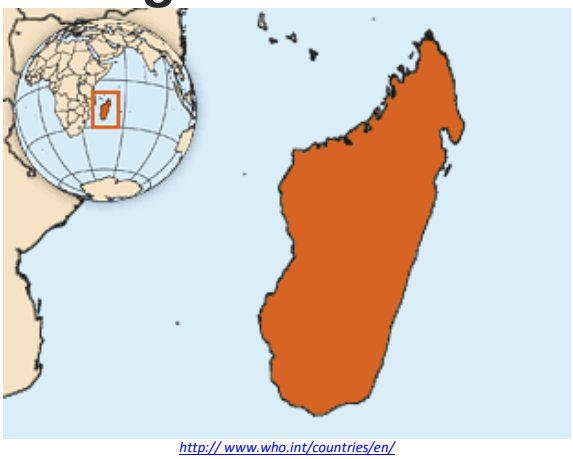
World Health Organization

Country Cooperation Strategy *at a glance*

Madagascar



http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Low-income
CURRENT HEALTH INDICATORS	
Total population in thousands (2012)	22 294
% Population under 15 (2012)	42.72
% Population over 60 (2012)	4.45
Life expectancy at birth (2012) Total, Male, Female	62 (Male) 64 (Both sexes) 65 (Female)
Neonatal mortality rate per 1000 live births (2012)	22(13-37) (Both sexes)
Under-5 mortality rate per 1000 live births (2012)	58 (41-82) (Both sexes)
Maternal mortality ratio per 100 000 live births (2010)	240 [160-400]
% DTP3 Immunization coverage among 1-year-olds (2012)	86
% Births attended by skilled health workers	
Density of physicians per 1000 population (2007)	0.161
Density of nurses and midwives per 1000 population (2004)	0.316
Total expenditure on health as % of GDP (2011)	4.1
General government expenditure on health as % of total government expenditure (2012)	15.3
Private expenditure on health as % of total expenditure on health (2011)	36.9
Adult (15+) literacy rate total (2009)	64.5
Population using improved drinking-water sources (%) (2011)	34 (Rural) 78 (Urban) 48 (Total)
Population using improved sanitation facilities (%) (2011)	19 (Urban) 11 (Rural) 14 (Total)
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2010)	81.3
Gender-related Development Index rank out of 148 countries	-
Human Development Index rank out of 186 countries (2012)	151

Sources of data:
Global Health Observatory, April 2014
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Despite the 2009-2013 crisis, some improvements have been observed thanks to public health initiatives such as, in particular, improved access to drinking water, intense malaria pre-elimination efforts and a campaign to improve children's health. Much nonetheless remains to be done in order to reduce the bulk of deaths that are avoidable.

Malaria remains a major public health concern in Madagascar, though the incidence rate has fallen from 9.28% in 2000 to 1.54% in 2009. In 2010 tuberculosis prevalence was estimated to be 489 per 100 000 of population and incidence 266 per 100 000.

Neglected tropical diseases (lymphatic filariasis, schistosomiasis, soil-transmitted helminthiases, leprosy, rabies, plague) affect the majority of the population living in rural areas and slums.

According to surveys of household living conditions conducted in 2005 and 2010, the national incidence of disease was 7.2% and 12.4% respectively. In the poorest quintile, the incidence rate has increased from 6.5% to 13.2%. There has been a recrudescence of diseases that indicate the growing vulnerability of the population in some regions.

HEALTH POLICIES AND SYSTEMS

Health coverage remains limited, and access to care is particularly difficult in rural areas, where 35% of the population lives more than 10 km from a health facility. Health-services utilization is still low: only 31.2% of the population attend basic health-care centres as outpatients.

Private, non-profit institutions (chiefly faith-based NGOs and civil society organizations) are present but do not coordinate with the public sector. Although varied and sometimes overlapping with the public health-care system, private-sector non-profit institutions (private clinics, independent practitioners, etc.) have a considerable comparative advantage over the public system in rural areas (immunization services, antenatal check-ups and deliveries). Special attention should be given, however, to better coordination of health coverage.

Implementation of the national community health policy has been effective but insufficiently coordinated; as a result of the crisis, there has been a proliferation of agencies working with communities directly, and each of them operates independently. Health-care coverage actually decreased between 2008 and 2012 with the closure of a number of health facilities. Services are limited by technical shortcomings such as lack of: (i) the necessary technical competencies to provide quality care and (ii) proper medical equipment and material.

Although the share of financing provided by the public sector has fallen, funds from other donors rose from US$ 92 to US$ 160 million between 2008 and 2010. Less than 10% of this funding, however, was channelled through the public authorities. This violation of the principles of the Paris Declaration has significantly impacted on aid effectiveness.

Despite the fact that certain products are provided free of charge, affordability of services remains a big obstacle given the low level of health-insurance coverage.

COOPERATION FOR HEALTH

The 2005 National Health Policy and the 2008 Madagascar Action Plan (Poverty Reduction Strategy Paper) are the reference points for the 2001-2011 health-sector development plan and the medium-term expenditure framework, and also for the development of a draft human resources development plan.

In May 2008, Madagascar also subscribed to the International Health Partnership and related initiatives (IHP+), which aligns development partners with a single, budgeted national strategy, a monitoring and evaluation framework and a joint review process to improve harmonization. This strategy focuses on results and mutual accountability for achieving the health-related Millennium Development Goals. Another encouraging development occurred in December 2008, when the Ministry of Health and 22 development partners signed up to the guiding principles of a sector-wide approach (SWAp) to address the challenges facing the health sector.

The political crisis of 2009 and the reluctance by technical and financial partners to fund the health-sector development plan discontinued implementation during that year. Since then, no framework documents for health-sector development have been updated, although subsectoral policies (for reproductive health, malaria and HIV/AIDS) do exist.

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2008-2013)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: Institutional support for the Ministry of Health, WHO	• Development/revision of policies and strategies, from coordination to implementation, and partnerships for health • Development of a sectoral approach and implementation of the Rome and Paris Declarations on ownership, alignment and harmonization in the health sector • Formulation of guidelines for public-private partnerships in the health sector • Strengthening of the national health information system • Capacity-building to establish national health accounts • Knowledge management capacity-building • Promotion of operational research, particularly in the areas of health, reproduction, the determinants of health and health systems research
STRATEGIC PRIORITY 2: Health system strengthening	• Capacity-building for health professionals and management teams to improve the operational effectiveness of regional health departments and health districts and the quality of services • Implementation of hospital reform through drafting of legislation and regulations and strengthening of management capacities • Drafting a human resources development plan based on strategic workforce planning • Establishment of a national observatory for human resources • Capacity-building for educators at health workforce training institutions • Review of pharmaceutical policy documentation; periodic updates to the national list of essential medicines • Implementation of the strategic plan for management and quality control; rational use of medicines and health inputs • Strengthening the national system of pharmacovigilance • Promotion of traditional medicine • Strengthening of community participation mechanisms • Implementation of health financing strategies based on the principles of equity and social protection
STRATEGIC PRIORITY 3: Maternal and adolescent health, infant survival	• Implementation of the roadmap for accelerating reduction in maternal and neonatal mortality • Implementation of the reproductive health policy • Implementation of infant survival interventions
STRATEGIC PRIORITY 4: Communicable disease prevention and control	• Strengthening implementation of strategies to eliminate malaria as a public health concern • Scaling up of interventions for universal access to preventive health services • Support care and treatment of STIs, HIV and AIDS • Capacity-building for community health workers to facilitate more effective contributions to the prevention, detection and treatment of tuberculosis • Control of neglected tropical diseases and chronic noncommunicable diseases • Disease surveillance and epidemic response
STRATEGIC PRIORITY 5: Management of the health consequences of emergencies and disasters	• Initial rapid assessments and ongoing evaluations following disasters, to quickly identify health needs and mobilize resources • Coordination of interventions • Local capacity-building
STRATEGIC PRIORITY 6: Health promotion	• Implementation of the national health promotion policy

NB work on the 3rd generation CCS began in early 2014

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