ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: MADAGASCAR

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ACRONYMS

AC	agent communautaire
APC	Advancing Partners & Communities
CCAC	comité de coordination de l'approche communautaire (community approach coordination committee)
CCDS	comission communale de développement sanitaire (commune commission on health development
CoGe	comité de gestion (management committee)
CoSan	comité de santé (health committee)
CHS	community health system
CSB	centre de santé de base (community-level health facility)
DRSP	direction régionale de santé publique (regional public health directorate)
FANOME	fonds d'approvisionnement non-stop aux médicaments essentiels (essential non-stop drug fund)
FP	family planning
IUD	intrauterine device
MSANP	Ministère de la Santé Publique (Ministry of Public Health)
NGO	nongovernmental organization
PAC	paquet d'activités communautaire (package of community activities)
PDSS	Plan de développement du secteur santé (Health Sector Development Plan)
PhaGeCom	pharmacie à gestion communautaire (community-managed pharmacy)
PNSC	Politique nationale de la santé communautaire (National Community Health Policy)
SDSP	service district de santé publique (district public health service)
TB	tuberculosis
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene
TWG	technical working group
USAID	Unites States Agency for International Development
VDC	village development committee
VHC	village health committee
WASH	water, sanitation, and hygiene
ZHSO	zonal health support office

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

MADAGASCAR COMMUNITY HEALTH OVERVIEW

Developed in 2009, Madagascar's *National Community Health Policy (PNSC)* is the principal framework for community health. The policy's overall objective is to improve health, particularly for vulnerable populations. It outlines three strategic directives:

1. Promote community participation and ownership in health and social development.
2. Optimize community access to a high-quality package of health promotion, preventive, curative, and rehabilitative services.
3. Harmonize community health and social development interventions through better coordination and standardization; integration of community health data into national systems; routine monitoring and evaluation; and development of replicable approaches.

The *PNSC* summarizes the role of *agents communautaires* (ACs), or community agents, as part of a holistic vision for community development. ACs are a link between the formal health sector and the *fokontony*, or the country's lowest-level administrative division that is equivalent to a village or group of villages. They conduct household visits to improve family health practices; distribute health products; conduct curative interventions; contribute to epidemiological surveillance activities in communities; and refer clients to *centres de santé de base* (CSB), or community-level health centers, for services they do not provide. The *Package of Community Activities* (PAC) Guide, created in 2008, outlines the specific services that ACs deliver.

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Package of Community Activities Guide (Guide de Paquet d'activités communautaires (PAC))*	*National Community Health Policy (Politique nationale de la santé communautaire (PNSC))*	*National Community Health Policy Implementation Guide (Guide de mise en œuvre de la politique national de santé communautaire)*	*Health Sector Development Plan (Plan de développement du secteur santé (PDSS) 2015–2019)*
Last updated	2008	2009	2014	2015
Number of community health provider cadres	1 main cadre: agents communautaires (ACs)			
Recommended number of community health providers	*Information not available in policy*			
Estimated number of community health providers	34,000 ACs			
Recommended ratio of community health providers to beneficiaries	1 AC : 1 village			
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, regional, district, commune, fokontany			
Key community health program(s)	Various programs in specific health areas including nutrition, malaria, and reproductive health			

In 2014, Madagascar's Ministry of Public Health (MSANP) released the *National Community Health Policy Implementation Guide*, which aims to harmonize implementation of different community health projects and programs under the PNSC framework. The *Implementation Guide* also describes the many health actors responsible for conducting and coordinating community health activities. These include *comités de santé* (CoSan), or health committees at the country's two lowest-level administrative divisions, the commune and the fokontony. The CoSan plans and manages community health activities, mobilizes resources, and facilitates communication between stakeholders in health at different levels. *Comités de gestion* (CoGe) manage community pharmacies (PhaGeCom).

The *Health Sector Development Plan 2015–2019* (PDSS) reviews the successes and shortcomings of Madagascar's health sector and sets priorities and objectives. Specifically, it discusses several implementation challenges, including poor dissemination of health policies and strategies, as well as the continued operation of uncoordinated, vertical programs outside the *PNSC* framework, resulting in a multitude of management tools, reports, and trainings. The *PDSS* elaborates on priority interventions to resolve these issues, such as increasing efforts to disseminate the *PAC*, *PNSC*, and the *PNSC Implementation Guide* and developing a nongovernmental organization (NGO) community health directory.

Together, these policies guide service delivery across many health areas, such as maternal and child health, and HIV and AIDS. They also outline specific criteria and processes related to ACs, such as selection, supervision, reporting, training, and incentives. The *PDSS* also highlights several implementation challenges in the years preceding its development, including a lack of a sustainable motivation mechanism, failure to meet selection criteria, and that many ACs are not trained with the *PAC* guide.

Table 2. Key Health Indicators, Madagascar

Total population[1]	23.7 m
Rural population[1]	65%
Total expenditure on health per capita (current US$)[2]	$14
Total fertility rate[3]	4.1
Unmet need for contraception[4]	19.0%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[4]	29.2%
Maternal mortality ratio[5]	353
Neonatal, infant, and under 5 mortality rates[4]	24 / 48 / 72
Percentage of births delivered by a skilled provider[4]	43.9%
Percentage of children under 5 years moderately or severely stunted[4]	50.1%
HIV prevalence rate[6]	0.4%

[1]PRB 2016; [2]World Bank 2016; [3]INSTAT, PNLP, IPM, and ICF International 2016; [4]INSTAT and ICF Macro 2010; [5]World Health Organization 2015; [6]UNAIDS 2015.

Policies also mention gender issues as they relate to community health. The *PDSS*, for example, indicates that Malagasy men tend to use health facilities less than women, suggests that AC selection processes should strive for greater gender balance, and advises integrating case management of victims of gender-based violence into reproductive health programs.

A variety of health programs operate across Madagascar. Policies outline health area-specific programs, including their community components, such as malaria, community nutrition, HIV and AIDS, WASH, and school health and nutrition. The MSANP oversees many of the programs while NGOs may assist with planning, financing, resource mobilization, implementation, and monitoring and evaluation. Many programs have operated in rural, urban, and peri-urban areas for more than 10 years. Programs are often multi-sectoral, with partners in the education, finance, agricultural, and private sectors.

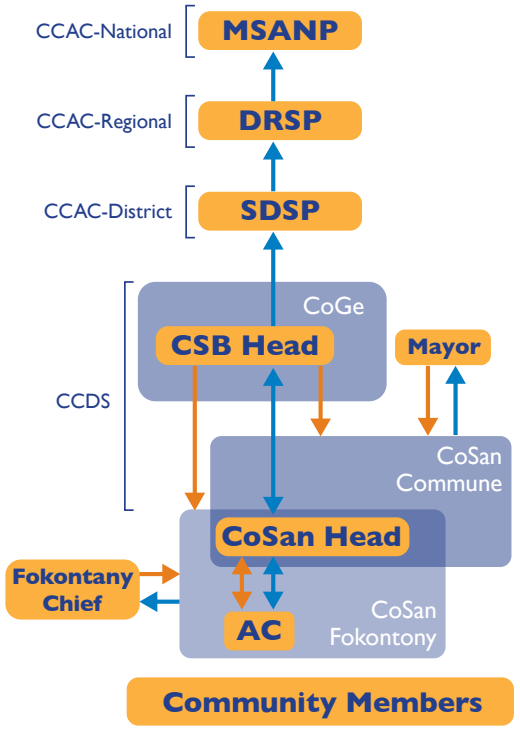
LEADERSHIP AND GOVERNANCE

Community-level service delivery in Madagascar is managed and coordinated at multiple levels. Each supports policy and program efforts.

- Actors at the **national level**, such as those at the MSANP, define norms and standards, develop policies and guidelines, and coordinate the health sector. The community approach coordination committee (CCAC-National), which includes regional health directors and development partners, plans and coordinates national health activities; disseminates health information, messages, and tools; compiles, analyzes, and shares national health data and makes recommendations; conducts feasibility studies; and provides operational support to regional coordination bodies.
- The regional public health directorate (DRSP) plans, guides, and monitors health program implementation and performance at the **regional level**. A regional committee (CCAC-Regional) plays a similar role to the CCAC-National, including coordination; data collection, analysis and dissemination; and program monitoring. It comprises representatives from the DRSP, the district government, doctors, health program committees, and NGO partners.
- At the **district level**, the district public health service (SDSP) coordinates and supports service delivery in facilities and communities, including implementing the PNSC; monitoring outcomes; promoting community engagement in health activities; and conducting disease surveillance. The CCAC-District has a similar composition and role to the CCAC-Regional.
- At the **commune level**:
  - The commune commission on health development (CCDS) identifies health and addresses issues as they arise; coordinates and monitors activities across partners; manages the health management information system and analyzes results; supports the CoSan Commune and the CoGe; and organizes quarterly meetings. Members include the mayor of the commune and representatives from the CoSan, CoGe, and NGO partners.
  - The CoSan commune guides implementation in accordance with priorities and decisions of the CSB, CCDS, and local leaders under the mayor's supervision. It comprises a municipal or commune councilor as well as the heads of the CoSan fokontony, which comprises ACs.
  - The CoGe oversees the PhaGeCom, which includes managing health supplies and the resources generated from a cost-recovery system. The CSB head leads the CoGe, and the mayor initiates a communal process to elect its four other members.
- At the **fokontany level**, the Cosan fokontany guides implementation of health activities in each village. The fokontony chief oversees the CoSan fokontony while the CSB provides technical supervision to ACs within the CoSan.

Figure 1 summarizes Madagascar's health structure.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MSANP CCAC-National	–	
Regional	DRSP CCAC-Regional	University Hospital Regional Referral Hospital	
District	SDSP CCAC-District	District Referral Hospital	
Commune	CCDS CoSan Commune CoGe Mayor	CSB	
Fokontany	CoSan Fokontany Fokontany Chief	AC	

* NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

ACs are volunteers and the primary community health providers in Madagascar, though other cadres may play roles in delivering health information and services in communities as well.

Their main functions are to improve community health behaviors through sensitization and promotion, during home visits; distribute basic health and nutrition products; ensure first-line treatment according to guidelines; and to conduct disease surveillance. ACs are expected to implement the *PAC*, but their training and scope of practice may vary based on local needs and the health areas of the implementing partners that support them.

Table 3 provides an overview of ACs.

Table 3. Community Health Provider Overview

	ACs
Number in country	34,000
Target number	*Information not available in policy*
Coverage ratios and areas	1 AC : 1 village Operate in urban, rural and peri-urban areas. ACs work in a village or an election sector – several of which comprise a fokontany. The CSB head, the CoSan, and commune or fokontany leaders may require ACs to cover additional geographical areas during emergencies.
Health system linkage	ACs deliver services on behalf of the government and receive support from CSB.
Supervision	The CSB head provides technical supervision and reviews AC monthly reports. ACs also receive guidance during quarterly CoSan fokontany meetings and from the CoSan head. The fokontany chief oversees the CoSan administratively. NGOs and other program implementers may also supervise ACs. These programs should align with the *PNSC* and other national guidance. Policies do not indicate how actors are to share supervision responsibilities.
Accessing clients	On foot Bicycle Public transport Clients travel to them
Selection criteria	From the community Male or female At least 18 years of age Can read and write Humanitarian conviction or disposition Available, motivated, and willing to do voluntary work Dynamic and sociable, good communicator Reputable and honest Preference for candidates who are not members of other local or community structures
Selection process	ACs are selected through a community vote. The fokontany chief assembles community members, leads the verbal election process, and signs off. If an AC resigns, CoSan members assemble to replace him or her according to selection criteria.
Training	Although ACs are supposed to be trained to implement the *PAC*, the *PDSS* indicates that many are not. Many ACs are, however, trained over time to implement other programs led by government partners. CSB heads also play a role in training and mentoring ACs. Madagascar's Training and Improvement Service and the MSANP validate all curricula.
Curriculum	*Guide du paquet d'activités communautaires* (2008). Includes components related to maternal and child health, including FP; adolescent health; nutrition; WASH; tuberculosis (TB); neglected tropical diseases; non-communicable diseases; dental health; disaster response; violence prevention; disability assistance; mental health; and traditional medicine.
Incentives and remuneration	ACs may receive financial and nonfinancial incentives, which the MSANP, NGOs, and the community fund. Financial incentives may include per diems; cash payments; performance-based payments; and small profits from commodity sales. Nonfinancial incentives may comprise in-kind payments; certificates; badges; uniforms; and trainings.

HEALTH INFORMATION SYSTEMS

ACs use program-specific registers and case management forms to document their activities. They collate the information into monthly paper-based activity reports using standardized templates that the MSANP designed to streamline and integrate data across its many diverse programs. In 2010, the MOH created a supplementary monthly reporting form to collect data on communities, community-based financing at the PhaGeCom, and selected vertical programs.

To harmonize data across its many programs and minimize AC reporting responsibilities, the MSANP developed a standardized monthly report form for use nationwide.

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ACs send monthly reports to the CoSan fokontany head, who passes them to the CSB head. The CSB head combines community-level and facility data and sends it to the SDSP, where it is integrated with data from first-level hospitals and entered electronically into the health management information system. The DRSP combines this data with those from secondary hospitals and submits them to the national level via the electronic system. Health information subunits of the MSANP receive the aggregated data and then incorporate them with any data from parallel vertical programs. At each level of the health system, data should also be shared with health and development partners and the CCAC.

The CoSan also tracks financial data related to its management activities, which are shared with the CCDS and local leaders like fokontany chiefs and mayors.

Reporting data is intended to flow back down the system from the national level, but community health policies do not clearly define the mechanisms by which this is to happen. However, CSB heads are supposed to share data with ACs and the CoSan to improve the quality of their interventions and activities. The blue arrows in Figure 1 show the flow of data.

HEALTH SUPPLY MANAGEMENT

Madagascar has initiated a cost-recovery system to restock community pharmacies and offer qualified poor community members selected drugs for free.

Madagascar instituted community-based financing to ensure the permanent availability of health inputs and better equity in health care through the non-stop essential medicines supply fund (FANOME). The FANOME is a cost-recovery system generated by a percentage of the profit margin of drug sales from the PhaGeCom as well as through contributions from actors at the fokontany and commune levels. The funds from the FANOME help to resupply the PhaGeCom and contribute to an equity fund managed at the CSB, which permits community members who qualify as poor to access certain drugs for free. The CoGe and commune leaders oversee the equity fund.

To obtain medicines and commodities, ACs complete supply request forms and submit them to the CSB. The CSB head compiles the orders from all ACs on one order form and sends it to the CoGe. The CoGe transmits the order request to the district pharmacy, and retrieves, pays for, and registers the supplies. ACs pick up the orders at the PhaGeCom and distribute or sell them at the community level at the price established by the MOH, which includes a small mark-up that ACs may keep. ACs access back-up supplies at the PhaGeCom as well.

In some areas, ACs access supplies through private sector supply points. They submit supply request forms to the supply point and pay their cost upfront. The supply point representative submits the order to an NGO involved in procurement, which sends the supplies to the supply point where ACs retrieve them.

ACs place syringes and lancets in sharps containers and bring them to the CSB along with expired medicines. They put contaminated materials (e.g., gloves, blood testing materials) and paper and plastic waste into separate containers to be dropped in designated pits at the CSB or a designated area in the community.

The full list of commodities that ACs provide is not available, but Table 4 displays selected medicines and products included in the *National List of Essential Medicines and Health Inputs in Madagascar*.

Table 4. Selected Medicines and Products Included in the *National List of Essential Medicines and Health Inputs in Madagascar* (2014)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☑	Insecticide-treated nets
	☑	Paracetamol
	☑	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☑	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

The 2008 *PAC* details the main package of services that ACs are supposed to provide. ACs may be able to undertake additional responsibilities per local needs and programs. For instance, in some areas ACs are piloting chlorhexidine administration for umbilical cord care in newborns. Table 5 summarizes how ACs may provide clinical services, health education, and community mobilization.

ACs refer clients to the CSB when needed and CSB staff counter-refer patients for follow-up care. Using FP as an example, ACs may refer clients to the CSB for condoms; oral contraceptive pills; injectable contraceptives; implants; intrauterine devices (IUDs); and emergency contraceptive pills. From there, CSB staff may refer clients to district referral hospitals, regional referral hospitals, and university hospitals for permanent methods and those which are unavailable elsewhere.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Table 6 illustrates the interventions ACs may provide, according to policy, in FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral[1]	Follow-up
FP	Condoms	AC	AC	AC	AC
	CycleBeads®	AC	AC	Unspecified	AC
	Emergency contraceptive pills	AC	Unspecified	Unspecified	Unspecified
	Implants	AC	No	Unspecified	Unspecified
	Injectable contraceptives	AC	AC[2]	AC	AC
	IUDs	AC	No	AC	AC
	Lactational amenorrhea method	AC		AC	AC
	Oral contraceptive pills	AC	AC	AC	AC
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	AC	No	AC	Unspecified
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	AC	AC	AC	AC
	Iron/folate for pregnant women	AC	Unspecified	AC	AC
	Nutrition/dietary practices during pregnancy	Unspecified		AC	Unspecified
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	AC	AC	AC	AC
	Recognition of danger signs in mothers during postnatal period	AC	AC	AC	AC
Newborn care	Care seeking based on signs of illness	AC			AC
	Chlorhexidine use	Unspecified	Unspecified[3]	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	AC		Unspecified	Unspecified
	Nutrition/dietary practices during lactation	Unspecified		Unspecified	Unspecified
	Postnatal care	AC	No	AC	AC
	Recognition of danger signs in newborns	AC	AC	AC	AC

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	AC	AC	AC	AC
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	AC	AC[4]	AC	AC
	Exclusive breastfeeding for first 6 months	AC		AC	AC
	Immunization of children[5]	AC	No	AC	AC
	Vitamin A supplementation for children 6–59 months	AC	AC	AC	Unspecified
HIV and TB	Community treatment adherence support, including directly observed therapy	AC	AC	AC	AC
	Contact tracing of people suspected of being exposed to TB	Unspecified	Unspecified	Unspecified	Unspecified
	HIV testing	AC	Unspecified	AC	AC
	HIV treatment support	AC	Unspecified	AC	AC
Malaria	Artemisinin combination therapy[6]	AC	AC	AC	AC
	Long-lasting insecticide-treated nets	AC	AC	Unspecified	AC
	Rapid diagnostic testing for malaria[6]	AC	AC	AC	AC
WASH	Community-led total sanitation	AC	AC		
	Hand washing with soap	AC			
	Household point-of-use water treatment	AC			
	Oral rehydration salts[6]	AC	AC	AC	AC

[1] Policies do not indicate that ACs should refer for every FP method; rather, they imply they should refer clients to initiate or continue FP methods.
[2] ACs may administer injectables only if trained.
[3] Available policies do not explicitly mention AC administration of chlorhexidine; however, chlorhexidine is included on their monthly reporting forms and they are piloting the intervention in selected areas.
[4] Some guidance indicates ACs may provide de-worming medication; other instruction suggests they must refer clients for it.
[5] Includes immunizations for newborns.
[6] ACs provide this intervention only as part of integrated management of childhood illness in children under 5 years of age.

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