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Madagascar ACCESS Activity: Midterm Evaluation Brief

About the ACCESS Activity & Evaluation

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The Accessible Continuum of Care and Essential Services Sustained (ACCESS) program is a five-year, $90 million health program funded by the United States Agency for International Development (USAID). The program focuses on improving the capacity and the quality of service delivery at district, community, and facility levels. ACCESS also works with the Ministry of Public Health (MOPH) and other national-level stakeholders to inform policy and guideline development in addition to advocacy on key health service delivery issues. The goal of ACCESS is to accelerate sustainable health impacts for the Malagasy people—as measured by sustained reductions in maternal and child mortality and morbidity. ACCESS is implemented in 13 of 22 regions[1] of Madagascar by Management Science for Health (MSH) in partnership with Johns Hopkins Center for Communication Programs, Catholic Relief Services, Population Services International (PSI), the American College of Nurse-Midwives, American Academy of Pediatrics, Action Socio-Sanitaires Organisation Secours, and Dimagi.

Data for Impact (D4I) facilitated the midterm evaluation to provide information to USAID and ACCESS implementing partners for learning and course correction. The evaluation sought to identify what is working and what is not working and offer solutions or areas of focus for the remaining program years.

Evaluation Questions:

1. To what extent has ACCESS improved the quality of health services and the continuum of care?
2. To what extent did ACCESS implement a capacity building approach and how effective has it been?
3. To what extent have ACCESS social and behavior change initiatives been implemented?
4. How effective is the program's approach to supportive supervision and monitoring, while building MOPH leadership and capacity to conduct these efforts on its own?
5. What are recommendations across all questions that will reinforce and strengthen ACCESS activities and initiatives for the duration of the program?

Evaluation Design & Methodology

Using a non-experimental design and mixed methods approach, D4I collected primary qualitative data through **28 key informant interviews** (KIIs) and **20 focus group discussions** (FGDs) with **186 participants**. Due to budget and time constraints, data were collected in **6 of 14 regions** where ACCESS is implemented—SAVA, Boeny, Vatovavy Fitovinany, Atsimo Andrefana, Vakainakaratra, and Amorin'I Mania. Respondents included ACCESS staff, women of reproductive age, Malagasy government officials, community health workers, community groups, mothers, and fathers.

The study also included a **desk review of program data**, a scan of **peer-reviewed articles** on related topics, and an **analysis of secondary data** collected from district-level indicator data from the Madagascar MOPH District Health Information Software (DHIS2) platform for 2019 to 2021. Data analysis was completed for the primary qualitative data from the KIIs and FGDs in Dedoose, as well as quantitative analysis of secondary data sources.

[1] As of report writing in April 2022, Vatovavy and Fitovinany were two separate regions in 2021. Therefore, the program's current coverage is now 14 of 23 regions.

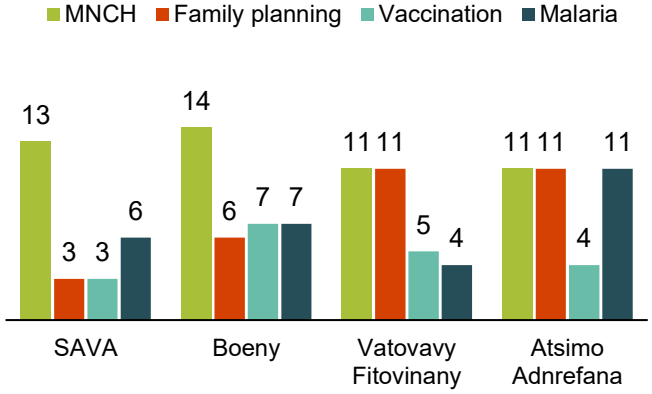
NOTE: This brief summarizes *Madagascar ACCESS Activity (Accessible Continuum of Care and Essential Services Sustained): Midterm Evaluation Report*, by Bergson, S., Moonzwe, L., Indriamihaja, Rakotonirina, J., Jacobs, B., Koch, R. (2022).

Key Results

The ACCESS program's approaches showed promise and contributed to the improved quality of health services, increased capacity of health service providers, and improved health behaviors.

- ACCESS has contributed to **improved quality of health services and the continuum of care** through increased access and availability due to the ACCESS quality improvement approach and the implementation of promising approaches such as clinical capacity building and mobile clinics. Further, the program improved equity in access, use, and benefit, especially in gender and targeting youth populations. Also, coordination and referrals were enhanced between community health volunteers (CHVs) to centre de santé de base (CSBs) and CSBs to district hospitals. At the national level, the program contributed to policies and guidelines on health service delivery.
- The ACCESS **capacity strengthening approach** was extensively referenced across KIIs and FGDs (see Figure 1). Reported evidence of successful capacity strengthening efforts included implementation at the subnational level for CHVs and CSB staff.
- ACCESS program's **social behavior change (SBC) approach** addressed a wide range of health behavior topics, most notably WASH, maternal and child health, and family planning, using a variety of tools and channels to reach target populations, plus data use to inform decision-making on SBC approaches.

Figure 1. Number of coded excerpts on "capacity building" by region and health area from KIIs and FGDs (n=127)



Recommendations

Sustaining ACCESS's successful initiatives is essential for the remaining program implementation period. At the same time, it is crucial to address persistent gaps in the availability of and accessibility to quality health services to ensure sustainable health impacts for the Malagasy people. The following recommendations are suggested:

- **Planning**: Make efforts to better reflect the needs of regions, districts, and communes in ACCESS activities and refocus on collaborative scheduling. Increase teamwork, communication, and visioning with government partners and reduce imposed planning.
- **Infrastructure and materials:** Continue to support the rehabilitation of CSBs and CHVs in partnership with the government.
- **Capacity strengthening and training:** Continue to strengthen CHVs' skills to meet CSB and community needs.
- **SBC implementation:** Strengthen SBC activities and visibility through a range of mechanisms including sharing information on SBC interventions with Direction Régionale de la Santé Publique and MOPH for better coordination. Continue monitoring and reporting on SBC activities at district and community levels and consider SBC data from DREAM@MSH1 for use in the national DHIS2 platform.
- **Supervision:** Plan and fund trainings that lead directly to implementation and ownership. Undertake joint supervision planning with government counterparts. Respect quarterly supervision timelines.

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