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Project Mitao: Monitoring, Evaluation, & Learning Report

Service Accessibility and Readiness Assessment

1 Project Background

Project Mitao aims to improve situational knowledge of the complex factors driving the spread of sexually transmitted infections (STIs) and HIV in the rural Anosy region of southeast Madagascar. Employing a participatory action research approach, Project Mitao combines extensive data collection and analysis with regular roundtable convenings, bringing together a range of stakeholders to develop a community-driven strategy for combatting HIV and STIs. In addition to researching young people's knowledge and behaviour regarding sexual and reproductive health and rights (SRHR), Project Mitao has examined SRHR service provision and capacity in undertaking a comprehensive survey to assess the capacity of the *Centres de Santé de Base* (basic health centres, or CSBs) in the rural sites of Mahatalaky, Sainte Luce, and Tsagnoriha.

Madagascar's healthcare system is comprised of *agents communautaires* (community agents, or ACs); CSBs; and district, regional, and university hospitals. As the first level of healthcare service provision, the 2,645 CSBs and 15,164 ACs play a crucial role in promoting community health (Ministère de la Santé Publique, 2019). Divided into two service provision categories, CSBs II are designed to be staffed by doctors, paramedics, nurses, and midwives and offer maternity care; they tend to be concentrated in the national capital of Antananarivo and the surrounding region (Lang et al., 2018). Equipped with only nurses and caregivers, CSBs I offer vaccination and basic health services, such as medical consultations and contraception (Ministère de l'Économie et des Finances, n.d.).

Since 60% of the country's population live within five kilometres of a CSB, these facilities are often the most accessible formal medical facilities for patients in rural areas. However, gaps in CSB capacity impede service provision, with 76% of CSBs lacking necessary equipment (Lang et al., 2018). Of the CSBs II mandated to employ staff doctors, 47% lack these personnel, and 52% of CSBs I are managed by only one staff member (Ministère de la Santé Publique, 2019). In its National Strategic Plan for Strengthening Community Health (2019-2030), the Ministry of Public Health has affirmed its commitment to addressing these challenges by assuring the availability of required materials, equipment, and management tools for CSBs and reinforcing their role in the development of community health (Ministère de la Santé Publique, 2019).

Across Project Mitao target sites, CSBs provide key healthcare services, with 84% of the young people who participated in the project's knowledge, attitudes, practices, and beliefs (KAPB) surveys citing CSBs or hospitals as sources of sexual health information. Tsagnoriha and Sainte Luce are equipped with CSB Is, whilst Mahatalaky has a CSB II that, according to healthcare professionals interviewed by the project team, is mandated to provide HIV treatment. The nearest hospitals are located in the district capital of Fort Dauphin and the neighbouring village of Manambaro, which are at least a four-hour journey by public bus. To assess service accessibility and capacity in Mahatalaky, Tsagnoriha, and Sainte Luce, Project Mitao surveyed the Chiefs of the three CSBs using an adapted Service Accessibility and Readiness Assessment tool. This report offers a summary of key findings, gaps, and disparities in service provision across the three CSBs.

2 Methodology and Data Collection

The Service Accessibility and Readiness Assessment (SARA) survey used by Project Mitao was an abbreviated version of the World Health Organization (2015) tool, and questions were adapted to investigate infrastructure, staffing, sexual health services, and procurement. Surveys were translated into Malagasy and conducted in May and June 2019 with the Chiefs of the three CSBs.

Surveys were conducted by pairs of SEED's international and Malagasy national staff. The CSB Chiefs were informed of the purpose of the SARA survey and provided consent to participate in the research. Data were collected using paper surveys and inputted to Excel. These data were then analysed to identify capacity across service provision categories and differences amongst the sites.

3 Summary of Key Findings

- All three CSBs operate with severely limited staff, infrastructure, and utilities.
- Price and availability of contraception varies substantially across sites. Only male condoms are consistently free, whilst access to long-acting reversible contraception (LARCs) is limited.
- STI testing was unavailable in all three CSBs.
- HIV testing was reported to be consistently free and in-stock, but none of the CSBs offer follow-up testing or antiretroviral therapy (ART).
- The three Chiefs of the CSBs reported several instances where the CSBs did not follow or were unaware of national guidelines regarding SRHR services.

4 Results

4.1 Human Resources and Infrastructure

In Mahatalaky, two midwives and one pharmacist serve a population of approximately 12,000 people across seven village clusters *(fokontany)*, assisted by 14 government-sponsored ACs who practice mobile health promotion. Four additional ACs, who are funded by the Korean International Cooperation Agency (KOICA), sensitise young people about sexual and reproductive health (SRH). The CSB operates with no phone, no computer, and no emergency transport vehicle. There is reliable electricity from a community grid source but no running water because the pipe that connects the CSB to a well is currently broken. The CSB is a concrete structure comprised of four rooms, with no designated space for private consultations. The clinic operates 24 hours a day, seven days a week.

The CSB in Sainte Luce is staffed by one volunteer midwife and is assisted by two ACs, serving a total estimated population of 2,500. The clinic has no phone, computer, or emergency transport vehicle. The building has no electricity, but non-potable pumped water is available on the property. It is a concrete structure with three rooms and no designated space for private consultations. The Sainte Luce CSB operates 13 hours a day, seven days a week.

In Tsagnoriha, one midwife operates the CSB, which serves approximately 8,000 people. This Chief is assisted by 13 KOICA ACs and 10 Integrated Management of Childhood Illnesses ACs who raise awareness about child health. The CSB has no phone, computer, emergency transport, running water, or electricity. The Tsagnoriha CSB is a wooden structure comprised of three rooms, with no designated private consultation area. One midwife staffs the CSB 24 hours a day, seven days a week.

4.2 Family Planning Services

The Mahatalaky CSB has the widest variety of available family planning services. The midwives reportedly utilise job aids and guidelines to facilitate family planning provision. In-person parental consent is reportedly required for adolescents seeking family planning, although the head midwife noted that this is often overlooked, with written consent accepted as an alternative. Oral contraception and male condoms are free and consistently in stock. The implant and intrauterine device (IUD) are also free and in stock, but patients must pay for needles, gauze, alcohol, and other supplies necessary for insertion. These materials can be purchased at the pharmacy located inside the facility at a cost of 500 to 1,000 Malagasy Ariary (MGA)[1] ($0.15 to $0.30). Female condoms are offered for free but have been recently out of stock. Emergency contraception is available at a cost of 500 to 1,000 MGA ($0.15 to $0.30).

Sainte Luce offers substantially fewer family planning options. Contraception is not available to adolescents without parental consent, and staff do not use any family planning guidelines or checklists. The CSB offers male condoms, oral contraception, and hormonal injections. Male condoms are the only form of contraception that has been both free and consistently in stock during the three months prior to data collection. Oral contraception and the hormonal injection both cost 500 MGA ($0.15) and have been out of stock during the past three months. Female condoms, IUDs, implants, and emergency contraception have reportedly never been offered at the Sainte Luce CSB.

Like the other sites, the Tsagnoriha CSB frequently experiences shortages of certain contraceptive methods. However, the Chief reported consistent stocks of male condoms, hormonal injections, and IUDs, all of which are provided free of charge. Oral contraception is offered for free in Tsagnoriha, but stocks have been unreliable during the past three months. Female condoms, implants, and emergency contraception are never offered in the Tsagnoriha CSB. Reportedly, parental consent is required for any young woman under the age of 24 seeking the IUD or implant.

4.3 STI Services

All three CSBs offer STI testing, including for adolescents and without parental consent. Mahatalaky and Tsagnoriha reported having STI treatment guidelines on-site and receiving STI training during the two years prior to data collection. However, none of the CSBs currently have STI testing in stock. At the time of data collection, Mahatalaky had been without STI tests for two years, and Sainte Luce for three months. The Tsagnoriha CSB was unable to report how long it had been without STI tests. None of the facilities reported having rapid syphilis testing available. All three CSBs reported that, when testing is available, the service is free.

[1] 96.7% of the population in the region live on less than $1.90 (~7,000 MGA) per day (Healy, 2018)

The CSBs reportedly offer STI treatment, and all had medications in stock at the time of data collection[1]. Mahatalaky and Tsagnoriha reported having stable supplies of medication for STI treatment over the last three months, but Sainte Luce reported stock-outs. In all three CSBs, the cost of STI treatment depends on the diagnosis and regimen. The Chief of the Sainte Luce CSB specified that treatment costs 2,000 to 5,000 MGA ($0.55 to $1.40), whilst the Chief of the Tsagnoriha CSB reported that treatment costs an average of 1,000 MGA ($0.30).

4.4 HIV Services

All CSB staff have received training and printed guidelines on HIV testing protocol, but none of the clinics have private consultation rooms for HIV counselling[2]. HIV testing was free and in-stock at the three CSBs at the time of data collection. HIV tests are reportedly available to all patients, including pregnant women and adolescents, with no fluctuations in price over the last three months. All CSBs use rapid testing kits. Mahatalaky and Tsagnoriha have had stable testing HIV supplies, but Sainte Luce reported periodic stock-outs during the past three months[3]. Mahatalaky and Sainte Luce reported encouraging partner notification after HIV testing as part of their HIV protocol. After a positive diagnosis from the HIV rapid test, patients from all three village clusters must travel to the hospital in Fort Dauphin for follow-up testing and counselling.

None of the CSBs offers HIV treatment, such as ART and prophylaxis for HIV-positive pregnant women or their infants. Although Mahatalaky is reportedly mandated to treat HIV [4], the Chief explained that neither follow-up testing nor ART are currently offered. CSB staff have not received training and do not utilise guidelines on ART management. All CSBs provide family planning and breastfeeding counselling for HIV-positive women, but none reported routine HIV testing for infants born to HIV-positive mothers. Since none of the CSBs offer HIV treatment, the prices of follow-up testing and ART are unknown.

4.5 Health Systems and Service Integration

Survey findings indicate limited integration of STI and HIV services between rural CSBs and Fort Dauphin. Chiefs of the Mahatalaky and Sainte Luce CSBs reported referring patients to Amboanato Hospital in Fort Dauphin for follow-up HIV testing and initiating ART, antiretroviral prophylaxis, and ART management. Mahatalaky reported communicating with Amboanato Hospital about specific cases and referrals, but Sainte Luce and Tsagnoriha did not.

[1] The type of available medications was not specified; follow-up research will investigate the specific kinds of treated offered.

[2] According to Project Mitao's research, the known HIV prevalence in these sites is extremely low. Key informant interviews highlighted one unconfirmed case of an HIV-related fatality. During follow-up convenings, which occurred after the completion of the SARA surveys, the Chief of the Mahatalaky CSB confirmed that there had been one diagnosed case of HIV. Consequently, information about follow-up with HIV-positive patients is likely hypothetical.

[3] Since August 2019, HIV testing supplies in the entire Fort Dauphin district have been unavailable.

[4] During a follow-up convening, stakeholders reported that HIV treatment was mandated at certain CSB IIs, but this policy has not been verified.

All CSBs reported challenges in SRH supply chain and procurement processes. The main source of pharmaceuticals for the CSBs is the regional medical store run by the *Service de Santé des Districts* (District Health Service, or SSD). To restock supplies, the CSB Chiefs send lists of requested resources to the SSD and collect them during monthly SSD meetings in Fort Dauphin. The primary reason cited for stock-outs was that materials were not being delivered from the central supplier. The Chief of the Tsagnoriha CSB acknowledged that prices of medications and services increase during stock-outs.

5 Discussion

While inconsistent and limited across the three CSBs, all facilities had certain contraceptive options available at the time of data collection. Condoms were dependably in-stock and free in all three CSBs, but the cost and availability of all other family planning options varied. Male condoms, oral contraception, and hormonal injections were offered in all sites, but the availability of female condoms, implants, IUDs, and emergency contraception differed across facilities. According to Project Mitao's KAPB survey and extensive qualitative research, the hormonal injection is the most commonly used form of family planning amongst young women in these sites.

However, with 96.7% of the population in the region living on less than $2 per day (Healy, 2018), the equivalent of 7,000 MGA, the cost of 500 to 1,000 MGA every three months for contraception could be prohibitively high. Although LARCs, such as the implant and IUD, are the most effective forms of birth control and require minimal patient follow-up, these options were likely to be more expensive and out-of-stock. The prices of family planning options, according to the three CSB Chiefs, contradict the accounts of young people and certain key informants, who reported significantly higher costs of contraception during Project Mitao's focus groups and interviews.

Crucial gaps in supply chain and affordability prevent these CSBs from effectively providing STI services. For several months prior to data collection, none of the sites had had STI testing supplies. STI treatment is available in all sites but, ranging from 1,000 MGA ($0.30) to 5,000 MGA ($1.40), is potentially unaffordable for many patients. Without testing capacity, it is unclear whether STIs are being treated effectively or if symptoms are merely being managed. In the absence of formal diagnoses, improper treatment can lead to prolonged infections, heightened side effects, and further transmission.

Capacity for HIV testing is comparably high, with all three sites currently reporting that they had free rapid tests in stock. Two of the three CSBs also reported consistent supply over the last three months. None of the CSBs offer follow-up testing, ART initiation, ART management, or ARV prophylaxis for HIV positive pregnant women or their infants. Although HIV testing is accessible, people with positive diagnoses in these rural CSBs would have to travel to Fort Dauphin, or possibly even relocate, to receive continuous HIV care. This gap between HIV testing and treatment services contributes to HIV transmission and can prevent people living with HIV from receiving necessary care.

All three CSBs misunderstood or failed to comply with several national guidelines regarding SRH services. Despite the 2017 Reproductive Health and Family Planning Law that eliminated the need for parental consent for adolescents seeking family planning (UNFPA, 2018), each CSB reported restrictions on contraceptive access for young people.

The *Comité National de Lutte Contre le SIDA* (National Committee for the Fight against AIDS) National Strategic Plan for Multisector Prevention of STIs, HIV, and AIDS mandates that infants born to HIV positive mothers must be tested for HIV, but all three CSBs reported that they do not offer this service. This plan has also set the target of screening 95% of pregnant women for syphilis during antenatal visits, which is currently impossible in all three sites due to prolonged stock-outs of STI tests.

Although the government has offered free ART through Global Fund financing since 2005 (Raberahona et al., 2019), none of the CSB Chiefs reported that ART was a free service, highlighting further disparities amongst service costs and potential barriers to treatment provision.

6 Conclusion

The Service Accessibility and Readiness Assessment (SARA) survey has identified opportunities for further research that will strengthen situational knowledge of STIs and HIV in rural Anosy. Since the sites reported a lack of STI testing supplies, it is important to investigate the protocol that CSB nurses and midwives use to prescribe treatment regimens in the absence of formal diagnoses. Further research should investigate the discrepancies in reported pricing of family planning materials. Additionally, Project Mitao should examine CSB staff's understanding of how the reported new national policy – which mandates free healthcare including sexual health services to young people under 24 years of age [1] – can be feasibly implemented within these under-resourced settings.

This survey highlights inconsistencies in service provision capacity and awareness about service costs, which can be alleviated through improved training and stakeholder education. Due to the lack of adherence to family planning and HIV guidelines, policy updates should be communicated to healthcare providers and community members alike, and service provision must be standardised across facilities. To ensure that misbeliefs about pricing do not deter health-seeking, the cost of SRHR services should be clarified and properly regulated across healthcare facilities.

The lack of STI testing, frequent stock-outs of family planning options, and current unavailability of ART severely undermine SRHR service provision across sites. The three CSBs conveyed challenges in obtaining drugs and supplies from the regional medical store and periodic stock-outs of important drugs and medical supplies. Stakeholder coordination and supply chain management must be improved to ensure that SRHR services are affordable and accessible for all young people.

[1] This new national policy was first identified during correspondence with the district Ministry of Public Health. As information regarding the policy is still anecdotal, future research will seek to obtain formal documentation of the policy to understand funding details, timeline, and scope.

7 References

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