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Request for Information (RFI) number: RFI-687-17-002
RFI Issuance Date: September 18, 2017
Response Date and Time: October 2, 2017, 05:00 PM Antananarivo time

The United States Government, represented by the United States Agency for International Development Mission in Madagascar (USAID/Madagascar), posts this RFI to inform potential partners about an upcoming health activity, ***Accessible Continuum of Care and Essential Services Sustained*(ACCESS)**, which has been designed to help Madagascar achieve sustainable development goals. This RFI also seeks feedback from capable and interested organizations; it presents an opportunity for stakeholders to provide review, commentary, and feedback regarding the draft Program Description (attached).

Your response to this RFI must be received electronically by USAID/Madagascar on or before **05:00 p.m. Antananarivo local time on Monday, October 2, 2017**. Please send all feedback to verabemanantsoa@usaid.gov with the subject line "RFI-687-17-002 - Accessible Continuum of Care and Essential Services Sustained (ACCESS)."

The issuance of this RFI does not constitute a Request for Application (RFA), does not represent an award commitment on the part of USAID/Madagascar, nor does it obligate the USAID/Madagascar to pay for any costs incurred in the preparation and submission of a response hereto. USAID/Madagascar reserves the right to share or withhold feedback or answer or not answer any questions received; however, input received by USAID/Madagascar will be considered in finalizing the Program Description for this activity. Information received in response to this RFI shall become the property of USAID.

Interested parties who are unable to retrieve the RFI from grants.gov may request a copy of the complete RFI by writing to verabemanantsoa@usaid.gov.

Sincerely,

Jessica R. Faber
Regional Agreement Officer
USAID/Southern Africa

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Attachment: Draft Program Description

Proposed Activity Name:	Accessible Continuum of Care and Essential Services Sustained (ACCESS)
Proposed Total Estimated Amount:	$75,000,000 - $85,000,000
Proposed Time Frame:	July 2018 - July 2023
Proposed Award Type:	Cooperative Agreement

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Abbreviations

ACCESS	Accessible Continuum of Care and Essential Services Sustained
ACT	Artemisinin-Based Combination Therapy
AIRS	Africa Indoor Residual Spraying
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASSS	Annuaire des Statistiques du Secteur Santé
AU	African Union
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
CARMMA	Campaign for the Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa
CDCS	Country Development Cooperation Strategy
CCDS	Comité Communal de Développement de Santé
CHV	Community Health Volunteer
CLTS	Community-Led Total Sanitation
COSAN	Comité de Santé
CSB	Centre de Santé de Base
CSO	Civil Society Organization
CU5	Children Under Five
DCA	Development Credit Authority
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DO	Development Objective
DPT3	Diphtheria, Pertussis and Tetanus
EMAD	Équipe de Gestion des Activités de District
ENA	Essential Nutrition Actions
EPMCD	Ending Preventable Maternal and Child Deaths
FP	Family Planning
FP2020	Family Planning 2020
FFP	Food for Peace
GH	Global Health
GHSC-PSM	Global Health Supply Chain- Procurement and Supply Management
GOM	Government of Madagascar
HMIS	Health Management Information System
HSS	Health Systems Strengthening
ICS	Integrated Country Strategy
IEC	Information, Education, and Communication
IFPRI	International Food Policy Research Institute
IMPACT	Improving Market Partnerships and Access to Commodities Together
IPC	Interpersonal Communication
IPTp	Intermittent Presumptive Treatment of Malaria in pregnancy
IR	Intermediate Result
IRS	Indoor Residual Spraying

ISM	Integrated Social Marketing
ITN	Insecticide-Treated Net
LAM	Lactational Amenorrhea Method
LARC/PM	Long-Acting Reversible Contraceptives and Permanent Methods
LLIN	Long-Lasting Insecticide-Treated Bed Net
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goal
MI	Médécin Inspecteur
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
M&E	Monitoring and Evaluation
MOPH	Ministry of Public Health
MOWEH	Ministry of Water, Energy and Hydrocarbons
NNP	National Nutrition Policy
NAPN	National Action Plan for Nutrition
NWSS	National Water and Sanitation Strategy
NGO	Nongovernmental Organization
NSFH	National Solidarity Fund for Health
OMS	Outcomes Monitoring Survey
ORS	Oral Rehydration Salts
PAD	Project Approval Document
PCMD	Preventing Child and Maternal Deaths
PHE	Population, Health and Environment
PNSC	Politique Nationale de Santé Communautaire
PDSS	Plan de Développement de Secteur Santé
PhaGeCom	Community Pharmacies
PMI	President's Malaria Initiative
PNSC	Politique Nationale de Santé Communautaire
PSA	Public Service Announcement
RANO	Rural Access to New Opportunities (WASH)
RHA	Regional Health Authorities
RMAC	Rapport Mensueld'ActivitéCommunautaire
RMNCH	Reproductive, Maternal Newborn and Child Health
SALAMA	Centrale d'Achat de Médicaments Essentiels et de Matériel Médical de Madagascar
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SDSP	Service de District de Santé Publique
SDIS	Service Delivery Indicator Survey
SRH	Sexual and Reproductive Health
SRSP	Service Régional de Santé Publique

SUN	Scaling Up Nutrition
SWA	Sanitation and Water for All
TMI	Total Market Initiative
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VSLA	Village Savings and Loan Associations
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WRA	Women of Reproductive Age

I. Executive Summary

Madagascar is a country of enormous potential but faces formidable social and economic development challenges. Prior to the 2009 political crisis, Madagascar experienced relatively strong economic performance and was on track to meet several of its Millennium Development Goals (MDGs). However, following the political crisis, most donors, including the United States Government (USG), imposed restrictions on development assistance. This effectively halted development and investments in the country. The percentage of the Malagasy population living under $1.90 per day in 2012 was nearly 78 percent[i]. Madagascar's progress on health indicators faltered and, in some cases, reversed. It wasn't until 2014 that the USG lifted sanctions on the Government of Madagascar (GOM) and, in the case of the health sector, bolstered its efforts to improve the public health system.

The GOM's global vision is that "By 2030, the entire population is healthy, lives in a safe environment, and has a better and productive life". The Ministry of Public Health's (MOPH) National Health Sector Development Plan or *Plan de Développement du Secteur Santé* (PDSS) for 2015-2019 outlines consensus-driven and evidence-based priorities and objectives; and, defines expected results, strategies, and interventions to achieve the objectives. The plan identifies the following focus areas: (1) governance and leadership; (2) improvement of access and use of basic health services; (3) information management systems; (4) human resources; (5) health infrastructure and equipment; and (6) financing. For the past several years, the GOM's contribution to the health sector has generally ranged from 4 to 7 percent and, most recently in 2017 was set at 5.29 percent.

The primary purpose of the United States Agency for International Development's (USAID) work in Madagascar is to improve health outcomes among poor and underserved populations through improved healthy behaviors and increased access to quality health services. More specifically, USAID's work aims to reduce maternal and child morbidity and mortality and support efforts towards progressive malaria elimination.

The ACCESS activity will contribute to USAID/Madagascar's five-year (2016-2020) Health Development Objective (DO) focused on "sustainable health impacts accelerated for Malagasy People." By building upon the successes and lessons learned from USAID's health programs Mikolo, MAHEFA, MahefaMiaraka, and Maternal and Child Survival Program (MCSP), this activity will increase the capacity of the Malagasy health system to deliver quality essential health services to rural and urban populations with an increased focus on youth. The activity will strengthen the service delivery continuum through community health volunteers (CHVs), primary health facilities or *Centre de Santé de Base* (CSBs), and district hospitals by improving clinical and non-clinical skills of health providers and focused efforts on strengthening health systems at the district level and below. The activity will also engage with regional health authorities to ensure coordination and effective management of health activities in their districts. Work at the national level will focus on the development of in-service training curricula for health providers and development of performance improvement and quality assurance measures. In addition, ACCESS will work to develop healthy norms and health seeking behaviors and build the capacity of Malagasy institutions to lead and coordinate social and behavior change activities.

II. Relationship to U.S. Government Strategy, Mission Integrated Country Strategy, and Health Sector Results Framework

2.1 U.S. Government Strategy

The ACCESS activity will contribute to the mandates of the President's Malaria Initiative (PMI), Preventing Child and Maternal Deaths (PCMD), Family Planning 2020 (FP2020), USG global Water, Sanitation and Hygiene (WASH) initiatives, and USAID's vision for Health Systems Strengthening (HSS) approach.

USG assistance for malaria control in Madagascar is funded through PMI, which addresses malaria through four major interventions: indoor residual spraying (IRS); promotion and distribution of long-lasting insecticide-treated bed nets (LLINs), intermittent preventative treatment of malaria in pregnancy (IPTp), and malaria case diagnosis and treatment. PMI's global objective is to, by 2020, reduce malaria mortality by one-third and morbidity by 40 percent as compared to 2015 levels.

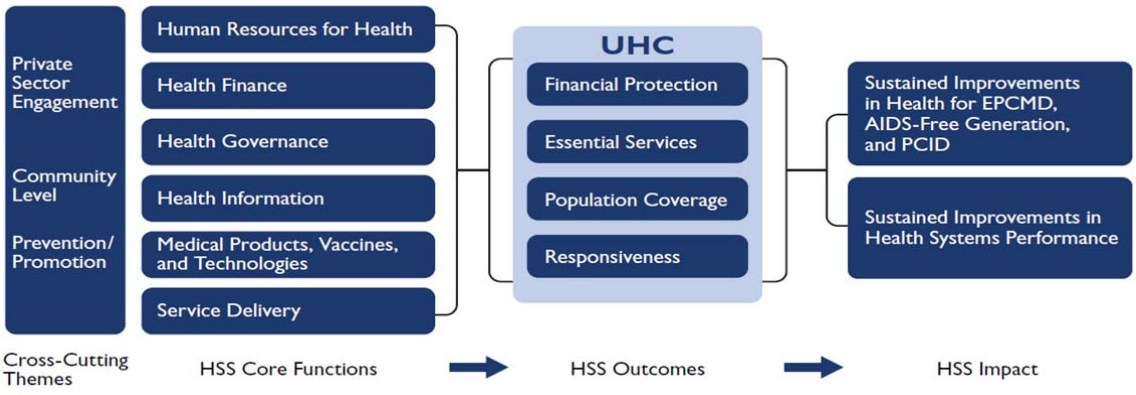
Since 2014, USAID has bolstered its focus on PCMD and Madagascar was identified as one of the 24 priority countries. For Madagascar, the specific PCMD goals include saving 230,000 child lives and 8,000 women's lives by 2020. The PCMD strategy's global performance is measured by six key indicators: contraceptive prevalence rate; contraceptive security; under-five mortality; births attended by skilled birth attendants; diphtheria, pertussis, and tetanus (DPT3) vaccination by age 12 months; and people protected from malaria with an LLIN.

Family Planning 2020 (FP2020) is a global partnership, which includes USAID, supporting the rights of women and girls to decide, freely and for themselves, whether, when, and how many children they want to have. FP2020 is working to enable 120 million more women and girls globally to use contraceptives by 2020.

This activity will also be key in contributing to USAID's global WASH mandates under the USG's Senator Paul Simon Water for the Poor Act (2005) and Water for the World Act (2014) which are designed to address clean water supply and sanitation challenges.

The ACCESS activity supports USAID's 2015-2019 Vision for HSS approach which presents an integrated, comprehensive, and holistic approach to improve health systems at the country level, including national, sub-national (regional and district), and community levels. The HSS vision reflects an Agency-wide vision that outlines the approaches, outcomes, and drivers for targeted, country based programming that will result in sustainable health systems performance. The following diagram presents the health system's core functions as portrayed in USAID's Vision of HSS:

Figure 1. USAID HSS Functions, Outcomes and Impact



2.2 Mission Integrated Country Strategy

USAID/Madagascar does not currently have a Country Development Cooperation Strategy (CDCS). However, the ACCESS activity will contribute to achieving the goals of the U.S.G Madagascar Integrated Country Strategy (ICS) 2015-2017 and will be considered in any future strategies. The ICS is a multi-pronged strategy that provides a framework for USG engagement with the Malagasy people and the GOM. It aims to reduce poverty, improve food security, enhance citizen security, educate future leaders in democratic principles, and protect future USG interests in the country. The ACCESS activity will help achieve Goal 3 of the strategy: "The Malagasy people and their environment remain resilient; they continually mitigate, adapt and transform from shockers or stresses." Interventions will work toward Objective 3.2 of that goal, which is to "Improve health through increased use of targeted Malagasy health, nutrition, water and sanitation services."

2.3 Health Sector Results Framework

This activity will be integral to attaining USAID/Madagascar's 2016-2020 Health Sector Strengthening Project Approval Document (PAD) goal and desired results. The overall DO for the PAD is "Sustainable health impacts accelerated for Malagasy People." The activity will contribute to the following intermediate results (IR) in that framework:

IR 1: Care Seeking and Healthy Behaviors Adopted
- 1.1 Knowledge of Healthy Behaviors, Services and Products Improved
- 1.2 Barriers to Healthy Behaviors Reduced
- 1.3 Local Leaders and Institutions Support Care Seeking and Healthy Behaviors

IR 2: Availability and Delivery of Quality Integrated Health and WASH Services Increased
- 2.1 Knowledge and Skills of Health and WASH Providers Improved
- 2.2 Integration of Community Health Volunteers into the Health System Improved
- 2.3 Management of Health Care Facilities and WASH Infrastructures Improved
- 2.4 Availability of Commodities Improved

IR 3: Health System and WASH Sector Performance Improved
- 3.1 Timely and Complete Quality Data Reporting for Decision-Making Improved
- 3.3 Commodity Supply Chains Strengthened

The results framework reflects a shift from the humanitarian aid approach adopted during the period of the political crisis, to one that aims to strengthen the overall health system in order to sustain and improve health outcomes.

The USAID/Madagascar health sector strategy hypothesizes that: *If strategic investments in health system strengthening are increased and community-level health service delivery is maintained, then progress will be accelerated toward eliminating preventable child and maternal deaths*. These activities will be undertaken in close coordination with the MOPH and the Ministry of Water, Energy and Hydrocarbons (MOWEH) and other health sector donors to ensure harmonization of approaches and geographic scope to increase impact on health in Madagascar.

III. Relationship to Partner Country Strategy

The GOM's vision is that "By 2030, the entire population is healthy, lives in a safe environment, and has a better and productive life". The National Development Strategy or *StrategieNationale de Relance du Développement* (SNRD), released in February 2014, identifies health as one of the four key pillars of development along with economic growth, governance and rule of law, and environmental protection and climate change mitigation. USAID's previous investments in family planning (FP), maternal, neonatal and child health (MNCH), WASH, nutrition, and malaria respond directly to the core objectives and strategic priorities of the GOM.

The PDSS 2015-2019 aims to realize this vision through the following objectives: improving accessibility and affordability of preventative and curative health services; stimulating demand for and use of health services; equitable coverage and quality health infrastructure; effective participation and coordination of government, civil society and donors; decentralization of the health system; improving the health information system; and scaling up high impact interventions to accelerate the reduction of maternal and infant mortality, reduce the prevalence of major communicable diseases (HIV/AIDS, malaria and tuberculosis), and neglected diseases and noncommunicable diseases.

The GOM signed onto the African Union's (AU) Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) initiative and developed an action plan that articulates a costed strategy for Ending Preventable Maternal and Child Deaths (EPMCD) with the following priorities: post abortion care, obstructed labor and uterine rupture, eclampsia/pre-eclampsia and postpartum hemorrhage to address maternal death; and addressing asphyxia, infections, and the availability of life-saving commodities to reduce neonatal and child mortality.

In April 2017, MOWEH announced commitments to improving WASH at the recent Sanitation and Water for All (SWA) meetings in Washington, D.C. Actions that the GOM committed to included incremental budget increases for the WASH sector, provision of improved sanitation to approximately 14 million people and reducing open defecation by 84 percent by 2018. These commitments reflect the MOWEH National Water and Sanitation Strategy (NWSS) for 2014-2018.

The MOPH initiated the implementation of its Universal Health Coverage (UHC) strategy that was validated in December 2015. In April 2017, the GOM passed a decree establishing a national health solidarity fund, called the National Solidarity Fund for Health (NSFH) as part of its UHC efforts. The solidarity fund will cover the costs associated with preventive, curative, and rehabilitation care. Since 2016, the MOPH has been piloting UHC in three districts in three regions and assessing the willingness to pay and potential payment mechanism.

In July 2017, the MOPH updated the National Community Health Policy or the *Politique Nationale de Santé Communautaire* (PNSC) and the new policy bolsters the MOPH's engagement in the community health platform. The policy reflects the Malagasy government's commitment to anchoring community level care as a critical piece of the national health system. The PNSC aims to strengthen and facilitate community involvement, participation and empowerment in the development of health systems at the local level to improve access, equity and quality of health services. The MOPH will also establish a system to coordinate interventions and document best practices across communities. Finally, in 2017, the GOM has allocated budget funds for three regions for human resources, infrastructures and operating costs in order to improve the quality of services.

As a signatory to the Scaling Up Nutrition (SUN) movement, the GOM is working to scale up specific high-impact interventions to accelerate the reduction of chronic malnutrition. The GOM aims to accomplish this goal through its National Nutrition Policy (NNP) developed in 2004 and the National Action Plan for Nutrition 2017- 2021 (NAPN).

IV. Program Context

4.1 Population Health Status

Though there have been some limited improvements, the effects of Madagascar's political crisis on economic and social outcomes have been devastating. The country now ranks 158 out of 188 countries in the 2016 United Nations Human Development Index[ii] and 78 percent of the population is living under $1.90 per day[iii]. Madagascar's current population is 24.8 million and the annual population growth rate is estimated to be 2.7 percent[iv]. During the period of political instability, Madagascar suffered from a rapid deterioration of essential health services, primarily due to reduced domestic and external resources and poor predictability and implementation of the budget. Additionally, food insecurity now affects nearly four million people, or nearly one-fifth of the population. Madagascar faces significant and recurrent natural disasters, principally cyclones, flooding and drought, and locust outbreaks, which lead to widespread food insecurity and increase susceptibility to epidemics, including malaria.

Although Madagascar's under-five mortality rate declined from 72 to 62 per 1,000 live births between 2008 and 2012[v], major challenges persist in FP, maternal and child health (MCH), neonatal health, WASH and nutrition. About one-third of deaths of children under five are attributed to pneumonia, malaria, and diarrhea. The neonatal mortality rate increased marginally from 24[vi] to 26[vii] per 1,000 live births from 2008 to 2012 and accounts for 42 percent of under-five deaths. The maternal mortality ratio (MMR) has also stagnated at 478 maternal deaths per 100,000 live births over the last two decades. Only 38 percent of deliveries take place in a health center and 44 percent are assisted by a qualified health provider[viii]. Postpartum hemorrhage and post abortion complications are the top causes of maternal mortality.

Over the past 15 years some of Madagascar's health indicators have improved, mostly in the areas of child health and malaria. From 2003 to 2013, the number of new malaria cases and deaths decreased overall. However, malaria remains endemic in 90 percent of Madagascar and the entire population is considered to be at risk for the disease. In 2015, there were an estimated 450,000 cases of malaria, causing approximately 360 deaths[ix] and severe malaria remained among the top five causes of reported overall mortality. In 2014/2015, however, there was an observed increase in malaria cases that was attributed to cyclones, heavy rains and flooding, and stockout

of malaria commodities in many parts of the country. Data from late 2015 to the first half of 2016, which followed the September to December 2015 insecticide-treated nets (ITN) distribution campaign, shows malaria cases decreased by 39.1 percent and malaria deaths decreased by 60.4 percent during this time period.[x]

The national immunization rate for all antigens steadily decreased during the last decade: the DPT3 vaccination coverage rate among children 12-23 months of age dropped from 85 percent in 2005 to 69 percent in 2015. This, combined with a very weak health system, resulted in the recent reemergence of vaccine-derived poliovirus type 2. After a nine year absence, Madagascar experienced vaccine derived poliovirus outbreaks due to gaps in population immunity – a result of a deteriorating routine immunization system, hard-to-reach areas and general insecurity.

Over the past two decades, the total fertility rate decreased from 6 to 4.5 children per woman and FP uptake increased modestly from a modern contraceptive prevalence rate (mCPR) of 29 percent[xi] to 33 percent[xii]. The unmet need for FP increased from 14.6 percent[xiii]to 18 percent[xiv] of women. There are still urban (39 percent) and rural (32.1 percent) discrepancies in mCPR, as well as wide regional variations[xv]. The mCPR also varies significantly across wealth quintiles with only 22.7 percent of the poorest Malagasy people using modern methods, compared with 35.2 percent of the richest[xvi]. In addition, unmet need, at 17.7 percent among women of reproductive age married or in a union, remains a serious constraint and the current contraceptive mix relies heavily on short-term methods, such as injectable contraceptives (19.9 percent of all married women of reproductive age) and oral contraceptives (6.6 percent)[xvii].

Out of Madagascar's total population, 45 percent are under the age of 15 years old[xviii]. Presently, 5.2 million Malagasy people are aged 15-24 and by 2050, the total number will increase to 8.8 million[xix]. The adolescent fertility rate in Madagascar has steadily increased, with approximately 26 percent of adolescent girls giving birth before their 19th birthday[xx].

Only 52 percent of the current population has access to safe drinking water, and only 12 percent has improved sanitation facilities. In rural areas, only 35 percent of the population has access to an improved water supply and 9 percent access to improved sanitation. Limited access to clean water, high rates of open defecation, and poor hygiene behavior directly affect the prevalence of waterborne diseases. Diarrhea is the second leading cause of child mortality in Madagascar, with 15 percent of mortality in children under five (CU5) attributed to diarrhea[xxi].

Madagascar has the fourth highest rate of chronic malnutrition rate in the world[xxii]. The prevalence of chronic malnutrition, or stunting, in CU5 was 48.6 percent in 2016, down very slightly from 49.2 percent in 2008[xxiii]. The International Food Policy Research Institute's (IFPRI) Global Hunger Index shows that the prevalence of wasting among Malagasy children has remained essentially the same for the past 20 years and is actually higher than it was when IFPRI first began its estimates in 1992. The southeastern area of Madagascar is particularly vulnerable to acute food insecurity.

4.2 Health System Structure

The MOPH at the national level is represented by the cabinet of the Minister of Public Health and the directorates reporting directly to the Director General for Health under the Secretary General of the MOPH. Madagascar is administratively divided into 22 regions, 119 administrative districts (only 112 health districts), 1,579 communes, and 17,500 fokontany, the equivalent of villages in most African countries. Each region has a regional health directorate and

a regional hospital. Contrary to other administrators in Madagascar, the fokontany chief is chosen through a grassroots selection process by community members and is not affiliated with a political party.

The health delivery system in Madagascar takes place at four levels: central, regional, district and *commune* (i.e. community and village). The regional health team known as the *Service Régionale de Santé Publique* (SRSP) supervises district health teams known as *Service de District de Santé Publique (SDSP)* to plan and implement integrated health programs. The *SDSP* is headed by a medical chief called *Médécin Inspecteur* (MI) and is responsible for technical supervision of all CSBs and district hospitals in its jurisdiction. Each health district typically contains 10 to 25 CSBs and one hospital. The district hospital is the first referral structure for CSBs. At the community level, communes are responsible for health promotion and primary care services in villages. There is at least one public CSB serving each commune. The public sector health system comprises the following[xxiv]:

- There are six university teaching hospitals in the capital city and in five other regions, plus 10 specialized referral centers
- There are 16 regional hospitals for patients requiring a higher level of care that serve as tertiary care health facilities
- There are 87 first referral district public hospitals
- There are 2,588 public CSBs. Among these 1,662 are known as CSB Level II, expected to be staffed with at least one physician, and 926 CSB Level I, which are staffed by a nurse or paramedic, and in some cases a nurse's aide.

Overall, the public health system is marked by little or no integration of preventive and curative care, an absence of continuity of the care, commodity insecurity, irrational use of drugs, and even non-clinical activities are of poor quality, with poor patient reception, long waiting hours, and poor patient communication.

The MOPH has a critical staff shortage at all levels of the public health system, especially for service provision below the central level. In addition, health workers are not distributed equitably throughout the country, resulting in higher concentrations of qualified health staff in the urban areas. According to the 2013 National Health Statistics, *Annuaire des Statistiques du Secteur Santé* (ASSS), rural regions have less than one doctor for every 10,000 inhabitants. The MOPH is finalizing a human resources strategy, which aims to recruit and equip various paramedical staff at the CSB level over the next several years.

In current per capita terms, Madagascar has the lowest total health expenditure in the world, at $13.67. The share of healthcare that is externally financed is large. In 2013, 83 percent of total public health spending in Madagascar was provided by foreign aid, raising questions about the long-term sustainability of health financing. Health spending is also increasingly concentrated in salaries, with labor making up 85 percent of MOPH spending in 2013, up from 54 percent in 2006, though this high portion of spending is somewhat offset by external health funding[xxv].

In 2003, the MOPH instituted a user fee policy that charges clients for health commodities at public health centers and established an 'equity fund' to be used to provide free medicine to the poor. However, the health system faces challenges in adequately targeting beneficiaries, often resulting in under-coverage of the funds. Since the launch of the National UHC policy in 2015, UHC, through various channels including microinsurance activities, is a strategic priority for the MOPH as health service affordability continues to be a challenge for many Malagasy. Protection against financial risks, ensuring adequate availability of effective quality health service, and

reducing exposure to health risks are the basic pillars of the strategy. Donors and partners, including USAID, aim to reduce financial barriers to healthcare. In particular, micro-insurance or mutuelles have shown promise, but many communities struggle to get beneficiaries to sign-up for the schemes.

4.3 USAID/Madagascar support to Madagascar's health system

The primary purpose of USAID's work in Madagascar is to improve health outcomes among poor and underserved populations through improved healthy behaviors and increased access to quality health services. More specifically, USAID's work aims to reduce maternal and child morbidity and mortality and support efforts towards progressive malaria elimination. Access to and utilization of primary health facilities continues to be a challenge as the country faces a myriad of health systems challenges including a dearth of qualified health workers, medical and commodity insecurity, and weak health and management information systems.

USAID has supported the implementation of the GOM's PNSC since 2009. The community health system expands the reach of the public health system and serves as the first point of contact with beneficiaries. USAID has supported the community health system in 15 of Madagascar's 22 regions, and 15,000 CHVs provide health information focused on behavior change communication (BCC) and basic preventive and curative services in these regions. Most recently, the community health system has been supported by two USAID awards, the Mikolo activity (2012-2018) covering the eastern and southwestern regions of Madagascar and the MAHEFA activity (2010-2015) and its follow on MahefaMiaraka (2016-2021) covering northeastern and western Madagascar. From a USAID perspective, it is important that the two community-level activities be merged into one activity, ACCESS, to ensure that one coherent, consistent strategy is used throughout the country's health system and that all economies of scale are employed to maximize resource use.

Following the end to the political crisis in 2014, USAID has re-engaged with the MOPH and support shifted to assisting the newly-established government in rebuilding the health system. In addition to continued support to the community health platform, USAID has initiated support to CSBs and hospitals and is further strengthening linkages between CHVs and the CSBs. This includes a focus on improving formal referral and counter-referral systems, supervision, reporting, and the supply of essential health commodities between CHVs and CSBs. The current MahefaMiaraka award is particularly focused on building the health service planning, management, and governance capacities at the district-level. In parallel, MCSP has worked to build the skills of doctors and midwives in hospitals and primary health facilities to deliver quality clinical services and improve health governance at hospitals and CSBs. This includes developing and updating curricula and training of health providers on family planning, malaria, and MNCH topics.

USAID has also supported service delivery in the private sector through socially franchised clinics operated by Marie Stopes to provide Long Acting, Reversible, Contraceptives and Permanent Methods (LARCS/PM). In addition, through the Integrated Social Marketing (ISM) activity (2013-2017), USAID supports a network of socially franchised clinics to provide FP and MCH activities. ISM also implements national campaigns aimed at increasing healthy behaviors and social marketing of health products sold at pharmacies and distributed by the CHVs at the community level. Through the community-based social marketing program USAID improves access to the following commodities: water purification tablets/liquid, zinc tablets and oral rehydration salt to treat diarrhea; pneumonia treatment; ITNs to prevent malaria, and short-acting FP methods including oral and injectable contraceptives, as well as condoms.

At the national level, HSS activities target improvements in HMIS, health commodity supply chain, and development of supportive policies in the health sector. USAID, through the Measure Evaluation project, supports national level efforts to build and strengthen a sustainable health information system capable of generating high quality health information that is used to support programmatic and policy decision making at local and national levels. Measure Evaluation's activities focus on strengthening collection, analysis, and use of routine health data, improving country-level capacity to manage health information systems, and improving methods tools and approaches to address health information challenges. Through the Global Health Supply Chain for Procurement and Supply Management (GHSC-PSM), USAID is building the capacity of the public sector supply chain system to ensure that products are reaching the last mile, improve cost recovery and strengthen Logistics Management Information Systems (LMIS). USAID's Improving Market Partnerships and Access to Commodities Together (IMPACT) activity, currently under procurement, will build on the work of GHSC-PSM to improve the capacity of the health system to ensure that quality pharmaceuticals and health commodities are available and accessible to all Malagasy people on a sustainable basis. The activity is a Total Market Initiative (TMI) that will build the capacity of the GOM to manage supply of pharmaceuticals and health commodities; encourage expansion of the commercial sector to reach new markets and consumer segments; support social marketing to increase coverage of essential health products at affordable prices; and promote health products to create demand.

V. Program Description

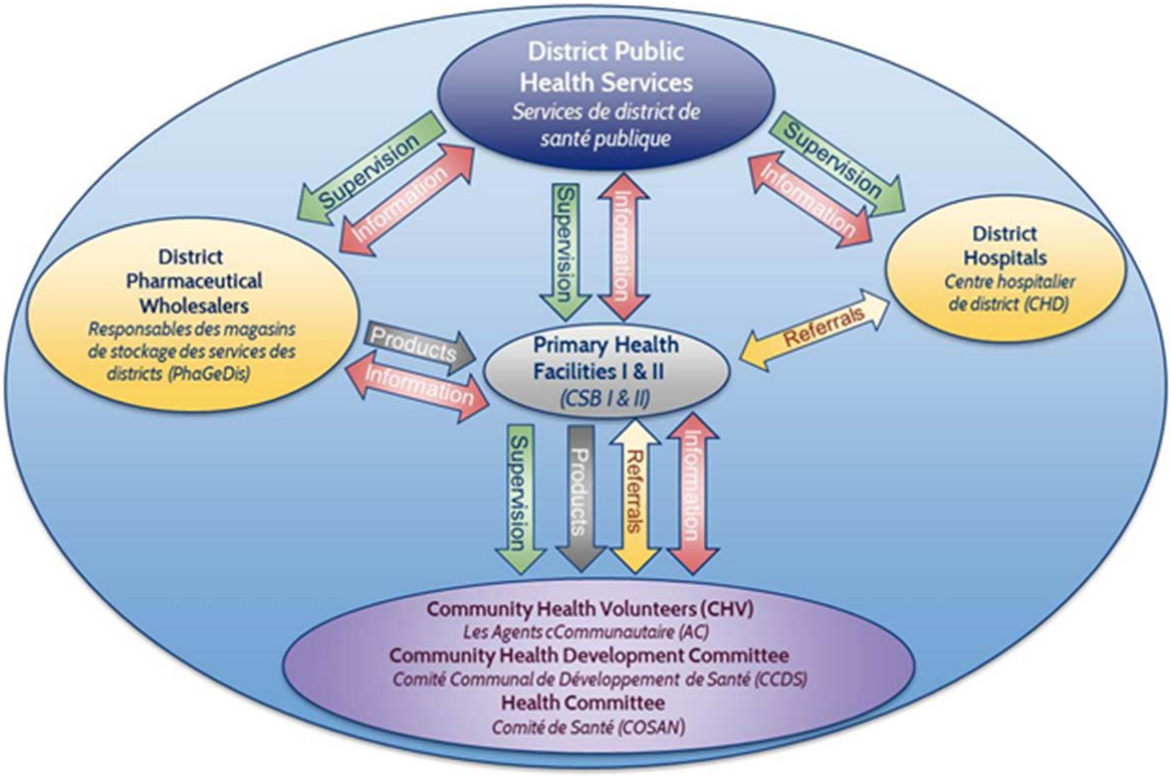
5.1 Technical Scope

The aim of this activity is to build the capacity of MOPH actors at the district level and below in all districts in the implementation regions, to design, develop, manage, deliver, monitor and evaluate health services and programs in their catchment areas. The activity will also engage with regional health authorities with limited interventions to ensure coordination, planning and effective management of health activities in their districts. Work at the national level will focus on informing policy, guideline development, as well as advocacy on key health service delivery issues. ACCESS will work to improve the clinical skills and health governance skills of primary health care providers to deliver high quality, accessible preventive and curative health services. To expand the reach of the public health system, the activity will work to improve the skills and motivation of community health volunteers to deliver quality health services and ensure they work under the supervision of their respective CSB. Finally, ACCESS will promote positive health behaviors, including care seeking behaviors in the target communities through a comprehensive and contextualized social and behavior change (SBC) approach and improve the capacity of the MOPH and local institutions to design, implement, and monitor and evaluate SBC activities. The activity will work towards the following objectives: 1) Quality health services are sustainably available and accessible to all Malagasy communities in the targeted regions; 2) Health systems function effectively to support quality health service delivery; 3) The Malagasy people sustainably adopt healthy behaviors and social norms.

The ACCESS activity's service delivery approach should be patient-centered and be respectful of and responsive to the individual's life experiences and socio-cultural values while, anticipating other health needs for the client or family members as appropriate. All approaches and interventions in this activity should be adapted to underserved areas (such as slums) or populations (such as youth).

ACCESS will focus on how beneficiaries can effectively access preventive and curative services across the district health system consisting of CHVs, CSBI and II, and district level hospitals under the support oversight of the SDSP. It should not replace government staff or assume responsibility for government functions such as supervision or training; rather, it should focus on building the capacity of the MOPH to carry out these functions. At times and in certain districts, this may involve more significant involvement than in others. However, the intent is for ACCESS to support the MOPH and increase its ownership and capacity to effectively manage health activities.

Figure 2. Madagascar's District Health System



This activity will be USAID/Madagascar's flagship health project that will build on USAID's extensive experience and investments toward strengthening the health system. ACCESS should consolidate gains made through existing and previous programs and scale up successful models and interventions while placing less emphasis on piloting new interventions and models. A strong focus should be placed on closely monitoring and evaluating progress towards meeting targets, improving service quality, and improving health outcomes. The incumbent will be a technical leader, using experiences on the ground, project data, and lessons learned to inform dialogue and policy discussions at all levels of the health system.

5.2 Activity Principles

1. The Malagasy people have uninterrupted access to essential health services and products of similar quality and consistency regardless of where they reside (rural or urban) or their ability to pay for services.

2. A robust and regularly monitored referral and counter referral system, allows beneficiaries to transition seamlessly throughout the district health system starting with services at the community level, to the primary health facility (CSB I/CSB II), up to the district hospital.

3. The delivery of quality, respectful health services requires trained healthcare providers with clinical and management skills, health commodities, appropriate infrastructure, and medical equipment and supplies.

4. Functional and supportive district health management teams and systems are essential to the delivery of quality health services at the facility and community levels.

5. Care-seeking and healthy behaviors are determined by a complex set of factors including gender, age, knowledge, self-efficacy, social norms, and barriers and incentives, whether actual or perceived.

5.3 Activity Objectives

Activity Objective 1 - Quality health services are sustainably available and accessible to all Malagasy communities in the targeted regions

Note that this activity objective supports the PAD's IR 2 and sub-IR 2.1 and 2.2

Sub Objectives:

1.1 Quality community health services are available as first point of contact with the health system

1.2 Quality health services are available to all the Malagasy people at the CSB and district hospitals

1.3 Functional continuum of care across service delivery channels is able to be provided throughout the district

This objective focuses on improving the quality of health services available at the district hospital, CSB I and CSB II, and community and ensuring the continuity of care through these service delivery channels. The ACCESS activity will ensure continuous integrated maternal, newborn and child care throughout the life cycle focusing on women of reproductive age (WRA) including adolescents (15-19 years) and other WRA (19-45 years) before pregnancy, during pregnancy, childbirth, post-natal, and CU5. The activity will improve the skills of health care providers and community health volunteers to provide a comprehensive package of essential health services. The CSB I, CSB II, and district hospitals should be able to provide the basic package of Reproductive, Maternal, Newborn and Child Health (RMNCH), nutrition and WASH services, including life-saving interventions to address key causes of maternal, child and newborn mortality. Health providers should be well equipped take full advantage of each encounter with beneficiaries to provide appropriate information, counseling, and services. Recognizing that a well-functioning referral and counter-referral system is integral to ensuring the quality, accessibility and timely use of the continuum of essential health services, ACCESS will incorporate a comprehensive approach for building, and continually monitoring a robust and sustainable referral system. The system should enable patients to transition between community,

CSB, and district level facilities and track patients and care outcomes, including the specific services and follow-up care they receive at each level of the district health system.

1.1 Quality community health services are available as first point of contact with the health system

The activity will support continued delivery of quality health services by CHVs, while concurrently strengthening the links between CHVs and CSBs. In addition to delivering quality services, improving the competency of CHVs to adequately identify and refer severe and complicated cases will be a particular priority during the implementation period. Strong emphasis should be placed on measurably improving the quality of services and monitoring progress with data and achievement of results throughout implementation. CHVs play an important role in strengthening the continuum of care by providing patients appropriate referrals and follow up and also ensuring appropriate counseling during each encounter with their clients.

The expanded package of services provided by CHVs includes:

1. *Infant and child health*: Newborn essential care including the use of chlorhexidine for home births; immunization demand generation; identification and referral of unvaccinated children; support to vaccination campaigns; promotion of preventative child health practices, such as growth monitoring and handwashing; early recognition and prompt diagnosis of simple pneumonia, diarrhea and malaria; and CSB referrals for complicated cases.

2. *Maternal health:* Referral of pregnant women to primary health facilities for antenatal care (ANC) and births; early recognition of danger signs and referral; postpartum counseling; misoprostol for home deliveries; counseling on exclusive breastfeeding, maternal nutrition and birth spacing.

3. *FP:* Counseling on all FP methods including lactational amenorrhea method (LAM), counseling on birth spacing, provision of short-acting modern contraception and referral for long-acting methods;

4. *Nutrition:* Promotion of essential nutrition actions - sensitization on iron folate, exclusive breastfeeding, complementary feeding, micronutrient supplementation, iodized salt, vitamin A, food diversification, and control and treatment of malaria and helminthic infections to prevent anemia. There will also be a focus on appropriate referrals to health facilities for cases of acute nutrition.

5. *WASH:* Promotion of key WASH messages including drinking potable water everyday (boiling water, using point-of-use treatment products, or using an improved water source); use of improved latrine/safe disposal of children's feces; adopting healthy hygiene behavior including practice of handwashing at critical moments and promotion of personal and household hygiene.

6. *Health commodity distribution:* Distribution of pharmaceutical commodities and promotion and social marketing of life-saving health products, including misoprostol to address postpartum hemorrhage, chlorhexidine to prevent newborn infection; treatment for pneumonia and diarrhea; water treatment; family planning commodities such as oral and

injectable contraceptives and condoms; and malaria screening tests and malaria treatment.

Although CHVs lie at the core of the PNSC and are considered an integral part of the formal health system, the GOM does not include CHVs under its cadre of paid employees and they work on a voluntary basis. Given the importance of the role of CHVs in expanding the reach of health services in remote and underserved areas, developing approaches for motivation on a sustainable basis is essential. CHVs in Madagascar are primarily motivated by community recognition and community-led construction of health posts to facilitate CHVs' work. Donor-funded programs provide bicycles, training, and in some cases stipends. CHVs supported by USAID/Madagascar health programs earn a modest fee by socially marketing health commodities that are made available through a vast network of commodity supply points. However, given the magnitude of the responsibility of CHVs, current incentives may not sufficiently motivate CHVs. The applicant should propose innovative and sustainable approaches for CHV motivation that are in line with the PNSC.

CHV financial security is an important motivating factor for successful job performance. The ACCESS activity should work to improve CHV access to financial services, including, but not limited to, savings and loans clubs (such as Village Savings and Loan Associations (VSLAs)), and microfinance institutions and/or banks for formal savings and loan products. The activity should link CHVs to USAID/Madagascar's partner financial institutions offering guaranteed loan products under a Development Credit Authority (DCA) agreement. The ACCESS activity shall also propose mechanisms for demand generation for loan products and provide training to CHVs on basic financial management.

1.2 Quality health services are available to all the Malagasy people at the CSB and district hospitals

A recent Service Delivery Indicator Survey has shown that the availability of basic and comprehensive emergency obstetric care is limited with only 17.2 percent of CSB II and 73.5 percent of district hospitals offering these services. The diagnostic accuracy for common child illnesses (including malaria with anemia, diarrhea, and pneumonia) and some common adult conditions is alarmingly weak at 34 percent among physicians. In addition, health providers adhered to 21.9 percent of the clinical guidelines for managing maternal and neonatal complications. It was also found that less than 50 percent of the health facilities had the standard technical guidance at their health facilities[xxvi]. In addition, a facility readiness survey conducted in 2014 indicated that only 86 percent of regional and district hospitals and 53 percent of CSBs have clean water, which is critical for infection prevention and control at health facilities[xxvii].

To improve health service quality, ACCESS will support the MOPH to continue to build the clinical skills and improve the performance of providers at the CSB I, CSB II, and district hospitals to deliver evidence-based interventions. This component will be informed by current international guidelines and quality of care standards pertaining to the essential packages of care outlined below. Interventions under this component will incorporate direct support to the MOPH at the national level to develop their work plans and strategies for training, supervision and skills maintenance and to include a continuous quality improvement component based on the concepts of health governance and accountability. Furthermore, the activity will provide advice and technical assistance to the MOPH for the development of technical clinical norms and guidance in the areas of maternal and newborn health, child health, immunization, malaria, WASH, and FP. Support should include development and updating of in service training curricula and enabling the MOPH to conduct in-service trainings that reach all of the ACCESS

activity's implementation regions and districts. The health areas in which the activity will work to improve performance of the providers and other support includes:

1. *Integrated management of childhood illness:* case management for fever including appropriate diagnosis and treatment of malaria, diarrhea treatment, and pneumonia treatment, and immunization.

2. *Sexual and reproductive health (SRH) and FP:* with adapted approaches targeting adolescents (i.e. 15-19); counseling on birth spacing, delayed childbearing, provision of modern contraceptives, including long-acting and reversible contraceptives and permanent methods (LARC/PM)(for interval and postpartum periods). Trainings must include provider behavior change to ensure delivery of youth friendly services.

3. *Maternal health services:* provision of ANC, malaria in pregnancy, delivery services, newborn care and evidence-based interventions to reduce maternal and newborn mortality, and simple surgeries (at district hospitals only).

4. *Nutrition:* maternal nutrition counseling of female adolescents and mothers; child nutrition counseling focused on essential nutrition actions.

5. *WASH:* Application of the national WASH-friendly health facility approach focused on provision of clean water and improved sanitation at health facilities. This work may include basic WASH infrastructure to ensure health facility level infection prevention and preventative health measures (at CSB only).

Health providers in Madagascar have limited experience implementing youth friendly services and this presents a barrier to accessing SRH services. The barriers are largely due to cultural sensitivities surrounding access to these services by unmarried youth. In addition to improving clinical skills of providers, ACCESS will implement provider behavior change activities to support provision of respectful and appropriate youth friendly service delivery.

As ACCESS, builds up the capacity of the public health system to deliver LARC/PM, the activity will operate mobile outreach vans to offer these services. These mobile outreach teams will improve accessibility of essential services to underserved hard to reach populations while building local organizational capacity to deliver high quality FP services to improve sustainability of these services. A mobile outreach team should be selected and trained in close coordination with district health authorities and CSBs directors (*Chef CSB*). The teams should visit communities selected based on agreed upon criteria at least once per quarter. Mobile outreach vans may also be used to support health campaigns and events as required by local authorities.

1.3 Functional continuum of care across service delivery channels throughout the district

The PNSC establishes a referral and counter-referral system between CHVs and health facilities, which includes referral and data collection tools. CHVs are intended to serve as a primary contact to the health system and facilitate the transition of beneficiaries to primary health facilities as needed. USAID's community health programs have also invested in successful community-led emergency transport solutions to address some of the access barriers to health facilities. At present, the referral system is not fully functional; beneficiaries cannot be tracked effectively across service delivery channels and it is challenging to ensure that referred clients

have reached the health facility, received a service and have been counter-referred as needed. In addition, the vast majority of referrals are for ANC or immunization with referrals for life-threatening events either not happening or not recorded. The ACCESS activity will identify solutions to strengthen referral and counter-referral systems by addressing operational and physical barriers to effective referrals. Interventions should prioritize referrals between CHVs and CSBs and only begin to build up the referral system between CSBs and district hospitals in districts where significant progress has been made between the CHV and CSB. Interventions should also take into account demand side barriers to effective referrals as described under objective 3 below. Furthermore, the PNSC outlines the important role of establishing strong links between CHVs and CSBs to ensure that volunteers receive appropriate support, mentoring, and supervision. By the end of the implementation period, the activity will institutionalize CHV and CSB coordination and harmonization and completely transfer the training, motivation, and supervision of CHVs to the public health sector (i.e. CSBs and*Comité de Santé* (COSANs)). These activities are further detailed under Objective 2.1.

Priority intervention areas will include, but are not limited to the following:

Table 1. Objective 1 Illustrative Performance Indicators

Priority Intervention Areas	**USAID/ Madagascar Health Results Framework**	**Illustrative Performance Indicators**
Increasing skills and competencies of health workers in priority interventions to reduce maternal, neonatal and child mortality	IR 2.1	Number of newborns not breathing at birth who were resuscitated Percentage of pregnant women receiving ANC by skilled personnel Percentage of health providers able to properly diagnose and treat malaria/pneumonia Percentage of children between 12-23 months of age who received their 3rd dose of DPT by 12 months of age
CHVs provide quality services with appropriate motivation and supervision mechanisms in place to sustain performance	IR 2.2	Percentage of CHVs provided with supportive supervision from a public sector provider in the last three months Percentage of CHVs able to correctly diagnose and treat simple cases of pneumonia, diarrhea, and malaria

Referral system strengthening between CHVs and CSBs to increase health care and prompt treatment;	IR 2.2	Percentage of CHV referrals that completed referrals at referral site Number of cases referred for maternal, child or newborn emergencies who completed referrals

Activity Objective 2 - Health systems function effectively to support quality health service delivery

Note that this activity objective supports the PAD's IR2 and IR3

Sub Objectives:

2.1 Service quality at the community and CSB is maintained through appropriate management, governance, supervision, oversight, and motivation mechanisms

2.2 Quality data is available at the CSB and district level, is used for decision making and integrated into the national HMIS

2.3 Health commodities continuously available at CSBs and CHVs

This objective focuses on the management systems that support the flow of clients, data, commodities and supplies up and down the health system. USAID seeks to sustainably strengthen key components of the health system at the district level and below to improve health service delivery and management. While activities will focus primarily at the district and below, USAID recognizes that ACCESS will be involved at the regional and central levels as is necessary to support the needs of the district. The activity will implement interventions build the leadership, management, and governance capacity of key actors in the district health system to ensure effective monitoring and supervision is provided at the district, CSB, and community. The activity will also ensure that health districts are able to correctly quantify, forecast, and manage their health commodity needs and that quality data is collected and is used to inform district planning and decision making.

2.1 Service quality at the community and CSB is maintained through appropriate management, governance, supervision, oversight, and motivation mechanisms

The ACCESS activity will include a cross-cutting component focused on building non-clinical leadership and management capacities and strengthening governance processes, at all levels of the district health care system. Drawing on best practices from previous and ongoing USAID programs, other efforts in Madagascar and/or proven strategies from other countries with comparable contexts, the program will employ appropriate participatory approaches to: (a) clarify and reinforce the specific functions of and relationships between key health governance structures (such as EMAD, Community Health Development Committee or *Comité Communal de Développement de Santé* (CCDS), COSAN, *etc.)* and actors at each level of the system; (b) devise appropriate interventions for building the requisite leadership and management capacities of each. Interventions should employ innovative approaches and tools for managing the severe shortage of trained clinical and non-clinical staff and supervisors, and ensure the availability of

the appropriate tools and health system inputs needed to deliver on their specific roles and responsibilities; and (c) establish or strengthen mechanisms for boosting, regularly monitoring and managing performance at each level.

The SDSP, operated by EMAD, and led by the MI, is in charge of the development of the district health plan, managing funds from the central government and donors, coordinating health actors (both public and private) within the district, and overseeing public health facilities. Many EMAD struggle to effectively supervise health providers, due to a lack of sufficient human resources and inefficiencies in their planning and operations. Most districts do not have a sufficient number of supervisors and supervisors are often only trained to provide oversight in one programmatic or health area. A recent survey conducted in the regions covered by MahefaMiaraka indicated that only 63.5 percent of CSBs received supportive supervision from the MOPH in the three months preceding the survey. Given that there is no immediate solution to addressing human resource challenges in country, the ACCESS activity will propose innovative approaches to improve the efficiency of the EMAD and support the provision of more effective and integrated supervision of health providers. ACCESS will provide support to enable the EMAD to sustainably assume their roles as managers and regulators of all health activities in their districts, ensure that MOPH guidance and protocols are applied, and lead coordination efforts in their districts, including outbreak response. The activity will also build the capacity of EMAD to monitor health outcomes, use data for decision making, and respond to the needs of their districts.

Depending on key health indicators and the specific needs of the district, ACCESS should assist the EMAD to develop a customized plan of action that outlines specific interventions to address technical and managerial limitations. The performance of district health authorities is variable throughout the country and can vary significantly depending on the level of motivation of health providers, district health teams, and the MI. There are national efforts currently directed towards the development and implementation of a Results Based Financing (RBF) scheme targeting the district health system. Several pilots have been conducted by donors and the MOPH is likely to develop and implement a national RBF scheme. ACCESS should participate in the national RBF committee to ensure that the design of the scheme and key indicators account for improvements in service quality and improved health outcomes. The activity should identify areas where the new national RBF scheme can be implemented in close consultation with USAID and ensure alignment with the district's plan of action. During the life of this activity, ACCESS is expected to graduate well-performing districts and address potential disincentives to graduation. These may include small grants for graduated district to establish revolving drug accounts, fund supportive supervision, conduct refresher training in core areas, etc. A timeline for graduation from direct ACCESS support should be established with clear criteria and targets. The ACCESS activity is results-focused and close monitoring of district performance measures will play an important role in determining if project activities are meeting targets and anticipated results. The applicant should actively monitor and evaluate progress and performance measures throughout implementation and adjust strategies and interventions as necessary.

CSBs are marked by challenges related to bad client reception, long waiting hours, and poor patient communication. In addition, health providers are limited in their ability to identify, monitor, and course correct key weaknesses in the management and governance of their facilities that may compromise service quality. *Chef CSBs* continue to struggle to fully assume their roles as supervisors and mentors of CHVs, and a recent survey in the regions covered by MahefaMiaraka has revealed that only 29 percent of CHVs received supportive supervision from the public sector in the past three months. To address these challenges, the ACCESS activity, in coordination with the MOPH, will develop or update existing health governance frameworks to

strengthen leadership and management capacities of clinical providers (doctors, midwives and other clinical staff). Interventions may include developing and/or updating existing curricula to include management competencies and tools for delivering quality services, in line with international quality of care standards and guidelines. In addition, ACCESS should strengthen capacities for managing data, oversight of the referral/counter-referral system, logistics, equipment and supplies, as well as appropriate supervision over CHVs. Finally, the ACCESS activity should introduce non-clinical quality improvement processes and tools in CSBs to address patient flow, wait times, communication, and respectful care.

In addition, to interventions described under Objective 2.1 to improve quality of care at district hospitals, the activity should limit interventions at district hospital under this objective to building the capacity of health workers to use data for decision making to improve performance of health providers and health outcomes. It is also important to that district hospitals are able to conduct maternal death audits so that causes of death are monitored and used to inform interventions under ACCESS.

The PNSC establishes the important role of community structures in health system planning and management, including a COSAN that is overseen by a CCDS. The COSAN is charged with identifying the needs of the community and addressing these needs through annual planning and implementation of health services at the community and facility levels. The COSAN is also the principal liaison between the community and the formal health system, and provides a platform for community members to express concerns and ask questions about health and social issues. Despite their importance, however, many community structures still lack the ability to effectively fulfill their roles, which are essential to ensuring the quality and sustainability of the community health system. The ACCESS activity will propose approaches to establish CCDS and/or COSANs in communities where they do not exist, build their capacity to develop action plans, reinforce their leadership and advocacy skills, and sustain their activities beyond the project's support.

2.2 Quality data is available at the CSB and district level, is used for decision making and integrated into the national HMIS

The lack of quality, reliable, and timely data severely limits the ability of Malagasy health system actors to effectively plan and manage services that respond to the needs of beneficiaries. Currently, CHVs are tasked with the completion of a lengthy *Rapport Mensueld' Activité Communautaire* (RMAC) that is submitted to the *Chef CSB*. The low level of education of the CHVs and difficulty associated with completion of the lengthy reports, result in ongoing issues with data quality, completion, and timeliness. In addition to data from CHVs, data from CSBs is also submitted to the district for compilation. The completion rate remains low at 53.3 percent for CSB I, 77.4 percent at CSB II and 8.6 percent from CHVs[xxviii]. In many districts, data entry and compilation do not take place due to the complexity of the task and magnitude of data entry. There is a strong momentum at the MOPH to develop a unified and standardized HMIS using District Health Information Software 2 (DHIS2) to address ongoing challenges with health data. USAID's Measure Evaluation activity is working on developing a unified and functional HMIS at the national level. ACCESS will coordinate with Measure Evaluation and other multilateral partners to improve data collection systems at the community, CSB, and district. The activity will also work with appropriate district authorities and health workers to build their capacity to manage, analyze, and use data for planning and decision making. This will be built into the governance frameworks implemented at each level of the health system as described under Objective 2.1. ACCESS will link in with larger HSS efforts at the national level for timely data use and feedback up and down the chain.

2.3 Health commodities continuously available at CSBs and CHVs

When clients seek care from health providers, they are reliant upon a functioning supply chain and LMIS to ensure essential medicines and supplies are available in every service delivery point down the last mile. It is a complex system involving data, forecasting, quantification, procurement, shipping, warehousing, distribution, finances, price structures, stock management, and competent personnel to operate the multiple aspects of the system. The availability of commodities at CSBs and for CHVs continues to be a challenge as the MOPH works to improve the public sector supply chain, cost recovery, and LMIS. In parallel, there is a need for health providers to acquire the necessary skills to effectively manage health commodities and forecast their needs. To address these challenges, it will be critical for the ACCESS activity to coordinate closely with the USAID/Madagascar supported IMPACT activity. IMPACT is designed to improve the capacity of the health system to ensure that quality pharmaceuticals and health commodities are available and accessible to all Malagasy people on a sustainable basis. While USAID's IMPACT activity works to address the issues with public and private sectors supply chain from the national to the district level, ACCESS will improve the skills of health providers in pharmaceutical and commodity forecasting in order to ensure that CSBs (including CHV needs) order commodities in a timely manner, maintain appropriate stock levels, and maintain appropriate storage conditions.

As mandated by the community health policy, CHVs are able to distribute or sell commodities that they obtain from their associated CSB or from donor supported supply points. It is, therefore, essential that the ACCESS activity work to build their skills in managing their stock, forecasting their needs, and managing income generated from sales of socially marketed commodities, to purchase additional products, and report timely and complete data for the LMIS. This training will also improve their ability to apply for available USAID supported DCA-backed loans, expand the package of health products they are able to provide to their communities and engage in other income generating activities.

Priority intervention areas will include, but are not limited to the following:

Table 2. Objective 2 Illustrative Performance Indicators

Priority Intervention Areas	USAID/ Madagascar Health Results Framework	Illustrative Performance Indicators
Introduction and promotion of non-clinical quality improvement processes and tools (e.g. patient flow, wait times, strategic use and placement of information, education and communication (IEC) materials)	IR 2.3	Client satisfaction with health services in USG-supported districts (disaggregated by health worker cadre, type of facility, urban/rural facility location, services sought)

Pharmaceutical and commodity forecasting in order to ensure that CSBs and CHVs order commodities in a timely manner, maintain appropriate stock levels, and maintain appropriate storage conditions	IR 3.3, 2.4	Percentage of health service delivery points that experience stock outs of tracer essential drugs in the last quarter
Health data quality, management and use to improve patient outcomes	IR 3.1	Percentage of USG-supported CSBs that submitted routine reports on time Percentage of target districts and health facilities that have a systematic approach to track and display priority indicators Percentage of USG supported districts that submit timely and complete reports to the regional level
Strengthening of community and district structures, including EMAD, COSAN, CCDS and WASH coalition to improve health and sanitation planning, governance, accountability	IR 1.3	Percentage of community structures with a functional CCDS Percentage of community structures with a functional COSAN Percentage of communes where community structures participated in the development of the last annual health plan Percentage of districts where capacity has been assessed and action plans developed Percentage of districts that have graduated from project support

Activity Objective 3 - The Malagasy people sustainably adopt healthy behaviors and social norms.

Note that this activity objective supports the PAD's IR 1

Sub-objectives:

3.1 The Malagasy people demonstrate knowledge and practice of healthy behaviors

3.2 Communities and institutions promote and support healthy behaviors

3.3 Barriers to healthy and health-seeking behaviors for the poor and underserved are reduced

This objective focuses on the adoption of care-seeking and healthy behaviors among poor and underserved populations. USAID seeks to improve health outcomes by increasing knowledge and practice of healthy behaviors, products, and services among the target population; reducing barriers to healthy behaviors and care-seeking, including financial, geographical, and social barriers; and increasing support from local leaders and institutions. These results will be achieved through health promotion and other SBC activities at the national, regional, district and community levels; community-driven problem solving to address barriers; introduction of health and WASH financing options; and capacity building of local actors and institutions.

3.1 The Malagasy people demonstrate knowledge and practice of healthy behaviors

Poor uptake of low-cost, low-barrier health behaviors, like handwashing and exclusive breastfeeding, remains an obstacle to improved health outcomes in Madagascar. The 2012/2013 MDG survey found that just 42 percent of children under six months are exclusively breastfed, and 38 percent of caregivers of CU5 reported reducing a child's intake of liquids during diarrheal episodes rather than increasing it. Estimates indicate that only 15-30 percent of rural households in USAID-supported zones regularly wash their hands with soap. Moreover, only 10 percent of pregnant women receive the recommended three doses of IPTp, and barely half of children aged 12-23 months are fully vaccinated. The practice of these key behaviors, among others, is prerequisite to achieve USAID/Madagascar's health objectives.

The ACCESS activity will work at the community, facility, district, and national levels to increase the adoption of healthy and care-seeking behaviors among the Malagasy people using a comprehensive approach to social and behavior change. The project will address issues of self-efficacy, knowledge, and social norms, as well as consider age, gender, financial and geographical barriers to healthy behaviors. ACCESS will conduct formative research to identify priority behaviors in its regions of implementation. Some of the current priority behaviors include: use of FP (including postpartum); proper and consistent use of LLIN; acceptance of IRS, improved maternal nutrition; attending ANC (including IPTp); care-seeking for pregnancy danger signs; facility delivery or skilled birth assistance; vaccination; essential newborn care; exclusive breastfeeding; complementary feeding; household water treatment; latrine use; handwashing with soap; care-seeking and treatment for infant and child illness (especially malaria, diarrhea, respiratory infections and other fever), treatment adherence, etc.

BCC has been widely implemented in Madagascar with varying degrees of success; however, many behavioral indicators remain poor, as described in the Background section. Therefore, the ACCESS activity will conduct and apply social and behavioral research to develop evidence-based approaches to addressing barriers to healthy behaviors. It will emphasize data-driven behavior change approaches and carry out impactful interventions that go beyond BCC, addressing barriers to healthy behaviors and applying innovative concepts in behavioral science such as improving the sustainability of behavior change and using nudges (wherein adoption decisions are influenced by how choices are presented). Behavior change interventions (BCIs) should be actively monitored and regularly evaluated, with timely feedback informing changes to both strategy and operational approaches to ensure results.

Health promotion through interpersonal communication and mass media also continue to play an important role in creating demand for health services. The 2015 Outcomes Monitoring Survey (OMS) in Mahefa project intervention zones found that 68 percent of respondents had received MCH messages; of those, nearly 40 percent received their messages from mass media and another 19 percent cited interpersonal communications through a CHV as a source of information. Therefore, potential BCIs may include traditional communication-based approaches, such as interpersonal communication through CHVs, healthcare providers, and peer educators (including counseling and follow-up); local radio campaigns and listening groups; and mid-media IEC tools. The ACCESS activity will also support the MOPH in implementing health campaigns and events including maternal and child health week, vaccination campaigns, and world days.

Particular efforts will be made to link interpersonal communication (IPC) to service delivery by ensuring CHVs and health agents provide counseling on relevant topics at each and every encounter. Social and behavior change activities BCC will also include an increased focus on health messages, using text messages and digital media applications (which could include Facebook, etc.) to specifically target adolescents in urban and peri-urban areas. These efforts will be carefully evaluated to identify success in adoption of desired behaviors.

3.2 Communities and institutions promote and support healthy behaviors

IPC efforts should be complemented by dynamic community-level interventions facilitated by COSAN and CCDS groups, such as participatory needs analysis, goal setting, collective action, and community monitoring, as exemplified by the KaominaMendrika and community-led total sanitation (CLTS) approaches. The ACCESS activity will propose an approach to identify behavioral determinants and implement participatory solutions at the community and household levels, while remaining scalable. The ACCESS activity will strengthen the CCDS, COSAN and local WASH coalitions; and civil society to improve community self-assessment, ownership, and action to better promote healthy behaviors and advocate for quality health services. Support will focus on capacity building for the establishment of CCDS/COSAN or WASH coalition action plans and strengthening of leadership and advocacy skills.

A component of this work should include community engagement in building, utilization and maintenance of WASH infrastructure. ACCESS will work with appropriate private sector experts to build locally adapted WASH infrastructure. Close coordination with the USAID funded Rural Access to New Opportunities (RANO) WASH activity will be essential to ensure economies of scale when using private sector partners and adapting WASH technologies. Moreover, project cross sharing of appropriate adapted and gender sensitive SBC tools will be necessary to improve on efficiencies and minimize duplication.

To ensure the sustainability of this approach, these community based committees will receive training on financial management and be linked to VSLAs and microfinance institutions, where appropriate. Other community leaders and institutions will also be engaged for health promotion activities, including religious and traditional leaders and youth and women's associations. Finally, the applicant should propose an approach to build the capacity of Malagasy institutions to successfully design, implement, and monitor and evaluate BCIs, particularly those related to communication such as campaigns, public service announcements (PSAs), and radio series. The activity will provide expert technical assistance to strengthen design and monitoring and evaluation (M&E) of BCIs by local institutions, rather than simple execution of IPC under the direction of international organizations. Support to the MOPH will focus on planning, coordination, and M&E, whereas local nongovernmental organizations (NGOs) should be

further coached in operational research, design, mass media production, and other technical areas. The activity may provide small grants for NGOs to carry out BCIs. Finally, ACCESS will work with local social and behavior change communication (SBCC) coalitions and civil society organizations (CSOs) to create a health communication and behavior change platform for advocacy on key health issues and for coordinated response to humanitarian emergencies.

3.3 Barriers to healthy and health-seeking behaviors for the poor and underserved are reduced

The ACCESS activity will support operationalization of the MOPH's new UHC strategy and efforts to expand UHC in additional districts for increased geographic reach. This may include an expansion of microinsurance schemes, scale up of the National Solidarity Fund for health and/or results based financing. In order to ensure appropriate decentralized application of the UHC/health financing efforts, the ACCESS activity will ensure close coordination with other partners providing technical assistance on UHC/health financing at the central level.
USAID/Madagascar has supported communities to pilot interventions that promote equity and reduce financial and geographical barriers to care-seeking behaviors. Interventions to address financial barriers include micro-insurance through use of community health insurance schemes (mutuelles), village savings and loans associations (VSLAs), income-generation schemes, and vouchers to access subsidized health services. Where these have been successful, there is a need to develop schemes that are sustainable beyond project support, to scale up, and consolidate. The ACCESS activity shall propose ways to increase the number of community health insurance options and link them in ways that expand the risk pool, as well as how to better link community health insurance and VSLAs to appropriate microfinance institutions. These activities will directly support the MOPH's UHC strategy and lessons learned should be actively shared with the MOPH and donors.

The ACCESS activity will also work to support communities to develop improved emergency transportation systems, which have the potential to reduce geographical barriers to care-seeking and contribute to improving referral systems particularly for maternal and child health services. In addition, through the KaomininaMendrika or other participatory approaches, communities will self-assess to identify other barriers to healthy behaviors and implement local solutions to address those barriers. Promising innovations may be scaled up across ACCESS intervention areas.

Priority intervention areas will include, but are not limited to the following:

Table 3. Objective 3 Illustrative Performance Indicators

Priority Intervention Areas	USAID/ Madagascar Health Results Framework	Illustrative Performance Indicator
Community-level health promotion and sensitization to increase healthy behaviors and uptake of health services and products	IR 1.1, 1.2	Percentage of infants age 0-5 months exclusively breastfed in the past 24 hours Percentage of CU5 who slept under LLIN in the last 24 hours Percentage of WRA who can

		name at least two modern contraceptive methods Number of women who give birth with assistance by a trained health provider Percentage of children with acute respiratory infection (ARI) symptoms taken to the health facility Number of communities verified as open defecation free (ODF) as a result of USG assistance
Innovations to promote adolescent and youth health, with a focus on reaching the poor and underserved	IR 1.1, 1.2	Number of new users of modern contraception ages 15-19 years old
Work with private sector to expand community and household level WASH infrastructure	IR 1.2, 1.3, 2.3	Number of clean water sources constructed with a maintenance and extension plan
Capacity of stakeholders (e.g. MOPH, leaders, NGOs, etc.) to assess community needs, develop key messages and advocate for improved services	IR 1.1, 1.3	Number of COSANS developed and implemented SBCC interventions Number of CSOs/NGOs that promote care seeking and healthy behaviors as part of their mission Number of community leaders that participate in activities to promote care seeking and healthy behaviors
Reducing barriers to healthy and health seeking behaviors and promoting universal healthcare access and coverage	IR 1.2	Percentage of target population covered by risk pooling mechanisms Number of households using savings and loans mechanisms Percentage of communities with an established emergency transport system

		Percentage of women of reproductive age who believe their partner supports the use of modern contraceptives

VI. Implementation Requirements

The ACCESS activity will be implemented in up to 10 regions of Madagascar that have been selected in coordination with MOPH and donors. These regions were chosen due to their maternal and child mortality rates, malaria prevalence and incidence and previous USAID investment. The applicant will ensure that all districts in the selected regions are covered and that implementation approaches are carefully adapted to different rural, peri-urban, and urban contexts.

During the first two years of implementation, the activity will cover AtsimoAndrefana, Atsinanana, and VatovavyFitovinany regions that have been previously served by USAID's Mikolo activity with the full package of interventions described in the Program Description. Due to the presence of USAID's RANO WASH activity in Atsinanana and VatovavyFitovinany and the presence of the United Nations Children's Fund (UNICEF) WASH activities in AtsimoAndrefana, ACCESS will not implement WASH infrastructure-related activities in those regions. However, all WASH SBC activities should be conducted in coordination with these activities on the ground. Interventions related to Objective "*1.2 Quality health services are available to all the Malagasy people at the CSB and district hospitals"* as well as activities related to construction of small scale WASH infrastructure in communities and CSBswill be implemented in an additional seven regions, currently served by the MahefaMiaraka activity including Menabe, Melaky, Boeny, Sofia, Diana, Sava, and Analinjrofo during the project's entire implementation period. This information is displayed on Table 4.

Following the first two years of implementation, the activity will implement the full package of interventions in the regions covered by MahefaMiaraka as the activity initiates close out in January, 2021. During that time, the applicant, in consultation with USAID, will revisit data on contraceptive prevalence rates, malaria epidemiology, maternal and child mortality rates, and other key outcome indicators and sub indicators to determine if results are being achieved and make revisions, if needed, before devising a roll-out plan.

Table 4. Regional coverage of the activity's interventions

Region	**Small scale WASH infrastructure**	**Clinical training (Obj 1.2)**	**All other interventions**
Atsinanana	None	Year 1 to 5	Year 1 to 5
VatovavyFitovinany	None	Year 1 to 5	Year 1 to 5
AtsimoAndrefana	None	Year 1 to 5	Year 1 to 5
Analinjrofo	Year 1 to 5	Year 1 to 5	Year 3 to 5
Sofia	Year 1 to 5	Year 1 to 5	Year 3 to 5
Diana	Year 1 to 5	Year 1 to 5	Year 3 to 5

Boeny	Year 1 to 5	Year 1 to 5	Year 3 to 5
Menabe	Year 1 to 5	Year 1 to 5	Year 3 to 5
Melaky	Year 1 to 5	Year 1 to 5	Year 3 to 5
Sava	Year 1 to 5	Year 1 to 5	Year 3 to 5

6.1 Contingency Planning

While this activity will focus primarily on improving the capacity of the public sector health providers and health authorities to deliver services, applicants are encouraged to submit a contingency plan in the event that it becomes necessary to work with and through the private sector. The implementation of this plan would be rolled out in consultation with USAID.

6.2 Collaboration

The ACCESS activity has been designed to complement USAID's investments in Madagascar's health system and contribute to overall efforts to improve the quality of service delivery. It is expected that ACCESS will coordinate with the following projects, supported by USAID, that aim to improve health service delivery to varying degrees:

1. MahefaMiaraka, is a five-year (2016-2021) activity designed improve community engagement and ownership of health services, improve healthy and health seeking behaviors, and improve health service planning, management, and governance. The project will also work on improving key systems bottlenecks in order to improve quality services and ultimately contribute to reduced maternal, child and newborn mortality and morbidity. ACCESS will implement activities to improve the quality of clinical services at the CSB and district hospitals in the regions MahefaMiaraka operates. ACCESS will also build small scale WASH infrastructure in MahefaMiaraka's regions. These activities must be closely coordinated with MahefaMiaraka's interventions.

2. USAID's TMI activity, IMPACT, will be responsible for ensuring health product availability at the community pharmacy (PhaGeCom) level in the public sector by supporting improvements in the processes and operations of Madagascar's central medical stores for public sector commodities, or C*entrale d'Achat de Médicaments Essentiels et de Matériel Médical de Madagascar* (SALAMA). ACCESS will collaborate with IMPACT and work with GOM at the national level to develop incentive schemes for CHVs to facilitate community-based distribution of both public and socially-marketed products.

   IMPACT will also provide technical assistance to USAID's DCA partners for the development of loan products, promotion of loans, and training potential borrowers on business and financial management. ACCESS will closely coordinate with IMPACT to ensure that potential beneficiaries including community health volunteers, health committees, and villages savings and loans committees receive appropriate training, are linked to these financial institutions and have the necessary support to access loans.

3. USAID's Measure Evaluation activity provides technical assistance to the MOPH for the development of a unified Health Management Information system. ACCESS will work coordinate with Measure Evaluation to ensure that support to district health management teams and health providers is in alignment with national efforts. ACCESS should be highly involved in any initiatives to update or improve data collection tools at the community, CSB, and district levels.

4. USAID's RANO WASH activity and Water Development Alliance activity focus on building WASH infrastructure and leveraging private sector investment to expand access to potable water and improved sanitation facilities and promote WASH messages. In regions of overlap with these two activities, ACCESS will ensure alignment and harmonization of efforts. When selecting districts and facilities for the constructions of WASH infrastructure, ACCESS will assess the level of need and prior USAID or other donor investment in WASH activities in these areas.

5. PMI's Africa Indoor Residual Spraying (AIRS) program works with the MOPH to conduct malaria prevention IRS campaigns. ACCESS should work in close coordination with AIRS in areas of overlap to support BCC and community mobilization initiatives.

6. USAID's Food Security and Disaster Assistance (FSDA) Office supports two projects in five regions that carry out activities aimed at reducing food insecurity among vulnerable populations and helping to build resilience in communities facing chronic poverty and recurrent crises such as drought. These projects support nutrition activities including growth monitoring and promotion, essential nutrition actions (ENA), SBC, cooking demonstrations, supplementary feeding for children, and referrals for cases of acute malnutrition. FSDA's WASH activities include work with the private sector to build potable water systems and sanitation infrastructure to increase community access to clean water. ACCESS should ensure coordination and harmonization with FFP activities on the ground.

7. Population, Health and Environment (PHE) is a multifaceted approach to sustainable development that combines FP and other health services with community-based natural resource management and biodiversity conservation efforts. Collaboration with USAID's PHE activities will help ensure ACCESS does not undermine resource conservation efforts and has the potential to more effectively improve health services delivery as well as our biodiversity efforts.

ACCESS will also coordinate with health projects funded by other development partners in its implementation regions including UNICEF, UNFPA, World Bank, Global Fund and the European Union.

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[i] World Bank Poverty & Equity Data 2016
[ii] United Nations Development Programme (UNDP) Human Development Report (HDI) 2016
[iii] World Bank Poverty & Equity Data 2016
[iv]World Bank Data 2016
[v] Demographic & Health Survey (DHS) 2008-2009 & Millennium Development Goals (MDG) Survey 2012-2013
[vi] DHS 2008-2009
[vii] MDG 2012-2013
[viii] World Bank Service Delivery Indicator Survey (SDIS) 2016 *(NB. This Survey has not been published yet)*
[ix] Malaria Indicator Survey (MIS) 2016
[x] MIS 2016
[xi] DHS Survey 2008-2009
[xii] MDG Survey 2012-2013
[xiii] DHS Survey 2008-2009
[xiv] MDG Survey 2012-2013
[xv] MDG Survey 2012-2013
[xvi] MDG Survey 2012-2013
[xvii] MDG Survey 2012-2013
[xviii] DHS Survey 2008-2009

[xix] Population Reference Bureau (PRB) 2017
[xx] DHS Survey 2008-2009
[xxi]Joint Monitoring Programme WHO/UNICEF 2015 Report
[xxii] MDG Survey 2012-2013
[xxiii] International Food Policy Research Institute (FPRI) 2016
[xxiv]Annuaire des Statistiques du Secteur Santé 2013
[xxv] UNICEF 2015
[xxvi] WB SDIS 2016
[xxvii] Maternal and Child Survival Program (MCSP) Facility Readiness Survey (FRS) 2014
[xxviii] Measure Evaluation 2015