

Community LLIN Distribution and Economic Empowerment in Madagascar

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Context

- **Malaria:** a leading cause of morbidity and mortality in children < 5 and pregnant women
 - >70% of the population below the poverty line
 - >76% live in rural areas
 - >65% lives more than 5k from a health facility
 - Limited access to many areas
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- **How to reach rural populations?**

LLIN Distribution - A

Complimentary National Strategy

- Led by Ministry of Health
- Supported by donors – Global Fund, USAID, UNICEF, Red Cross and others
- Implemented by MoH and RBM partners
 - Routine ANC free LLINs to PWUF
 - Campaign distribution (geographically targeted)
 - Commercial sector distribution
 - Community Health Workers (CHWs)



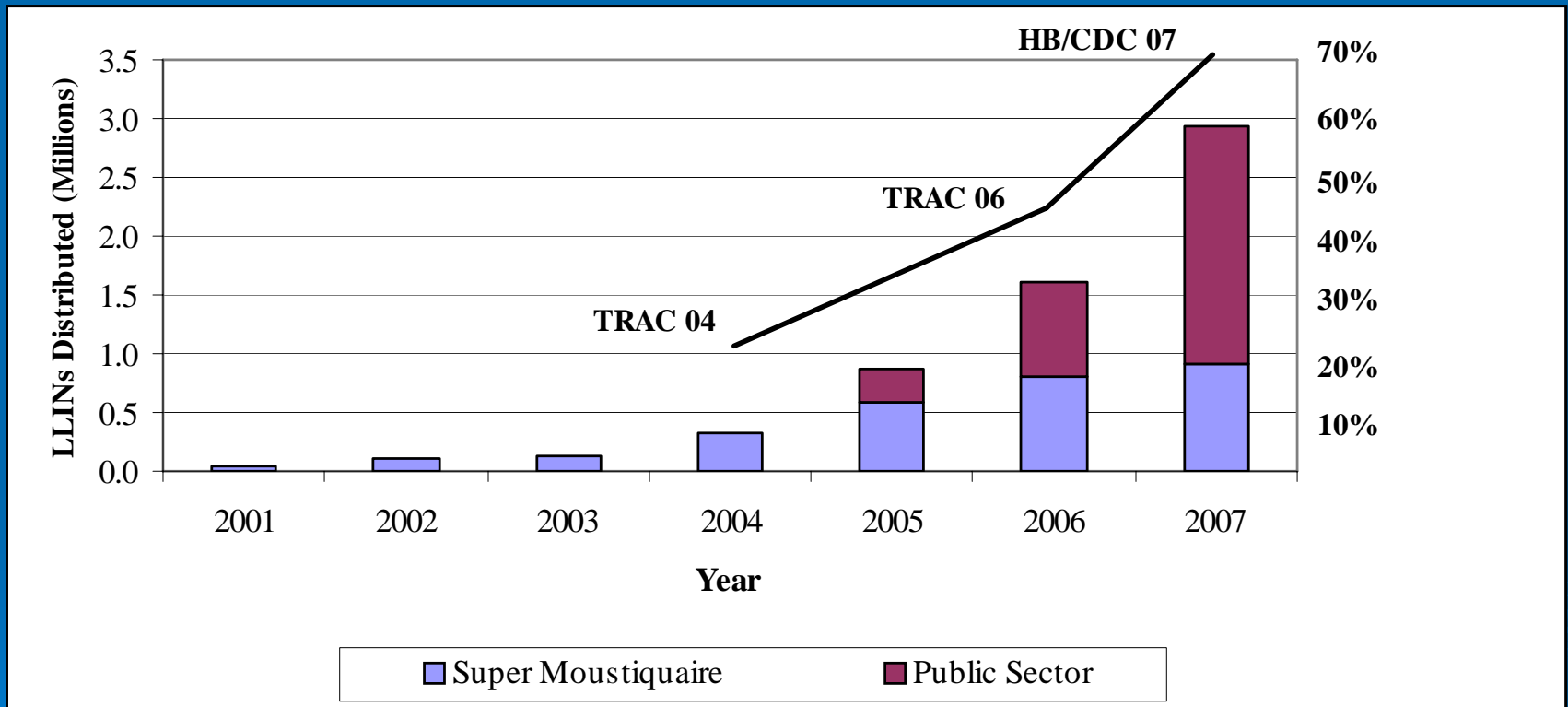
Community Health Workers

- Network of >5,000 CHWs nationwide
- Trained and supported by local health facilities & NGOs (PSI, Santenet, MCDI, ADRA, CARE, CRS and local organizations)
- CHWs: Volunteers and entrepreneurs
- BCC & product distribution
- System of incentives based upon subsidized product sales

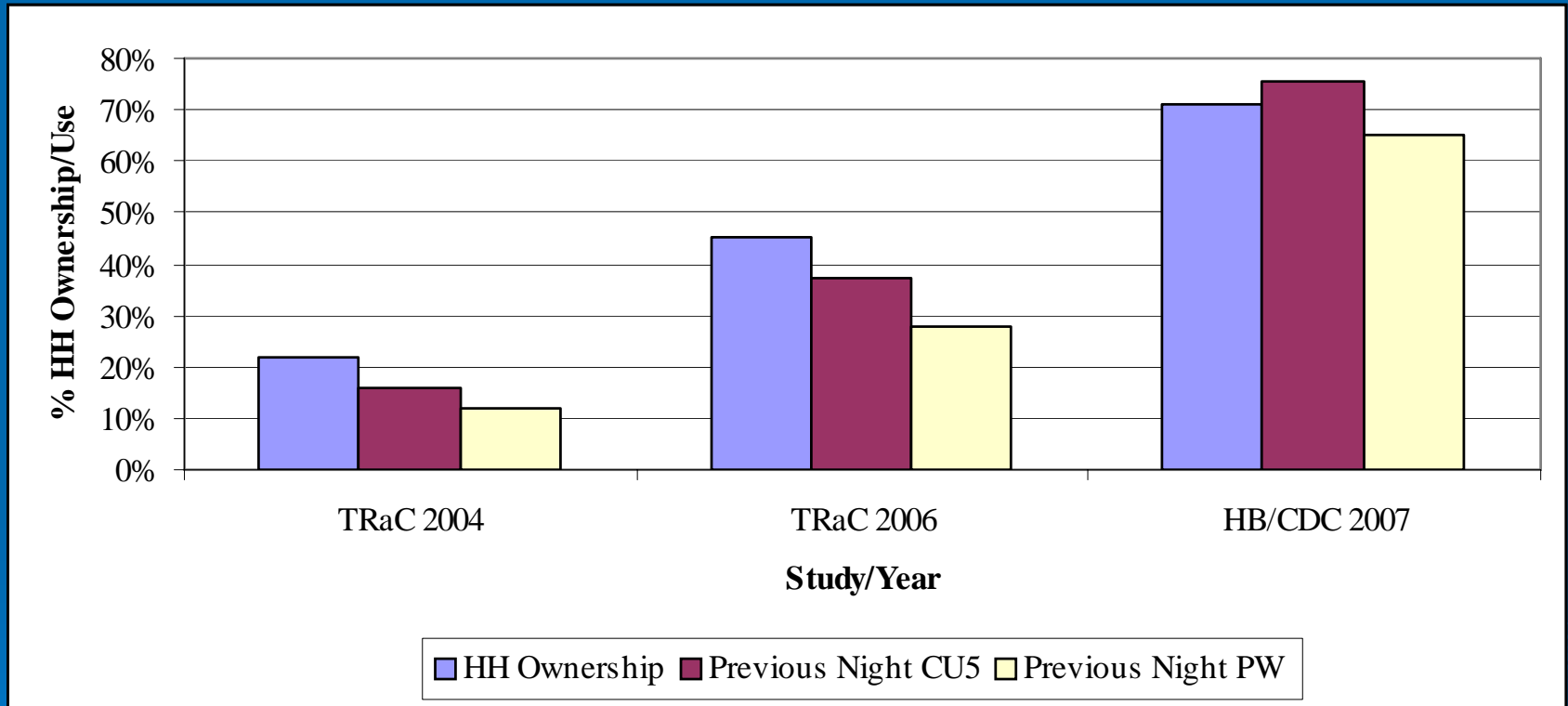
CHW Incentives & Health Impact

- LLINs the driver for network = \$0.56/LLIN
- 2.7 million LLINs marketed since 2005 with approximately 25% distributed via CHWs
- Halo effect on other health interventions (family planning, malaria case management, referral to health facilities, etc)

LLIN Distribution & HH Ownership



LLIN Ownership and Use



The Future

- Expand network of CHWs with support from GFR7 and PMI/USAID
- Targeted interventions based on research (DHS)
- Transition from CQ to ACT at community level
- ‘IMCI-C’: Malaria, diarrhea and ARI
- Greater involvement of environmental NGO/CBOs

Preconditions to Replicate in Other Countries

- Supportive, proactive government
- Complementary approach
- Active civil society
- Motivated communities and entrepreneurial people
- Geographics: distance, accessibility, rural (i.e. may make sense in DRC, but not smaller countries)