Madagascar PY4 Summary & Results

Geographic Implementation Areas

Regions
- 16/22 (72%)

Districts
- 76/114 (67%)

Facilities
- 822/1,867 (44%)

Population

Country
- 24,235,390

MCSP-supported areas
- 23,705,697

Technical Areas

Program Dates

July 1, 2014–April 30, 2019

Cumulative Spending through End of PY4

[redacted]

Demographic and Health Indicators

Indicator	# or %
Live births/year[1]	796,800
MMR (per 100,000 live births)[2]	498
NMR (per 1,000 live births)[2]	24
U5MR (per 1,000 live births)[2]	72
TFR (births per woman)[2]	4.8
ANC 4+[2]	49.3%
SBA[2]	43.9%
IPTp2+[2]	6.4%

Sources: [1] INSTAT (Institut national de la Statistique, 2015), [2] DHS 2008–2009.

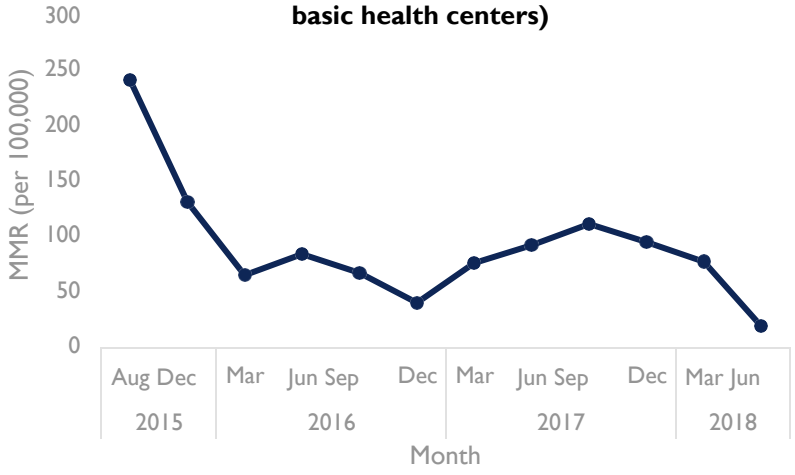
Strategic Objectives

- Provide support and technical leadership in MNH, immunization, and FP at the national level to the MOH.
- Increase to and improve quality of MNH and immunization health services in US Government priority regions.
- Increase access to long-acting PPFP methods in US Government priority regions.
- Improve prevention and treatment of MiP in ANC; improve malaria case management of children and adults at the primary care level.
- Strengthen the capacity of pre-service training institutions to educate midwives according to International Council of Midwives standards and competencies.

Key Accomplishment Highlights

- Supported data use for decision-making and improved accountability through the implementation of an MNH quality dashboard at 822 health facilities across all 16 US government regions.
- Expanded access to long-acting PPFP methods by building the capacity of 380 providers in PY4, which increased the total number of providers reached with PPFP training to 1,030 across 576 facilities over the life of the project.

Figure 1. Decreasing maternal mortality ratio in lower level health centers (N=183,483 total women delivered and 151 total maternal deaths in 513 basic health centers)



Madagascar

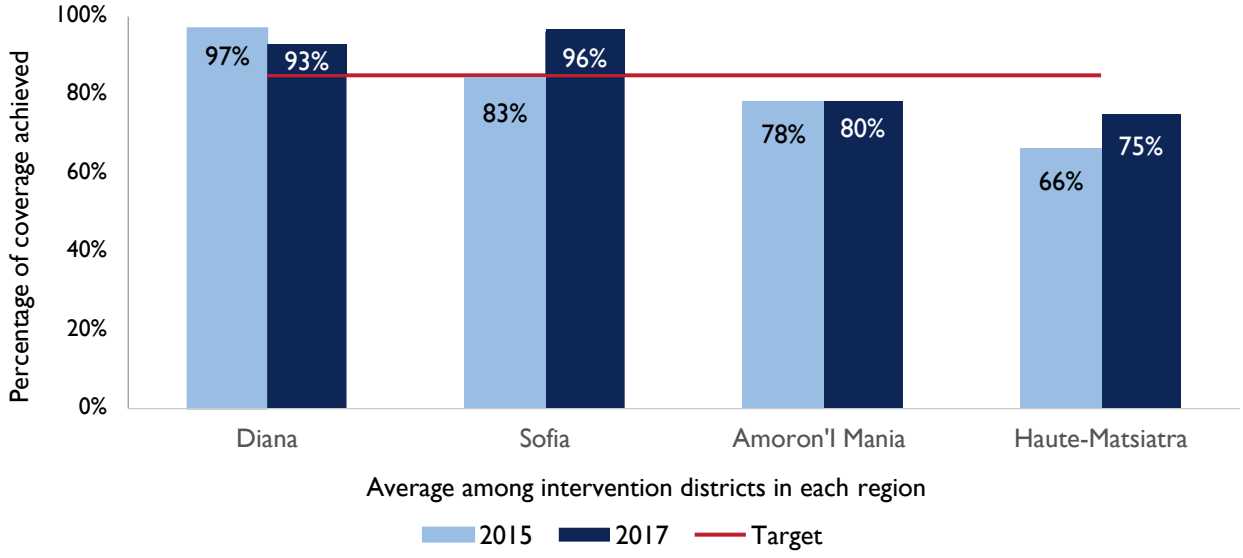
Key Accomplishments

In PY4, MCSP gradually phased out activities in selected regions/districts to consolidate work in a smaller number of regions and facilities and strengthen successes from prior programmatic years. Priority program strategies centered on promoting a favorable, national RMNCH and immunization policy environments and strengthening national MOH technical leadership. Key accomplishments in this area are shown by MCSP's influence in improving policy and clinical governance through the continued support of protocols and strategic plans. Furthermore, MCSP continually strengthened and reinforced providers' clinical competencies in priority technical areas through training, supportive supervision, and mentoring (MNH, FP, immunization, and malaria).

Technical Support to MOH at the National Level

At the national level, MCSP continued to provide technical expertise to the MOH for disseminating and implementing key RMNCH national policy and technical documents developed in PY3, including the Reproductive Health Norms and Protocols and the updated MNH and FP training curricula and job aids. MCSP also supported the development of an action plan and budget for activities related to PSBIs, as part of the Every Newborn Action Plan, and the Adolescent Sexual and Reproductive Health Budgeted Operational Plan to support the 2018–2020 Adolescent Sexual and Reproductive Health Strategic Plan developed in PY3. MCSP also continued to assist the national EPI by supporting the national-level data quality committee tasked with monitoring, analyzing, and managing RI data; preparation for the national vaccination coverage survey; implementation of the eleventh, twelfth, and thirteenth rounds of the FAV (polio national and subnational campaigns) in priority districts; and documentation required to obtain its Certification of Polio Eradication, which was attained in the middle of 2018 and is a major milestone for the country and region. Figure 2 shows the percentage of children (0–59 months) immunized with oral polio vaccine in the FAV rounds supported by MCSP, including the eleventh and twelfth campaigns.[6]

Figure 2. Improving trends in children immunized with oral polio vaccine



[6] Data from the twelfth polio campaign are not in Figure 1 because the campaign was subnational, and MCSP provided support only in Haute Matsiatra and Sofia Regions.

Capacity-Building of Providers and Local MOH Staff to Improve Access to and Quality of MNH, FP, and Immunization Services

> *"MCSP's approach to building the capacity of [district managers] to conduct [data quality self-assessment] has been transformational. It helps them to improve the quality of the data, analyze it, and quickly understand any problems. And, managers have become more confident and motivated to use this data for decision- making."*
>
> *—Dr. Lantosoa Ratsarahajarizafy, Point Focal Régional EPI, Sofia Region*

In PY4, MCSP focused especially on strengthening the capacity of district managers, facility managers, and providers to lead and sustain activities related to the capacity-building of providers—including training, supervision, data use for decision-making, and QI—to enable strengthened coverage and quality of high-impact RMNCH services across system levels and the lifecycle continuum. To that end, MCSP strengthened the skills of 620 providers through supportive supervision activities, including remote supervision (or mobile mentoring) with telephone calls, thereby increasing the total number of providers reached by MCSP's capacity-building activities to 1,454 providers over the life of the project. MCSP also continued to build the capacity of 59 district managers and regional health management team staff members, who in turn independently trained over 200 providers in eight regions—highlighting the successful transfer and appropriation of skills to MOH staff as part of MCSP's sustainability plan.

In immunization, MCSP conducted practical capacity-building sessions on data management and data quality self-assessment with six district managers in two districts; afterward, the district managers conducted data quality self-assessment with district health facilities. This approach aims to ensure data quality self-assessment will take place after MCSP closes and in additional health facilities.

Perspectives from 66 providers and 12 supervisors on the LDHF and supportive supervision approaches were documented through short interviews in three selected regions. When asked about their capacity-building experience, providers noted that the LDHF approach made them feel more confident in their abilities and helped them retain their competencies because it allowed for frequent practice of skills under the observation of a supervisor, who provided immediate feedback. Supervisors agreed that continued skills practice, enabled by the LDHF approach, gave providers the experience to translate skills learned into practice. They noted that over the course of implementation, they saw many of their supervisees improve and maintain skills with which they had previously struggled in a classroom-based training approach.

Data Use for Decision-Making and QI Initiatives

MCSP supported data use for decision-making and improved accountability through the implementation of an MNH quality dashboard at 822 health facilities across all 16 regions. This effort tracked key indicators to help providers and managers identify gaps in facility-level care and included as a subset five regional and two district hospitals—as well as 10 *centres de santé de base* (basic health centers) that received additional support—through continued support to facility-level QI teams.

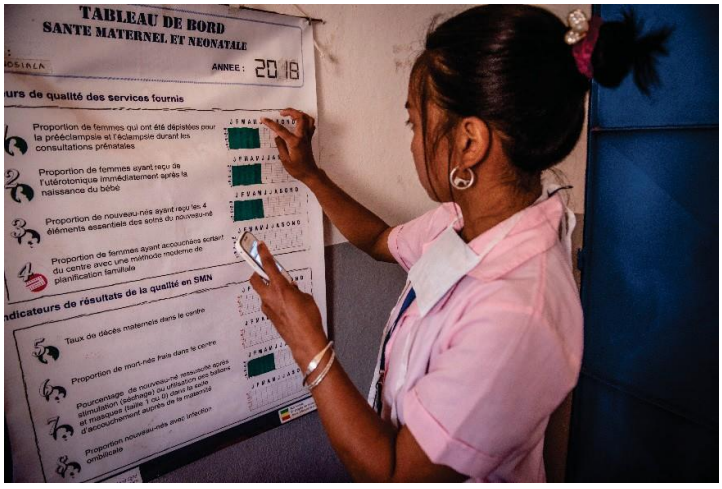
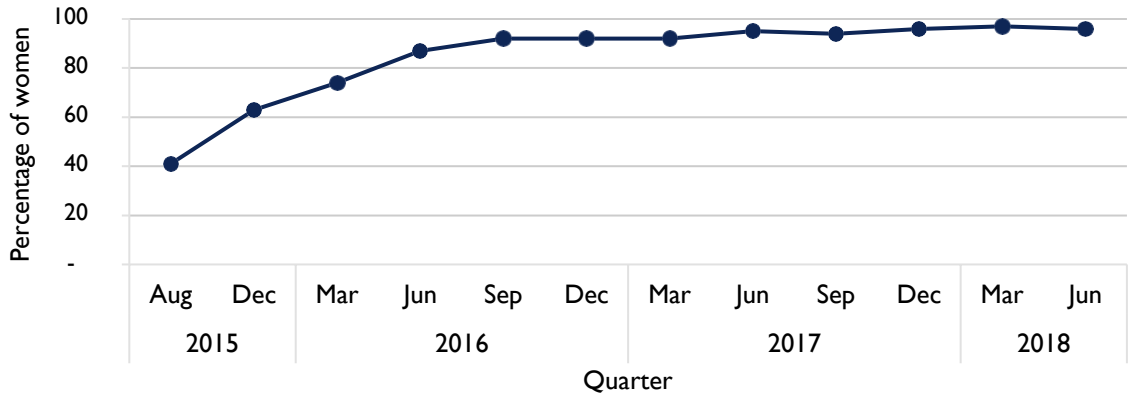


Figure 3. A midwife uses the standard MNH indicator dashboard in an MCSP-supported CSB. Photo by Karen Kasmauski, MCSP.

For example, at the 513 basic health centers that regularly tracked a common dashboard of quality of care indicators, early detection of PE/E during ANC was highlighted as critical because it is a leading, direct cause of maternal mortality and morbidity. Since the implementation of the MNH dashboard (from October 2015 to June 2018), the percentage

of women with blood pressure measured to screen for PE/E during ANC visits increased from 41% to 96%, as shown in Figure 4 below. The MMR at basic health centers decreased from 242 deaths per 100,000 total deliveries (live and stillborn) to 20 deaths per 100,000 total deliveries. Newborns not breathing or crying at birth, but who were successfully resuscitated, increased from 71% to 90%. The institutional fresh stillbirth rate decreased from 16.4 per 1,000 total births to 8.4 per 1,000 total births.

Figure 4. Increasing percentage of women screened for PE/E with a blood pressure check during ANC visits (N=1,002,989 total ANC visits in 513 basic health centers)

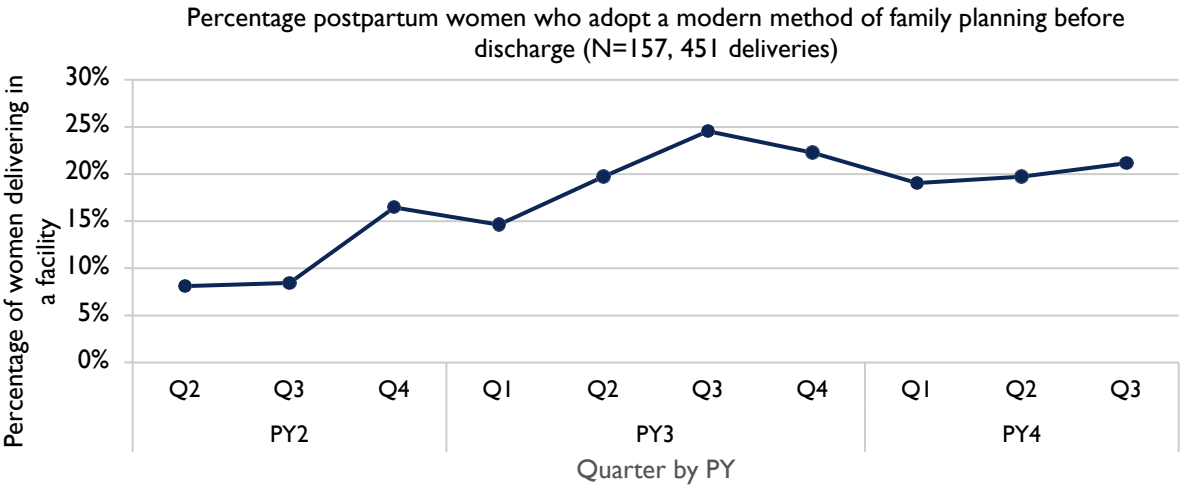


Source: MCSP quality dashboard.

Increased Access to Long-Acting PPFP Methods

As shown in Figure 5, MCSP progressed toward its goal to expand access to long-acting PPFP methods by building the capacity of 380 providers in PY4, which increased the total number of providers reached to 1,030 across 576 facilities over the life of the project. This contributed to an increase in PPFP uptake from 8% of women after delivery in 2016 to 24% in 2018 at 230 facilities. Additionally, MCSP provided technical support to the MOH to harmonize FP training materials and tools, including the documentation and use of Balanced Counseling Strategy Plus (BCS+) cards by providers to improve FP counseling; 98% of the providers using the tool attested to its usefulness. The *Tanora Mitsinjo Taranaka* intervention, which targets young and first-time parents, conducted a qualitative evaluation on *Tanora Mitsinjo Taranaka* activities at 11 health centers; *Tanora Mitsinjo Taranaka* intervention will be completed with MCSP's endline evaluation in PY5.

Figure 5. Significant improvements in immediate postpartum family planning in 230 health centers

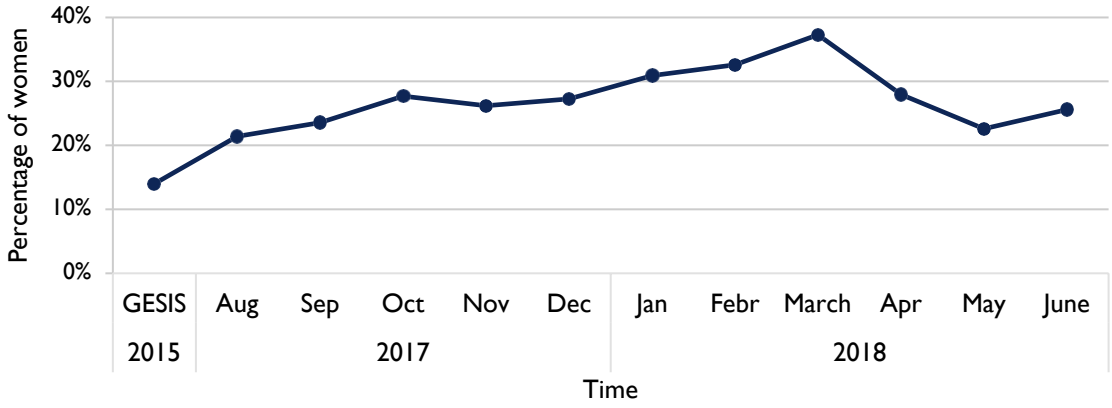


Source: MCSP-supported quality dashboard.

Prevention and Treatment of MiP at the Primary Care Level

To increase the uptake of IPTp and improve case management, MCSP strengthened the capacity of 389 providers on evidence-based malaria prevention and treatment care (with a total of 1,321 providers reached over the life of MCSP) and supported district managers in 10 regions to continue malaria technical updates of new providers and conduct supportive supervision. MCSP also introduced a tool to monitor availability of malaria commodities at 176 health facilities; the warning system contributed to a reduction in reported stock-outs in sulfadoxine-pyrimethamine (SP) within 2 months of implementation (from 64% at its height to 52%). Based on dashboard data from basic health centers, and as shown in Figure 6, the proportion of women who received at least three doses of IPTp-SP in 160 project-supported facilities increased from a baseline of 21% in August 2017 to 26% by June 2018.

Figure 6. Proportion of women who received at least three doses of IPTp-SP in 160 MCSP-supported facilities in 14 regions*



*GESIS 2015: average IPTp3 uptake for the year

Source: GESIS 2015, MCSP-supported quality dashboard (August 2017–June 2018).

At the national level, MCSP supported the MOH to conduct a study on malaria care-seeking behavior in pregnant women and caretakers of children and to assess the operational capacity of health facilities and malaria elimination readiness in eight targeted districts. The results of all assessments will be disseminated in PY5.

Capacity-Building of Providers to Respond to the Pneumonic Plague Outbreak

The pneumonic plague epidemic, which started in August 2017 and affected regions that were not traditionally endemic to the plague, highlighted that providers were unprepared to manage the influx of cases and were most at risk of infection due to gaps in IPC practices. In PY4, MCSP continued to provide support to the national plague response and case management TWGs and developed a pool of 17 national trainers and 263 regional trainers from 75 districts to support the cascade of provider trainings at the subregional level. MCSP also supported district managers and the regional health management team to conduct provider IPC and plague case management trainings in five priority regions, which to date has resulted in 631 providers from 224 health facilities in 31 districts trained. MCSP's support in the implementation of IPC measures extended to 12 major hospitals in the five priority regions.

Way Forward

As MCSP prepares to close in PY5, it aims to transfer ownership of health system challenges to the MOH in order to institutionalize key interventions and sustain gains beyond the life of the project. MCSP will shift its focus during the closeout period to documenting its results and lessons learned, including the implementation of malaria assessments and end-of-project evaluation. MCSP continues to support the institutionalization of activities and approaches at all levels of the MOH, consolidate advocacy and technical support of policy at the national level, and operationalize policies at the subnational level. MCSP's cascaded training approach for

the MNH curricula has resulted in increased capacity of health workers to respond to patient needs and deliver quality care, which will outlast the life of the project. Furthermore, the data quality dashboards introduced a method for mapping and redesigning patient care pathways to improve flow, efficiency, and provision of high-impact interventions, which providers will continue to use. A learning event will take place in Madagascar with high-level officials from the MOH and other partner organizations, and MCSP will communicate the successes of in Madagascar to key stakeholders and actors who will continue its legacy.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	**Achievement**
Number of people trained through US Government-supported programs (cumulative PY1–PY4)	1,454 providers (target: 1500, 97% achieved)
Percentage of target districts and health facilities that have a systematic approach to track and display priority indicators	100% (target: 100%, 100% achieved)
Percentage of women receiving a uterotonic in the third stage of labor in MCSP-supported areas	98% (target: 95%, >100% achieved)
Percentage of babies not breathing/crying at birth who were successfully resuscitated in MCSP-supported areas	90% (target: 95%, 95% achieved)
Percentage of women receiving PE/E early detection (proportion of women who receive blood pressure measurement during ANC)	96% (target: 95%, >100% achieved)