

Implementing an Emergency Transport Scheme in Rural Madagascar

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Context

Background

- Madagascar is the fourth-largest island in the world.
- Total population: 22,434,363 in 2014.
- 80% of the population live in rural areas.
- 65% of the population live more than 5 km from a health facility with lack of formal transport service.
- World Economic Forum ranked Madagascar 139 out of 140 countries in terms of quality of roads (WEF, 2016).
- Madagascar belongs to the group of least developed countries, according to the United Nations.

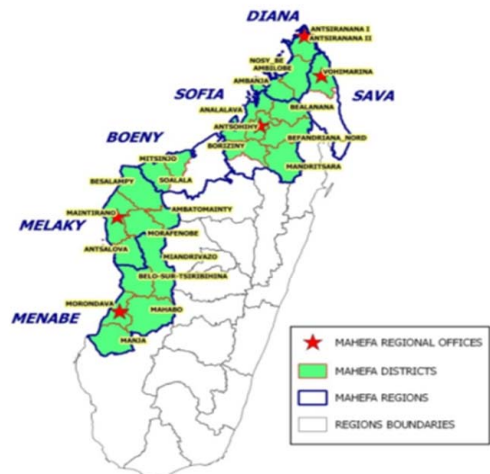


Fig. 1: Regions where the MAHEFA program was implemented

National health priorities

Reaching almost 4 million people in rural Madagascar, the MAHEFA program's activities supported the priorities of the Ministry of Health (MoH) and provided a significant contribution to reaching the 2019 targets set in the National Development Plan for the Health Sector.

National priorities by 2019:

- Reduce maternal mortality rate from 478 to 300 per 100,000 live births.
- Reduce new born mortality rate from 26 to 17 per 1,000 live births.
- Raise rate of deliveries in health facilities from 44% to 90%.
- Raise contraceptive prevalence rate from 28% to 38%.

Community-Based Integrated Health Program in Madagascar (MAHEFA, 2011-2016)

- Five-year USAID-funded program in 6 north/northwest regions of Madagascar.
- Integrated maternal and child health services through 6,080 Community Health Volunteers.
- Program reached almost 4 million people (1/5 of total population).
- 54% of program areas are inaccessible by car or truck at least 2 months of year.
- Mountainous, sandy areas, with access challenges in rainy season.

Approach to emergency transport

MAHEFA's emergency transport scheme (ETS) approach provided access to locally available and appropriate transport during health emergencies to improve health service access. The main activities conducted by the program to establish community based ETS were:

- Initial workshop to explain ETS in pre-selected *fokontany* (to assess interest and buy-in and to sensitize communities on the intervention.)
- A technical evaluation of the sites.
- Site selection and community-based ETS activity introduction. The community selected volunteer drivers and ETS management committee.
- Training for ETS management committee members, supervisors and drivers.
- Set cost and user fees. Guidelines on costing and potential ETS user fees were established so that communities can set their own prices based on demand, distances, and affordability.
- Establish reporting systems.



ETS Results

- Five districts had ETS in place.
- ETS activities were implemented in 11 communes covering 132 *fokontany* and 185,053 people.
- 160 ETS management committee members and 454 supervisors and riders trained.
- Five types of intermediate modes of transport (IMTs) were provided: stretchers with or without wheels (93), bicycle ambulances (50), cycle rickshaw ambulances (5), ox-drawn cart ambulances (8), and canoe ambulances (2).
- 4 eBox cooperatives established and provided with 2,562 bicycles.
- A total of 964 people were transported by the ETS from their community to health facilities.

One of the strengths of the MAHEFA program was having an integrated approach and package of services which did not look at supply or demand side work in isolation, but made sure that key components like community engagement and transport were fully integrated from the outset. This integrated approach sets MAHEFA apart from many other community health programs.

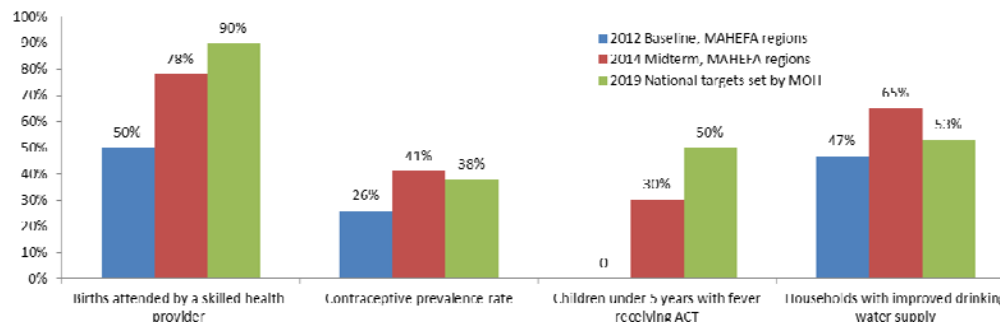


Fig. 2: MAHEFA Baseline and Midterm Results Compared to National Targets, Selected Indicators

Conclusions and lessons learned

- Essential to conduct a needs assessment to help ensure that community-based ETS is specific to the geography and local context.
- Focus on community engagement: Investing the time to establish community management systems, publicly recognize drivers, and sensitize the community for demand creation is essential to ensure that transport is accessible, volunteer drivers remain motivated, and community members know about the transport. Sensitizing midwives and other community care providers regarding service availability will also help to improve ETS uptake.
- Use locally produced modes of ETS. Building local capacity on transport production was an important part of the ETS innovation and promoted local ownership and cultural acceptance.
- Plan local solutions for maintenance and repair costs from the onset.
- Collect data on ETS use and services received by ETS users.

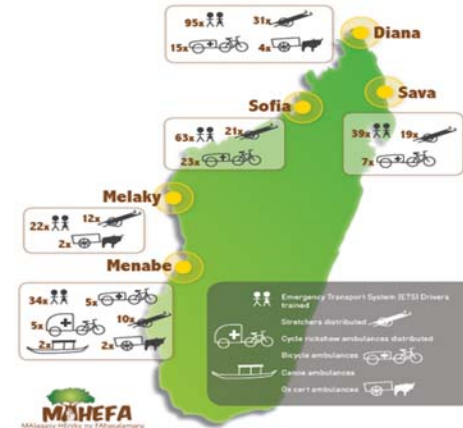


Fig. 3: Intermediate modes of transport put in place under MAHEFA

The road ahead

The USAID Community Capacity for Health Program (Mahefa Miraka) 2016-2021

- Build on the achievements of the previous MAHEFA program and improve the sustainability of the existing community health system, support improvement of MoH systems, and increase quality of services across the continuum of care.
- Expand the intervention from six to seven regions, 24 to 34 districts and 3,000 to over 5,000 *fokontany*, aiming to reach approximately 6.1 million people.