Evaluation

Madagascar ACCESS Activity (Accessible Continuum of Care and Essential Services Sustained)

Midterm Evaluation Report

December 2022

USAID FROM THE AMERICAN PEOPLE

DATA FOR impact

ACCESS Activity

Midterm Evaluation Report

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Abstract

This midterm evaluation examined the progress of the Accessible Continuum of Care and Essential Services Sustained (ACCESS) program to identify promising approaches, ongoing challenges, and recommendations. The evaluation focused on five questions:

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

The evaluation used a mixed methods approach, including primary data collection through key informant interviews and focus group discussions; secondary review of program documents; and analysis of existing program and MOPH District Health Information Software data. The data suggested that ACCESS is achieving its intended objectives. These objectives include improving health service quality and the continuum of care, developing a capacity building approach at the subnational level, and promoting healthy behaviors and supportive supervision. Work towards these objectives contributed to health systems strengthening. The data also indicated continuing challenges around lack of health seeking behavior, preferences for seeking services from private providers or traditional healers, poor infrastructure at community and basic health center levels, and programmatic delays with capacity building and quality improvement. The COVID-19 pandemic has exacerbated these challenges, particularly in relation to capacity building and quality improvement. Key recommendations include improved planning/coordination of joint supportive supervision activities; meeting equipment/infrastructure needs; and acceleration of the district graduation approach rollout and certification process.

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Cover

A community health volunteer educates two pregnant women about malaria prevention. Photo by USAID ACCESS Program staff in Antananarivo, Madagascar, used by permission.

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Abbreviations

ACCESS	Accessible Continuum of Care and Essential Services Sustained
ACT	artemisinin-based combination treatment
ADS	aides cliniques [clinical aides]
AIM	Alliance for Innovation in Maternal Health
ANC	antenatal care
AQS	Assurance de Qualité de Services [service quality assurance]
ASC	Accompagnateurs de Santé Communautaire [community health coaches]
BRF	Bureaux Régionaux de Formation [regional training offices]
CAC	Community Action Cycle
CCDS	Comités Communaux De Développement De Santé [community health development committees]
CCR	contraceptive coverage rate
CHRD	Centre Hospitalier de Référence de District [district reference hospital]
CHV	community health volunteer
CLTS	Community-Led Total Sanitation
COSAN	Comité de Santé [village health committee]
CPN1	first prenatal consultation
CPN4	fourth prenatal consultation
CSB	centre de santé de base [basic health center]
D4I	Data for Impact
DEPSI	Direction des Études, de la Planification et du Système d'Information [Department of Studies, Planning and Information System]
DHIS2	District Health Information Software
DRSP	Direction Régionale de la Santé Publique [Regional Directorate of Public Health]
DSSB	Director of Basic Health Care
EMAD	Équipe de Management de District [district health management team]
EMAR	Équipe de Management de Région [regional management team]
EPI	Expanded Programme on Immunization
EQ	evaluation question
FFSDP	Fully Functional Service Delivery Point
FGD	focus group discussion
FP	family planning
FY	fiscal year
ICN	Integrated Community Nutrition
IMCI	integrated management of childhood illness
KI	key informant
KII	key informant interview

LDHF	low-dose high-frequency
LDP	Leadership Development Program
MNCH	maternal, neonatal, and child health
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
PDSS	Health Sector Development Plan
PMP	performance monitoring plan
PROGRES	Program for Organizational Growth, Resilience, and Sustainability
PSI	Population Services International
QI	quality improvement
RCR	referral and counter-referral
RDQA	routine data quality assessment
RDT	rapid diagnostic test
RMA	monthly activity report
SBC	social and behavior change
SDSP	Service de District de Santé Publique [District Public Health Unit]
SILC	Savings and Internal Lending Communities
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene

Executive Summary

In recent years, Madagascar has made strides in reducing infectious diseases and improving the well-being of its citizens through the implementation of the National Development Plan 2015–2019 and the Health Sector Development Plan (PDSS) 2020–2024, which prioritize the prevention and management of diseases, universal health coverage, and maternal, neonatal, and child health (MNCH), in particular, through the improvement of health facilities and localized care. Access to healthcare is a challenge for much of the population because more than 25 percent lives more than 10 kilometers from a health center. These issues are further compounded by an uneven distribution of health personnel, lack of geographic accessibility, and insecurity. Out-of- pocket expenditures on health are also high and increasing as a percentage of total health expenditures.

The Accessible Continuum of Care and Essential Services Sustained (ACCESS) program is a five-year health program funded by the United States Agency for International Development (USAID)[1] and is led by Management Sciences for Health (MSH). It is implemented in 13[2] of the 22 regions of Madagascar.[3] ACCESS seeks to build the capacity of subnational health management teams (*Équipe de Management de Région* [EMAR; regional management team] and *Équipe de Management de Distric*t [EMAD; district management team]) to plan, manage, monitor, and evaluate their health programs, and to improve the quality of service delivery at the district, community, and facility levels. Work at the national level focuses on informing policy and guideline development, and advocacy on key health service delivery issues. At the district level, ACCESS enhances the clinical and health governance skills of primary healthcare providers to deliver high quality and accessible preventive and curative health services. The program also works to improve the skills and motivation of community health volunteers (CHVs) to deliver quality health services and ensure that they work effectively with their respective *centre de santé de base* (CSB) [basic health center]. Last, ACCESS promotes positive health behaviors, including care seeking behaviors, through a comprehensive and contextualized social and behavior change (SBC) approach, and improves the capacity of the Ministry of Public Health (MOPH) and local institutions to design, implement, monitor, and evaluate SBC activities.

The end goal of the ACCESS program is to accelerate sustainable health impacts for the Malagasy people—as measured by sustained reductions in maternal and child mortality and morbidity. The conceptual framework is built on three outcome objectives:

[1] Cooperative Agreement number 72068718CA00003; started September 27, 2018; end date: September 26, 2023.
[2] As of report writing in April 2022, Vatovavy and Fitovinany were two separate regions in 2021. Therefore, the program's current coverage is now 14 of 23 regions.
[3] Amoron'i Mania, Analanjirofo, Atsimo Andrefana, Atsinanana, Boeny, Diana, Haute Matsiatra, Melaky, Menabe, Sava, Sofia, Vakinankaratra, Vatovavy, and Fitovinany.

Objective 1: Quality health services are sustainably available and accessible to all communities in the targeted regions.

Objective 2: Health systems function effectively to support quality health service delivery.

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

ACCESS began in fiscal year (FY) 2019 and is scheduled to be completed in FY2023. Key implementing partners are: MSH; Johns Hopkins Center for Communication Programs; Catholic Relief Services; Population Services International (PSI); the American College of Nurse-Midwives; American Academy of Pediatrics; *Action Socio-Sanitaires Organisation Secours* (Malagasy nongovernmental organization), and Dimagi. Because the ACCESS program is in its fourth year of implementation, Data for Impact (D4I) facilitated this evaluation to provide information for USAID and ACCESS implementing partners for the purposes of learning and course correction.

This mid-term evaluation assessed how well the ACCESS program was working and what modifications may be needed to facilitate the achievement of its goals in subsequent years of implementation. The evaluation focused on five main evaluation questions (EQs):

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

The evaluation used a mixed methods approach, including qualitative and quantitative data collection and analysis and a desk review of program data. Given the time allotted for data collection, the evaluation team was only able to collect primary qualitative data in six regions. These regions were selected based on the following criteria, with designations of "high vs. low" performing based on the program's performance monitoring plan (PMP):

- Complete package of activities with water, sanitation, and hygiene (WASH):
  - SAVA, high performing; Boeny, low performing
- Complete package of activities without WASH:
  - Vatovavy-Fitovinany, high performing; Atsimo-Andrefana, low performing
- Family planning (FP) package:
  - Vakinakaratra, high performing; Amoron'i Mania, low performing

[4] SBC activities include health promotion and mobilization activities through CHVs and activities implemented with community and village health committees (*Comité de Coordination et du Développement* [CCDS] and *Comités de Santé* [COSAN]) and community leaders, such as Champions for Change, Integrated Community Nutrition (ICN), Savings and Internal Lending Communities (SILC), Community Action Cycle (CAC), and Community-Led Total Sanitation (CLTS).

The study team collected primary data through 28 key informant interviews (KIIs) and 20 focus group discussions (FGDs) with a total of 186 participants. A review of secondary program documents was conducted as was a scan of peer-reviewed articles on related topics. PMP data and results and health indicator data from the Madagascar MOPH District Health Information Software (DHIS2) platform were reviewed. The data analysis used both qualitative analysis derived from KII notes, FGD transcripts, and additional notetaking from document review, and quantitative analysis of interview and focus group excerpts coded by theme and code co-occurrence analysis.[5]

Data from the evaluation suggested that ACCESS was achieving its intended objectives and intermediate results related to improved health service quality and continuum of care, capacity building at the subnational level, promotion of healthy behaviors, and supportive supervision. This included the program's contributions to national policy on health service delivery; improved data collection, quality, and use for health service decision making; and increased access and availability of health services by addressing challenges of geography, affordability, and clinical capacity. These results built a strong foundation for sustainable health systems strengthening. The data also indicated that sustainability and continuation of capacity building, continuing stockouts, and remaining equipment and resource needs (including human and financial resources at the MOPH level) were challenges and fueled perceptions of inadequate health service quality, pushing community members toward alternative health seeking behaviors. In addition, these issues were heavily exacerbated by COVID-19, which delayed implementation of some of the program's quality improvement (QI) and clinical capacity building activities.

Based on the qualitative and quantitative data analyzed, ACCESS has contributed to improved quality of health services and the continuum of care through (EQ1):

- Increased access and availability due to the ACCESS QI approach, including the humanization of care.
- The implementation of promising approaches, such as clinical capacity building, improved equipment and CSB infrastructure, and mobile clinics.
- Improved equity in access, use, and benefit, especially in terms of gender and targeting youth populations.
- Improving coordination and referrals between CHVs to CSBs and CSBs to district hospitals.
- The program's contributions to national-level policies and guidelines on health service delivery.

[5] Code co-occurrence analysis presents the "…frequencies for which all code pairings were applied to the same excerpt and, by default, overlapping excerpts. Such a display can expose both expected and unexpected patterns in which two codes were (or were not) used together. These patterns illuminate how concepts related to the research questions and represented by the code system are combined in the natural schema (i.e., cognitive frameworks that help organize and interpret information) activated by study participants as they report on the topic represented by project codes." Excerpt from Dedoose [website]. (n.d.) User guide. [Accessed April 21, 2022]. Retrieved from https://www.dedoose.com/userguide/analysisandfiltering

In addition, the ACCESS program capacity building approach was effective to the extent that (EQ2):

- Capacity building efforts were implemented at the subnational level, with training and monitoring opportunities for CHVs and CSB staff.
- The graduation approach has started implementation to measure progress at the district level.
- The Fully Functional Service Delivery Point (FFSDP), Leadership Development Program (LDP)+, and Program for Organizational Growth, Resilience, and Sustainability (PROGRES) capacity building approaches were perceived as promising approaches that contributed to improving the quality of health services.
- There were data quality improvements at CHV and CSB levels, including the development of data dashboards and the use of data for decision making.

However, district MOPH actors continued to need support to ensure uptake and adoption of both capacity building and QI efforts. Moreover, stockouts persisted, which significantly affected health service quality.

Last, the findings suggested that the ACCESS program's SBC approach contributed to the following results (EQ3):

- Addressing a wide range of health behavior topics, most notably WASH, maternal and child health, and FP using a variety of tools and channels to reach target populations.
- Using data to inform decision making on SBC approaches.
- Promoting positive gender norms and increasing the affordability of health services.
- Encouraging the adoption of healthier behaviors, especially the use of mosquito nets, contraception, and routine health seeking behavior.

In particular, the findings suggested that the ACCESS program's supportive supervision approach, including field visits, *Accompagnateurs de Santé Communautaire* (ASC; community health coaches) supervision, and mentoring and coaching contributed to the improved quality of health services. This included immediate course corrections on healthcare service provision, improved data collection and use, and enhanced clinical capacity.

The ACCESS program's approaches showed promise and contributed to the improved quality of health services, increased capacity of health service providers, and improved health behaviors. Sustaining these successful initiatives is essential for the remaining program implementation period. At the same, it is crucial to address persistent gaps in the availability of and accessibility to quality health services to ensure sustainable health impacts for the Malagasy people.

Based on the key findings identified, the intermediate results, promising implementation approaches, and areas in need of strengthening, the following recommendations are suggested for MSH and ACCESS program partners:

Recommendations: Planning

- Make efforts to better reflect the needs of regions/districts/communes in ACCESS activities and to refocus on collaborative scheduling.

- Increase teamwork, communication, and visioning with government partners (especially for supportive supervision) and reduce imposed planning.

Recommendations: Infrastructure/Materials

- Continue to support the rehabilitation of CSBs in partnership with the government, especially in terms of WASH.
- Provide additional health equipment and infrastructure improvements based on clearly stated needs from the CSBs.
- Establish an emergency buffer of materials to ensure stability and consider the development of pre-packaged kits for important health products that include the health product itself and any other supplies needed for use by CHVs or at the CSB level.

Recommendations: Capacity Building/Training

- Continue to strengthen the CHVs' skills (MNCH skills, integrated management of childhood illness [IMCI] at the community level, monthly activity reporting [RMA]) in alignment with CSB and community needs.
- Provide additional training on "humanization of care" to reduce/eliminate remaining instances of poor reception of clients.
- Continue to strengthen referral and counter-referral systems; retrain CHVs, as needed.
- Establish mentoring between high performing and lower performing CSB officers.
- Fully resource and accelerate the implementation of the graduation approach.

Recommendations: SBC Implementation

- Share information on SBC interventions with the Direction Régionale de la Santé Publique (DRSP; Regional Directorate of Public Health) and other government counterparts for better coordination.
- Continue monitoring and reporting on SBC activities at district and community levels and consider what SBC data from DREAM@MSH6 would be useful in the national DHIS2 platform.
- Continue to strengthen SBC visibility through posters, and further establish SILC and deepen ICN activities, if these interventions will continue.
- Consider additional SBC WASH resources , (i.e., "nudges," social norms, emotional drivers, and economic motivators) based on lessons from other USAID WASH initiatives.

Recommendations: Supervision

- Plan and fund additional trainings that lead directly/efficiently to implementation and ownership.
- Similar to the recommendation on planning, undertake joint supervision planning (and budgeting) with government counterparts.
- Respect quarterly supervision timelines.

[6] MSH's customized DHIS2 system.

Program Background

Introduction

In recent years, Madagascar has made strides in reducing infectious diseases and improving the well-being of its citizens through the implementation of the National Development Plan 2015–2019 and the Health Sector Development Plan (PDSS) 2020–2024, which prioritize the prevention and management of diseases, universal health coverage, and maternal, neonatal, and child health (MNCH), in particular, through the improvement of health facilities and localized care. The country faces challenges in terms of healthcare access, with persistently high rates of maternal mortality of 426 per 100,000 live births in 2018, and as of 2021, infant mortality of 47 per 1,000 live births.[7] Maternal and neonatal deaths are largely due to complications of pregnancy and childbirth, such as septicemia and hemorrhage, whereas under-five mortality is mainly due to acute respiratory infections, including pneumonia, and diarrheal diseases, malaria, malnutrition, and measles. Modern contraceptive use remains low at 43 percent among women in union ages 15–49, and even lower, at 34 percent, among adolescent girls and young women ages 15–19.[8] Access to healthcare is a challenge for much of the population because more than 25 percent lives more than 10 kilometers from a health center. These issues are further compounded by the uneven distribution of health personnel, lack of geographic accessibility, and insecurity. Out-of-pocket expenditures on health are also high and are increasing as a percentage of total health expenditures.

The Accessible Continuum of Care and Essential Services Sustained (ACCESS) program is a five-year health program[9] funded by the United States Agency for International Development (USAID) and led by Management Sciences for Health (MSH). It is implemented in 13[10] of the 22 regions of Madagascar,[11] focusing on improving the capacity and the quality of service delivery at district, community, and facility levels. ACCESS also works with stakeholders at the national level to inform policy and guideline development, and advocacy on key health service delivery issues.

This mid-term evaluation assessed how well the ACCESS program was working and what modifications may be needed to facilitate the achievement of its goals in subsequent years of implementation. The evaluation used a mixed methods approach, including a desk review of

[7] Institut National de Statistique (INSTAT), United Nations Children's Fund (UNICEF). (2018). *Enquête nationale sur la situation socio-démographique des ménages (MICS 6)*. Antananarivo, Madagascar: INSTAT and UNICEF. Retrieved from https://www.unicef.org/madagascar/mics2018
[8] National Institute of Statistics (INSTAT) and ICF. (2021). *Madagascar demographic and health survey, 2021*: *Key indicators*. Antananarivo, Madagascar and Rockville, Maryland, USA: INSTAT and ICF. Retrieved from https://dhsprogram.com/publications/publication-PR131-Preliminary-Reports-Key-Indicators-Reports.cfm
[9] Cooperative Agreement number 72068718CA00003; started September 27, 2018; end date: September 26, 2023.
[10] As of report writing in April 2022, Vatovavy and Fitovinany were two separate regions in 2021. Therefore, the program's current coverage is now 14 of 23 regions.
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program documents, key informant interviews (KIIs), focus group discussions (FGDs), and an assessment of program monitoring indicators from the program's Performance Monitoring Plan (PMP) and the Madagascar Ministry of Public Health (MOPH) District Health Information Software (DHIS2) platform. The evaluation was structured and aligned with the program's logical framework and results framework highlighting themes related to the quality of health services and the continuum of care, capacity building, social and behavior change (SBC), and supportive supervision and monitoring (Figures 1 and 2). Recommendations are provided on how the program could be modified to reach targeted outcomes more effectively in years four and five of implementation. Suggestions for course corrections are likewise offered.

Figure 1. ACCESS logical framework from the 2018 Cooperative Agreement

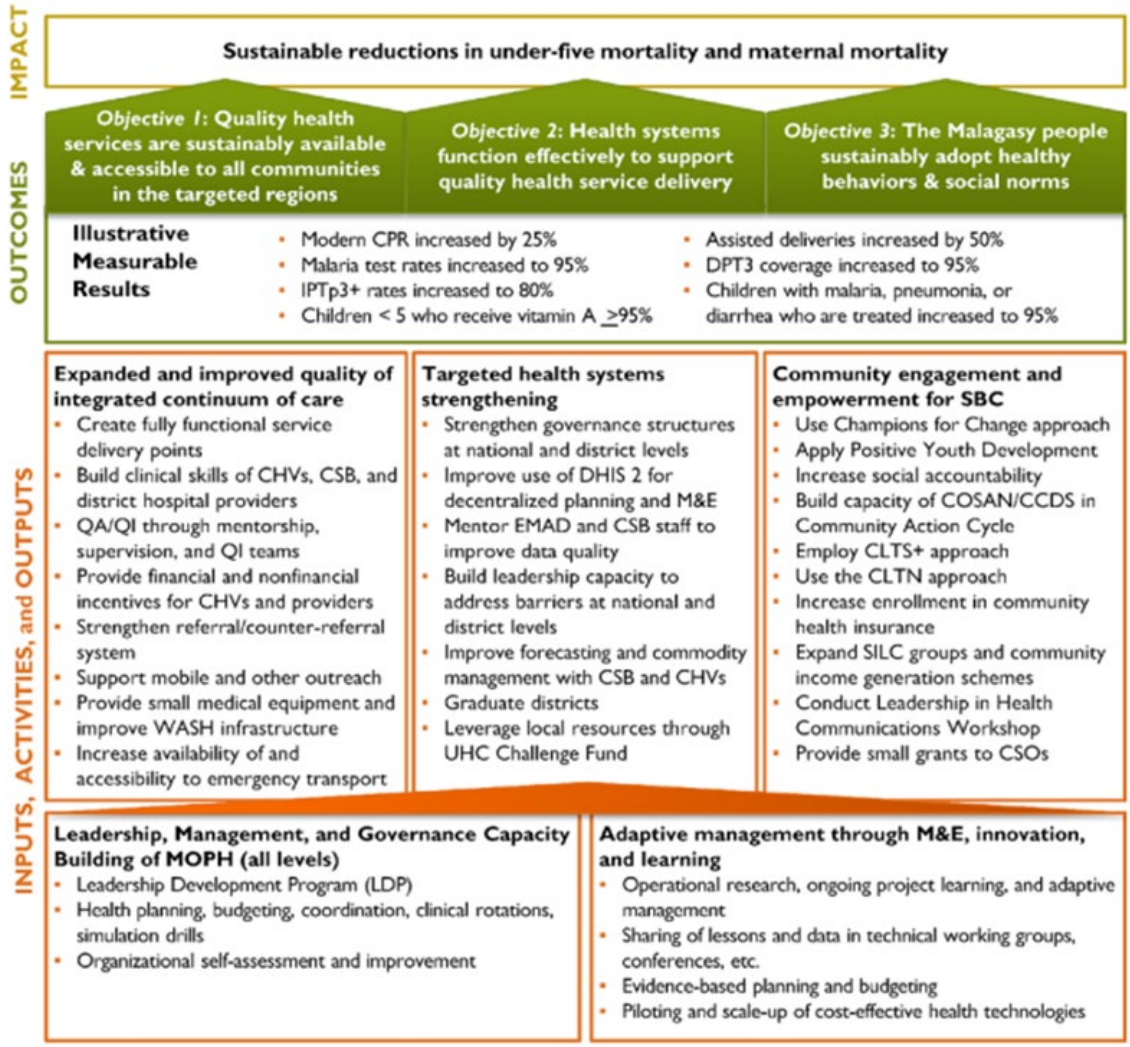
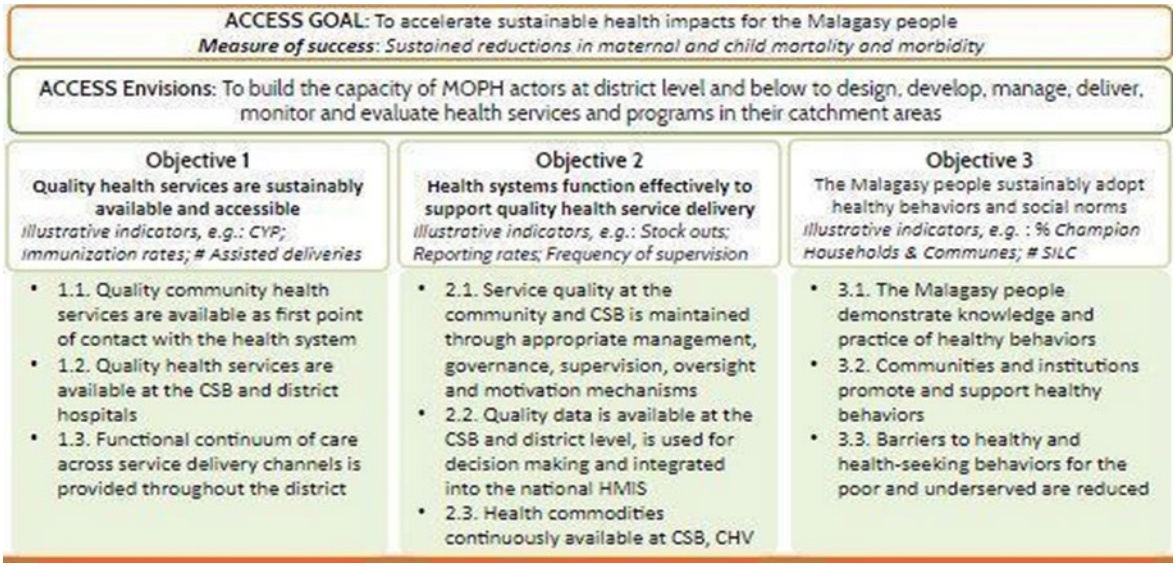


Figure 2. ACCESS results framework



Program Description

With a budget of more than 90 million USD, ACCESS seeks to build the capacity of subnational health management teams (*Équipe de Management de Région* [EMAR; regional management team] and *Équipe de Management de Distric*t [EMAD; district health management team]) to plan, manage, monitor, and evaluate their health programs, and to improve the quality of service delivery at district, community, and facility levels. Work at the national level focuses on informing policy and guideline development, and advocacy on key health service delivery issues. At the district level, ACCESS enhances the clinical and health governance skills of primary healthcare providers to deliver high quality and accessible preventive and curative health services. The program also works to improve the skills and motivation of community health volunteers (CHVs) to deliver quality health services and ensure that they work effectively with their respective *centre de santé de base* (CSB; basic health center). Last, ACCESS promotes positive health behaviors, including care seeking behaviors in the target communities through a comprehensive and contextualized SBC approach, and improves the capacity of the MOPH and local institutions to design, implement, monitor, and evaluate SBC activities. The end goal of the ACCESS program is to accelerate sustainable health impacts for the Malagasy people, as measured by sustained reductions in maternal and child mortality and morbidity.

ACCESS builds on community platforms created through the MSH-led USAID-funded *Mikolo* Project, USAID's *Mahefa Miaraka,*[12] and previous USAID investments, and is guided by USAID's integrated life cycle and continuum of care strategy. The program is operationalized around three objectives: (1) availability and accessibility of quality health services to all communities in the targeted regions; (2) functionality of health systems to support quality health service delivery; and (3) sustainable adoption of healthy behaviors and social norms among Malagasy people. Technical assistance includes the following components: (1) clinical capacity building and improvement of clinical quality; (2) expansion of service delivery; (3) demand generation and SBC; (4) small-scale water, sanitation, and hygiene (WASH) infrastructure improvements; and (5) clinical capacity building/training of CHVs, CSB, and district hospital providers. These packages are designed to achieve local ownership and sustainability through smart capacity building and problem solving for sustainable solutions; differential interventions and technical assistance; graduation of districts from receiving direct technical assistance; and cost sharing.

ACCESS also implements a quality improvement (QI) approach, which started at the community level at the end of fiscal year (FY) 2020, using a low-dose high-frequency (LDHF) training approach with CHVs to build their capacity in maternal and newborn health, family planning

[12] Implemented in seven overlapping regions in north and west Madagascar: Analanjirofo, SAVA, DIANA, Sofia, Boeny, Melaky, and Menabe (also in orange in the map in Figure 3). After completion, these regions transitioned fully over to ACCESS in 2021.

(FP), and integrated management of childhood illness (IMCI) topics during monthly meetings, and reinforcing or correcting practices through onsite supervision. CHVs are evaluated for knowledge and their performance is observed during clinical and non-clinical activities. More recently (FY22), QI has extended to the CSB level through the *Assurance de Qualité de Services* (AQS; service quality assurance) person-focused approach with malaria, immunization, infection prevention, and health management tools added to the roster of topics, again using LDHF training activities during monthly district meetings and onsite supervision. Health workers are also evaluated in terms of knowledge, and performance is observed through supervision and patient satisfaction surveys. Last, QI activities for CSBs and *Centre Hospitalier de Référence de District* (CHRD; district reference hospital)/*Centre Hospitalier Régional de Référence* (regional reference hospital) levels are newly initiated through the Alliance for Innovation in Maternal Health (AIM) approach, which emphasizes QI tools and techniques (such as plan, do, study, act, and healthcare process analysis), and the testing and documentation of solutions and sharing of best practices.

Figure 3. Target regions, by intervention package

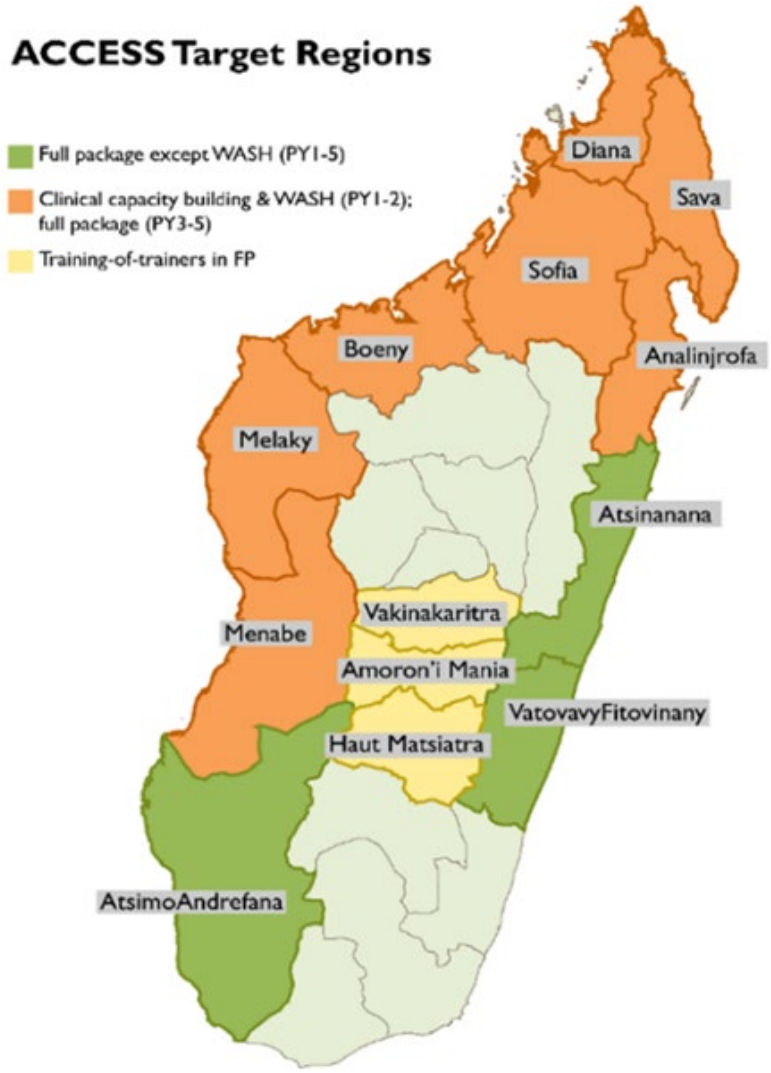


Figure 3 shows a map of the ACCESS target regions and the different intervention packages. ACCESS began in FY 2019 and is scheduled to be completed in FY2023. Key implementing partners are: MSH, Johns Hopkins Center for Communication Programs, Catholic Relief Services, Population Services International (PSI), American College of Nurse-Midwives, American Academy of Pediatrics , Action Socio-Sanitaires Organisation Secours (a Malagasy nongovernmental organization), and Dimagi.

Because the ACCESS program is in its fourth year of implementation, Data for Impact (D4I) facilitated this evaluation to provide information for USAID and the ACCESS implementing partners for the purposes of learning and course corrections. The evaluation design considered simultaneous efforts from the IMPACT project's midterm evaluation—a USAID-funded partner project being implemented concurrently with ACCESS—and ACCESS's own internal midterm review conducted in mid-2021 and a midterm evaluation survey (conducted concurrently) to

describe the midterm status of the program. Efforts were made to share protocols and data to limit duplication and the potential for respondent fatigue. In addition, evaluation and data collection teams were coordinated across the concurrent evaluations to maximize efficiencies and reduce bias.

Evaluation Methods

This mid-term evaluation used a non-experimental design and employed mixed methods to answer the following five main questions, each with sub-questions:

1. To what extent has ACCESS improved the quality of health services and the continuum of care?
    - 1.1 To what extent is the ACCESS QI approach improving the availability and accessibility of quality health services[13] to Malagasy communities in targeted regions?
    - 1.2 Which of the ACCESS implementation approaches appear to be the most promising and should be prioritized? For those that are not showing promise, what alternatives or complementary options should be considered?
    - 1.3 How is equity (in access, use, and benefit) exemplified (specifically focusing on youth and gender)?
    - 1.4 Has ACCESS improved health service access and coordination? If so, in what ways? Is there room for improvement, if so, how?
    - 1.5 To what extent has the ACCESS program contributed to national-level policies and guidelines on health service delivery?
2. To what extent did ACCESS implement a capacity building approach and how effective has it been?
    - 2.1 To what extent have capacity building initiatives for MOPH actors been implemented at the subnational (district) level? How appropriate is the capacity building approach and has it been conducted with appropriate frequency? In what areas has the capacity building approach been most successful?
    - 2.2 What is the uptake/adoption of these capacity building efforts by district-level MOPH actors and what keys to success can be learned from high-performing districts?

[13] According to the Cooperative Agreement, Sub-Objective 1.2., (p. 34): Quality health services are defined in accordance with national policy and essential service packages, as well as high-impact interventions for reproductive, maternal, newborn, child, and adolescent health, including clinical and nonclinical elements and aligned with USAID Health, Population, and Nutrition's integrated life cycle and continuum of care strategy.

2.3 To what extent was the graduation approach implemented and what are the lessons? What is the degree of ownership of the FFSDP[14], LDP+,[15] and the PROGRES[16] capacity building approaches?

2.4 To what extent has data quality improved as a result of the capacity building approach (up to the national health management information system level)? Are data consistently available in the DHIS2? Do any data gaps exist (rejection data)?

2.5 What concrete examples illustrate the use of data for decision making?

2.6 How consistently are routine data quality assessments (RDQAs) undertaken (at regional, district, health facility, and community levels) and what are the common findings?

2.7 How frequently do stockouts occur?

3. To what extent have the ACCESS SBC initiatives been implemented?[17]

3.1 What SBC initiatives[18] have been implemented as planned?

3.2 What are existing gaps in SBC initiatives' implementation?

3.3 How did formative research inform the design of SBC messages and materials?

3.4 To what extent have the SBC initiatives contributed to the promotion of positive social norms, gender, and youth-related considerations?

3.5 What information can existing data provide about exposure to and impressions of the SBC campaigns and the various media produced and broadcast (including community-based infection prevention and control messages)?

4. How effective is the program's approach to supportive supervision and monitoring, while building MOPH leadership and capacity to conduct these efforts on its own?

4.1 What course-correction measures have been implemented as part of the ACCESS knowledge management and learning strategy?

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[14] Fully Functional Service Delivery Point, as defined by MSH: The FFSDP application and methodology are a standards-based whole-systems QI tool that encourage health providers to change their predominantly clinical and curative focused behaviors and practices into behaviors and practices that foster teamwork, improve management, emphasize community health, and prioritize prevention. These new behaviors are known to lead to more effective service delivery and thus to improved health outcomes.

[15] Leadership Development Program+, as defined by MSH: An experiential learning and performance improvement process that empowers people at all levels of an organization to learn leadership, management, and governing practices; face challenges; and achieve measurable results.

[16] Program for Organizational Growth, Resilience, and Sustainability, as defined by MSH: PROGRES is a participatory organizational assessment process that helps civil society organizations and government institutions identify areas requiring support to foster sustainability and resilience. PROGRES can also be adapted for use by organizations working in areas outside health.

[17] SBC activities include health promotion and mobilization activities through CHVs and activities implemented with community and village health committees (*Comité de Coordination et du Développement* [CCDS] and *Comités de Santé* [COSAN]) and community leaders, such as Champions for Change, Integrated Community Nutrition (ICN), Savings and Internal Lending Communities (SILC), Community Action Cycle (CAC), and Community-Led Total Sanitation (CLTS).

[18] Specifically, the national SBC umbrella campaign, Be M'Ray, and other SBC initiatives (e.g., CLTS, ICN, Champions for Change, CAC, and initiatives targeting SILC groups).

4.2 How has the learning process been adopted/implemented to contribute to program objectives?

4.3 To what extent has the program documented the use of data for decision making?

5. What are recommendations across all questions that will reinforce and strengthen ACCESS activities and initiatives for the duration of the program?

    5.1 What are recommendations related to the quality of health services and the continuum of care?

    5.2 What are recommendations related to the capacity building approach?

    5.3 What are recommendations related to SBC initiatives?

    5.4 What are recommendations related to the monitoring and supportive supervision approach?

During the evaluation, question 2.3 was revised into 2.3a on the graduation approach:

- Is the graduation approach an idea that merits implementation in the last years of ACCESS? Is this something that will be useful?
- Will the graduation approach measures/indicators adequately quantify success/sustainability and ultimately graduation? Is something important missed?
- To what extent has ACCESS defined and chosen districts that are appropriate for the graduation approach? Is this a good path?

The second half of question 2.3 about capacity building and ownership was separated into its own question, 2.3b: What is the degree of ownership of the FFSDP, LDP+, and the PROGRES capacity building approaches?

The evaluation protocol and data collection tools are presented in Appendix 1.

Secondary Data Review

Program Document Review: Evaluators reviewed key program documents shared by implementing partners, including the Cooperative Agreement, annual/quarterly reports, the monitoring, evaluation, and learning plan, workplans, the internal mid-term review, and other documentation, to understand the range of activities that had taken place to date, their geographies, and key target populations. This document review helped inform the development of the data collection tools and provided context for the data analysis. Data on indicators related to the program's "graduation approach" were also reviewed, along with other existing data, such as such as performance results on monitoring indicators specified in the PMP.

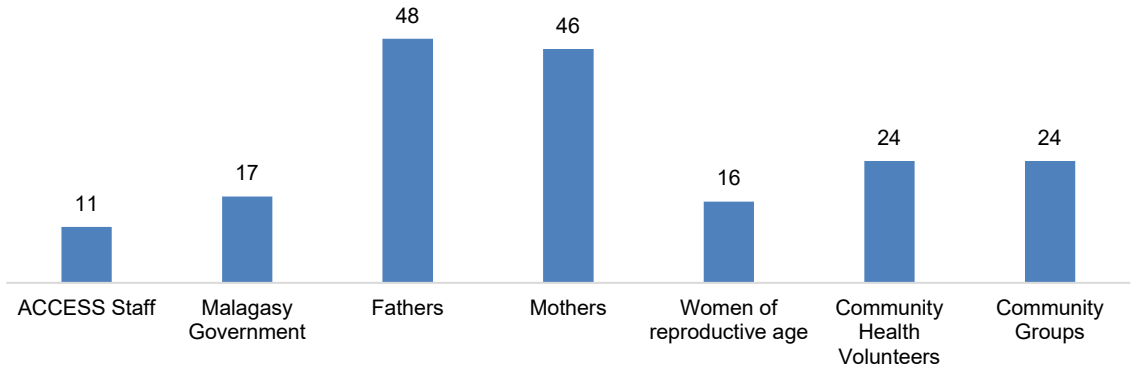
Literature Review: Data from a literature review were used, as applicable, to supplement information gaps in the existing program documents, especially related to recent innovations and best practices that might be incorporated in the second half of program implementation. The literature review also considered and identified evidence to inform alternative approaches for activities that were not working as expected.

Primary Data Collection

Madagascar is administratively subdivided into 23 regions (22 regions before August 2021). Each region is subdivided into districts and each district is subdivided into communes. Each commune is subdivided into *fokontany* (villages). Given the time allotted for data collection, the evaluation team was only able to collect primary qualitative data in six regions. These regions were selected based on the following criteria, with designations of "high vs. low" performing based on PMP indicator results:

- Complete package of activities with WASH:
    - SAVA, high performing; Boeny, low performing
- Complete package of activities without WASH:
    - Vatovavy-Fitovinany, high performing; Atsimo-Andrefana, low performing
- FP package:
    - Vakinakaratra, high performing; Amoron'i Mania, low performing

Figure 4. FGD and KII participants, by type of stakeholder (n=186)



The 20 FGDs and 28 KIIs involved a total of 186 evaluation participants. Figure 4 shows the breakdown of participants by type of stakeholder. Ninety-one females and 95 males participated.

Key Informant Interviews: Primary data collected through KIIs followed a semi-structured interview guide asking about successes and challenges related to the midterm evaluation questions. The aim of the KIIs was to assess how the four ACCESS technical assistance packages and the program's implementation strategies had (or had not) facilitated the availability and accessibility of quality health services; effective health system functioning in support of quality health services; and the adoption of healthy behaviors and social norms. The evaluation team coordinated with ACCESS staff to identify 28 key informants (KIs) and to tailor the interview guide to participants at national, subnational, and community levels. KII participants in the targeted regions included MOPH representatives at all levels of the health system.

Table 1. KII participants

KII Participants (n=28)	Total	Male	Female
Central	5	4	1
Central - ACCESS staff	9	4	5
SAVA*	5	5	0
Boeny*	4	2	2
Vatovavy Fitovinany	3	1	2
Atsimo Andrefana	2	1	1
TOTAL	28	17	11

*Two ACCESS staff members were also interviewed in SAVA and Boeny.

As shown in Table 1, the number of representatives interviewed varied according to the region's activity package, with priority given to interviewing stakeholders working in maternal and child health who were likely to have knowledge of the ACCESS program. In addition, nine ACCESS program staff members participated in the KIIs.

At the national level, the Director of Family Health, the Director of Basic Health Care, and the Director of the Expanded Programme on Immunization were appointed in mid-2021. As a result, the former Director of Family Health was asked to participate as a KI, while the Director of Basic Health Care (DSSB) participated, with help from staff members. Last, the Director of the Expanded Programme on Immunization was able to participate because he was previously the Regional Director of Public Health in Boeny. Therefore, he already had strong knowledge of the ACCESS program.

Interviews were conducted face-to-face by the local consultant team or by the international team using Zoom/Microsoft Teams in either Malagasy or French. In a few cases, small group interviews were conducted where several KIs were interviewed at the same time. Interview guides were tailored for each stakeholder type to facilitate in-depth discussion of the subject matter and topics with which participants were expected to be most familiar. Notes were taken during KIIs and completed by listening to the audio recording using a notes grid containing each question, with verbatim quotes recorded under each.

Focus Group Discussions: The team conducted FGDs using a semi-structured FGD guide designed to help understand changes in health service delivery, health behavior, and social norms at a subnational level. Participants represented the consumers of health services at district and facility levels, and key actors in activities implemented at the community level, including CHVs and community groups. A standard FGD guide was used for all discussions; however, the guide included probing questions that were specific to the target participants. Discussions were conducted in Malagasy in small group settings, while maintaining COVID-19 precautions.

FGDs aimed to identify the perceived effects of the ACCESS program on the health of the Malagasy population. A total of 20 FGDs were conducted. For each selected CSB, FGD participants included users of health services, CHVs, and members of community groups working in the commune where the CSB was located. Participants were selected from the following groups:

1. Women who received services at the CSB and CHV level, including:
    a. Mothers with at least one child under the age of five or pregnant, living in the *fokontany* for at least five years where the CSB was located.
    b. Young women ages 18–24 who did not yet have a child, living in the *fokontany* for at least five years where the CSB was located.
2. Male fathers with at least one child under the age of five, living in the fokontany for at least five years where the CSB was located.
3. CHVs associated with the CSB for at least five years.

4. Community group members: Actors and partners who supported SBC/capacity building initiatives in the commune where the CSB was located.

The choice of "living in the village for at least five years" was made so that the participant could speak to the evolution of the program before and during the ACCESS program. CHVs were asked to assist in recruiting participants for the FGDs. The interviewers explained the inclusion criteria to the CHVs and asked them to seek consent and to invite consenting participants to the FGDs. A group of six to eight participants was formed for each of the typologies mentioned above. Before the FGDs, the facilitator conducted a verification session to confirm the eligibility of each participant. The FGDs were conducted in Malagasy and recorded to enable the generation of verbatim transcriptions, which were then translated to French, checked for accuracy, translated to English, and checked for accuracy. COVID-19 precautions were maintained in all face-to-face interviews.

Table 2. Number of FGDs and FGD participants, by region

FGD type by region	Number of FGDs	Male participants	Female participants	Total participants
CHV	2	6	10	16
Community Groups	1	5	3	8
Mothers	2	n/a	16	16
Fathers	2	16	n/a	16
SAVA Totals	**7**	**27**	**29**	**56**
CHV	1	2	6	8
Community Groups	1	3	5	8
Mothers	1	n/a	6	6
Fathers	1	8	n/a	8
Boney Totals	**4**	**13**	**17**	**30**
Community Groups	1	2	6	8
Mothers	2	n/a	16	16
Father	2	16	n/a	16
Vatovavy Fitovinany Totals	**5**	**18**	**22**	**40**
Mothers	1	n/a	8	8
Fathers	1	8	n/a	8
Atsimo Andrefana Totals	**2**	**8**	**8**	**16**
Women of reproductive age	1	n/a	8	8
Vakainakaratra Totals	**1**	**n/a**	**8**	**8**
Women of reproductive age	1	n/a	8	8
Amorin'I Mania Totals	**1**	**n/a**	**0**	**8**
TOTAL	**20**	**66**	**92**	**158**

Table 2 shows the number of FGDs and FGD participants, by region and by gender.

Qualitative Data Analysis: All KII notes were typed and FGD transcriptions and notes translated into French and then English for analysis. A qualitative software program, Dedoose, was used to facilitate the coding and analytical process. Thematic analysis and coding were used to analyze the interview notes and FGD transcripts. Team members responsible for coding "shadowed" each other to validate each other's coding. Codes were then reviewed to see if clustering was appropriate. Unused or rarely used codes were combined, as relevant. Code patterns were further explored by disaggregating responses by the participant's stakeholder type, region and package type, and gender. Illustrative quotes were identified that answered each evaluation question. The data were then sorted and ranked by salience/relevance, and the results were used to inform discussion among evaluation team members. The Dedoose code list is provided in Appendix 2. Intra-method triangulation was employed to allow for a deeper analysis of the text derived from the qualitative data collection and was used for confirmation of perspectives and consensus around course corrections and learning. Quantitative analysis techniques were also employed to quantify patterns in the data and to support and complement the qualitative analysis approach.[19] This included analyzing coded experts and code co-occurrence matrices; for example, to identify the number of times that a given code, such as "increased accessibility," was reflected in participants' verbatim text or notes compiled by the researchers about the interview/discussion. Similarly, analysis was conducted on given codes and their co-occurrence with other codes, such as "challenge."[20,21]

Indicator Data Analysis: The evaluation team requested a small amount of district-level indicator data from the DHIS2 for the years 2019 to 2021 to conduct a sub-analysis of the program's graduation approach. Methods and results are described in more detail under EQ2.

Presentation and Validation: The evaluation team prepared two presentations with the preliminary and in-depth findings and recommendations for USAID, and then conducted a validation session and discussion with the ACCESS program team. Feedback from stakeholders was considered and reflected (as appropriate) in the writing of the evaluation report.

[19] Miles, M. B., Huberman, A. M., Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook*. Los Angeles, California: Sage Publications.

[20] A code co-occurrence matrix presents the "…frequencies for which all code pairings were applied to the same excerpt and, by default, overlapping excerpts. Such a display can expose both expected and unexpected patterns in which two codes were (or were not) used together. These patterns illuminate how concepts related to the research questions and represented by the code system are combined in the natural schema (i.e., cognitive frameworks that help organize and interpret information) activated by study participants as they report on the topic represented by project codes." Excerpt from Dedoose [website]. (n.d.) User guide. [Accessed April 21, 2022]. Retrieved from https://www.dedoose.com/userguide/analysisandfiltering

[21] Namey, E., Guest, G., Thairu, L., Johnson, L. (2008). Data reduction techniques for large qualitative data sets. In Guest, G. & MacQueen, K.M. (Eds.), *Handbook for team-based qualitative research* (pp. 137–61). Lanham, MD: AltaMira Press.

Challenges and Limitations

This evaluation used a non-experimental design and relied on inputs from stakeholders who may have been unintentionally biased in their perspectives. However, the evaluation team believed that the approach used in the evaluation was sufficient to draw conclusions and develop recommendations, with triangulation among opinions and thoughts of stakeholders, regular monitoring data, and other evidence. Moreover, due to budget and time limitations, sample selection was purposeful and did not include all 14 regions where the program was being implemented. Another limitation may have been potential respondent fatigue or crossover from other concurrent evaluations. KIIs have been conducted in recent years with similar groups of stakeholders for other evaluations and data collection efforts. Although it is encouraging that the program is committed to knowledge generation, this may have limited the degree of new insights that could be obtained or may have made participants weary of participating. Last, the evaluation was conducted in the COVID-19 context, which (in some cases) limited face-to-face meetings and required careful management of focus group sessions (with social distancing, masks, etc.) and coordination of team travel for data collection.

Findings

The findings are organized by the five evaluation questions, with each section starting with the full evaluation question itself and a summary of the findings.

Evaluation Question 1: To what extent has ACCESS improved the quality of health services and the continuum of care?

Based on the qualitative and quantitative data analyzed, ACCESS contributed to the following results:

- Increased quality of health services and the humanization of care.
- Improved equipment and CSB infrastructure, including WASH.
- Increased access to care through mobile clinics.

The findings are presented in each section by sub-evaluation question and in relation to themes that emerged in terms of implementation of promising approaches as well as challenges, equity, health access and coordination, and the program's contributions to national-level policy.

EQ 1.1. To what extent is the ACCESS QI approach improving the availability and accessibility of quality health services to Malagasy communities in targeted regions?

The ACCESS program improved the quality of health services and the continuum of care in Madagascar, resulting in increased availability of and accessibility to health services at the community level (i.e., commune and district). Through clinical capacity building of CSB staff and CHVs, along with supportive supervision, quality health services were more available. Before the ACCESS program, community members commented that CSB staff were often unavailable, unwelcoming, or provided inadequate care. Overall, FGD participants noted that improvements made during the ACCESS program positively changed their healthcare experience at the community level, as illustrated in the following quotes:

> *Change is happening, especially in healthcare because many people are going to the hospital. Even with a minor illness, people are already going to the health center. Many women are also coming to the health center and getting checked. Part of the reason for these changes is the [FP] by-laws put in place; people are also more interested… There is also the sensitization done by the CHVs. As for vaccines, people are actively getting vaccinated since 2018.* (FGD, Fathers, Vatovavy Fitovinany)

> *We can see that they take good care of us whatever the illness. Before, when the illness was not serious, we referred to [the district hospital]. However, since their arrival, we only refer to [the district hospital] when we don't know what to do with the disease. When we are very sick, they give us rooms and we stay in the hospital, they treat us well and take all the responsibilities, not as before when we are sick…They only refer the cases they cannot solve.* (FGD, Mothers, Vatovavy Fitovinany)

These were years in which people were very enthusiastic about going there [the CSB]. As soon as you get sick, you're very motivated to see the doctor even when you're about to give birth. So the enthusiasm of people to go to the health centers has really increased. (FGD, Mothers, Vatovavy Fitovinany)

Similarly, improvements in quality of care at CSBs had increased access to and use of health services. Before ACCESS, community members noted a greater preference for seeking care from traditional healers or private hospitals. However, in the sample quotes from FGDs below, improvements in quality had prompted a change in health seeking behaviors:

Before, we used to go to the traditional midwives to give birth, we only went to hospital when there was a complication, but for the past three years, we have started to go to the hospital to give birth. (FGD, Fathers, Atsimo Andrefana)

Despite traditional medicine, people start to go to health centers. People start to be convinced. Positive changes are observed, but very slowly. (FGD, Community Groups, Boeny)

The findings from FGDs were reflected in the PMP indicators. Table 3 presents a snapshot of PMP indicators showing positive progress from FY20 to FY21 in such areas as malaria and pneumonia treatment for young children, new modern contraceptive users, antenatal care (ANC) visits, and women giving birth at the health facility (albeit a small increase), and decreases in the maternal death rate at both the CSB and district hospital levels.

Table 3. Illustrative indicators from ACCESS program PMP showing positive progress

Indicator	FY20	FY21
Percentage of children under 5 testing positive for malaria who are treated with artemisinin-based combination treatments (ACT)	84%	92%
Percentage of children under 5 suspected of pneumonia receiving antibiotics by trained facility workers or CHVs in US Government-assisted programs	89.4%	91%
Number of new modern contraceptive users	545,048	686,612
Percentage of pregnant women attending at least 4 ANC visits with a skilled provider	36%	42%
Percentage of women giving birth in a health facility receiving US Government support	36%	37%
Maternal death rate (per 100,000 live births) - CSB - District hospital	 56 996	 31 951

ACCESS QI approaches, including a more people-centric approach to care, were specifically mentioned as resulting in better reception and management of patients at the CSB, and encouraging an increase in the use of both CHV and CSB services, especially for ANC visits, as illustrated in the KII quote below:

I have experience with those procedures which involve humanized ANC, that is to say, the way or method of receiving clients until they leave the CSB. The conditions of reception, including the equipment and medicines, and the management tools are fully met to receive the patients. A big change has been noticed, because when we were still trainees, we did not receive such training from the midwives. Now, we know how to behave well in front of pregnant women. It concerns childbirth and the ANC. We changed our communication toward the customers. We often heard that the midwives are very mean [behavior and attitude]. The population fears them and pushes them to not attend the CSB. It particularly [this] concerns the older midwives. Nevertheless, after this training, we have changed our behavior and the way we talk. (KII, Malagasy Government, Atsimo Andrefana)

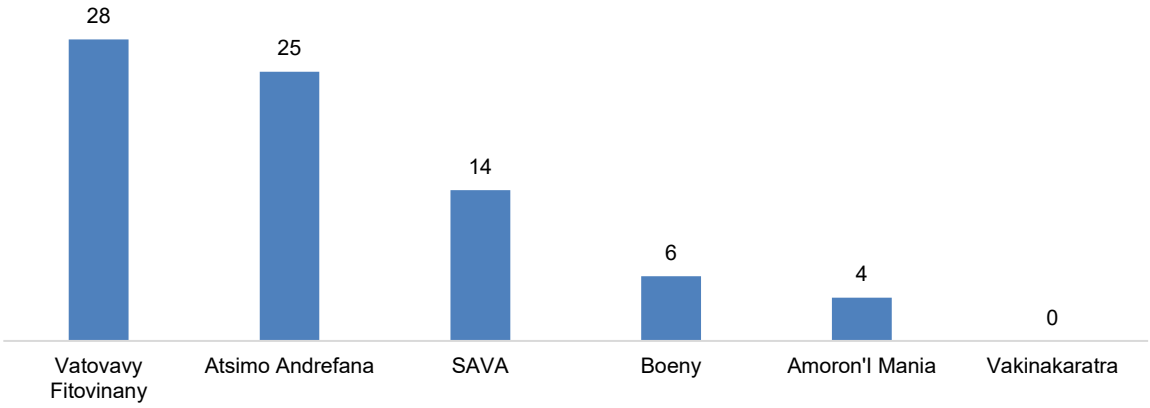
Capacity building of CHVs had enabled them to play an important role in increasing access and use of care through sensitization about the availability of CSB services. As of FY22, there were more than 17,500 trained CHVs almost equally split between men and women. The following FGD quote illustrates their important role:

What I know about CHVs: [They are] the hospital ambassadors at the community level. They do the work of the healthcare workers, a kind of representative of the doctors and midwives, the intermediaries between the healthcare workers and the population. They are the bridge that connects them. (FGD, Father, Atsimo Andrefana)

Taken together, these findings indicate that QI approaches, such as the humanization of care, were effective alongside sensitization and referral activities by CHVs, and as noted in the following KII quote, were perceived as increasing attendance at the CSB:

Before, the attendance rate of people in the CSB was 50 percent. Then it reached 70 percent in a month. The number of ANC visits was around 140 when I came here but now we have more than 170 ANC visits per month. Last year, I already found 200 people in one month…people feel well treated and this improves their motivation to attend the CSB. (KII, Malagasy Government, Atsimo Andrefana)

Figure 5. Number of coded excerpts on "increased accessibility" of healthcare services in KII and FGD interviews, by region (total excerpts=77)



Improvements in accessibility were not always uniform across the regions/packages included as data collection sites in the evaluation. As seen in Figure 5, many coded excerpts about increased

access to care came from Vatovavy Fitovinany and Atsimo Andrefana (full package—clinical capacity building except WASH) and were equally split between male and female participants.

A somewhat more negative tone was expressed about the availability and accessibility of quality healthcare from FGD participants in the Boeny region. Noted challenges related to the quality of health services and their affordability, and were cited as reasons for a reluctance in healthcare seeking behaviors, as highlighted in the following quotes:

> *There is also the non-examination of the patient, concerning the diagnosis of the illness… then the doctor prescribes the medicines right away when he should at least look at the blood pressure, temperature, and others… it's bit sad when we go to the CSB*. (FGD, Mothers, Boeny)

> *The care of mothers and children is not correct. When the care cannot be done here, she is forced to fend for herself, so many people die. If she is taken to X or Y [district hospital locations], the treatment requires a certain amount of money. Often, some die in childbirth, they do not reach the facility because of financial problems.* (FGD, CHVs, Boeny)

During the validation of the midterm evaluation findings, the ACCESS program team discussed that specific ACCESS program activities had started later in Boeny because the region was previously managed by *Mahefa Miaraka* and transitioned over to ACCESS.[22]

EQ 1.2. Which of the ACCESS implementation approaches appear to be the most promising and should be prioritized? For those that are not showing promise, what alternatives or complementary options should be considered?

Promising Approaches

The ACCESS logical framework focuses on expansion and improvement of health service quality and an integrated continuum of care. This is achieved through clinical skills building at CHV, CSB, and district hospital levels; strengthened referral systems; infrastructure improvements (including WASH in some locations); mobile care and outreach; and access to emergency transport. Promising approaches mentioned by interview participants are detailed in this section.

Clinical Capacity Building

As noted in the previous section, the ACCESS QI/quality assurance approach included clinical capacity building of CSB staff and CHVs in such health areas as MNCH, malaria, FP, and vaccination. In addition, healthcare providers received training on service quality, including the humanization of care, data collection and reporting, and CSB standards. Training included guidance on how to complete immunization and FP forms ("bac à fiches"), patient intake and management, performing ANC procedures, and completing reports. This increased clinical

[22] Regions formerly supported by the Mahefa Miaraka project participated in clinical capacity building for the first two years with community activities (full package) added in 2021.

capacity also allowed CSB staff to care for patients that they were previously unable to treat and to provide better quality services.

A KII participant noted this improvement in clinical capacity as a cornerstone of the ACCESS program in the following quote:

> *Yes, there have been changes in terms of quality. For example, there has been improvement in filling out management tools, such as the EPI and FP form. Change and improvement in quality also relates to supervision. In addition to improvements in filling out management tools, reception and disease management have also improved.* (KII, Malagasy Government, Antananarivo)[23]

Figure 6. Number of coded excerpts on "capacity building," by region and health area from KII and FGD interviews (total excerpts=127)

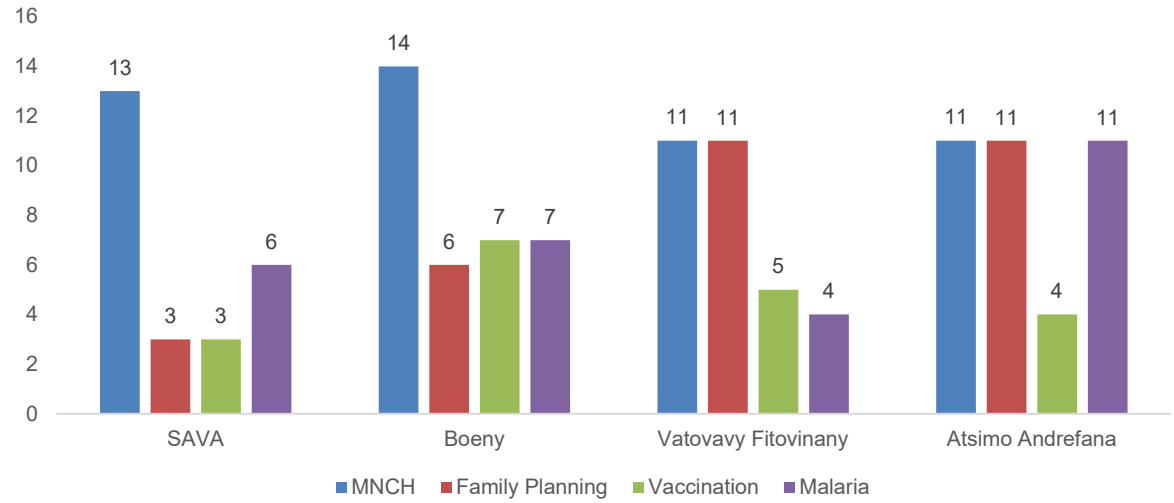


Figure 6 shows the number of excerpts on capacity building, disaggregated by region in full package plus WASH and full package regions, and by health area. Capacity building was referenced extensively and nearly to the same extent in all four regions. Across the KIIs and FGDs, Atsimo Andrefana and Boeny had the two highest instances of application of the capacity building code (37 and 34, respectively). The prominence of capacity building in these two regions is logical given that both areas were lower performing in terms of MNCH indicator performance. Given ACCESS's programmatic focus, it is not surprising that many of the excerpts on capacity building co-occurred with MNCH or FP.

Although clinical capacity building was perceived as effective in improving the quality of health services and increasing the availability and accessibility of healthcare in communities, the concentration of capacity building activities was not universal across implementation regions. Moreover, participants expressed a desire to repeat the training for new staff and for refresher training for current staff. In addition, clinical capacity building was most effective in CSBs where

[23] EPI = Expanded Programme on Immunization and FP=family planning

staff who had received training from ACCESS (most of the time, the head of the CSB) effectively trained other CSB staff in the same areas. These sentiments are reflected in the KII quotes below:

> *ACCESS implements targeted training, with participants selected based on CSB staff skill level. This approach is effective, but I would recommend that all staff be trained, especially new staff. I would propose criteria for participant selection, such as newly recruited staff and the number of inhabitants served by the CSB, because some indicators are population dependent.* (KII, Malagasy Government, Vatovavy Fitovinany)

> *Before the ACCESS program…the health workers were very mean and this behavior or attitude toward the patients led to psychological disturbances [stress, fear]. Thanks to the training provided, this entire disturbance no longer exists. Before, the CSB chief didn't share knowledge. There is no longer skill transfer…but with the program's initiative, the transfer of skills between the CSB leader and the second care provider occur automatically*. (KII, Malagasy Government, Atsimo Andrefana)

Training and the cascade approach or sharing of knowledge was not always consistent or did not always involve the right people, as described in the following FGD quotes:

> *We could be competent, but the training is insufficient, there has been no training for a long time, the work [has] increased, that's what makes us complain*. (FGD, CHVs, SAVA)

> *On capacity building, there is generally an additional training for trainers, but I have not been trained. On MNCH, for instance, I did not myself understand what the midwife was saying at the time of the evaluation. I was surprised to see the checklist. My conclusion is that the CSB Head should always be involved in the training of service providers because sometimes this provider may find it difficult to share what he or she has learned. And it is always the CSB Head who is evaluated*. (KII, Malagasy Government, Atsimo Andrefana)

Improved equipment and CSB infrastructure

As a part of the ACCESS QI approach, the program team provided equipment to both CHVs and CSBs, and infrastructure improvements in regions covered by the full program package and full package plus WASH sites. According to the year 1 annual report, ACCESS initiated efforts to strengthen the work of 1,620 CHVs through the provision of equipment and supplies and monthly group supervision in 22 EMAD in three full package regions.

For CSBs, KII and FGD participants noted the provision of medical equipment, such as scales and beds, and infrastructural changes, including for latrines and drinking water facilities. For example, in year 2, the annual report noted that 22 health facilities were rehabilitated, and in year 3, a $4.5 million donation of medical materials and equipment. The following FGD and KII quotes illustrate how these activities contributed to perceptions of improved quality of care and health infrastructure:

Since ACCESS has existed, the CSB has had materials, beds…the CHVs too. I would [also] like to say that ACCESS must strengthen their equipment for the CSB and for the CHVs, so we can fight diseases. (FGD, CHVs, Boeny)

[ACCESS is] improving quality through the provision of supplies and materials—masks, handwashing devices, tables, etc., and infrastructure, such as latrines and drinking water facilities. (KII, Malagasy Government, SAVA)

Participants recognized that health services were more complete and that CSBs were furnished with essential equipment and improved facilities. One participant described this improvement in terms of better facility setup and cleanliness:

The cleanliness of the hospitals; previously there was one room to receive the patients, but now there is a room for each fokontany. The hospital is well fenced in and must be cleaned every day. (FGD, Mothers, Vatovavy Fitovinany)

Although improved equipment and CSB infrastructure were documented as a promising approach, increases in the volume of patients seeking services and requirements for facility upkeep also had budget implications. Participants commented on persistent challenges at CSBs and discrepancies in infrastructure improvement implementation, with poor CSB structures insufficient to adequately provide care for patients. Moreover, doctors, nurses, and CSB staff still lacked certain materials to provide quality care, as described in the quotes from patients below:

P1: For us here in X, it's a question of water, it's a question of pumps. The hospital is now without water, when I gave birth to this child, there was really no water in the hospital. P2: For me, it's like my friend said, the water issue is the main problem for us here. (FGD, Mothers, Vatovavy Fitovinany)

The materials are insufficient, that's why people go to private [healthcare providers]. There they think about earning money; they have all the materials, except the surgery. Here they can only use what they have. That's the way it is. (FGD, Mothers, Boeny)

In the FGD quotes below, community members from full package plus WASH regions included in the evaluation discussed continuing challenges with WASH infrastructure, despite this being a key component of the package:

Yes, that's right, the toilet block is classified as non-existent in the CSB. It is used by the CSB staff, but not by the patients. The patient should benefit from this sanitary infrastructure designed for them; but it is the opposite. The person in charge is the only beneficiary of the toilet and the shower; he locks the door. The others manage elsewhere. I was already a victim, we were going to have a meeting and I took my child; the midwife's husband shouted at me: "You can't pee there, do it elsewhere!" As such, other people can't access it, even sick people can't wash. (FGD, CHVs, Boeny)

In our health center, what we lack are toilets. The toilets are difficult. If people with diarrhea come in, the feces scatter around the health center. The health center should have toilets but they don't have any. We are having difficulties—what was built before is already in bad condition, so we ask for help from the state for this. (FGD, Fathers, SAVA)

Continuing challenges with WASH raised by FGD participants may reflect the staged rollout of WASH initiatives, which picked up speed in year 3, but was also delayed by COVID-19. According to the FY21 annual report, a WASH workplan for the seven northern regions was agreed on with the MOPH and the Ministry of WASH, and multiple workshops were held on sustaining WASH services at health facilities, with engineering consultants deployed to monitor WASH construction work. ACCESS started training health workers in *Formation Sanitaire Amie de WASH* (WASH-friendly health training), with the development of actions plans and follow-up for certification. In addition, hygiene committees were either set up or restarted at 163 of 205 CSBs covered by ACCESS. Maintenance and small repair of WASH infrastructure was performed as was latrine and water point construction. However, this pervasive problem of WASH infrastructure remained a challenge, with the FY22 Q1 report noting that a lack of WASH budget was a main concern for CSBs. ACCESS-supported WASH technical assessments in Boeny, SAVA, DIANA, Sofia, and Analanjirofo indicated remaining needs in terms of water points, cleaning equipment, and potable drinking water.

Mobile clinics increasing access to FP, immunizations, and antenatal care

To further improve the accessibility and availability of health services, mobile clinics were employed to provide FP (in partnership with PSI), ANC, sexually transmitted infection services, vaccination services, health sensitization, and capacity building for CSB staff, especially for remote communities. This was noted as a promising approach in the following KII quote:

> *The most promising approaches include capacity building on maternal and child health [training, supervision, competency assessment] and mobile clinics for villages located far away from CSBs.* (KII, Malagasy Government, Antananarivo)

As of year 1, mobile clinics were operational in seven regions; this increased to 10 regions in year 2. In Q1 FY22, 8,690 women received care from the mobile teams, including FP services, such as implants, IUDs, and injectables. In some cases, according to the program document review, the number of consultations offered at mobile clinics surpassed those of the CSB in the same location.

KII participants also noted that mobile clinics contributed to an increase in vaccination rates, as seen in the following quote:

> *There was an improvement at the CSB II level and at the community level. At the CSB II level, regarding the vaccination program, the ACCESS program [mobile clinics] have made it possible to implement an advanced strategy.* (KII, Malagasy Government, Atsimo Andrefana)

Overall, according to FY20 and FY21 annual reports, vaccinations provided by mobile clinics increased with visits made across 10 regions; 3,270 tetanus-diphtheria vaccines were provided to children and 313 to pregnant women during mobile clinic ANC visits. The quote above may also reflect specific vaccination and ANC follow-up efforts conducted in 22 districts in

Atsinanana, Atsimo Andrefana, and Atsinanana, resulting from supervision visit data reviews with CHVs.

However, FGD participants also noted that COVID-19 vaccine hesitancy remained, because a community member explained that they were unwilling to attend mobile clinics, afraid of being forced to receive a COVID-19 vaccine:

> *In the health sector, when there are 4x4's passing by or when there are several strangers on the way to school, parents do not send their children to school on the pretext that there are vaccination activities at school. Parents don't go to the CSB, when something happens, because they think that once there, they will be forced to get vaccinated when they don't want to get vaccinated. This is a big obstacle and since then, several illnesses have emerged, because there is a lack of care due to the fact that they self-medicate and then die.* (FGD, Mother, Boeny)

Challenges

Continued use of traditional healers; preference for private providers

Despite efforts to encourage the population to seek healthcare services at the CSBs, the continued use of traditional healers was mentioned in multiple regions. In addition, as illustrated in the quotes below, private providers were sometimes preferred, furnishing more affordable care or better payment options. Because these quotes represent qualitative data, they cannot fully describe the situation in the entire region; however, in 2021, in Mahajanga I district, the capital of the Boeny region, the rate of CPN1 [1st prenatal consultation] was 70 percent (national target 62%), whereas the rate of CPN4 [4th prenatal consultation] was 67 percent (national target 45%). Moreover, the rate of deliveries at health facilities was 49 percent (national target 39%).

> *Actually, women here still rely on traditions, they go to the traditional midwife and trust them. Decoctions and traditional medicine still play a significant role, so few women go to health centers.* (FGD, Mothers, Boeny)

> *Q: Why do you go to a traditional healer? Mother (P8): It is due to lack of money*
> *Q: Why else don't they see the doctor? Is that all? Mother (P8): It may be due to distance, remoteness as well, therefore, they do not come to the CSB.* (FGD, Mothers, SAVA)

> *Also, the patients don't come here when they don't have money, they just give paracetamol and others when you don't have money, they don't accept credit, while at the private ones, they accept credit and they really take care. They give the medicines. Here, they only give the prescription and the pharmacy does not accept to give free medicines. We have to pay right away even though we have no money and we still have to wait for the Wednesday market to be able to sell products. Whereas the freelance doctors accept credit and people go there when it is an urgent matter.* (FGD, Mothers, Boeny)

> *The continued use of traditional healers or preference for private providers may also be linked to perceptions that CSBs still lack adequate staff, equipment, space, and experience continued stockouts, as noted in the quotes below:*
> *The doctor is making efforts, but the little problem is the lack of medicines and*

materials, even if the doctor is skilled. Because of the lack of medicine and materials, patients are referred to X by calling the ambulance. The doctor detects the disease but the means are insufficient, so we prefer the care in X. (FGD, Fathers, SAVA)

At times, there are many patients and there is only one doctor. Some patients vomit, others have fever, "let's look at the temperature, and soak something in cold water." One doctor treats a whole community, but that is not enough. Sometimes, many patients arrive at the same time. He does not know what to do. The doctor can't neglect his work, but he follows steps. He checks the temperature, the blood pressure, he does the test. He spends about 15 minutes per patient, it is 15 min times 50 for example. It depends because there are times when he takes care immediately, he does not wait for the nurses for the administration of medicines because the illness is serious. The number of doctors needs to be increased because sometimes they have to deal with a lot of things. He takes care of thousands of people in the community. (FGD, Father, Boeny)

According to the FY21 annual report, the average stockout rate of tracer medicines across all delivery levels and ACCESS program regions was 10.6 percent, while the lowest average stock out rate t CSB level was 9.4 percent, and averaged slightly higher at 12.9 percent for CHVs. Although stockout rates at CSB level improved overall from FY20 to FY21, certain essential medicines showed increased stockout rates, such as misoprostol, which dipped to less than 3 percent stockout rate at both CSB and CHV levels in FY20 and increased to more than 12 percent in FY21.

Last, as noted earlier in this section, CSBs needed further WASH rehabilitation support.

EQ 1.3. How is equity (in access, use, and benefit) exemplified (specifically focusing on youth and gender)?

Gender equity

ACCESS interventions promoted improved equity in access, use, and benefit between genders. In year 1 of program implementation, ACCESS participated in the finalization of the National Policy for Gender and emphasized the monitoring of indicators disaggregated by gender and the integration of gender topics in SILC groups training sessions. Moreover, awareness tools for community mobilization by CHVs through home visits included key messages on gender. In another example, after the start of the COVID-19 pandemic, posters were produced and integrated on combating domestic violence during confinement. During KIIs and FGDs, participants acknowledged gender-equitable access to health services and quality of care at the CSB level. KII participants encouraged the continuation of gender-transformative approaches, such as targeting men with SBC interventions, to promote their participation in health-related decision making, as illustrated in the following KII quotes:

Both men and women now attend our center following awareness raising by ACCESS. Today, some men accompany their wives; it's something that was unthinkable before. (KII, Malagasy Government, Atsimo Andrefana)

> *[When asked about health service access] Yes, there are implications for men. For example, raising men's awareness so that they agree to accompany their wives during ANC visits and become involved in FP.* (KII, Malagasy Government, Vatovavy Fitovinany)

Youth focus

A review of ACCESS program documents highlighted initiatives focused on youth, especially at the community level, including youth savings clubs in established SILCs, developing Youth Corners in 22 schools in full package regions (year 1), and training of CHVs on adolescent health in partnership with the MOPH. At the national level, ACCESS contributed to the National Policy on Youth Health, hosted a youth workshop with the MOPH and the Ministry of Youth and Sports, and supported urban youth-focused social media efforts to raise awareness on FP, unwanted pregnancy, menstrual hygiene, and cervical cancer screening using a mobile app called TAFA or "*Tanora Filamatra Aho*".

When asked about youth-centered approaches, responses from KII participants were mixed. On the positive side, the program's youth focus was acknowledged, as noted by two different government stakeholders at the central level:

> *When I hear ACCESS, what comes to mind is youth health awareness activities.* (KII, Malagasy Government, Antananarivo)

> *ACCESS contributes to the improvement of youth's health thanks to their collaboration with the Family Health Directorate in the implementation of reproductive health for adolescents and youth.* (KII, Malagasy Government, Antananarivo)

However, youth services were also noted as needing renewed focus by a government stakeholder at the central level, whereas another KII respondent in the SAVA region commented that ACCESS interventions were less targeted toward youth and remained uniquely focused on women:

> *In my opinion, the ACCESS program has already identified its target beneficiaries, who include pregnant women and children under 5. Adolescents do not seem to be part of their priority targets…Awareness raising among the youth takes place only during the celebration of World AIDS Day, while they should have been mobilized a long time ago. ACCESS promotes equity; however, as the program targets women, men are barely seen around.* (KII, Malagasy Government, SAVA)

These qualitative data noting a lack of focus on youth contrasted with program documents reviewed for the evaluation, where efforts targeting youth were highlighted, especially in terms of Objective 3—SBC activities. As of FY22, youth ages 10–19 represented 31 percent of new contraceptive users; there were 3,328 youth champions trained across the 14 regions; and there were continued efforts to establish Youth Friendly Corners in schools (*Tanora Filamatra Aho*) and Youth Friendly Health Centers.

Geographic equity

A small number of participants expressed perceptions of inequity about ACCESS program implementation. One KII participant noted that certain CSBs received more support, including monitoring and supervision visits by ACCESS staff, as illustrated in the following KII quote:

> *At the CSB level, ACCESS does not provide the same level of support to CSBs. Some CSBs receive frequent visits from the program, such as X CSB, while others don't; therefore, there is no equity.* (KII, Malagasy Government, SAVA)

EQ 1.4. Has ACCESS improved health service access and coordination? If so, in what ways? Is there room for improvement, if so, how?

Coordination and continuum of care, starting with CHVs

ACCESS has facilitated improved coordination among key stakeholders, especially between CHVs and CSBs/CHRD and government counterparts, through annual workplans and regular meetings. The planning of activities has facilitated the effective implementation of program activities, as described in the KII quote below:

> *The involvement of central, regional, and district-level managers or technicians through ACCESS has improved coordination. The ACCESS team always consults with the central level for any activities to be implemented, such as the organization of training sessions, periodic reviews, or the development of workplans at all levels.* (KII, Malagasy Government, Antananarivo)

ACCESS has also facilitated an improved continuum of care at the community level with CHVs as the essential starting point. Through clinical capacity building, CHVs can provide better and additional basic healthcare services and monitoring, such as providing certain medicines, conducting malaria rapid tests, and monitoring pregnant women's health and children's vaccinations. This improved clinical capacity has expanded healthcare access for communes that are distant from CSBs, as described in the FGD quote below:

> *The community finds that it is progressing because the communities where the CHVs work are 7 or 3 km from a CSB. The advantage they have found is education and care in the community without going to the CSB.* (FGD, CHVs, SAVA)

The CHVs are the foundation of the care continuum, encouraging community members to attend the CSB for regular checkups, ANC consultations, and vaccinations, and to receive care for more complicated illnesses through referral. This role is described in the following FGD quotes:

> *The existence of the CHV mitigates the disease, because the CHV carries out a home visit, they visit every household and transfer to the CSBs, that pregnant women should not give birth in a [traditional] midwife's house. They also sensitize women to carry out prenatal consultations and to get children under the age of five vaccinated.* (FGD, Fathers, Atsimo Andrefana)

> *Everyone has their own responsibility…if the child is under 5 years old, he is first taken to the CHV, and if the CHVs are unable to treat him, he is transferred to the CSB to continue his treatment.* (FGD, Fathers, Atsimo Andrefana)

This is also a standard in the FFSDP approach—the health facility identifies which CHVs were involved in actions related to emergency transport and those who were not.

Through ACCESS, the continuum of care between the commune and district level has also improved. According to the FY21 annual report, 4,667 fokontany (48%) had an operational emergency transport system or medical evacuation system.

In terms of referral, participants discussed the process of receiving a letter of referral to seek care at the district hospital for more challenging cases. Data on referrals from the program document review highlighted the use of referral and counter referral (RCR) cards from CHVs to the CSB in three regions using CommCare[24], with 2,730 (56%) cases with completed referrals and 99.37 percent cases of counter-referral back to the CHV.

In general, participants had positive impressions of the referral process and noted that referrals contributed to successful deliveries and resolving complicated health challenges. This is illustrated in the FGD quotes below:

> *If a woman has complications in childbirth and they have already done everything they can, they will refer the woman and monitor her. They give a letter of transfer and the family comes along. It is like the case of a fracture, we are obliged to go to [the district hospital].* (FGD, Father, Atsimo Andrefana)
>
> *We were referred when my wife gave birth. We had stayed 2 days at CSB2, we were then given a letter and we were sent to X [district hospital]. When we arrived in [the district hospital], the letter was presented and we were well received.* (FGD, Father, Vatovavy Fitovinany)

Although the referral process worked in many areas, there were still challenges regarding the continuum of care, especially at the district level. First, many participants stated that access to care at the district level was limited due to financial issues. Some FGD participants also perceived that the cost of district hospital care and transport was too expensive and many (as a result), refused care.

> *The impact of the lack of transport to the CSB is the delay, ACCESS does not subsidize transport to the CSB. The negative impact is also the lack of transport for patients to transfer to the district hospital* (FGD, CHVs, SAVA)
>
> *Yes, they gave us a letter so that we could go, but when we don't have the means, we looked for other solutions not to go. If we go, we don't know the way with the illness that we have. So we went to a free doctor who cured the patient.* (FGDs, Mothers, Boeny)
>
> *It depends on the person's finances. It's not possible to do it if there is not enough money because it is costly to transport the referee.* (FGD, Mothers, SAVA)

[24] CommCare is an mHealth application used by CHVs for reporting data.

In addition, transportation to the district-level facility was often limited due to the availability of public transportation and the condition of the roads. In cases of emergencies or during the night, this was a limiting factor in the continuum of care, as illustrated in the following quote:

> *There is room for improvement in the area of emergency transportation. It is a bit difficult to implement [in cases where a person is sick but the motorcycle cab is not available], therefore, I think it needs to be standardized because the RCR will depend on transportation, even if the RCR form has already been filled out by the CHV. This means that the program should design and institutionalize an emergency transportation system adapted to the community: in a riverside locality, provide an exclusive emergency dugout canoe; otherwise, provide a converted bicycle [equipped for the transportation of a patient]. These types of systems would first be used in the three communes and would serve as models, and later on, be replicated in the other communes/fokontany*. (KII, ACCESS Staff, SAVA)

KII and FGD participants spoke of persistent challenges, especially for CHVs, including a lack of adequate materials and resources to sufficiently reach the population, notably inconsistent stocks of medicine, but also bicycles or other forms of transportation. Moreover, as described in the FGD quotes below, their status as volunteers without compensation was understood as a challenge, potentially limiting their motivation or time/capacity to meet the needs of the community:

> *What is the capacity of the CHVs to take care of patients in their neighborhoods, especially concerning materials, such as RDTs [rapid diagnostic tests], malaria treatment, and diarrhea? For medicines, we don't have a depot, we raise awareness, but they do not come thinking about the distance. If there was a depot for the CHVs, we can help if it is a disease that could be taken care of by the CHVs*. (FGD, CHVs, Boeny)

> *This is causing a change because the knowledge is associated with the materials they have distributed, the knowledge is increasing, but it is the lack of medicines that prevents us from doing our work and we are forced to send them to the CSB. Because we don't have drugs, we don't have tests.* (FGD, CHVs, Boeny)

Taken together these results indicate improvements in the continuum of care, and especially the important role of CHVs in facilitating this continuum; however, remaining challenges were also identified. It should be noted that cost and transportation issues at the district level were somewhat outside the scope of the ACCESS program. As such, attention should be given to supporting the CHV role as the starting point of care at the community level.

EQ 1.5. To what extent has the ACCESS program contributed to national-level policies and guidelines on health service delivery?

ACCESS has made significant contributions to national-level policies and guidelines through its participation in policy development and national consultation meetings and the dissemination and reinforcement of policies and guidelines translated into practice at CSB and CHRD levels.

Most recently, ACCESS supported the National Policy for the Training of Health Workers, workshops on Madagascar's National Community Health Policy, and the development of

training guidelines for CHVs. Previous efforts contributed to the National Health Promotion Policy and National Strategy to Strengthen Community Health.

At district and commune levels, ACCESS disseminated and translated policy and guidelines into action. For example, to increase the appropriate use of misoprostol by CHVs, ACCESS disseminated and provided training on MOPH policy and standard operating procedures. ACCESS's role in this dissemination and reinforcement was positively mentioned in KII interviews with government counterparts in SAVA:

> *ACCESS provided assistance to the DRSP team in the compilation and updating of national policy documents [IEM, PGE, PDSS, etc.]. All health staff are now aware of new updates and the recommendations related to these guidelines.* (KII, Malagasy Government, SAVA)[25]

> *ACCESS contributes to the implementation of the health service delivery policy, for example through the implementation of PCIMEC[26] and training on the use of misoprostol for hemorrhage prevention. We have also received job aids on how to use artesunate suppository, but we have not had the drug yet.* (KII, Malagasy Government, SAVA)

[25] DRSP = Direction Régionale de la Santé Publique (Regional Directorate of Public Health); IEM = Initiative Emergency Madagascar ; PGE = Politique Générale de l'Etat (general state policy); PDSS = Health Sector Development Plan

[26] Integrated management of childhood illness at the community level.

Evaluation Question 2: To what extent did ACCESS implement a capacity building approach and how effective has it been?

The ACCESS capacity building approach follows a series of steps that aim to sustainably reinforce capacities at all subnational levels by increasing clinical, organizational, and leadership capacities. This includes facilitating training with a practical skills component, completing a formative follow-up to assess skills and make corrections, and training of trainers to continue this process at the district and commune levels. As part of this process, ACCESS established regional and district-based skills labs to provide the necessary space and tools to conduct training and skills evaluations.

Based on the quantitative and qualitative findings, ACCESS has contributed to the following results:

- Improved capacity among CSB staff and CHVs through various approaches, including clinical capacity building, cascade training, and follow-up field visits.
- Graduation approach dashboard data used to identify promising districts in terms of ehealth performance indicators.
- Improvement in data quality through RDQAs, including completeness, timeliness, and accuracy.

These results are described in further detail in the sub-sections below.

EQ 2.1. To what extent have capacity building initiatives for MOPH actors been implemented at the subnational (district) level? How appropriate is the capacity building approach and has it been conducted with appropriate frequency? In what areas has the capacity building approach been most successful?

Overall, the provision, uptake, and adoption of capacity building initiatives was a cornerstone of the ACCESS program across all 13 regions, albeit one that will continue to be rolled out into FY23 due to COVID-19 delays. In high-performing districts, success factors for QI with CHVs included the LDHF approach's consistent focus on training and improving the abilities of low performing CHVs and their associated CSBs. It was also promising that CHVs were (re-) evaluated and provided with additional training and onsite supervision, as needed.

Clinical capacity building for CSB staff and CHVs

Clinical capacity building started in year 1 with the provision of training and other capacity building on the basic package of health services in all 13 regions, ensuring that all health providers had the same basic level of skills and knowledge. Health themes included maternal and newborn essential care, malaria, nutrition, vaccination, FP, infection prevention, and RCR. ACCESS started by focusing on three regions and collaborated with the MOPH, the program's consortium, and other partners to refine the existing community health strategy (PNSC-National Community Health Policy), including the hiring of *accompagnateurs en santé communautaires* (ASC; community health coaches) and *aides cliniques* (ADS; clinical aides), who were paid by ACCESS to provide supportive supervision to CHVs. In addition, new

approaches to malaria management were introduced, including the use of rectal artesunate capsules for pre-referral treatment of children with severe malaria and other training topics, including integrated health, IMCI, and immunization, especially related to measles outbreak response campaigns. ACCESS focused on the improvement of ANC referral rates and referral of pregnant women to give birth at a health facility.

In year 2, the CHV-focused community AQS approach was finalized to work with CHVs and *Comités de Santé* (COSAN; village health committees) to review data, locate users experiencing service interruptions, and observe and improve CHVs' technical skills using the LDHF training approach every three months, and to evaluate performance.. The LDHF approach was noted by one KI as effective but also time consuming to achieve full coverage of all CSBs:

> *The approach used is a classroom workshop combined with skills validation and supervision. This cycle, known as LDHF…is most effective in safe motherhood, FP, EPI, and malaria management. This technique shows promise for all programs…except for the duration of implementation, because our Service de District de Santé Publique [SDSP; District Public Health Unit] has 40 CSBs…the frequency of this approach is every three months, [i.e., only four times in one year].* (KII, Malagasy Government, Vatovavy Fitovinany)

In year 3, a CHV classification system was finalized by the DSSB defining three categories of CHV: (1) basic MNCH promotion; (2) essential package (i.e., FP injectables and support in IMCI);[27] and (3) the specific package, including all activities. A total of 12,370 CHVs among 16,810 across 10 regions (73%) were assessed as polyvalent. In addition, supply chain management responsibilities were reinforced with the ASC and ADS, especially around the prompt completion of order forms to signal a stockout. Health personnel from hospitals and CSBs participated in Alliance for Innovation on Maternal Health (AIM) training, and CSB staff participated in FP training (including for IUD insertion). On-the-job training was provided by mobile clinic staff. Coordination on vaccination activities also took place, including the COVID-19 vaccine, and there was training on adolescent and youth health.

Last, as of year 4, training and capacity building continued, along with the AQS approach and further expansion of skills, such as additional training on the provision of FP injectabless and pregnancy testing kits and the use/optimization of CommCare to report community-level surveillance data and to generate alert messages (SMS) for emergency health situations, such as a sudden increase in deaths or reported disease. Health staff benefited from training on maternal and neonatal death reviews and Emergency-Triage-Assessment-Treatment training.

During KIIs and FGDs, the improvement in clinical capacity through the ACCESS program was described as including training, monitoring, and the provision of resources to CHRD, CSB staff, and CHVs. Training topics mentioned during interviews included patient intake, immunization, and FP, and guidance on the completion of forms and data collection/reporting.

[27] Integrated management of childhood illness

ACCESS capacity building and the QI approach with CHVs also included resources to provide care in the community for basic health services. CHVs received training and materials on FP, vaccination, and malaria, which helped expand access to services, especially in areas located far from the CSB. The important role of CHVs and the materials to support their competencies are described in the FGD quotes below:

> *He [the CHV] treats the illnesses of children less than 5 years of age because he has received training on these illnesses. He has medicines. Apart from these cases, if he has not received training; he gives us a letter and refers us to the CSB.* (FGD, Mothers, Atsimo Andrefana)

> *The existence of books makes our work easier. We have not studied medicine but it is in the book: how malaria is transmitted, how malaria manifests itself, and when you give such and such medicine or when you go to the doctor, and the person is cured.* (FGD, CHVs, Boeny)

Cascade training to develop practical skills

ACCESS established a pool of trainers (*Bureaux Régionaux de Formation* [BRF; regional training offices]) at the regional and district levels who were responsible for training healthcare providers. The training of trainers allowed capacity building efforts to expand at the subnational level. Healthcare service providers who received training were typically CSB chiefs or second-in-command, who were expected to train CSB staff and CHVs on the skills they had learned. This cascade approach ensured that healthcare providers at all levels could receive the training they needed. Participants found that this training with follow-up skills assessment were highly useful, as illustrated in the following KII quotes:

> *All capacity building initiatives on maternal and child health started with the updating and validation of training curricula. This was followed by training of trainers for MOPH and ACCESS teams, and the training of EMARs/EMADs who will in turn train healthcare providers*. (KII, Malagasy Government, Antananarivo)

> *MOPH agents' capacity strengthening was implemented at the subnational level by the creation of a trainers' pool [region and district] who will train the stakeholder [Chief of CSB and the second agent] in two waves. Formative follow-up is done six weeks after the training and skills evaluation is done four weeks after the formative follow-up to assess the capacity of the agent.* (KII, Malagasy Government, Boeny)

However, as mentioned earlier under EQ 1.1, participants identified as a challenge that those who received training from ACCESS, specifically the CSB heads, *had not* passed on the training learnings to other CSB staff, especially for new CSB staff who had arrived after the training.

Therefore, participants recommended that training should be prioritized for *all* CSB staff, as illustrated in the following quotes:

> *As for the health personnel, in relation to capacity building, there are those who benefit and others who do not because the number is limited. For example, among the three midwives who perform ANC and deliveries in our CSB 2, only one midwife is supported by the ACCESS program during capacity building. Thus, the providers' skills are not the same. There are also some community agents who have*

received training while others have not. (KII, Malagasy Government, Vatovavy Fitovinany)

This training is not very effective because the CSB chief had to transfer competencies to providers. Examples include the resuscitation of the newborn; skills transfer [is needed] to midwives who will have to do the tasks. (KII, Malagasy Government, Boeny)

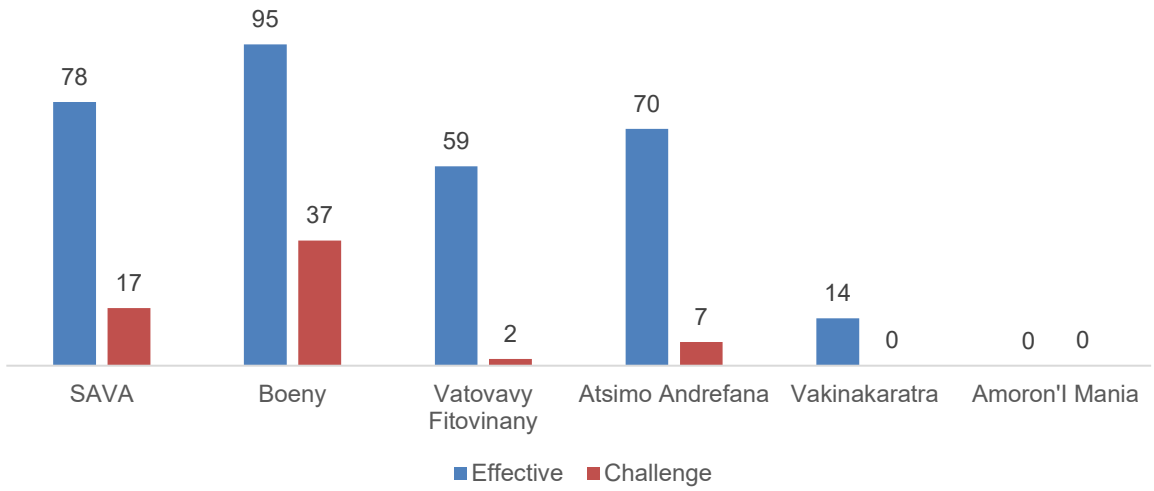
Field visits to CSBs

EMARs/EMADs conduct field visits to CSBs to carry out supervision and skills validation after training. This was described by an ACCESS field staff member as assisting service personnel to learn on the job and make changes:

During our visits to the health facilities, we noticed the lack of supervision. Some did not report data, others did not follow the protocol or did not work, altogether. It is through supervision that the results have improved. Supervision will be a priority in 2022. Training will also be provided to newly assigned personnel or new recruits in 2022. (KII, ACCESS Staff, SAVA)

KII and FGD informants expressed positive perceptions about the efficacy of capacity building approaches. Figure 7 displays the number of excerpts on capacity building, disaggregated by region, and compares the number of times capacity building was discussed as effective with the number of times it was identified as a challenge. Overall, participants had positive perceptions about the efficacy of capacity building activities; however, participants from Boeny identified challenges more than those from other regions.

Figure 7. Number of coded excerpts on "capacity building," by region, effective vs. challenge, from KII and FGD interviews (total excerpts=379)



Challenges included the frequency of health personnel training and a continued lack of resources, especially due to COVID-19, as illustrated in the quotes below:

This capacity building approach was successful; however, it was not implemented with appropriate frequency. When COVID restrictions were removed, several training sessions took place at the same time or in a short period of time, unlike at

the beginning of the ACCESS program, where training frequency was appropriate because COVID did not exist. (KII, Malagasy Government, SAVA)

It would also be good to reintroduce the training courses because they have not been available for several years now, also since we forgot to ask for them. (FGD, CHVs, SAVA)

In addition, as shown in the following FGD and KII quotes, informants noted the need for continued training, reinforcement, and refreshers:

We have trainers [but it] is not enough. There are a lot of providers who need support. And if you are in the field, you understand that onsite reinforcement is better, because it is working. If you haven't mastered something, you learn it right away, otherwise we demonstrate it. And there are a lot of providers who need that support, butut the number [of trainers] is limited, as is their availability. That is why, with other approaches, for example, the TETU or AIM[28] have reinforced the hospital team. So, we even go to the hospital and it is at the hospital level that we will train the colleagues and finish this activity.[29] (KII, ACCESS Staff, Antananarivo)

Training has been conducted. And how many have been followed? You will see the difference. Sometimes there is no follow-up and what about validating skills? Sometimes there is not for a whole quarter. That's really saying something about the availability of people to conduct follow-ups. It's not all ACCESS; it's the [supportive supervision] team and separate trainers from the regional teams. And these are often the same people. (KII, ACCESS Staff, Atsimo Andrefana)

My point is that most of the time they do visits, but in a hurry. We've been doing this for over 10 years and we've come a long way, the prophets are not sacred on their land and we need support. We want them to come and see us often. (FGD, CHVs, SAVA)

Last, training sessions should target the right health worker, as described in KIIs:

This training is not very effective because the trained chief medical officer has to give the training back to the midwives who will have to do the work. So, you have to train those who are doing the work. (KII, Malagasy Government, Boeny)

Yes, one lesson learned is to involve all program managers in the upcoming training workshops. The problem is that there is only one facilitator from the central office. (KII, ACCESS Staff, SAVA)

FY21 data recorded 1,352 health workers trained according to needs identified by the EMADs. The training reached nearly three-quarters of all health facilities across the ACCESS regions. In certain regions (including Atsimo Andrefana), training and subsequent supervision efforts were delayed or reduced due to COVID-19. In addition, FY21 data showed that only 33 percent of CHVs were provided with supportive supervision from a public sector provider in the past three months due to delayed rollout of the community-level AQS approach, although these efforts picked up speed in Q1 FY22, increasing to 45 percent.

[28] AIM - Alliance for Innovation on Maternal Health is a QI approach.
[29] TETU - *Tobim-pahasalamana Tomombana sy mahomby* is a QI approach.

In summary, the importance of cascade training and follow-up field visits cannot be discounted, but there were insufficient personnel to conduct these field visits and to ensure the quality and timeliness of cascade training, with COVID also delaying rollout. ACCESS staff were addressing the issue. The most recent FY22 Q1 report noted that members of each region's BRF met to discuss the frequency and quality of supportive follow-up, including the use of checklists, dissemination of reference documents, use of remote training through e-learning and ACCESS U[30], and dashboards to better understand training needs.

Capacity building with CHVs

As noted in the previous section, ACCESS provided CHVs with training on community awareness raising and promoting healthy behaviors at the community level, including encouraging visits to the CSB. Training included a gender focus, with a promotional and advocacy video developed in year 1 and later integrated in CommCare, emphasizing the importance of a gender-sensitive environment in the workplace, at the community level, and in ACCESS activities. However, like informants at the CSB level, one CHV from Boeny expressed the need for more consistent scheduling of training sessions and support, as shown in the following quote:

> *… I am suggesting that capacity building of the CHVs and of all the groups of people who should benefit from such sessions of capacity building be made a priority in order to succeed in our efforts to communicate messages. Maybe that's why the messages are not always received by the community. That's why projects don't fully succeed: we don't know when [ACCESS and ACCESS-supported training] are going to come back .* (FGD, CHVs, Boeny)

EQ 2.2. What is the uptake/adoption of these capacity building efforts by district MOPH actors and what keys to success can be learned from high- performing districts?

As noted in the section above, high-performing regions embraced the LDHF training approach and noted the importance of targeted/focused implementation, based on performance data. One CHV also noted the equal importance of both material and moral support in the following quote:

> *For me, the material and moral support has encouraged me to work even more, even if it is voluntary. We won't become civil servants. We have to follow the trends, the technologies.* (FGD, CHVs, Boeny)

National MOPH coordination

Some national-level government stakeholders expressed concern about a lack of capacity building/QI coordination and partnership with the ACCESS program and that this may have affected a sense of government ownership, as illustrated in the following quote:

[30] An online learning module, which promotes self-learning for use by ACCESS technical staff, MOPH and health workers (CSB and CHRD).

Yes, it is good, but ACCESS should have worked with the Ministry. ACCESS was organizing so many meetings, workshops, and it was doing so on its own; it should have left some tasks with the Ministry. (KII, Malagasy Government, Antananarivo)

However, ACCESS staff and subnational actors both expressed concern about the capacity of the MOPH to provide adequate support to ACCESS-initiated activities in the future, as described in KI the quotes below:

We are sitting down and thinking about how we are going to help the department and help the structure of the department itself. The system has adopted these approaches and has the conviction and the will to continue, despite the fact that ACCESS is gradually withdrawing. That's the first big challenge—the availability of infrastructure, of health inputs. This has been a challenge. ACCESS has a department that really looks after the availability of management tools and CHVs. But still, with what is happening in the field, even if we train people, even if they are efficient, if the health inputs and materials are not available, it is still a big challenge. (KII, ACCESS Staff)

When the ACCESS program ends, the government will have to increase MOPH's budget because improvements depend on this. For instance, the Medical Inspecter cannot hold the review without a budget. The MOPH will not be able to recruit more staff without a budget, and we will be waiting on technical focal points for such recruitment. (KII, Malagasy Government)

EQ 2.3a. To what extent was the graduation approach implemented and what are the lessons?

The evaluation team worked with key ACCESS staff to modify this question into the following set of sub-questions:

- Is the graduation approach an idea that merits implementation in the last years of ACCESS? Is this something that will be useful?
- Will the graduation approach measures/indicators adequately quantify success/sustainability and ultimately graduation? Is something important missed?
- To what extent has ACCESS defined and chosen districts that are appropriate for the graduation approach? Is this a good path?

Overall, because of delays in finalization and rollout, full assessment for the evaluation was not possible. A question on familiarity with the graduation approach was included, but the KIs could not fully articulate information on the approach at the time of data collection for the evaluation.

Using program documents provided by the ACCESS team and DHIS2 data on the districts chosen to participate in the graduation approach, an initial (and basic) assessment of the approach indicated that it held promise, with appropriate measures/indicators chosen as well as locations. However, with full finalization of the approach, implementation must be prioritized along an accelerated timeline.

ACCESS identified 16 promising districts as qualified to be part of the graduation approach using criteria and indicators (from the program's PMP).[31] Although the top performing districts were chosen, ACCESS also prioritized the representation of each of the 14 regions among the first round of districts.

The graduation approach monitors results in relation to indicators grouped as follows: (1) health performance indicators; (2) institutional capacity indicators; and (3) community and social mobilization indicators.

At the time of this evaluation, the methods for scoring institutional capacity and community and social mobilization indicators were not available; therefore, the team focused on the health performance indicators. Data from the DHIS2 were used to understand trends in the 16 districts during the first three years of program implementation (2019, 2020, and 2021) and to compare their current status in terms of health performance with the MOPH's 2021 reference values.

The following health performance indicators were reviewed:

- CCR
- CPN1 coverage rate (CPN1)
- CPN4 coverage rate (CPN4)
- Delivery rate in health facilities (FB)
- IPT3 rate (intermittent preventive treatment of malaria among pregnant women) (IPT3)
- Rate of children under five years old with malaria treated with ACT (MAL)
- Diarrhea case management rate in children under five (DIAR)
- Pneumonia case management rate in children under five (PNEU)
- Penta3 vaccination rate at 12 months (PENTA)
- Newborn resuscitation rate—separately, because this indicator was only added in 2021

Data were extracted and shared by USAID from the DHIS2 platform.

Table 4 shows the districts with a positive trend (in green) in health indicator performance (9 indicators). In this analysis, a district was considered to have made positive progress when the observed value of the relevant indicator in 2021 was higher than in 2019. An increase of one point was considered meaningful, because, on average, the number of inhabitants in each district in Madagascar is estimated at 225,213; accordingly, even one percent of the population is a large number of people. When the value for 2021 was less than or equal to the value for 2019, the district was designated as non-performing (in red). However, when values fell between 95 percent and 100 percent, the district was designated as performing positively (in green).

[31] Mahajanga-I, Nosy Be, Brickaville, Toliara-II, Mananjary, Ikongo, Vohipeno, Vatomandry, Antanamabao Manampotsy, Befadriana Avaratra, Mampikony, Mahabo, Sainte Marie, and Sakaraha.

Table 4. Health performance indicators (9), by district and positive or negative trends for 2019 through 2021

16 Districts	# with positive trend	Nine health performance indicators Green = positive progress; red = negative progress								
		CCR 14/16	CPN1 12/16	CPN4 9/16	FB 10/16	IPT3 6/16	MAL 3/16	DIAR 13/16	PENU 13/16	PENTA 9/16
Mahajanga-I	5									
Nosy-Be	4									
Brickaville	7									
Tulear-II	5									
Mananjary	6									
Ikongo	8									
Vohipeno	6									
Vatomandry	6									
Antanambao Manampotsy	4									
Andapa	7									
Ambatomainty	7									
Befandriana avaratra	6									
Mampikony	5									
Mahabo	7									
Sainte-Marie	3									
Sakaraha	2									
Total number of districts with positive progress on 6 or more indicators, indicating likelihood of graduation	**9**									

The following are three illustrative examples from Table 4:

1. The CCR for Mahajanga-I was 58 percent in 2019 and 67 percent in 2021. As such, Mahajanga-I showed positive progress in terms of the CCR (in green).
2. The CCR for Befandriana-Avaratra was 38 percent in 2019 and 33 percent in 2021. As a result, Befandriana-Avaratra did not show positive progress in terms of the CCR (in red).
3. The DIAR in Mahajanga-I was 98 percent in 2019 and 97 percent in 2021. This district qualified as showing positive progress (in green).

More than half of the districts—nine of 16 (56%)—showed positive progress between 2019 and 2021 on six or more of the nine indicators. Nosy-Be, Sainte-Marie, and Sakaraha showed positive progress on four indicators or less. The most common indicators showing positive progress were CCR, DIAR, and PENU.

Table 5 shows the districts (in green) that achieved the reference value set by the MOPH for each indicator as of 2021.[32] A district was considered "on target" when the observed value was greater than or equal to the MOPH benchmark.

Table 5. Health performance indicators, by district and positive or negative values for 2021 compared with MOPH reference value

16 Districts	# indicators where reference value is reached	Nine health performance indicators Green = positive progress; red = negative progress								
		CCR 36%	CPN1 62%	CPN4 45%	FB 39%	IPT3 61%	MAL 99%	DIAR 90%	PENU 95%	PENTA 94%
Mahajanga I	7									
Nosy-Be	6									
Brickaville	5									
Tulear II	2									
Mananjary	6									
Ikongo	7									
Vohipeno	4									
Vatomandry	6									
Antanambao Manampotsy	4									
Andapa	4									
Ambatomainty	1									
Befandriana avaratra	5									
Mampikony	3									
Mahabo	6									
Sainte-Marie	3									
Sakaraha	3									
# of districts that achieved the reference value		**9/16**	**15/16**	**10/16**	**10/16**	**6/16**	**1/16**	**9/16**	**5/16**	**7/16**

[32] The reference value (%) is noted at the top of each column.

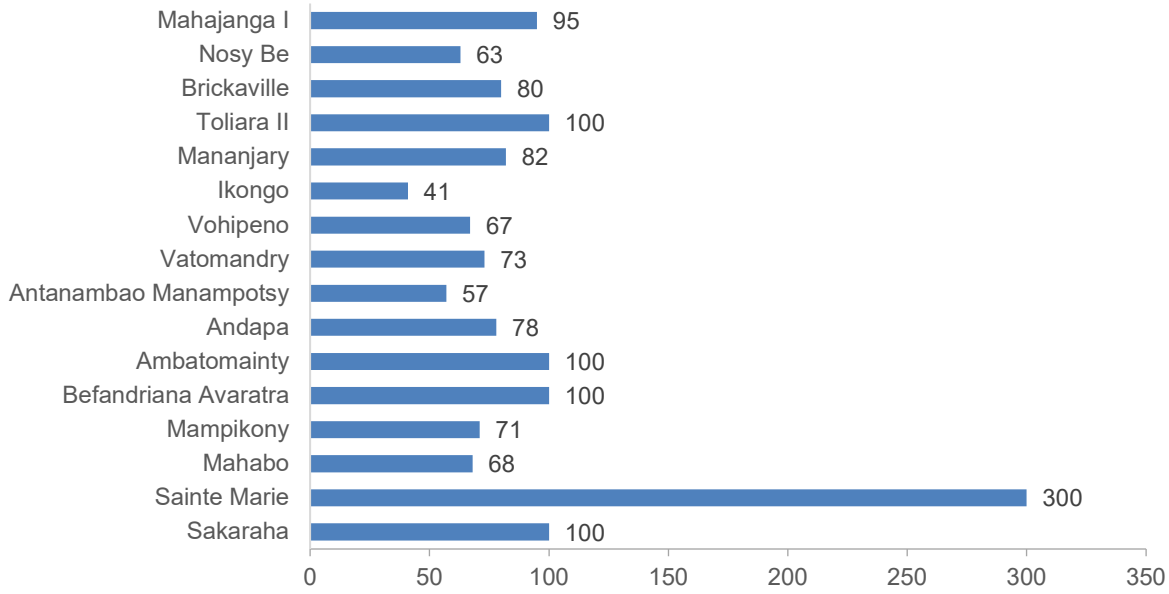
The following are two illustrative examples from Table 5:

1. The CCR of Mahajanga-I in 2021 was 57 percent compared with a reference value of 36 percent. Therefore, this district was performing well (green) in terms of contraceptive coverage.
2. The IPT3 rate for Mahajanga-I in 2021 was 58 percent compared with a reference value of 61 percent. Therefore, this district was not performing well in terms of malaria control among pregnant women.

Fewer than half the districts—6/16 (38%)—met or exceeded these thresholds and seemed well on the path toward graduation. The most common indicators for which reference values were *not* achieved were malaria treatment with ACT in children and pneumonia case management in children under five. As expected, in comparing the two tables, one can see more "green" in Table 3, indicating that the 16 districts chosen were demonstrating positive progress, even though they had yet to attain the optimal reference value by the end of FY21. For example, although the Tulear II district in Atsimo Andrefana only met the threshold for 2/9 indicators (Table 4), it has shown positive progress on five indicators since 2019 (Table 3). Interestingly, Mahajanga I district in the Boeny region (a region visited during the evaluation), already showed positive progress on five of nine indicators in 2019 and had met the MOPH thresholds for seven of nine indicators despite its late start with the ACCESS program. In another example, Ambatomainty district was only able to reach the threshold for one indicator, but showed good progress on eight of nine indicators from 2019–2021. As such, it may be helpful if the graduation approach also takes into consideration the "positive" progress of each district or their change over time, even though they may not reach the MOPH reference value by the end of the program.

Figure 8 shows the distribution of newborn resuscitation rates in 2021 across the 16 districts.

Figure 8. Newborn resuscitation rates, by district



It is assumed that the resuscitation rate of newborns in the district of Sainte Marie—300 percent—is an outlier due to incorrect data; four districts had a resuscitation rate of 100 percent (Toliara II, Ambatomainty, Befandriana Avaratra, and Sakaraha). In the majority of cases (10 districts of 16), the rate was more than 50 percent, whereas only the district of Ikongo had a rate of 41 percent.

During the validation session, the ACCESS team shared a more finalized approach for scoring the institutional capacity and community and social mobilization indicators, including supervisory guidance and a graduation approach dashboard. They noted recent .meetings with the 16 districts to discuss and plan around their results, and to develop a pathway toward certification. ACCESS staff indicated that district health leadership was fully onboard with the approach and was taking pride in their health indicator performance.

After much discussion, the evaluation team felt confident that the graduation approach merited implementation, and a group of first round districts were chosen, fully representing the ACCESS coverage area. It was noted, however, that this strategy—what will likely be a strong legacy of the ACCESS program—was only finalized in year 4 and must be properly resourced so that it can be implemented efficiently and comprehensively without delay.

EQ 2.3b What is the degree of ownership of the FFSDP, LDP+, and PROGRES capacity building approaches?

The second half of EQ2.3 related to knowledge of, and adoption and ownership of the various ACCESS program capacity building approaches. According to the document review, PROGRES and LDP+ were finalized, validated, and rolled out first in year 1, whereas the FFSDP was somewhat delayed. Primarily during the KIIs and some FGDs with CHVs, participants were asked what approaches they were familiar with. Each approach is explored below in detail, but a few of quotes from KIs are shared here initially to show that informants were indeed knowledgeable about the capacity building approaches and could describe examples of implementation and ownership:

> *When we talk about ACCESS, what comes to mind is the LDP+ and PROGRES* (KII, Malagasy Government, Antananarivo)

> *[The] Medical Inspector with the Adjoint technique (technical assistant) and Adjoint administrative (administrative assistant), human resource staff, nutrition staff, and ACCESS agents participated in the [PROGRES] assessment. Afterwards, the results were shared with staff working in malaria, communications, vaccinations, sexual and reproductive health, and the PhaGDis [Pharmacie de Gros de District]. Each participant in plenary reviewed his/her responsibility in his own program, and to see where they failed. Decisions adopted included: after PROGRES, the Medical Inspector will appoint his deputy to act in his absence, and each future meeting must be recorded with minutes [this was not the case in the past].* (KI, ACCESS Staff, SAVA)

> *PROGRES identifies the issues, the current situation, and solutions. An assessment takes place one year later to determine if there is a change. The EMAD has adopted the PROGRES approach in practice. An evaluation is undertaken in accordance*

with the coaching mechanism. For example, a low delivery rate will be monitored by the coach and he will make sure that the CSB increases its delivery rate. (KII, Malagasy Government, SAVA)

[There's] been a change in the relationships among staff. For example, if the CSB chief is absent at the post, the other staff are all aware of the activities and tasks assigned to the CSB. The previous situation was that the other collaborators do not receive training apart from the CSB leader. They are no longer aware of all the approaches to be made on the CSB activities. As a result of the LDP+ approach, there is always a sharing of experience and information. If the Head of CSB is absent, as already mentioned above, the other staff and even the CHVs (when concerned) are all informed and aware of the activities to be carried out. The initiative of the skill transfer has become a routine in the field of work. (KII, Malagasy Government, Atsimo Andrefana)

FFSDP/TTM[33]

FFSDP is a holistic QI approach and is described in the Cooperative Agreement as follows:

An FFSDP is one that simultaneously has enough trained and committed staff; drugs, commodities, and equipment; infrastructure; information; referral mechanisms; community participation; and patient-centered care (e.g., waiting times, interpersonal communication, confidentiality, care respectful of gender and age). When all these elements are present, service providers can deliver an integrated package of services, according to national quality standards, that meets their clients' needs… The approach addresses the whole system at the health facility through: (1) quality standards-based evaluation, (2) evidence-based work planning, and (3) work plan implementation using educational and intervention tool.

In FY19, ACCESS hired ADS in the three full-package regions—qualified nurses, midwives, or doctors—to support clinical skills building and the implementation of the FFSDP. The program was validated and adapted with MOPH input in FY20 to align with standards in Madagascar and to add essential components, such as standards for RCR. A baseline was conducted at 144 sites, a facilitator's guide was developed, and a module was included in the DHIS2 to track results. In FY21, EMAD and EMAR were oriented to TTM (FFSDP) and despite COVID-19, the approach was introduced at 632 health facilities, with certain facilities completing their primary and secondary assessments. As of the most recent FY22 Q1 report, TTM had been introduced in the remaining facilities, evaluations continued, and scores were monitored.

[33] In Malagasy: *Toeram-pitsaboana Tomombana sy Mahomby*

Figure 9. Evolution of the TTM (FFSDP) average scores of 23 CSB between the baseline and third line assessment

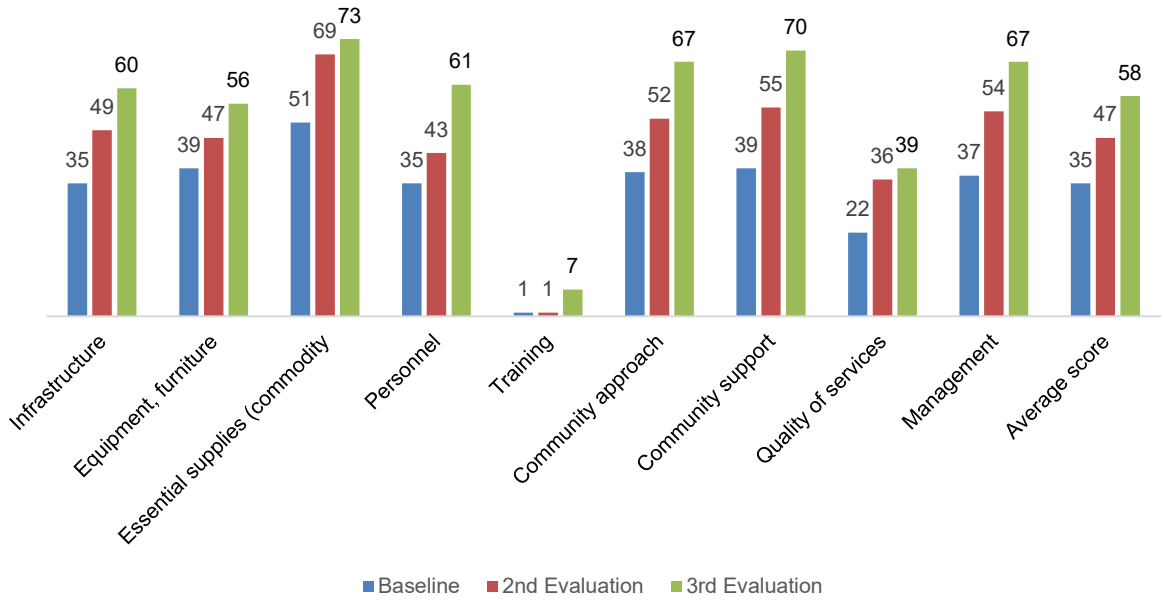


Figure 9 is an example from the FY22 Q1 report with key TTM (FFSDP) indicators and the evolution of scores from the baseline to the third evaluation, all showing a positive trend over time.

KII and CHV FGD participants were specifically asked about their experiences with TTM/FFSDP and how the TTM/FFSDP approach strengthened the clinical capacity of health professionals. As shown in the following KII quotes and reflected in the data above, the approach was considered effective and contributed to improved service delivery:

> *Everyone agrees that the TTM tool helped improve service delivery at health centers. One example is X CSB, which has learned all the lessons and applied all the recommendations of the supervisors [who conducted that assessment]. This CSB has applied the lessons learnt through the TTM tool [and found additional community partners to improve service delivery and relationships with the community].* (KII, Malagasy Government, Vatovavy Fitovinany)

> *[FFSDP] was the most effective and most promising approach because it is about assessing where the CSBs were, and providing them training in what they need to know. An assessment is conducted after 3 months to determine whether or not they have improved their performance.* (KII, Malagasy Government, SAVA)

> *This approach is effective because it motivates staff to work. It is about personal motivation. Everyone has to make an effort, for example, filling out stock cards every day. Yes, it's like in any supportive supervision: use of registers, stock cards, display of the dashboard. Like in any supportive supervision, the supervisor gives recommendations, for example, daily cleaning of offices.* (KII, Malagasy Government, Vatovavy Fitovinany)

Some participants from the SAVA region shared lessons learned in terms of the importance of coordination with elected officials and some limitations in terms of the willingness of health workers to be scored on new activities as responsibilities. These are described in the following KII quotes:

> *The learnings were: coordination issues between the CSB and the mayors must be addressed. Following the training, the mayors showed more involvement in health matters. And the approach is always too focused on the positive side, there were never any negative results during the assessment.* (KII, Malagasy Government, SAVA)

> *This activity was not effective because monitoring is undertaken after each training session, and some health workers are reluctant and scared by new activities and responsibilities.* (KII, Malagasy Government, SAVA)

> *The FFSDP [TTM] is relevant but needs improvements…this tool [can be] really useful to us at the DSSB level…standards for CSBs were discussed under the FFSDP, which was problematic because the standards were imposed without consideration of the local context, the situation of the country.* (KII, Malagasy Government, SAVA)

LDP+

LPD+ is MSH's own learning and performance improvement approach focused on facility leadership, management, and governance to improve teamwork and promote team-based planning. The approach targets EMAD managers and leaders, and CSB and district hospital managers and providers. It was the first QI approach rolled out in FY2019 after validation with the MOPH. A pool of training facilitators was established and work began in three of the full package regions. In FY20, the approach was rolled out at the central level with key government stakeholders. Although the first-round regions started their implementations, at least one DRSP postponed its LDP+ activities due to COVID-19. In FY21, ACCESS conducted a mini-LDP+ review to understand the low use of misoprostol, with 68 percent of the SDSPs participating in the approach. Although implementation continued, it was slow, especially at the central level in terms of orienting and engaging stakeholders due to COVID-19. As of FY22 Q1 reporting, the LDP+ was implemented in 60 SDSPs, with eight SDSPs having completed their first LDP+ cycles and seven evaluated as high performing.

KIs (16, not including ACCESS staff), especially government counterparts, gave positive feedback on the LDP+ process, which helped health professionals and management teams identify problems in their planning processes and was linked to an improvement in health indicators. This is illustrated in the following KII quotes:

> *The LDP+ tool is also very important. It helps professionals acquire managerial skills and is useful to solve problems. There have been several positive feedbacks about this tool.* (KII, Malagasy Government, Antananarivo)

> *If we take the LDP+, for example, there are several steps. The first step is for planning and the second is for evaluation. In Boeny, for instance, I was there and there were some activities related to the expanded program on immunization. The EMADs and the CSB Heads first conducted planning activities, and reflected on*

how to increase the immunization coverage rate. During the second step, (i.e., evaluation), we noticed that the coverage rate really increased. I don't know if this was due to the ACCESS LDP+ or if it was the staff who were more motivated, but in any case, there was an improvement in the immunization coverage rate. (KII, Malagasy Government, Antananarivo)

In my opinion, LDP+ is a highly developed tool used by EMAD because in addition to leadership and governance, it can also be used for situational analysis before decision making. For all annual activity planning—even for operational workplans with program managers developed with the EMAD—we have used LDP+… The Medical Inspector also uses the LDP+ to manage teams in the SDSP; they stated that LDP+ and PROGRES helped them do their work. (KII, Malagasy Government, SAVA)

I know someone who benefited from the [LDP+] training and his capacity increased. This is relevant because we learned how to be a leader and a manager. I received good feedback about LDP+; it helps in the improvement of how to work well and how to motivate. (KII, Malagasy Government, Antananarivo)

One informant at the central level raised issues with LDP+ and suggested additional training topics in the following KII quote:

A training should not place the focus on one single theme. The LDP+ training did not explore the difference between a leader and a manager. The training participants all work in one level of the health system; they are all managers, but are not all leaders. They should be trained to become a manager and a leader at the same time. Other themes that need to be addressed include corruption, accountability, performance, administrative reform, openness to discussion, and inclusion of civil society. (KII, Malagasy Government, Antananarivo)

PROGRES

PROGRES is a QI approach to organizational development previously developed under the *Mikolo* Project. The tool uses service delivery indicators and self-assessment to measure institutional maturity and a performance improvement plan for capacity development. The approach is coupled with LDP+ and the assessments are repeated, until the district is certified for "graduation."

In FY19, the approach (including orientation documents) was finalized and validated, with initial rollout with four SDSPs. By FY20, supervision was taking place in DSSB departments as was follow-up with the four original SDSPs. Data were also integrated in the DHIS2. By FY21, 25 SDSPs had applied the approach in 10 regions, whereas implementation was limited at the central level due to COVID-19. ACCESS engaged its district coordinators to decentralize the implementation process. As of FY22, expansion remained stagnant, with 25 of 60 SDSPs undertaking PROGRES implementation. This slow rollout was due to the lack of central and regional facilitators and EMAD's prioritization of other activities, potentially indicating a lack of ownership or one that was temporarily stalled.

As shown in the quotes below, participants who stated that they were familiar with the approach (9 KIs, not including ACCESS staff) stated that they appreciated the PROGRES approach, which

trained participants to identify problems and create solutions, while improving organizational skills and increasing resiliency:

> *The PROGRES approach helps to overcome the problems. The ACCESS program provides support to the CCDS [Comité de Coordination et du Développement Sanitaire; community health committee] and to the CSB for the resolution of health problems at the community level and in the CSB.* (KII, Malagasy Government)

In the quotes below, informants also noted that PROGRES affected regional and district-level governance and the provision of CSB services—even providing an example of adoption through the standardization of job descriptions:

> *[PROGRES] allows us to look for the root causes that block activities by asking the question "Why?" For example, why do women still give birth at matrons' homes when CSBs have appropriate equipment and qualified staff? The trained physicians were all men, whereas women wanted to give birth only with the help of women. So we added women to the delivery services.* (KII, Malagasy Government, Antananarivo)

> *Prior to that, everyone had their own way of describing their job, some didn't even have a job description. Following training we received on PROGRES, we standardized our job descriptions.* (KII, Malagasy Government, Vatovavy Fitovinany)

Like the other capacity building approaches, and as seen in the KII quote below, participants stated that the approach was successful when it was applied with the specific context in mind:

> *PROGRES identifies the issues, the current situation, and solutions. An assessment takes place one year later to determine if there is a change. EMAD has adopted the PROGRES approach in practice. The evaluation was undertaken in accordance with the coaching mechanism. For example, a low delivery rate will be monitored by the coach and he will make sure that the CSB increases this delivery rate.* (KII, Malagasy Government)

KII participants noted the lack of facilitators and trainers in the quote below and again, a desire for better representation of the local context:

> *Yes, the one lesson learned is to involve all program managers in the upcoming training workshops. The problem is that there is only one facilitator from the central office.* (KII, Malagasy Government)

> *PROGRES is very informative but it still needs to be improved. It needs to be updated and adapted to the local context because sometimes, it is very difficult to understand. For instance, it is difficult for people to understand certain aspects on resource mobilization and institutional communication. It's instructive, but it needs to be improved.* (KII, Malagasy Government, Antananarivo)

EQ 2.4. To what extent has data quality improved as a result of the capacity building approach (up to the national health management information system level)? Are data consistently available in DHIS2? Do any data gaps exist (rejection data)?

Data Quality Improvement

Overall, the data suggested that routine data were increasingly being used for decision making and the targeting of activities. However, two systems currently exist: DREAM@MSH, specifically for ACCESS program monitoring (including tracking of training and SBC indicator data) and the Malagasy government's (MOPH) DHIS2. Data quality will continue to improve with the finalization of RDQA procedures and their incorporation in the national DHIS2 platform.

Training in data collection and verification

Data collection and verification for reporting and use is at the very nexus of the ACCESS program and is centralized around the DHIS2 platform. Community level data—routine surveillance data—are collected by CHVs mostly on paper and, in a small subset of regions, through CommCare (initiated for CHVs by the previous USAID *Mikolo* Project, it also includes an e-learning component). At the CSB level, DHIS2 is used for routine monitoring reports (RMA). Data feed up to the district level, and CSB and mobile clinic data are added.

In FY19, joint supervision started with EMAD/EMAR teams strengthening the quality of data reporting and monthly monitoring report indicators agreed on. ACCESS assessed the reasons for data delays and found that they were due to CSBs that were far away and also the lack of Internet. A data QI manual was developed as were data management tools. MSH uses an MSH-customized version of DHIS2 called DREAMS@MSH to track program-specific indicators.

In FY20, ACCESS started to institute data dashboards to improve data quality and use for decision making in DHIS2, and developed a data quality assessment tool in Excel while monitoring RDQA activities in the three full-package regions. ACCESS instituted training and started to strengthen the CommCare system to facilitate better communication between the community/CHVs and the CSB, especially about referrals. ACCESS also facilitated disease surveillance and reporting through tablets for data tracking related to COVID-19 disease investigation.

In FY21, ACCESS continued data-related QI activities and the Data Quality Assurance Strategy, including an RMA data verification tool for ASCs and ADCs to use in CHV supervision (called *Outils de Vérification et Validation des RMAs*). In addition, RMA reporting from the community level was further integrated in CommCare in preparation for CommCare scale up. Last, as of FY22Q1, ACCESS finalized and validated an RDQA process as a national tool planned for transfer to the *Direction des Études, de la Planification et du Système d'Information* (DEPSI; Department of Studies, Planning and Information System) and continued plans for further CommCare refinement and rollout.

KII and FGD participants discussed ACCESS support for data collection and verification, including training for CSBs and CHVs to collect and verify data, scheduling follow-up to review and assess health data, and providing tools to facilitate data collection. As described in the KII quotes below, the quality of reports and the processes to validate reporting have improved:

> *The support of ACCESS matches with the expectation of the district of Tulear II. If we make an evaluation before the acquisition of program support, we found a large gap between the activity reports of the CSBs before and now. After the implementation of the coaching system, the EMAD teams validate their reports and provide coaching in case of adjustments to be made. Then, it was pointed out that there was a small error in the reports and the quality of results has improved. Thus, the program support meets our expectations. After overall review, the error rate is less than 5 percent today after coaching and the errors are gradually decreasing. But before, the CSB reports always had corrections to be made and the error rate was very high.* (KII, Malagasy Government, Atsimo Andrefana)

> *There is a change and an improvement thanks to the DHIS2 training provided by ACCESS and the allocation of communication credit to call the CSB agent. The validation of CSB data before transcription to the monthly activity report lasts two half days per month.* (KII, Malagasy Government, Boeny)

ACCESS supported data collection at the community level by providing CHVs with tools and scheduling monthly data reviews with the CSBs before sending the district report.

> *The quality of data from CHVs has improved compared with the Mahefa project's data. In the past, they used to fill out the reports at the time of their meeting (and I don't read reports that are prepared in a hurry like that!) Now, CHVs pay attention and are involved in the filling out of the reports. I notice now during our meetings that CHVs are bringing complete reports with them. I verify the reports as well as the purchase orders. Things have improved.* (KII, Malagasy Government, SAVA)

> *Data quality has improved through the ACCESS CSB approach. At the CHV level, after the group gatherings, the CHV and the CSB Head verify the accuracy of the CHV's monthly activity report data, followed by data verification using the data verification and validation tool with the district team on location. This tool improves the quality of health data because it compares with the data in DHIS2.* (KII, ACCESS Staff, SAVA)

Completeness and timeliness of data

KII participants also expressed a belief that the completeness and timeliness of data reporting had also improved, as illustrated in the following quotes:

> *Our reporting circuit is as follows: at the end of the month the CSBs write a report on all the activities carried out. The CHVs also send monthly reports to the CSB for review. The CSB sends all monthly activity reports to the district level by the 10th of the month. Since the arrival of the ACCESS program, timeliness and completeness have improved and been respected.* (KII, Malagasy Government, Vatovavy Fitovinany)

> *Health data quality has improved as a result of the ACCESS capacity building approach.* (KII, Malagasy Government, SAVA)

According to the FY21 annual report, 92 percent of CSBs submitted complete reports on time, an increase from 83 percent in FY20. This proportion of timely reporting was lower, at 67 percent for CHV data submission. In the following KII quotes, participants stated that getting quality data in a timely manner remained a challenge, which negatively affected decision making. Moreover, participants noted that continuing support for data QI was essential:

> *The challenges are to get reliable data and to ensure a good completeness and promptness of data.* (KII, Malagasy Government, Boeny)
>
> *Efforts have been and are being made, but the main challenge remains data validity and reliability. If we only talk about immunization, the figures are a disgrace: data from immunization coverage surveys are very different from those of administrative coverage….the data from the CHVs are sometimes incorrect.* (KII, Malagasy Government, Antananarivo)
>
> *The CSB will be able to keep the completeness [of reporting] but not the promptness.* (KII, Malagasy Government, Boeny)
>
> *Community data completeness and timeliness need to be improved.* (KII, Malagasy Government, Antananarivo)

As of FY22, it is expected that the adoption of a national RDQA tool will improve data quality, along with efforts to ensure the sustainable transfer to the MOPH and DEPSI.

Data dashboard

As noted above, by year 2, ACCESS supported the development of data dashboards to facilitate data use in decision making. This was mentioned as effective in the KII quotes below:

> *Support brought by ACCESS agents stimulated change, because together, we improved the dashboard that was shared with the CSB.* (KII, Malagasy Government, Boeny)
>
> *A dashboard has been created and is being implemented. We already implemented it last year in five regions and now we are scaling it up to all ACCESS regions because we hope to reach a percentage of data use for all CSBs. This dashboard relates to key indicators on quality of care. For example, the number of women who received uterotonics. This is already in DHIS2, but it is also an indicator of quality of care because we can say that the care given by the provider is of quality if it follows the protocol and this is also the data protocol.* (KII, ACCESS Staff, Antananarivo)
>
> *For example, if there is a lack of skills in immunization and malaria management, the ACCESS program provides training to address these gaps. The ACCESS program also supervises and monitors the dashboard to see if the objectives are being met. For example, in the national malaria control policy, every case of fever should receive a malaria RDT. Thus, the ACCESS program ensures the availability, management of inputs, and reporting.* (KII, Malagasy Government, Vatovavy Fitovinany)

EQ 2.5. What concrete examples illustrate the use of data for decision making?

Participants understood the importance of collecting high quality data to use for decision making and agreed that good, verified data can be used to evaluate health service performance and identify gaps.

> *Yes, data help in decision making through the orientations, recommendations, and action plans based on the data. We can verify performance.* (KII, ACCESS Staff, Antananarivo)

> *The main advantage is decision making. Appropriate decision making depends on data quality.* (KII, Malagasy Government)

> *The use of data gives indications where we are relative to our goal and enables us to plan the activities to be carried out. For example, in the area of EPI, should we engage in awareness raising? In advanced strategies? The activities will ultimately depend on the situation.* (KII, Malagasy Government)

> *The data allow us to know the level of performance of each activity at the CSB 2 level, as well as the level of use of each activity by the community. Thanks to the data, we can make decisions.* (KII, Malagasy Government, Vatovavy Fitovinany)

Participants from several regions also gave examples of how quality data were used for decision making locally to improve health services:

> ***SAVA:*** *In the case of malaria, when the number of RDT+ increases, a field visit must be undertaken. The results have been verified and there is an actual increase in malaria cases. Appropriate measures have been taken: awareness raising, supply of RDTs, and ACT drugs.* (KII, Malagasy Government, SAVA)

> ***Vatovavy Fitovinany:*** *Data are used to determine the performance of the CSB. For example, if the number of deliveries at the CSB decreases, meetings with CHVs and matrons will be held to investigate the reasons for such decreases.* (KII, Malagasy Government, Vatovavy Fitovinany)

> ***Boeny:*** *Low vaccination coverage can be observed through data. With these results, we take decisions on LDP+ implementation and adopt the advanced strategy.* (KII, Malagasy Government, Boeny)

EQ 2.6. How consistently are routine data quality assessments (RDQA) undertaken (at regional, district, health facility, and community levels) and what are common findings?

As described in the previous section, the RDQA process (including an RDQA tool and data quality supervision tool) has been validated and finalized, and is ready for handover to government counterparts (MOPH through DEPSI). There is also a specific RDQA— mRDQA— for malaria indicators. As of years 2 and 3, RDQA activities were taking place at the CHV, CSB, and district levels. However, the quantity and consistency of RDQA efforts were not yet tracked.

Data for Decision Making and RDQA

According to FY22 Q1 reporting, 78 percent of CSBs and 85 percent of districts used health information data for decision making. Similarly, 83 percent of districts performed data quality checks and data analysis, and provided feedback to those at lower levels, just 2 percentage points lower than the 85 percent target. Participants stated that RDQA activities contributed to

increased data quality because they provided a regular opportunity to identify and fix errors. Overall, participants agreed that the RDQA activities were essential for ensuring quality data, as seen in the KII quotes below:

> *The district conducts RDQAs at the CSB 2 level every three months. The district compares the reports sent by the CSB with data from the CSB 2 (e.g., the outpatient register). They also check the use of management tools and the completeness of the registers. The RDQA allows for accurate information and good decision making.* (KII, Malagasy Government, Vatovavy Fitovinany)

Challenges identified for improving data quality centered on the need for more resources in terms of closer supervision of the RDQA process and remaining gaps in CHV report monitoring. Informants indicated that a lack of supervisors affected the efficacy of the RDQA approach. Participants from the SAVA region expressed concerns, shown in the following KII quotes, about the planning of RDQAs with relevant health actors and barriers in receiving timely feedback:

> *RDQA is an approach that has been applied only recently in a few health facilities, and we don't yet have a clear view on how data are improved. We have seen improvements in data quality, especially for community data. For example, we no longer see data inconsistencies regarding RDT and ACT provision. Two months ago, before we arrived, there used to be inconsistencies between the number of children who received ACT, which was high, and the number of RDTs performed, which was low. After pointing this out to the CHV, there were no more inconsistencies.* (KII, ACCESS Staff, SAVA)

Community health workers from Boeny also reported a lack of monitoring and follow-up on their reports. In the following quotes, FGD and KII participants noted errors or incompleteness in CHV reports and expressed a need to continue providing support to improve data quality at the community level:

> *Regarding the report, we don't know if it's good or bad. At our last meeting, he only said that those who have not yet sent in their October report should do so.* (FGD, CHVs, Boeny)

> *Yes, data are systematically available in DHIS2 at the central level. It is only for community data that there is an issue. At the central level, there is no issue regarding data incompatibility during uploads to DHIS2 thanks to our strong Internet connection. However, the issue is timeliness. CSBs do not have much of a problem with the 80 percent target by the 15th of the month, the issue is with community data.* (KII, ACCESS staff, SAVA)

In terms of improvements in data quality, there was significant improvement in the CSBs' abilities to provide accurate data, but these efforts could be undermined by a lack of supervision and consistent monitoring, especially at the CHV level. In addition, the creation of data dashboards had improved processes and the use of data for decision making at the district level. However, it was recognized that two DHIS2 systems still existed. As such, the sustainable transfer of ownership and integration of relevant components in the existing national DHIS2 system is a priority for the remaining program period.

EQ 2.7. How frequently do stockouts occur?

Stockouts remained a challenge that significantly affected health service quality. Although the mandate for solving the issue was led by the IMPACT program[34], ACCESS also had a role to play. ACCESS consistently partnered with IMPACT to address stockout issues, and indicators (stockouts of key tracer drugs) were monitored at CSB and CHRD levels. Importantly, the ACCESS team monitored compliance with the sending of PhaGDis Purchase Order Reports to SALAMA[35] to clearly communicate needs in a timely manner, to reduce stockouts, and to ensure that there was a two- to four-month buffer stock of essential drugs and supplies. Recently, consumables, such as oral rehydration solution, zinc, and Amoxicillin, were added to the list of tracer medicines in the RMA reporting template to better track availability.

The availability of medicines seemed to be a determining factor in clients' choice of CSB attendance over other health service providers, such as private hospitals and traditional medicine.

Figure 10. Proportion of excerpts that relate to "healthcare experience" that co-occur with challenge

Healthcare Experience	Availability of Care	Availability of Medicine	Access to Care	Stockouts
38.46%	39.89%	64.08%	34.41%	59.26%

As seen in Figure 10, compared with other codes pertaining to the healthcare experience, more than half of the excerpts about "stockouts" and "availability of medicine"[36] were co-coded with "challenge."

KII and FGD participants stated that health service providers, including CHVs, experienced stockouts of medicines. Participants often had to look for medicines at private pharmacies or were referred to the district level as a result. In addition, as noted in the FGD quotes below, stockouts affected the price of medicines, something which participants felt like they had little control over:

> *It has already been said that there is a frequent shortage of medicines, which is why doctors refer to X when the medicine is incomplete due to the lack of medicine and means, which is not enough.* (FGD, Fathers, SAVA)

> *Sometimes this pharmacy is open but there are times when it is always closed. Before, the doctor always had medicines. He used to sell his own medicines but there is a very big difference between the price of the medicines at his place and the*

[34] Improving Market Partnerships and Access to Commodities Together (IMPACT), is also funded by USAID and aims to sustainably improve the health of the Malagasy population through a strengthened health system and efficient health market, contributing to universal health coverage.

[35] Association focused on the procurement of essential generic medicines, medical consumables and medical equipment for public health facilities and private non-profit organizations operating in the field of health in Madagascar.

[36] The "stockout" code was applied to excerpts containing the word "stockout" and discussing the stockout of medicines. The "availability of medicine" code was applied to excerpts discussing the availability and unavailability of all types of health products, including medicine and health center equipment and materials.

one at the pharmacy. And because you go to him, you can't say anything; he gives you the medicines and gives the price of the whole. You can't do anything about it. The medicines at the pharmacy are cheaper. Nowadays, there is no more at his place. He writes the prescriptions and we buy at the pharmacy, but the pharmacy is rarely open, although the medicines are cheaper. On the other hand, most of the time, there is no medicine. (FGD, Mothers, Boeny)

Participants also stated that CSBs lack medicine and healthcare materials, such as malaria tests or alcohol, which are essential for providing care. On the other hand, although medicine might be provided freely, other medical supplies, such as syringes or bandages, were sold for a cost. Patients often searched for these products at private pharmacies or were unable to be treated due to these challenges, and expressed this in the FGD quotes below:

According to our friend, the staff that receives us is satisfactory with a smile and daily communication, as soon as you enter, you are satisfied. On the other hand, concerning the material, it is like what he said, you are sick, there is only one medicine and you have to look for the others at the drugstore. Even if we want to weigh the babies, there is no baby scale, we have to go to X to be able to weigh the babies, we go to the nun's house whereas, the CSB should usually have one. You want to know if your child is well nourished, as my child is very slender, we don't know if he is malnourished even though he is always eating. He was taken to the CSB and the CSB said that he should take such and such medicine; we looked for the medicine which was available only at the nuns in X. Therefore, I am not satisfied; in fact, I am not satisfied at all. (FGD, Fathers, Boeny)

There are needs for mothers and children that do not exist at the CSB, for example, alcohol. Often the pharmacy at the CSB is closed. So if you give birth at midnight, you have to knock on the door of another pharmacy located a little further up. You can't do anything without alcohol, as the hour passes. If there is a loss of time, the mortality rate increases. We should have a kit. There used to be some but I don't know where they went: soap, alcohol, cotton, and nappy… Since 2009, there has been no kit. (FGD, CHVs, Boeny)

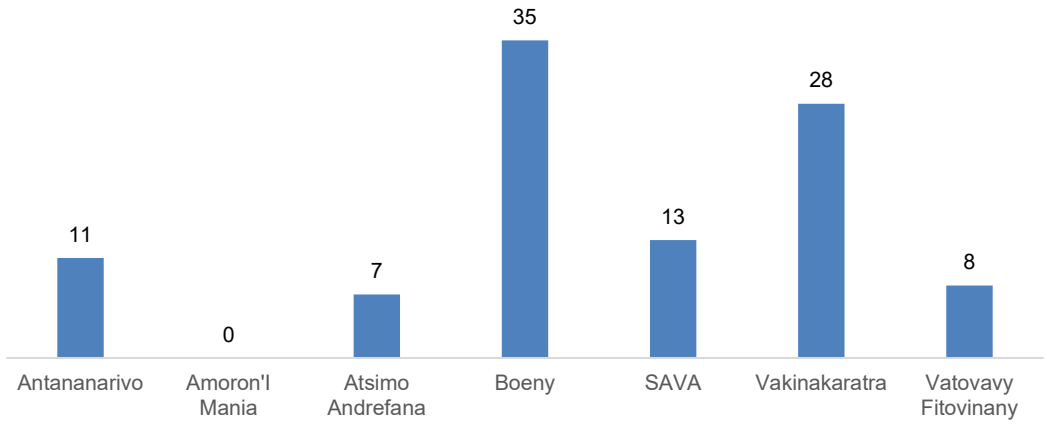
Overall, the continued challenge with stockouts of medicines and healthcare materials affected the quality of health services and, as mentioned in the quote below, peace of mind or trust in the facility. Addressing this challenge is pertinent to improving health services.

The care is not very satisfactory. I'm not really satisfied because when you are sick, they give a prescription to buy medicines at the pharmacy and then you have to come back for instruction, the truth is that there are no medicines available here. Medicines available are paracetamol and amoxicillin syrup for a sick child. We have to come back and forth to buy the rest of medicines at the pharmacy whereas you are not in right mind because of the child's illness. That's the problem. (FGD, Mothers, Boeny)

On the positive side, one participant from Atsimo Andrefana reported experiencing *fewer* stockouts and commented in the following FGD quote that medicines were increasingly available:

Recently, medicines are no longer a problem. Before, there was no medicine, we were given the prescription and we bought them at the market or at the drugstore in X. But now, we get them at the hospital. (FGD, Fathers, Atsimo Andrefana)

Figure 11. Excerpts on stockouts, by region (total excerpts=99)



However, as seen in Figure 11, informants in Boeny region indicated more challenges with stockouts. In the following quote, one informant described how stockouts deterred people from seeking care:

> *The reason why people do not come to the CSB is due to the lack of medicines. Medicines are not available. In the case of serious illness, people go directly to private centers or to X. This is why people don't come here. But when it is a simple illness, they come to the CSB, because here we do not spend much money. In case of serious illness, we are better taken care of [by other providers].* (FGD, Fathers, Boeny)

While these examples and the concentration of "challenges" might indicate regional differences in stockout levels, since the coding and quotes were derived from interviews and not a representative sample of respondents, data should be interpreted carefully. It is also worth noting that interviews were held in December during the rainy season, a moment when supply chain ruptures were more frequent.

Evaluation Question 3: To what extent have the ACCESS SBC initiatives been implemented?

The ACCESS program is charged with implementing a comprehensive SBC approach, with tailored activities that build on previous approaches from the *Mikolo* and *Mahefa* Projects and that engage at multiple levels with households, communities (in the CAC), health providers, and facilities. These efforts are meant to be gender-transformative and to incorporate adolescents and youth with campaigns that include mass media, community mobilization, facility-based communication, and digital media. Specific attention is also focused on reducing open defecation (through the CTSL approach) and incorporation of ICN and SILC group trainings.

The quantitative and qualitative findings suggest that ACCESS contributed to the following intermediate results:

- SBC campaigns implemented by ACCESS staff and CHVs addressed a wide range of health behavior topics, most notably WASH, maternal and child health, and FP.
- SBC activities encouraged improved health behaviors, such as using FP, improved handwashing practices, and improved social norms relating to gender.
- SBC activities require continued support for supplies and community follow-up to ensure sustainability.

EQ 3.1. What SBC initiatives have been implemented as planned?

SBC activities covered a broad range of health topics, from WASH and the prevention of diarrhea to messages encouraging women to complete ANC visits and deliver at the health facility, as well as chlorhexidine use with newborns and, in FY21, misoprostol. In FY19, one of the first SBC activities was to sensitize parents to the pre-referral treatment of children with rectal artesunate capsules and the importance of quickly completing this referral, including through the use of emergency transport. ACCESS worked with the MOPH to co-develop the National SBC Strategy with 20 high priority behaviors—the foundation for the ACCESS SBC strategy and the Be M'Ray campaign. In FY20, SBC topics meaningfully expanded to include COVID-19. Malaria-focused efforts were also emphasized, especially in rural areas, including radio spots and support for the country's 910 hotline, which is a source for information about malaria. Community-level SBC activities related to stemming open defecation, ICN approaches, and messaging about early pregnancy and marriage. As of FY22, SBC activities were implemented with an eye toward sustainability and handover to the MOPH. With the inclusion and handover of *Mahefa-Miaraka*-supported regions, there was renewed emphasis on training to bring these regions up to speed, including the integration of SBC data (collected in DREAM@MSH) and use of an SBC dashboard.

The ACCESS team and CHVs mainly supported the implementation of SBC initiatives in the intervention regions, along with engaged community groups.

In the following FGD quotes, participants described their encounters with CHVs on SBC initiatives, who often advised them on what to do in the case of illness and facilitated access to CSBs and/or hospitals:

> *As far as I know, the CHV is a person who has undergone extensive training in health.* (FGD, Mothers, Vatovavy Fitovinany)

> *Health awareness, he gives solutions in case of illness, and sends us to the hospital too.* (FGD, Mothers, Vatovavy Fitovinany)

CHVs were also considered trained health workers and deemed suitable to advise the population on health matters, as described in the following KII and FGD quotes:

> *The objective is to sensitize the population by training all CHVs. This training activity is already planned.* (KII, Malagasy Government, Boeny)

> *What I do know is that the CHV is a health educator who encourages people to visit health centers.* (FGD, Women of Reproductive Age, Vakinanakaratra)

> *For the time being, the CHV with the CSB are sensitizing about vaccinations. That is why I say that progress in the health field is up to the CHV.* (FGD, Fathers, Atsimo Andrefana)

ACCESS provided training and support to CHVs to conduct SBC interventions, including books and visuals, as described in the following FDG quote:

> *In the book, there are pictures and advice, which helps us to convince people in the community because it is seen in pictures and it is written.* (FGD, CHVs, Boeny)

The most well-known SBC initiatives included Be M'Ray, SILC, and CLTS, which were most familiar to the KII participants, with some differences among regions. Figure 12 depicts the number of times SBC initiatives were mentioned by name among the 20 KII participants, while Figure 13 counts the number of mentions of specific approaches across interviews.

Figure 12. SBC initiatives mentioned by KII participants by name (n=20)

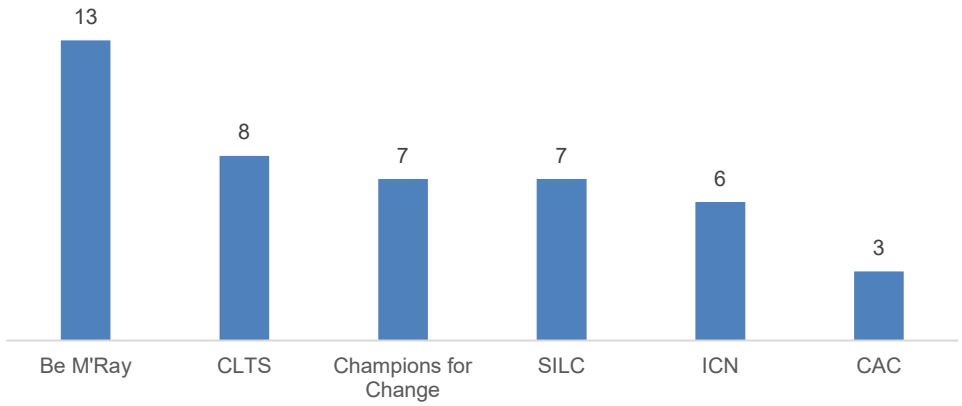
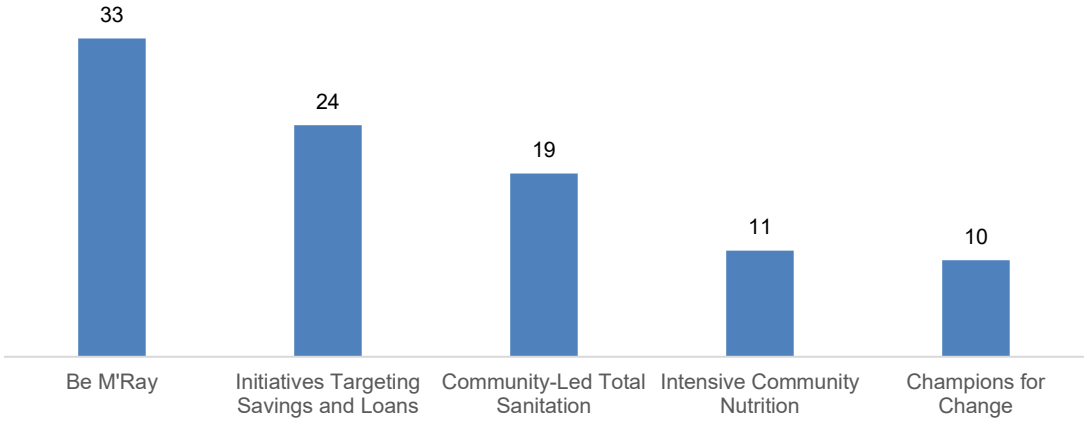


Figure 13. Number of excerpts on SBC initiatives by name (total number of excerpts=90)



Although there were 24 coded excerpts on SILC, the approach was mentioned by seven people, whereas 13 KII participants noted their familiarity with Be M'Ray in 33 coded excerpts.

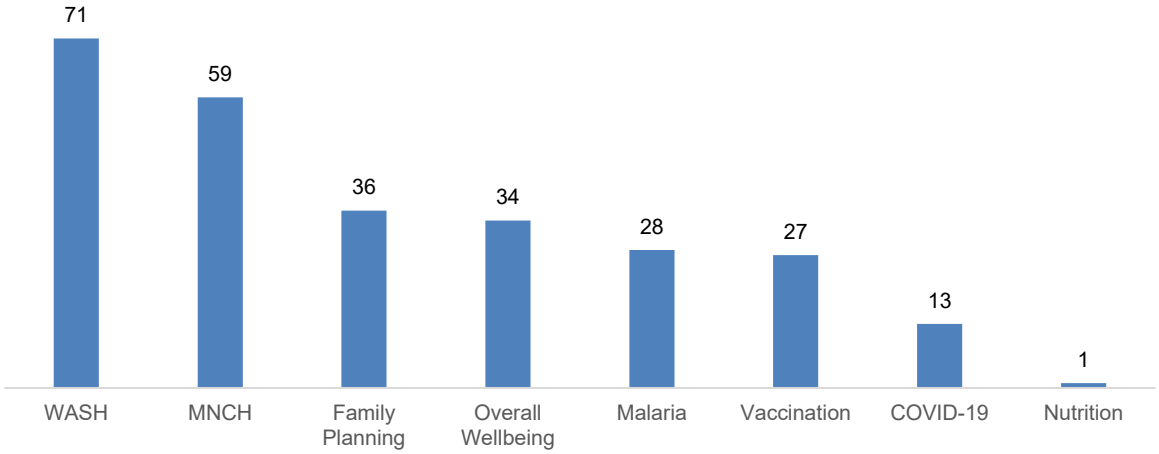
Participants, especially KII participants, had active involvement in the SBC initiatives, whether in terms of identifying health problems in the village or participating in activities that promoted SBC interventions, as described in the following quotes:

> *Be M'Ray and CLTS are SBC interventions. A competition was organized for each commune to promote those projects. The population took this competition seriously because they felt honored if they won, so everyone made a great effort. The CHVs and the fokotany leaders took their responsibility in the follow-up of the work and the standards.* (KII, Malagasy Government, Atsimo Andrefana)

> *Community Action Cycle, SILC, Champions for Change, and Be M'Ray are in process here now. Champions for Change is included in Be M'Ray. I choose CAC [as a promising approach]. Its implementation is going as planned. The fokotany identifies the health problems in their village and they themselves seek the solutions. CAC promotes this equity.* (KII, ACCESS Staff, SAVA)

FGD participants discussed participating in and receiving sensitization on a variety of health areas, most notably WASH, MNCH, and FP, whereas nutrition—the ICN intervention—had the least mentions. COVID-19 sensitizations were also mentioned less frequently, but they were only started after the onset of the pandemic (Figure 14).

Figure 14. Number of excerpts on SBC initiatives by health area (total number of excerpts =269)



When asked about the messages learned from the SBC interventions, many participants expressed their improved understanding of WASH and the importance of vaccines and FP:

> *The message I remember is the one saying that each family should have its own latrine and that no one should do open-air defecation anymore.* (FGD, Community Group, Boeny)

> *There is collaboration [on SBC] between CHVs and CSBs because the CHV can raise awareness about the vaccine and give explanations about FP.* (FGD, Father, SAVA)

> *Most young people are more and more aware of early pregnancy through the ACCESS Be M'Ray program. CHVs select young people. In my opinion, young people need more sensitization like the "Mendrika Salama and Be M'Ray" approaches.* (KII, Malagasy Government, Atsimo Andrefana)

Overall, the implementation of SBC initiatives was mainly linked to sensitizations by CHVs and awareness-raising events and activities organized by ACCESS. They were mentioned by stakeholders at multiple levels as important and impactful in influencing the community to take note of various health issues and to move toward healthier behaviors.

EQ 3.2. What are existing gaps in SBC initiatives' implementation?

Overall, some inconsistencies in SBC implementation were noted across regions. First, ICN was not as well-known as an SBC activity/theme in any of the regions. National-level informants stated in the KIIs that there was a need to reinforce this initiative:

> *ICN is important for the community. This activity should be strengthened because the community suffers from malnutrition because they sell their products instead of eating them. We should also conduct a malnutrition screening at the community level.* (KII, ACCESS Staff, Antananarivo)

> *Let's talk about Integrated Community Nutrition. This initiative did not go as planned, as observed in one region: there is no community site in Vatovavy Fitovinany, there is no support in terms of inputs or equipment.* (KII, Malagasy Government, Antananarivo)

In addition, a lack of materials and resources at times delayed the implementation of activities in some regions, especially for WASH activities, as noted in the following KII and FGD quotes:

> *The existing gap in the implementation of the SBC initiative is the shortage of soap and water for handwashing after toilet. In conclusion, the problem is focused on the supply of supplies.* (KII, Malagasy Government, Atsimo Andrefana)

> *The project [CLTS] has a good vision but its implementation is sometimes impossible. For example, latrines were built up, but the real problem is the lack of water.* (KII, Malagasy Government, Antananarivo)

> *They [ACCESS] should at least sensitize the community to build toilets. The rainy season will come, many people don't have toilets. The feces will scatter and this will lead to diseases. If it is their responsibility, they should go on site and make people aware that they need to build toilets because the rainy season will come and the waste will spread. That's my opinion, but I don't know much about their duties.* (FGD, Father, Boeny)

These qualitative points, especially those related to WASH challenges, were echoed in program documentation where (as of Q1 FY22) WASH was the most common theme in COSAN CAC action plans, and 1,491 latrines were prioritized for construction across 10 regions.

Together, these gaps in SBC initiatives pointed to persistent challenges in the sustainability of SBC interventions and changed behavior. In the following FGD quotes, participants expressed that persistent SBC gaps in terms of tools, resources, and the lack of SBC follow-up challenged the long-term potential for sustained behavior change:

> *The relationship of the CHVs with the areas they serve only exists when there are events—antiparasitic, insecticide-treated mosquito nets, it is during these events that they work. But there is no daily relationship.* (FGD, Mother, Boeny)

> *… how is it that in the south of the country, where there is great water scarcity, people are told that they need to wash their hands each time after going to the toilet, but no support measures are provided?* (KII, Malagasy Government, Antananarivo)

> *Sensitizations are made but without proper follow-up or proper continuation. The majority of the people <u>try</u> to comply with the sensitizations, but there is no follow-up.* (FGD, Community Group, Boeny)

EQ 3.3. How did formative research inform the design of SBC messages and materials?

Data were used to inform SBC initiative design and ensure that SBC initiatives were linked to community needs and adapted to the local context. For example, as early as FY19, data on diarrhea rates were used to inform the targeted dissemination of SBC messaging. This use of data to tailor and target SBC activities is further described in the KII quotes below:

> *Yes, data helps in decision making through the orientation, recommendations, and action plans based on data. We can verify the performance.* (KII, ACCESS Staff, Boeny)

> *At the district level, SBCs and community health promoters plan together the media communication plan, which changes every month. For example, in case of an*

increase in malaria cases, the media plan will focus on broadcasting messages about malaria. (KII, ACCESS Staff, SAVA)

ACCESS did exactly that, formative research, before it started its activities, which is important. (KII, Malagasy Government, Antananarivo)

Ongoing data collection was also used to inform decision making and improve and adapt SBC activities to the changing needs of the community, as described in the following KII quote:

There are indeed data about exposure to and/or impressions of the SBC campaigns and various media produced and broadcast. For instance, CSBs issue monthly reports on the number of radio spots, the topics covered, the number of action plans completed in the CAC, the number of "champions of change" (households), youth champions, and couples champions. All these data are systematically collected. CHVs are required to report to the CSB on the number of plans and activities they manage in the community. CSBs are required to report monthly by the 15th on the number of spots, themes, and number of CAC action plans. The data inform decision making because we plan activities based on these reports. We analyze the deficient areas and we increase actions in those areas. (KII, ACCESS Staff, SAVA)

These findings indicated that SBC initiatives were formulated based on the various needs of the community. However, there may have been a positive bias in these comments because they were mainly shared by ACCESS staff and government stakeholders.

EQ 3.4. To what extent have the SBC initiatives contributed to the promotion of positive social norms, gender, and youth-related considerations?

SBC initiatives promoted positive gender norms and gender transformative behavior because men and women were encouraged to share decision making on important family matters, such as FP and parenthood. Positive social norms in terms of health seeking behavior were also supported through the SILC, although it is unclear whether these efforts were scaled enough to show true benefit.

This approach is articulated in the following FGD and KII quotes:

Q17 : Have you heard any message on gender equality? P5: Men and women are alike; therefore, one shouldn't be considered superior to the other. P3: Men and women have the same rights, including the right to express themselves both in public and at home. (FGD, Community Groups [female participants], Vatovavy Fitovinany)

There are real considerations of gender and youth, for example, by soliciting fathers and commending them for taking their children to the health center. (KII, Malagasy Government [male participant], SAVA)

The message that has caused the biggest change and has had the greatest success is the message on planned parenthood as there are no more serial birth deliveries. Before, mothers gave birth although the older child does not even have one year old yet. It is obvious that mothers' lives have changed. Their lives aren't as tough and difficult as they used to be. (FGD, Community Groups [female participants], Vatovavy Fitovinany)

Increase affordability of health services

The SILC initiatives improved financial accessibility to quality health services and improved the standard of living by making CSB care accessible, but it was unclear whether this had occurred at adequate scale or was associated with improved health seeking behavior or practices. As of the FY22 Q1 report, there were 758 SILCs established under ACCESS in six regions (22%) from a planned 3,440 SILC groups by the end of the program.

Positive results are described in the following KII quotes:

> *This initiative promotes positive social norms because funds can be used in emergencies, such as serious illnesses. In general, Voamamy [the SILC] makes life easier for members. Currently, CSB attendance rates are increasing thanks to Voamamy. For example, if a member of Voamamy is sick and comes to the CSB without money, if he or she brings his or her Voamamy card, the CSB staff will provide the necessary care and prescribe all the medicines and the group treasurer will pay afterwards.* (KII, Malagasy Government, Vatovavy Fitovinany)

> *The SBC initiative has had a positive impact on health. Also, the SILC has improved the standard of living of the members. Thus, they are able to attend the CSB and get healthcare without worrying about the price of medicines.* (KII, Malagasy Government, Vatovavy Fitovinany)

EQ 3.5. What information can existing data provide about exposure to and impressions of the SBC campaigns and various media produced and broadcast (including community-based infection prevention and control messages)?

Impact of SBC initiatives

Through the SBC initiatives outlined above, communities across several ACCESS intervention regions shared examples of adopting healthier WASH and health seeking behaviors as a result of sensitization activities. However, additional data are needed from the ACCESS program's own midline evaluation (separate from this evaluation) to quantitatively confirm this. As noted previously, SBC indicators are collected in the program's own DREAM@MSH system.

In Boeny, Vatovavy Fitovinany, and SAVA, communities discussed notable improvements in hygiene with the construction and use of latrines, handwashing, and handwashing with soapy water before and after cooking, eating, caring for their children, and using latrines. Informants expressed that the adoption of healthier WASH behaviors was reducing the incidence of diarrheal diseases in their communities, as described in the following FGD quotes:

> *Before, people constructed latrines without covers, but now they construct latrines with covers. Diarrhea is in recession as flies cannot deliver microbes anymore. The sensitization on children's hygiene was a success too. In the past, children did not wash hands before eating but now this has changed; this reduced the frequency of diarrhea and vomiting. Sensitizations have an impact on everyday life.* (FGD, Community Groups, Vatovavy Fitovinany)

> *By the start of the project, people said that it is taboo for them to defecate at home. Once we convinced them, only a very few people didn't have a latrine in the village of X. Almost everyone ended up having a latrine.* (FGD, Community Groups, Boeny)

However, according to population level data from the 2021 Demographic and Health Survey, while a handwashing location (fixed or mobile) was observed in 86% of the population, improved facilities with both soap and water, ranged from 36% in Boeny (average) to only 9% in SAVA.[37]

Communities also shared examples of adopting healthier malaria behaviors. Community distribution of mosquito nets was accompanied by sensitization activities and this resulted in an increased use of mosquito nets in several communities, which community members believed was connected to the lower incidence of fever in the community, as described in the FGD quotes below:

> *Fever becomes less common because people are now used to using mosquito nets.* (FGD, Community Group, Vatovavy Fitovinany)

> *Concerning mosquito nets and malaria, before the distribution of mosquito nets, mosquito nets were found only inside the " ravovory" for fishing purposes. Since those distributions, I didn't see anyone using mosquito nets for fishing anymore. People are now using them for prevention against diseases.* (FGD, Community Group, Boeny)

> *There is a decrease because the parents follow the instructions; insecticide-treated mosquito nets have been distributed for the last three years, which is done every year.* (FGD, Father, Atsimo Andrefana)

SBC initiatives had also increased access to and use of FP products. One KI shared a perception that the number of early pregnancies was declining due to the Be M'Ray program:

> *Most of the young people are more and more aware of early pregnancy through ACCESS [Be M'Ray] programs. CHVs select young people. In my opinion, young people need more sensitization like in the "Mendrika Salama and Be M'Ray" approach.* (KII, Malagasy Government, Atsimo Andrefana)

Sensitizations had also improved FP practices, including spacing of births, and made contraceptive methods more accessible to women and youth, as noted in the following FGD quotes:

> *For me, things have changed in the last three and a half years. Before, when I did not yet use FP, the CHVs did not sensitize people because they did not like to do FP at the health center because there is money to pay for the injection. But when the CHVs were well trained, they sensitized mothers and young people of the community at the center to do it because if the mother gives birth to a lot of children, it can cause health problems for the mother and the child.* (FGD, Women of Reproductive Age, Vakinanakaratra)

[37] National Institute of Statistics (INSTAT) and ICF. (2021). *Madagascar demographic and health survey, 2021*: *Key indicators*. Antananarivo, Madagascar and Rockville, Maryland, USA: INSTAT and ICF. Retrieved from https://dhsprogram.com/publications/publication-PR131-Preliminary-Reports-Key-Indicators-Reports.cfm

Parents' awareness of the use and the importance of using contraceptive methods was raised; no parents now give birth to many children. (FGD, Community Group, Vatovavy Fitovinany)

Last, informants noted a perception of increased use of CSB health services due to SBC initiatives. Informants noted that more pregnant women received ANC at CSBs and delivered their babies in the hands of professional heath workers, as opposed to being attended by a traditional midwife in a non-hospital setting:

Despite traditional medicine, people start to go to health centers. People start to be convinced. Positive changes are observed, but very slowly. That's the case with all the health problems because educating and changing people's behaviors is a difficult task. (FGD, Community Group, Boeny)

Now women who have been sensitized by the health workers go for prenatal consultations and children under five years old are vaccinated. (FGD, Fathers, Atsimo Andrefana)

A larger number of children also received recommended vaccines, such as the BCG vaccine, which as reflected in the following FGD quote, was perceived as resulting in a decrease in tuberculosis in their age group:

Thanks to the sensitizations made on children's vaccination, a lot of children got the BCG vaccine, which resulted in a decrease in the cases of tuberculosis. Another proof that the sensitizations were a success is that the number of sick people cared for in health centers decreased. People now live with an acceptable level of cleanliness, even those who used to be very dirty now change their clothes before going to the market. (FGD, Community Group, Vatovavy Fitovinany)

Taken together, these findings potentially indicate that SBC initiatives—which constitute a large investment for the ACCESS program—may have had a concrete impact on the communities' health seeking and healthy behaviors. These results seem to be related to participation in sensitization activities organized by the CHVs and ACCESS; however, further mid-line evaluation data are needed to confirm the qualitative data shared here.

Effective SBC Tools and Strategies

The main avenues through which SBC was carried out—as mentioned by informants—were community gatherings and events, house visits, radio and television broadcasts, and posters. Radio was commonly mentioned by KII and FGD participants, more than 20 times. Community gatherings and events were also noted as helping CHVs reach large groups of people and encouraging discussion among participants, as noted in the following FGD quote:

I sensitize groups of people by working with groups of 5 persons or 10 persons per group, communicating the messages verbally to them, with some visual aids used as support. They see pictures that illustrate the various advantages, we try to bring further explanations to the pictures, and we create discussions with them, while aiming to convince them. This should be effective to convince them. We can also visit people in their houses. (FGD, Community Group, Boeny)

In addition, CHV participants mentioned that home visits were a more useful way to sensitize because they encouraged more active interaction with community members:

> *We do home visits; we go to the home to talk about vaccination, talk about CPN, and…general hygiene or water hygiene. When I do the sensitizations, I will go and discuss…with interaction or discussion.. with 3, 4, or 5 people. So we discuss awareness through home visits.* (FGD, CHVs, SAVA)

Radio and television broadcasts, and posters were mentioned in the following quotes:

> *Q: How did you find out about FP for young people?*
> *Woman of Reproductive Age (P1): Through radio and television sensitizations.*
> (FGD, Women of Reproductive Age, Amoron'I Mania)

> *Q: Through which means of communication did you hear these messages ?*
> *Community Group Member (P1): We saw posters posted by community agents.*
> (FGD, Community Groups, Vatovavy Fitovinany)

FY20 and FY21 PMP data quantified reaching more than 2.5 million and 2 million people, respectively, across all mediums with FP messages: radio, television, electronic platforms, community group dialogues, interpersonal communication and in print.

Participants also discussed the importance of choosing appropriate SBC tools for the context in terms of sensitizations. For example, in the following quotes, FGD participants noted that CHVs and health promoters should consider the timing of their SBC interventions and the tools used to engage with the population, with consideration of such factors as distance and literacy:

> *It would be appropriate to seek the best time to do the sensitizations, choosing the moments when the maximum number of people are gathered.* (FGD, Community Groups, Vatovavy Fitovinany)

> *In the countryside, many people cannot read or write. Sensitization is not done by the people who are supposed to do it. If it is possible, record the sensitizations and play those recordings at the CSB so that whoever goes to the CSB hears it. Even if there are posters, they can't read. Those who hear can in turn communicate to their friends. There is sensitization throughout the year.* (FGD, Fathers, Boeny)

Involvement of community stakeholders

The involvement of and coordination between community stakeholders is key to successful implementation of SBC activities. Multiple KII participants mentioned that different actors successfully played a role in implementing SBC activities:

> *All the actors involved have participated in those efforts. Each entity has taken their responsibilities for promoting these projects with ACCESS. For example, the committee including the CSB team and members of the mayor's team take action on monitoring the effective use of those latrines. The CHVs and folkotany leaders are responsible for monitoring the construction work on the quality and standards required, as well as providing supervision when needed.* (KII, Malagasy Government, Atsimo Andrefana)

> *Personally, I have noticed a greater collaboration between different actors in the community: the districts, the community agents, the fokontany chiefs, the Heads of CSBs, and even the teachers. Concerning sanitation, I recently did a field visit with*

two other entities— the Ministry of Water and Sanitation and the Ministry of Education. There is good collaboration. (KII, Malagasy Government)

The different stakeholders are actively involved. When the mayors and authorities are involved, the population always shows enthusiasm. (KII, Malagasy Government, SAVA)

Key messages coming from the district are communicated to the CSB and CHV, according to the program. (KII, Malagasy Government, Boeny)

Evaluation Question 4: How effective is the program's approach to supportive supervision and monitoring, while building MOH leadership and capacity to conduct these efforts on their own?

Supportive supervision and mentoring are an ACCESS program strategy meant to foster local buy-in, ownership, and sustainability using a decentralized approach. According to the original Cooperative Agreement, supportive supervision was meant to be provided in a gender-sensitive manner and to underscore improvements that considered human resource themes, such as staff retention, motivation, and stress reduction. Supportive supervision was also linked with on-the-job training and e-learning modules (in a small number of locations through CommCare) and performance reviews and professional education requirements that took place onsite as much as possible.

Based on the quantitative and qualitative findings, ACCESS contributed to the following results:

- Supportive supervision approaches, including field visits, ASC peer supervision, and a coaching system, contributed to the improved quality of health services. However, continued support in the form of budget and human resources are needed to continue this effective approach.

EQ 4.1. What course-correction measures have been implemented as part of the ACCESS knowledge management and learning strategy?

Starting in FY19, the frequency of supportive supervision activities for CHVs was increased to at least once a month, to stimulate performance improvement and better reporting to CSBs. CHV training focused on MNCH, FP, and IMCI topics and was then reinforced with supportive supervision. Close monitoring of health indicators helped tailor and differentiate approaches among the regions to course correct. For example, in FY19, a sharp decrease in treatment of diarrhea in children under five in Atsimo Andrefana led to intensified IMCI training sessions and supportive supervision of health workers to increase the quality of service provision.

ACCESS supported district health management teams (EMAD) to conduct monthly group supervision visits with CHVs to support them in completing monthly reports (RMAs). The supervisor used checklists and supervision grids during the visit, as described in the KII quote below:

> *When a community's results are consistently poor, we plan together to supervise that community, and during supervision, we provide support because it is formative supervision. We have also used this method to select CHVs to be included in a training*. (KII, ACCESS Staff, SAVA)

Supervision was also used to select high-performing health workers to invite to training sessions. Moreover, high-performing CHVs were trained during the program's first year of implementation in "full package" regions to become CHV supervisors (ASCs supported by the program) which acted as a performance incentive and a method to further support CSBs in their monthly supervision of CHVs. This was noted in the following KII quotes:

At the community level, there is the AQS whose objective is to train supervisors who will perform the ASC function. The aim is to train efficient ASCs for the care of sick children and give supervisors the capacity to help the CHVs. (KII, ACCESS Staff, SAVA)

The CHVs are classified by performance using the AQS for CHVs. The community AQS is the performance evaluation for the CHVs…the ASCs are there to help, not directly supervise, but to accompany the CHVs to accomplish their activities. The difference is that CHVs are directly connected to the Ministry of Health and to the CSB, although changing, but the ASC is connected to the ACCESS program. (KII, ACCESS Staff, Antananarivo)

Informants also mentioned to importance of follow-up to ensure that CHVs retain learning, including refresher training for CHVs with mannequin practice and competency assessments. As mentioned in the following KII quote, a coaching system was also implemented, where each EMAD member was responsible for coaching a certain number of CSBs:

In practice, there is a monthly review of the CHVs regarding their performance and their working methods, which facilitates and improves the quality reporting on achievements. There is also the supervision that we have talked about. It starts with the supervision of the CHVs. Then the coaching system at the district level. Each CSB is distributed in the region. Each member of EMAD must coach a number of CSBs. We each have six to coach. We each share the CSBs. (KII, Malagasy Government, Atsimo Andrefana)

EQ 4.2. How has the learning process been adopted/implemented to contribute to program objectives?

In FY20, the LDHF approach to onsite training was streamlined and adopted by the MOPH as the standard monitoring tool. The approach includes e-learning, which is followed by onsite supervision and reinforcement. In FY21, orientations on supportive supervision were provided remotely to BRF and EMAR/EMAD in preparation for onsite supervision through the LDHF approach. Field testing of the ACCESS U e-learning took place with the intention of integrating the platform in the existing supportive supervision structure and to transition ownership to the MOPH. Last, at the beginning of FY22, in addition to targeted supportive supervision on SBC and CLTS, ACCESS was updating the DREAM@MSH training tracker to align with the LDHF process and document supportive supervision visits at necessary intervals.

According to KII participants and CHVs in FGDs, the approach to supportive supervision and monitoring was effective in ensuring that supervision and follow-up were conducted jointly by the MOPH and ACCESS. Participants found the supervision to be effective because it allowed for immediate course correction, as indicated by KII participants below:

For example, let's take the case of the CSB in X, where the reports are late, and the indicators are deficient [which is the cause of Y {district's} poor performance]. We conducted supportive supervision and we found out that they do not use any management tools, apart from the ANC register where all activities should be recorded, but this is missing certain services performed. The SDSP representative immediately made the corrections. (KII, ACCESS Staff, SAVA)

Corrective action is taken as the practice progresses. There is a checklist that the supervisor can easily refer to. The supervisor gives immediate recommendations on the practice of the approaches given during the training. The training always begins with a theoretical session and is followed by practice. (KII, Malagasy Government, Atsimo Andrefana)

All recommendations and corrective actions are documented. We have already received some recommendations from ACCESS, such as that the chair of the COGE [Management Committee] should always be present when inputs are received. The supervisor told us that all staff should wear badges. All staff have adopted these recommendations and are convinced that it is a good practice. (KII, Malagasy Government, Vatovavy Fitovinany)

Figure 15. Number of excerpts on supportive supervision by region, effective vs. challenge (total number of excerpts=164)

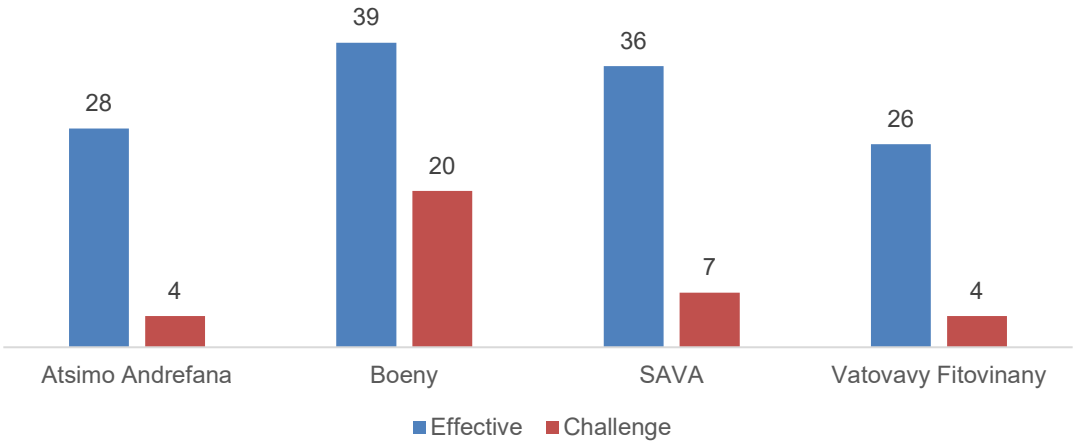


Figure 15 shows that participants in most regions spoke about effective supportive supervision; however, two Boeny informants indicated some challenges. The KII and FGD quotes below noted a lack of supportive supervision and follow-up:

There is no supportive supervision or follow-up so far. (KII, Malagasy Government, Boeny)

Q: Now the next question: Is there a system of supervision, monitoring, and evaluation of your activities? CHV (P2): There is none yet at the level of our fokontany. (FGD, CHV, Boeny)

Challenges to ensuring supportive supervision also related to finance because informants noted that sustaining periodic supervision would require strengthening the state budget. There was also a lack of awareness on the ACCESS program's supervision objectives. This is described in the KII quote below:

Monitoring and supervision are necessary and are included in the EMAD terms of reference, but the implementation depends on the means available and the time of the District. (KII, Malagasy Government, Boeny)

Overcoming this challenge will require greater government stewardship and ownership. A KI at the central level suggested that the MOPH had structures that could undertake this responsibility:

> *MOPH has a Training and Development Department—the Service de Formation du Personnel—which supervises the Regional Training Offices established by the ACCESS program. When the ACCESS project ends, this department should ensure that achievements are sustained.* (KII, Malagasy Government)

4.3. To what extent has the program documented the use of data for decision making?

The use of data for decision making was widely adopted across ACCESS implementation regions, especially to differentiate and contextualize approaches. For example, ACCESS staff commented in the follow quotes that data were used to inform programming, including identifying regions and districts that required supervision field visits and increased capacity building, and informing CSBs and CHVs on health service programming.

> *When indicators show low performance, LDP+ prompts us to conduct an analysis, asking a series of questions—why, why, why… and when we get to the root cause, we can determine the actual activities that need to be carried out. Concerning supervision, it is not conducted impromptu, it is planned based on data: we plan the supervision based on low performance indicators.* (KII, ACCESS Staff, SAVA)

> *During the analysis of the data in DHIS2, we identify the areas where we have provided supervision and conducted activities (e.g., TTM [FFSDP]). We look at what has changed and what has not. We plan field visits accordingly for the cases where nothing has changed, but we always call before each visit to inquire about the cause of the failure because sometimes, it is just an action or service that has not been recorded.* (KII, ACCESS Staff, SAVA)

Concrete examples of data use to inform health service programming and ACCESS program support are also discussed in further detail under EQ 2.5.

Evaluation Question 5: What are recommendations across all questions that will reinforce and strengthen ACCESS activities and initiatives for the duration of the program?

The results of this evaluation suggest several conclusions and recommendations that can be useful to future programming. In this section, recommendations and discussion of the recommendations are noted in terms of areas for improvement.

Quality of health services and continuum of care

Recommendations: Planning

- Make efforts to better reflect the needs of regions/districts/communes in ACCESS activities and to refocus on collaborative scheduling.
- Increase teamwork, communication, and visioning with government partners (especially for supportive supervision) and reduce imposed planning.

This evaluation made it possible to observe that each region and each district has specific and differentiated needs in terms of health services and the continuum of care. As a result, ACCESS should further support the EMAR and EMAD in identifying the specific needs of each ACCESS region and district. It is not a matter of training the EMAR and EMAD, but of creating a sustainable environment for stakeholders to sit down together periodically and identify specific needs in health services and the continuum of care, and to better plan activities for each region and district. However, the goal for each region and district remains the same: to improve health performance, institutional capacity, and social and community mobilization objectives.

At times, the EMAR, EMAD, and CSB health staff expressed an imposition of activity planning by the ACCESS field team. It is therefore advisable (and more sustainable) to put in the extra effort for renewed commitment to joint planning and scheduling to create a productive environment for discussing activity timelines and resource requirements. Deliberate and thoughtful joint planning and scheduling efforts will help amplify and sustain the contributions and ownership of government partners. In addition, continued joint planning of activities, especially for supportive supervision, is a way to involve and implicate key government stakeholders. Joint planning for supportive supervision is also an opportunity to budget for the implementation of these activities together. Even if a “mock” budget is developed during the process, this will help EMAR, EMAD, and health staff understand and plan for all aspects of continued supportive supervision implementation and capacity reinforcement once ACCESS ends.

Recommendations: Infrastructure/Material

- Continue to support the rehabilitation of CSBs in partnership with the government, especially in terms of WASH .
- Provide additional health equipment and infrastructure improvements based on clearly stated needs from the CSBs.

- Establish an emergency buffer of materials to ensure stability and consider the development of pre-packaged kits for important health products that include the health product itself and any other supplies needed for use by CHVs or at the CSB level.

ACCESS's interventions are largely focused on improving the operation of health facilities and the provision of quality health services. To offer an adequate continuum of care to the population, the program also invests in infrastructure and equipment. KIs and focus group participants underscored this continued need and suggested that ACCESS could further support and accelerate the rehabilitation of CSBs in partnership with the government. To be clear, the suggested activities are not full construction projects; instead they include small rehabilitations, such as latrine building at health facilities or WASH infrastructure to compliment SBC activities in the community. These specific needs and the feasibility/sustainability of any additional infrastructure or equipment improvements should be defined collaboratively and inevitably must conform with the Cooperative Agreement and USAID regulations. If additional opportunities for this work can be identified, investing in these efforts in partnership with the MOPH and other government counterparts could be an important legacy for ACCESS, and would help ensure its visibility and effectiveness in supporting the continuum of care and sustaining positive health behaviors.

The problem of continued stockouts of medicines and supplies is complex and should be addressed in a systems framework in partnership with IMPACT. It is recognized that the health input supply system involves a long, multi-step process from ordering to delivery, and requires the involvement of several stakeholders from different sectors and at different levels. It only takes one stakeholder or one step to fail for the whole system to break down and stockouts to occur. It is therefore suggested that ACCESS should continue to focus on efforts to understand and address supply chain problems in partnership with the IMPACT program, but also take the lead on organizing supply system players in its own programmatic sphere of influence (i.e., up to the district level)

Recommendations: Capacity Building/Training

- Continue to strengthen the CHVs' skills (MNCH skills, IMCI at the community level, monthly activity reporting [RMA]) in alignment with CSB and community needs.
- Provide additional training on "humanization of care" to reduce/eliminate remaining instances of poor reception of clients.
- Continue to strengthen RCR systems; retrain CHVs, as needed.
- Establish mentoring between high performing and lower performing CSB officers.
- Fully resource and accelerate the implementation of the graduation approach.

KIs mentioned the important efforts that ACCESS has made in engaging and training health professionals, including facility-based ASC and ADS and CHVs, noting that the training, skills building, and supportive supervision received were very useful for their practice. Although not uncommon across sub-Saharan Africa, CHVs' work as volunteers with no renumeration is recognized as is their role as an essential component of the ACCESS program. This topic is

gaining more attention globally with human rights and gender implications.[38] Over the remaining implementation period, it is recommended to further sustain training and capacity building efforts (with attention to scheduling and [for CHVs] transport requirements), and consider implementation of a mentoring approach between the best and worst performing participants (i.e., CSB staff and/or CHVs). In addition, to reviewing the process for identifying training participants with the EMAR and EMAD, it is recommended to ensure that training participants have the required profile and commit to share/cascade their learning once the training is completed. One option could be to institute with the EMAR and EMAD a screening tool to better meet the profile required by each training. Last, continued focus and resources for infrastructure, standard materials and equipment, sufficient health inputs, and competent personnel will contribute to stronger and sustained quality health services.

In theory, the district graduation approach designed by ACCESS is an innovative approach meant to create a positive competitive environment and to sustain progress after graduation and the end of the program. However, at the time of this evaluation, indicators and scoring mechanisms relating to the graduation approach package were only partially available. It was therefore impossible to determine whether it is a fully effective approach, although there are several districts well on their way to graduation. The approach is already recognized as resource intensive to implement. In these early stages, a pilot study might be useful to provide additional evidence of the approach's potential to signal progress that is readily sustainable (and properly incentivized).

Recommendations: SBC Implementation

- Share information on SBC interventions with the DRSP and other government counterparts for better coordination.
- Continue monitoring and reporting on SBC activities at district and commune levels, and consider what SBC data from DREAM@MSH could be useful in the national DHIS2 platform.
- Continue to strengthen SBC visibility through posters, and further establish SILC and ICN activities, if these interventions will continue.
- Consider additional SBC WASH resources, (i.e., "nudges," social norms, emotional drivers, and economic motivators) based on lessons from other USAID WASH initiatives.

The involvement of community members is a prerequisite for the use of preventive and curative care services and for the acceptance of the referral system. Therefore, it is suggested that ACCESS build on the philosophy of the graduation approach and strengthen SBC approaches to build a sense of "empowerment" instead of "assistance." This "empowerment" vision will in turn facilitate the sustainability of SBC activities already initiated by ACCESS. The strengthening of SBC activities should not only focus on the use of health services and products, but could also be

[38] Ballard, M., Johnson, A., Mwanza, I., Ngwira, H., Schechter, J., Oder, M. …Nepomnyashchiy, L. (2022). Community health workers in pandemics: Evidence and investment implications. *Global Health: Science and Practice,*10(2): e2100648. Retrieved from https://www.ghspjournal.org/content/10/2/e2100648.

considered for an expanded WASH SBC approach that builds on USAID lessons learned related to the use of nudges and rational habit theory.

To ensure better monitoring and evaluation of SBC activities, it is also suggested that SBC-specific indicators continue to be monitored in the DHIS2 platform and through the SBC dashboard, but also considered for integration in the national DHIS2 platform. In addition, the deployment of human resources to ensure the sustainability and smooth handover of SBC activities is essential.

Recommendation: Supervision

- Plan and fund additional trainings that lead directly/efficiently to implementation and ownership.
- Similar to the recommendation on planning, undertake joint supervision planning (and budgeting) with government counterparts.

Respect quarterly supervision timelines.The following KII quote articulates that in years 4 and 5, accelerated focus on implementation, supervision, and sustainability is warranted:

> *Training…at some point you have to know that you have to stop. Now, we have to focus on the situation for those who have received training and immediately go to the field to implement; not meet at the table and say what to do again. We have to…go to the field and start pushing people to do the supervision, to really put these capacities directly into the field and lighten the "theoretical" side.* (KII, ACCESS Staff, Antananarivo)

During this evaluation, some health workers suggested that formative supervision should be geared more toward putting the knowledge gained during training into practice. Other respondents even suggested that these training sessions should be stopped and that the focus should solely be on practice. It is crucial to review with each region's EMAR and EMAD the training and follow-up supervision to be planned to be consistent with the real needs of each region and district because capacity and needs will vary. This suggestion is consistent with the previous recommendation on joint planning with government partners, rather than imposed planning.

Conclusion

Table 6 shows a summary of the conclusions indicating the implementation of a well-planned program that is achieving scale using replicable interventions that are data driven.

Table 6. Summary of conclusions

EQ1: Quality
1.1 Improved access and availability in *most* regions 1.2 Clinical capacity building and infrastructure improvements are effective approaches. Roles of CHVs are essential 1.3 Gender equity is improved; somewhat fewer examples of activities to promote youth equity; concerns that implementation is inequitable 1.4 Strong examples of coordination among CSB, CHV, and ACCESS staff at the district level; improvement and resourcing can continue 1.5 Alignment with Health Sector Development Plan 2024; supporting translation of MOPH policy at regional/district levels (updates, etc.)
EQ2: Capacity
2.1 Capacity building implementation across all regions to varying degrees 2.2 District MOPH actors uptake of training and transfer of knowledge not always happening at CSB level 2.3 FFSDP, LDP+, and PROGRES effective when implemented; graduation approach is a work in progress 2.4 Data quality has improved at all levels 2.5 Data are being used for decision making 2.6 Data quality assurance at the community level can be improved through the optimization of tools like CommCare 2.7 Stockouts remain a problem and affect the quality of care at the CSB level
EQ3: SBC
3.1 Be M'Ray, CLST, CAC, and Champions for Change have been implemented as planned; SILC is yielding mixed results 3.2 ICN can be improved and more broadly implemented 3.3 Research used to design initiatives 3.4 Improvement of health behaviors and promotion of positive gender social norms seen 3.5 Data are only recently collected systematically on SBC activities
EQ4; Supportive Supervision
4.1 Partnering with EMAD to course correct efficiently (e.g., corrective training) 4.2 Supported through LDP+; accountability, and ownership 4.3 Data dashboard in use
EQ5: Reinforcing and Strengthening ACCESS Activities and Initiatives
1.1 Finalization and adequate resourcing and rollout of graduation approach 1.2 Improved sharing of SBC interventions and data with government counterparts 1.3 Improved planning and collaboration for supportive supervision

In summary, the challenges and focus over the remaining implementation period relate to sustainability, transfer, and systemization or institutionalization of activities and, where appropriate, graduation. It is hoped that the voices, data, and insights reflected in this evaluation can make a valuable contribution to reaching these objectives.

Appendix 1: Dedoose Code Sheet

- **IMPACT Role**
- **ACCESS Approaches/Intro and EQ2**
  - ACCESS Geographic Presence
  - AIM
  - Approach for Strengthening Clinical Competence: Law Dose High Frequency (LDHF)
  - LDP+
  - PROGRES
  - Plateforme AQS CSB
  - Plateforme AQS Communautaire
  - SILC, SLTS, ICN et Approche Champion
  - TIP TOP palu
  - TTM/FSSDP
  - TUP
- **Health Services Quality/EQ1**
  - ACCESS Quality Improvement (QI)
    - Improved Infrastructure/Equipment
    - Humanization of care
    - Improved health in the community
    - Clinical capacity building
    - Improved accessibility of quality healh services
    - Improved availability of quality health services
  - Health services coordination
    - Change in access
    - Change in coordination
  - Equity in access, use, and benefit
    - Gender or youth focused equity
- **Health Capacity and Infrastructure/EQ2**
  - Capacity building
    - Mobile Clinic
    - Human Resources
    - Supply Chain
    - Data Management (i.e. COMECARE)
    - Monitoring and Evaluation
    - Tools/Logistics/Equipment
    - Location
    - Training/Coaching/Follow up
    - Effectiveness
    - Lessons learned
    - Graduation Approach
    - Uptake/Adoption MOPH Actors

- Health data
  - Efforts/Decision making
  - Routine data quality assessments (RDQA)
  - Enhanced data collection/data quality
- Stock outs

Healthy Behaviors/EQ3

- SBC communication tools/strategies
- Stakeholders engagement in SBC
- Gaps SBC initiatives
- Impact of SBC initiatives
- Social and Behavioral Change (SBC) initiatives
  - Be M'Ray
  - Champions for Change
  - Community Action Cycle
  - Community-Led Total Sanitation
  - Initiatives targeting Savings and Internal Lending Community groups
  - Intensive Community Nutrition

Supportive Supervision and Monitoring/EQ4

- ACCESS approaches
- Effectiveness of ACCESS approaches
  - Techniques/Tools/Strategies
- Learning/Course Correction

Recommendations_Proposed Solutions /EQ5

- Feedback on ACCESS Project
- Health Capacity and Infrastructure
- General/Other(i.e. funding)
- Health Services Quality
- Healthy Behavior
- Supportive Supervision and Monitoring

Health Care Experience

- Referral
- Availability of care/services
  - Availability of medicine
    - Pharmacy
- Access to care
- Satisfaction
- Type of care/service/test
  - Finger test
  - Vitals check(e.e.blood pressure, etc)

Health Services Type

- Hospital
- CSB
- Private practice
- CHV
- Traditional/Self care

Health Areas
- Vaccination
- Overall wellbeing/health
- Children's Health (i.e. PCIMEC)
- COVID-19
- Other diseases (i.e. Diarrhea, thyphoid fever, fever, cough, cold, etc.)
- Nutrition
- Family planning
- Maternal health and neonatal care
- Malaria
- WASH

Implementation/Efforts
- Community level/CHV level
- National/Central level
- District level
- Regional level
- MOPH actors/Sub-national level
- Health center level/CSB level

ACCESS Role
- Impact on health service delivery/EQ1
  - National level policies/guidelines
- Promising ACCESS implementation approaches/EQ1
- Sustainability/EQ1
  - Long lasting impact of ACCESS

Challenges
- COVID-19 related
- Environment related

Non Response
- Don't Know, No Experience/Knowledge
  - Blank/No Explanation Given

Quotations

Appendix 2: Staff Biographies

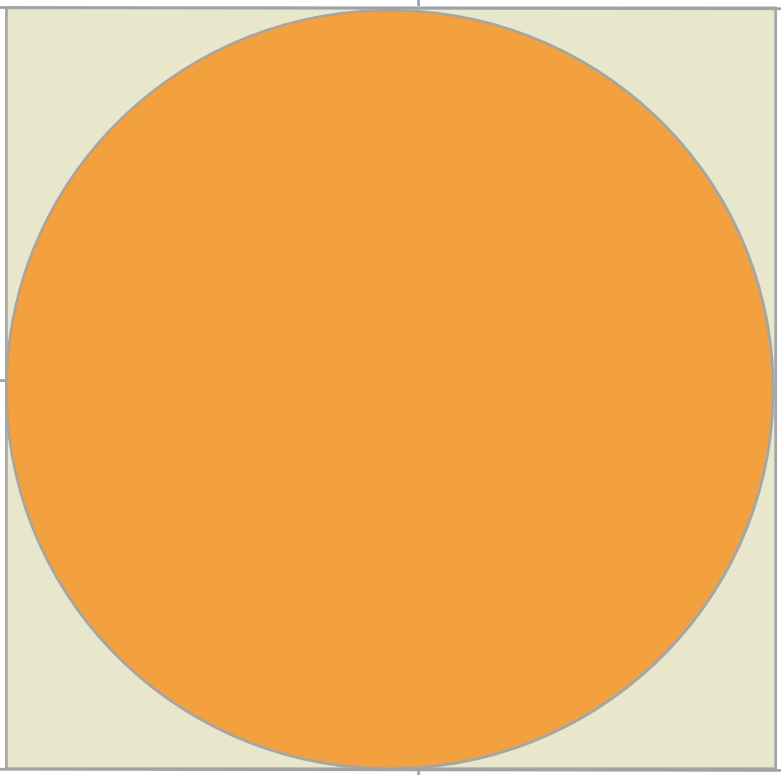
Susan Bergson – Team Lead. Susan has more than 20 years of expertise in public health, research, and evaluation ,with degrees in Social Work, Women's Studies, and a Master's in Public Health from Tulane University. Susan started her career in Côte d'Ivoire and continued with postings in Malawi and Thailand. She is currently based in the Netherlands. Her technical background includes experience in agricultural livelihoods, climate change, COVID-19, emergency response, food security, health informatics, HIV/AIDS, maternal and child health, primary care, renewable energy, sexual and reproductive health, supply chain management, tuberculosis, and vision access. Susan led the evaluation design, data collection, analysis, and report writing efforts.

Lwendo Moonzwe – D4I Activity Lead. Lwendo is a research and evaluation specialist. She has her PhD in Sociology and a Master's in Public Health. Her technical background includes experience in the areas of behavioral communication change, culturally based intervention design, education, food security, HIV/AIDS, human rights, maternal and child health, nutrition, sexual and reproductive health, and women's empowerment. She served as the D4I activity lead, providing oversight and backstopping support to the team.

Julio Rakotonirina – Lead Field Researcher. Based in Madagascar, Julio has worked his way up through the health system, from Chef CSB to Director of University Hospital and then Minister of Public Health, while being a Consultant/Expert and University professor. He has more than 20 years of experience in developing countries, especially in Madagascar, Benin, and Comoros, as a Team-Leader, Teacher/Trainer, Researcher, Expert-Consultant, and Medical Doctor. As a Specialist in Epidemiology since 2005, PhD in Public Health since 2010, and Professor in Epidemiology since 2015, he has strong and evolving skills in health systems management and epidemic management and, as a Researcher and Expert-Consultant, is published widely with >50 peer reviewed publications. He is actively involved in international/African multidisciplinary expert networks, including the Demography Statistics for Africa (DEMOSTAF) project and PERSUADE-II—the Partnership to enhance technical support for analytical capacity and data use for HIV, TB, and Malaria in Southern and Eastern Africa.

Balkissa Jacobs – Researcher. Balkissa is a Research and Evaluation Specialist. With a background in Economics, she also holds a Master's in Business Administration and a Master's in Public Policy with a focus on Poverty Alleviation. She is experienced in the areas of social policy, child, youth and family poverty, social protection, financial literacy and empowerment, asset-based community development, social capital, disadvantaged youth and adult workforce development, maternal and child health, HIV/AIDS, and nutrition. Balkissa is fluent in French (native) and English and has supported the evaluation with data analysis.

Rebekah Koch – Research Assistant. Rebekah is a recent graduate of Emory University's Master's in Development Practice program with an interest in gender and applied research and evaluation. Rebekah previously served as a Peace Corps volunteer in Cameroon and has supported CARE's work in humanitarian relief. Rebekah is fluent in French and assisted in the literature review, data collection, and analysis.



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