Madagascar Country Summary, March 2017

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Madagascar—Selected Demographic and Health Indicators			
Indicator	**Data**	**Indicator**	**Data**
Population[1]	24,235,390	TFR (births per woman)[3]	4.8
Live births/year[2]	796,800	ANC +4[3]	49.3%
MMR (per100,000 live births)[3]	498	SBA[3]	43.9%
NMR (per 1,000 live births)[3]	24	IPTp2+[3]	6.4%
U5MR (per 1,000 live births)[3]	72	DTP3[4]	69%

Sources: [1] United Nations Population Division. World Population Prospects 2015; [2] INSTAT (Institut National de la Statistique) 2015; [3] DHS 2008/2009 ; [4] WHO/UNICEF Estimates of Immunization Coverage, Madagascar 2015.

Strategic Objectives

- Provide support and technical leadership in maternal and newborn health (MNH) and family planning (FP) at the national level to the government/Ministry of Health (MOH)
- Increase access to and improve quality of MNH and Immunization services in USG priority regions
- Increase access to postpartum long-lasting FP methods in USG priority regions
- Improve prevention and treatment of malaria in pregnancy (MIP) in the context of focused antenatal care (FANC)
- Strengthen the capacity of pre-service training institutions to educate midwives according to International Confederation of Midwives (ICM) standards and competencies
- (Added in PY3) Initiate process to increase number of non-surgeon physicians able to provide essential surgery services

Program Dates	July 2014 – March 2019
Financial Summary thru PY3	Expenditures thru PY2 [redacted]; PY3 Budget [redacted]; Total [redacted]
Geographic Scope	16 USG-supported regions: Alaotra Mangoro, Amoron'I Mania, Analamanga, Atsinanana, Atsimo Andrefana, Boeny (districts of Soalala and Mitsinjo), Diana, Haute Matsiatra, Ihorombe, Melaky, Menabe, Sava, Sofia, Vakinankaratra, Vatovavy Fitovinany, Analanjirofo

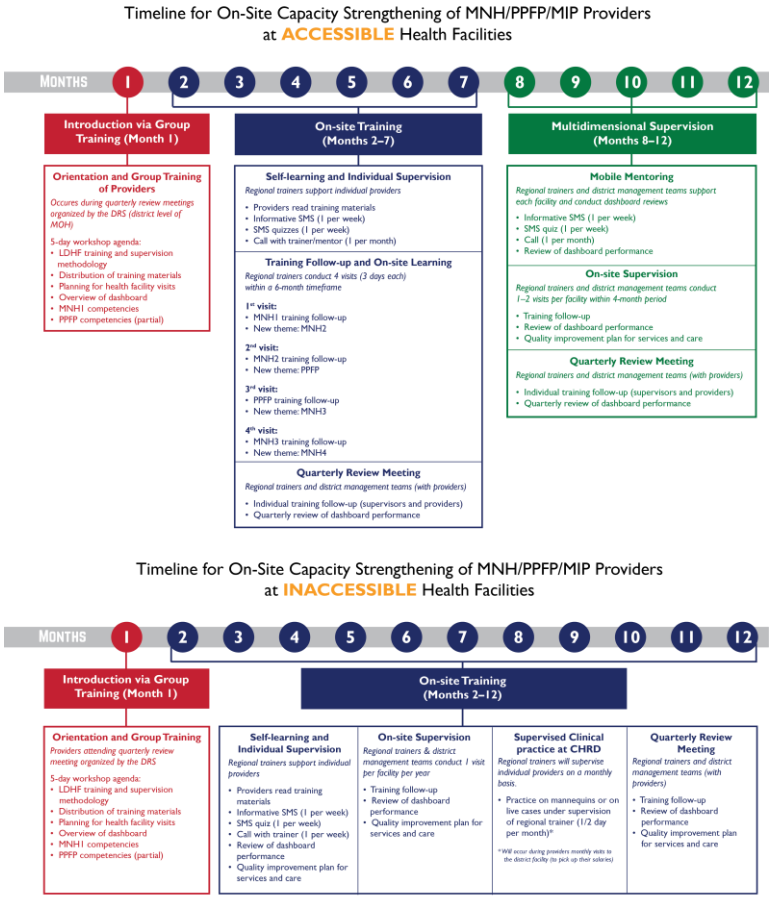
	No. of regions (%)	No. of districts (%)	No. of facilities (%)
Geographic Presence	16 / 22 (72%) Population: 23,705,697	75 / 114 (66%) Population: 17,677,722	690 / 1,867 (37%)
Technical Interventions	PRIMARY: Immunization, Malaria, Maternal Health, Newborn Health, Reproductive Health CROSS-CUTTING: , HSS(Quality Improvement [QI]), ICT4D, Gender, PSE		

Key Accomplishments

The Maternal and Child Survival Program (MCSP) in Madagascar began in July 2014 and is focused on reducing preventable deaths among pregnant women, newborns and children. MCSP provides strategic support to the national health system by strengthening policies, including national guidelines for maternal, newborn, and child health (MNCH) best practices as well as overall governance support to achieve country MNCH and family planning (FP) goals. In addition, MCSP supports the MOH in 16 USG-supported regions to develop their work plans and strategies for training, supervision and skills maintenance at all levels of the health system and to integrate a quality improvement (QI) component based on the concepts of clinical governance (CG) and accountability.

In PY2, at the national level, MCSP provided technical expertise to the MOH in key areas including: updates to RH norms/procedures and strategic plans, misoprostol and chlorhexidine scale-up plans, and the national budgeted plan for FP2020; participation technical working groups for RH at the community level, the Universal Health Coverage (UHC) strategy, development of a respectful maternity care curriculum; dissemination of the national 2015-2019 Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Roadmap; production and dissemination of community health worker and provider job aids, postpartum family planning (PPFP) communication materials to support provision of high-quality FP services; technical support to the measles campaign, evaluation of the polio response, and joint evaluation of the Expanded Programme on Immunization (EPI); the adoption and implementation of the WHO's 2012 IPTp-SP guidelines, and the development of a national malaria scorecard to monitor and chart progress across key indicators.

Figure 1. Adapted LDHF Training Approach for Providers at Accessible and Inaccessible Health Facilities in PY3



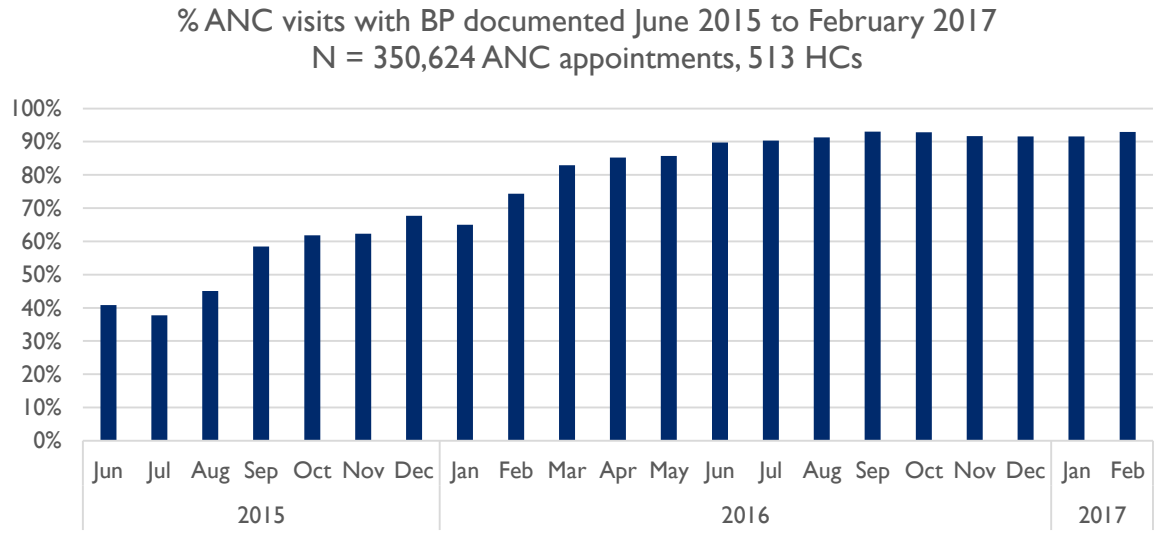
At the sub-national level, MCSP's main interventions included capacity-building of health providers through a "low dose, high frequency" (LDHF) approach to training, coupled with post-training support to help providers maintain their newly-acquired skills. Through Q1 of PY3, MCSP strengthened the capacity of 754 health providers to provide quality services in MNH and immunization through trainings led by national and regional trainers, in collaboration with the MOH. By expanding its existing pool of trainers with an additional 14 new national and 132 new regional trainers updated in MNH, MIP and PPFP counseling in all 16 regions of the country, MCSP now has a total of 186 trainers that can provide continuous support to trained front-line providers. 89 trainers and supervisors were orientated on supportive supervision – which combines on-site supervisory visits with mobile mentoring (mMentoring) via SMS messaging and a periodic phone calls – to ensure that trained providers retain knowledge and technical skills. In PY3, MCSP has responded to the MOH's mandate limiting providers' absences from their post to attend trainings by rolling out an adapted LDHF training approach to 128 national and regional trainers, as well as 314 previously trained health providers, and 80 new providers in five project regions. The multifaceted approach includes traditional group training with onsite training and post-training mobile mentoring (see Figure 1). The use of on-site training has allowed MCSP to train a second provider at the targeted CSBs, which will improve coverage by ensuring continuous and consistent quality of care (see Figure 2).

MCSP has supported measurement and data use for decision making and improved accountability through the implementation of a MNH quality dashboard at the CSB (primary health center) level. Since the first year of the project, MCSP more than tripled the number of facilities using the MNH quality dashboard – from 217 health facilities at the CSB and CHD level across 5 districts at the end of PY1, to 513 health facilities across 10 regions at the close of PY2 (with 526 providers in total trained use of the dashboard), to 674 facilities by the end of PY3 Q1. Tracking key indicators, including quality of care indicators in across the targeted health centers (HCs) helped providers view data and chart improvements or gaps in facility level care. For example, since the start of implementation, improvements were seen in women screened for pre-eclampsia and eclampsia (PE/E) during antenatal care (ANC) services (from 38% to 99%) and more women received a uterotonic immediately after birth of the baby (from 84% to 96%). Newborns who received all four elements of essential newborn care increased from 69% to 93%. Figure 3 illustrates the improvements in PE/E screenings.

Figure 2. Number of health facilities covered per region

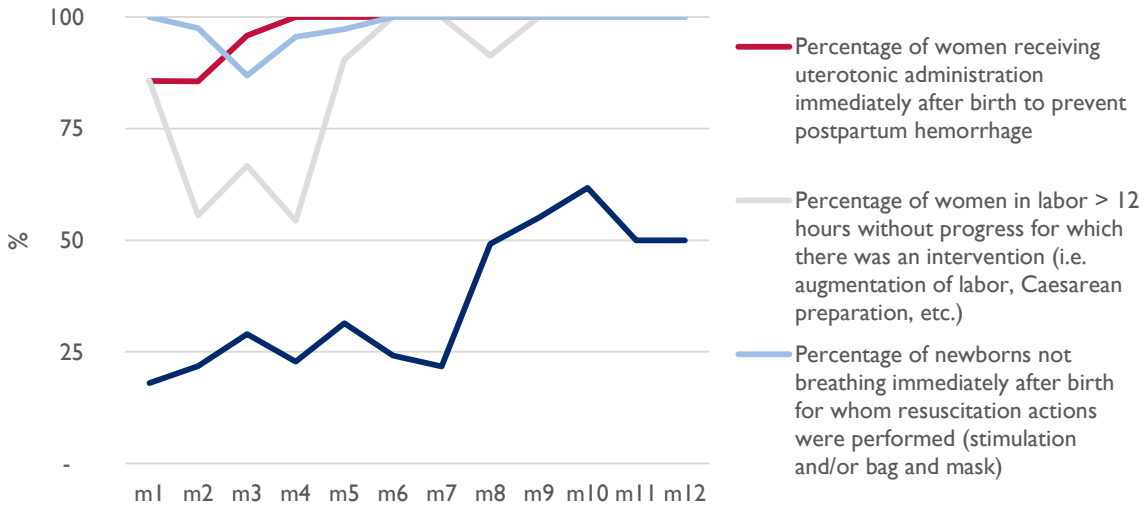
Region	Total of # CSB2	# of CSBs Supported by MCSP	Coverage
ALAOTRA MANGORO	78*	69	88%
AMORON I MANIA	48	26	54%
ANALAMANGA	197	87	44%
ATSIMO ANDREFANA	72	38	53%
ATSINANANA	127	47	37%
BOENY	32*	21	66%
DIANA	60	46	77%
HAUTE MATSIATRA	95	58	61%
IHOROMBE	18	14	78%
MELAKY	46*	37	80%
MENABE	89*	53	60%
SAVA	64	24	38%
SOFIA	82*	64	78%
VAKINANKARATRA	91	53	58%
VATOVAVY FITOVINANY	100	37	37%
TOTAL	1 199	674	56%

Figure 3. HCs: Improving PE/E Early Detection



MCSP successfully implemented its CG/QI initiative in partnership with key MOH departments, organizational partners and professional associations. The CG/QI initiative supports the provision of high-quality RMNCH services by institutionalizing the use of data for decision-making at all levels of the healthcare system, and the implementation of improvement teams in facilities to assess and inform performance across key indicators. Over the course of PY2, MCSP supported the CG/QI initiative in four regional referral hospitals, through creation/support of quality committees within hospitals and regional management teams and by promoting data use for decision making. The three common improvement objectives for all CG/QI hospitals are: (i) in routine maternal and newborn care, (ii) emergency maternal care: management of postpartum hemorrhage (PPH) (iii) emergency newborn care: resuscitation of newborns not breathing/not crying. A fourth cross-cutting objective -- focused either on hospital management or on respectful maternity care – was determined by each individual health facility. Dashboards tracking key indicators in these areas are posted in the 4 CHRR each month to help providers visualize improvements and gaps in care. Figure 2 shows trends in 3 quality of care indicators over time (since start of implementation).

Figure 4. Improving quality of care in 4 Regional Referral Hospitals, Dec 2015–Dec 2016



Note: The horizontal axis reflects months of implementation instead of dates because each hospital started implementation at different times (in different months).

MCSP has introduced the CG/QI initiative to a fifth regional referral hospital in Q1 of PY3 and will continue to roll-out the program to an additional three hospitals and ten CSBs by the end of PY3. The availability of accurate, real-time, and site-specific data gathered through CG/QI activities will improve each facility's ability to identify gaps and enact corrective actions to improve the level of care provided, and thus improve the health outcomes of women and their families.

MCSP progressed towards its goal of expanding access to long-acting PPFP methods in Madagascar by training 41 new regional trainers in PPFP, who in turn implemented PPFP trainings (including implants and intrauterine devices) of 289 providers from 289 health facilities in PY2, and an additional 57 providers in to date in PY3. The trained providers were also supported in the provision of services by the development and dissemination of 7 key PPFP job aids, and the donation of basic PPFP supplies and start-up kits at 64 health facilities. MCSP also conducted a First-Time Parents (FTP) Formative Assessment in PY2 to help inform future adolescent RH interventions, and organized a national workshop in October 2016 to disseminate the assessment's results with key stakeholders. Additionally, MCSP led the organization of a National Family Planning Conference attended by 400+ participants from all 22 regions of the country, and which resulted in increased commitment and engagement by from MOH staff and parliamentarians to prioritize the adoption of reproductive health laws and guidelines to increased FP access, as well as galvanized regional health staff to develop and implement action plans for their respective FP priorities; those plans were then submitted to the central Directorate of Family Health and incorporated in to the costed national action plan. In Q1 of PY3, MCSP also supported a national workshop attended by the MOH, NGOs, and technical and financial partners, with the goal of integrating the preexisting PPFP curriculum and a post-abortion FP module into the national FP training package for providers.

Intermittent preventive treatment during pregnancy (IPTp) using sulfadoxine-pyrimethamine (SP) has been adopted as policy in Madagascar's the 93 endemic districts since 2004. Despite a relatively high rate of ANC attendance, the percentage of women in zones who reported receiving at least one dose of SP during an ANC clinic visit was 31% and only 22% reported receiving two or more doses (MIS 2011). MCSP has worked closely with the MOH in its goal to improve prevention and treatment of MIP within the context of FANC by conducting trainings (in MIP/FANC case management) that reached 350 providers, 265 regional trainers, and 11 national trainers in PY2, and an additional 585 providers in Q1 of PY3. MCSP also supported the development and dissemination of tools, including: IPTp guidelines, and 3 malaria job aids on IPTp, case management, and uterine measurement. Additionally, MCSP field-tested a gestational age assessment tool to improve the administration rates of the first dose of IPTp-SP. MCSP also developed a concept note for a malaria care-seeking behavior study, in collaboration with the MOH's malaria division, which will focus on obtaining a deeper understanding of community perceptions and practices related to malaria in both rural and urban areas of Madagascar, as well as how they influence the utilization of malaria healthcare services.

To advance the global polio eradication goal, MCSP has provided technical support to national polio campaigns since August 2015 and contributed to increasing oral polio vaccine (OPV) coverage to over 90% for each round. MCSP contributes to planning, monitoring and results analysis for national polio campaigns and OBRAs and providing technical guidance to follow-up on OBRA recommendations. OBRA V (conducted in December 2016) revealed that cVDPV polio transmission has been interrupted (However, there is still a risk of outbreak due to insufficient financial and human resources, polio surveillance indicators not 100% achieved, and pockets of lower campaign and routine OPV coverage). In addition, MCSP supported the global polio switch from tOPV to bOPV in Madagascar in April 2016 - a key step toward polio eradication. These efforts are complemented by MCSP's support to routine immunization strengthening through implementation of the Reaching Every Child (REC) strategy in 10 priority districts in coordination with Mahefa and Mikolo. MCSP provided technical input to the REC and HSS guidance for RI strengthening at regional, district and community levels. The REC and HSS Guidelines have been drafted and are being used for aligning the Gavi HSS funding with USAID support for routine immunization in Madagascar.

To maintain quality of services and to sustain the impact of MCSP's results, the network of pre-service training institutions was targeted to ensure conformity to the International Confederation of Midwives (ICM) standards and competencies. MCSP has worked closely with the MOH, UNFPA, and Faculties of Medicine

to update the midwifery training curricula and has strengthened the capacity of pre-service institutions in 5 regions through donations of key basic equipment, as well as through trainings on effective teaching skills, MNH technical updates and the management of skills labs.

MCSP's comprehensive approach to building the capacity of providers across all levels of the health system – through the training of national, regional, and district trainers and supervisors – and its focus on a LDHF competency-based training approach has led to several hundred providers in 16 regions of the country with increased RMNCH knowledge and skills. Additionally, MCSP's innovative integration of an MNH dashboard in supported facilities, along with a more robust CG/QI initiative in targeted facilities ensures that the local MOH departments are better able to track and improve the quality of services provided and thus bolster improved health outcomes for the communities served.

Challenges

In PY2, the MOH issued a mandate limiting providers' absences from their post to attend trainings no more than one week per quarter, in order to reduce the frequency of facilities without a provider. MCSP has responded by adapting its LDHF competency-based training approach to include more site-based and self-learning activities, as well as mobile learning/mentoring components to ensure that providers can still have opportunities to acquire and retain skills. The roll-out of this adapted training approach has highlighted that need for additional technical support to supervisors to ensure timely data collection and submission at the regional level. Additional conflicting schedules with the MOH's national campaigns continue to hinder MCSP's ability to implement quarterly programming.

Progress on pre-service activities has been impeded due to the Faculty of Medicine in Antananarivo's reluctance to participate in external assessments, making it difficult for MCSP to evaluate the implementation of the updated midwifery curricula and to conduct assessments of trained instructors. MCSP will continue its advocacy efforts at the national level to enable the implementation of the aforementioned assessments.

Way Forward

In subsequent years of the project, MCSP will continue to provide strategic support to the MOH to strengthen and harmonize national policies and guidelines to achieve Madagascar's MNH, immunization and FP goals, which include the operationalization of the CARMMA Roadmap, the improvement of routine immunization outcomes, and the implementation of youth-friendly RH policies. Additionally, MCSP will bolster its efforts to increase the coverage and quality of RMNCH services with the roll-out of its adapted LDHF training strategy to a total of 1,500 providers across 900 CSBs and regional hospitals (including 78 clinical training sites) in the project's 16 regions; 700 providers from targeted facilities will also be trained in PPIUD insertion. MCSP will also continue the expansion of the CG/QI initiative into additional regional hospitals and 30 primary health facilities, starting in PY3. Within the realm of MIP, MCSP will continue to work with the partners to ensure that IPTp messages (in line with the new WHO policy) are disseminated at the community level, and to update 3,250 providers on the new MIP protocols, via the MIP session integrated into the MNH training, which targets providers responsible of ANC and delivery services. MCSP will also continue supportive supervision of trained front-line health providers to ensure retention of knowledge and practical skills, and will provide technical support and updates to targeted midwifery institutions to improve the teaching skills of preceptors, and the clinical skills of both preceptors and students. By the end of the project, MCSP will have initiated the institutionalization of national norms and protocols for training non-surgeon providers in essential surgery – including the development of one clinical site and a pool of 10 national trainers – in order to increase the number of doctors available to provide life-saving surgeries in Madagascar.

Selected Performance Indicators for PY2		
MCSP Global or County PMP Indicators	**Target**	**Achievement**

Number of people trained through USG-supported programs (national trainers, regional trainers and providers trained in MNH)	PY1 & PY2: 1,085 PY3: 803	PY1 & PY2: 924 PY3 (to date): 80
Percentage of target districts and health facilities that have a systematic approach to track and display priority indicators	Districts: 100% Health facilities: 90%	Districts (in 10 regions): 75% (56/75) Health facilities: (in 14 regions): 76% (524/690)
Number of women receiving a uterotonic during the third stage of labor in MCSP supported areas	21,348	16,546 (77.5%)
Number of babies not breathing/crying at birth who were successfully resuscitated in MCSP supported areas.	1,250	1,190 (95.2%)