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# Analysis of the Operational Policies Related to Financing and Procuring Contraceptives in Madagascar

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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## EXECUTIVE SUMMARY

Contraceptive security exists when every person can choose, obtain, and use high-quality contraceptives whenever he/she needs them. Two of the most important factors in achieving contraceptive security are adequate financing and efficient contraceptive procurement mechanisms.

The USAID | Health Policy Initiative, Task Order 1 and the USAID | DELIVER PROJECT, Task Order 1 are working to develop a methodology for identifying operational policy barriers in the financing and procurement of family planning (FP) products. The projects selected Madagascar to pilot test this methodology.

Madagascar's population grew from 4.8 million people in 1955 to 18.5 million in 2005. Even with rapid population growth, Madagascar's FP program has been highly successful; undoubtedly the population would have grown faster than it did in the last 10 years if the country had not made great strides in improving access to FP services. The 1997 and 2004 Madagascar Demographic and Health Surveys (DHS) show that use of all contraceptive methods increased significantly from 19.4 percent to 27.1 percent of all married women of reproductive age. However, Madagascar's contraceptive prevalence rate (CPR) is still relatively low when compared with other sub-Saharan African countries. Field interviews for Madagascar's next DHS are currently under way, and preliminary results are expected sometime in early 2010. The government of Madagascar expects that, given its recent efforts to strengthen and prioritize family planning, CPR among currently married women will continue to increase.

Beginning in 2002, Madagascar's government began to place a high priority on family planning to help address rapid population growth. In January 2004, the Ministry of Health changed its name to Ministry of Health and Family Planning. By December 2004, the ministry had launched its first five-year National Family Planning Strategy and adopted a repositioning family planning initiative to increase demand for and access to FP services and reduce the high unmet need for these services. In September 2007, to further prioritize family planning in the country and increase access to contraceptive commodities, the Government of Madagascar declared that all contraceptives would be provided free of charge to clients in the public sector. Prior to September 2007, the government charged clients in the public sector for contraceptives—at amounts commensurate with the government's cost of procurement and transportation.

These policy efforts have paid off for Madagascar: surveys found only 2 percent stockout rates for injectable contraceptives at service delivery points in 2007, and for 2008, there were no stockouts reported for injectable contraceptives at service delivery points at the district level. Injectable contraceptives continue to be the most popular modern contraceptive method (49% of all married women using modern contraceptives used injectable contraceptives, according to the 2004 DHS).

However, while the government's decision in 2007 to make contraceptives free of charge in the public sector helps ensure that family planning is a priority, the policy may also have a negative unintended consequence. Implementation of this policy has resulted in the elimination of a revenue source used by district pharmacies to fund transport of contraceptives from the central to the district level. District pharmacies are typically run by nongovernmental organizations (NGOs). Prior to the 2007 policy decision, these NGOs were covering operating costs with the money generated from the cost recovery program. Therefore, while district pharmacies still have the financial responsibility to transport contraceptive commodities from the central level, as a result of the policy change, they no longer have funds available to cover these costs. As a result, a possible unintended consequence of this policy may be product availability issues at the service delivery level.

Furthermore, another challenge to contraceptive security in Madagascar is financial sustainability. As of 2008, the country is largely reliant on donor support for contraceptives (USAID, the United Nations Population Fund, and the World Bank provide the majority), affecting long-term sustainability.

Madagascar’s central medical stores for public sector commodities is a parastatal not-for-profit organization called SALAMA. SALAMA is quasi-governmental in that its primary client is the government of Madagascar—although it looks like a private sector company with a board of directors and the same financial considerations as any other commercial company.

SALAMA relies on an annual influx of capital from the Malagasy government to purchase the necessary pharmaceuticals. SALAMA does not receive funds from the government until approximately two months after delivery of goods. Because most SALAMA suppliers require a 40 percent advance, particularly on smaller purchases such as the injectable contraceptive, this can cause cash flow problems for the agency as the government provides an increasing share of financing for contraceptives.

The above factors indicate that while political commitment to family planning and contraceptive security in Madagascar is strong, the system for financing and procuring contraceptives through the public sector is still reliant on donor funding. In addition, without the financial assurances from the cost recovery program that existed prior to the government’s 2007 decision to provide all contraceptives free of charge, the districts may lack the revenue for transportation and distribution of contraceptives from the central to district levels.

This report includes recommendations for addressing some of the identified challenges related to procurement and financing (see Table 1).

**Table 1. Recommendations for Addressing Financing and Procurement Challenges**

Financing		
	Challenge	Recommendation
1.	Since the government’s decision in 2007 to make contraceptives free of charge in the public sector, financing for transporting contraceptive commodities from the central to the district level has been vulnerable. While district pharmacies still have the financial responsibility to transport contraceptive commodities from the central level, they no longer have funds available to cover these costs.	<ul style="list-style-type: none"> <li>Assure that finances are available for transporting contraceptives to the district level. The Ministry of Health and Family Planning should consider adding a budget line item to district budgets that gives specific funding earmarked for covering transportation costs from SALAMA in Antananarivo to the district level.</li> </ul>
2.	While the government’s decision in 2007 to provide contraceptives free of charge in the public sector was intended to increase access to family planning, several aspects of the public sector logistics system—such as transportation—may have been weakened by this policy decision.	<ul style="list-style-type: none"> <li>Analyze the impact and some of the unintended consequences of the decision to make contraceptives free of charge.</li> </ul>

3.	Even though family planning has strong political commitment and receives donor support for contraceptive commodities, this study highlighted several issues of coordination—between the ministry and SALAMA and between donors and the ministry.	<ul style="list-style-type: none"> <li>• Develop a tool that provides transparency to government partners and donors regarding funding cycles for better coordination.</li> </ul>
<b>Procurement</b>		
	<b>Challenge</b>	<b>Recommendation</b>
1.	<p><i>Quantification</i>—It is difficult for SALAMA to plan for customer demand. Quantification for contraceptives is currently a program activity managed by the Division of Family Planning. The data that are available to SALAMA comes in the form of orders placed by its customers, and some customers are irregular in their ordering practices.</p>	<ul style="list-style-type: none"> <li>• SALAMA should track orders as well as issues. In a setting where SALAMA can only fill about 80 percent of the products requisitioned, and receives no other downstream demand or inventory data, it needs to take advantage of the information that it does receive to monitor stock status and forecast future needs.</li> <li>• SALAMA should continue its collaboration with the Department of Family Planning and other partners on quantification exercises for contraceptives that model best practices.</li> <li>• If it has not already done so, SALAMA should articulate clear inventory and supply policies that will strengthen its management of all of its goods, including contraceptives.</li> </ul>
2.	<p><i>Product Selection</i>—SALAMA is required to solicit bids on generic products.</p>	<ul style="list-style-type: none"> <li>• SALAMA needs to define a process for justifying sole-source procurement so that it can procure some non-generic products, such as Jadelle, that have only a single supplier.</li> </ul>
3.	<p><i>Suppliers</i>—SALAMA’s purchases are relatively small, particularly for antiretrovirals. Therefore, it does not elicit many respondents to its requests for quotes. Limited supplier choice is often associated with higher unit prices for goods.</p>	<ul style="list-style-type: none"> <li>• To improve its supplier base and ultimately to achieve a lower cost per unit delivered, SALAMA has to be able to issue more unrestricted requests for quote, but it also has to make itself a more attractive customer. There are a number of ways SALAMA could do this: <ul style="list-style-type: none"> <li>○ Consolidate purchases. If the product shelf-life constraints and SALAMA warehouse space permit it, SALAMA could group products or take fewer, larger shipments of certain goods.</li> <li>○ Offer better payment terms. Capital permitting, SALAMA could offer to pay its suppliers by letter of credit or other more secure payment mechanism.</li> <li>○ Network with other institutions in the <i>Association des Centrales d’Achats Africaine des Médicaments Essentiels (ACAME)</i> to define good supplier criteria and to obtain references for new suppliers to approach for quotes with future business.</li> <li>○ Define and track supplier performance metrics for timeliness, accuracy, and quality; communicate these to the suppliers and provide feedback after each purchase.</li> </ul> </li> </ul>

4.	<p><i>Financing</i>—SALAMA is often paid by the government of Madagascar two months after it receives goods from suppliers. Suppliers generally require some payment in advance of delivery.</p>	<ul style="list-style-type: none"> <li>• SALAMA requires adequate capital in order to finance procurement. Lack of capital under the current circumstances has more impact on SALAMA-procured medicines than on donated contraceptives, but it may have an impact in the future as SALAMA's role in contraceptive procurement grows.</li> </ul>
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NOTE: The information in this report was collected in December 2008 prior to the March 2009 coup, which has led to suspension of foreign assistance by many donor countries, including the United States. As of this writing, the political situation remains unresolved.

## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CNLS	National AIDS Control Committee
CPR	contraceptive prevalence rate
DAMM	National Drug Control Laboratory of Madagascar
DHS	Demographic and Health Survey
DPF	Division of Family Planning
DMPA	Depot Medroxyprogesterone Acetate
DPLMT	Division of Pharmacy, Laboratory and Traditional Medicines
FANOME	community-level revolving drug fund
FHI	Family Health International
FISA	Fianakaviana Sambatra (Madagascar International Planned Parenthood Federation affiliate)
FP	family planning
HIV	human immunodeficiency virus
MAP	Madagascar Action Plan
MOHFP	Ministry of Health and Family Planning
MSM	Marie Stopes Madagascar
NGO	nongovernmental organization
PAIS	Program for Integrating Health Commodities
PDSS	Sector-Specific Plan for Health Sector Development
Ph-G-Comm	community-level pharmacy (at health center)
Ph-G-Dis	district-level pharmacy
PSI	Population Services International
SWAp	Sector-Wide Approach (to Health)
STI	sexually-transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## INTRODUCTION

The USAID | Health Policy Initiative, Task Order 1 and the USAID | DELIVER PROJECT received funding from the Contraceptive Security Global Leadership Priority of USAID's Global Health Bureau/Office of Population and Reproductive Health to develop a methodology for countries to identify the key operational policy barriers to efficient procurement and financing of health commodities, especially contraceptives. The goal is to help national governments, donors, and other key stakeholders improve the policy environment for contraceptive security.

NOTE: The information in this report was collected in December 2008 prior to the March 2009 coup, which has led to suspension of foreign assistance by many donor countries, including the United States. As of this writing, the political situation remains unresolved.

Before describing the methodology, it is important to first present definitions of common terms that appear throughout this report:

*Contraceptive security* exists when every person can choose, obtain, and use high-quality contraceptives whenever he/she needs them. Contraceptive security requires political commitment by governments and donors, multi-stakeholder coordination at multiple levels, a whole market approach where the opportunity exists, consistent availability of contraceptive supplies, and finally, adequate financing and efficient procurement mechanisms for the purchase of contraceptives—two areas this report examines in-depth.

*Operational policies* are defined as the formal or informal guidelines rules, regulations, codes, plans, procedures, and administrative norms that governments use to translate national laws and policies into programs and services. *Operational policy barriers* are the operational policies or norms that pose obstacles or challenges to commodity security. These may be unintended consequences of policy implementation or the result of policies and procedures that are insufficient to safeguard contraceptive supply.

## Methodology

The Health Policy Initiative and the USAID | DELIVER PROJECT are working to develop a methodology to identify operational policy barriers in the financing and procurement of family planning (FP) products. The projects first piloted the methodology in Malawi; Madagascar is the second application of this methodology.

The study included two phases: (1) conducting a policy analysis to gain an understanding of the policy and stakeholder landscape and (2) validating the current policy landscape for contraceptive security and identifying critical operational policy barriers. First, the study team engaged a local Malagasy consultant to gather the country's policy documents and make arrangements for multiple stakeholder interviews during the study team's visit to Madagascar (see Annex A: Study Team Members). As part of this effort, the consultant assisted in preparing an inventory of all policies, regulations, and guidelines that pertain to financing and procuring health commodities, particularly contraceptives, in Madagascar (see Annex B: Documents Reviewed).

In December 2008, the study team visited Madagascar to conduct the analysis. The team interviewed approximately 25 organizations at both the national and district levels regarding operational policy barriers to the financing and procurement of contraceptives (see Annex C: Stakeholders Interviewed). This report summarizes the barriers identified and the team's recommendations for addressing them.

## **Study Limitations**

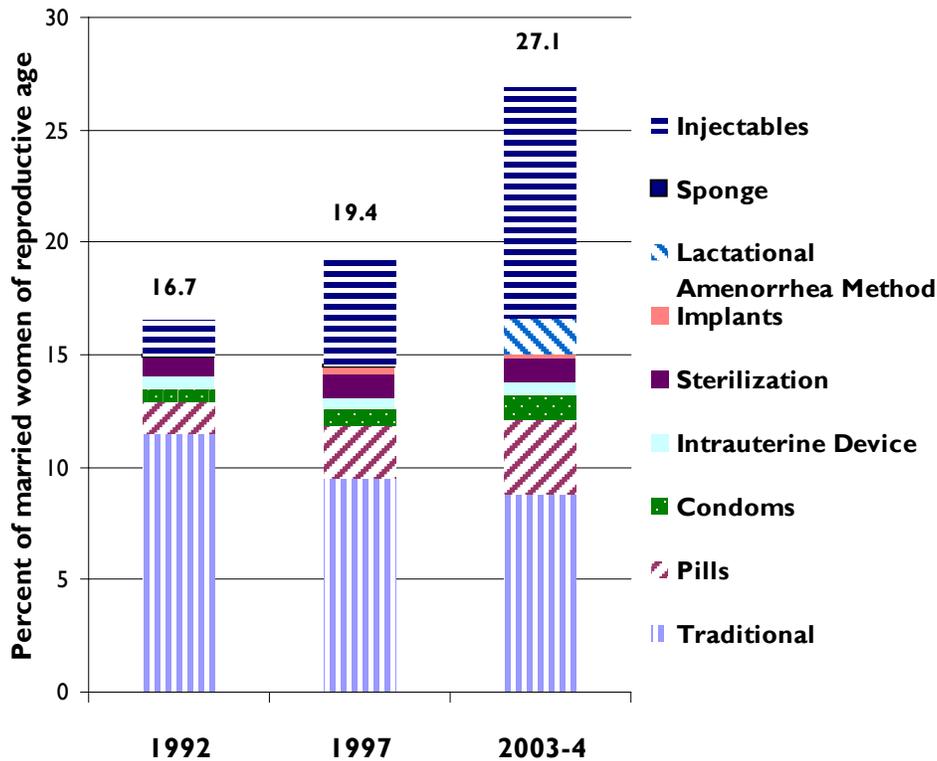
While the study team interviewed approximately 25 stakeholders in Madagascar, the site visit lasted only two weeks, which could be considered a limitation. Because of time constraints, the team was only able to visit two districts in the region of Analamanga—one of which was the capital city of Antananarivo and the other was a district near the capital called Ambohidratrimo. While the team reviewed most of the primary policy documents that pertain to contraceptive financing and procurement, the team did not have access to as many operational policies, such as those governing procedures, guidelines, and regulations.

## **The Policy Environment for Family Planning in Madagascar**

Madagascar's national vision is to become a prosperous nation, with a high growth economy and a strong role as a competitor in the global marketplace. To achieve this status in the global economy, Madagascar understands that it must pay special attention to population growth and its negative impact on economic development and prosperity. Madagascar's population size has grown rapidly since the 1950s. In 1955, the population was 4.8 million; by 1985, the population had ballooned to 10.4 million. Twenty years later, in 2005, Madagascar's population had reached 18.5 million people; experts predict that that number will reach 78 million by 2050 at the current fertility level (5.2 children per woman according to the 2004 Madagascar Demographic and Health Survey).

Even with rapid population growth, Madagascar's FP program has been highly successful; undoubtedly the population would have grown faster than it did in the last 10 years if the country had not made great strides in improving access to FP services. The 1997 and 2004 Madagascar Demographic and Health Surveys (DHS) show that use of all contraceptive methods increased significantly from 19.4 percent to 27.1 percent of all married women of reproductive age (see Figure 1). However, Madagascar's contraceptive prevalence rate (CPR) is still relatively low when compared with other sub-Saharan African countries. Field interviews for Madagascar's next DHS are currently under way, and preliminary results are expected sometime in early 2010. The government of Madagascar expects that, given its recent efforts to strengthen and prioritize family planning, CPR among currently married women will continue to increase.

**Figure I. Total Contraceptive Use in Madagascar**



Source: Madagascar Demographic and Health Surveys

Beginning in 2002, Madagascar’s government began to place a high priority on family planning to help address population growth. In fact, in January 2004, the Ministry of Health changed its name to Ministry of Health and Family Planning (MOHFP). The name change demonstrated the high level of political commitment to family planning. By December 2004, the ministry had launched its first National Family Planning Strategy for 2005–2009 and adopted a repositioning family planning initiative to increase demand for and access to FP services and reduce the high unmet need for these services (23.6 percent of all married women expressed an unmet need for FP services according to the 2004 DHS). In September 2006, the ministry began efforts to reposition family planning in Madagascar in view of the country’s development plan, the Madagascar Action Plan (MAP). The ministry introduced the *Plan Sectoriel en Planning Familial 2007–2012* (Sectoral Plan for Family Planning) in order to achieve the MAP’s objectives through increased family planning. The ministry also created an Executive Secretariat for Family Planning within the ministry and a Family Planning Steering Committee.

In September 2007, to further prioritize family planning in the country and increase access to contraceptive commodities, the Government of Madagascar declared that all contraceptives would be provided free of charge to clients in the public sector. Prior to September 2007, the government charged clients in the public sector for contraceptives—at amounts commensurate with the government’s cost of procurement and transportation.

These policy efforts have paid off for Madagascar: the country reported only 2 percent stockout rates for injectable contraceptives at service delivery points in 2007. In 2008, there were no stockouts reported for

injectable contraceptives at service delivery points at the district level.<sup>1</sup> Injectable contraceptives continue to be the most popular modern contraceptive method (49% of all married women using modern contraceptives used injectable contraceptives, according to the 2004 DHS); thus, a low rate of stockouts is critical to maintaining a strong FP program.

### **Public Sector Sources of Contraceptives**

Since the September 2007 policy decision, women have been able to obtain all contraceptive methods free of charge. Madagascar's health system is decentralized, with seven health regions, 111 districts, and more than 1,597 communes within those districts. At the district level, women can obtain contraceptives at the Pha-G-Dis, or district pharmacy that is typically managed by a nongovernmental organization (NGO); at the commune level, women can obtain contraceptives at the *centre de santé de base* (health center) that has a Pha-G-Com or pharmacy based at the health center. The public sector system provides injectable and oral contraceptives, intrauterine devices, spermicide, and CycleBeads. While condoms are available at the Pha-G-Dis and Pha-G-Com levels, the national family planning program does not consider them an FP commodity. The study team learned that condoms are handled by the National AIDS Control Committee (*Comité National de Lutte Contre le SIDA—CNLS*) separately from the family planning commodity supply chain.

### **Private Sector Sources of Contraceptives**

In addition to public sector health services, Madagascar has several private sector sources for contraceptives and FP services. Population Services International (PSI) has had a social marketing program for contraceptives in Madagascar since 1998. The PSI contraceptive portfolio includes oral and injectable contraceptives, implants, CycleBeads, condoms, and intrauterine devices. PSI relies on the 5,000–7,000 *agents de santé de base* in Madagascar (community health workers) to sell and distribute contraceptives. PSI's last point of sale, however, is the *depot de médicaments* (medicine warehouse). The community health workers are managed and trained by local nongovernmental organizations and are permitted to sell the contraceptives for a small price. Population Services International receives its commodities from USAID, the Institute for Reproductive Health at Georgetown University, central medical stores, and a pharmaceutical wholesaler (PHARMAD).

Marie Stopes International's local affiliate, Marie Stopes Madagascar (MSM), has 15 clinics across the country that provide maternal and reproductive health services, including family planning. MSM has operated in Madagascar since 1992 and is known for increasing access to long-term and permanent family planning methods through 11 mobile clinics with trained doctors and nurses who work through rural community health centers, as well as a social franchise of private reproductive health providers under the BlueStar brand. MSM obtains its contraceptive commodities from Marie Stopes International and directly from district health authorities.

The International Planned Parenthood Federation also has a local affiliate in Madagascar, called Fianakaviana Sambatra (FISA). FISA has operated in Madagascar for 45 years and was the first nongovernmental organization in Madagascar to provide contraceptives and family planning services. Through its several clinics, FISA provides FP services, treatment of sexually-transmitted infections, HIV testing and counseling, and postabortion care. The organization does charge a small fee for contraceptives and FP services and gets its commodities from the International Planned Parenthood Federation as donations, FARMAD, the central medical stores, PSI, and other sources.

Despite their contributions to increasing access to family planning in Madagascar, neither PSI nor FISA has tax-exempt status for importing contraceptives into Madagascar. USAID and United Nations agencies

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<sup>1</sup> SanteNet I Project, Public Sector Contraceptive Stockout Surveys for 2006, 2007, 2008.

are both exempt from taxes for all pharmaceuticals, including contraceptives, imported into the country. Currently, PSI and FISA rely on their donors to pay the import taxes for any commodities imported into Madagascar. With different tax treatment between the public and social marketing sectors, organizations such as PSI may be required to account for this tax payment in the cost of their products.

### **Community-based Distribution of Contraceptives**

Madagascar is also recently making efforts to expand access to popular contraceptive methods through a community-based distribution program that allows *agents de santé de base* to sell and administer injectable contraceptives. In 2007, Family Health International (FHI) began implementing a program that allowed community health workers to sell oral contraceptives, CycleBeads, spermicide, and condoms and administer injectable contraceptives.

The community-based distribution program that included the administration of injectable contraceptives began just prior to the September 2007 MOHFP decision to make all contraceptives in the country free of charge. For a time after this decision, there was confusion about whether the programs run by FHI, PSI, and FISA could charge anything for contraceptives. The government finally settled with the social marketing organizations to allow social marketing—and charging for contraceptives and FP services—to continue. For the community-based distribution program, the Malagasy government decided to allow community health workers to charge a small fee to cover their transport fees necessary to restock their supply of contraceptives, but that the contraceptive commodities themselves should still be free. Today, community health workers that the study team visited charge 200 Malagasy ariary (approximately 10 cents) for one administration of injectable contraceptives and 50 ariary for one month's supply of oral contraceptives (approximately 3 cents). The program relies on supplies from the public sector and central medical stores; community health workers must travel to the nearest *centre de santé de base* to resupply.

# FINDINGS: FINANCING OF CONTRACEPTIVES IN MADAGASCAR

Adequate and consistent financing for contraceptives and supplies is critical to achieving contraceptive security. In Madagascar, financing for contraceptives is provided primarily through donor contributions. The United Nations Population Fund (UNFPA), USAID and the World Bank (through UNFPA's procurement system) are the major providers of contraceptive commodities. Since 2006, however, the Government of Madagascar has purchased a small quantity of injectable contraceptives from its own budget. The government plans to continue to increase this contribution over the upcoming years (although there are no specific goals for increases in government contribution). The overall funding level to meet *the current contraceptive demand* is adequate; although, Madagascar is highly reliant on donor provision of contraceptives. This section of the report examines the overall funding environment for health, the commitment to and availability of funding for contraceptives, and the operational policies affecting contraceptive financing.

## Overall Funding for Health

The overall funding environment for health is an important macro-level consideration. Funding for health in Madagascar is mandated by the MAP—"Commitment 5: Health, Family Planning and the Fight Against HIV/AIDS"—and the sector-specific plan for developing the health sector, the *Plan de Developpement du Secteur Santé* (PDSS), 2007–2011. The MAP is an overall development and poverty-reduction plan with eight "commitments" to various development areas, mirroring the eight Millennium Development Goals.

The MAP for 2007–2011 replaces the first poverty-reduction strategy, the *Document de Stratégie de Réduction de la Pauvreté*. The PDSS is a health sector-specific development plan intended to operationalize the priority strategies, goals, and objectives for health articulated in the MAP. The PDSS implements and is consistent with the *Politique Nationale de Santé*, the National Health Policy. According to the PDSS, the PDSS sector strategy is meant as a unified plan to implement both the MAP and National Health Policy.

According to the PDSS, 32 percent of costs for health services are currently covered by the Government of Madagascar; 36 percent by donors; and 32 percent by private monies (19 percent of private spending is out-of-pocket expenses—70 percent of which is used to buy pharmaceuticals).<sup>2</sup> General health spending per capita in Madagascar is lower than the average in sub-Saharan Africa—US\$11.90 per person as compared with US\$12.90 on average for sub-Saharan Africa as a whole. Of the US\$11.90 per capita annually spent on health services, the government contributes only US\$5; the remaining US\$6.90 is provided by donors and through out-of-pocket expenses.

While some of the health centers at the community level have mutual insurance schemes to help finance health services, the large majority of funding for health services comes from the central level and passes through a decentralized administrative structure—first central, then regional, then district, and finally community level. Nevertheless, as Madagascar is largely rural, the Malagasy government steadily increased financing for the "periphery" or locally-based health services and decreased spending at the central level between 1998 and 2006. The PDSS reports that although funding for health services is gradually becoming more decentralized, most of the progress in decentralization has occurred at the district level, and much of the objectives and targets for decentralization to the community level are still a work in progress.

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<sup>2</sup> PDSS document, p. 22.

Drugs in Madagascar are available in the public sector for a small charge through a cost-recovery program. As of the 2007 policy decision, however, contraceptives are the exception to this practice. Prior to 2007, contraceptives were also sold for a small amount that would help the community- and district-level pharmacies recover their costs for stocking, storage, and transportation. Today, all contraceptives are free of charge in the public sector. Pharmaceuticals for malaria and leprosy are also free of charge.

At the community level, some community health centers have a revolving drug fund called a FANOME that assists community members to purchase the necessary drugs. The small income from the sale of a drug is added to the FANOME for resupply and restocking. This system seems to work for essential medicines and other pharmaceuticals, but contraceptives are rarely resupplied through the FANOME. Although there may be operational policies at the community level to cover the transportation of essential medicines from the district-level pharmacy to the community level, the communities do not seem to apply these policies to contraceptives—regardless of the fact that contraceptives are considered essential medicines and are included in the essential drugs list.

Madagascar's central medical stores for the public sector is a parastatal not-for-profit organization called SALAMA. SALAMA is quasi-governmental in that its primary client is the government of Madagascar—although it looks like a private sector company with a board of directors and the same financial considerations as any other commercial company.

SALAMA relies on an annual influx of capital from the Malagasy government to purchase essential medicines. In October of every year, the Government of Madagascar and MOHFP create annual budgets for the following fiscal year beginning in January. The Malagasy government pays SALAMA *once per year* for government pharmaceutical procurements—in February or March. Because SALAMA is not fully capitalized and receives a lump sum from the Government of Madagascar only once a year, the organization typically only pays a portion of the cost of a procurement before the delivery and many times pays 100 percent on the delivery date for a pharmaceutical procurement.

For donated products from donors such as USAID and UNFPA, SALAMA receives the commodities directly into the warehouse. Although the FP commodities are integrated into SALAMA's main warehouse in Antananarivo, there are still 22 separate pharmaceutical warehouses for the public sector because of vertical programs and other donor practices. Madagascar is trying to significantly reduce the number of warehouses and pharmaceutical storage facilities in and around the capital through the *Programme d'Action pour l'Intégration des intrants de Santé* (PAIS), a national strategy for integrating the procurement and delivery of all health commodities for the public sector.

As of the study team's interviews in December 2008, SALAMA procures 60 percent of all essential medicines for Madagascar's public sector (those included in the *Liste Nationale des Médicaments Essentiels*).

## Financing for Contraceptives

At the policy level for financing, Madagascar demonstrates strong commitment to family planning. From the MAP to the PDSS to the *Plan du Développement du Secteur Santé*, Madagascar's major development documents and policies articulate a clear vision for family planning services in the country, including sustainability. In the MAP, Commitment 5 (which aligns with Millennium Development Goal 5) lists as one activity to “identify and implement an innovative financing strategy to ensure sustainability and general availability of family planning programs.”<sup>3</sup>

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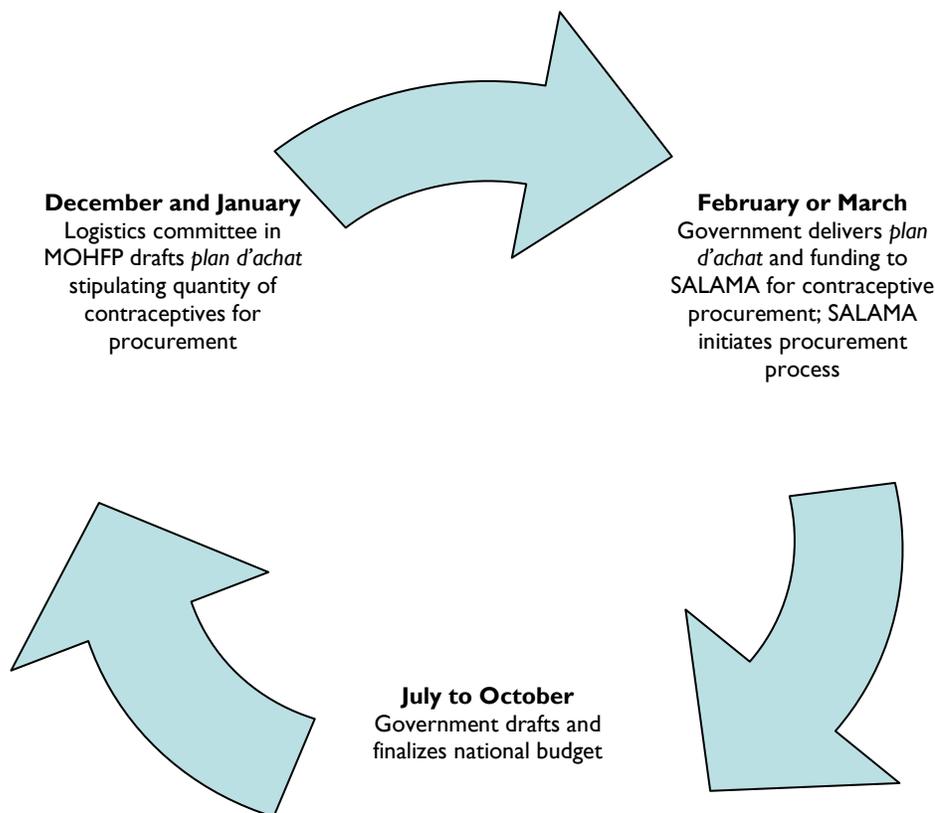
<sup>3</sup> MAP: *Madagascar Action Plan* or *Plan d'Action de Madagascar* summary document, p. 77.

Since the policy decision in September 2007 to allow contraceptives to be free of charge for the public sector, sustainability of Madagascar’s family planning commodities has not been assured and may pose a threat to the logistics and distribution system. As of 2008, USAID and UNFPA provide approximately 90 percent of Madagascar’s contraceptives. UNFPA provides Depo-Provera®, implants, and oral contraceptives; USAID provides female and male condoms, oral contraceptives, and Depo-Provera®. Male condoms are not currently treated as an FP method.

Beginning in the 2006 funding cycle, the Madagascar MOHFP started to procure small amounts of contraceptives to begin to take on more of the responsibility for the financing and procurement of contraceptives. The ministry chose to procure injectable contraceptives because these are the most popular modern method. In 2008, the ministry purchased a small quantity of Petogen® (approximately US\$200,000 worth), a brand of three-month injectable contraceptives from a South African company affiliated with German-based Helm Pharmaceuticals.<sup>4</sup> Although there are no specific goals for increasing government contributions, each year since 2006, the ministry has increased the amount of injectable contraceptives it purchases.

As described in the previous section, the Government of Madagascar provides financing to the central medical stores, SALAMA, one time per year in either February or March. The government begins developing the national budget in July of each year, and the budget is voted on and approved annually in October (see Figure 2).

**Figure 2. Funding and Procurement Cycle for Contraceptives in Madagascar**



<sup>4</sup> Helm Pharmaceuticals was responsible for registering Petogen® in Madagascar with the national drug laboratory (Agence du Medicament de Madagascar—DAMM).

Apart from the funding cycle, the MOHFP plans contraceptive procurements twice annually—once at the end of December and again in June to make adjustments. The *Comité Logistique* is the logistics committee chaired by the MOHFP. This committee forecasts the annual contraceptive needs using district-level pharmacy data and presents the quantities and total funding gap to partners and donors in January. At this January meeting, the partners and donors discuss their contributions of commodities; the ministry compiles this information into a *plan d'achat*—a plan for purchased and donated contraceptives for the public sector. SALAMA receives the *plan d'achat* and necessary funding for MOHFP contraceptive purchases in February or March annually.

When the study team asked the MOHFP about the Petogen® procurement and why the ministry decided to procure Petogen® instead of the Depo-Provera® that UNFPA and USAID donate, the Department of Family Planning did not seem to know that the injectable contraceptives procured by SALAMA were not the same brand or packaging as the bulk of the injectable supply for the country. While Petogen® is the same formulation as Depo-Provera® and acts for three months, the dose vials are packaged separately from the syringes, in contrast to Depo-Provera®, which is packaged with a syringe for administration. This misunderstanding demonstrates the need for better coordination between the SALAMA, the ministry, and its partners because often a different product with seemingly small differences will have implications for administration and use at the consumer level.

Although contraceptives in Madagascar are included on the essential drugs list, this inclusion does not seem to guarantee contraceptives the same treatment that other essential drugs receive. As this report will describe in the next section, current policies stipulate that essential drugs for Madagascar are exempted from customs fees and entry tax. Even though contraceptives are included in the country's essential drugs list, they do not consistently receive this exemption.

The study team also identified an apparent omission from Madagascar's registered drug list. The *Direction de l'Agence de Medicament de Madagascar* (National Drug Quality Laboratory—DAMM) in the MOHFP maintains a list of all contraceptives registered for distribution in Madagascar. The most recent version of this list does not include the most popular modern contraceptive product: Depo-Provera®. Petogen®—the injectable contraceptive procured by the Ministry and SALAMA in 2008—is registered with the DAMM, as is one other injectable contraceptive manufactured by Organon from the Netherlands.

While the government's decision in 2007 to make contraceptives free of charge in the public sector is intended to increase access to family planning, it may have an unintended consequence on contraceptive availability at the service delivery level and, ultimately, the sustainability of commodities for the family planning program. In making contraceptives free of charge, the policy eliminates the cost recovery system for contraceptives. Prior to the 2007 policy decision, districts and communities used the revenue from the cost recovery program to cover the transportation costs charged by SALAMA for distributing contraceptives from the central level (9% of the value of the contraceptives). Without this source of revenue, district pharmacies will not have the funds to cover these costs—yet they will still have the financial responsibility to transport contraceptives. Accordingly, stakeholders suggest that district pharmacies may lack the incentive to order contraceptives from SALAMA.

While the unintended consequences were not yet apparent at the time of the study, numerous stakeholders highlighted these potential consequences as an important concern. The study team learned from several districts that the remaining funds left from 2007—when districts could recover costs on contraceptives—are expected to “disappear” in the first quarter of 2009. In December 2008, a national family planning coordination meeting held outside of Antananarivo addressed this potential issue and resolved to ask donors to provide more resources for financing transportation of contraceptives. It is currently unclear how those resources will be provided and by which donor or partner.

As previously mentioned, community-level pharmacies do have operational policies and guidance for covering the costs of picking up essential drugs from the district level to transport them to the community level. However, because contraceptives are not treated as essential drugs, these resources are not available for transporting contraceptives.

## Financing Recommendations

In general, neither the Department of Family Planning within the ministry nor SALAMA highlighted any significant issues with financing contraceptives, aside from the transportation issue. Neither donor funding cycles nor payments from the Ministry of Finance to SALAMA for annual procurements were an apparent challenge (although, with the small size of the current government procurements of contraceptives, this may be difficult to conclude).

The study team recommendations for strengthening operational policies for financing contraceptives are made within the framework that the Government of Madagascar aims to take on increasingly more responsibility for procuring contraceptives with its own funds. As a system that relies heavily on donor commodities and strong donor support, there are few financing challenges that prove insurmountable, but for a sustainable FP program in the future, the study team proposes that the Malagasy government consider the following recommendations as it evaluates how to take on more of the financing for contraceptives:

- **Assure that finances are available for transporting contraceptives to the district level.** The Ministry of Health and Family Planning should consider adding a budget line item to district budgets that gives specific funding earmarked for covering transportation costs from SALAMA in Antananarivo to the district level. Districts that are geographically close to the capital may retrieve contraceptives using district transportation, but districts that are much further from the capital and inaccessible during the rainy season do not have alternative ways of funding transportation for contraceptives.
- **Analyze the impact and some of the unintended consequences of the decision to make contraceptives free of charge.** There could be additional impacts on contraceptive security and the availability of contraceptives at the community level that may not have been anticipated. Is the current supply and financing structure adequate to accommodate the increased demand from FP promotional campaigns and the community-based distribution program through community health workers?
- **Develop a tool that provides transparency to government partners and donors regarding funding cycles for better coordination.** Even though family planning has strong political commitment and receives donor support for contraceptive commodities, this study highlighted several issues of coordination—between the ministry and SALAMA and between donors and the ministry.

# FINDINGS: PROCUREMENT OF CONTRACEPTIVES IN MADAGASCAR

## Legal Framework

Procurement of contraceptives, as well as other medicines and medical supplies in Madagascar is governed by the Health Code of 1962. This code has been further elaborated over the past 46 years by a series of public announcements and decrees. Tax-free importation of goods is described under the *Code des Douanes*, Note 75 MEFB/SG and *Arrêté 16152 (2007) (Portant Franchise des droits et taxes à l'importation)*. Importation of contraceptives as well as other essential medicines by the government and by bilateral partners is exempt from value added tax and importation taxes. However, the ports are managed by a private, commercial firm. Therefore, all other handling fees and port charges apply to these goods as they would to other shipments. Contraceptives and other essential medicines imported by private firms are subject to a 20 percent tax by the customs agency. This tax is based on the assessed commercial value of the goods.

The Family Planning Sector Plan (2007–2012) contains an objective pertinent to the issues of finance and procurement. Under the goal of creating a favorable environment for family planning, a specific objective reads: *Objective: Improved coordination for forecasting, procurement and financing of contraceptives.*

## Agencies Involved in the Procurement Process

Many agencies are involved in procuring goods for the generic essential medicines program.

**Product selection.** According to SALAMA personnel, all goods procured by SALAMA must be selected from the national essential medicines list. This list is updated by the Division of Pharmacy, Laboratory and Traditional Medicines (DPLMT) every two years in consultation with the MOHFP, the Family Planning Division, and concerned partners such as WHO and other United Nations agencies. The DPLMT is also the administrator of the PAIS, the national project to integrate drug management. In this effort, the DPLMT partners with the United Nations Children's Fund (UNICEF), WHO, UNFPA, CNLS, PSI, and USAID. All contraceptives used in the public sector are on this list. Interestingly, medical devices, such as condoms, are listed by their "active molecule," the lubricant, not as condoms.

**Product registration.** All medicines for human consumption are subject to registration under the DAMM. Registrations currently last for five years, although the DAMM is considering reducing registration validity to three years. Typically, the manufacturer's agent or the agency interested in importing the product takes responsibility for registering the product. If all paperwork is complete and satisfactory, registration can take as little as three weeks. Lack of registration has not been a barrier to the importation of goods on the generic essential medicines list. Registration of a particular product is by manufacturer and brand, and it was not possible to ascertain what percentage of medicines or of contraceptives procured by SALAMA was actually registered.

The DAMM is responsible for quality control on a national level. The DAMM is also a founding member of the Franco-African Quality Control Laboratory Network and has partnered with the WHO, the European Pharmacopeia, and the U.S. Pharmacopeia on various efforts designed to strengthen the capacity of its quality control lab.

**Forecasting, quantification, and the development of procurement plans.** The tasks of forecasting and quantification of contraceptives, as well as the development of procurement plans, are the responsibility of the Department of Family Planning. It is an iterative process that engages development

partners such as USAID and UNFPA, as well as other Malagasy agencies such as the Department of Family Planning for budgeting and SALAMA for assessing stock status. A report of the logistics committee on its acquisition plans is the product of an annual workshop, and the logistics committee, with support from the USAID | DELIVER PROJECT, is responsible for monitoring implementation of these acquisition plans.

**Preparing and issuing requests for quotes.** SALAMA operates under a 10-year convention with the government of Madagascar, making it the only organization that can supply medicine to MOHFP sites. The current convention runs from 2006–2016. SALAMA prepares and issues requests for quotes on behalf of agencies that use its procurement services, particularly the MOHFP. In the case of injectable contraceptives procured on the MOHFP’s behalf, SALAMA issues a limited request for quote to three qualified vendors rather than issuing a public request for tender.

**Supplier evaluation and selection.** SALAMA works with approximately 30 international suppliers, as well as 20 local suppliers to provide about 360 different generic medicines, more than 200 non-drug consumables, and more than 200 lab reagents. Responses to requests for quotes are evaluated by a committee, including a representative of SALAMA, and in the case of reproductive health program goods, the Division of Family Planning (DPF). A challenge related to the procurement of antiretroviral drugs is that only a small number of vendors reply to the requests issued by SALAMA.

**Developing and issuing supplier contracts.** Developing and issuing contracts with suppliers is the responsibility of SALAMA.

**Quality control and inspection.** Quality control is largely in the hands of the supplier. The DAMM analyzes samples in response to reported problems. In 2007, in addition to the 26 quality control inspections conducted specifically for SALAMA, the DAMM performed 82 mini-lab assessments. About 20 percent of the products tested were found to be non-conforming, but this is unsurprising as the products tested were already suspect due to some other observation. The DAMM has never been required to test contraceptives and does not currently test any hormonal products, condoms, or other contraceptive medical devices because quality is largely assured by USAID and UNFPA as the principal donors.

**Customs clearance and receipt and inspection of goods.** These responsibilities fall to the recipient. In the case of the injectable contraceptives procured by SALAMA, the consignee was the MOHFP, so ultimately the ministry was responsible. SALAMA, as the ministry’s procurement agent, provides technical assistance with customs clearance and receipt. All tariffs and port fees are clearly documented by Madagascar International Container Services, Ltd., the private firm that runs the port at Toamasina. The last port tariff schedule publication was updated in January 2008. On the other hand, taxes and their collection are the responsibility of the customs office.

## **Procurement Processes**

The study team was not able to obtain any written policies or standard operating procedures related to procurement from SALAMA. Without documentation, it is not possible to confirm whether SALAMA has policies that pose barriers to contraceptive procurement, but the available information suggests a functional organization that ensures supplies of donated and government procured contraceptives to the public sector. There was no documentation indicating that dollar thresholds were being applied to select different procurement strategies (e.g., shopping on the local market vs. competitive tender). The national policy is to procure generic medicines, a best practice.

SALAMA prepares and issues requests for quotes on behalf of agencies that use its procurement services, particularly the MOHFP. Although the preferred tendering method is open tender, SALAMA

procurement procedures allow limited international tender for medicines. In the case of the injectable contraceptives purchased in 2007 and 2008, SALAMA solicited bids from three pre-qualified suppliers.

One main operational challenge for SALAMA procurement in general is the uncertainty in the date of availability of funds. SALAMA does not receive funds from the government until approximately two months after the delivery of goods. Because most SALAMA suppliers require a 40 percent advance, particularly on smaller purchases such as the injectable contraceptive purchase, this can cause cash flow problems for the agency. The injectable contraceptive vendor selected in 2008 permitted SALAMA to pay its invoice upon receipt, which was obviously an attractive aspect of its bid. Occasionally, SALAMA also has difficulty obtaining three quotes on international tenders, especially when the quantities that it purchases are modest. SALAMA contracts a fixed price for the goods that it procures and does not currently manage any long-term framework contracts with suppliers. Even when multiple shipments are scheduled under a single contract, the contracts do not exceed one year, with the contracts being basically tied to the annual funding cycle.

In addition to the contraceptives purchased for the government by SALAMA, contraceptives continue to be donated by bilateral partners such as USAID and UNFPA. In terms of procurement, SALAMA and these donor agencies are independent—although SALAMA does store and distribute donated contraceptives on the Government of Madagascar’s behalf. Condoms are not managed by SALAMA but instead by the CNLS.

To manage exemption from import tariffs, SALAMA and bilateral donors are exempt from filing through the government’s computerized trade network system and follow a manual process. Although this is a well-intended solution, it raises additional challenges for aggregating and reporting national data on tax exempt imports, including medicines and other humanitarian aid. Other agencies, including PSI and the International Planned Parenthood Federation, that provide subsidized goods and services to the Malagasy population on a non-profit basis and that are seeking to procure and import contraceptives into Madagascar are not currently exempt from import tariffs.

### **SALAMA as Procurement Agent**

SALAMA operates under a 10-year convention with the government of Madagascar, making it the only organization that can supply medicine to MOHFP sites. The current convention runs from 2006–2016. During an interview, a World Bank representative expressed confidence in SALAMA’s *technical* capacity to conduct procurement using World Bank procedures but expressed concern that SALAMA lacked sufficient capital to guarantee timely payment to its suppliers or to provide its suppliers with letters of credit. This was seen as severely limiting the number of suppliers SALAMA can access. SALAMA staff echoed this point when discussing its procurement of ARVs.

SALAMA can offer annual contracts to vendors, but these contracts are for fixed quantities and delivery schedules. SALAMA does not currently have multi-year contracts with vendors or use more flexible framework contracts for procuring goods. In this sense, it is constrained by its interpretation of World Bank procurement procedures and by its restricted capital.

The study team requested documentation on the tender process, but the references provided more information on the district-level pharmacy ordering process and inventory control than procurement. The study team did not receive any documents that could be identified as operational guidelines for the procurement process.

Contraceptives continue to be donated and procured primarily by USAID and UNFPA. These agencies have well-documented procedures for quantification, procurement, and product quality control. However,

since 2006, the Government of Madagascar has been procuring a portion of the national program’s injectable contraceptive requirement. In 2008, the government procured 67,647 units of injectables, which represented 5 percent of the quantity required for the public sector (see Table 2). UNFPA and USAID supplied 55 percent and 40 percent, respectively, of the injectable requirement. In the short term, the government plans to increase its budget for contraceptive procurement by 3 percent per year.

**Table 2. 2008 Public Sector Injectable (DMPA) Procurement**

<b>Program</b>	<b>Funding Source</b>	<b>Procurement Agency</b>	<b>Quantity Units</b>	<b>Cost (US\$)</b>
MOHFP	Government of Madagascar	SALAMA	67,647	\$128,500
MOHFP	UNFPA	UNFPA	750,000	\$637,500
MOHFP	USAID	USAID	540,000	\$589,380
<b>TOTAL</b>			<b>1,357,647</b>	<b>\$1,355,380</b>

The government of Madagascar is committed to assuring FP services for the population and is making a significant financial contribution to procurement. Its requirement estimation is closely coordinated with its two major procuring partners (UNFPA and USAID) and has contributed to maintenance of an inventory of injectable contraceptives sufficient to ensure full supply across the public sector service delivery network in Madagascar.

Mainly because of the relatively small volume that it procures, SALAMA does not obtain the best price for injectable contraceptives. USAID and UNFPA buy hundreds of millions of units directly from the manufacturers in order to service dozens of countries every year. SALAMA is procuring a far smaller volume from a regional distributor. It is reasonable to ask if there are any contraceptive products for which SALAMA might be able to obtain a comparable or better procurement price to that of USAID or UNFPA. During discussions with donor partners, the idea of the Government of Madagascar financing contraceptive implants was raised. Because the donors do not obtain a deep volume discount on implants and are more restricted in terms of suppliers, SALAMA may have a competitive advantage in procuring the government’s implants. This is a matter for ongoing discussion, and there is some natural hesitancy against depending on a sole funding source for any one product.

## **Procurement Challenges**

SALAMA faces four key challenges in ensuring the timely and effective procurement of contraceptives. These problems are related to the following functions:

- I. **Quantification.** It is difficult for SALAMA to plan for customer demand. Quantification for contraceptives is currently a program activity managed by the DPF. The data available to SALAMA come in the form of orders placed by its customers, and some customers are irregular in their ordering practices. Accordingly, SALAMA has to deal with a substantial number of emergency orders during the course of a year. These problems have, generally, not affected

contraceptives for which medium- and long-term forecasts and procurement plans are updated at least annually with support from USAID and UNFPA.

- 2. Product selection.** SALAMA is required to solicit bids on generic products. In the case of injectable contraceptives, SALAMA was ultimately able to procure Petogen® as described earlier, but for other products such as Jadelle® that have only one supplier, it will need to develop a clear process for sole-source justification. This issue applies to many other products such as equipment-specific laboratory reagents.
- 3. Suppliers.** SALAMA's purchases are relatively small, particularly for ARVs. Therefore, it does not elicit many respondents to its requests for quotes. Limited supplier choice is often associated with higher unit prices for goods.
- 4. Financing.** SALAMA is often paid by the government of Madagascar two months after it receive goods from suppliers—most typically in a single tranche in February or March. Suppliers generally require some payment (typically 40%) in advance of delivery. In the case of Petogen®, the supplier allowed SALAMA to pay upon receipt. In October 2008, SALAMA announced that it was debt-free. Unfortunately, the lack of debt has not yet improved its cash flow.

Costs are in constant fluctuation. At the same time, one of SALAMA's stated goals is to provide constant pricing for MOHFP facilities, as well as manage and distribute free, donated goods. SALAMA can buffer the price of goods, to a degree, through holding inventory, but that imposes additional costs for warehousing and management on its end.

## Product Availability

Availability of contraceptives is high, nationally. One of the indicators used to measure availability is the six-month stockout rate, which is the percentage of facilities experiencing a stockout of a particular product for any duration over a defined six-month period. From a sample of 96 family planning sites, the MOHFP reported a six-month stockout rate of zero for Depo Provera (the most popular modern method of contraception) and a six-month stockout rate of 1 percent for Lo-Femenal in the first six months of 2008.<sup>5</sup> According to SALAMA, as far as other medicines are concerned, it procures roughly 60 percent of the goods described in the generic essential medicines list. In terms of fill rate, SALAMA representatives told the study team that it can generally supply 80 percent of those products ordered by the Pha-G-Dis on any given order.

## Product Quality

For contraceptives, USAID and UNFPA have their own quality-control procedures for pre-shipment quality control and for addressing complaints and problems post-shipment. SALAMA was not aware of any complaints regarding the quality of contraceptive products. SALAMA collaborates with the DAMM and the *Centrale Humanitaire Médico-Pharmaceutique* on strengthening quality control, particularly through pharmacovigilance (or monitoring a drug's performance and adverse reactions).

The DAMM has been expanding its capacity in pharmacovigilance since 2006 and is one of four countries in Africa that form the WHO Pharmacovigilance Monitoring Center. The DAMM has capacity for running laboratory tests, such as dissociation, on medicines and can also identify active molecules in products such as paracetamol, but it has not been involved in quality control for hormonal contraceptives

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<sup>5</sup> Ministère de la Santé et du Planning Familial Direction, *Réunion de Coordination Nationale en Santé de la Reproduction/Planning Familial*, 10 – 12 Décembre 2008, Antananarivo, p. 11.

or condoms. The injectable contraceptives procured and imported by SALAMA did not have AMM registration, but this did not pose a barrier to importation—nor have there been reports of any quality problems related to injectable contraceptives or any other contraceptive.

## Procurement Recommendations

The study team recommends that SALAMA take the following actions to address operational policy issues:

### Quantification.

- SALAMA should track orders as well as issues. In a setting where SALAMA can only fill about 80 percent of the products requisitioned, and receives no other down stream demand or inventory data, it needs to take advantage of the information that it does receive to monitor stock status and forecast future needs.
- SALAMA should continue its collaboration with the Department of Family Planning and other partners on quantification exercises for contraceptives that model best practices.
- If it has not already done so, SALAMA should articulate clear inventory and supply policies that will strengthen its management of all of its goods, including contraceptives.

### Product selection.

- If it has not already done so, SALAMA needs to document its procedures and define a process for justifying sole-source procurement so that it will be able to procure products, such as Jadelle, that have only a single supplier.
- The Department of Family Planning should work with its international partners and the DAMM to investigate the possibility of procuring implants such as the Sino-Implant.
- The MOHFP should discuss with its partners whether it should continue to use its procurement resources for injectable contraceptives or whether the government can identify a different contraceptive product that it can procure at a more advantageous price.
- The MOHFP should assess supplier prices and discuss with its donor partners whether there would be any advantage to having the partner that is getting the best price handling the procurement of the full public sector requirement. Because there are no current budget shortfalls for commodities under the current practice, the savings from this additional efficiency could be used to expand access to long-term methods such as implants (an objective of all three institutions).

**Suppliers.** To improve its supplier base and ultimately to achieve a lower cost per unit delivered, SALAMA has to be able to issue more unrestricted requests for quotes, but it also has to make itself a more attractive customer. There are various ways it could do this:

- Consolidate purchases. If the product shelf-life constraints and SALAMA warehouse space permit it, SALAMA could group products or take fewer, larger shipments of certain goods.
- Offer better payment terms. Capital permitting, SALAMA could offer to pay its suppliers by letter of credit or other more secure payment mechanism.
- Network with other institutions in the *Association des Centrales d'Achats Africaine des Médicaments Essentiels* (ACAME) to define good supplier criteria and to obtain references for new suppliers to approach for quotes with future business.
- Define and track supplier performance metrics for timeliness, accuracy, and quality; communicate these to the suppliers and provide feedback after each purchase.

**Procurement financing.** SALAMA requires adequate capital in order to finance procurement. Lack of capital under the current circumstances has more impact on SALAMA-procured medicines than on

donated contraceptives, but it may have an impact in the future as SALAMA's role in contraceptive procurement grows.

- One of SALAMA's stated goals is to provide constant pricing for MOHFP facilities, but at the same time, SALAMA cannot hold unlimited quantities of inventory. Shifting some of the inventory upstream through long-term framework contracts could be part of the solution as long as SALAMA's suppliers can guarantee their prices for the contract's duration.

## CONCLUSION

Madagascar's efforts to strengthen public sector provision of contraceptives and political commitment to family planning have paid off; the country reported only 2 percent stockout rates for injectable contraceptives at service delivery points in 2007 and none in 2008. Injectable contraceptives continue to be the most popular modern contraceptive method, supported by a strong government commitment to scaling up a community distribution program. However, since the government's policy decision in September 2007 to allow contraceptives to be provided free of charge in the public sector, sustainability of Madagascar's family planning commodities has not been assured. As of 2008, USAID and UNFPA provide approximately 90 percent of Madagascar's contraceptives. UNFPA provides Depo-Provera®, implants, and oral contraceptives; USAID provides female and male condoms, oral contraceptives, and Depo-Provera®. Madagascar's central medical stores for public sector commodities, SALAMA, relies on an annual influx of capital from the Malagasy government to purchase the necessary pharmaceuticals and does not receive funds from the government until approximately two months after the delivery of goods.

These factors indicate that while political commitment to family planning and contraceptive security in Madagascar is strong, the system for financing and procuring contraceptives through the public sector is still reliant on donor funding, without the financial assurances from the cost recovery program that existed prior to the government's 2007 decision to provide all contraceptives free of charge.

## **ANNEX A: STUDY TEAM MEMBERS**

### **USAID | Health Policy Initiative, Task Order I**

- Margot Fahnestock, USAID | Health Policy Initiative/Washington
- Hasimboahangy Rahelisoazanadrainy, local consultant

### **USAID | DELIVER PROJECT, Task Order I**

- John Durgavich, USAID | DELIVER PROJECT/Washington
- Avotiana Ravotamanga., USAID | DELIVER PROJECT/Madagascar

### **USAID/Washington**

- Jessica Klein, Program Analyst

## **ANNEX B: DOCUMENTS REVIEWED**

*Plan Sectoriel en Planning Familial* (Sector-specific Plan for Family Planning)

*Programme d'Action pour l'Intégration des Intrants de Santé (PAIS)* (Program of Action for the Integration of Health Products)

*Plan d'Action Madagascar 2007–2012* (Madagascar Action Plan) (Available in English)

*Plan de Développement Sectoriel Santé (PDSS)* (Development Plan for the Health Sector)

*Politique Nationale en Santé de la Reproduction* (National Reproductive Health Policy)

*Normes de Performance en Système de Gestion* (Norms for Performance Management Systems)

*Normes de Performance en Planification Familiale* (Norms for Performance in Family Planning)

*Liste des Médicaments Contraceptifs Enregistrés à Madagascar* (List of Registered Contraceptives in Madagascar)

*Plan Stratégique de Sécurisation des Produits de Santé de la Reproduction à Madagascar* (Strategic Plan for Reproductive Health Commodity Security in Madagascar)

*Nouvelle stratégie pour le bien être des familles Malagasy* (New Strategy for the Well-Being of Families in Madagascar)

## ANNEX C. STAKEHOLDERS INTERVIEWED

	Organization	Contact
1.	Technical Team, Department of Family Planning, Ministry of Health and Family Planning (MOHFP)	Dr. RASETRIARIVONY Llasoa Dr. RIVOHANTANIRINA Nicole, Service for Reproductive Health Commodity Security Dr. RAZAFINDRAVONY Bakolisoa Dr. RAMANANJANAHARY Haingonirina, Service for Scaling Up Family Planning Dr. RAKOROARIVONY Germain, Services for Adolescent Reproductive Health
2.	Ambohidratrimo District	Dr. RAJOHNSON Désiré, Chief Medical Officer
3.	USAID	Ms. GRATZON-ERSKINE Kovia, Health, Population and Nutrition Officer Dr. ANDRIAMITANTSOA Benjamin, Child Survival, Family Planning and Nutrition Program Manager Ms. HUGHES Barbara, Director Health, Population and Nutrition Office
4.	Implementation Unit for the National Program, World Bank	Dr. RAKOTOMALALA Rémi, National Coordinator
5.	Director of Mother and Child Health, MOHFP	Dr. RASAMIHAJAMANANA Eugénie
6.	Director of Family Planning, MOHFP	Dr. RAKOTOELINA Bako Nirina
7.	Director of Planning, MOHFP	Dr. ANDRIAMANANTSOA Josué Lala
8.	SWAp (Sector-wide Approach to Health)	SWAp Focal Point
9.	Antananarivo Ville District	Dr. RAKOTOMANGA Sammy, Chief Medical Officer
10.	Fianakaviana Sambatra (FISA)	Dr. RAKOTOMANGA Dominique, Executive Director Dr. RABEARIMONJY Haingo
11.	Family Health International (FHI)	Dr. RAHARISON Serge, Project Director
12.	National bilateral for family planning: USAID-funded SantéNet 2	Mr. CAKIR Volkan, Project Director Dr. NIRINA
13.	MCDI (district-level project)	Dr. RIJA
14.	Population Services International (PSI)	Mr. MCKENNA Brian
15.	United Nations Population Fund (UNFPA)	Mr. KALASA Benoit, Madagascar Representative, Country Director for Comoros, Mauritius, and Seychelles Mr. MAERIEN Jozef, Deputy Representative Dr. RAVAOMANANA Edwige, in charge of reproductive health program
16.	Vice Minister of Health, MOHFP	Dr. RAHANTANIRINA Marie Perline
17.	SALAMA	Mr. ANDRIANJAFY Tahiana, Executive Director Mr. RAZAFIMBELO Patrick, Commercial Director Mr. SOLOFOHARIJAONA Jeanson, responsible for stocks

	<b>Organization</b>	<b>Contact</b>
18.	Director of Community Health Services, MOHFP	Dr. ANDRIAMBELO Lala
19.	Assistant Technical Director in the Division of Finance, MOHFP	Mr. TSITOANY Joël Landry Odon
20.	Responsible for legislation and regulation for customs taxes, Ministry of Finance	Mr. RAMBELOARISOA Raphaël
21.	Responsible for PHAGES in the Division of Pharmacy, Laboratory and Traditional Medicines	Assistant Director
22.	National Agency for Medicines in Madagascar	Dr. RNDRIASAMIMANANA Jean-René, Director
23.	United Nations Children's Fund (UNICEF)	Logistics Officer
24.	Analamanga Region	Dr. RAOELINA ANDRIZANADRAJAO Bernard, Regional Director for Health and Family Planning
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