Madagascar
Mother and Child Health Week

Lessons learnt in improving children's lives

November 2017

unicef

Leave no one behind

Mother and Child Health Week provides a high-impact package of integrated services delivered at the community level to children under five

Introduction

To reach the most number of children possible, regular events to deliver an integrated package of key nutrition and health interventions to children and mothers, commonly referred to as Child Health Days (CHDs), were introduced in the Eastern and Southern Africa Region (ESAR) over two decades ago. Conducted twice a year, these activities can last one day, a week or a month. Interventions during CHDs vary by country, but core activities include vitamin A supplementation (VAS), deworming, immunisation, and social mobilisation and communication activities to promote immunisation and the uptake of new vaccines. Many countries also include the promotion of key health and nutrition practices, screening for malnutrition, hand washing and sanitation.

This summary brochure documents key components of the *Semaine de la Santé de la Mère et de l'Enfant* (SSME) (Mother and Child Health Week) programme in Madagascar. Using existing quantitative data and newly gathered primary qualitative data, the documentation exercise addressed seven key themes: the SSME programme including core interventions and coverage; decentralisation and ownership; coordination, supervision and training; supply and provision of services; community experiences; issues of equity; and sustainability.

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Madagascar

In order to reach the most children possible with key interventions, Madagascar began to implement a VAS programme for children aged six to 59 months in 1998. Building on the Expanded Programme on Immunisation (EPI), which took a vertical approach to health service delivery in the form of campaign-style events, the VAS campaigns were held biannually from 2002, and in 2005 were expanded to include deworming.

In 2006, the SSME was established to provide a package of free high-impact interventions to reduce maternal and child mortality. SSMEs are held in April (or early May) and October (or early November) every year.

In 2017, the SSME package included VAS, deworming, 'mop-up' immunisation, screening for malnutrition, antenatal care and HIV testing. The campaign is run in tandem with African Vaccination Week every April, and in April 2017, the UNFPA implemented its programme for screening for fistula in pregnant women at the same time.

Government stakeholders at both national and district levels reported that widening the package of interventions was positive, but noted that greater harmonisation of supporting partners was needed.

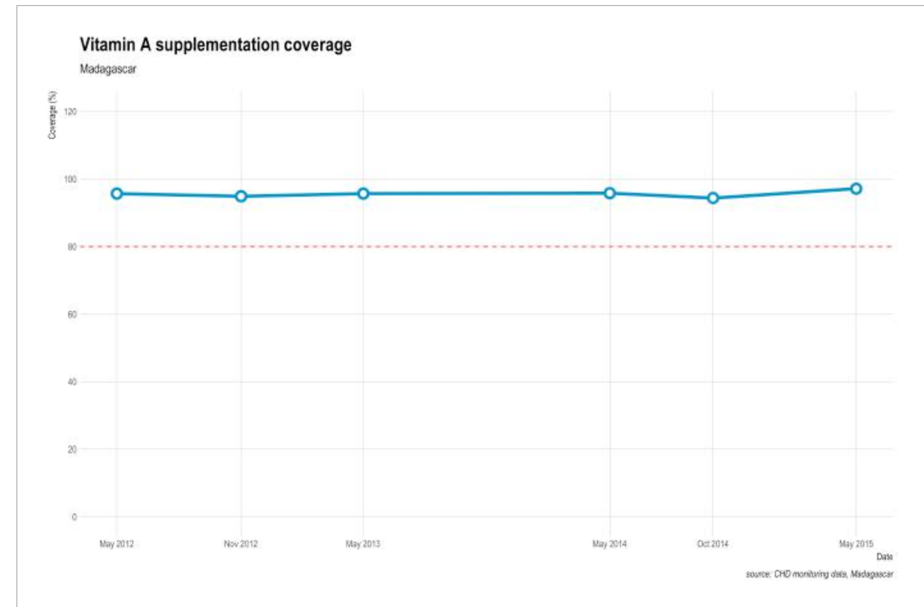
Non-government stakeholders reported challenges with increasing the number of interventions and suggested that some partners wanted to integrate even more interventions into the week, without having the necessary funding. As such, they suggested that SSME had become a *'victim of its own success'* with non-nutrition focused programmes seizing the opportunity to add additional campaign services to the week.

SSME overview

Interventions

Vitamin A supplementation

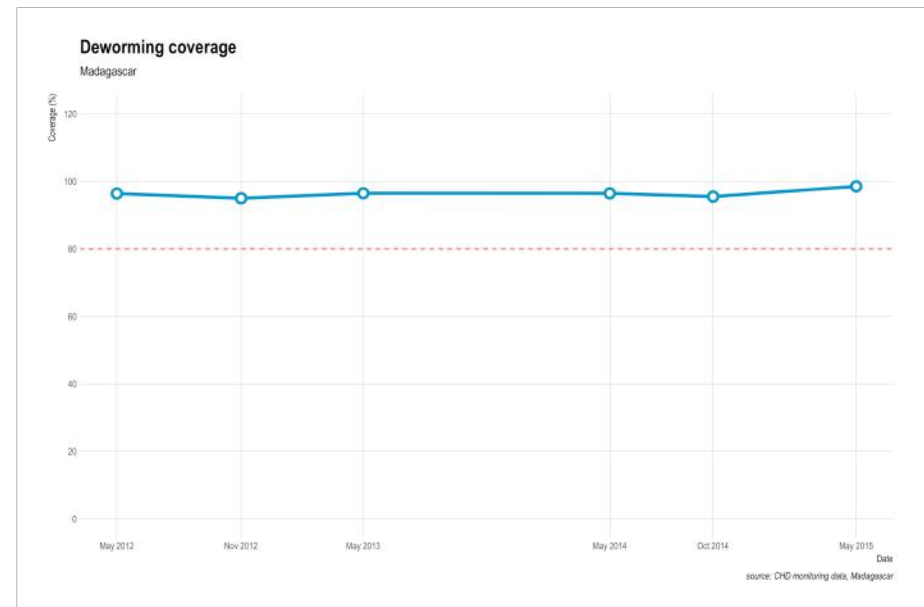
In Madagascar, nutrition has been the driver for the SSME programme since its inception, and VAS has always been considered its primary component. Mass VAS was rolled-out biannually from 2002 onwards, and although coverage did increase, by 2005 it remained at 72%. When the SSME programme was introduced in 2006, the target for VAS coverage was raised to 96%. SSME monitoring data from 2012-2015 indicated that the average national coverage for VAS over that period was 95% (see graph 1). Regional variations in coverage for VAS were minimal. The high coverage rates of VAS highlight the success of the campaign style approach.



Graph 1: SSME monitoring data from May 2012 to May 2015 indicated the average national coverage for VAS to be around 95%.

Deworming

Deworming has been implemented alongside VAS from 2005 and was rolled into the SSME service package as a key intervention. According to SSME monitoring data, all campaigns between May 2012 and May 2015 attained over 90% coverage nationally, with a mean of 96% (see graph 2). Little regional variation in coverage was evident. District-level participants explained that unlike VAS, uptake of deworming was encouraged by health workers during routine services, and was therefore frequently sought by caregivers outside the SSME.



Graph 2: According to SSME monitoring data, all campaigns between May 2012 and May 2015 attained over 90% coverage nationally, with a mean of 96%

Malnutrition screening

In 2009, screening for malnutrition using mid- upper-arm circumference (MUAC) and identification of bilateral oedema measurements was piloted in 27 districts during SSME, and has been scaled-up slowly since. By 2016, screening had been integrated into the national SSME package in 56 of Madagascar's 113 districts. Although some district-level stakeholders suggested that community health workers require further training to be able to take measurements reliably, MUAC screening is regarded as an important addition to the key interventions offered as part of SSME. Additional resources are being invested to track children who are identified during SSME and require follow-up in their referral

Mop-up immunisation

Immunisation is provided as a key component of routine service delivery in Madagascar, based *'la stratégie fixe'* (the fixed strategy) where those living within a radius of less than 5km attend a health facility for routine vaccination; and '*les stratégie avancée'* (outreach strategy) where health workers travel to areas beyond the facilities' 5km radius, including hard-to-reach areas, to administer vaccination to vulnerable and unvaccinated children. During SSME, vaccination is offered to 'mop-up' missed opportunities, and to target difficult to access children through advanced outreach. Because of weaknesses in routine services, offering vaccinations during SSME acts as an important safety net.

Social mobilisation

Social mobilisation has been a core component of SSME since its inception, used to raise awareness about key interventions and mobilise communities to seek services. In remote and hard-to-reach areas, mobilisation efforts remain critical and multiple strategies have been employed including interpersonal communication, the distribution of information education communication materials, public announcements and radio broadcasts. *Mobilisateurs* and community health workers are the primary drivers of social mobilisation for SSME across the country, because they are known and trusted by the communities they serve.

‘Nearby here there's the port, and that’s next to the sea, so there's a lot of worms. The deworming in SSME is to remove the worms and parasites. The parasites come out when you have taken the deworming tablet. When children have parasites, they do not eat well, they have no appetite. But with the deworming treatment they are gone’.

Caregiver, Akemba Bas, Toliara I

Decentralisation and ownership

The 2009 political crises had a significant impact on Madagascar's health infrastructure. The Ministry of Public Health experienced substantial budget cuts due to government instituted reductions in social and healthcare services, and with significant donor withdrawal, expenditure for healthcare gradually reduced. Today, the health system remains underfunded, and its infrastructure weak.

The centralised nature of the health system in Madagascar has limited the level of ownership, control and flexibility afforded to the district health offices. UNICEF has encouraged the development of tools to generate increased district ownership and has supported planning activities and budgeting targeted to the needs of specific populations. Each of the country's 113 districts prepare microplans for every round of SSME and these are submitted to the central level for review prior to the release of funds.

Since its inception in 2006, 80% or more of the funding for SSME has been provided by external partners, and after 22 rounds of SSME, Madagascar continues to demonstrate a limited degree of government ownership. The Ministry of Public Health includes a budget line for SSME activities in their annual planning, as part of their allocation of funds to improve mother and child health, and funding system for SSME pools government funds with funding from other donors.

Funding for SSME remains insufficient, and stakeholders confirmed that with limited additional input from the government, resources restricted what could be achieved during the campaign.

'For increased ownership, we must give flexibility to the regions or districts. So far, what we say is that nationally we have the SSME from X date to Y date, and everybody has to do it. Why not leave the flexibility to each district to organise by saying you can organise the SSME based on your agenda, the staff that you have, and then the duration can be based on that.

You have to reserve or give money to the districts so that they can supervise to the furthest areas. We must give them the means, that is, the transport. There are districts that do not have transport to go to those remote areas, so we have to give them the means to plan and to do their job.

That would at least be a way of generating some ownership at the district level, which, for me, is likely to be more successful than ownership at the national level'.

National-level stakeholder

Coordination, supervision and training

Within the Ministry of Public Health, planning for the SSME is coordinated by a technical committee, further divided into sub-committees that focus on the central-level organisation of specific SSME activities. With the expanded number of interventions offered as part of the SSME, there has been a corresponding increase in the number of partners operating in the SMME sphere. Although government stakeholders identified issues that arose due to external funding, the coordination of partners, from a national perspective, appeared to be harmonised.

A budget for training is included in the district microplans and training is cascaded from the central to regional, district and then community levels. The cascade mechanism from the district to the community level appeared to be working effectively, but district-level officials reported receiving limited support from higher levels.

The structure for monitoring and supervision of SSME is organised centrally, with supervision structures also cascading down to district and community levels, but with national level stakeholders conducing ad hoc direct supervision in certain community facilities.

SSME coverage data are collected by health workers and community health workers during SSME activities, and entered by hand using standardised tally sheets. At the community level, community health workers report data to the health facility to which they are attached on a daily basis via the tally sheet, text message or email.

Community health workers and district stakeholders agreed that daily reporting ensured they could monitor coverage within specific catchment areas, and targeted door-to-door mobilisation could be implemented if and where necessary.

'In general, coordination for the SSME works well. We have several partners who are involved in the financing, but also on the technical side. There is truly collaborative technical support that the partners bring during the various preparations of the week. It is not only at the central level, but also at the regional and district level, to raise awareness and coordinate activities among the various local partners'.

National-level stakeholder

Distribution of supplies for SSME is coordinated and managed by the Ministry of Public Health, in collaboration with representatives from the government's planning division and health statistics departments who contribute to procurement planning with projections of the amount of commodities required. UNICEF supports the government to procure both vitamin A and Albendazole for SSME, and to manage distribution at the district level. Financial support also comes from Nutrition International.

Human resource shortages persist across the Malagasy primary health care system. Many participants emphasised the challenge that health facilities faced in providing routine services, immunisations and outreach during SSMEs.

It was agreed that community health workers and *mobilisateurs* had become the driving force behind SSME implementation. They undertook administration of VAS, deworming, and screening for acute malnutrition, completed tally sheets, mobilised caregivers and shared information on SSME interventions in order to build trust with communities. District-level participants confirmed the role these cadres played in the success of SSME implementation, but noted the lack of adequate training and limited incentives challenged.

'Community health workers are the basis of the SSME. We must take them into account. They leave their work in the fields. We have to motivate them a little more as they do a lot of the work for us'.

District-level stakeholder, Ambatolampy

Supply and provision of services

Community perceptions

Although the social norm is for mothers to take responsibility for their children's health, decisions to seek care or attend clinics are usually taken by both parents. A mother is more likely to identify symptoms in a child, but will consult the child's father should care be needed. In terms of preventative care, mothers were responsible for attending routine services for vaccination and presenting at SSMEs.

Due to high rates of unemployment, fathers have assumed increasing responsibility for the health of their families, and have started to attend routine services and SSME with their children. From an equity perspective, increased male involvement in SSMEs could be regarded as positive progress, yet this does not necessarily represent a shift in social norms.

Rather, male caregivers suggested that their availability to attend SSMEs was a direct result of the complex political and economic situation in Madagascar, and was associated with shifts in livelihood patterns since the political crises.

As part of the SSME programme, the government sought to bring services closer to communities to maintain high coverage and mitigate access, transport and financial barriers. Caregivers highlighted the positive benefits of the increased outreach and the establishment of service delivery posts within their communities, noting the short distance they had to travel to access interventions. They emphasised that having service delivery points in accessible community areas encouraged attendance.

'There is a lot of child death here. What I know about SSME is that it is a campaign to give vitamin A and deworming medicine to children. These things are important because I think they are for the prevention of disease in children. There is a lot of impact of SSME in the community. In our village, many children are no longer so ill because they have already had the medicines from the SSME.

It is easy to come to the SSME, I walk as it is only five minutes to this mobile site. But even though the distance is near, there are still some people who do not bring their children. They are rumours, you know some people hold their ideas deep inside. I don't believe the rumours and I know the medicines are good because there are people who make us aware.

I like that the SSME has a defined period, the days in a certain month. We hear about the SSME on the radio, and there are mobilisers in the community who stick-up posters with the dates. I prefer that the mobilisers come to talk to us, because I can ask questions, I can ask them about what I do not understand'.

Caregiver attending SSME, April 2017

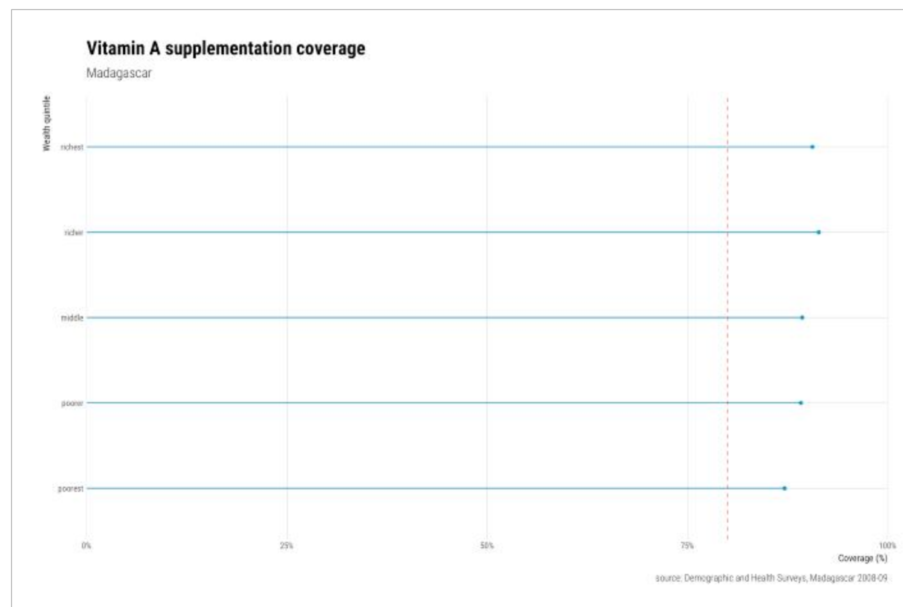
Equity

In order to explore issues of equitable delivery of and access to services, an analysis of wealth quintile at the household level was undertaken using the most recent DHS dataset (2008-2009) that includes five categories from poorest to richest. Nationally, the overall pattern is one in which there is high coverage (mean 89%) with little variation by wealth quintile, with the richest quintile having coverage of 91% and the poorest 87% (graph 3).

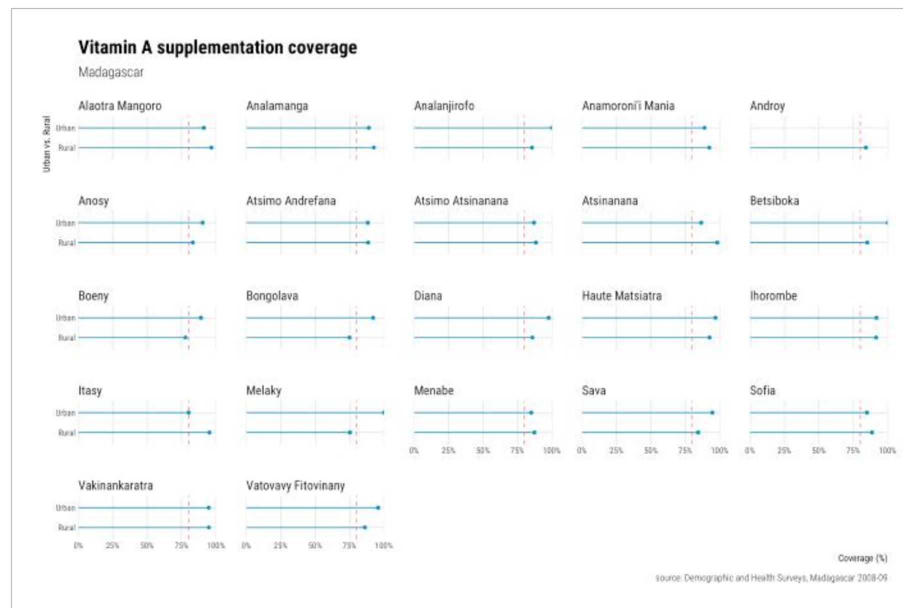
In the DHS data, there is little difference in VAS coverage between urban and rural settings (see graph 4), with mean coverage among urban households at 90% compared to rural households at 89%. In the qualitative data, however, stakeholders suggested that administration of SSME is most challenging in rural areas due to geographic and logistical challenges.

Across all stakeholder groups, no association was made between a child's gender and access to SSME. This finding was triangulated with the quantitative analysis of coverage data from the DHS where little difference between male and female uptake of VAS services is observed.

Many stakeholders suggested that high coverage rates are indicative of the programme's 'equity focus', however discussions about equity remain both sensitive and politically charged.



Graph 3: According to the DHS data (2008-2009), there was little variation in national coverage by wealth quintile, with the richest quintile having coverage of 91% whilst the poorest had coverage of 87%.



Graph 4: According to the DHS data (2008-2009), there was little difference in VAS coverage between urban and rural settings, with the mean national coverage among urban households of 90% and 89% among rural households.

It was widely acknowledged that a campaign-style approach to interventions in Madagascar (e.g. VAS and deworming) would have to be maintained in the short- to medium-term. Few stakeholders spoke about sustainability in relation to the integration of SSME services into routine care, particularly as discussions about routine services highlighted the weaknesses of the health system. The majority of participants indicated that discussions about transitioning interventions was somewhat premature.

Discussions about sustainability of the SSME focused on the need for continued support from external partners. Many stakeholders recognised the value of increased advocacy and 'high-level' commitment, and some suggested that the political will of the government to the programme was evidenced by the increased appropriation of operational elements of the SSME by the Ministry of Public Health. Political commitment was recognised by all national-level stakeholders as a critical component of successful sustainability. Stakeholders at all levels stressed that the SSME programme '*must continue*'.

'Some people just can't be reached by routine services. The SSME is the one moment when they can have all the things offered for health programmes, nutrition, WASH, everything in one moment'.

National-level stakeholder

Conclusion

The SSME programme has been successfully implemented in Madagascar for eleven years and effectively provides critical services to improve the health of children across the country. In 2016, several positive achievements were documented: strong political ownership; increased fiscal control, particularly regarding the formation of microplans at the district level and effective social mobilisation, all of which have contributed to the high coverage rates reported for VAS and deworming. Despite the difficult operational environment, several key components have contributed to the success of SSME in Madagascar:

Planning and coordination. Planning for the SSME is coordinated at the national level by a technical committee that includes representatives from both the health and nutrition sectors. Frequent coordination meetings have assisted with planning and the review of microplans, the implementation of policy, mobilisation of resources, development of procedures, and the coordination of monitoring and evaluation activities at the national level. The expanded number of interventions offered as part of the SSME has led to a corresponding increase in the number of partners operating in the SSME sphere and the coordination of partners is critical in ensuring a harmonised approach.

Effective social mobilisation. In Madagascar, social mobilisation and community engagement have been key to raising awareness of SSME and encouraging utilisation of services offered. Multiple methods of social mobilisation have been used, but actively disseminating messages through community health workers and *mobilisateurs* has been highly beneficial. Because they are ‘close’ to the community, these volunteers are able to foster trust, help dispel negative rumours or misconceptions, and encourage attendance at SSME.

Equity-focused approach. The national coverage rates for SSME interventions are consistently high, but to address disparities in coverage at regional and district levels, Madagascar has prioritised an equity-focused approach. This aims to ensure that SSME services reach the most vulnerable children in the hardest-to-reach areas. With the development of district microplans, interventions and resources can be tailored towards engaging those most in need. At the district level, communication and advocacy strategies have been developed through collaborative efforts between traditional and administrative leaders, heads of schools, and representatives from the Ministry of Public Health and Ministry of Communication.

	Lessons learnt and good practices
SSME programme	• Because of district-level planning, services can be adapted to respond to the priorities and needs of Madagascar's regions and districts. Bringing interventions closer to communities through outreach and mobile services has helped maintain high coverage and mitigated access, transport and financial barriers, making it easier for caregivers to attend the service with their children. • Social mobilisation efforts are critical and the mixed strategies that have been employed (routine, mobile, outreach) have helped to maintain high coverage, particularly in relation to engaging communities in remote and hard-to-reach areas. Social mobilisation activities are seen to be most successful when delivered by *mobilisateurs* and community health workers because they are trusted by their communities. • In 2009, screening for malnutrition using MUAC was incorporated into the core SSME package after it was successfully piloted in 27 districts. The pilot enabled mechanisms for referral and follow up to be carefully established before the intervention was then scaled to 56 districts in 2016, with the intention of scaling up further.
Decentralisation and ownership	• Due to lack of domestic resources and budget cuts across social sectors, the SSME remains one of the best strategies for ensuring high coverage for selected interventions. Despite limited decentralisation and dependency on external support, achievements have been made. Each of the country's 113 districts develop microplans for every round of SSME and this has facilitated greater planning and input at the district level. In addition, the 2014 revision to the national budget included resources specifically for the SSME, including budget lines for supervision, social mobilisation, transport and logistics.
Coordination, supervision and training	• Planning for the SSME has benefitted from active representation of both health and nutrition sectors on the national technical committee. Coordination meetings held in advance of an SSME have helped to facilitate planning, the review of microplans, and the mobilisation of resources. As a result, coordination for monitoring and evaluation activities has improved at the central level, and there is stronger alignment between the government and external partners. This positive coordination has supported the development of planning and monitoring mechanisms for SSME that are budgeted for with SSME funds. A budget for training for SSME is also incorporated into district microplans. This facilitates training and support to be cascaded from the district to the facility level.
Supply and provision of services	• Community health workers and *mobilisateurs* are a driving force behind SSME implementation. These cadres are heavily invested in their communities and encourage positive engagement with SSME services. • Despite distribution challenges, districts are able to reallocate commodities between facilities and engage with the regional level to support the redistribution of supplies across districts to ensure that there are no stock-outs at service points during SSMEs.
Community perceptions	• Social mobilisation and community engagement is key in raising awareness of SSME and encouraging utilisation of services offered. Together the provision of effective treatment and health education has helped to build community trust in the interventions and progress had been made in overcoming rumours that associated SSME services with infertility, illness and death. • Fathers and male caregivers are increasingly involved in healthcare seeking for their children. Although this was attributed to shifts in livelihoods and the socio-economic environment as a consequence of the political crises, the fact that men are now presenting for services provides a valuable opportunity to maximise their positive engagement.
Issues of equity	• An equity-focused approach has been adopted through the outreach strategy during SSME. This has helped to bring services closer to the community thereby mitigating access barriers. The acceptability of SSME has enabled the programme to establish itself as a highly effective strategy to address equity issues and reach the most vulnerable. During SSME, interventions and resources are directed towards engaging those most in need at the local level, and poorly performing areas are targeted for additional support and supervision.

Recommendations

Despite the successes, a number of challenges remain and must be addressed to ensure the success and sustainability of the programme.

Expansion of the SSME package. The SSME package of interventions has developed significantly since the inception of the programme in 2006. In addition to the core interventions offered during the campaign in April 2017 (VAS, deworming, 'mop-up' immunisation, screening for malnutrition, antenatal care and HIV testing), the SSME was also aligned with the African Vaccination Week and the UNFPA programme of fistula screening. Expanding the number and scope of interventions offered through the campaign has led to concerns that the focus of SSME may shift away from nutrition. Coordination amongst partners with competing priorities has proved challenging, particularly in relation to securing funding, and there is a sense that other programmes are likely to seize the opportunity to 'ride on the success' of the SSME.

Data management. The use of census data from 1993 as the denominator for projecting population size is problematic, particularly in terms of estimating commodity needs and coverage at local levels. The census data is over 25 years old, and is no longer accurate in terms of current population size and distribution. Its continued use has led to issues of inconsistent reporting and overestimation of coverage of services.

Decentralisation. There has been limited decentralisation of SSME management to the district level. Although budgeting and planning is conducted by each district during their microplanning, final decisions in terms of financing and resource management remain with the Ministry of Public Health at the central level, and there is little sense of ownership at the community level.

Government funding. Madagascar is heavily dependent on support from donors for all its programmes, including SSME. External partners need to sustain efforts to foster increased political will for SSME, and to support the government to increase their commitment and dedicate more resources for the programme. The limited funding for SSME leads to fewer activities being implemented than outlined in district microplan and delays in the release of funds from the central level to the districts compounds the situation. The result is that important components are scaled back or removed from the campaign, sometimes at short notice. Unless the government assumes greater ownership, the sustainability of the programme is not guaranteed.

	Recommendations
SSME programme	• Further consideration should be given to the extent that additional interventions are offered through SSME. A key strength of the SSME is that it is nutrition focused and key interventions are mutually supportive. If additional services are to be included, government and agencies should be encouraged to commit sufficient additional resources. In addition, referral and follow-up mechanisms should be strengthened to ensure children identified during SSMEs receive the care they need and opportunities to improve health outcomes are not missed beyond the campaign. • Social mobilisation should be continued and supported with adequate resources. Particular attention should be given to communication strategies that mitigate issues associated with campaign fatigue and encourage caregivers to utilise services (both campaign and routine) in a timely and appropriate manner. • Addressing issues associated with the denominator used for the analysis of data is important for ensuring the quality and accuracy of reporting. Systematic use of routine data for programme design, planning and monitoring will mitigate the issue of data quality. Triangulation of head counts during campaign and projections from the national bureau of statistics will also help. In parallel with continuing the development of data management capacity at sub-national levels, advocacy at the national level should encourage the reconciliation of denominators used during analyses. Support should be given to strengthen data management systems across both SSME and routine services, particularly in relation to referrals.
Decentralisation and ownership	• Increased capacity needs to be built at regional and district levels, particularly in relation to effective planning and for the accountable management of funds. At the central level, there is a need to advocate for increased domestic resources to support primary health care services in general. The government should be supported to make realistic central budget allocations in accordance with district plans and to facilitate the timely release of funds. Before additional interventions are added into the SSME package, adequate resourcing must be confirmed.
Coordination, supervision and training	• Sustained support should be given to improve training and supportive supervision, particularly for lower cadres of health workers including community health workers. Effective training should build competencies to not only deliver key interventions, but to understand and communicate the health benefits of the interventions, and to develop skills to collect good quality data. Integration of national-level supervision with district- and community-level supervision will help to provide additional support at more local levels, streamline data requirements and further strengthen coordination between government and partners.
Supply and provision of services	• Mechanisms for the distribution of adequate supplies must be strengthened so the effectiveness of the SSME programme is not jeopardised by supply-side issues. In parallel, capacity for human resource management at sub-national levels needs to be strengthened. Clear staffing strategies and consistent incentives for community health workers and *mobilisateurs* need to be put in place to ensure the provision of quality services during the campaign.
Community perceptions	• It is critical that targeted social mobilisation be continued and adequately resourced to build community trust, overcome rumours and misconceptions, and encourage the positive utilisation of SSME services. This is particularly important in the wake of scaled-up polio campaigns and subsequent 'campaign fatigue' amongst community members. In response to recent shifts in care-seeking practices, social mobilisation should also be tailored to engage male as well as female caregivers and to maximise the positive involvement of male caregivers in the health and wellbeing of their children and family.
Issues of equity	• An improved system to systematically collect data by intervention is needed and data should be disaggregated by service delivery mode (e.g. fixed, outreach or campaign). Building capacity and competency at regional and district levels to access and interpret coverage data is essential. This would enable more evidence-based planning for SSME that includes equity as a key component, and would strengthen the development of microplans that target the most vulnerable.

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