINGS AND LENDING COMMUNITY EMPOWERS RURAL HOUSEHOLDS

Throughout Madagascar most families struggle with financial instability. Eighty percent of families work as farmers generating seasonal, unreliable income. In southwestern Tulear II District, the arid climate puts even greater stress on a farmer's income.

As part of its initiative of health promotion and sustainability, the USAID Mikolo Project set up Savings and Internal Lending Communities (SILCs) in rural villages of Madagascar. The objective was to empower group members to become more financially literate and flexible. Members have their individual personal savings in addition to the group savings fund that members can borrow from.

SILC *Ezaka*, the all-female SILC group in the town of Ankililoaka, has distinguished itself with its significant internal savings fund and the resulting social impact. USAID Mikolo technicians reported their credit at 1,282,117 ariary (USD$400) at the end of the 2015 to 2016 cycle, and a savings fund of $409. Members decided to invest their savings to increase output; they bought two tons of rice in January 2016 (summer harvest) and sold it in April, boosting their savings to $622.

Ultimately, the SILC groups promote financial independence and can help members better manage their family's resources. USAID Mikolo technicians educate these groups on how to tie their financial security to their health security. Families building resources and stability can have better access to health care, such as drugs, treatment, family planning, and disease prevention, as well as funds for home improvements and personal hygiene.

In addition, those families are freed from the idea that every day must be spent in the rice fields in order to make a living, and were able to visit the community health center when sick or for antenatal care. SILC loans can be used to pay for health emergencies or to improve living conditions. Maria, a mother of three and member of the SILC *Ezaka* group, took out a loan to renovate her home.

This model SILC group grew significantly in June 2016, with a savings of $971 and nine new members who had seen the positive impact SILC had on the lives of others in their community. Not only are they improving their own lives, but they are showing others that women have the power to lead themselves out of poverty. The USAID Mikolo Project worked to strengthen the existing SILC groups and to educate new ones all over Madagascar to be sustainable and internally supported.

"Our house was literally crumbling. Since the purchase of a new tin roof and the renovation of the walls, my whole family is healthier. The indoor air has improved a lot, my children don't get respiratory illnesses, and we no longer have to worry about the weather. I'm happy and proud to be part of this group."

- Maria, a member of SILC *Ezaka*

BUILDING RESILIENCE THROUGH SAVING AND LENDING

As in most resource-poor settings around the world, people living in rural communities in Madagascar can be left destitute by shocks such as a major health crisis, the destruction of their livelihoods from climate phenomenon, or the ruin of their homes from natural disaster.

Savings and Internal Lending Communities (SILCs) aim to offset these risks. They empower rural communities to improve their finances and quality of life while also creating a fund from which members can borrow money for emergencies.

Jean Lardo, 34, is a pioneer in the development and continuation of SILC groups in his community. He was recruited as a field agent by the USAID Mikolo Project in September 2015 to promote the SILC approach in his community. As a field agent, he was tasked with helping create new SILC groups by educating people in Vohipeno District about the benefits of saving and borrowing money.

Field agents receive 24,000 ariary (USD$8.00) per month from USAID Mikolo for a year as a compensation. During this period, Lardo was able to help start and support nine SILC groups throughout the district with the support of USAID Mikolo technicians. In September 2016, he was certified as a private service provider (PSP). This new position allowed him to be independent of the project and gave him more autonomy since PSPs are paid by the groups they oversee rather than the project.

"This new opportunity allows me to earn 90,000 to 100,000 ariary ($30-35) per month, and I consider it a great personal achievement to see that I can contribute to improvement of living conditions of my friends and family and to the development of the entire community," he said.

Lardo did not complete his basic education, which for many would limit their income potential, but Lardo's PSP status enabled him to be a positive influence in his community as well as to make a good salary to support his family. Today, he supervises 22 SILC groups across multiple communes and divides his time between training new leaders, providing financial education, and supervising current groups. He receives 200 ariary ($.06 cents) from each member per month for his services.

"Jean Lardo educates us on how to improve our group's system and making all the members more financially self-sufficient," said Eugene Maharamy, a member of the Fanilo group that Lardo supervises.

Through the PSP system, as Lardo's groups increase their financial independence, strength, and size, his own financial flexibility increases as well, making it a beneficial and sustainable endeavor. As a PSP, Lardo continually seeks innovative solutions for improving the SILC groups he supervises and thus the community as a whole. He wants to create a network of all the groups in his area to help coordinate the construction of health huts, water wells, and canoes for emergency transport in isolated areas.

Photo **MSH/Samy Rakotoniaina**

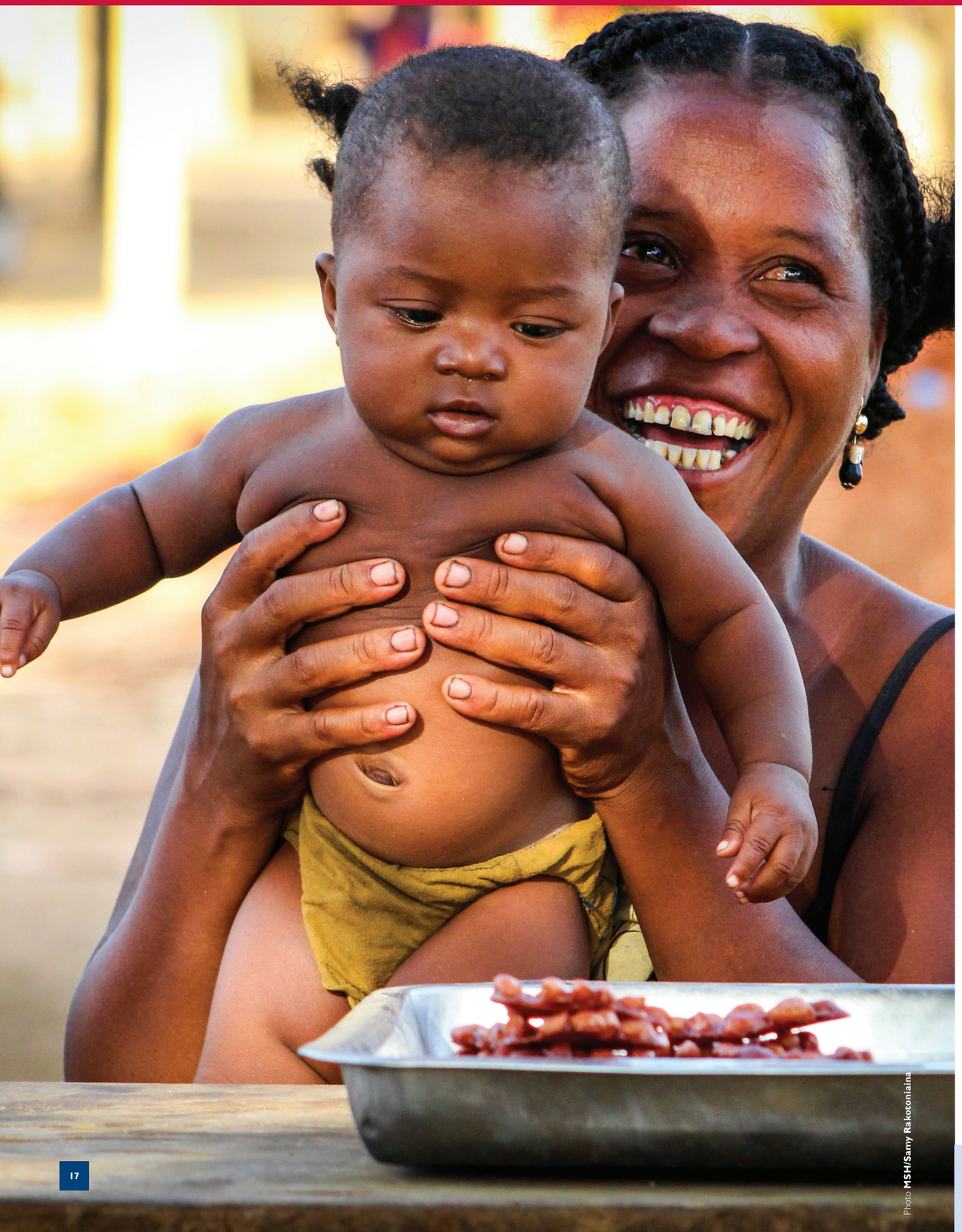

Photo **MSH/Samy Rakotoniaina**

A TRADITIONAL HEALER TRADES OLD CUSTOMS FOR NEW HEALTH TRAINING

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- Quoted

In rural Madagascar, traditional beliefs that define sickness as an unavoidable part of life often prevail over modern medicine. With few alternatives, isolated populations far from health centers often rely on healers for health issues. Incantations and medicinal plants are used during ceremonies where the patients put their lives in the hands of the spirits and the healer. Often, patients belatedly turn to modern health care services, after the treatment provided by a healer has failed.

Esorontsoa, a traditional healer from the village of Bejio in southwest Betioky Sud District, was long active in the region and served a population of more than 12,000. He is known for his exceptional skill using medicinal plants to cure illness.

But, in 2012, after seeing health conditions for local women and children worsening, Esorontsoa volunteered to become a CHV. As part of a movement to improve access to basic health care services, the USAID Mikolo Project taught him and his peers about patient care, basic community health education, referrals to health centers, family planning, maternal and child health, growth monitoring, and promotion of healthy habits. USAID Mikolo's approach is designed so the CHVs can become versatile and improve their skills over time.

Esorontsoa eventually gave up traditional medicine entirely because he believed he could better serve his community as a CHV. His reputation as a healer made his transition easier, both in terms of educating the community, and in terms of monitoring the health of and treating women and children. In August 2016, Esorontsoa received an upgraded CHV status, as he continued to receive training, onsite supervision, and performance assessments from USAID Mikolo technicians.

Today, at age 39, Esorontsoa continues to work to improve maternal and child health in his village. "I am grateful for this project and the trainings I've received, but mostly I'm grateful for the head of the health center for his support and collaboration," Esorontsoa said. "I feel even more useful to my community now as a CHV than as a healer."

USING MOBILE TECHNOLOGY TO IMPROVE COMMUNITY HEALTH

In rural areas of Madagascar, CHVs are instrumental in improving maternal and child health care services. They raise awareness of disease and unhealthy habits, help monitor child growth and nutrition, counsel the communities they serve on family planning, provide services, and treat simple illnesses, such as pneumonia, diarrhea, and malaria.

As part of the government health system, CHVs fill out activity reports and collect data, which they feed into the national health information system. The Ministry of Public Health uses this information, entered on multiple registry books, to inform policy, programmatic strategies, and other decision-making.

"The whole set of books weighs at least 10 kg, and I have to walk to the health center with all of them on a monthly basis," said Lynda Razafiharilalao, a CHV in central Madagascar. "It's also difficult keep track of all the different types of registries."

In addition, there are often errors in the paper registries, and the reports can be late, lost, or ruined.

To address these challenges and improve health care and counseling, the Ministry of Public Health developed a mobile health (mHealth) initiative with the support the USAID Mikolo Project. A pilot program was established in two regions, between April and September 2017: CHVs used a smartphone application that guided them through case management and counseling a patient, and instantly recorded data. This application makes it easier for CHVs to work with clients and provide care, as well as aids the reporting process.

Razafiharilalao is one of 50 pilot users of the mobile application. She monitors the weight of 75 children under the age of five each week in the village of Ambohidava in Ambohidratrimo District, a two-hour walk from the nearest health center. With her new smartphone, she records data on the mHealth app and uses is to receive counseling advice, depending on the child's condition. The head of the health center can supervise her activities from a distance in real time, which improves the service quality Razafiharilalao is able to provide as well as help her keep track of the community members.

Although the limited battery life of her smartphone poses challenges, Razafiharilalao said the mHealth initiative has significantly improved her work as a CHV. She feels more confident about the services she offers and is more efficient in reporting data. In the mHealth pilot, 88.5% to 94% of CHVs reported monthly data on time, compared to 46% to 75% of CHVs using the paper system only.

Louise Rasoamahaleo, another mHealth user in the town of Anjeva Gara in Manjakandriana District, has registered 87 children so far. "I used to take notes in a notebook so that sessions with patients weren't too long, and then would have to transcribe all the information to the registers at the end of the day," she said. "Today, with the app, I'm faster and more efficient, and even have more time for other activities."

The Ministry of Public Health and the USAID Mikolo Project continued to scale up the mHealth program to reach an additional 550 users in four regions of Madagascar.

"She is one of the most active community health volunteers in the commune. She mastered the technology in no time and, as the smartphone also eases communication between us, we have been able to ensure that referred cases actually come to the health center."

-Dr. Lalatiana Rakotoarivony

Photo **MSH/Samy Rakotoniaina**

Photo **MSH/Samy Rakotoniaina**

EPIDEMIC CONTROL STARTS IN THE COMMUNITY

Bubonic plague is endemic in Madagascar. Typically, the country experiences 400 to 600 cases of the disease each year. However, in 2017, the plague also took the pneumonic form. Between August 1 and November 26 there were 2,417 confirmed, probable, and suspected cases of plague, according to the World Health Organization (WHO).

More than three-quarters of the cases were clinically classified as pneumonic. Spreading from person to person through the air, pneumonic—or pulmonary—plague is much more virulent and contagious than the bubonic plague, which spreads to humans through infected fleas or rats or direct physical contact with infected cadavers. Left untreated, pneumonic plague is fatal. However, both bubonic and pneumonic plagues are treatable with antibiotics. Therefore, timely case identification is critical for saving lives and controlling spread of the diseases. As the Madagascar experience shows, effective epidemic control starts in the community.

November 8, 2017, a middle-aged man living in the remote village of Angalampona in Miarinarivo commune in Ambalavao District, died unexpectedly. At the time of his death, the USAID Mikolo Project had been supporting local health authorities to establish two local plague watch committees—in Miarinarivo and Mahazony communes—and five village watch committees as part of the national response to the ongoing plague epidemic. The village watch committees included the village head and two CHVs who received mobile telephone credit from the project to alert public health authorities to any suspected cases. A week after the man's death, his 15-year-old son died. The head of the village, who had received training on recognizing signs of plague, suspected that the boy and his father had died of plague. She then alerted the health center in Miarinarivo commune.

The alert triggered an investigation by the district health authorities, who travelled to Angalampona on November 23 along with members of the Miarinarivo commune watch committee, including the head of the health center, USAID Mikolo staff, and a team from WHO. They arrived in the village with an ambulance, antibiotics, disinfecting equipment, and individual protective equipment. Upon arrival, the head of the village and a CHV brought the team to the household of the deceased. Four other family members were experiencing symptoms of pneumonic plague. These can include fever, headache, weakness, and rapidly developing pneumonia with shortness of breath, chest pain, cough, and sometimes bloody or watery sputum.

They were rushed to the health center, where two of them died soon after arrival. Two girls, aged 5 and 15 years, stabilized after receiving antibiotic prophylactic treatment. Serological tests at the Pasteur Institute of Madagascar confirmed both girls had pneumonic plague.

Four days later, a second investigative team of district health authorities and USAID Mikolo and WHO staff met with 32 local health and community leaders from Miarinarivo commune to review the situation, plan, and coordinate a response. The plan focused on contact tracing—identifying those who were in contact with the suspected/infected persons, continued education on preventive practices, and systematic spraying of houses to disinfect and help control the outbreak.

The project then expanded its support to the neighboring commune of Sendrisoa, and mobilized, with the head of the health center, all village heads, and CHVs to expand contact tracing and ensure follow-up. A total of 117 people in Miarinarivo commune and 64 people in Sendrisoa were identified as potential contacts, and all were started on preventive antibiotic treatment. USAID Mikolo staff worked with the health centers in the three communes to ensure that they had sufficient supplies of antibiotics so they were prepared to respond to the outbreak and other emergencies.

As of December 1, 2017, no new cases had been identified and no more plague-related deaths had been recorded in the three communes of Miarinarivo, Mahazony, and Sendrisoa. The broad and swift response involved a ready-to-go system featuring strong surveillance and action by local community members. Active contact tracing continued, and the village and commune watch committees, the health centers, and the district health authorities continued to be supported throughout the end of the plague season in April. Soon, support for this kind of work will include a mobile health application developed by the USAID Mikolo Project to facilitate the real-time capture and analysis of case data.

The story from Angalampona is one of many similar stories that played out across communities in Madagascar during the pneumonic plague epidemic. USAID Mikolo worked in the 11 most-affected districts, directly supporting 220 villages and 30 communes to set up functional epidemic watch committees. The project trained and supported 1,101 community health workers, village and other local leaders, and health center staff. At the district and regional levels, the USAID Mikolo Project works with health authorities to develop and implement response plans and conduct investigations. Project staff also helped develop the national response plan and mobilize the resources to implement it and support the logistics needed for epidemiological surveillance and response.

The combined efforts of the Ministry of Public Health, WHO, USAID and its implementing partners—including USAID Mikolo—the Pasteur Institute of Madagascar, United States Centers for Disease Control and Prevention, International Committee of the Red Cross, and many others culminated in the containment of the epidemic in less than three months. Without the watch committees, local leaders, and CHVs, this success would not have been possible, and the global community would have faced greater risk of the spread of the deadly disease.

THE USAID MIKOLO PROJECT

Additional information can be obtained from:

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