REPOBLIKAN'I MADAGASIKARA
Fitiavana - Tanindrazana - Fandrosoana

2012-2013 INTERIM PLAN

MINISTRY OF PUBLIC HEALTH

"WORKING TOGETHER FOR THE HEALTH OF THE POPULATION"

MADAGASCAR 2012

FOREWORD

Given the politico-socio-economic crisis that the country is enduring on one hand, and the obsolescence of the Health Sector Development Plan on the other, the Ministry of Public Health and its partners have agreed to develop a two-year interim plan. Given the highly reduced amount of resources that can be mobilized, coordinating and harmonizing external aid with the Ministry's priorities is of utmost importance to maximize the efficacy of priority interventions, for promoting health means to help people manage their health and health determining factors in a better way as stated in the Bangkok Charter, dated August 2006. This is both to recognize the essential role of curative healthcare activities and to have the ultimate belief as well, that promotional activities should be the foundation of real health development that guarantee the economic advancement of a country.

In this way, the Ministry plays a very important role in the development of the country for only a healthy human capital can have an effective productive force and revive the economy. Leveraging this capital is of prime importance and hence the interest in developing this interim plan to help promote health for all and by all, which constitutes in itself a challenge.

Let us hope, with the help of this interim plan which serves as a reference point and gives direction for the two years to come that all stakeholders will be able to help the Madagascan people in enjoying their right to good health. Let us wish that the priority interventions respond to the actual needs of the population and that everybody finds not just their physical well-being but also mental and social well-being.

Lastly, I extend my sincere gratitude to all those who have directly or indirectly contributed to developing this interim plan 2012-2013. I also express my deep appreciation to our partners who have always supported us all in the process. Let us unite our forces for everyone's health.

Antananarivo, 21 September 2012

Ministry of Public Health

CONTENTS

ABBREVIATIONS AND ACRONYMS

CHW	Community Health Worker
IYCF	Infant and Young Child Feeding
HW	Health worker
BCG	Bacillus Chalmette-Guerin
DHO	District Health Office
QHB	Quarterly Health Bulletin
ISC	Intra domiciliary Spraying Campaign
CBC	Communication for behavioral change
MTEF	Medium Term Expenditure Framework
TDC	Treatment and Diagnosis Center
CFSVA	Comprehensive Food Security and Vulnerability Analysis
DHC (I/II)	District Hospital Center (level I and II)
RRHC	Regional Reference Hospital Center
UHC	University Hospital Center
IC	Interpersonal Communication
PNC	Prenatal Consultation
CRENA	Ambulatory Center for Nutritional Rehabilitation and Education
CRENI	Intensive Nutritional Rehabilitation Center
BHC I	Level I Basic Healthcare Center
BHC II	Level II Basic Healthcare Center
DAFA	Director of Administrative and Financial Affairs
DSP	Directorate of Studies and Planning
DOTS	Directly observed Treatment Short
DHP	Directorate of Health Promotion
DHR	Directorate of Human Resources
RDPH	Regional Directorate of Public Health
DSEMR	Directorate of Child, Maternal and Reproductive Health
DIS	Directorate of Information system
DTPHepB Hib3	Diphtheria-Tetanus-Pertussis Hepatitis B
DVSSE	Directorate of Health Monitoring and Epidemiological Surveillance
WASH	Water-Sanitation-Hygiene
HE	Health establishment
FANOME	*Fandraisan'Anjara No Mba Entiko* – Funding for continuous medicine supplies
HEFs	Health Equity Funds
UNFPA	United Nations Fund for Population Activities
OF	Obstetric Fistula
HF	Health Facilities
GPEEC	Projected management of posts, staff and competences
HRM	Human Resource Management
IEH	Information, Education and Communication
OVIs	Objectively verifiable indicators
STIs	Sexually Transmitted Infections
VIA	Visual Inspection with Acetic Acid

JICA	Japan International Corporation Agency
ICK	Individual Childbirth Kit
GAM	Global Acute Malnutrition
MEI	Ministry of Economy and Industry
CNCDs	Chronic non-communicable diseases
MFB	Ministry of Finance and Budget
LLIN	Long-Lasting Insecticidal Nets
SM	Safe Motherhood
NCDs	Non-communicable diseases
MPH	Ministry of Public Health
CD	Communicable diseases
NFW	Nutrition for women
C-Sec	Cesarean Section
MDGs	Millennium Development Goals
WHO	World Health Organization
NGO	Non-Governmental Organization
PAIS	Action Program to Integrate Healthcare Supplies
IMCI	Integrated Management of Childhood Illnesses
C-IMCI	Community-Integrated Management of Childhood Illnesses
HSDP	Health Sector Development Plan
HSSPDP	Health Sector and Social Protection Development Plan
TR	Taking responsibility
EPI	Expanded Program on Immunization
FP	Family Planning
PhaGDis	District Wholesale Pharmacy
PHAGECOM	Community-Managed Pharmacy
IP	Interim Plan
GDP	Gross Domestic Product
MPA	Minimum Package of Activities
NHRDP	National Human Resource Development Plan
AWP	Annual Work Plan
TFP	Technical and Financial Partners
CBR	Community based rehabilitation
RH	Human Resources
MARs	Monthly Activity Reports
ODR	Owned domestic resources
IHR	International Health regulations
RUMER	Register of Essential Medicines Usage and Receipts
SALAMA	SALAMA Purchase Center
DPHS	District Public Health Service
AIDS	Acquired Immunodeficiency Syndrome
LRDs	Lifestyle-related diseases
IDSR	Integrated Disease Surveillance and Response
ARH	Adolescent Reproductive Health
DHE	Department of Health and environment

DME	Department of Monitoring and Evaluation
DOH	Department of Occupational Health
MDR-TB	Multi drug-resistant Tuberculosis
CCR	Contraceptive Coverage Rate
ICT	Information and Communications Technology
DU	Data usage
UNICEF	United Nations Children's Fund
RUHEF	Rational Use .....Health Equity Fund
USAID	United States Agency of International Development
HIV	Human Immunodeficiency Virus
WASH	Water, Sanitation and Hygiene

EXECUTIVE SUMMARY

Based on the evaluation report for the achievement of the Millennium Development Goals (MDGs), initiated by the United Nations System in Madagascar this year, 2012, the Malagasy Government i.e. its Ministry of Health has spared no effort in improving the situation. It thus refers to the document framework and international declarations to which it is committed to comply with.

At the national level, the Health Sector and Social Protection Development Plan (HSSPDP 2007-2011) expired in December 2011. It is the same for the National Health Policy since 2008.

The politico-socio-economic crisis in Madagascar resulted in the setting up of a Transition Regime since 2009. In order to reduce the negative impact of the crisis on the health of the population in general and on the vulnerable groups in particular, all the stakeholders decided to prepare an interim plan spread over two years.

The technical and financial partners, conscious of the deteriorating health of the population, have gradually renewed their collaboration with the Ministry of Public Health; their contribution is mainly directed towards priority interventions in the Health Sector.

It was observed that the Ministry of Public Health (MPH) found its budget being reduced to half this year; its budget allocation is approximately that of 2001 and 2004. In short, the Madagascan Government is facing a gigantic project with very limited resources. However, this situation does not prevent the Ministry from taking up challenges for the years 2012-2013, such as:

- Opening and re-opening of Health Facilities;
- Human Resource Development (for staff and capacity building through continuous training);
- Improvement in taking responsibility and the fight against non-communicable diseases.

The Plan was conceived following a joint collaboration process between the Ministry of Health and its Technical and Financial Partners (TFPs), with due respect to the national and international documents available for the sector.

After an initial analysis of the main problems, the challenges and stakes were assessed. The Interim Plan aims to: i) Determine concrete actions to implement the strategic guidelines of the Sectoral Policies after an analysis of the current situation and the priority problems; ii) Define the expected results along with strategies and priority interventions, in order to achieve the fixed objectives for the period 2012-2013; iii) Present the operational implementation plan as per the themes of intervention; iv) Budget for priority interventions as per the themes; vi) Develop a monitoring and evaluation mechanism at the national, regional, and the peripheral (districts) level. This process aims to coordinate and harmonize high-impact interventions prioritized by all stakeholders, for better synergy, and thus optimize the resources that can be mobilized.

The Ministry of Public Health and its partners agreed to combine priority interventions in a consensual and inclusive manner. Themes were identified for which each contributor was called upon to take his position along with priority actions to be taken and the funds to be allocated. All Interim Plans of all stakeholders were consolidated.

The themes are: human resources, provision of health services (including the health of mother and child, fight against communicable diseases and non-communicable diseases, and health promotion at community level), the hospital system, inputs and supplies, funding system, information system, infrastructure and equipment, and last but not the least, leadership and governance.

I. INTRODUCTION

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

This sentence taken from the preamble of the Constitution of the World Health Organization (WHO) is a perfect illustration of the place that health enjoys, among essential factors for the well-being of humanity and its comprehensive development.

To promote health is to clearly and simply help people master their health and the factors that determine health (Bangkok Charter, August 2006). This involves recognizing the essential role of curative healthcare activities along with the ultimate conviction that promotional activities should be the foundation of real health development which in turn guarantees economic advancement of a country.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" as defined by the WHO. The Health Sector thus holds a very important place in the social and economic development of a country, where man is both, an actor and a beneficiary.

But, given the unstable political and economic situation that prevails in the country, the Ministry of Public Health was compelled to resort to a short-term Interim Plan based on a joint agreement with the technical and financial partners. This alternative is taken in order to reduce the precariousness and deterioration in the health of the population. However, it was observed that the budget has to transcribe public and sectoral policies in terms of objectives and expected results in health development. The current plan is thus conceived to help materialize the implementation of national strategies and priority interventions in accordance with the Millennium Development Goals (MDGs) and the challenges of the Ministry, which are:

- Opening and re-opening of Health Facilities;
- Human Resource Development (for workforce and capacity building through continuous training);
- Improvement in taking responsibility and the fight against non-communicable diseases.

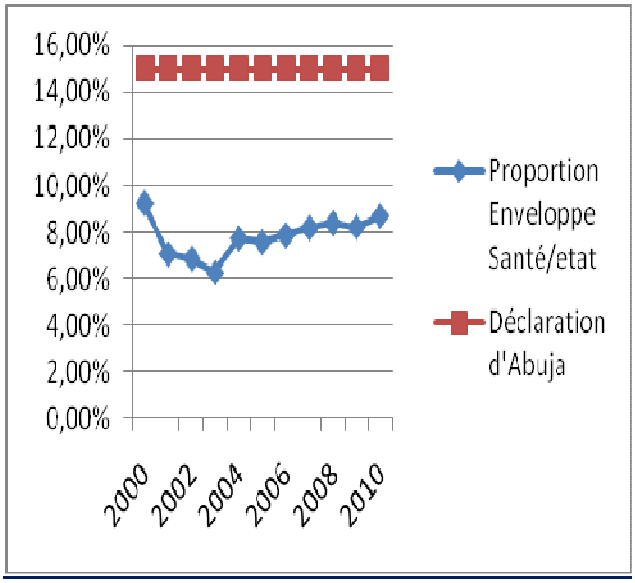
That said, an overall analysis of the current situation is in process in order to improve the understanding of the pros and cons of the measures taken.

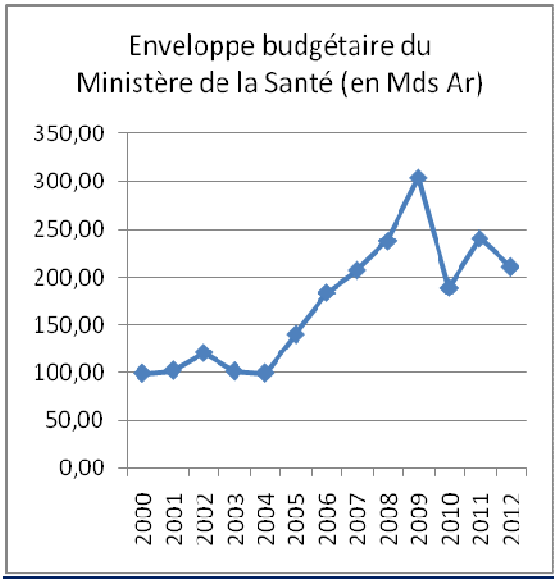
II. SITUATIONAL ANALYSIS

II.1. SOCIAL, POLITICAL AND ECONOMIC SITUATION

The economic-socio-political crisis that the country is facing, accentuated by the global financial crisis and suspension of aid and funds meant for public investment, are weakening the Madagascan economy. It created negative growth, i.e. -3.7% in 2009. Funding for big development projects especially in the social sectors has greatly reduced. The country is committed to the ABUJA declaration which states that at least 15% of the national budget must be allocated to the health of the population, but it still remains a dead letter because the proportion of budget allocated to health as compared to the overall budget of the State has never crossed the 10% limit during an entire decade, as shown in the following graph:

Graph 1: ANNUAL VARIATION IN THE BUDGET ALLOCATED TO HEALTH, FROM 2001 TO 2012 (%)





Source:

President of the Republic of Madagascar (PRM), "Finance Law 2001-2002-200 (Antananarivo: PRM, 2001 to 2004)

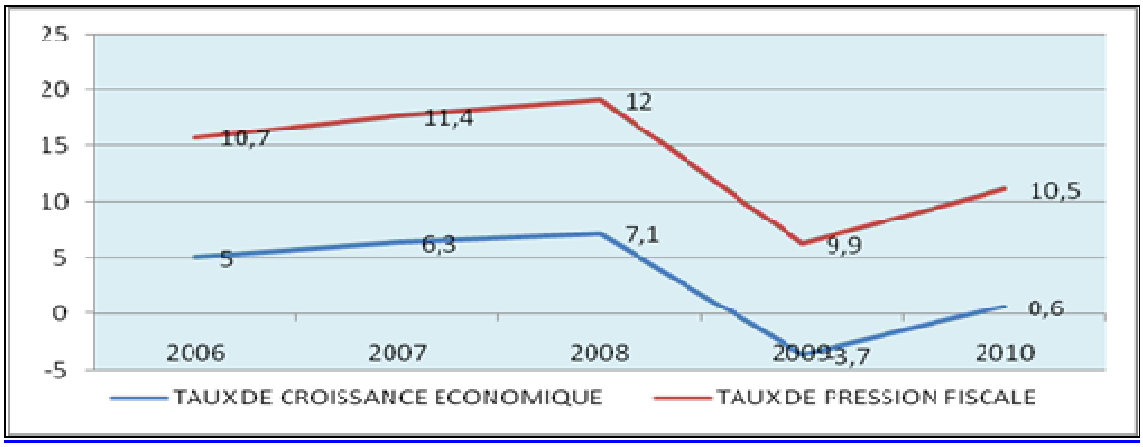
Ministry of Finance and Budget, "Monitoring budget implementation", (Antananarivo: MFB, 2005 to 2009)

Directorate of Studies and Planning (DSP)/MPH "Monitoring budget implementation" (Antananarivo: DSP/MPH 2010-2011)

The situation saw a slight improvement in 2010, translating into a positive growth of 0.6% explained by a rise in the fiscal pressure rate which increased to 10.5% of GDP compared to 9.9% in 2009. We recovered 2269.5 billion Ariary from fiscal and non-fiscal receipts compared to 1855.9 billion Ariary in 2009, which is an increase of 22.3%[1]. The following graph shows changes in the fiscal pressure rate and economic growth rate during the last five years.

Graph 1: CHANGES IN THE FISCAL PRESSURE RATE AND ECONOMIC GROWTH RATE FROM 2006 TO 2010 (%)

[1] **Ministry of Economy and Industry, "Program Implementation Report" (Antananarivo, 2010)**



Source:

Ministry of Economy and Industry, "Program Implementation Report" (Antananarivo: MEI, 2010)

Economic growth improves gradually as the fiscal pressure rate rises. It was observed that more than half of the State investment budget is made up of external funding. In 2010 for example, external funding for the public investment program went up to 931.7 billion Ariary (70%) compared to internal funding of 398.1 billion Ariary (30%); [2]some technical and financial partners having suspended their budgetary aid and the uncertainty caused by the unstable macroeconomic environment encouraged the Madagascan Government to adopt a restrictive budget policy in the light of the budget deficit, and the risks of inflationary pressure and social explosion given the increasing impoverishment of the population. The health sector suffers from this budgetary constraint because the nominal value of its budget excluding the balance (for Operating and Investment) was reduced to 214.5 billion Ariary in 2012 compared to 240.4 billion Ariary in 2009, which is a reduction of approximately 11%.[3] However, inflation remained relatively stable in the last two years with an average rate of 9.3% in 2010 compared to 9% in 2009.[4]

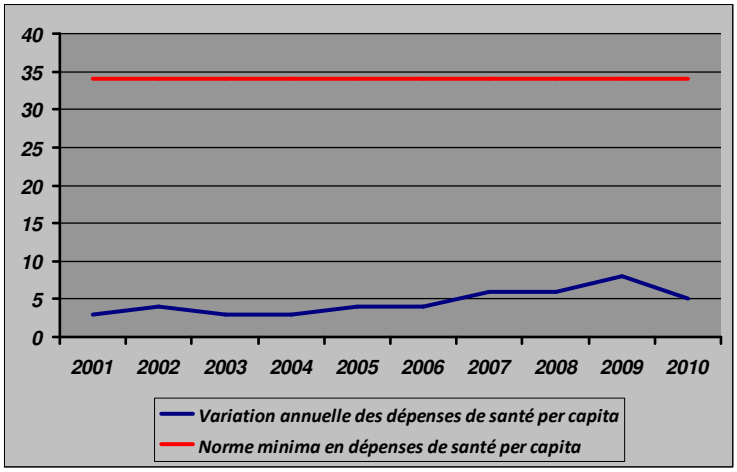
After the political events of 2009, the poverty rate saw a rise of close to 8 points in 2010, increasing from 68.7% in 2005 to 76.5%. In 2010, the incidence of poverty was 54.2% in the urban areas compared to 82.2% in the rural areas. In other words, the poorest households live in the rural areas.

The poorest regions are *Vatovavy Fitovinany* and *Atsimo Antsinanana* where the incidence of poverty is more than 90%.[5]It was observed that to be poor means to be living at less than 468,800 Ariary, that is, approximately 234 dollars per person per year. In Madagascar, after an analysis of the results of the periodic household survey or PHS 2010, close to 90% of the population from families with more than seven members live below the poverty line; children are the most affected, in that, 84.5% of children less than 4 years of age and 82.1% of children between 5 and 14 years are poor. [6]This situation which is a result of several factors is exacerbated by the recurring and cyclical political crises that hinder development in the country.

[2] Ministry of Finance and Budget, "Monitoring budget implementation", (Antananarivo: MFB, 2010)
[3] Directorate of Studies and Planning (DSP)/ Planning Department (Scheduling)
[4] "Program Implementation Report" (Antananarivo: MEI, 2010)
[5] MEI "Program Implementation Report", (Antananarivo: MEI, 2010)
[6] United Nations "Newsletter", June 2011, Edition 00

The inevitable fall in such a situation penalizes the population because households find themselves compelled to bear almost all expenses necessary for preserving their health. The contribution of the State in improving the health of the population remains minimal. This fact is emphasized in the graph below:

Graph 3: PUBLIC EXPENDITURE PER INHABITANT ALLOCATED TO THE HEALTH OF THE POPULATION, FROM 2001 TO 2010 (In USD)



Source:

Directorate of Studies and Planning (DSP) "Budgetary Evaluation 2001-2010" (Antananarivo: DSP, 2011)

Exchange rate: 1 USD=1956.28 Ariary (22 August 2011)

The State's contribution to public health expenditure per inhabitant has reduced between $ 3 and $ 8 during the past 10 years, compared to an international norm of a minimum of $ 34; approximately 75% of the expenditure on health is thus a personal responsibility, including household expenses. But then, more than half the population has continued to live in poverty throughout the last ten years. In 2001, 69 out of 100 individuals lived in poverty compared to 76.5 out of 100 in 2010, that is, an increase of 6.9 points within a span of 10 years. A majority of the Madagascan people thus find themselves financially incapable of getting themselves treated without the help of the public authorities.[7]The challenge under the Millennium Development Goals (MDGs) is to reduce the ratio of poverty to 35% by 2015; the Ministry of Health plays a definite role in this struggle because man is both an actor in and a beneficiary of development. The healthier he is, the greater his productive strength, which is an important gear in the development of the country.

[7] **National Institute of Statistics (INSTAT), "Regular Household Surveys", (*Antananarivo:* INSTAT, 2010**

II.2. SOCIO-HEALTHCARE SITUATION

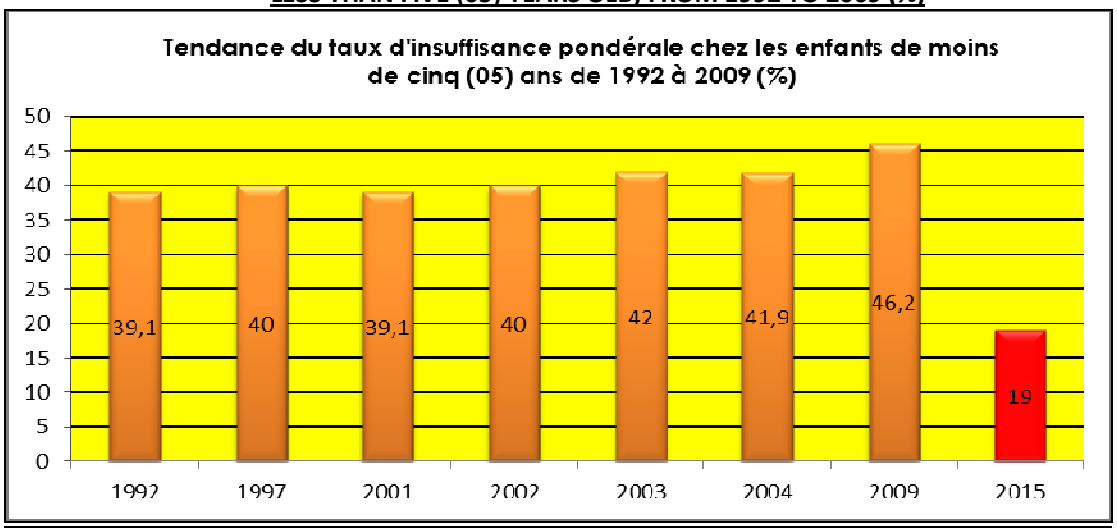
✓ Budgetary constraint, lack of human resources - closing down of health facilities.

Across the country, the number of health facilities closed down rose to 113 in June 2012.[8] Lack of personnel, suspension of external aid by the partners and the budgetary constraint adopted by the State are the main factors that mainly created this situation. The health system is thus unable to cover the requirements for a normal functioning of the health facilities, especially at the regional and peripheral level, and this is at the expense of the people, a majority of whom can no longer ensure the vital minimum, given the poverty ratio of 76.5. To give an illustration, in the regions *Anosy*, *Androy* and *Atsimo Andrefana*, out of 147 public BHCs in the districts, 19 BHCs or 13% have to cover 11.6% of the total population which are closed due to a lack of human resources.[9] Therefore, in terms of access to health services, the households find themselves incapacitated not only geographically but also financially.

✓ Malnutrition and food insecurity

Madagascar figures among 20 countries where the chronic malnutrition prevalence rate is higher than 45%.[10] Chronic malnutrition in children of less than five years of age shows a rising trend; since this rate rose to 50.1% in 2009, urgent measures need to be taken if we want to achieve the millennium goals that aim to reduce the chronic malnutrition rate to 26% by 2015. The graph below lays emphasis on the nutritional status in children less than five years of age, from 1992 to 2009.

Graph 4: TREND IN THE RATE OF UNDERWEIGHT CHILDREN LESS THAN FIVE (05) YEARS OLD, FROM 1992 TO 2009 (%)



Source: ***1992***-1997-2004-2009: Department of Monitoring and Evaluation (DME)/Directorate of Studies and Planning (DSP) "Monitoring of MDGs" (Antananarivo: DME, 2010)

2001-2002-2003: Primature, "National MDG Monitoring Report 2007", (Antananarivo: Primature, 2007)

✓ Child mortality

[8] **Directorate of the Health Districts June 2012**

[9] **United Nations "Newsletter", June 2011, Edition 00**

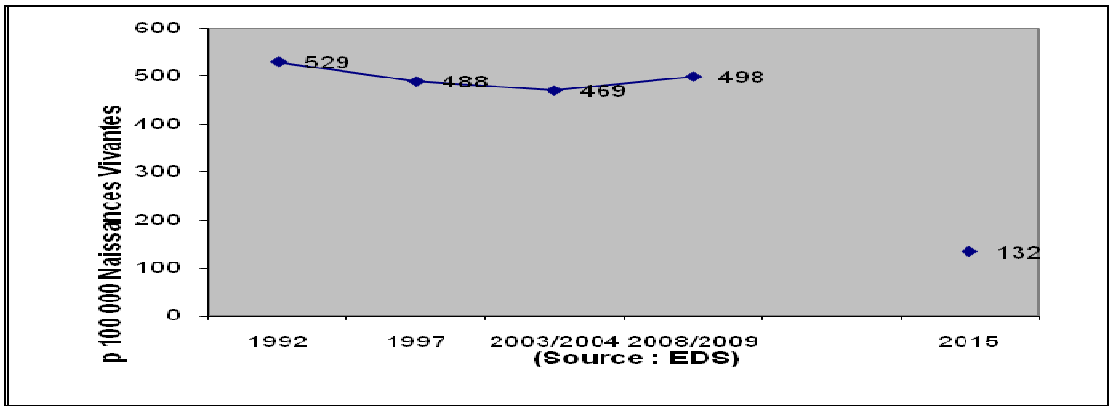
10 United Nations System (UNS) "United Nations Interim Program" (Antananarivo: UNS, February 2012)

MDG 4 estimates a reduction in mortality rate to 31% by 2015 (National MDG Monitoring Report 2007); yet, it is important to continue making efforts to safeguard the achievements. Child mortality rate (out of 1000 children) was 48% in 2009. Consequently, an annual reduction of at least 8% in the mortality rate is essential to achieve the target by 2015. As for the infant and child mortality, it was 72% in 2009.

✓ Maternal mortality

MDG 5 which aims to reduce maternal death to 132 in 100,000 live births by 2015 runs the risk of not being achieved if appropriate corrective measures are not taken to reverse the trend. The graph below illustrates this:

Graph 5: CHANGES IN MATERNAL MORTALITY FROM 1992 TO 2009 (Ratio)



Source: Department of Monitoring and Evaluation (DME)/Directorate of Studies and Planning (DSP) "Monitoring of MDGs" (Antananarivo: DSP, 2010)

This graph shows the results of the survey which was conducted every five years. Also, in order to have a fairly broad view of the impact of interventions made, the year 1992 is taken as the first point of reference. Accordingly, from 1992 to 1997, maternal mortality clearly reduced from 529 to 488 deaths in 100,000 live births, which is a reduction of 41 points in five (05) years. On the other hand, since 1997, maternal mortality has stagnated between 488 and 499 in 100,000 live births.

✓ The common and sometimes dangerous communicable diseases constitute another important public health problem despite a clear improvement in curbing malaria.

As for the main communicable diseases, the prevalence rate of HIV/AIDS is at less than 1%, but the situation continues to be a matter of concern among groups that are at risk such as men having sexual relations with men (MSM), wherein the prevalence rate goes up to 14%.

The incidence rate for malaria shows a reduction from 39.13 per 1000 inhabitants in 2007 to 9.77 per thousand inhabitants in 2010 (18.21 in 2008, 14.99 in 2009).[11] The in-hospital mortality due to malaria as compared to deaths from all causes has seen a clear improvement. It came down from 11.50% in 2007 to 5.66% in 2010, which is a reduction of 5.84% (Source SSS).

[11] **Source: Global Malaria Program database**

Tuberculosis continues to be a chronic recurrent illness in Madagascar. The tuberculosis incidence rate (all forms combined) increased to 123 cases per 100,000 inhabitants in 2010.[12]

The neglected diseases that can be parasitic, viral, and contagious are another public health problem in Madagascar. They tend to add on to each other in the same locality and several of them affect the same individual. Given the maps available, the division of district-wise endemicity is as follows:

- 98 districts for Lymphatic Filariasis
- 95 districts for Schistosomiasis
- 111 districts for Geohelminthiasis
- 33 districts for Cysticercosis
- 96 districts for Leprosy
- 111 districts for Rabies

Since 2005, an annual drug mass distribution campaign has been organized by the national program for the fight against filariasis. The year 2008 onwards, the other programs for the fight against neglected diseases were integrated into the campaign. These include:

- Program to fight Bilharziosis
- Program to fight Taeniosis
- Program to fight Geohelminthiasis

More than half the population that is 56.5% which is equivalent to approximately 11 million people, lives in extreme poverty; as per an analysis of the results of the periodic household survey or PHS 2010, close to 90% of the population from families with more than seven members live below the poverty line. Therefore, more than half the population finds itself financially incapacitated to cover its health expenditure.[13]

121,000 to 353,000 people were affected by natural catastrophes during the past three years. Deterioration in living conditions of the population is observed because in 2010 only 44.9% have access to drinking water and 35.2% improved sanitation infrastructure. [14]

Besides, the Ministry of Health has the main responsibility of ensuring the well-being of the population so that it can actively participate in the sustainable development of the country. In addition, this Interim Plan proposes to contribute to the advancement of the Madagascan people, as much as it is possible given the availability of resources that can be mobilized.

II.3. PILLAR-WISE KEY ISSUES

II.3.1 Human Resources

In case of human resources, there are norms to be respected. They help in better monitoring and evaluation of the quality of services offered to the users and above all better performance measurement of the health system put in place.

Bringing the personnel up to standard not only in terms of numbers but also in terms of the quality of health facilities, inevitably influences the supply of quality health services and boosts demand. In 2010, the population ratio for one Public Service Physician was 1:5188 compared to the norm of 1:10,000 (WHO), the

[12] **Ministry of Economy and Industry, "Program Implementation Report" (*Antananarivo*: MEI, 2010)**
[13] **United Nations System (UNS)** "United Nations Interim Program" (Antananarivo: UNS, February 2012)
[14] **United Nations System (UNS) "United Nations Interim Program" (Antananarivo: UNS, February 2012)**

ratio of women at a reproductive age to one Public Service Mid-wife is 1:3140 compared to a norm of 1:5,000 (WHO) and the population ratio for a Public Service Nurse is 1:6853 compared to the norm of 1:5,000 (WHO).[15] As a result, we can conclude that the physicians and paramedics are in sufficient numbers; the problems faced are related mainly to the distribution and retention of qualified human resources who are not employed in a rational and objective manner for various reasons.
It was observed that the staff in the Ministry of Public Health are aging; the average age of the health personnel is currently around 52 years, which is 10 years less than the legal retirement age.[16] What about the next generation? A rotation plan for human resources across time and space is, therefore, fundamental to responding to the needs of human resources in real time, thus preventing the health facilities from closing down due to staff shortages. However, recruitment is restricted by the available budgetary heads managed by the Ministry of Finance and Budget which leads to the situation where the Ministry of Health hires personnel on a contractual basis especially in the enclosed areas, and this is done in agreement with its financial partners, to overcome the lack of human resources in the health facilities.

Supplying a quality health service for all is not possible without adequate infrastructure, sufficient funding and human resources which are qualified, motivated and evenly distributed across the entire territory. The health system in Madagascar is suffering from a shortfall in human resources. At the end of the year 2011, 56 BHCs were re-opened, which include 45 BHC1 and 11 BHC2. A large majority of the health facilities do not respect the minimum norms for personnel required and 90% of the BHCs are run by single workers including health aides, 45% of whom are going to retire in 2012. In addition, from 2011 to 2015, 23.58% of the health workers inclusive of all categories are going to retire given the mandatory retirement age. While the available human resources are insufficient to fulfill all the human resource needs in the health sector, the deployment and redeployment of staff for the new subsidiary hospitals is one of the challenges of the Ministry of Public Health.

The rural exodus of 2009 is being felt again due to the difficulty in attracting and retaining health workers in remote and/or enclosed areas, in addition to the factors related to problems of geographical accessibility, infrastructure, discomfort and insecurity. This results in the need to set up a system of incentive schemes in the remote and/or enclosed areas, in terms of construction of accommodation for Officers along with supplying incentive scheme kits.

On the other hand, the problem of coordination related to the deployment and redeployment of health workers also creates inequality in the division of existing human resources that are mainly concentrated at the central level at the expense of the health facilities at the peripheral level. This justifies the need to further update procedures in human resource (HR) management and the need to hold a national coordination workshop for HR managers.

In addition to that, non-mastery of administrative and human resource management by the officers causing delay in catering to the files related to the rights and benefits of health workers is a demotivating factor for the personnel in the accomplishment of their daily tasks. Incoherence in the data available, lack of reliable data and lack of real time updates, both at the peripheral and the central level, hinder fact-based decision-making.

[15] **Directorate of Studies and Planning (DSP)/ Department of Health Statistics (DHS) "Statistics Yearbook 2010" (Antananarivo: DHS, 2010)**
[16] **Express Madagascar, Interview of Jean de Dieu Rakotomanga (ex -SG of MPH) (Antananarivo: Express, 07 January 2012)**

Non-availability of a framework (Human Resource Policy/ National Human Resource Development Plan) retracing the main intervention guidelines to be implemented in human resource development, is a major handicap in identifying and implementing the solution to problems in human resources. Moreover, it is of utmost importance to develop GPEEC (Provisional management of jobs, staff and skills) in the Directorate of Human Resources (DHR) in order to aid efficient management of staff, jobs and skills; especially in order to set up a real career plan for health workers.

Updating the National Human Resource Development Plan (NHRDP) is an ideal solution to serve as a guide for the strategy decision responding to chronic human resource crisis in the health sector and hence, to contribute to improving human resource supply at all levels of the health system in Madagascar.
Consequently, it is indispensable to develop continuing education and build capacities of health workers as required, to help them make a good contribution to achieving the expected results at all levels.

II.3.2. Service delivery

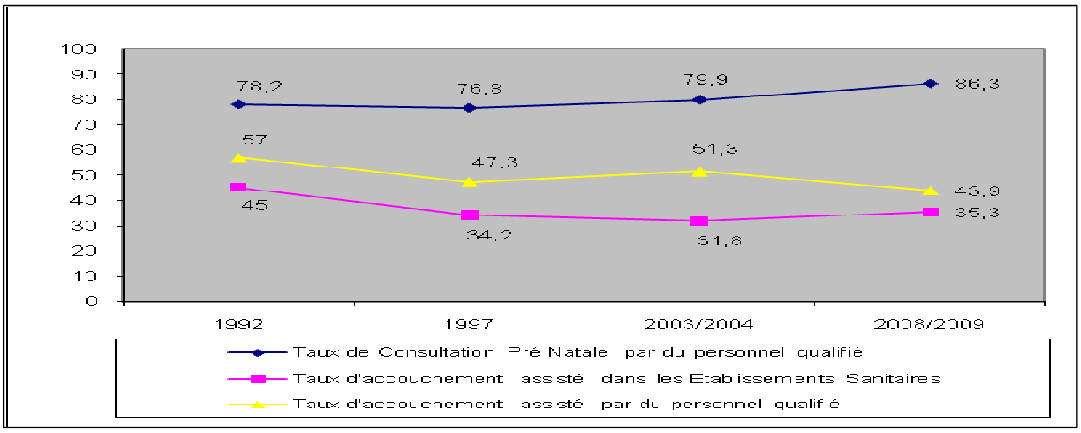
a- Maternal and child health

MDG 5 "Improving maternal health" is among the objectives which are difficult to achieve because it calls for a doubling of efforts by improving access of pregnant women to neonatal and postnatal care, developing medical facilities to bring them closer to the people, and accelerating action toward the opening up of rural areas. Pregnancy and childbirth-related health problems in mothers are among the main causes of maternal mortality in Madagascar, since on an average, 8 women die every day due to pregnancy-related complications.[17]

The assisted childbirth rate is alarming, coming down from 45% in 1992 to 35.3% in 2008-2009.[18] This situation encourages us to reflect on the factors that determine the population's non-utilization of public services. The neonatal mortality rate was around 24% in 2009.

✓ Assisted Childbirths with a downward trend

Graph 6: CHANGE IN THE RATE OF PRENATAL CONSULTATION AND THE RATE OF ASSISTED CHILDBIRTH IN HEALTH FACILITIES (%)



[17] **National Report on Monitoring MDGs, (Antananarivo, 2007)**
[18] **Department of Monitoring and Evaluation (DME)/DSP, "National MDG Monitoring Report", (Antananarivo: DME, 2010)**

Source:

Department of Monitoring and Evaluation (DME)/DSP/MPH "MDG Monitoring Report", (Antananarivo: DME, 2010)

As paradoxical as it can be, despite an increased proportion of pregnant women taking prenatal consultation, childbirths in health facilities remain very low i.e. short of 50% for 16 years (1992 to 2009).

The contraceptive coverage rate is relatively low at 26.1% in 2010.

MDG 4 "Reducing child mortality rates" appears difficult to achieve because the Madagascan children are still subject to high mortality and morbidity risks. Access to quality healthcare, prenatal education, strengthening of infrastructure and health personnel, and improving health system management, all constitute major projects to be undertaken by the State over and above intensification of the current programs.

The vaccine coverage rate in children less than 1 year old is still not at an optimal level with a high number of unimmunized / partially immunized children. In 2010, the vaccine coverage was 84% for BCG and 82% for DTPHep3HiB compared to 84% for Measles vaccines.[19] Disease prevention has still not reached the desired stage because at 90%, vaccine coverage is low, with a high dropout rate of 12 to 13%.

In the rural areas, 35% of the rural households are affected by food insecurity, and 48% others are vulnerable to it. It is in the South that the "inadequate" food security prevalence is the highest. Approximately 55.5% of the households find themselves in this profile category, that is, they mainly consume tubers (especially cassava) with some foods of plant origin.[20] Food and nutritional security survey and household vulnerability survey (CFSVA+N) carried out in August-September 2010 in Madagascar shows that it is in the *Atsimo Andrefana* region that the global acute malnutrition rate (GAM) is the highest (8.1%). The floods that resulted from the *Bingiza* cyclone in this region in February 2011 can aggravate the deteriorating nutritional health of the population. This vulnerability appears, among other things, through a resurgence of malnutrition in children less than five (05) years old.

b- Communicable diseases

The fight against neglected tropical diseases and the emerging and re-emerging diseases is running into multiple problems.

On the one hand, coverage of communicable disease management has reduced. In fact, the *Bingiza* cyclone resulted in floods in the country in February 2011 leading to damage to material and the closing down of several health centers, loss of life of a considerable number of disaster victims all across the island; [21] also, the ministry was compelled to make an additional expenditure which creates an imbalance in the budgetary plan.

Regarding the main communicable diseases, the estimated HIV prevalence among the adult population of 15 to 49 years is 0.37%, that is, approximately 35,000 people are estimated to be carrying HIV in Madagascar. Despite the low prevalence, the situation remains worrisome among groups that are most exposed to risks such as men having sexual relations with men, wherein the HIV prevalence goes up to 14.7% (SE/CNLS).

[19] **Ministry of Economy and Industry (MEI), "Program Implementation Report" (Antananarivo: MEI, 2010)**
[20] **United Nations "Newsletter", June 2011, Edition 00**
[21] **United Nations "Newsletter", June 2011, Edition 00**

On the other hand, tuberculosis incidence rate (all forms combined) is 123 for 100000 inhabitants in 2010 compared to 119 in 2009, 120 in 2008 and 121 in 2007. In short, tuberculosis still remains a chronic recurring disease in the country.

PHS 2010 showed that malaria is one of the main diseases that affects the Madagascan population and is still a significant public health problem because in-hospital deaths continue to take place; the incidence rate for malaria shows a reduction from 39.13 per 1000 inhabitants in 2007 to 9.77 per thousand inhabitants in 2010 (18.21 in 2008, 14.99 in 2009) (Source: Global Malaria Program database). The in-hospital mortality due to malaria as compared to deaths from all causes has seen a clear improvement. It came down from 11.50% in 2007 to 5.66% in 2010, which is a reduction of 5.84%. (Source SSS). Finally, the weakness in the surveillance system for monitoring potentially epidemic diseases on a weekly basis in terms of completeness and speed in particular continues to be a problem to be resolved.

The tendency to pay less attention to the so-called neglected diseases explains the weak resources that are allocated to them at the international as well as the national level. Consequently, various problems have been observed in the implementation of the fight against these. They are mainly:

- Community and social mobilization activities: lack of integration.
- Coordination activities: lack of review by concerned officers, incomplete maps, problems in reporting, difficulty in border surveillance.
- Rightly named response activities: acquiring inputs, material and equipment to fight against the vectors and some reservoirs, shortfall in trained health workers or those with upgraded skills.

C- Non-communicable diseases

Insufficient integration of the fight against non-communicable diseases has caused a resurgence of this disease leading to the deaths of close to 80% of the population in developing countries.[22] In Madagascar, in our health system, given the difficulty in accessing services for the fight against NCDs, the prevalence of hypertension at 35.8% (STEPS survey/MPH/LRD/WHO in 2005) can explain that a Stroke is the first cause of mortality at the UHC/RRHC.[23] In 2009, *Befelatanana*, the gynecology and obstetrics hospital registered 479 cases of gender-based violation, with 22.3% in less than 10 years of age and 72% for 10-18 years (source: DFNCD, 2012)

In addition, gynecological cancer is one of the components of reproductive health which affects the health of women. It is noted that national statistical data for this disease is not available. Nevertheless, in 2010, the only oncology service in the country recorded 1800 new cases of cancers out of which 32% were cases of breast cancer and 25% are of cervical cancer; more than 60% of the cases are observed to be at an advanced stage which are almost fully managed by the patients and their families. Screening with VIA, a cost-effective and efficient strategy, currently covers only 4.5% of the health districts. In brief, there is shortage of human resources, infrastructure, inputs and equipment[24].

Finally, mental disorders as well as dental or ocular diseases are significant morbidity factors and a global burden in non-communicable diseases, but they largely lack funding, given that the technical and financial partners are more inclined to intervene in the field of communicable diseases.

---

[22] United Nations General Assembly, 2011

[23] DHS/DSP "Statistics Yearbook 2008-2009-2010", (Antananarivo: DHS, 2008 to 2010)

[24] Ministry of Public Health/DSMER "Operational Plan for Implementation of Commitment of Madagascar at the Global Strategy of the United Nations Secretary General for Mother and Child Health" (Antananarivo: MPH, 2010)

d- Health promotion in the community

Key messages of WASH (washing hands, access to drinking water, using toilets) are still far from being completely incorporated in the daily life of the people. In fact, the usage rate of the improved source of water is 70% in the urban areas compared to 38.4% in the rural areas.[25] In brief, a fairly significant number of people still use unsafe drinking water. Regarding the excreta disposal devices, several of them continue to be those which do not respect the norms for disposing off excreta or those which even encourage defecation in the open. The table below shows the existing disparity in this regard:

Table 1: Area-wise distribution of the types of toilets used by the Madagascan population (%)

TYPE OF TOILET	URBAN AREA	RURAL AREA
Toilets with western seats	2.6%	0.6%
Turkish toilet	7.9%	3%
Toilets with platforms of smooth concrete, porcelain, or fiberglass	5%	0.8%
Toilets with wooden or earthen platforms	42.3%	30.8%
Open hole	10%	6.1%
In the open	30.7%	58.5%

Source: INSTAT, "Periodic Household Surveys PHS 2010, preliminary report", (*Antananarivo*: INSTAT, 2010

Lack of water-sanitation-hygiene (WASH) infrastructure in the communities (communes and villages) encourages bad WASH habits to perpetuate into the community because most of the BHCs that were supposed to cover this under health promotion do not even have the infrastructure. In other words, non-existence of toilets and water conveyance in BHCs have a negative influence on the health behavior of the population and among other things, encouraging defecation in open air, using unsafe water for drinking purposes, etc. The access rate for improved toilets is 39.8% while the access rate for drinking water is 44.9% (PHS 2010).

Moreover, road safety is a social problem which is frequently talked about in the media. It was observed that deaths or traumas (57.5) are related to road accidents.[26] Regarding domestic violence, this health and social plague deserves special attention because according to a survey conducted in 2010 by the Department for the Fight against Lifestyle-related Diseases (DFLD), out of 2231 cases, 21.1% were victims of domestic violence, 0.7% were victims of sexual violence and 0.7% of abuse. In all the cases, victims are mainly women.

[25] **INSTAT, "Periodic Household Surveys", (Antananarivo: INSTAT, 2010**

[26] Directorate for the Fight against Non-Communicable Diseases (DFNCD) "Study Report on the situation and extent of trauma and violence in Madagascar" (Antananarivo: DFNCD, December 2010)

Health workers are used to giving advice in a prescriptive manner because very few of them have been trained in the techniques of interpersonal communication, so much so that patients do not feel involved in taking responsibility of their own health. This has repercussions on service provision. Therefore, a weak involvement on the part of the community is observed in the activities of the Expanded Program of Immunization (EPI) along with a low service utilization rate for services meant for the mother, children and the young, despite health education being provided. Not to forget the dissatisfaction of the population regarding the quality of services provided.

Social quality of a community should be defined and stakeholders in the health sector should be aware of it. The activities of the Municipal Council for Health Development (MCHD), a coordinating and decision-making body in the community, are not harmonized and depend on the ones planned under the COSAN (Health Committee) Action Plans. All activities of the community should be mentioned in the guide named "Guide PAC" (Community activities package) to facilitate their implementation. This implementation guide should be available and easily understandable by stakeholders who wish to work for and support the actions undertaken for community health.

The actions are divided on the question of health and environments (66,000 annual deaths related to the environment) while a strategic alliance and joint actions are particularly recommended by the Libreville Declaration. Diarrheal diseases are the 3rd biggest cause of child morbidity and mortality. This situation is a reflection of the lack of coherence, synergy, or harmony in the joint interventions undertaken.

Also, it is desirable to have innovative strategic reorientation to promote community health and encourage the population to adopt a healthy behavior.

II.3.4 Supply system for health inputs

The "Inputs and Supply" theme faces a problem of budget constraint (especially in the case of blood transfusion and contraceptive products). In fact, funding allocated for the supply of health inputs has seen a fall as compared to the preceding year due to a reduction in the overall budgetary allocation for the Ministry.

The inputs necessary for catering to the major endemic diseases are funded largely by external partners which results in the risk of stock shortages in case of delays in releasing funds or signing agreements. In addition, sharing of responsibility between the MPH, the municipality and the dealers in managing the Community-Managed Pharmacies (PhaGCom) or the District-Managed Pharmacies (PhaGDis) leads to lack of control and monitoring in every way and encourages their closing down. In short, their respective functions and powers are vague and hamper proper management of the pharmacies. Such a situation can cause damage to the continuity of credit revolving funds used.

Besides, the lack of a storage system in the districts adds to this failure. The lack of sanctions on the part of the administration against cases of theft/breaking in and misappropriation of public funds (in the PhaGDis) is an even greater flaw in the public service administration.

Also, neither the State nor FANOME takes the responsibility of customs clearance and distribution charges.

The viability of the FANOME system can also be compromised due to a reduction in the beneficiary margin from 1.35 to 1.15 towards 2010-2011, while price rise continues to become intolerable in the country. The BHCs enjoy only 8% of the beneficiary margin to provide for the cost of different functions

(e.g. transporting medicines to the BHCs, cost of moving the liquid assets to the bank, purchase of management tools, COGE allowances, etc.) not to forget, compensating for broken or perished medicines; 7% of the beneficiary margin to be recovered from the PhaGDis dealers' rights. A reduction in this margin has an impact on the functioning of the health facilities and in delivering paid FANOME inputs, thus creating a problem in continuous general functioning of the system.

In the end, stock shortages at the Madagascar Agency for Essential Medicines, SALAMA, mostly hinder the availability of medicines at the health facilities and results in orders not being honored in real time; more so since its creation, the *Salama* Purchase Center does not have its own warehouse such that the rent is one of the major expenditures and is difficult to meet. This situation has a negative impact on the financial status of SALAMA and generates additional costs for health inputs.

II.3.5 Funding system

Following a budgetary evaluation for the period 2001-2010 initiated by the Ministry of Public Health in 2011, it was observed that during the last decade, the implementation rate of public investment was not so satisfactory, except in 2004. Budget implementation, on an average, was around 62%. This phenomenon can be explained by the difficulties faced by the Ministry in using open credits and in justifying expenditure in foreign investment managed by the technical and financial partners (less than 20% over 5 years).

Additionally, the political crisis led to a suspension of some external aid and funding provided by the technical and financial partners, thus disturbing the Ministry's budgetary plan, 70% of which is fed by external funding with respect to the budget for public investment.

Faced with such a situation, the Madagascan State felt compelled to adopt an austerity policy with the aim to bring about a stable macroeconomic environment to reduce the risk of widespread inflation which can create a social explosion, insecurity and anarchy in the country. The budget of the Ministry of Public Health is thus reduced to half (48%) in 2012, thus weakening its capacity to respond to multiple health problems striking the country.

However, absence of a clear direction on the endlessly vague budget allocation as per the priority of the sector hampers the rationality of the budget plan. Poor implementation of decentralization of the highly centralized budget management is one of the main causes of low budget consumption in the health sector; a situation which has inevitable negative repercussions on the quality of coverage of health services offered.

Insufficient information about health expenditure managed by the technical and financial partners also has a negative influence on the Ownership, Alignment, and Harmonization of external aid in compliance with the Paris Declaration, thus disbanding the efforts made by all stakeholders.

Faced with these problems which hinder the proper functioning of the health system, the Ministry of Health is attempting to take remedial measures by prioritizing high impact interventions considered to be relevant and adequate.

II.3.6 Information System

Absence of a reference framework for the Information system is a main cause of its dysfunction. The lack of coordination and integration of the information system results in a multitude of information sources, thus affecting the quality and reliability of data.

Further the lack of systematic feedback leads to a negative impact on the quality of data and the actions to be taken on data analysis, especially in the use of information in operational research. In this context, strengthening the use of the Ministry's intranet will help improve local communication through the formative monitoring of users.

Absence of efficient tools to address the indicators and to enable appropriate and timely decision-making necessitates the use of DEVINFO and SMS Project which will contribute to the speeding up the availability of information.

The problem of ownership of administration at each level of responsibility in the Health Information System "SIG/MAR", providing National Health Information System (NHIS) management through Monthly Activity Reports (MARs) for all categories of public or private health facilities (HF) in Madagascar (BHC, DHC, UHC, RRHC and HE) is caused by the absence of a clear view of the essential indicators allowing a proper analysis of the situation necessary for decision-making at each level of the health system. But the problem in funding the preparation and distribution of health sector annual statistics persists, along with the problem of acquiring records to help in data collection.

Most of the materials put together, especially the network-related materials are currently in a dilapidated and obsolete condition, although efforts were made to improve communication, security, and the link between different levels (central, regional and district), and among other things, the implementation of a communications and assistance infrastructure in setting up an information system network.

The NGOs working in the field of health come under the Ministry in-charge of Population; hence, it is often difficult to integrate them into the reporting, monitoring, and evaluation system at every level.

Among the Millennium Development Goals (MDGs) figures the reduction of mortality and morbidity by providing services of quality accessible to all categories of the population. The problems observed are on the one hand illustrated by an absence of an Epidemiological Surveillance System and an integrated, alert and efficient health monitoring system to help trigger an adequate and efficient response in terms of time and space, and on the other hand, by a weak coordination in systematic data collection and investigation and their transmission to different levels in order to have epidemiological information and to be able to send out an early warning in case of delays in transmitting epidemiological information received from the operational level, which is often caught by the Media.

II.3.7 Infrastructure and equipment

Insufficient number of health services (only one Oncology service for Madagascar) and the deteriorated and dilapidated condition of the infrastructure are mainly the result of a lack of funding allocated to investment in this sector. This phenomenon is aggravated by bad weather and the process of decentralization currently in progress, leading to ignorance of technical service norms by the municipal officials to provide services of quality at every level: non-standardized construction and technical services that no longer respond to the

needs for taking adequate care of patients (70% of health facilities) hinder the performance of the health system in place, and the missing updates of the health card does not allow proper planning for upgrading the technical services [infrastructure, materials, equipment] at every level of healthcare.

It was observed that 42 out of 1549 municipalities do not yet have health facilities. Moreover, the poor external consultation rate at the BHC has risen from 30.30% in 2010 to 34.5% in 2009 (Statistics Yearbook 2009)[27] is partly explained by the closing down of the health facilities after the natural catastrophes and absence of timely rehabilitation due to lack of funds.

No health facilities rehabilitation plan exists as of today. Additionally, the upkeep of the buildings must be taken up, in principal, by the municipalities but that is rarely put in practice in reality.

The insufficient and dilapidated means of transport for the health workers hinder the implementation of mobile and advanced strategies; an absence of synergy arising from the non-harmonization of the program: from completing construction, to providing equipment, to employing the required personnel, delays the functioning and use of health facilities.

II.3.8 Leadership and governance

The theme of Governance brings together priority interventions from a strategic point of view. Wide coordination in the health sector and in activities in the community at the Regional and District level remain a big challenge for the MPH. Some financial partners have bypassed the national health system to implement the projects that they support. But, according to the Reports on Cooperation in Development, this approach has limitations in terms of efficiency in producing results (RCD Summary vice Primature responsible for Economy and Industry, 2012). Such coordination must already be Strengthened in the MPH with regard to human resources and monitoring and evaluation of program activities, for example. Budget follow-up has highlighted a weak budget implementation rate and a not-so-efficient or in fact an un-operational audit and monitoring system at all levels of the system. This encourages a lax attitude in financial management. Absence of monitoring of FANOME enables easy diversion of funds and burglaries.

Strategic decision-making requires that the health policy documents (PNS, PDSS) and strategy, law and regulation documents, be up-to-date. It is the same for program strategy documents (malaria, tuberculosis, human resources, etc.) which are either in the preparation, validation or distribution stage.

Monitoring and implementation of legislations pertaining to health remain insufficient particularly for mother and child health. Dissemination of the law pertaining to hospital reforms and related texts, has not yet been carried out, and the EVASAN statutory instruments are not updated.

Some public hospital facilities are still without a PEH. There is no national plan for strategies to humanize hospitals and the implementation of recommendations on the principles of healthcare humanization is still at the trial stage in some hospitals.

No Action Plan for strengthening AC/COSAN interventions is available to date. Absence of coordinated strategies for harmonizing implementation of the PNSC in the field: interveners act and implement the interventions in a piecemeal, fragmented and disorganized manner, not showing any concrete consolidated

[27] **Ministry of Economy and Industry, "Program Implementation Report" (Antananarivo: MEI, 2010)**

results. Yet, a PNSC Implementation Guide is being considered and a revision of the PAC Guide is being planned.

There is still a lack of integration of community activities and those related to advanced and mobile strategies. We see serious trends towards verticalization while resources are becoming rarer and rarer and needs are amplifying.

Consequently, in the face of the magnitude of the problem that the Ministry of Public Health has to deal with, (1) an action plan, (2) an operational implementation plan, and (3) a monitoring plan appropriate for every theme, are all annexed to provide palliative alternatives considered apt by all stakeholders.

III. STAKES AND CHALLENGES

In the face of problems in the health system of the country, or in the socio-economic and health situation of the country, the Ministry of Public Health is committed to achieving the Millennium Development Goals. Improving access to quality healthcare for all is a prerequisite for a sustainable health development plan.

The main guidelines of the Ministry of Public Health for the year 2013 are as follows:

- Improving access and use of quality health services for all,
- Strengthening quality services for survival of the mother and the child
- Strengthening the fight against communicable and non-communicable diseases, and epidemiological surveillance
- Developing a harmonized community approach in all health programs
- Health system strengthening
- Human Resource Development (for staff, capacities and skills)
- Strengthening funding and management mechanisms

IV. PURPOSE:

The purpose of this interim plan is to stimulate the demand and develop a quality service delivery system adapted to the socio-economic and health conditions prevalent at all levels of the health system. The goal is to enhance public accessibility to healthcare services and bring down all forms of health exclusion.

V. EXPECTED RESULTS:

The result matrix of this interim plan is summarized by the following table:

EFFECT	PRODUCTS
EFFECT: IMPROVED PUBLIC ACCESS TO QUALITY HEALTHCARE SERVICES	**PRODUCT 1: MINIMUM PACKAGE OF ACTIVITIES PROVIDED TO THE POPULATION AT EACH LEVEL**
	PRODUCT 2: AVAILABILITY OF HEALTHCARE SUPPLIES WITH RATIONAL MANAGEMENT AND USAGE AT ALL LEVELS
	PRODUCT 3: COORDINATED AND EFFICIENT HEALTH SYSTEM

In order to improve service delivery at all levels of the health system, accessibility of the population to quality healthcare services must be strengthened.

- ✓ The provision of a minimum package of activities at each level is a product enabling achievement of this goal.
- ✓ Regular availability, rational management and usage of healthcare supplies at all levels also hold an important place.
- ✓ The coordination and efficiency of the health system are prerequisites for giving the population access to quality healthcare services in the context of current socio-economic and health conditions.

VI. STRATEGIC GUIDELINES (SG)

The improvement in public accessibility to quality healthcare services is measured by two performance indicators.

EFFECT: **PUBLIC ACCESS TO QUALITY HEALTH SERVICES**	**INDICATORS**	**TARGETS** for 2013
PERFORMANCE INDICATORS	**Usage rate of external consultations in BHCs**	32.8%-40%
	Childbirth rate in Health Centers	21-44%

Usage rate of external consultations in BHCs at once outlines the direct results of BHC activities and the use of health center by the population. This indicator enables to get information on accessibility/confidence/quality of reception and the parameters related to the incidence of diseases, etc...

Childbirth rate in health centers: reflects the usage of health centers with regards to maternity. But accessibility (geo and cultural or customs)/welcome/insecurity,...etc, have significant implications on deliveries at the centers

VI.1-STRATEGIC GUIDELINE 1: MINIMUM PACKAGE OF ACTIVITIES PROVIDED TO THE ENTIRE POPULATION AT EACH LEVEL

This minimum package of activities focuses on the priority needs of the population. It relies on four elements

- VI.1.1- AVAILABILITY OF HEALTHCARE PERSONNEL ENSURING FUNCTIONING OF ALL THE HEALTH INSTITUTIONS BY PRIORITISING CLOSED BHCs/DHC1 TRANSFORMED TO DHC2/NEWLY BUILT ANNEX HOSPITALS BY 2013.
- Provision of basic healthcare services at all levels of the health system.
- Community participation in health development (including stimulation of demand for healthcare services).
- Availability of necessary equipment and infrastructure.

VI.1.1- AVAILABILITY OF HEALTHCARE PERSONNEL ENSURING FUNCTIONING OF ALL THE HEALTH FACILITIES BY PRIORITIZING CLOSED BHCs/DHC1 TRANSFORMED TO DHC2/NEWLY BUILT ANNEX HOSPITALS BY 2013.

The availability of qualified and motivated personnel, especially in remote/far-off areas, lays the foundation for providing the entire population at each level with access to a minimum package of activities.

Challenge: To meet the functional needs of all health institutions through the equitable and rational distribution of human resources.

OBJECTIVES	**STRATEGIES**	**INDICATORS**	**TARGETS** for 2013
PERFORMANCE INDICATORS		**Percentage of BHC2 managed by a doctor**	From 53.9% to 69.02%
To beef-up the number of health workers in health institutions facing the human resource crunch, especially in remote/far-off areas, by 2013.			
	Redeployment/Recruitment of health personnel		
		Number of re-opened BHCs	56 BHCs
		Number of BHCs managed by health workers retiring in 2012 and whose staff would be replaced	170 BHCs
		Number of hospitals adequately staffed with quality personnel.	Nine (09) hospitals
		Workforce recruited by Health facilities	600 paramedics 300 Doctors 300 Administrative Officers
	Contracting of health workers		
		Number of personnel contracted for service by BHCs	193
	Motivation/loyalty towards job of health workers in remote/far-off areas		
		Number of regions with districts benefiting from incentives	5-10
		Revision of average additional remote area allowance earned by a worker transferred to a far-off place	Revision due in 2013
		Assessment reports available with recommendations from five regions	Report available in 2013

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
		enjoying incentives	
To enhance the skill sets of health workers providing technical and administrative services by 2013.	Training and development of health care personnel		
		Number of nurses trained in anesthetics and intensive care for DRHCs	20
		Number of General Practitioners trained in emergency obstetrical surgery for DRHCs	20
		Number of trained administrative officers in RDPH and **SDSP**	300
		Number of laboratory technicians trained for RRHC	14
		Number of DRHCs with surgical units	20
To have enough health workers trained for dealing with CD cases.	Enhancing the skill sets of health workers dealing with CD cases	Number of health workers trained for dealing with CD cases for BHC1, BHC2, DRHC	2,227 health workers trained to deal with CD cases

VI.1.2-PROVISION OF QUALITY PRIORITY SERVICES, AT ALL LEVELS OF THE HEALTH SYSTEM

The availability of a Minimum Package of preventive, promotive and curative Activities at each level (Central/Regional/District/BHC) is essential for resource optimization, synergism and effort coordination for a better operational efficiency of the service delivery system.

Challenge: To improve public access to quality preventive, promotive and curative services.

SERVICES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS	**Number of basic health facilities offering the minimum package of preventive, curative and promotional activities at each level**	**2412-2468**

VI.1. 2.1- Reproductive, Maternal and Child Health

In today's context, bringing down the maternal, neonatal and infant morbidity and mortality constitutes a goal to be borrowed from the UN Secretary General's Global Strategy for Women's and Children's Health. Enhancing quality services for the survival of mother and child figures amongst the broad guidelines of MPH

Challenge: To improve the accessibility and utilization of health services for mothers, infants and youth.

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**DTP HepB Hib3 Vaccine Coverage Rate**	80%-90%
		Childbirth rate in health facilities	21%-44%
SO1-To reduce the percentage of underweight children under five years of age from 15% to 12% by 2013.	Increase in the demand of promotional, preventive and curative healthcare services	Percentage of underweight children under five years of age recorded at BHC (%)	15% to 12%
	Improvement in the availability and accessibility of quality services		
	Up scaling of high impact activities and introduction of innovative activities.		
	Strengthening institutional support promoting good health of women, children and adolescents		
SO2- To increase the DTP HepB Hib3 Vaccine Coverage Rate from 80% to 90% by 2013.	Increase in the demand of promotional, preventive and curative healthcare services	DTP HepB Hib3 Vaccine Coverage Rate	80% to 90%
SO3- To increase the percentage of BHCs applying IMCI strategies from 13% to 25%.	Improvement in the availability and accessibility of quality services	Percentage of CSBs applying clinical IMCI	13% to 25%
	Up scaling of high impact activities and introduction of innovative activities.		
	Strengthening institutional support promoting good health of women, children and adolescents		
SO4- To increase the Prenatal Consultation (PNC 4) rate from undefined to 60% at Health Facilities (HF) by 2013.	Increase in the demand of promotional, preventive and curative healthcare services	Prenatal Consultation (PNC 4) Rate at Health Facilities (HF)	Undefined to 60% at Health Facilities (HF)
SO5- To increase the childbirth rate at Health Facilities (HF) from 21% to 44% by 2013.	Increase in the demand for promotional, preventive and curative healthcare services	Childbirth rate at HF	21% to 44%
SO6- To increase the rate of cesarean sections at public DHC2/RRHC/UHC from 0.5% to 1.80% by 2013.	Improvement in the availability and accessibility of quality services at all levels of the health system. Up scaling of high impact activities and introduction of innovative activities. Strengthening institutional support promoting good health of women, children and adolescents	Rate of cesarean sections at public DHC2/RRHC/UHC	0.5% to 1.80%
SO7- To enhance the Contraceptive Coverage Rate from 28% to 32% by 2013.	Increase in the demand of promotional, preventive and curative healthcare services	Contraceptive Coverage Rate	28% to 32%

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	Improvement in the availability and accessibility of quality services		
	Up scaling of high impact activities and introduction of innovative activities.		
	Strengthening institutional support promoting good health of women, children and adolescents		
SO8- To increase the number of youth-friendly BHCs offering integrated services from 10 to 40 by 2013.	Increase in the demand of promotional, preventive and curative healthcare services	Number of youth-friendly BHCs offering integrated services (ARH/FP/STIs/HIV-AIDS)	From 10 to 40%
	Improvement in the availability and accessibility of quality services at all the levels. Strengthening institutional support promoting good health of women, children and adolescents		

VI.1. 2.2- Communicable diseases:

Challenge: To improve the control on Communicable diseases (including HIV-AIDS) and management of risks and emergencies

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS			
SO1: To increase the availability of treatment arrangements for communicable diseases in all the regions	Reinforcing the fight against communicable diseases at the regional level	- Number of TDCs available - Number of health facilities integrating HIV activities in MPA Percentage of Pregnant women having slept under LLIN the previous night - Percentage of confirmed malaria cases correctly treated at health facilities	- 211 TDC - 1750 health facilities - 85% - 98%
SO2: To have emergency stocks in sufficient quantities at all system levels	Repositioning medical emergency kits in health institutions	Number of health institutions with emergency medical kits	1 Central Service and 22 IDSRs
	Assistance in the prevention and handling of emergency situations	Instances of assistance provided in the prevention and handling of emergency situations	41-48
SO3: To lay out inter sectorial decisions and recommendations pertaining to Governance, Risk and Control	Conducting periodical meetings for GRC coordination	Number of Minutes of GRC inter sectorial meetings containing decisions and recommendations	Twice a year
SO4: To reduce epidemic-related mortality in 22 regions,	Improving the responses and reactions to epidemics at all levels	Plague fatality rate Number of epidemic cases due to vaccine-preventable diseases	From 11.08 to 10% 0 case
SO5: To reduce the incidence of major diseases, endemo-epidemic disease and neglected tropical diseases			
	Reinforcing the fight against Leprosy	Rate of leprosy-induced grade 2 disability (for 1,00,000 persons)x	From 1.67% to 1.29% by 2013
	Enhancing control measures to eradicate malaria from Madagascar	Prevalence of malaria at BHC level	From 3.9% to 3.5%
	Strengthening the fight against tuberculosis	Cure rate for Bacilliform Tuberculosis	From 83.44% to 84.5%
	Strengthening the fight against Neglected Diseases: Bilharziosis, Cysticercosis, Lymphatic Filariasis,	Treatment coverage rates	Filariasis - 75% Taeniosis - 85% Bilharziosis - 85%

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	Rabies, Geohelminthiasis...		Geohelminthiasis - 85%
		Number of new anti-rabies treatment centers set up	25
SO6: Integrate the fight against AIDS in the health system up to the peripheral level	Intensification of HIV case-finding measures	Percentage of pregnant women having benefited from HIV screening counseling in PNC	0.03 to 0.8%
	Strengthening of the availability and accessibility of medical and psychosocial care for PLWHIV	Plague fatality rate Number of epidemic cases due to vaccine-preventable diseases	From 75% to 95%

VI.1.2.3- Non-communicable diseases:

Challenge: To promote the fight against NCD

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Number of target women screened using VIA (cervical cancer)**	From 4.5% to 7%
		Utilization rate of dental centers	From 10% to 13.5%
SO1: To increase service accessibility in the fight against NCD in at least 03 regions by 2013	Up scaling preventive measures and promotional care for cervical cancer by the Visual Inspection with Acetic Acid (VIA) method; usage has increased from 46 to 138 health institutions	Percentage of target women screened using VIA	4.5-7%
	Up scaling of treatment with cryotherapy of VIA-positive women	Percentage of VIA-positive women treated using cryotherapy	40%-60%
	Up scaling of preventive measures and handling of sickle cell anemia	Number of sickle cell anemic children monitored	850 -1500
	Strengthening healthcare arrangements for cancer cases as per the norms	Operational radiotherapy center	0-1
	Promotion of activities for handling road traffic accidents	Number of promotional activities for handling road traffic accidents	0-4
	Promotion of activities for handling NCD	Number of CHWs in charge of CBR of persons in supervised disability support centers	14
	Strengthening the treatment for non-communicable diseases.	Number of specialized consultations provided	4-6
	Providing advanced strategy dental services or care	Utilization rate of dental centers	From 10% to 13.5%
	Up scaling of preventive measures and promotional care	Number of cataract surgeries performed	4852-8000
	Holding refractive error detection campaigns in schools and at community level	Number of refractive errors detected	7982-9000
	Improving care facilities for persons with disabilities	Number of persons (new cases) taken care of in rehabilitation centers	Not defined-7000

VI.1.2.4-. Promotion of community health

Challenge: To promote community health in healthcare sector development.

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Percentage of CHWs striving to promote the approach: Know, List out, Inform and Follow-up**	**0-50%**
		Percentage of municipalities with operational Health Committees	**38% - 80%**
SO1: To reinvigorate community participation in healthcare sector development			
	Appointment by Municipal order of Health Committees, Municipalities, including Fokontany Health Committee - Coordination meeting	Percentage of municipalities with operational Health Committees	38 - 80%
	Participation in monitoring and inspection of PHAGECOM	Percentage of BHCs with functional management committee	100% till 2013
	Strengthening of capabilities of community participants for social mobilization and health promotion	- Number of operational community agents in IEH/CBC	120 community volunteers trained in IEH/CBC in 03 regions by 2013.
SO2: To boost the utilization rate of services for mothers, children and the youth by reinforcing awareness campaigns/social mobilization			
	Stimulation of demand/social mobilization for the health of mother and child	Childbirth rate at health facilities	21% - 44%
	Stimulation of demand/social mobilization for the health of mother and child	Vaccine coverage rate	90%
	Organizing a cascade training using Know, List out, Inform and Follow-up approach	Percentage of CHWs striving to promote the approach: Know, List out, Inform and Follow-up	50%
SO3: To reduce the morbidity rate due to nosocomial infections from 50% to 25% using preventive measures in three (3) regions by 2013.	Implementing integrated preventive measures	Morbidity rate due to nosocomial infections	From 50% - 25% in three (3) regions by 2013.
SO4: To promote traditional medicine and pharmacopoeia amongst the population.			
	Celebration of African Traditional Medicine Day	Number of celebrations	Once a year
SO5: To ensure the quality of medicines provided to the population	Seizure of medicines not conforming to standards		
SO6: To ensure sharing of health-related information and efforts deployed by the Health Ministry	Communication from the Ministry	Number of QHB publications	4 releases per year
	Improving follow-up and assessing the impact of messages broadcast via the	Audience reach of the program «Feon'ny fahasalamana» (%)	10-15%

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	program «Feon'ny fahasalamana» on the community		
	Awareness:	Road traffic accidents	
SO7: To offer community services to the population settled far away from health facilities to improve service accessibility			800
	Improving the skill set and providing kits to C-IMCI community agents	Number of functional C-IMCI sites	
	Mobile strategies integrated in remote areas for FB and vaccination	Percentage of BHC/Districts undertaking advanced/mobile strategies	
	Up-scaling of Mendrika Salama Municipality	Number of operational "Mendrika Communities"	72-90
SO8: To have healthcare facilities at workplace			
	Up scaling of focal points of regions	Number of operational regional focal points for Occupational health facilities	6-22
	Standardization of Occupational Health structures	Number of structures in conformity with Occupational Health standards	0-16

VI.1.3- INFRASTRUCTURE AND EQUIPMENTS

Challenge: To comply with standards for health infrastructure and technical facilities

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Average rate of bed occupancy**	**43% - 50%**
		Percentage of functional BHCs	98% - 99%
SO1: To increase the availability of basic healthcare services and quality hospital treatment in 22 regions by 2013.	Putting in place healthcare infrastructure and equipment	Number of new operational annex hospital centers	09 hospitals
	Setting up international standard healthcare infrastructure	Number of international standard hospitals	01 hospital
	Construction of BHCs	Number of BHCs constructed	6 BHCs
	Up scaling healthcare infrastructure and equipment as per norms	Number of new operational ophthalmic centers	02 centers (HJRA, Fénérive-Est RRHC)
	Up scaling healthcare infrastructure and equipment to standard norms	Number of new available sickle cell anemia treatment centers	01 center
	Up scaling healthcare infrastructure and equipment to standard norms	Number of rehabilitated health institutions	02 psychiatry units rehabilitated 01 Ophthalmology unit of University Public Healthcare Center

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
			rehabilitated
	Creating housing facilities for healthcare personnel in remote/distant areas	Number of officers recently lodged in remote/distant areas	12 residential units for Heads of post constructed
	Up scaling healthcare infrastructure and equipment to standard norms	Number of BHCs with basic equipment	From 120 to 106
	Up scaling healthcare infrastructure and equipment to standard norms	Number of new operational DHC2	07 newly transformed DHCs
	Rehabilitation of old BHCs made of local material	Number of rehabilitated BHCs/hospital centers	-25 BHCs rehabilitated -15 rehabilitated health centers -Eight (08) rehabilitated administrative buildings
SO2: To have a Cancer Center with cobalt therapy services by 2013.	Equipping the Cancer Center with a cobalt therapy device	Operational Cobalt therapy center	1 hospital
SO3: To increase the number of UHCs/RRHCs with a management structure as per norms defined by the Hospital Reform Act.	Standardization of management structures in conformity with the Reform Act	Number of UHCs/RRHCs with a management structure in conformity with the norms defined by the Hospital Reform Act.	From 02 UHCs/RRHCs in 2011 to 22 UHCs/RRHCs in 2013
SO4: To ensure vaccine security at all levels by 2013.	Standardization of technical facilities	Number of refrigerated trucks acquired	From 0 in 2011 to 01 refrigerated truck in 2013
	Standardization of technical facilities	Number of new centers (BHC) equipped with refrigerators	120 new refrigerators
	Standardization of technical facilities	Number of RDPH (regions) equipped with cold storage rooms	From 0 in 2011 to 13 in 2013
	Standardization of technical facilities	Number of cold storage rooms created at the central level	From 0 in 2011 to 1 in 2013

VI.2-STRATEGIC GUIDELINE 2: IMPROVEMENT IN THE REGULAR AVAILABILITY, RATIONAL MANAGEMENT AND USAGE OF QUALITY HEALTH INPUTS AT ALL LEVELS

The success factor in making quality healthcare services accessible to the population also depends on the availability of inputs as on the service offering capacity.

AVAILABILITY OF HEALTH INPUTS WITH THEIR MANAGEMENT AND RATIONAL UTILIZATION AT ALL LEVELS

Challenge: To improve the availability and accessibility of essential drugs, medical consumables, reagents at all health institutions

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Rate of availability of essential drugs (EGD) at BHCs**	**95-100**
SO1: To ensure the availability of Health Inputs at all levels,			
	Improvement in the management of health inputs	% of health facilities equipped with IDK, OC KIT, vaccines, food products, therapeutic products, testing KIT, FP products and LLIN	100% of health institutions
		-% of health facilities equipped with LLIN	100% of BHCs
	Integration of healthcare supplies of different programs by PAIS	Number of programs integrated with SALAMA network	7 in 2011 to 21 in 2012
	Analysis of drug quality control	Percentage of drugs analyzed	352/500
	Provision of BTC (Blood Transfusion Centers) with blood bags and blood grouping reagents and serological screening of blood-borne infections	Availability rate of blood bags and reagents at BTCs	100%
	- Supply of essential drugs to health facilities	Number of health facilities with an availability rate of essential drugs of between 95 to 100%	All BHCs
	Provision of Public Hospital Centers and PhaGDis with international standard massive solutions and alcohol for medical use	Number of serum products	8,88,960 in 2011 to 8,93,425 serums in 2013
	Provision of laboratories and medical imaging centers with reagents and consumables	Percentage of laboratories with consumables	100% of DRHC, RRHC, UHC
	Cold Chain Operationalization	Percentage of BHCs with uninterrupted cold chain functionality	100%
SO2: To integrate traditional medicine and pharmacopoeia in health system	Integration of RTA in BHCs	Percentage of BHCs integrating traditional medicine and pharmacopoeia	100%
SO3: To harmonize management tools in public health facilities	Finalization, multiplication and distribution of management tools	- Number of Health Institutions with management tools	66 Pha Gdis 27 DRHCs 16 RRHCs 06 UHCs
SO4: To arrange the funding of forwarder/warehousing charges and the flow of free supplies funded by TFP through State budgetary grant	Inclusion of this grant in the MINSANP budget and pleas to MFB	Funds earmarked during the preparation of 2014 budget	In 2013
SO5 To redefine a profit margin for smooth functioning of FANOME thereby enabling continuous availability and accessibility of supplies and financial assistance essential for the operation of health facilities	Drafting and adoption of an interdepartmental decree fixing profit margins for FANOME	Adoption of decree	In 2013

VI.3-STRATEGIC GUIDELINE 3: OPTIMIZING THE HEALTH SYSTEM

The coordination and collaboration between different participants on one hand, and the harmonization and integration of services on the other, promote the efficiency and dynamism of the health system management.

Components:

- Strengthening of good governance and transparency in the Health sector in Madagascar by involving all stakeholders
- Strengthening of information, surveillance and communication system while promoting operational research on the health system in Madagascar.
- Strengthening the mechanisms for funding and management.

VI.3.1- DEVELOPING FUNDING AND MANAGING MECHANISMS:

Challenge: To optimize financial resources while strengthening funding and management mechanisms

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS	**-Budget implementation rate (%)**		72% (2011) to 99% (2013) for the STATE budget
SO1: To enhance the budget management capabilities of the budgetary actors	Developing budget management capabilities of Heads of post	-Budget implementation rate (%)	72% (2011), 95% (2012) to 99% (2013) for the State Budget
SO2: To optimize financial resources and increase the gains from health expenses by 2013	Optimization of financial resources	Introduction of a viable funding mechanism	Ad Hoc Committee put in place
	Fanome management control at RRHC and UHC level	% of RRHCs and UHCs misusing Fanome, audited	60% (2011) - 25%(2012)
	Management control of health institutions, particularly management of pharmacies and units' own resources	Number of audited hospital Centers/Boards	4-16
	Support to districts in planning, costing and budgetary control	Percentage of regions with a consolidated AWP	13-22
SO3: To increase the number of vulnerable persons brought under care with Equity Fund	Collaboration with local authorities for the identification of the disadvantaged and help with their treatment	Number of vulnerable persons brought under care with Equity Fund	23788-24639
SO4: To make available the information on financing and the rational and equitable distribution of resources by 2013			
	Documentation of rational criteria and goals of the budgetary allocation	Availability of eligibility criteria and rational distribution of resources	Resource allocation criteria identified and validated
	Documentation on the 3 possible funding	Availability of funding scenarios at each level	Availability of case study of 3 funding scenarios at each

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	scenarios at each level of the Health system	of the Health system	level of the Health system
SO5 To strengthen social protection (Medical insurance, mutual health insurances, equity funds,...) and progressive universal coverage			
	Implementation of social protection (Medical insurance, mutual health insurances, equity funds,...) and progressive universal coverage	Number of municipalities involved in the PH4 initiative	**Half of the municipalities involved in the PH4 initiative are in the three pilot regions**
	Educating the population to embrace social protection	Number of operational mutual health insurances	**From 20 to 70 by 2013**
SO6: To increase the usage of hospital equity funds from 15% to 60%	Utilization rate of HEF	Reinvigoration of URCOFEH	15%-60%

VI.3.2- RELIABLE AND OPERATIONAL INFORMATION SYSTEM:

Challenge: Strengthening of information, surveillance and communication system while promoting operational research on the health system in Madagascar.

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Rate of promptness and completeness of MARs of BHCs**	Completeness of MARs of BHCs from 92.9 to 95.5 % by 2013 Promptness of MARs of BHCs from 79.2% to 80% by 2013
SO1: To harmonize the information system at all levels of the health system by 2013.	Operationalization of integrated data bank system	Number of regions with integrated databases updated at least every three months	From 5 to 22 by 2013
	Operationalization of National Human Resources Observatory	Number of regions with National Human Resources Observatory per category and per institution database on personnel management, updated every three months	**From 0 to 22 by 2013**
SO2: Strengthening information management	Provision of GIS/MARs data collection tools	Rate of completeness of MARs at District level	Completeness of MARs of BHCs from 92.9 to 95.5 % by 2013
	Preparation and distribution of health statistics yearbook at each level	Number of regions having health statistics yearbooks	0-22 regions
	Standardization of resources and computerization of patient management	Number of Public Hospital Units equipped with functional software for management of hospital patients and activities	5 Public Hospital Units
	Improving level-based monitoring of utilization of health information management software (CHANNEL and GESIS)	Number of monitored Districts using CHANNEL and GESIS	112 districts
	Improving communication tools	Number of equipped districts	112 districts, 22 regions

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	and devices		
	Strengthening the data collection (Surveys) and analysis (cases) system (UDD)	Number of districts with personnel capable to use information as decision-making tool (UDD)	74 Districts
SO3: To Strengthen epidemiologic monitoring in the national territory integrating surveillance of maternal deaths and health in the border areas	Strengthening of epidemiologic monitoring and responses as well as surveillance of maternal deaths at RDPH and SDSP level	National average rate of completeness of weekly surveillance reports on diseases	5%-15%
	Strengthening of Data transmission system	Number of media-based data deliveries	From 3 to 15 by 2013
SO4: To have a reliable framework of health information, follow-up and evaluation at all levels in 22 regions by 2013.	Revitalizing the control-assessment structures at regional level	Number of regions with operational control-assessment focal point and research infrastructure	0-6 regions
	Development of local partnership	Number of regions with activity reporting rate of more than 80%, including NGOs	- Seven (07) Officers - Regional mapping of NGOs and Societies
	Setting up Observatory and Cyber health sites	Number of established and operational telemedicine sites	0-8
SO5 To develop operational research in health	Promotion of program-based and level-based research works in health	Number of published results of operational research in health	3-6

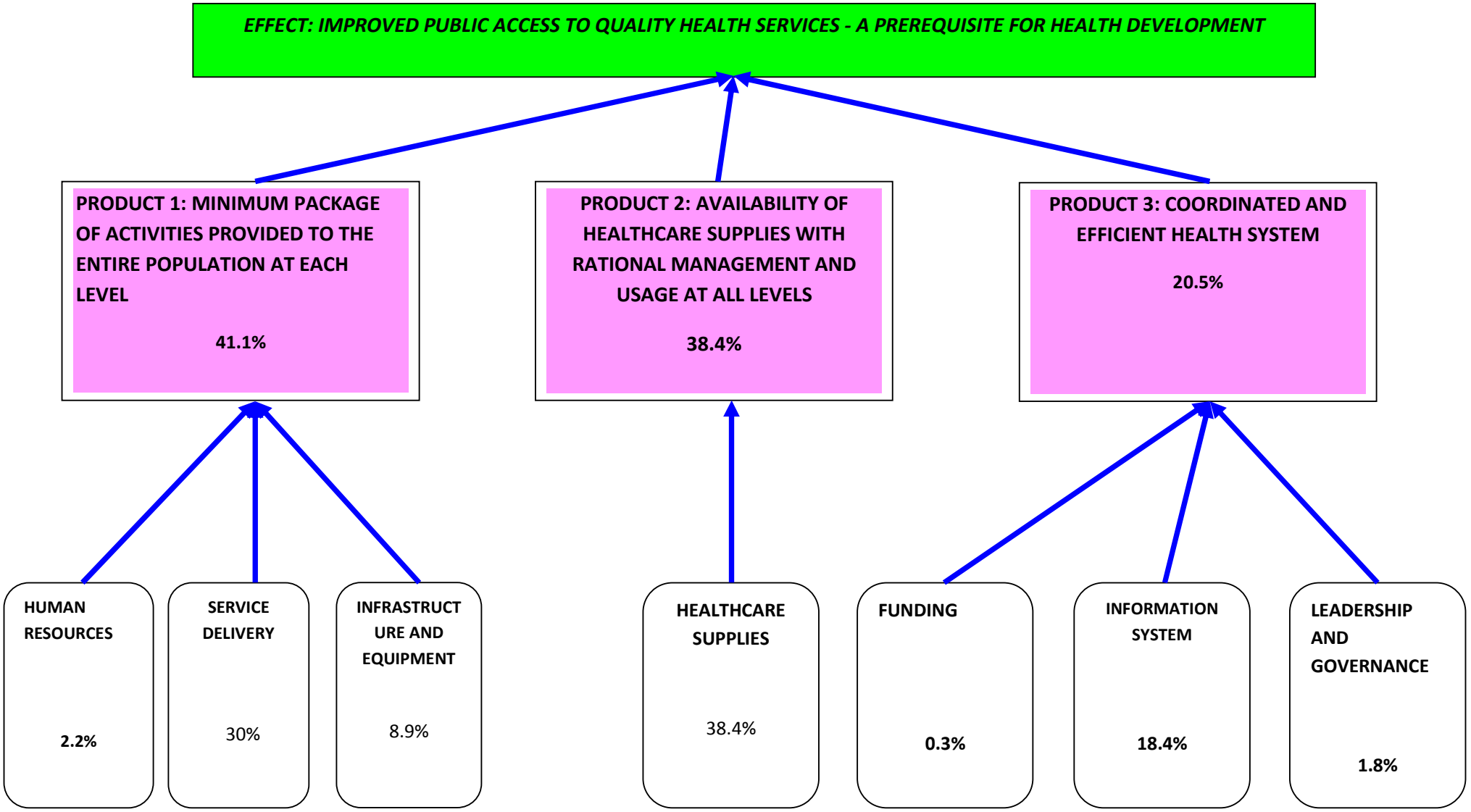
VI.3.3 STRENGTHENING OF GOOD GOVERNANCE AND LEADERSHIP

Challenge: To Strengthen good governance and transparency in the Healthcare sector in Madagascar by involving all stakeholders

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
PERFORMANCE INDICATORS		**Availability of HSDP 2014-2018, current till the end of 2013**	End of 2013
SO1: To make updated reference documents available on the political and organizational framework of the health sector by 2013	Putting in place a political and legal environment promoting public access to quality healthcare services	Availability of updated reference documents on political and organizational framework of the health sector by 2013	Interim Plan until 2012 HSDP 2014-2018 And other national policies
SO2: To ensure follow-up on laws related to the health of the mother and child at all levels by 2013.	Strengthening institutional support promoting good health of women, children and adolescents	Availability of law implementing decrees related to health of the mother and child	Law implementing decrees related to health of the mother and child
SO3: To operationalize coordination structures at all levels with all the stakeholders by 2013.	Revitalizing the coordination system with all the partners	Number of joint audits organized with partners	03 Joint audits with partners until 2013
	Establishing a participative control and coordination system (partners included) at	Number of periodic audits of BHCs and partners conducted at Regional and District level	06 periodic audits per district per year 2 per region

OBJECTIVES	STRATEGIES	INDICATORS	TARGETS for 2013
	all levels		
SO4 To strengthen the control and supervision system in 8 regions by 2013	Establishing a performance monitoring system at all levels	Existence of performance scorecard for districts and regions	Diana, Vatovavy Fitovinany, Atsimo Atsin, Anosy, Androy, Analamanga, Analanjirofo and Melaky
SO5 To improve planning, programming, audit and control-assessment at all levels by 2013.	Developing bottom-up planning based on results	Number of regions with AWP consolidated and drafted following the bottom-up process	from 13 to 22 regions by 2013
SO6: To contribute to the efficacy of decentralization of resources, coordination and community approach by 2013	Transfer of resources and skills	Percentage of funds allocated to peripherals against the MPH budget	From 30% to 40% by 2013
SO7: To make available the updated AWP of each level	Reviewing the per-level Minimum Package of Activities	Availability of updated AWP at each level based on the broad guidelines of the MPH	AWP updated at each level

VII OVERALL DISTRIBUTION OF BUDGET ALLOCATED PER PILLAR



VIII CONCLUSION

This interim plan is of great importance as it contributes to the Ministry's mission defined for the coming two years. This plan enables to highlight: (i) The major problems and priorities of the health sector; (ii) The results expected from the proposed assistance schemes; (iii) Strategic priorities, (iv) Relevant indicators enabling tracking of defined targets in the context of the socio political crisis.
Despite the difficulties encountered during the process, the results achieved through this interim plan highlight the willingness of the Ministry of Public Health and its partners to bring down, as far as available resources are concerned, the precariousness in the population's health conditions.
The pillar-based priority assistance schemes have been consolidated to take the form of a unique interim plan. The budget distribution (internal and external) is mainly focused on the supply pillar having a share of 38.4% of the total budget in order to improve the availability and supply of drugs and consumables.

The services (health of mother and child, campaigns against diseases) take the second position with the share of 30.1%. The availability of adequate and operational infrastructure and equipment represents 8.9% of the total share... The human resources pillar represents 2.2% of the total budget.

The decision making powers and institution of an efficient coordination system fall under the leadership and governance pillar with a financial incentive of 1.8%. The information system (source of collection and verification of achievements of the health sector) is a decision-making tool at all levels and uses up 18.4% of the funding. Finally, the Funding pillar gets only a share of 0.3%.

Consequently, to further improve the performance of the health sector, involvement of all stakeholders working in the healthcare domain at all levels is truly desired; the technical, institutional, organizational and financial parameters deserve to be reconsidered for a better harmonization and synergy of assistance schemes, efficacy and efficiency of health programs. Besides reliability of information, the transparency in programming, management and follow-up of assistance schemes and mobilized resources are not any less important.
And most importantly, it is the articulation of priority strategies, not only national but also regional, that is essential so that together we can have a healthy and strong human capital participating actively in the development of the country. Thus, the necessary adjustments with the involvement of all the concerned participants would be useful to gain a better understanding of the drafting of the Health Sector and Social Protection Development Plan (HSDP) 2014-2018 that will be coming up very soon.