



INTEGRATION OF NUTRITION, FOOD SECURITY, AND IMMUNIZATION PROGRAMS IN MADAGASCAR

Technical Consultation Report

MOMENTUM Country and Global Leadership



MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This Technical Consultation Report is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.

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Suggested Citation

MOMENTUM. *Integration of Nutrition, Food Security, and Immunization Programs in Madagascar*. 2023. Washington, DC: USAID MOMENTUM.

ACKNOWLEDGEMENTS

MOMENTUM Country and Global Leadership is part of a suite of innovative awards funded by the U.S. Agency for International Development (USAID) to holistically improve voluntary family planning (FP) and maternal and child health (MCH) in partner countries around the world. The project focuses on technical and capacity development assistance to ministries of health and other country partners to improve outcomes.

ABBREVIATIONS

AC	<i>agent communautaire</i> (community-based agent)
ACF	Action Contre la Faim
ADRA	Adventist Development and Relief Agency
AFD	Agence Française de Développement
APART	<i>autorités politiques, administratives, religieuses, et traditionnelles</i>
AS	<i>agent de santé</i> (healthcare provider)
ASOS	Action Socio-sanitaire Organisation Secours
AVSF	Agronomes et Vétérinaires Sans Frontières
AVI	<i>Activité de Vaccination Intégrée</i>
BCG	Bacille Calmette-Guérin
BNGRC	Bureau National de Gestion des Risques et des Catastrophes
CCC	care and counseling center
CRENAS	<i>centre de récupération et d'éducation nutritionnelle ambulatoire pour la malnutrition aiguë sévère</i>
CRENI	<i>centre de récupération et d'éducation nutritionnelle intensive</i>
CRS	Catholic Relief Services
CSB	<i>centre de santé de base</i> (primary healthcare center)
CSEP	<i>cadre de suivi et évaluation de la performance</i> (performance monitoring and evaluation framework)
DEPSI	Direction des Etudes, de la Planification, et des Systèmes d'Information (directorate of health information and systems)
DHS	Demographic and Health Survey
DPEV	Direction du Programme Elargi de Vaccination (directorate in charge of EPI)
DRSP	Direction Régionale de la Santé Publique (regional ministry of public health office)
EMAD	<i>équipe managériale du district</i> (district health management team)
EMAR	<i>équipe managériale de region</i> (regional health management team)
EPI	Expanded Programme for Immunization
FANOME	Fonds d'Approvisionnement Non-stop en Médicaments Essentiels
FAO	Food and Agriculture Organization
GRSE	<i>groupe régional de suivi et d'évaluation</i> (regional supervision and evaluation team)
HCD	human-centered design
IEC	information, education, and communication
MAM	<i>malnutrition aiguë modérée</i> (moderate acute malnutrition)
MAPI	<i>manifestations post-vaccinales</i> (adverse effects post-vaccination)
MAS	<i>malnutrition aiguë sévère</i> (severe acute malnutrition)
MEV	<i>maladies évitables par la vaccination</i> (illnesses preventable through vaccination)
MSP	Ministère de la Santé Publique (Ministry of Public Health)

NGO	nongovernmental organization
ODK	Open Data Kit
ONN	National Office of Nutrition (Office National de Nutrition, or ONN) and
ORN	Office Régional de Nutrition (Regional Office of Nutrition)
OSC	<i>organisation de la société civile</i> (civil society organization)
PAM	Programme Alimentaire Mondial (World Food Program)
PEC	<i>Prise en charge</i> (case management)
PHAGDIS	Pharmacie de Gros du District (district-level body in charge of management of medicine)
PTF	<i>partenaires techniques et financiers</i> (technical partners and donors)
RMA	<i>rapport mensuel d'activités</i> (monthly report of activities)
RSH	<i>rapport de surveillance hebdomadaire</i> (weekly surveillance report)
SANIDA	Sécurité Alimentaire et Nutrition par l'Intensification et la Diversification Agroécologique
SDSP	Service de District de la Santé Publique (district MSP office)
SNUT	Service de la Nutrition (national nutrition support unit)
UCP	Unité de Coordination des Projets
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

BACKGROUND

Like many countries, Madagascar suffered a backsliding of immunization performance in the last three years since the COVID-19 pandemic. The percentage of Malagasy children aged 12–23 months considered “zero-dose” rose sharply from 24% in 2019 to 35% in 2021, reaching the highest level in the last 25 years. This means that in 2021, about 462,000 children did not receive the DTP-1 vaccine and were classified as zero-dose. The outbreak of measles in 2023 points to immunity gaps resulting from high prevalence of zero-dose and low vaccination coverage. The World Health Organization (WHO) has identified Madagascar as one of the 20 priority countries for the “Big Catch Up” to ensure zero-dose children are caught up with their vaccinations and connected to health services.

Similarly, studies have shown Madagascar to have high malnutrition rates, with wasting and stunting rates among children estimated at 8% and 40%, respectively, in 2021.¹ Children who are zero-dose are vulnerable to vaccine-preventable diseases and may encounter substantial barriers to other preventive and curative care services. Consequently, they are at a heightened risk of experiencing poor health outcomes. Similarly, children suffering from wasting endure rapid weight and muscle loss, putting them at risk of stunted growth and weakened immunity. As a result, they are more susceptible to contracting infectious diseases, which can lead to severe disease or even death.

Zero-dose children with wasting are consequently at an elevated risk for infections, yet are likely to encounter significant barriers when seeking the necessary care to combat these infections. They are exposed to similar vulnerabilities, and malnutrition serves as an important deprivation indicator for zero-dose children. The high rates of both zero-dose (one out of five children ages 12 to 23 months) and wasting (8% of children under-five) in Madagascar highlights the importance for integrated approaches to child health. The integration of immunization and nutrition activities has been shown to have positive impacts on child health and wellbeing. The MOMENTUM Country and Global Leadership team worked with the district Expanded Programme for Immunization (EPI) managers from Antananarivo and conducted a three-day human-centered design (HCD) workshop on the October 17–19, 2022 to identify barriers to reaching zero-dose children and co-design solutions to address them. One of the recommended solutions to reaching zero-dose children is the integration of immunization and nutrition services and commodities. By integrating immunization and nutrition activities, the country can address both preventable diseases and malnutrition, helping to improve the health and wellbeing of its children.

Over the past few years, multiple programs on nutrition and food programs were carried out at the national and/or subnational level, like PENIM² (*Programme Innovant d’Education Nutritionnelle en Milieu Urbain à Madagascar*), SANOI³ (*Programme Regional de Sécurité Alimentaire et Nutritionnelle*), KALY TSINJO⁴ and PARN⁵ (*Programme d’Amélioration des Résultats Nutritionnels*). Most recently, a campaign combining vitamin A supplement uptake and routine immunization activities (*Activité de Vaccination Intégrée*, or AVI) was implemented by the directorate in charge of EPI (*Direction du Programme Elargi de Vaccination*, or DPEV) with stakeholders. In addition, two large USAID-funded food security and resilience projects, FIOVANA and

¹ Sources: (1) Institut National de la Statistique and ICF. *Madagascar Demographic and Health Survey*. 2021. (2) UNICEF, WHO, World Bank: *UNICEF, WHO, World Bank Joint Child Malnutrition Estimates (JME): Levels and Trends*. 2023. <https://data.unicef.org/resources/jme-report-2023/>

² PENIM: <https://gret.org/projet/programme-innovant-deducation-nutritionnelle-en-milieu-urbain-madagascar/#:~:text=Le%20projet%20vise%20%C3%A0%20%C3%A0,d%20activit%C3%A9s%20compl%C3%A9mentaires%20de%20sensibilisation.>

³ SANOI: <https://www.commissionoceanindien.org/securite-alimentaire-appel-a-proposition/>

⁴ KALY TSINJO: <https://www.presidence.gov.mg/actualites/1159-lancement-officiel-des-tsenamora-et-de-la-distribution-des-kaly-tsinjo.html>

⁵ PARN: https://www.aliveandthrive.org/sites/default/files/attachments/AandT_Country-Brief_Madagascar9.pdf

Maharo, have been implemented by Adventist Development and Relief Agency (ADRA) and Catholic Relief Services (CRS) in Southeast and Southern Madagascar, respectively, since 2019.

In an effort to strengthen and institutionalize efforts to integrate immunization and nutrition services, the MOMENTUM immunization and nutrition team hosted a technical consultation on the integration of immunization and nutrition in Madagascar from May 15–16, 2023. The consultation convened government officials, partners, and civil society stakeholders in immunization and nutrition. Its objective was to examine the burden of zero-dose children and malnutrition and their correlation in Madagascar, assess the current practice and challenges with integration of immunization and nutrition, identify opportunities for integration, and initiate the process to develop the needed policy framework and operational guidelines to support integrated immunization and nutrition services in the country.

WHO SHOULD USE THIS REPORT

This report is meant to be used by the EPI, nutrition, and food security teams, including partners and donors (*partenaires techniques et financiers*, or PTF), and national, regional, and district EPI teams in Madagascar. This report will also be shared with MOMENTUM teams at their U.S. offices, the immunization and nutrition focal persons at USAID Washington, and the USAID mission in Madagascar. The purpose of sharing this report with these stakeholders is to stimulate discussions on how to integrate immunization, nutrition, and food security programs and services to reach zero-dose children and malnourished children with potent routine immunization vaccines, food supplements, and treatment in the country.

OBJECTIVES OF THE TECHNICAL CONSULTATION

1. To review the status of nutrition and immunization program performance focusing on zero-dose and wasting.
2. To examine the extent of, and gaps in, integration of immunization and nutrition services.
3. To identify opportunities for integration within and beyond the traditional immunization and nutrition partnerships.
4. To define a road map for integration of nutrition and immunization in the country.

EXPECTED OUTCOMES

1. Reviewed the status of nutrition and immunization program performance focusing on zero-dose and wasting.
2. Identified gaps in integration of immunization and nutrition services.
3. Identified opportunities for integration within and beyond the traditional immunization and nutrition partnerships.
4. Defined a road map for integration of nutrition and immunization in the country.

TABLE 1: SUMMARY OF THE SESSIONS

S/N	LIST OF SESSIONS (DAY 1)	LIST OF SESSIONS (DAY 2)
1	Introductions	Recap of Day 1
2	Opening remarks and goodwill message	Review of existing immunization and nutrition policies for gaps
3	Overview of workshop objectives and agenda	Presentation and discussion of group work output
4	Overview of zero-dose and other immunization indicators in Madagascar	Tea break
5	Overview of malnutrition in Madagascar	Overview of plans to conduct integration readiness assessment
6	Intersection between zero-dose and malnutrition in Madagascar – DHS analysis	Discussion
	Tea break	Lunch
7	Barriers to integration of immunization and nutrition: findings from key informant interviews and HCD workshops	Overview of the strategy for integrating immunization, nutrition, and food security programs
8	Discussion	Presentation and discussion of group work output
	Lunch	Developing the integration action plan
9	Case study on primary healthcare integration in Madagascar	Review of action plans and formation of the steering group
9	Discussion on barriers to integration	Recap of workshop and next steps
10	Models, partnerships, and opportunities for immunization and nutrition integration in Madagascar	
11	Group presentation	
12	Summary of Day 1 and outlook for Day 2	

ATTENDANCE

The workshop was attended by national, regional, and district-level participants of the Ministry of Public Health of Madagascar (*Ministère de la Santé Publique*, or MSP) and stakeholders, including from the DPEV, regional health management team (*équipe managériale de région*, or EMAR), and district health management team (*équipe managériale du district*, or EMAD). In total, there were 29 participants. Nine participants were from the government, seven from civil society organizations (*organisations de la société civile*, or OSCs), three from partner organizations, seven from the MOMENTUM country team, and three from the global offices. Seven of the participants were from the national level, five from the regional level, and seven from the district level. The workshop was facilitated by the MOMENTUM team in Madagascar, with technical support from the Baltimore team working in nutrition, food programs, and immunization. The session formats were comprised of PowerPoint presentations, group work, group work feedback, and discussion in plenary.

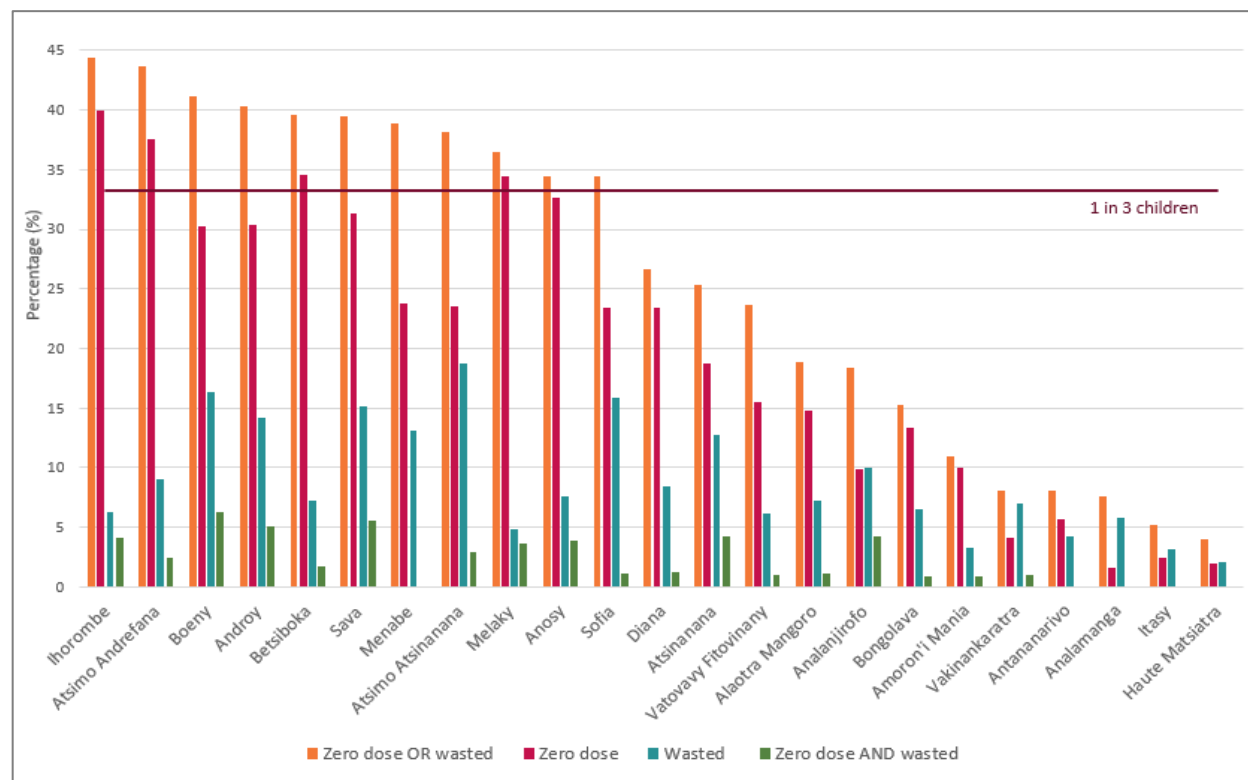
FINDINGS

SESSION 1: ANALYSIS OF THE CORRELATES OF ZERO-DOSE AND WASTING

The MOMENTUM team’s analysis of the co-occurrence and correlates of zero-dose and wasting was presented. The goal of the analysis was to better understand and characterize the clustering of vulnerabilities among children, specifically exploring the relationship between zero-dose and acute malnutrition (wasting) to inform integrated interventions to improve immunization and nutrition outcomes in Madagascar. The analysis focused on describing the prevalence and socio-demographic correlates of zero-dose and wasting as independent and as joint outcomes. Data came from the 2021 Madagascar Demographic and Health Survey (DHS), covering all 22 regions in Madagascar and limited to children 12–35 months of age. The analysis is part of the evidence generation to understand the burden of zero-dose and malnutrition, and to identify regions with the greatest dual burden to build a technical consensus on the need and models of integrated service delivery most relevant in Madagascar. In the analysis, zero-dose status was defined as a child having not received BCG, polio, pentavalent, or measles-containing vaccines, while wasting was defined as >2 standard deviations below the average weight for height, per WHO standards. Key findings from the analysis are detailed below.

The national prevalence of zero-dose was 18.8%, wasting was 9.3%, and stunting was 43.9%. Overall, 25% of children in Madagascar were either zero-dose or wasted, which translates to one in four Malagasy children being either zero-dose or wasted. The proportion of children who are both zero-dose and wasted was only 2.2%. Although this is a small proportion overall, this subpopulation with the double burden of the outcomes represents the children with the highest vulnerability.

FIGURE 1: SEPARATE AND JOINT OUTCOMES: PERCENTAGE OF CHILDREN 12 TO 35 MONTHS IN EACH REGION WHO ARE ZERO-DOSE OR WASTED, ZERO-DOSE, WASTED, OR ZERO-DOSE & WASTED



Examining the prevalence of outcomes at the regional level (Figure 1) reveals that the region with the highest zero-dose prevalence was Ihorombe (39.9%), and the region with the lowest was Analamanga (1.6%). The region with the highest prevalence of wasting was Atsimo Atsinanana (18.7%), and that with the lowest wasting prevalence was Haute Matsiatra (2%). The highest prevalence of children who were both zero-dose and wasted were found in Boeny (6.7%), and the lowest were in Antananarivo, Analamanga, Haute Matsiatra, Itasy, and Menabe—all of which had zero prevalence. Interestingly, nearly half of all children who were both zero-dose and wasted were in four regions: Sava, Atsinanana, Androy, and Analanjirofo. Boeny, the region with the highest prevalence of children with both outcomes, was not a top contributor to the burden of this problem. Burden is a function of both population size and prevalence of the outcomes. Another interesting finding was that 11 regions with the highest prevalence of children with either zero-dose or wasting were found along the western border and the southern part of the country (Figure 2). With Madagascar being an island nation, these were largely coastal regions.

Based on the intersection of both outcomes, regional typologies were created (as shown in Figure 3) to help identify the priority regions and intervention focus. The regions with the highest burden of both outcomes, that is, the high zero-dose and high wasting regions—Boeny, Androy, Sava, Menabe, Atsimo Atsinanana, and Sofia—were considered highest priority for zero-dose and nutrition interventions.

FIGURE 2: REGIONS IN MADAGASCAR WHERE MORE THAN 30% OF CHILDREN ARE EITHER ZERO-DOSE OR WASTED. DHS 2021

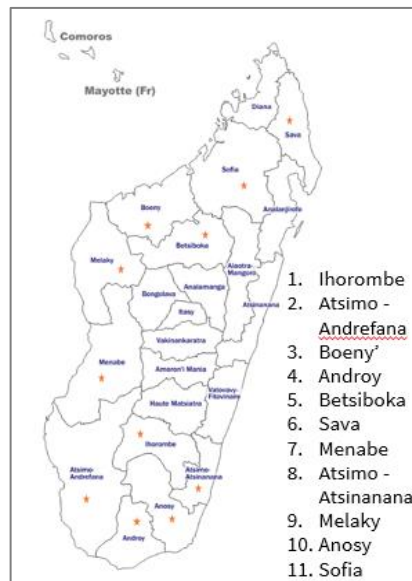
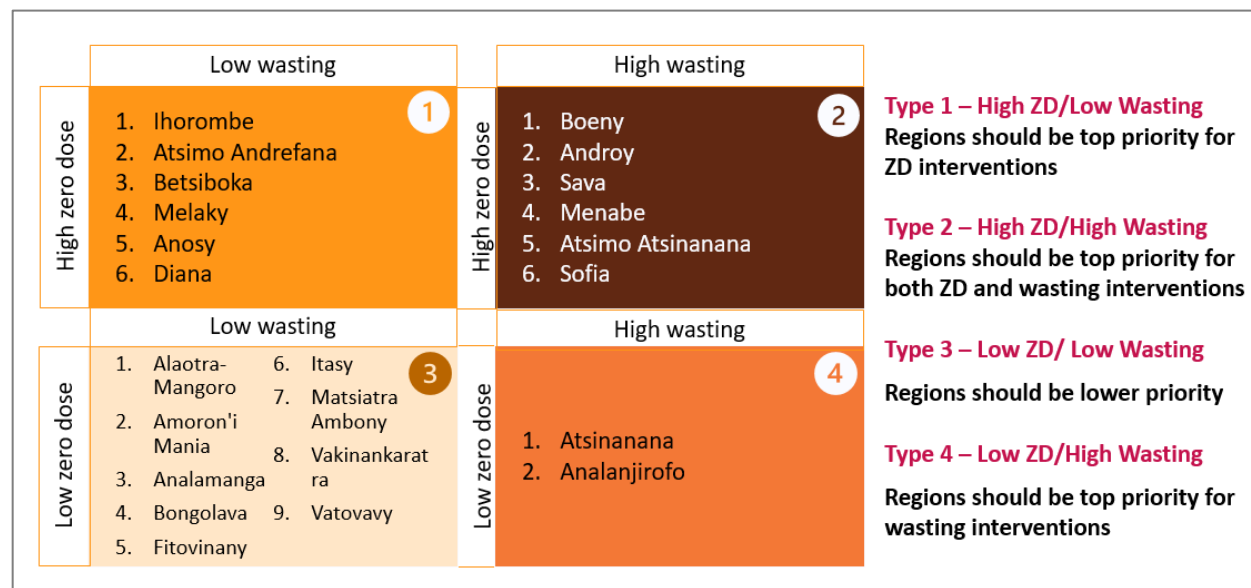


FIGURE 3: REGIONAL TYPOLOGY BY PREVALENCE OF ZERO-DOSE AND WASTING IN CHILDREN



While the prevalence estimate supports the prioritization of certain regions, additional considerations such as ongoing programs or partner presence may also inform the final choice of region for intervention.

Participants were not surprised about the higher prevalence of the outcomes in the coastal and southern regions. They cited geographical access as a significant hurdle in these areas, where many families face challenges due to the considerable distance to health facilities. Participants also mentioned that despite the higher production of foods in some regions like Sava and seafood from these coastal regions, nutritional habits and prioritizing food for sale rather than consumption may explain the high rates of wasting in children. It was noted that MOMENTUM, with the leadership of Save the Children, is conducting an ethnographic study on nutritional habits and decision-making at the family level in Antetetzambaro and Fanandrahana communes in the Atsinanana region. This study might provide some needed insights to explain the patterns observed in the DHS analysis. Participants also noted additional reasons, including the existence of migrating populations, areas that were hit by cyclones, traditional practices that promote poor nutritional habits, and religious restrictions.

The analysis also examined household-level factors correlated with wasting, and compared them to how prevalent the factors are in the general population of children 12–35 months. The following factors were statistically significantly associated with wasting at the ($p < 0.10$) level:

- Poorer wealth quintile
- No maternal education (and no maternal literacy)
- Larger family size
- Limited access to TV and radio
- Low antenatal care attendance
- Non-adolescent mothers (mothers >20 years)
- Male child sex

Factors not significantly associated with wasting were: urban/rural living, some maternal health factors (home delivery, non-receipt of tetanus vaccination), receipt of child vitamin A, recent child illness (cough, fever, or diarrhea), treatment of recent child illness, maternal marital status, sex of head of household, and mother vs. father decision-making autonomy.

Comparing the correlates of zero-dose and wasting status, the study found some key similarities and differences as follows: common factors associated with zero-dose and wasting were wealth quintile, maternal education, access to TV and radio. Children from the lower wealth quintile, those with less educated mothers, and those that come from households with low or no access to TV and radio were more likely to be zero-dose or wasted. Key differences were factors related to access to maternal care, which are strongly associated with zero-dose status, but not consistently with wasting. One in four (20.3%) of children in rural areas are zero-dose, but one in 10 (10.9%) in urban areas are zero-dose; there are less urban/rural differences in nutritional status.

SESSION 2: HOW DO NATIONAL PROGRAMS (NUTRITION, IMMUNIZATION, AND FOOD PROGRAMS) OPERATE IN MADAGASCAR?

This session was designed to outline the workings of the three programs to identify potential areas of integration and synergies. The session was organized as group work, aided by a questionnaire to guide the discussion (see Annex), followed by a plenary session to present and discuss/debate the output of each group. The outputs of the group work are synthesized in Tables 2 and 3 below.

IMMUNIZATION PROGRAM

Planning and coordination of the immunization program involves various coordination platforms at different levels. At the national level, the coordination platform is called DPEV-PTF, and meetings are held semi-annually for reviews, annually, and as needed for exceptional circumstances. At the regional level, the EMAR-PTF and OSCs hold monthly, quarterly, and annual meetings. Similarly, at the district level, the EMAD-PTF and OSCs meet monthly, quarterly, and annually. At the commune and fokontany levels, the coordination is done through primary healthcare centers (*centres de santé de base*, or CSBs), community-based agents (*agents communautaires*, or ACs), OSCs, and district-level community health coordination centers (*comités communaux de développement sanitaire*), with meetings scheduled monthly or quarterly.

The program involves multiple donors and partners, including WHO, the United Nations Children’s Fund (UNICEF), USAID, Gavi, and the Rotary Club.

In terms of service provision, the program offers various services and benefits such as vaccination, awareness-raising, surveillance of illnesses that are preventable through vaccination (*maladies évitables par la vaccination*, or MEV) such as measles and rubella, and management of adverse effects post-vaccination (*manifestations post-vaccinales*, or MAPI). These services are provided at different locations, including through CSBs, door-to-door visits, and fixed or mobile strategies. The responsibility for providing these services lies with different entities, including healthcare providers (*agents de santé*, or ASs), ACs, volunteers, associations, and churches, as well as political, administrative, religious, and traditional authorities (*autorités politiques, administratives, religieuses, et traditionnelles*, or APART). The target age groups for the services are children aged 0–59 months, pregnant women, and individuals aged 18 years and above for COVID-19 related services. The program uses implementation strategies based on distances: fixed services for distances up to 5 km, advanced services for distances ranging from 6 to 10 km, and mobile services for distances greater than 10 km.

Logistics play a crucial role in the program, and the delivery system for inputs and medicines follows a path from the laboratory to DPEV, then to the regional MSP office (*Direction Régionale de la Santé Publique*, or DRSP), district MSP office (*Service de District de la Santé Publique*, or SDSP), and finally to the field sites. The storage points for the delivery system can be found at DPEV, DRSP, SDSP, and field sites. Multiple stakeholders are involved in the delivery of inputs and medicines, including DPEV, EMAR, EMAD, PTF, and the community. Deliveries of inputs and medicines occur according to the requirements specified by monthly stock data sheets for average monthly consumption. Additionally, deliveries are made quarterly as required by SDSP and DRSP.

Communication channels used by the program include media, posters, flyers, town criers, and social networks. The communication agents responsible for spreading the program’s messages include AS, AC, APART, associations/OSC, journalists, and animators.

Supervision of the program is carried out at all levels of the health systems by MSP staff and PTFs. Inspections are conducted monthly, quarterly, and annually. The program uses an integrated supervision grid, known as Open Data Kit (ODK), and a dashboard as supervision tools.

For follow-up purposes, data storage and reporting are done using tools such as the monthly report of activities (*rapport mensuel d’activités*, or RMA) in both physical and electronic formats, weekly surveillance report (*rapport de surveillance hebdomadaire*, or RSH), and District Health Information System 2 (DHIS2). To assess program performance at all levels, the platforms used are DHIS2 and the dashboard. For evaluation purposes, the program uses an assessment tool/performance monitoring and evaluation framework (*cadre de suivi et évaluation de la performance*, or CSEP). Evaluations are carried out monthly, and assessments are conducted by regional supervision entities comprising SDSP, DRSP, the directorate of health information and systems (*Direction des Etudes, de la Planification, et des Systèmes d’Information*, or DEPSI), and PTF.

TABLE 2: HOW IMMUNIZATION PROGRAM OPERATES

S/N	THEMATIC AREAS	ANSWERS
1	Planning and coordination	
1.1	What coordination platforms exist at all levels, and how often do they meet?	<ul style="list-style-type: none"> • National: DPEV-PTF (frequency of meetings: half-yearly review, annual review, extraordinary meeting) • Regional: EMAR-PTF, OSCs (frequency of meetings: monthly, quarterly, annual) • District: EMAD-PTF, OSCs (frequency of meetings: monthly, quarterly, annually) • Commune/Fokontany: CSBs, ACs, OSCs (frequency of meetings: monthly, quarterly)
1.2	Who are the donors/partners?	WHO, USAID, UNICEF, Gavi, and Rotary Club
2	Service provision	
2.1	What are the services and benefits?	Vaccination, awareness-raising, MEV surveillance, MAPI management
2.2	What are the service locations?	CSB, door-to-door, fixed/mobile strategies
2.3	Who are the people responsible for providing these services?	AS, AC, volunteers, associations, churches, and APART
2.4	Who are the target age groups?	Children 0–59 months, pregnant women, people 18 years and over (for COVID-19)
2.5	What are the implementation strategies?	Fixed (up to 5 km), advanced (6–10 km), and mobile (>10 km)
3	Logistics	
3.1	What is the delivery system for inputs and medicines?	(1) laboratory → (2) DPEV → (3) DRSP → (4) SDSP → (5) health facility
3.2	Where to find delivery system storage points?	DPEV, DRSP, SDSP, field sites
3.3	Who is involved in delivering inputs and medicines?	DPEV, EMAR, EMAD, PTF, community
3.4	When do deliveries take place?	According to central MSP requirements (average monthly consumption) As required by SDSP (quarterly) As required by DRSP (quarterly)
4	Communication	
4.1	What are the communication channels?	Media, posters, flyers, town criers, and social networks
4.2	Who are the communication agents?	AS, AC, APART, associations/OSCs, journalists, animators
5	Supervision	
5.1	Who carries out the supervision?	AS at every level of the healthcare system, PTFs
5.2	How often are inspections carried out?	Monthly, quarterly, and annually
5.3	What supervision tool do you use?	Integrated supervision grid (ODK), dashboard

S/N	THEMATIC AREAS	ANSWERS
6	Follow-up	
6.1	What are the data storage and reporting tools?	RMA (physical and electronic), RSH, DHIS2
6.2	What are the platforms for assessing program performance at all levels?	DHIS2, dashboard
7	Evaluation	
7.1	What assessment tools are used?	CSEP
7.2	What is the evaluation frequency?	Monthly
7.3	Who carries out the assessment?	Regional supervision entities (SDSP, DRSP, DEPSI, PTF)

NUTRITION PROGRAM

In the area of planning and coordination, there are various nutrition coordination platforms at different levels. At the national and regional levels, there is a task force that meets quarterly at national level and twice a year at regional level. There is also a nutrition cluster at the national level that meets quarterly and as needed in emergency situations with the National Office for Risk and Disaster Management (*Bureau National de Gestion des Risques et des Catastrophes*, or BNGRC). Additionally, the National Office of Nutrition (*Office National de Nutrition*, or ONN) and Regional Offices of Nutrition (*Office Régional de nutrition*, or ORN) are involved in coordination. The program involves multiple donors and partners including: *Action Socio-sanitaire Organisation Secours* (ASOS), UNICEF, Action Against Hunger or *Action Contre la Faim* (ACF), *Santé Sud, Sécurité Alimentaire et Nutrition par l'Intensification et la Diversification Agroécologique* (SANIDA), ADRA, Food and Agriculture Organization (FAO), World Food Program or *Programme Alimentaire Mondial* (PAM), USAID, GRET, *Agronomes et Vétérinaires Sans Frontières* (AVSF), French Development Agency or *Agence Française de Développement* (AFD), and Aga Khan Foundation.

Under service provision, various services and benefits are provided at different locations. These include:

- Management of moderate acute malnutrition (*prise en charge de malnutrition aiguë modérée*, or PEC MAM) through community outreach prevention and monitoring provided by ACs
- Management of severe acute malnutrition (*prise en charge de malnutrition aiguë sévère*, or PEC MAS) at CSBs (without complications) and in hospitals (with complications)
- Growth monitoring and promotion, vitamin A supplementation, vaccination, and deworming provided by AS
- Specialized services provided by pediatric specialist AS and social workers at regional and university hospitals

The target age groups for these services are children aged 0–6 months, 6–59 months, pregnant women, and lactating women for prevention. The implementation strategies include: fixed services (at field sites and fixed sites), advanced/mobile strategies involving the community for vaccination, emergency response, and proximity care.

In terms of logistics, the delivery system for inputs and medicines involves UNICEF and the MSP-affiliated unit that coordinates projects (*Unité de Coordination des Projets*, or UCP) delivering to the national nutrition support unit within the family health directorate (*Service de la Nutrition*, or SNUT), which then distributes to SDSP and further to health facilities. ONN/ORN delivers directly to community sites.

The storage points for the delivery system can be found at SNUT, the district-level body in charge of management of medicine (*Pharmacie de Gros du District*, or PHAGDIS), the central medical store (SALAMA), ORN, and community sites. The delivery of inputs and medicines involves UNICEF delivering to SDSP through service providers, and then the CSBs receive them, currently at the expense of CSBs. Deliveries take place quarterly for Plumpy’Nut® and semi-annually for vitamin A.

Communication channels used by the program include: radio and TV, social networks, posters, banners, brochures, mobile sound systems, information, education, and communication (IEC), and care and counseling centers (CCCs). The communication agents responsible for communication activities include: journalists, DPS and MSP personnel, ACs, ASs, and OSCs.

Supervision of the program is carried out by various entities:

- SNUT conducts supervision during campaigns.
- ONN/ORN conducts unannounced supervision.
- EMAR conducts monthly supervision using national supervision grids—one for the CSB (at the *Centre de récupération et d’éducation nutritionnelle ambulatoire pour la malnutrition aiguë sévère*, or CRENAS) and another for the hospital (at the *Centre de récupération et d’éducation nutritionnelle intensive*, or CRENI).
- EMAD conducts half-yearly supervision.
- PTFs conduct quarterly supervision.
- Nongovernmental organizations (NGOs) are also involved in supervision.

The frequency of inspections is determined by each supervising entity, and different supervision tools such as the integrated supervision report templates for CRENAS and CRENI are used.

For follow-up purposes, data storage and reporting are done using tools such as RMA, DHIS2, and community reports. The platforms used for assessing program performance at all levels include SNUT, DRSP, SDSP, local NGO COMARESS (for community health level), and the regional supervision and evaluation team (*groupe régional de suivi et d’évaluation*, or GRSE). In terms of evaluation, the program uses a performance monitoring and evaluation framework. Evaluations are conducted monthly, and assessments are carried out by the *Comité de suivi régional* (CSR).

TABLE 3: HOW NUTRITION PROGRAM OPERATES

	THEMATIC AREAS	ANSWERS
1	Planning and coordination	
1.1	What coordination platforms exist at all levels, and how often do they meet?	<ul style="list-style-type: none"> • Task Force: national and regional (national meets quarterly, regional meets twice per year) • Nutrition cluster at national level (quarterly meeting and as needed, e.g., emergency situation with BNGRC) • ONN/ORN
1.2	Who are the donors/partners?	ASOS, UNICEF, ACF, Santé Sud, SANIDA, ADRA, FAO, PAM, USAID, GRET, AVSF, AFD, Aga Khan Foundation

	THEMATIC AREAS	ANSWERS		
2	Service provision			
2.1	What are the services and benefits?	Location	Services	Service Suppliers
2.2	What are the service locations?	Community site	PEC MAM Prevention and monitoring	ACs
2.3	Who are the people responsible for providing these services?	CSB	PEC MAS without complications Prevention and monitoring Vit A, vaccine, deworming	ASs
		Regional and university hospitals	PEC MAS with complications	Pediatrician specialist ASs, social workers
2.4	Who are the target age groups?	PEC: 0–6 months, 6–59 months, pregnant women Nursing women (prevention)		
2.5	What are the implementation strategies?	<ul style="list-style-type: none"> • Fixed (field site and fixed site) • Advanced/mobile: community with vaccination • Emergency • Proximity care 		
3	Logistics			
3.1	What is the delivery system for inputs and medicines?	UNICEF, UCP → SNUT → SDSP → Field sites ONN/ORN → Community site		
3.2	Where to find delivery system storage points?	<ul style="list-style-type: none"> • Plumpy'Nut: SNUT, PHAGDIS, FANOME • Phosphatidylserine: ORN, community site 		
3.3	Who is involved in delivering inputs and medicines?	UNICEF → SDSP via service providers → CSB (currently at CSB expense!)		
3.4	When do deliveries take place?	Plumpy'Nut: Quarterly Vit A: Semi-annually		
4	Communication			
4.1	What are the communication channels?	Media, social networks, posters, banners, brochures, IEC/CCC, mobile sound systems		
4.2	Who are the communication agents?	Journalists, DPS, MSP personnel, AC, AS, OSC		
5	Supervision			
5.1	Who carries out the supervision?	Responsible	Frequency	Tool
5.2	How often are inspections carried out?	SNUT	During campaigns	Integrated supervision template
		ONN/ORN	Unannounced	
5.3	What supervision tool do you use?	EMAR	Monthly	CRENAS, CRENI
		EMAD	Half-yearly	
		PTF	Quarterly	
		NGO		

	THEMATIC AREAS	ANSWERS
6	Follow-up	
6.1	What are the data storage and reporting tool	RMA nutrition, DHIS2, community report
6.2	What are the platforms for assessing program performance at all levels?	SNUT, DRSP, SDSP, COMARESS, GRSE
7	Evaluation	
7.1	What assessment tools are used?	Performance monitoring and evaluation framework
7.2	What is the evaluation frequency?	Monthly
7.3	Who carries out assessment?	CSR (national, regional, district)

SESSION 3: FOOD SECURITY PROGRAM IN MADAGASCAR

A presentation of the food security program in Madagascar was made at the workshop. Below are key highlights from the presentation and discussion.

- **Differentiating between emergency and development food assistance programs:** The workshop highlighted the distinction between emergency food assistance programs implemented in regions like Southern Madagascar, Somalia, Syria, and Yemen, and development programs such as the Productive Safety Net Program in Ethiopia and cash or food security programs like Asotry and Fararano in Madagascar.
- **Various types of food assistance programs:** The different types of food assistance programs include: food in kind, cash transfers for food, and food vouchers.
- **Food distribution system and modalities:** The workshop examined the distribution system, discussing options such as direct distribution to households or individuals on a biweekly or monthly basis, distribution through groups of households, distribution through traditional leaders, and distribution through a community-based, targeted distribution system.
- **Stakeholders involved in food distribution:** The workshop discussed the involvement of various entities in food distribution, such as the government, local or international NGOs, and direct distribution by organizations like PAM.
- **Food logistic cycle:** The different stages of the food logistic cycle include: procurement (offshore or local), transportation, warehousing, distribution, and monitoring.
- **Food distribution at the community level:** The workshop emphasized the importance of efficient processes at the community level, including registering new beneficiaries, issuing ration cards, planning for each distribution, setting up distribution sites, and reporting on distributions.
- **Food security projects in Madagascar:** The workshop discussed food security projects implemented in Madagascar, funded by organizations like USAID. These projects included activities related to nutrition, disaster management, agribusinesses, farmer field schools, and seed and supply fairs. Examples of specific programs mentioned were: essential nutrition action, growth monitoring and prevention, cooking demonstration, community-based management of acute malnutrition, and USAID’s FIOVANA and Maharo projects.
- **Emergency/humanitarian food assistance projects in Southern Madagascar:** The workshop highlighted various food assistance projects implemented by organizations like PAM, CARE, UNICEF, ACF, CRS, and

ADRA. These projects involved targeted unconditional food transfers, supplemental feeding for vulnerable groups, treatment of malnutrition, cash transfers, and support for agricultural activities.

- **Potential food security or food assistance programs to leverage for nutrition and immunization:** Participants discussed the potential of leveraging existing food distribution sites, farmer field schools, village savings groups, agribusiness groups, cash transfer programs, and planning immunization outreach in conjunction with monthly food distribution programs.
- **Collaboration between food assistance programs and immunization programs:** The workshop explored the possibility of integrating food assistance programs with immunization efforts, particularly by coordinating the timing of food distribution with immunization outreach and ensuring logistic support for both programs.

SESSION 4 : CARTOGRAPHY OF PARTNERS IN IMMUNIZATION, NUTRITION, AND FOOD PROGRAMS IN MADAGASCAR

Group work was conducted in the form of a “world café.” Table 4 below shows the mapping and distribution of partners in the areas of immunization, nutrition, and food security in Madagascar.

TABLE 4: IMMUNIZATION, NUTRITION, AND FOOD SECURITY PARTNERS DISTRIBUTION IN MADAGASCAR 2019–2023

	NUTRITION	IMMUNIZATION	FOOD SECURITY
Number of regions where program partners work	09	15	09
Number of programs from 2019 and 2023 (including emergency intervention and campaigns)	07	02	03
Partners (numbers of regions)	ASOS (17), UNICEF (23), ACF (05), Santé SudSANTÉ (02), SANIDA, ADRA, FAO, PAM, USAID, GRET, AVSF, AFD, Aga Khan Foundation	WHO (23), UNICEF (23), USAID (14), Gavi (23), Rotary Club	WHO (7), UNICEF (7), USAID (5)

SESSION 5: CHALLENGES OF INTEGRATION IN MADAGASCAR

Presentations on key barriers of integration from the HCD findings.

- The lack of personnel is identified as the biggest obstacle to integration in Madagascar.
- Insufficient technical capacity of healthcare personnel is also a major obstacle to integrated healthcare.
- The absence of policies and guidelines affects the coordination and quality of integrated healthcare services.
- Insufficient funding hampers the ability to provide integrated healthcare services.
- Inadequate infrastructure, including facilities, medications, and equipment, poses a challenge to integration.
- Lack of coordination between funding sources leads to poor infrastructure in certain contexts and hinders service delivery.
- The rigidity of the government in increasing the healthcare budget contributes to the funding deficit.

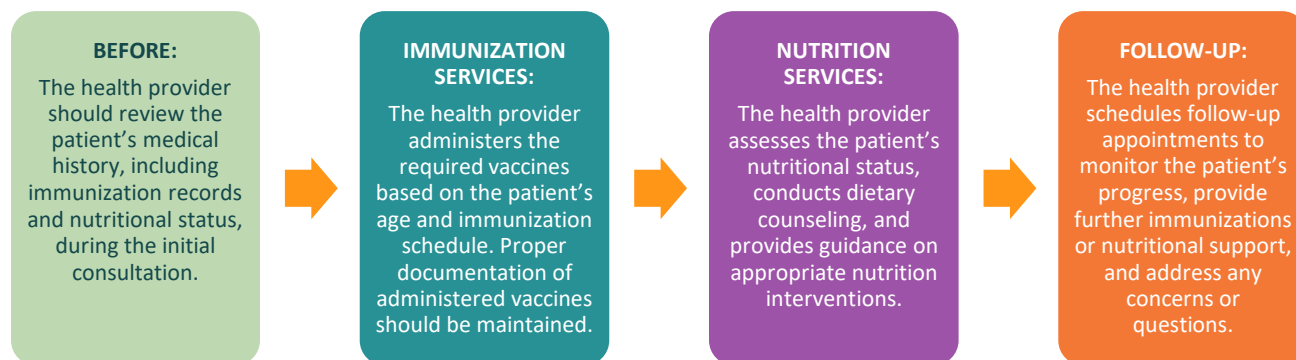
SESSION 6: SOLUTIONS TO INTEGRATION AT HEALTH FACILITY USING DIFFERENT SCENARIOS

SCENARIO 1: ONLY ONE HEALTH PROVIDER AT THE HEALTH FACILITY

In this scenario, where there is only one health provider at the health facility, the integration of immunization and nutrition services can be achieved through:

- **Co-location:** The health provider ensures that immunization and nutrition services are offered in the same location within the health facility. This allows for easier access and convenience for patients seeking both services.
- **Streamlined workflows:** The health provider develops streamlined workflows to ensure efficient delivery of immunization and nutrition services. This may involve optimizing appointment scheduling, ensuring adequate availability of vaccines and nutritional supplements, and coordinating the delivery of services to minimize waiting times. (See Figure 4 below).
- **Training and capacity building:** The health provider receives appropriate training and capacity building to deliver both immunization and nutrition services effectively. This includes staying updated on the latest guidelines, techniques, and best practices in both fields.

FIGURE 4: WORKFLOW WITH ONLY ONE HEALTH PROVIDER AT HEALTH FACILITY

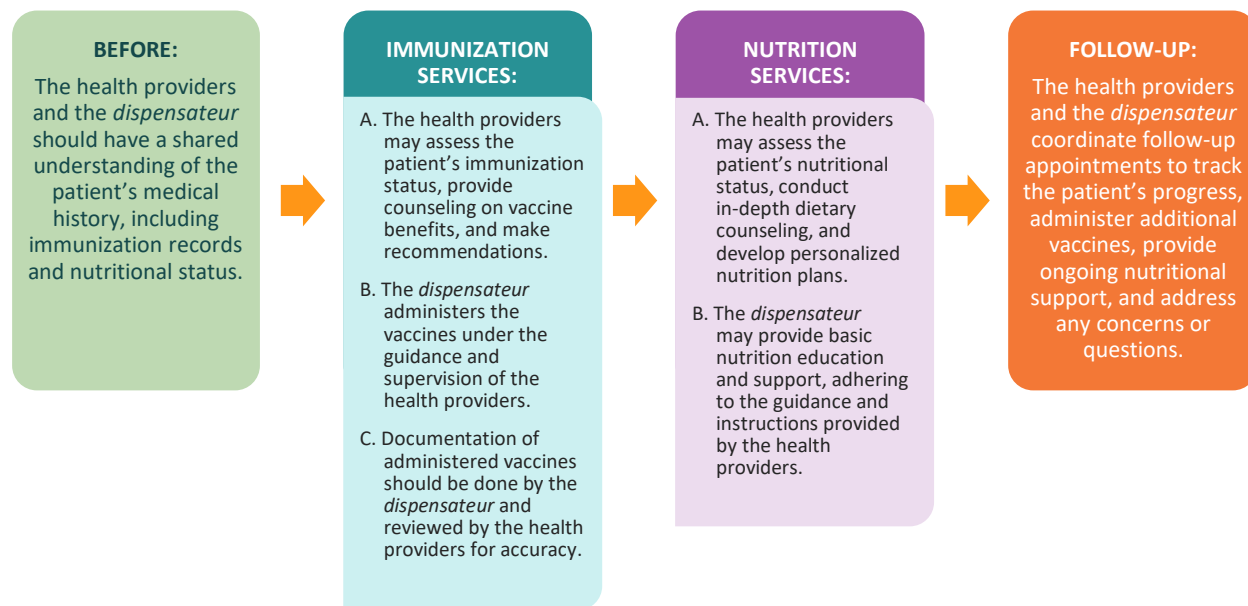


SCENARIO 2: TWO HEALTH PROVIDERS PLUS ONE *DISPENSATEUR*

In this scenario, where there are two health providers plus one *dispensateur* (literally, a dispenser, responsible for providing medications from the CSB's pharmacy to the patient), the integration of immunization and nutrition services can be achieved through:

- **Collaboration and coordination:** The health providers and the *dispensateur* work collaboratively and coordinate their efforts to ensure seamless integration of immunization and nutrition services. This involves regular communication, joint planning, and sharing of patient information.
- **Task shifting and delegation:** The health providers delegate certain tasks to the *dispensateur* to optimize the delivery of services. For example, the *dispensateur* can assist with basic immunizations and nutrition counseling under the guidance and supervision of the health providers. (See Figure 5 below).
- **Regular meetings and training:** The health providers and the *dispensateur* have regular meetings to discuss challenges, share experiences, and receive training updates. This promotes a culture of continuous learning and improvement in the delivery of integrated services.

FIGURE 5: WORKFLOW WITH TWO HEALTH PROVIDERS AND A *DISPENSATEUR*

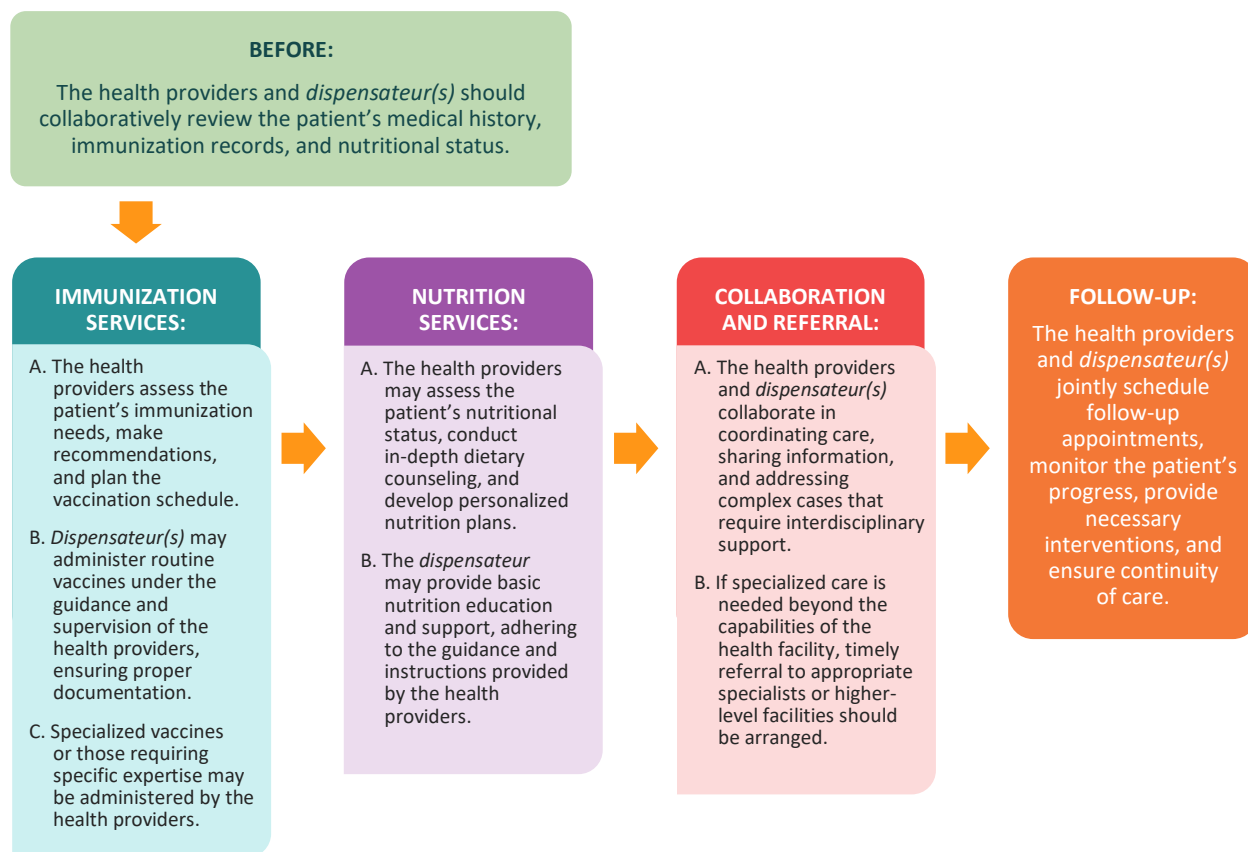


SCENARIO 3: THREE OR MORE HEALTH PROVIDERS PLUS ONE OR MORE *DISPENSATEUR*

In this scenario, where there are three or more health providers plus one or more *dispensateur*, the integration of immunization and nutrition services can be achieved through:

- **Multi-disciplinary team approach:** The health providers and the *dispensateur* work as a multi-disciplinary team, with each member contributing their expertise to the integration of services. This may involve regular team meetings, joint decision-making, and shared accountability. (See Figure 6).
- **Patient-centered care:** The team adopts a patient-centered approach, considering the individual needs and preferences of patients when delivering integrated immunization and nutrition services. This includes personalized counseling, tailored treatment plans, and comprehensive follow-up.
- **Efficient referral system:** In cases where specialized care is required beyond the scope of the health facility, an efficient referral system is established to ensure patients receive timely and appropriate care from higher-level healthcare providers or specialized services.
- **Continuous quality improvement:** The team prioritizes continuous quality improvement efforts, including regular monitoring and evaluation of integrated services. This allows for identifying areas for improvement, addressing gaps, and enhancing the overall effectiveness and efficiency of service delivery.

FIGURE 6: WORKFLOW WITH THREE OR MORE HEALTH PROVIDERS AND ONE OR MORE *DISPENSATEURS*



SESSION 7: HOW INTEGRATION CAN WORK IN MADAGASCAR

In this session, participants did group work to recommend how immunization, nutrition, and food security programs and services can be delivered in an integrated manner. Each group used the template below to document and report their work.

TABLE 5: TEMPLATE USED BY THE GROUPS TO OUTLINE THE APPROACHES FOR INTEGRATION OF IMMUNIZATION, NUTRITION AND FOOD SECURITY PROGRAMS

Thematic area	Activities per thematic area (using the SMART* framework)	Time	Targets (if applicable)	Required resources (if any)
Planning and coordination				
Service delivery				
Logistics				
Communication				
Supervision				
Monitoring				
Evaluation				

*SMART = specific, measurable, achievable, relevant, and time-bound

A synthesis of the solutions suggested by the workshop participants is provided below.

PLANNING AND COORDINATION

Develop an integrated healthcare plan that includes immunization and nutrition services, outlining specific objectives, strategies, and targets.

- Establish a coordination mechanism involving relevant stakeholders from the health sector, including government entities, NGOs, and community representatives.
- Conduct regular meetings and workshops to facilitate collaboration, information sharing, and joint decision-making among stakeholders.

Target groups:

- Identify target populations for integrated services, such as children, pregnant women, or specific vulnerable groups based on epidemiological and nutritional profiles.

Required resources:

- Human resources: Ensure an adequate number of trained healthcare providers, including immunization specialists, nutritionists, and support staff.
- Infrastructure and equipment: Assess and address infrastructure needs, such as proper facilities for vaccine storage, examination rooms, and nutrition counseling areas.
- Information systems: Develop or enhance existing systems for collecting, managing, and analyzing data related to immunization and nutrition services.
- Funding: Secure financial resources for the implementation and sustainability of integrated services.

SERVICE DELIVERY

- Integrate immunization and nutrition services within health facilities, ensuring co-location and streamlined workflows.
- Provide comprehensive training to healthcare providers on integrated service delivery, including immunization techniques, nutritional assessment, counseling, and monitoring.
- Develop standardized protocols and guidelines for delivering integrated services, addressing issues such as vaccine administration, growth monitoring, and micronutrient supplementation.

Target groups:

- Identify and prioritize specific populations for integrated services based on epidemiological and nutritional indicators, as well as equity considerations.

Required resources:

- Adequate vaccine supply: Ensure a consistent and reliable supply of vaccines, cold chain equipment, and related logistics.
- Nutritional supplements: Secure an adequate stock of high-quality nutritional supplements, fortified foods, and micronutrient powders.
- Health promotion materials: Develop and distribute educational materials on immunization, nutrition, and the benefits of integrated services.
- Monitoring and evaluation tools: Establish systems for monitoring coverage, quality of services, and patient outcomes, including growth monitoring and immunization coverage surveys.

LOGISTICS

- Review and improve efficiencies in the supply chain management system to ensure the timely delivery and distribution of vaccines, nutritional supplements, and other necessary commodities.
- Implement an effective cold chain system, including proper storage, transportation, and temperature monitoring of vaccines and perishable nutritional products.
- Conduct regular inventory management to prevent stockouts, minimize wastage, and maintain adequate supplies.

Target groups:

- Focus on reaching health facilities, outreach clinics, and other service delivery points where immunization and nutrition services are provided.

Required resources:

- Cold chain equipment: Ensure the availability of refrigerators, freezers, temperature monitoring devices, and backup power supply to maintain the cold chain.
- Transportation: Provide reliable vehicles and transport arrangements to facilitate the distribution of vaccines and nutritional supplies to health facilities in remote areas.
- Procurement and supply management: Allocate resources for procurement, storage, and inventory management systems, including personnel training and information systems.

COMMUNICATION

- Develop a comprehensive, evidence-based communication strategy to raise awareness about the benefits of integrated services, targeting both healthcare providers and the general population.
- Use various communication channels (including community meetings, radio, television, and social media) to disseminate information on immunization schedules, nutritional practices, and the importance of integrated services.
- Engage community leaders, influencers, and local organizations to promote community participation, trust, and support for integrated services.

Target groups:

- Tailor communication messages to specific target groups, considering their cultural beliefs, literacy levels, and language preferences.

Required resources:

- Communication materials: Develop culturally appropriate and visually appealing materials, including brochures, posters, and audiovisual aids, to support communication campaigns.
- Community engagement: Allocate resources for community mobilizers, health educators, and social mobilization activities to facilitate community acceptance and participation in integrated services.
- Training: Provide capacity building for healthcare providers on effective communication techniques, interpersonal skills, and community engagement strategies.

SUPERVISION

- Establish a robust supervisory system to ensure adherence to integrated service delivery guidelines, quality assurance, and performance monitoring.
- Conduct regular supervisory visits to health facilities, providing feedback, addressing challenges, and offering technical support to healthcare providers.
- Implement performance assessments and recognition mechanisms to incentivize healthcare providers and facilities for maintaining high-quality integrated services.

Target groups:

- Focus on healthcare providers delivering immunization and nutrition services, including nurses, doctors, midwives, and community health workers.

Required resources:

- Supervisory personnel: Allocate trained supervisors or mentors who have expertise in immunization and nutrition services to conduct supportive supervision.
- Performance assessment tools: Develop tools and indicators to assess the quality, efficiency, and effectiveness of integrated service delivery.
- Training: Provide capacity building for supervisors on effective supervision techniques, mentoring, and performance management.

MONITORING

- Establish a monitoring system to track the progress, coverage, and quality of integrated services, including immunization and nutrition indicators.
- Develop data collection tools and ensure their proper utilization, including immunization registries, growth monitoring charts, and electronic health records.
- Analyze monitoring data regularly, identifying gaps, challenges, and areas for improvement in integrated service delivery.

Target groups:

- Focus monitoring on health facilities, districts, and regional levels to assess the performance and impact of integrated services.

Required resources:

- Data management systems: Establish electronic or paper-based systems for data collection, storage, analysis, and reporting.
- Monitoring and evaluation personnel: Allocate trained staff responsible for data collection, analysis, and reporting at different levels of the health system.
- Data quality assurance: Provide training and resources for ensuring accurate and reliable data collection, including data verification and validation processes.

EVALUATION

- Conduct periodic evaluations to assess the effectiveness, efficiency, and impact of integrated service delivery.
- Use appropriate evaluation methods (e.g., surveys, assessments, and qualitative research) to gather feedback from healthcare providers, clients/patients, and other stakeholders.
- Disseminate evaluation findings widely to inform policy, guide decision-making, and improve the implementation of integrated services.

Target groups:

- Include the following groups in evaluation efforts: healthcare providers, administrators, patients, and other relevant stakeholders involved in integrated service delivery.

Required resources:

- Evaluation expertise: Engage qualified evaluators or researchers with experience in assessing integrated service delivery programs.
- Evaluation tools and methodologies: Develop or adapt evaluation tools and methodologies to measure the desired outcomes and impacts of integrated services.
- Dissemination and utilization of evaluation findings: Allocate resources for preparing evaluation reports, organizing dissemination events, and facilitating the utilization of findings by policymakers and implementers.

SUMMARY OF WORKSHOP RECOMMENDATIONS

1. **Conduct health facility service readiness assessment** to inform operational guide and service integration.
2. **Develop an integrated immunization and nutrition policy framework:** Participants should agree on a comprehensive policy framework that outlines the integration of immunization and nutrition services at all levels. This framework will provide guidance and direction for implementation.
3. **Create operational guidelines for integrated services:** Detailed operational guidelines should be developed to ensure the smooth implementation of integrated immunization and nutrition services. These guidelines will specify the standard operation procedures for healthcare providers.
4. **Strengthen coordination mechanisms:** Establishing effective coordination mechanisms between immunization and nutrition programs is crucial. This will enhance collaboration, communication, and data sharing between relevant stakeholders.
5. **Prioritize training and capacity building:** Participants should prioritize the training and capacity building of healthcare providers to ensure they have the necessary knowledge and skills to deliver integrated immunization and nutrition services. Training programs should focus on both technical aspects and the importance of interdisciplinary collaboration.
6. **Integrate immunization and nutrition services within healthcare facilities:** The proposed guideline should clearly describe how integration of immunization and nutrition services within healthcare facilities—such as vaccination clinics, primary healthcare centers, and nutrition centers—should happen. This may involve reorganizing workflows, adjusting service delivery models, and optimizing resource allocation.
7. **Strengthen health information systems:** Developing or enhancing health information systems to capture and track immunization and nutrition data is vital. This includes implementing standardized data collection tools, establishing robust reporting mechanisms, and ensuring data interoperability between different health information systems.
8. **Ensure joint monitoring and evaluation:** There should be a joint monitoring and evaluation framework to assess the impact of integrated immunization and nutrition services. This framework should include indicators for vaccination coverage, nutritional status, disease prevalence, and other relevant metrics.
9. **Build community engagement and awareness:** A comprehensive community engagement strategy should be developed to raise awareness about the importance of integrated immunization and nutrition services. This may involve conducting outreach activities, leveraging community leaders, and using various communication channels to disseminate information.
10. **Mobilize resources and financing:** Avenues for resource mobilization and financing to support the implementation of integrated services should be explored. This may involve seeking financial support from donors, engaging with private sector partners, and aligning budget allocations within the health sector.
11. **Conduct advocacy and policy dissemination:** To ensure the sustainability and scalability of integrated immunization and nutrition services, a policy framework, operational guidelines, and success stories should be disseminated to policymakers, stakeholders, and the public. This will garner support and promote replication in other regions of Madagascar.

NEXT STEPS

TABLE 6: ACTION PLAN FOR NEXT STEPS

	Activities	Timeline	Responsible
1	Sharing of workshop report	June 22, 2023	Hosea
2	Initial debriefing of key outcome of the workshop	June 19, 2023	Daniel, Tahina, Hosea
3	Review and finalization of report of the integration workshop	June 22–26, 2023	Hosea, Daniel, Chizoba, Habtamu, Tahina
4	Full debrief for the national program managers (immunization, nutrition, and food security) and partners, on the outcome of the 2-day workshop on integration	July 1, 2023	Tahina
5	Virtual technical discussion with ADRA to identify possible area of collaboration/integration with immunization	July 12–16, 2023	Chizoba
6	Health facility readiness assessment	July 2023	Chizoba
7	Workshop to develop guidelines on integration of immunization, nutrition, and food security (using feedback from the first workshop)	August/September 2023	Daniel, Chizoba, Habtamu, Tahina, Hosea
8	Implementation of intervention the guideline in select districts	November/December 2023	District Managers
9	Program monitoring and evaluation in the selected district	November 2023 to October 2024	MOMENTUM Country and Global Leadership/Madagascar

CONCLUSION

In conclusion, the workshop on integrating immunization, food programs, and nutrition represented a significant step towards achieving comprehensive and holistic approaches to some of Madagascar's major public health challenges. It provided a platform for multi-disciplinary collaboration, knowledge sharing, and capacity building among stakeholders in the fields of immunization, food programs, and nutrition.

The integration of immunization, food programs, and nutrition is crucial to maximize the impact of interventions and improve overall health outcomes. By combining efforts, the many stakeholders in these areas can enhance the effectiveness of immunization programs by ensuring that individuals receive adequate nutrition, which plays a vital role in strengthening their immune systems. Simultaneously, integrating nutrition and food programs with immunization initiatives ensures that children and vulnerable populations receive the essential nutrients they need to support their growth and development.

During the workshop, participants engaged in meaningful discussions and shared best practices, innovative strategies, and evidence-based approaches. The collaborative environment fostered a better understanding of the interconnectedness between immunization, food programs, and nutrition. It also highlighted the importance of coordination, data sharing, and policy alignment to achieve sustainable and impactful outcomes.

The workshop underscored the need for continued collaboration and knowledge exchange among various stakeholders, including government agencies, healthcare providers, NGOs, researchers, and community members. It emphasized the significance of integrating these sectors not only at the policy level but also in the design, implementation, and evaluation of programs on the ground.

Moving forward, it is essential to leverage the insights gained from the workshop to inform future interventions and policy development. Efforts should focus on strengthening partnerships, improving data collection and analysis, and promoting evidence-based practices. Moreover, fostering community engagement and awareness will be vital in ensuring the successful integration of immunization, food programs, and nutrition, as it requires active participation and support from individuals and families.

Integration of immunization, nutrition, and food security programs can create a comprehensive and sustainable approach to enhance public health outcomes, reduce health disparities, and promote overall wellbeing. This workshop serves as a launching point for continued collaboration, innovation, and advocacy in this important area. Working together, stakeholders can make significant strides in improving the health and nutrition of communities and achieving long-lasting positive impact.

ANNEX: QUESTIONNAIRE TO GUIDE THE DISCUSSION ON HOW DO NATIONAL PROGRAMS WORK?

S/N	THEMATIC AREAS	RESPONSE
1	Planification et coordination <ol style="list-style-type: none"> 1. Quelles sont les plateformes de coordination existantes à tous les niveaux et à quelle fréquence se réunissent-elles ? 2. Qui sont les donateurs/partenaires ? 	
2	Prestation de services <ol style="list-style-type: none"> 1. Quels sont les services et les prestations ? 2. Quels sont les lieux de prestation? 3. Qui sont les personnes chargées de fournir ces services et prestations ? 4. Quels sont les groupes d'âge cibles ? 5. Quelles sont les stratégies de mise en œuvre ? 	
3	Logistique <ol style="list-style-type: none"> 1. Quel est le système de livraison des intrants et médicaments ? 2. Où se trouvent les points de stockage du système de livraison ? 3. Qui participe à la livraison des intrants et médicaments? 4. Quand les livraisons ont-elles lieu ? 	
4	Communication <ol style="list-style-type: none"> 1. Quels sont les canaux de communication ? 2. Qui sont les agents de communication ? 	
5	Supervision <ol style="list-style-type: none"> 1. Qui effectue la supervision ? 2. Quelle est la fréquence des contrôles ? 3. Quel est l'outil de supervision utilisé ? 	
6	Contrôle <ol style="list-style-type: none"> 1. Outils de stockage de données et d'établissement de rapports ? 2. Quelles sont les plateformes d'évaluation des performances des programmes à tous les niveaux ? 	
7	L'évaluation <ol style="list-style-type: none"> 1. Quels sont les outils d'évaluation utilisés ? 2. Fréquence de l'évaluation ? 3. Qui réalise l'évaluation ? 	



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