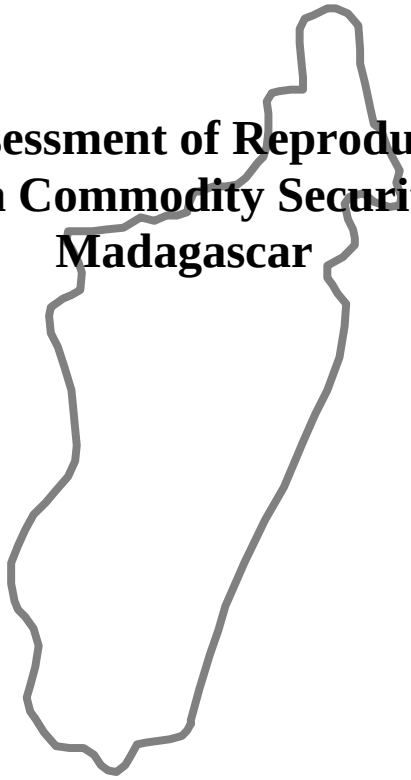
An Assessment of Reproductive Health Commodity Security in Madagascar



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Acronyms

APROPOP	Appui au programme de population au Madagascar/ Population program of Madagascar
CBD	Community Based Distribution
CHD	Primary care center/ Centre Hospitalier de District
CNLS	National Committee for the Fight against AIDS
CPR	Contraceptive Prevalence Rate
CS – (RH)	Commodity Security
CSB	Basic Health Centers
DELIVER	DELIVER Project (John Snow, Inc.)
DHS	Demographic Health Survey
EDS	Demographic Health Survey
EMAD	L'équipe de management du district/ District management team
EPM	Enquête auprès des Ménages
FISA	Fianakaviana Sambatra (IPPF affiliate in Madagascar)
FP	Family planning
GOM	Government of Madagascar
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INSTAT	National Institute of Statistics
KAP	Knowledge, Attitudes and Practices
LIAT	Logistics Indicator Assessment Tool
LMIS	Logistics Management Information Systems
LSAT	Logistics System Assessment Tool
MICS	Multiple Indicators Contraceptive Survey
Mg FMG	Malagasy Franc
MINSAN	Ministry of Health
MOH	Ministry of Health
NGO	Non-governmental organization
NPP	National Population Program
PF	Planification Familiale/ Family Planning
PFU	Participation Financière des Usagers/ User Fee System
Pha-G-Dis	District Pharmaceutical Warehouses
POLICY	Policy Project (The Futures Group International)
PSI	Population Services International
PNPDES	National Policy for Economic and Social Development

PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SPSR	Reproductive Health Commodity Security
SRA	Adolescent Reproductive Health program
SSR	Division of Reproductive Health
TPR	Total Prevalence Rate
USAID	United States Agency for International Development
WB	World Bank
WG	Working Group

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1. Introduction:

By the year 2015, the global contraceptive shortage is projected to increase from between $140 to $210 million annually, while other Reproductive Health (RH) commodities, including condoms for STI/HIV prevention, will have additional serious shortfalls. This is happening in the face of declining donor support, resulting in a growing gap between the resources that are available to finance contraceptives and those that are required. Many strategies for closing the projected global gap in contraceptives and RH commodities have been proposed. This global problem must be addressed on a country-by-country basis and requires the efforts of committed governments and organizations working together to reach consensus on a plan of action that will ensure a reliable supply of RH commodities.

A country achieves reproductive health commodity security when all women and men who need and want these commodities can obtain them. Many factors, in addition to the financial gap, determine the extent to which a country can secure a reliable supply of RH commodities. Some of these determining factors include, among others, the state of the distribution system; the quality and availability of services and products; the demand for RH commodities; and the political environment.

In Madagascar, reproductive health and family planning services have been offered for over three decades, through various sources including public, private and NGO clinics, workplace-based programs, mobile clinics and community based agents. FISA (Fianakaviana Sambatra), the IPPF affiliate in Madagascar, was offering family planning services in 1967 before the public sector began integrating these services into health centers in 1986. Family planning services expanded rapidly throughout the 1990s, in the public, private and NGO facilities and in the early 1990s STI treatment centers were installed.

Strengthening reproductive health commodity security is increasingly becoming a high priority for the Government of Madagascar, as well as for donors and stakeholders working in the country's health sector. Significant momentum has been gained in this arena since the new administration came into power in 2002. To date, family planning has been driven largely by donors and until the new Government became operational donors efforts to strengthen family planning and reproductive health programs were done with very little support or coordination from the Government.

A significant amount of financial and technical assistance for family planning and reproductive health has come from UNFPA, GTZ and the USAID bilateral program (a collaborative effort between John Snow Incorporated (JSI), referred to as Jereo Salama Isika in Madagascar, and The Futures Group International (TFGI), and conducted through the in-country Smaller Families/Healthier Families Project). This bilateral recently ended but will be reinstated in one year. Currently, with the Ministry of Health playing the role of a coordinating body, a number of organizations are collaborating to maintain the momentum gained over the last few years and initiate and expand upon activities that will ensure eventual, national, health comodtiy security, for reproductive health commodities. To assist the country in this process, in June 2003, USAID (through the TFGI/ POLICY Project, JSI/ DELIVER, Abt Associates/ PHRplus projects), and UNFPA provided funding and technical assistance to carry out a comprehensive assessment of Reproductive Health Commodity Security (RHCS), referred to in Madagascar as Sécurité des Produits de Santé de la Reproduction (SPSR). A multisectoral body of organizations and individuals participated in this assessment and the workshops centered around the assessment. These counterparts will continue to conduct activities and collect data that will feed into the development of a reproductive health commodity security national strategic action plan. The Futures Group/ POLICY Project and the JSI/DELIVER projects in Madagascar will continue to support and enhance these activities by providing technical support and financial resources over a one-year period.

The assessment was conducted with the following objectives in mind:

- to identify critical strengths, weaknesses and opportunities for assistance in the area of RHCS;
- to analyze historical trends and future projections in RH commodities use, namely for pills, injectables, implants, IUDs and condoms;
- to identify immediate follow-up actions that can be taken to strengthen RHCS based on consensus-based priorities;
- to assist the Government and its national and international partners to produce a one-year immediate plan of action for improving RHCS;
- to present findings to key stakeholders and facilitate discussions that initiates the development of a long-tern RHCS strategic plan.

In addition to helping stakeholders identify priority areas for strengthening RHCS and initiate the strategic planning process, the assessment served as a pilot test for a framework and diagnostic guide known as the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS). SPARHCS was developed by more than 40 organizations in the world-wide reproductive health community in order to assist countries like Madagascar with their RHCS strategic planning process. The SPARHCS is a comprehensive, long-term approach that helps countries develop a strategic commitment and funded action plan. An RHCS action plan will help Madagascar ensure availability of an adequate supply and range of choice of quality contraceptives and other reproductive health commodities, including condoms for HIV/AIDS prevention. A number of activities and in-depth assessments will run parallel to, and feed into, the strategic planning process. These activities are outlined in appendix A.

2. Methodology

The assessment of RHCS in Madagascar was conducted from May 24 to June 12, 2003. However, preparations had been made prior to this time by the POLICY and DELIVER projects and the Ministry of Health in Madagascar, the international consultants who participated in the assessment, and by members of the SPARHCS working group in the United States. Upon their arrival in-country, international consultants worked with the POLICY Project Madagascar and the Ministry of Health to organize a national stakeholders' workshop, held on May 27, 2003, with officials of participating ministries, donor agency personnel, technical assistance partners of ministries, and other public and private sector stakeholders acknowledged on page 3 and 4 of this report. The purpose of the workshop was to renew interest in "SPSR" or reproductive health commodities security (RHCS), to present an overview of what was known about RHCS in Madagascar, and to propose the approach that would be used to conduct the comprehensive two-week assessment. Key speakers from the Ministry of Health, USAID and UNFPA made opening statements and following the workshop, stakeholders volunteered to participate in various aspects of the assessment, according to their area of expertise and availability.

Building upon work that had already been conducted in Madagascar, the team of consultants formed working groups that reflected the five major components comprising the country's existing RHCS framework: demography; policy; demand; service delivery; and finance.

The diagnostic instrument, developed by the SPARHCS team in Washington, DC, served as a guide for the diagnosis rather than a checklist or questionnaire. The working groups used the survey instrument to identify and assess the range of challenges and opportunities affecting RHCS. The diagnostic guide was reorganized around the five components used in Madagascar and a copy of the French version of this is included in appendix C. (An English version is available upon request.) The new organization of the guide still captured the list of questions included in the previous guide but questions were grouped under their respective categories in order to facilitate data collection by groups.

Over a period of two weeks, the working groups performed a basic diagnosis of their respective components using several different methodologies, which varied slightly between the working groups. The methodology for collecting data included some combination of extensive document review and report analysis, data analysis and computer-based modeling, key informant interviews with stakeholders in multiple sectors, focus group discussions, field visits, and group work (in and out of workshops) with multisectoral teams. Each group began writing a report during the two-week period and produced a PowerPoint presentation, summarizing the findings from the two-week assessment.

In a second national workshop, held on June 10 and 11, 2003, an in-country representative from each working group presented findings from the assessment. Included in each Power Point presentation were key questions prepared by each group to guide workshop discussions. A process facilitator from the Ministry of Health, identified specifically for this purpose, guided these discussions. Stakeholders were then assigned to different groups and together identified a list of priority areas of action and, where possible, made recommendations which will be used to inform the development of the strategic plan. On the second day of the workshop, a representative from each working group presented findings from the small-group discussions to the larger audience.

The dissemination of findings from the assessment and the discussions that took place in the workshops allowed stakeholders to identify follow-up actions based on consensus-based priorities and assist the Government and its national and international partners to produce a one-year draft plan of action (see appendix A). The one-year draft plan of action was accepted by the Ministry of Health at the national workshop. Ongoing activities scheduled for the next year will feed into the strategic planning process. In the coming months, the team, led by the "RHCS/SPSR working group" is expected to continue this process to ensure the execution of the strategic action plan for RHCS in Madagascar.

Structure of Report:

This report presents findings identified by each of the working groups, organized under their respective RHCS components. An additional section outlining the projected scenarios conducted by the assessment team is included in section 6 of this report. Each section presents a situational analysis of the respective component in Madagascar, and describes the strengths and weaknesses of program elements, as perceived by stakeholders involved in the assessment process. Each section also highlights priority areas of action that were identified during the assessment as the most important RHCS issues to address in the immediate future and in the development of the RHCS strategic plan. Where appropriate, the priority areas of action are accompanied by recommendations made by stakeholders during the assessment and workshops. Further recommendations will be made by the SPSR/RHCS working group as they begin developing the RHCS strategic plan.

3. Demography

3.1 Situational Analysis

Table 1 presents a profile of socio-demographics in Madagascar. These indicators are referred to throughout this section.

Table 1. Socio-Demographic Indicators in Madagascar, 2002[1].

Total population (millions)	16.9
Population growth rate (2000-2005)	2.8 %
Total fertility rate (TFR)	5.68
% of population < 25 years[2]	64 %
Percent of population urban/rural (2001)	30/70
Urban growth rate (2000-2005)	4.9 %
Life expectancy male/ female	52.5/54.8
Infant mortality rate (per 1,000 live births)	88
Under five mortality rate male/female	150/144
Maternal mortality ratio (per 100,000 live births)	488
HIV prevalence rate[3]	< 1%
Adult literacy rate (% age 15 and above), 2001[4]	67.3%
Access to safe water	47 %
Public health expenditures (% of GDP) 2000[4]	2.6
% births with skilled attendants	47 %
Primary education enrollment (gross) male/female	94/92
Secondary education enrollment (gross) male/female	16/16
% Population living below national poverty line (1987-2000)[4]	71.3%
GDP per capita (US$), 2001[4]	288
GDP per capita annual growth rate (%) 1990 – 2001[4]	-0.6%
Human development index (HDI) value, 2001[4]	0.468

3.1.1 Background Information

Madagascar, formerly a French colony, established independence in 1960. Beginning in the 1970s, a military government held power; however, the political system was opened up in 1990 after several political and ecomonic crises. Opposition political parties were legalized in 1990 and the country is now a multiparty republic. Fifty-two percent of the population practices traditional religions; 41 percent of the population is Christian, split between Protestant and Catholic; and 7 percent is Muslim. The two official languages are Malagasy and French, with Malagasy being the dominant language in rural areas. The major ethnic groups in the country are Malayo-Indonesian (Merina and related Betsileo); Cotiers (mixed African, Malayo-Indonesian, and Arab ancestry - Betsimisaraka, Tsimihety, Antaisaka, Sakalava); French; Indian; Creole; and Comoran.

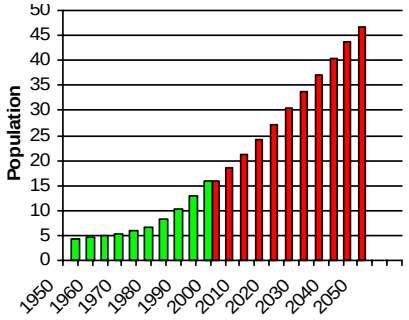
[1] UNFPA State of World Population 2002 Indicators. http://www.unfpa.org/swp/2002/english/indicators/index.htm
[2] 2003. US Bureau of the Census, International Databasehttp://www.census.gov/cgi-bin/ipc/idbagg
[3] SeroPrevalence survey conducted on pregnant women in 2003 should provide more accurate data on actual HIV prevalence rate.
[4] Human Development Reports 2003. http://www.undp.org/hdr2003/indicator/

3.1.2 Population Growth

The population of Madagascar was 16 million in 2000, four times greater than it was in 1950. Assuming the current population growth rate of 2.8 percent remains constant, the population is expected to triple by 2050 (see figure 1), creating challenges for economic and social development.

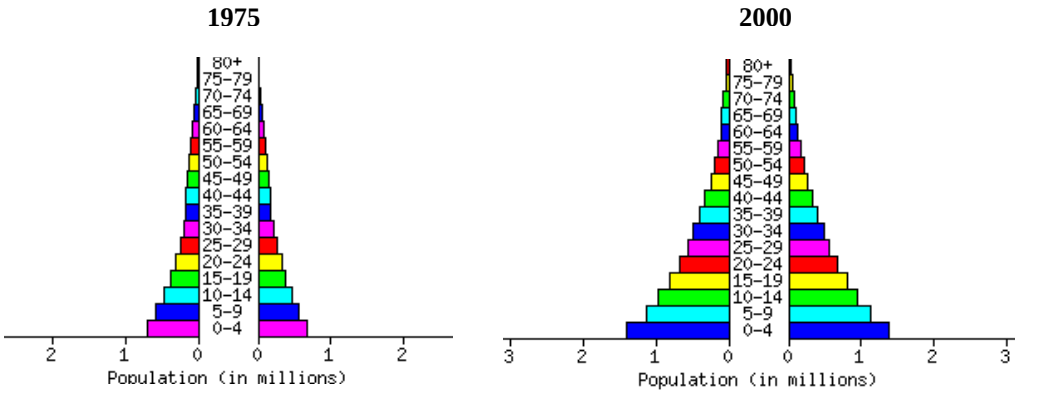
In general, the last fifty years have seen improvements in preventive health care and medical care. The impact this has had on population growth is further compounded by high fertility rates and low contraceptive use. Only 13 percent of women use a modern method and this is much lower in rural areas. Maternal mortality rate is 580 per 100,000 live births, life expectancy is still below 60 years and 9.1 percent of newborns do not survive their first year.

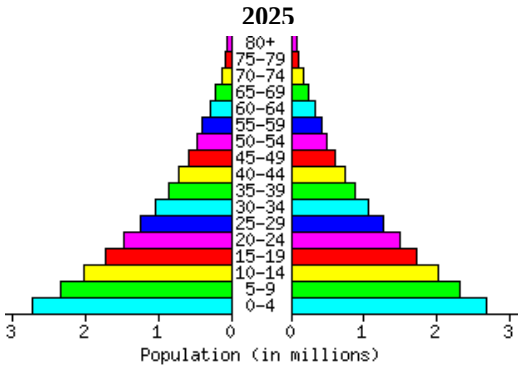
Figure 1. Population of Madagascar

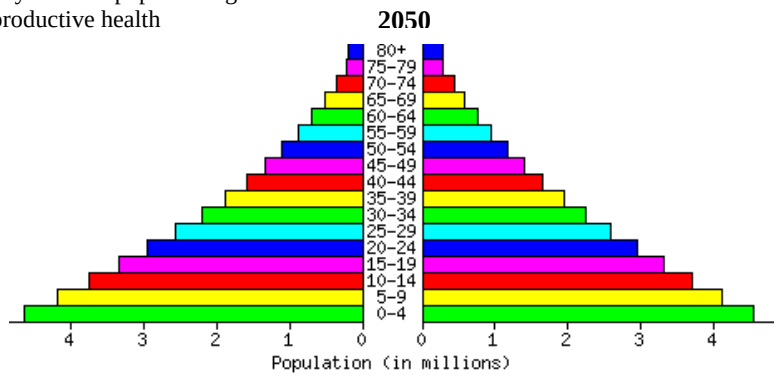


Over the next 50 years, the population age distribution will remain largely the same proportionally. This demographic composition is not mirroring that of sub-Saharan Africa, which is experiencing high mortality rates for their most productive members of society due to high HIV/AIDS prevalence rates. But like the rest of sub-Saharan Africa, the high fertility rate of 5.68, has resulted in a quickly growing young population, as can be seen in the population pyramid projections in figure 2.

Figure 2. Madagascar's Population Structure, 1975-2050







Since 1975 the number of people under the age of 25 has more than doubled, although their percentage of the population has only increased from 63 percent to 64 percent during this time. By 2050, this cohort of the population will be more than three-fold its current size and although it will be decreasing, it will still comprise 57 percent of the population. Even if replacement fertility were reached immediately, the population would grow for several decades because of the large numbers of people now entering their reproductive years. This population momentum will account for a substantial proportion of the country's future population growth. Education and better access to reproductive health services will play a significant role in enabling couples to choose smaller, healthier families. An increased contraceptive prevalence rate and an increased age at which women give birth to their first child would reduce population momentum. Therefore, securing a reliable supply and choice of contraceptive methods and improving access and quality of family planning and reproductive health care services will have a positive impact on increasing CPR and decreasing TFR. The assessment team has created three scenarios for population projections, in order to better understand how current changes in contraceptive use and fertility will play out in the future. (see section 6).

3.1.3 Education

Literacy rates are high in Madagascar at 82.2 percent for the 15-24 year old population and 67.3 for the population above 15 (see table 1).[i] Gender inequalities exist with respect to education, although differences are small: the youth literacy rate for females, stated as a percentage of males, was 92 percent in 2000. Education in Madagascar is compulsory for children between the ages of six and fourteen. Thus primary school enrollment rates are relatively high (94 percent for boys and 92 percent for girls).[ii]

Between 1998 and 2000 the Government spent 3.2 percent of GDP on education.[vii]Resources for health care and education have historically been unequally distributed throughout the country and there is a growing gap between a declining government-sponsored public school system and an increasingly vibrant and growing private school system. The elite and the well-off middle class place their children in private French-language schools, while the vast majority of the relatively poorer population, many of whom do not speak French, have little choice but to enroll their children in increasingly disadvantaged public schools.

3.1.3 Public Health

Malaria remains the most serious tropical disease in the country, especially in the coastal regions. However, rates are declining, especially in the central highlands, where malaria eradication campaigns have been very successful in the last decade. Other diseases of concern to Malagasys include schistosomiasis, tuberculosis, malnutrition and leprosy. The prevalence of schistosomiasis reflects the continued lack of adequate sewage facilities, especially in the rural areas. Only 47 percent of the population has access to clean drinking water[iii] and 40 percent of the population is undernourished[iv]. The high infant mortality rate can be largely attributed to malnutrition, diarrheal diseases, respiratory infections, and malaria.

In 2001, UNAIDS estimated 22,000 cased of HIV/AIDS in the country, yielding an adult prevalence rate of 0.3 percent.[vii] Prevalence is concentrated mostly among high risk groups such as sex workers and miners. However, the conditions are ripe for rapid spread of the disease to the general population: limited access to health and social services, low condom use, widespread poverty, and high rates of sexually transmitted infections. More than 14 percent of pregnant women in specific regions of Madagascar tested positive for syphilis in 1997; among sex workers the prevalence was as high as 35 percent. Internal migration and mobility and lack of reliable HIV seroprevalence data are additional factors that could contribute to a growing HIV/AIDS prevalence. In the absence of widespread effective STI/HIV/AIDS prevention programs, HIV prevalence is projected to soar as high as 15 percent of the adult population by the year 2015, leading to severe demographic, social and economic impacts.[v]

3.1.4 Access to Health Care

Eighty percent of the country's labor force is living in rural areas and this creates a challenge for ensuring health services are accessibile to the Malagasy people. The success of the country's decentralized health system in meeting the needs of its population is limited mainly by problems of access, service delivery, and quality. There is a shortage of health care personnel, especially in the rural areas. For example, there were only 11 physicians for every 100,000 people from 1990 – 2002. There percentage of births attended by skilled health personnel between 1995 and 2001 was 47 percent.[vii] As a result of problems with access and quality, health services are utilized by only 50 percent of the population.[vi]

Economic decline led to deterioration in medical services during the late 1980s and the early 1990s. Since 1976, public health care expenditure, as a percentage of GDP, has fallen from 9.2 percent to 2.6 percent.[vii] [viii] Important regional differences also exist, and lack human resource and financial capacity. For those unable to obtain modern medical treatment, traditional medicine remains popular.

3.1.5 Economy

The economy is dominated by agriculture, mainly fishing and forestry, which employs 75 percent of the population, accounts for 34 percent of GDP and contribubes more than 70 percent to export earnings. The industry sector (mainly food, energy, and bevarages are the main sub-sectors) contributes 13 percent of GDP while services make up 55 percent. High population growth rates and a staggering economy have contributed to low per capita incomes, as mentioned in table 1. GDP per capita was US$288.00 in 2001 and the average annual growth rate of GDP per capita was - 0.6 percent. More than 70 percent of the population lives below the poverty level and nearly 30 percent in extreme poverty.[vii]

In 2000, Madagascar qualified for debt relief under the Heavily Indebted Poor Countries Initiative (HIPC) and is currently preparing a Poverty Reduction Strategy Paper (PRSP), which is discussed further in the policy and finance sections of this report. Resources freed up from HIPC will be directed toward improving access to health, education, rural roads, water, and direct support to communities. As a result of the HIPC credits, as well as recent economic reforms, the average GDP growth rate is increasing and has exceeded population growth rates. The country's debt ratio has fallen from 46 percent in 1996 to 15.4 percent in 2000. Within an overall framework of poverty reduction, it is hopeful that the HIPC Initiative will maintain a debt ratio of approximately 5 percent from 2003 to 2019.[ix]

The post-independence socialist regime favored government ownership and direct control of the economy for many years. Between 1975 and 1990, the country lost about 40 percent of its per capita income. Due to external shocks and fiscal mismanagement, inflation escalated. Economic reforms have since that time have seen the privatization of state-owned enterprises and banks, and focused on petroleum products, food, transport, and telecommunications. Import duties have been reduced, a value-added tax has been imposed, and exchange rate controls have been lifted. As a result, foreign investment in Madagascar is on the rise. More than 200 investors, particularly garment manufacturers, have organized under the country's Export Processing Zone (EPZ) system since it was established in 1989. The absence of quota limits on textile imports to the European market[5] has helped stimulate this growth. In addition, Madagascar's eligibility for the African Growth and Opportunity Act, (AGOA) is significantly increasing Malagasy exports and foreign investment. With resepct to commodity exports, coffee and vanilla are the two biggest exports; cloves, shellfish, sugar, and petroleum products also occupy a share of exports.[x]

In 2002, due to social and political unrest following the disputed December 2001 presidential election, real GDP declined by 12 percent. Thousands of people lost their jobs and the percentage of the population living in poverty was estimated to have increased from 69 to 75 percent in one year.[xi]

[5] Lome Convention

4. Policy:

A policy environment conducive to contraceptive security is characterized both by sound policies and by the commitment to implement them. To enable forecasting, financing, procuring and delivery of contraceptives in a fair and equitable manner, favorable policies must be formulated where they do not exist and existing policies that act as barriers must be removed or reformed. Commitment and collaboration is needed at all levels, from the political level to civil society.

The working group responsible for conducting the policy component of the assessment looked at the political environment, the national policies affecting RHCS, the degree of stakeholder commitment, and coordination mechanisms that are currently being employed to address RHCS issues. Where possible, the team conducted an analysis of laws, regulations, and operational policies that affect access to contraceptives (although a more detailed operational policy barriers analysis will be performed in Madagascar later this year as part of the one-year bridging project).

4.1 Situational Analysis:

Overall, the policy environment for family planning programs in Madagascar is favorable, despite a 1920 French anti-contraception law that still exists. The National Population Policy of 1990 places family planning squarely in the context of an economic development strategy, while still recognizing the potential benefits to the family and community. Madagascar has participated in a number of key conferences focusing on population and development, including The International Conference on Population and Development (ICPD) and ICPD+.[6] Although ICPD marked the Government's renewed commitment and support to family planning, the population policy was in place even before the ICPD conference, thus demonstrating the country's long history of government and multisectoral commitment to the reproductive health agenda. The Constitution prohibits discrimination based on gender, demonstrated by the country's ratification of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Despite the many favorable policies that support family planning, it has only been recently that the Government has been committed to improving the family planning program. Until 2002 when the new Government was elected and became operational, family planning was an activity that concerned donors and was not a priority for the Ministry of Health and other Government stakeholders. Thus, donors efforts to strengthen family planning and reproductive health programs were done with very little support or coordination from the Government. The policy environment is changing however. Today, commitment to family planning and reproductive health continues with renewed vigor, as evidenced by recent public statements from the President and Minister of Health.

4.1.1 Stakeholder Commitment to RHCS:

Although recent history shows that the Government's commitment to family planning was weak, the new Government of Madagascar has placed family planning and reproductive health as a high priority and the President of Madagascar has recognized publicly that family planning is a necessary strategy for national development. The plethora of national policies and strategies relating to RHCS that exist in the country are supportive of this high-level commitment, even though many of the strategies and activities set forth in the policies have not been implemented. The Ministry of Health, currently in a period of readjustment, is supportive of leading the country through a process that will strengthen reproductive health commodity

[6] Other conferences include Mexico (1992); Rio de Janeiro (1992); Copenhagen (1995); Beijing (2000); and Johannesburg (2002).

security, using a collaborative, multisectoral approach. The current Minister of Health has explicitly expressed the country's need for practical and pointed technical assistance in order to improve RHCS in Madagascar. The Minister has also expressed the need to gather more information regarding the cost-effectiveness of interventions for the short and long term and stated that the country's limited resources present one of the major challenges of reaching ethnically, culturally, and geographically diverse populations with family planning and other health services.[xii]

It was not until recently that the MOH became engaged in the management of the family planning program. In the past, the MOH has made little effort to discuss strategies, policies and lessons learned with respect to family planning, with other development partners. However, today the Ministry of Health is taking on the responsibility of promoting family planning services and bringing together NGOs and other partners, most of which have been involved in IEC activities.

Despite the high level commitment to FP at the political level, commitment at lower levels is less obvious. There are no visible "policy champions" in terms of religious or community leaders and the NGO community, with one or two exceptions, seems to be in its infancy in terms of advocacy. This may reflect an environment that in the past did not encourage efforts to advocate for policy changes that could potentially strengthen family planning and reproductive health programs. Nevertheless, a few key players are currently advocating for policy change on reproductive health issues. Marie Stopes (MSM), for example, was primarily responsible for changing the law stating the age at which tubal ligation can take place.

Although the Government of Madagascar is expressing a renewed interest in the family planning program and is committed to achieving program goals, this commitment has still not been translated into financial commitments or statements of intent. Since its inception in 1986, the family planning program has been heavily dependent on donor funding. Given the required increase in funds for this area due to population increase and more ambitious goals for contraceptive use, and given an international climate where donor funds for FP are not increasing (with the possible exception that increased funds for condoms are becoming available, in order to strengthen country's HIV/AIDS prevention programs), the GOM will be faced with a growing financial gap for contraceptives. This gap is discussed further in the finance section of this report.

4.1.2 Overview of National Policies and Strategies:

There are a number of national policies that are supportive of RHCS, some of them expressing their support more explicitly than others. The content of these policies and the significance to RHCS is summarized below.

The Population Policy of 1990

The 1990 population policy states that the population is both the actor and the recipient of development. The overall emphasis of the policy's strategy is clearly fertility reduction, although it does include strategies for reducing infant mortality and improving quality of life (appendix). The more specific "action strategies" outlined for reducing fertility, emphasize IE&C activities; integration of FP into MCH clinics; support for the non-governmental sector; adoption of a multi-sectoral approach; and review of laws and regulations concerning the sale and advertising of contraceptives. Although ambitious, the goals outlined in the population policy may have been unrealistic, given that the Government did not outwardly encourage efforts to strengthen FP and made very little financial commitment to FP/RH programs; in the year 2003, the fertility rate is still close to six.

National Health Policy of 1998

The 1998 national health policy was adopted by the Ministry of Health and translated into a strategic plan for the years 1998-2000. The policy is based on a number of health sector reform strategies including decentralization, cost recovery, development of the private sector, improvement in human resources, community participation and reform of the health information system. Under the maternal and child health section, the policy establishes a goal of 20 percent contraceptive prevalence by the year 2000. Proposed strategies include increasing access to family planning at all levels of the health system (central, regional, and CSB). Recently, through the work of JSI, this policy has been operationalized; contraceptives were added to the essential drugs list and distributed through the District Pharmaceutical Warehouses (Pha-G-Dis) throughout the country.

With respect to improvements in the health of adolescents, the policy states as its objectives, prevention of unwanted pregnancies, induced abortions, STIs and HIV/AIDS. However, the strategies make no mention of offering services to adolescents. This may be a reflection of a religious conservative society that does not explicitly promote the provision of adolescent reproductive health services.

National Policy of Reproductive Health: 2000

Given the emphasis of the International Conference on Population and Development (ICPD) on the broad reproductive health agenda and being a signatory to the ICPD Plan of Action, Madagascar started to develop a national reproductive health policy in 1997. One reason for the development of the policy seems to be an explicit recognition that the national health program was weak, especially in matters of reproductive health. The comprehensive policy addresses issues of reproductive and sexual health, including prevention of STIs and HIV/AIDS. The policy addresses mothers, adolescents and youth, women and men and children under the age of 5. Family planning is listed as one of the strategies to prevent unwanted or poorly timed pregnancies. The policy also highlights the need for FP to reduce maternal mortality and abortion and supports all modern and "natural" FP methods including emergency contraception. All medical and paramedical personnel are authorized to provide family planning services; community based health agents are authorized to distribute oral contraceptives and barrier methods. The RH policy is the only policy that makes mention of the supply of contraceptives; it proposes strategies for the community health workers to obtain contraceptives and discusses the eventual inclusion of contraceptives in the essential drugs list, which has now taken place. The RH policy also includes a section outlining a minimum packet of activities that should be offered at the community level and the CSB level, including information dissemination and family planning services for both adolescents and adults.

The National Health Policy for Adolescents and Youth in Madagascar

An adolescent and youth health policy was established in 2000. This policy builds on the preventive accent of the broader national health policy, with respect to the prevention of unwanted pregnancies and induced abortions, and reduction of sexually transmitted infections, including HIV/AIDS among adolescents.

The policy outlines a number of strategies including information, advocacy, service delivery, employment and education. In regards to service delivery, the policy sets out to improve access to services by creating integrated service delivery sites. The policy is somewhat circumspect on the specific elements of the kinds of services and information that should be offered to youth. Contraceptives are not mentioned in the document, nor is the development of a curriculum on sex education, (although the strategy does mention the need for the development of "education of family life" for out-of-school youth and "education of the subject of population" for in-school youth and peer education). It is possible that the vagueness of the language in the policy reflects a certain level of political sensitivity in Madagascar. However, the aims of the policy, as

outlined above, suggest that the goal is improved access to quality family planning services for adolescents and youth within a framework of informed choice. This is certainly consistent with the conclusion section of the policy which mentions its intentions to respond to problems such as early pregnancy, STIs and HIV/AIDS, abortion and commercial sex work.

The National Policy of Essential Drugs:

Contraceptives were added to the essential drugs list in 1999 and as a result, are subject to the cost-recovery and cost-sharing measures that have been in place intermittently over the past decade. The cost recovery mechanism is soon to be reinstated.

National Policy for Promotion of Women's Rights:

Published in 2000, this policy aims to promote women and adolescents' right to reproductive health services. The policy states as its objectives the desire to promote utilization of family planning in rural and urban areas; to ensure that women are given adequate instruction and information about reproductive health; and to improve access to information and reproductive health services for women and adolescents.

In addition to the numerous policies that address reproductive health and family planning, three important strategy papers exist that serve as guidelines in the government's efforts to move toward reproductive health commodity security: the poverty reduction strategy paper, the "business plan" and the national HIV/AIDS strategic plan.

Poverty Reduction Strategy Paper (PRSP):

Consistent with the view that FP is a development strategy, the government's overall poverty reduction strategy, as outlined in the PRSP, stresses the importance of addressing women and adolescents' reproductive needs. Objectives for increasing CPR from 12 percent in 2002 to 25 percent in 2005, and for stabilizing HIV/AIDS at less than 1 percent prevalence, are stated within one of three broad strategies. The report also mentions the need to make reproductive health services, among others, more efficient by implementing sector reforms and by increasing public expenditures allocated to the health sector. The following objectives are included in the paper:

- Decrease maternal mortality rate from 488 in 2002 to 285 in 2005;
- Increase CPR from 12 percent in 2002 to 25 percent in 2005;
- Maintain HIV/AIDS prevalence rate at less than 1 percent;
- Decrease prevalence of syphilis among pregnant women from 11 percent in 2002 to 5 percent in 2005.

The final poverty reduction strategy report will be available in November 2003.
Although perhaps overly ambitious, these objectives illustrate the Government's strong commitment to strengthening RHCS in Madagascar. Recommendations regarding follow-up activities that could be conducted to help the government understand what will be required to achieve these goals, are included in section 6 of this report.

The Business Plan:

The Ministry of Health created what has been named the "Business Plan" for the years 2003 to 2005. It has become the central focus for planning and advocacy among health partners. Stated in the business plan are the following objectives related to reproductive health:

- Maintain the prevalence rate of HIV at less than 1 percent;
- Increase utilization of contraceptives for the prevention of AIDS;
- Increase contraceptive prevalence rate to 25 percent by the year 2005;
- Increase number of sites delivering family planning.

These objectives and the Government's commitment to the strategies outlined in the plan are signs of a strong commitment to reproductive health and HIV/AIDS programs. However, understanding how these objectives were designed and how realistic they are will be important for informing the development of the strategic plan for RHCS. In order to achieve the goals mentioned above, for example, the country would need to know the quantity of supplies needed to help the country achieve these goals. This is discussed in greater detail in section 6 of this report.

National HIV/AIDS Strategic Plan:

Although the prevalence of HIV/AIDS is relatively low (0.3 percent among the general population), the government has taken a proactive approach of responding to the epidemic and has developed an HIV/AIDS strategic plan for the years 2002-2006. At the present time, no formal HIV/AIDS policy exists but the HIV/AIDS strategic plan, as well as the national health policy, demonstrates the government's commitment to the fight against HIV/AIDS. Activities are implemented and monitored by the National AIDS Program, or the *Programme National de Lutte contre le SIDA*, and in 2002 an office of HIV/AIDS programs was established at the Ministry of Health to ensure technical quality of the interventions.

The HIV/AIDS strategy in Madagascar follows that of many countries, and takes a multisectoral approach which is led by the country's AIDS coordinating body, (CNLS). Of interest to stakeholders concerned with securing a reliable supply of commodities, are the sections in the strategy concerning condoms. Three objectives within the strategy pertain to increasing the use of condoms. The Government of Madagascar has also identified 20 high transmissions priority zones and is in the process of finalizing action plans for these hot spots. Sectoral action plans have also been developed for education, armed forces, tourism, population, youth, and sports.[xiii] Efforts made to strengthen the supply of RH commodities in the country will need to account for the expected increase in condom use in the near future, an expected outcome of governments, donors and NGO's efforts to increase knowledge and use of condoms.

4.1.3 The Impact of Madagascar's Policies on Reproductive Health Commodity Security:

Although the national policies and strategic plans are supportive of RHCS, little has been done in the country to implement these policies. The country's reproductive health and family planning services are largely donor driven. Although the number of family planning service delivery sites in the country is increasing and CPR is on the rise, these improvements observed at the national level mask the disparities that exist at the provincial and district levels. Modern contraceptive use is particularly low in rural areas and among lower socioeconomic classes and education levels. (EDS 1992, 1997, MICS 2000).

Impact of Policies on Finance of Health Services and Products:

Contraceptives, now that they are included on the essential drugs list, are classified as ethical pharmaceuticals, therefore recent revisions of policies pertaining to the financing of essential drugs have important implications for the financing and availability of contraceptives. Prior to the country's economic crisis, the government approved a policy to recover costs for essential drugs, which were formerly free in public clinics. The cost recovery mechanism (PFU) was dismantled during the crisis by the government, but later became a high priority for the Ministry of Health and is in the process of being reinstated. This is

discussed further in the finance section of this report. One study by INSTAT/DSM/Ilo, although it did not look specifically at contraceptives, found that the frequency of utilization after introduction of the PFU, improved or stayed the same, relative to the period before introduction of the PFU.[7] These results are consistent with outcomes of the Bamako Initiative and other cost recovery programs or revolving drug funds. INSTAT also found that introducing the PFU actually benefited the poor segment of the population – and even more so than the rich. Among 83 percent of the poor segment of the population, utilization stayed the same or improved, compared with 72 percent in rich areas.[xiv] Despite these successes, problems in implementing the PFU system occurred. A nation-wide audit of Madagascar's 2200 health centers implementing the PFU program showed that few centers showed positive results in terms of program operation and many health workers were not able to account for the money collected through user fees. To prevent this from happening in the new PFU system, the MOH created standards governing the management of funds at the Basic Health Centers (CSBs) and primary care centers.[xv]

4.1.4 Laws, regulations and operational policy barriers:

Counterparts from the policy team identified a number of issues related to the laws, regulations and operational policies which govern the delivery of RH services. Although many issues were identified during the two week assessment, a more detailed assessment is scheduled for later in the year, at which time an operational policy barriers analysis will be conducted. Still, the findings from this assessment provide an overview of some of the major issues affecting access to RHCS. Understanding potential barriers at the operational level is a key requirement for starting the strategic planning process. Key leaders and advocates can play an important role in eliminating such barriers and should be involved in the RHCS strategic planning process.

Anti-contraception law:

As mentioned previously, the 1920 anti-contraception law is still not abrogated, despite the existence of a population policy and other national health policies. However, following the conference of 1997 on Eliminating Legal Obstacles to Family Planning in Cotonou, the Government began the process of repealing the law. Although this anti-contraception law opposes the use of contraception, it is largely ignored and as a result, does not seem to be creating a barrier to improving RHCS. However, removing this law will ensure that future Governments, regardless of their position on family planning, will not be able to reinstate this law.

Three operational policies that were identified in the assessment were found to pose barriers to consumers' access to contraceptives. These barriers include the following:

Restricted consumer access to contraceptives through advertising:

One commonly mentioned barrier hindering consumers' access to contraceptives is the law governing the dissemination of information about contraceptive methods to clients. Because contraceptives are categorized as ethical pharmaceuticals, unlike condoms which are sold over the counter, they are subject to regulations that prohibit product promotion. Currently, the primary means of disseminating information about contraceptive methods is through physicians. This affects both the ability to conduct social marketing campaigns that reach target audiences, and the ability to inform the client purchasing the contraceptives. Thus, many NGOs working to socially market contraceptives, are relying on private practitioners and

[7] "Ilo" , the Malagasy word for *light*, is a joint endeavor of Cornell University and PACT, with USAID funding, aimed at improving the policy process through improved economic analysis and the expansion of the availability and use of such information.

pharmacists to channel this information to clients. However, the MOH does permit the airing of generic advertisements and radio programs that deliver health messages, as well as point of purchase advertising in pharmacies. The MOH has also made exceptions granting product promotion for the Cura7 STI kit and the PROTECTOR condom, which are currently being advertised in Madagascar.[xv] Product promotion improves knowledge about product composition and potential side effects and allows women to make informed choices about their preferred method. Nevertheless, many doctors are opposed to branded advertising, fearing that it may lead to automedication.[xvi]

Restricted access to information on contraceptives in the public sector:

At the client level, lack of information regarding the use of contraceptives becomes an ethical issue. Within the public sector, contraceptives are distributed without directions or information about chemical composition. Organizations working in the country agree that clients have a right to receive information about use of products and that doing so would ensure products are used effectively. For example, instructions about what to do if a woman misses a pill are currently not available at the point of purchase. This may be a result of donors' attempts to decrease costs on products procured for the public sector, but it may also be a reflection of the government's disapproval of providing information about contraceptives. Identifying potential barriers and developing a strategy for responding to them could help increase effectiveness of family planning programs and in turn, increase use of contraception.[xvi]

Restricted access to contraceptives due to lack of trained health care personnel and product availability:

Although the number of service delivery sites and pharmacies and the amount of training capacity of health care personnel vary across regions, contraceptives and information about family planning are often less accessible in the rural districts, relative to urban districts. Many community based agents working in the districts, as well as other health care personnel, do not have training in family planning service delivery. For those who do have adequate training, contraceptives may not be readily available. Organizations offering family planning services in Madagascar have expressed the need to address both training capacity and product availability, in order to improve access to and utilization of, family planning services. For example, training all doctors in family planning service delivery will have limited success if contraceptive supplies become depleted. One proposed intervention for improving access is offering training to Basic Health Centers (CSBs) and providing them with pills, injectables and condoms, while ensuring constant availability of contraceptives.

4.1.5 Coordination of Stakeholders

Until recently, the Ministry of Health, has played a very small role in managing family planning programs and coordinating donor activities. The country's donor-driven family planning program receives little direction from the MOH. However, there is evidence that the MOH is progressively becoming more involved in the planning and management of family planning programs. A number of coordination mechanisms exist, both formal and informal, addressing pertinent family planning and reproductive health issues in Madagascar. Stakeholders who were involved in the assessment described the following programs as very successful in improving RHCS:

National Population Program (NPP):

This interministerial group is led by the Ministry of Population and comprised of members of the National Population Commission, the National Office of Population, the Inter-regional Committee of Population, the National Assembly, the Ministry of Planning, and the Ministry of Finance. The program was initiated in

1997 by the Government in order to put into place the activities outlined in the population policy (PNPDES) and to work in synergy with other sectors in order to achieve economic and social development goals.
The partners' forum (forum des partenaires):

Since May 2003, the Minister of Health has been organizing this partner forum which allows development partners to coordinate their activities as outlined in the Business Plan.[xvii] This also allows partners to stay informed of new developments, identify opportunities for collaboration, and prevent duplication of efforts.

Health partners meeting:

A third coordination mechanism is the monthly health partners meeting led by the World Health Organization, which brings together donors including UNICEF, UNFPA, the European Union, USAID, JICA,GTZ and others. These meetings address various health and development issues, and provide an opportunity to exchange information about activities. Some of the information relates to health issues such as malaria and child survival while other information exchanges pertain to RHCS.

Contraceptive Task Force:

A fourth coordination mechanism is the contraceptive task force – a working group which was created by the Ministry of Health and is a forum that enables discussions and decisions on contraceptive financing and procurement.

The MOH is also involved in many other national task forces, including the *IEC task force*, which is currently developing and producing appropriate IEC materials that address adolescent reproductive health needs. This is done in collaboration with the USAID funded BASICS project. Another coordination mechanism is the *UNAIDS theme group*, which brings together donors from all areas of the health sector and promotes integration of HIV/AIDS strategies within other health programs.

4.2 Key Findings:

Strengths:

- The overall policy environment for FP/RH is favorable and the GOM has placed family planning in the context of economic and social development. National policies and strategies are all supportive of FP/RH and the country has ratified a number of treaties related to RHCS.

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- The Ministry of Health is taking on more of a coordinating role and a number of informal and formal coordination mechanisms have recently been developed. These coordination mechanisms, and the open communication channels they foster, will be important for designing a strategic plan that addresses the concerns, expectations and efforts of the Government, donors and NGOs. This is especially important as stakeholders work to increase availability of condoms for HIV/AIDS.

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- Stakeholders from multiple sectors are interested in improving RHCS in Madagascar and remain committed to the RHCS strategic planning process that is currently taking place.

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Weaknesses:

- Government commitment to date has not been translated into financial commitments or statements of intent. As a result, the contraceptive financing gap continues to grow. An increased need for condoms for HIV/AIDS prevention will exacerbate the financing gap. (However, recognition of this gap and the need to mobilize resources has been translated into an order placed by the GoM to UNFPA using World Bank funds.)

- The family planning program is largely donor driven and until recently the Ministry of Health has done little to coordinate the efforts of donors, although this appears to be changing.

- Operational policies inhibit product promotion and information dissemination, thereby presenting a challenge for reaching both users and non-users with important information (safety and educational).

- No mechanism for ensuring equity between districts exists, therefore huge disparities in quality of service delivery, training capacity of staff, and availability of commodities exists.

- In many districts access to contraceptives is restricted due to lack of trained health care personnel and product availability, especially in rural areas. Operational policy barriers are one factor contributing to this problem and therefore must be removed.

- An anti-contraception law from 1920 still exists in the country, which may in the future pose a major barrier to improving RHCS.

- There are very few policy "champions" or advocacy groups functioning at the mid-levels to raise awareness about RHCS issues.

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4.3 Priority Areas for Action:

There are a number of policy challenges that face Madagascar which must be dealt with if the momentum is to be maintained and indeed accelerated. Each of these challenges affects a different component of the RHCS system. The team members who worked on the Policy component and the workshop participants recommended that the following actions be included as priority areas that should be addressed in the development of the strategic plan. Many of these recommendations have implications for other aspects of the RHCS system:

Policy Recommendations:

- Strengthen the role/capacity of civil society organizations and policy "champions" to conduct advocacy activities;
- Strengthen the capacity of the Ministry of Health to conduct policy analysis by involving representatives in an operational policy barriers study and holding training sessions;
- Continue to collaborate with the National HIV/AIDS Campaign (CNLS) to include, as much as possible, key elements, (including expected increase in condom use), from their plans and programs in the contraceptive security action plan. This collaboration will prevent duplication of efforts in ensuring availability of an adequate supply and choice of commodities;
- Conduct an assessment of operational policy barriers affecting service delivery access, scope, timeliness and quality, that ultimately impact reproductive health commodity security.

Demand Recommendations:

- Re-examine regulations governing advertising of branded pharmaceuticals including contraceptives;
- Re-examine regulations governing the sale of contraceptives and medicines by private sector physicians;
- Re-examine regulations governing the distribution of contraceptives through community based sales agents;
- Re-examine standards governing the information that is provided with contraceptives in the public sector;

Service Delivery:

- Advocate for manpower policy reforms within the MOH especially concerning deployment of personnel and low staff salaries and incentives;

Finance:

- Convince the Government to back up ambitious program goals with clear financial commitment;
- Re-introduce the PFU system and provision for exemptions for the poor;
- Re-distribute resources (material and financial) for ensuring equity between districts, with respect to quality of service delivery, training capacity of staff, and availability of commodities.

5. Demand

Demand, in the context of reproductive health, is the consumption of any reproductive health commodity. Current demand is a measure of the current consumption of commodities while unmet need represents the women who want to use family planning but do not, for many reasons which are discussed in this section of the report. Understanding historical trends of demand has important implications for eliminating shortages and stock-outs and expanding reproductive health programs.

In the demand component of the assessment, counterparts explored four major thematic questions, including the following:

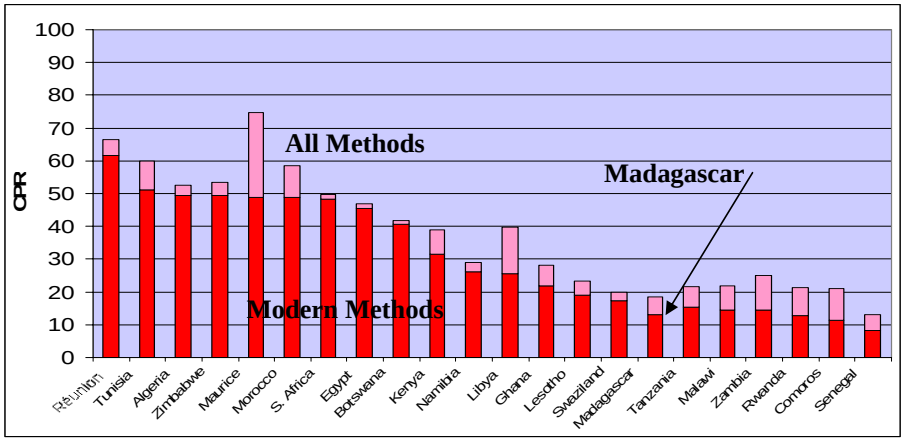
- What factors affect the non-utilization of contraceptive methods?
- What are the factors that influence unmet need?
- What approaches are being used to satisfy unmet need or expand the market for contraceptives?
- What major questions regarding market creation remain open and what policy priorities remain to be explored?

5.1 Situational Analysis:

5.1.1 Demand for Contraceptives:

Since about 1992, overall demand for RH commodities has been more or less stagnant. (Demand includes current contraceptive prevalence rate plus the percent of married women of reproductive age who would use, but do not currently use, family planning, if they had geographic and financial access.) By 2001, an average of about 50 percent of married women of reproductive age demanded contraceptive methods. Currently, the contraceptive prevalence rate is estimated at 13 percent for modern methods. Figure 3 illustrates how this contraceptive prevalence rate compares across the African continent.

Figure 3. Contraceptive Prevalence Rate in Africa



Some of the main factors determining demand for contraceptives include place of residence, age, and level of education. Table 2 provides a profile of contraceptive users in Madagascar and illustrates the variation that exists throughout the country, based on these factors.
CPR is highest in the capital area, and higher in the urban area than in rural areas. Part of the reason for this disparity is attributable to the historical concentration of FP services, both public sector and NGO clinics, in urban settings relative to rural areas. This factor also contributes to the geographic variation of CPR by region, where CPR is relatively higher in Antananarivo for instance than the more rural province of Toliary. As observed in other countries, CPR also varies by education level and is higher among women with education.

Table 2. Profile of Users

Sources : ***DHS*** *: Demographic Health Survey ;* ***MICS*** *: Multiple Indicator Survey;* ***EPM****: Enquête Auprès Des Ménages.*

	1992 DHS	**1997 DHS**	**2000 MICS**	**2001 EPM**
CPR All Methods*	17%	19%	19%	22%
For spacing	6%	8%	-	
For limiting	10%	12%	-	-
CPR All Modern Methods*	5%	10%	12%	16%
Oral	1%	2%	3%	5%
IUD	1%	1%	0.3%	0.1%
Injectables	2%	5%	7%	8%
Vaginal Methods	0%	0.1%	0%	0.1%
Condoms	1%	1%	0.4%	2%
Female Sterilization	1%	1%	1%	1%
Implants	0.4%	1%	0.4%	0.2%
CPR by Residence (All Methods) (Total = 100%)				
Capital	51%	53%	55%	47%
Urban	32%	27%	28%	29%
Rural	12%	14%	14%	20%
CPR by Province (All Methods)				
Antananarivo	29%	33%	*28%*	-
Fianarantsoa	10%	10%	*11%*	-
Toasmasina	18%	20%	*18%*	-
Mahajanga	10%	11%	*14%*	-
Toliary	8%	8%	*12%*	-
Antsiranana	10%	18%	*23%*	-

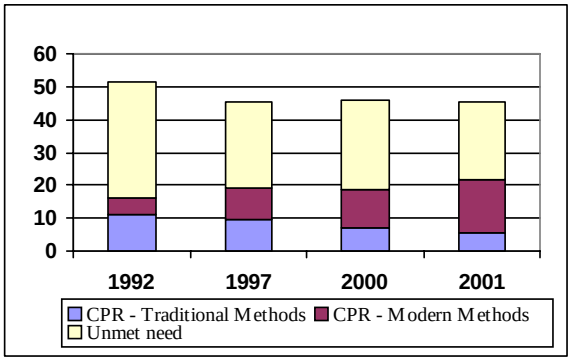
CPR by Age Group	1992 DHS	1997 DHS	2000 MICS	
15-19 years	6%	6%	11%	-
20-24 years	13%	16%	15%	-
25-29 years	183%	20%	*21%*	-
30-34 years	22%	24%	*24%*	-
35-39 years	21%	26%	*19%*	-
40-44 years	18%	22%	*24%*	-
45-49 years	**11%**	**16%**	*10%*	**-**
CPR by level of education (All methods)				
No instruction	1%	2%	*4%*	
Primary	4%	8%	*11%*	
Secondary or higher	19%	21%	*23%*	
Antananarivo	9%	17%	16%	
Fianarantsoa	2%	5%	7%	
Toasmasina	7%	9%	12%	
Mahajanga	3%	5%	9%	
Toliary	2%	5%	10%	
Antsiranana	3%	11%	15%	
CPR by level of education (Modern Methods)				
No instruction	3%	3%	*5%*	
Primary	12%	16%	*6%*	
Secondary or higher	57%	42%	*39%*	
CPR (modern) by standard of living				
Quintile 1 (poorest)		2.3%		
Quintile 2		3.0%		
Quintile 3		7.3%		
Quintile 4		12.4%		
Quintile 5(richest)		23.8%		
`Disparity Ratio (Q1/Q5) = 0.10`				
* Totals may not add up due to rounding.				

The bottom section of table 2 illustrates the large variation in CPR that exists across the standard of living continuum: in the poorest quintile of the population 2.3 percent of women are using modern methods while in the richest quintile 23.8 percent are using modern methods. The disparity ratio is measured on a scale from 0 to 1 where 0 indicates the greatest disparity. Thus Madagascar's score of 0.10 indicates a large dispersion.

5.1.2 Use of Modern Methods:

The growth rate in the use of modern contraceptive methods has been modest but positive while use of traditional methods has been declining. Figure 4 illustrates that in 1992, 17 percent reported using at least one method (modern or traditional) compared to about 22 percent in 2001. Compared to this growth rate for all methods (between 0.6 and 0.9 percent per year), the rate of use for modern methods has been increasing about 1.5 percent per year since 1992. This relative slow rate of growth in utilization has meant that unmet need has remained fairly significant over this period of time. Assuming that overall demand in 2000 and 2001 (when data on unmet need was not available at the time of the assessment) remained at the level achieved in 1997, 50% of demand remains unmet in 2001. Factors that may contribute to this unmet need are explored and described later in this section.

Figure 4. Demand for Contraceptives



Source: DHS 1992, DHS 1997, MICS 2000, EPM 2001

When assessing the demand for RH commodities, it is important to identify the source that women are using to obtain their methods. Table 3 provides a breakdown of users by source in both the rural and urban areas. As shown below, in rural areas more people use the public sector that the private sector; in urban areas a higher percentage of people go to the private sector.

Table 3. Profile of modern method users by sector (private, public)

and geographic location, 1997

Source	Urban (248 sites)	Rural (271 sites)
Public		
Hospital	27%	37%
Health Center	3%	10%
Dispensary	10%	9%
Health post	2%	6%
Total Public	42%	**62%**
Private		
Private facility	10%	3%
Pharmacy	5%	3%
Private doctor	9%	5%
FP Center/FISA	21%	20%
Religious	6%	4%
Other private	8%	5%
Total private	**59%**	**40%**
Total	**100%**	**100%**

Source : DHS/EDS 1997 ; see SAF/SALFA report on « Reorientation de sources d'approvisionments en produits contraceptifs pour la SAF et la SALFA » November 2001 for profile of users in these NGOs.

5.1.3 Factors contributing to non-utilization of methods:

The two major factors contributing to non-utilization of methods are lack of desire for contraception and lack of information. According to official surveys, a significant portion of the surveyed women indicated a desire to have more children: in 1997, 38 percent of women surveyed wanted more children (DHS 1997); in 2001 this percentage fell to 25 percent (EPM 2001). According to the 1997 DHS, 50 percent of the non-users said they had no intention of using family planning methods, and 6 percent were undecided. Based on findings from the EPM 2000, 1 out of 3 to 4 women surveyed said they did not know why they don't use family planning.

According to the last DHS in 1997, 88 percent of non-users also reported not having received any information on family planning. This represents 84 percent of the women in rural areas and 56 percent in the urban areas who have not received information about family planning. While married women of reproductive age who visit a health center represent a potential target population for receiving FP materials, only 1 out of 4 of these reported receiving information on family planning. In general, a strong opportunity exists for re-invigorating IEC activities. According to surveys, 84 percent of the target population approves of diffusing family planning methods through public channels. The 16 percent that does not approve constitutes a conservative religious minority.

As in many other countries, there was a strong positive correlation between level of education of the women in the target population and the level of contraceptive utilization. Similarly, the highest level of unmet need was among women living in rural areas. The highest level of unmet need by age group is among the 25 to 34 year olds. Table 4 summarizes information about unmet need for contraception, broken down by age group, place of residence, province, and level of education. With respect to level of education, these numbers show a positive correlation between use of contraceptives and level of education, as mentioned above.

Table 4. Profile of unmet need

	1992 DHS	**1997 DHS**
Unmet need, among married women of reproductive age	35%	26%
For spacing	16%	14%
For limiting	19%	12%
Unmet need by Age		
15-19 years	24%	22%
20-24 years	25%	22%
25-29 years	27%	34%
30-34 years	28%	34%
35-39 years	25%	28%
40-44 years	41%	27%
45-49 years	31%	17%
Unmet need by Residence		
Capital	-	16%
Urban	-	19%
All Urban	10%	17%
Rural	36%	27%

Unmet need by Region		
Antananarivo	34%	26%
Fianarantsoa	34%	23%
Toasmasina	38%	27%
Mahajanga	-	29%
Toliary	27%	24%
Antsiranana	-	26%
Unmet need by Level of Education		
No education	32%	24%
Primary education	40%	30%
Secondary education or higher	14%	19%
Unmet need by Age		
15-19 years	24%	22%
20-24 years	25%	22%
25-29 years	27%	34%
30-34 years	28%	34%
35-39 years	25%	28%
40-44 years	41%	27%
45-49 years	31%	17%

Source: DHS/EDS. DHS information from UNFPA synthesis report.

5.1.4 Factors affecting level of unmet need:

Three major factors are considered significant in influencing the level of unmet need for FP products: difficulty of reaching women who expressed need; the perceived (poor) quality of FP services; and factors surrounding the supply and perceived efficacy of available FP products.

- *Access Factors:* Given the geographical, population and physical infrastructure of Madagascar (about 75 percent of the population lives in rural areas), the target population is considered hard to reach. This is influenced by the inadequate road infrastructure to rural areas, and the historical concentration of public and private sector health centers nearer to the capital and other urban sites. During the assessment, problems with access were particularly underscored as an issue by providers and organizations providing family planning services and products. However, the issue of geographical access posing a barrier to contraceptive use requires further investigation. only 1 percent of the women surveyed in the EPM 2000 cited distance from a health center as a barrier to using contraceptive methods, and only 7 percent of them said they did not know where to obtain products. Geographic access may therefore not be a barrier. Provider bias, which exists for certain methods, may play a larger role in limiting the clients' access to the full range of family planning options

Quality of Services: Several issues relating to quality of services were cited by interviewees as potential barriers for women who expressed a need to obtain products or services. Some of these barriers are listed below:

- Services are not always available (findings from the assessment reported that less than 50 percent of the public health centers provided FP services, while the target is to have 100 percent coverage in these facilities);
- Infrastructure in health centers is considered inadequate, not stocked with the proper supplies and equipment to provide FP information or products;
- Lack of technical skills and poor attitudes of providers are considered to being factors limiting use of contraceptives;
- Most providers are male, despite a cited preference for female providers;
- There is poor follow-up, and often no follow-up, of women who are referred to higher level health centers for products and services;

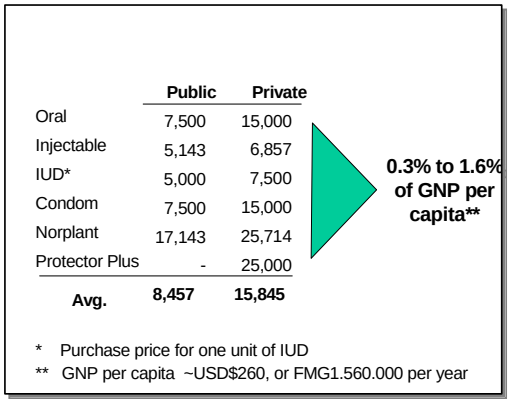
Product factors: Several issues relating to the products themselves, were cited by interviewees as potential barriers for women who expressed a need to obtain products or services. Some of these barriers include: the following:

- Several popular rumors continue to be propagated, mistakenly describing the side effects of some contraceptive methods; these rumors are considered difficult to dispel without grass-roots education efforts;
- There have been shortages in stocks of certain contraceptive products; (this is discussed further in the section on service delivery).
- A limited spectrum of contraceptive products is available, which poses an access barrier for women and limits their choice of contraceptive method.

5.1.5 The effect of contraceptive prices on utilization and access:

The effect of price on utilization and access requires further investigation in order to better understand this relationship. According to official surveys, the contraceptive product prices were not cited as a major barrier to utilization of methods. For example, the EPM 2000 found that only 1.5 percent of the respondents were not using family planning methods because the cost (price) of the methods was too expensive. The findings were corroborated by a recent willingness-to-pay study by FISA that found that family planning clients are willing and have the capacity to pay for the NGO (private) price of products. A simple analysis by the assessment team, presented in figure 5, estimated that average contraceptive prices in the public and private sector represent 0.3 percent and 1.6 percent of the average annual household income in Madagascar. However, in light of the health financing reforms that are being implemented in Madagascar (namely the re-institution of user fees in the public system), the issue of financial accessibility was considered potentially significant and worthy of further analysis. Such an analysis would to serve to anticipate and buffer the potentially negative effects of reform-related changes on the poorer segment of the population. Several studies are currently underway or planned to explore this issue, namely: 1) a study on general health delivery to indigent populations in Madagascar by the Ministry of Health; 2) a market segmentation study of FP products by the POLICY project; 3) a willingness-to-pay study by the POLICY Project, examining the willingness to pay for reproductive health services, contraceptives, and condoms for the protection of HIV/AIDS (this study would have a broader scope than a study conducted by FISA among an NGO network, and include public sector health facilities); and 3) an in-depth analysis of cost recovery and community-based health financing systems by DELIVER.

Figure 5. Estimated price for one-year supply of contraceptives



5.1.6 Current Expansion of the Contraceptive Market:

Several strategies are being developed and implemented to expand the market for contraceptives. Among others, the assessment team highlighted the following major programs and/or approaches being developed and implemented by either, or both, the public and private (NGO) sector:

- *Programs targeting Adolescent Reproductive Health:* These involve making condoms and pills available at youth centers, and reinforce the activities of existing programs led by community-based health workers. One such program is the *Top Réseau,* a pilot franchised network of health service providers and a related education and communication campaign initiated by PSI in two districts in the eastern province of Tamatave.
- *Youth Pair Educators (Jeunes Educateurs Pairs):* programs targeting youth are a strategic priority for both the public and private sector, both have committed to maintaining the momentum of youth-friendly activities started in recent years;
- *Formal education on reproductive health:* this targets middle school grade levels, and plans are being made for expanding this program to high-school;
- *Expanding the number of FP sites:* the government has committed policy to increase the percent of public health centers providing FP services from 42 percent to nearly 100 percent;

- *Quality improvements programs:* these are being reinforced and include refresher training for health providers and reinvigoration of IEC activities, combined with upgrading equipment in public health facilities;
- *HIV/AIDS campaigns:* such programs present opportunities for expanding the FP market as they target a priority population group, namely (marginalized) youth;
- *Promotion of the participation of men:* a study has already been conducted by FISA on the influence and implication of men in decision making regarding FP and contraceptive use, and is the beginning of future activities in the FP sector.

5.2 Key Findings:

Strengths:

- Use of modern contraceptive methods is increasing (at a rate of 1.5 percent per year) while use of traditional methods is declining;
- A strong opportunity exists for re-invigorating IEC activities; 84 percent of the target population approves of diffusing FP methods via public channels;
- Low prices for contraceptive methods have not been found to pose a barrier to utilization of methods; FP clients are willing and have the capacity to pay for the NGO (private) price of products;
- A number of strategies are currently being developed and implemented in both the public and private (NGO) sector, in an attempt to expand the market for contraceptives.

Weaknesses:

- Overall demand for modern contraceptive methods has been modest and relatively stagnant over the last decade;
- There is a lack of desire for some contraceptive methods, in general but in a more pronounced way in rural settings;
- Lack of information is available about contraceptive methods;
- Problems with geographical access could be posing barriers to contraceptive method use but further investigation is required to better understand this;
- A wide range of service quality problems act as barriers to contraceptive use. These quality problems include nonavailability of services; inadequate infrastructure; weak skills and attitudes of staff; limited number of females in medical profession; a poor referral system; supply shortages and stock-outs; and provider bias for certain methods.

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5.3 Priority Areas for Action

Based on the findings from this assessment, the following areas were deemed to be major areas in need of focus and further analysis:

Stagnation of demand: Further work needs to be conducted to identify the reason that demand is stagnating. The workshop participants and team members who worked on the demand component of the assessment expressed the need to:

- Conduct advocacy activities that will facilitate the creation of an environment of trust, and will promote FP as a need, involving the individual and the community as well as a fundamental right (with legal backing);
- Seek and obtain the commitment of the State and all the implicated administrative institutions at all levels (e.g., FAV, advocates for the fight against HIV/AIDS, central, government, provinces, districts, communities);
- Explore strategies for increasing geographic accessibility to services and products through either mobile strategies (e.g., community-based health workers) or through existing or new fixed structures;
- Reinforce providers' competence by conducting training sessions to update skills of providers and logistics managers. This will help improve the quality of services (quality of clinical care, availability of products, and product choice);
- Improve quality and availability of information about family planning products and services at all levels.

Research:

- Conduct research in order to better understand factors affecting the non-utilization of contraceptives and factors affecting access to and quality of services and products.

Actions and activities that stimulate or limit demand:

- Conduct pilot studies to identify how health provider skills are creating barriers to women's use of contraceptives. The pilot studies could consist of training programs for health care personnel and would investigate the impact of training on utilization of family planning services.
- Re-examine the re-introduction of user-fees. The upcoming willingness-to-pay study will be able to guide Government decisions about reinstituting this system, so that price does not pose a barrier to contraceptive use. A market segmentation study, also scheduled to take place later this year, would help stakeholders see opportunities for private sector development and help guide decisions made about reinstating the user-fee system.

Actions to affect IEC/BCC:

- Expand the use of IEC/BCC programs to stimulate different types of demand (eg. Spacing, limiting) and increase utilization;

Evaluate the extent to which programs are targeting the populations and areas with most need, and hence maximizing the impact of investments made in this area. This will help identify what actions need to be taken in rural and urban areas and at different levels of the health care system.

Improving Utilization:

- Conduct further investigation into the factors determining discontinuation of family planning methods, and whether or not this is a problem in Madagascar;
- Reinforce the activities of peer educators and multi-sectoral coordination and collaboration (e.g., through the creation of a taskforce;

- Reinvigorate IEC/BCCC campaigns, placing an emphasis on the rural sector, and particularly targeting the poor, the population with low levels of education, and adolescents. Messages should not be standardized, but rather adapted to the target populations according to the regions and socio-cultural factors;
- Leverage existing channels for information dissemination (e.g., existing programs such as Mpikabary, Mpihiragasy, etc.); link with the Ministry of Information and popularize family planning in collaboration with the Ministry of Population;
- Develop an advocacy workplan as part of the strategic planning process which encourages collaboration among authorities, parents, and various social groups.

Evaluation:

- Evaluate and monitor changes in demand to better understand the market. This could be accomplished by collecting historical data about target populations, monitoring and evaluating the impact of strategies for stimulating and satisfying demand (e.g., mobile versus fixed strategies), and conducting KAP surveys.

6. Future Population Projections

Improving reproductive health services and access to commodities, for both fertility reduction and prevention of HIV/AIDS, can help mitigate the rapid population increase and can contribute to the Government's objectives of reducing poverty, improving population dynamics and achieving sustainable development. It is possible to curb the current population growth rate, provided the political and financial commitment continues to increase.

In planning for the future of Madagascar's family planning program the question arises as to what is a reasonable trajectory for future growth in the CPR. The growth in the CPR is a critical parameter because it affects the overall demand for contraception and hence numbers of users, acceptors and commodities required. Table 5 below shows the recent experiences of Sub Saharan countries in terms of their CPR changes over recent years. It can be seen that the average increase was less than one percent per year change in the CPR (0.9 percent), with Madagascar experiencing exactly the average. A few SSA countries such as Ghana, Tanzania, Uganda and Malawi were able to achieve growth rates above 1 percent.

Table 5. Total Fertility Rates and Contraceptive Prevalence Rates in Sub-Saharan Africa

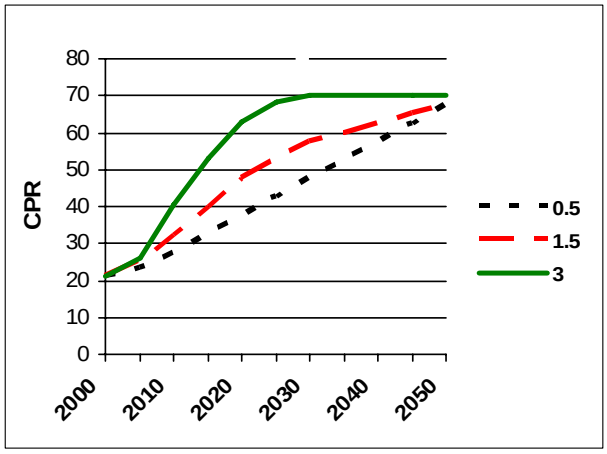
Country	TFR (15-49)	Total CPR	Modern CPR	Av. Annual %-point increase in modern CPR
Benin 1996	6	16.4	3.4	
Benin 2001	5.6	18.6	7.2	0.8
Burkina Faso 1992/93	6.5	24.9	4.2	
Burkina Faso 1998/99	6.4	11.9	4.8	0.1
Cameroon 1991	5.8	16.1	4.3	
Cameroon 1998	4.8	19.3	7.1	0.4
Cote d'Ivoire 1994	5.3	11.4	4.3	
Cote d'Ivoire 1998/99	5.2	15	7.3	0.6
Ghana 1988	6.4	12.9	4.2	
Ghana 1993	5.2	20.3	10.1	1.2
Ghana 1998	4.4	22	13.3	0.6
Madagascar 1992	6.1	16.7	5.1	
Madagascar 1997	6	19.4	9.7	0.9
Malawi 1992	6.7	13	7.4	
Malawi 2000	6.3	30.6	26.1	2.3
Mali 1987	7.1	4.7	1.3	
Mali 1995/96	6.7	6.7	4.5	0.4
Mali 2001	6.8	8.1	7	0.5
Niger 1992	7	4.4	2.3	
Niger 1998	7.2	8.2	4.6	0.4
Nigeria 1990	6	6	3.5	
Nigeria 1999	4.7	15.3	8.6	0.6
Senegal 1986	6.4	11.3	2.4	

Senegal 1992/93	6	7.5	4.8	0.3
Senegal 1997	5.7	12.9	8.1	0.8
Tanzania 1992	6.2	10.4	6.6	
Tanzania 1996	5.8	18.4	13.3	1.7
Tanzania 1999	5.6	25.4	16.9	1.2
Uganda 1988	7.4	4.9	2.5	
Uganda 1995	6.9	14.8	7.8	0.8
Uganda 2000/01	6.9	22.8	18.2	1.7
Zambia 1992	6.5	15.2	8.9	
Zambia 1996	6.1	25.9	14.4	0.9
Total Average annual increase				0.9

Notes: a) Only one country (Malawi) has had an average annual %-point increase of more than 2 and looking at the reported TFR, it renders the quoted CPR into question. b) Overall observed annual %-point increase for all countries is about 0.9. I suggest that we use a 0.9 annual increase for the first 6 years up to 2005, then 1.3 annually between 1995-2010, and then 1.8 between 2010 and 2015.

The assessment team explored three possible scenarios of future CPR increases. These three scenarios, which were presented at the national workshop in June, are illustrated in Figure 6. These scenarios helped the assessment team, and other stakeholders, gain an understanding of the future implications of increasing CPR and TFR.

Figure 6. Future Projections of CPR, Three Scenarios, FamPlan Model

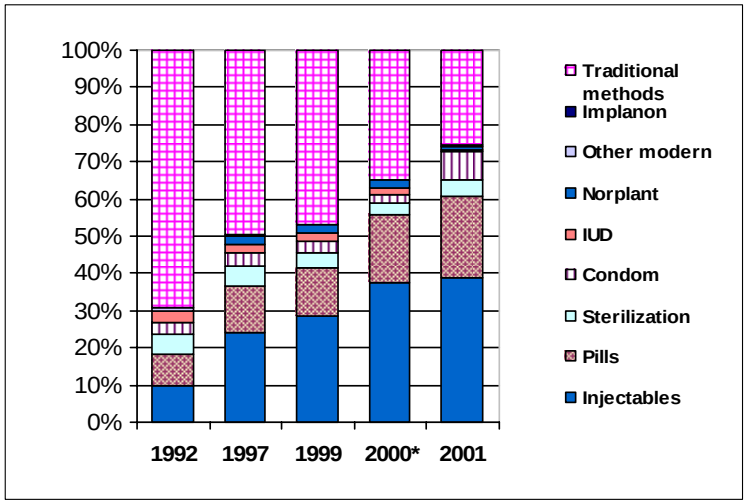


The first hypothesis, represented by the lowest line (smaller dots) in figure 6, assumes a change in CPR of 0.5 percent per year. Increased contraceptive use will result in the average women having fewer children and a reduction in total fertility rate from 6 to 2.6 by the year 2050. Under this scenario, 60 percent of women in union would be using contraception by 2045 and the total population would reach 57 million by the year 2050.

The second hypothesis, (the middle dashed line), assumes an increase in CPR of 1.5 percent per year. TFR would decrease from 6 to 2.5 by the year 2050; this decrease would occur more rapidly than under scenario 1. Under this scenario, 60 percent of women in union would be using contraceptives by the year 2035, much earlier than under the scenario described above. This scenario projects a population of 49 million by the year 2050.

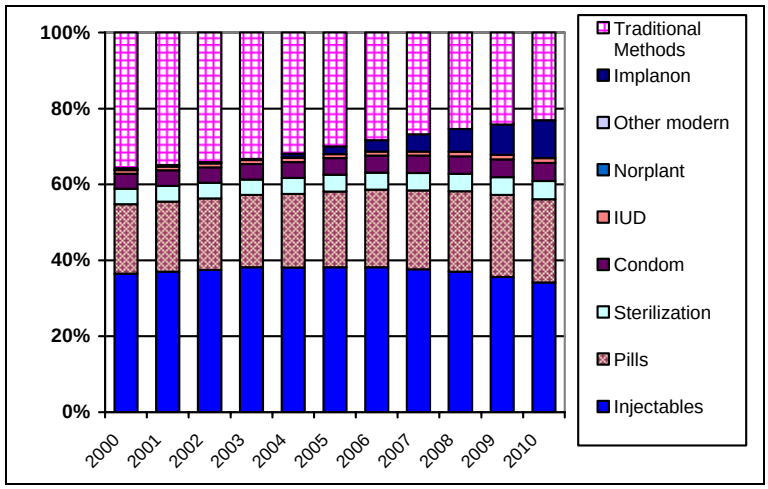
Hypothesis three is more optimistic than hypotheses 1 and 2, assuming an increase in CPR of 3.0 percent per year, resulting in TFR falling from 6 to 2.2 by the year 2050. By 2025 almost all women in union would be using contraception and the population would rise to 37 million by 2050.

Figure 7. Recent History of Method Mix



In addition to assumptions regarding the future course of the CPR the assessment team decided on the most likely change in the method mix. Figure 7 shows the recent changes in the method mix in Madagascar. It can be seen that the traditional methods are in decline, while modern methods are increasing.
Figure 8 shows the assumed changes in method mix into the future under the medium variant scenario. The low and high scenario variants are similar for method mix change and are not shown here.

Figure 8. Projected changes in method mix, medium variant scenario



The effects on the TFR of the three CPR scenarios can be seen in Figure 9. Under the 0.5 percent increase scenario the TFR slowly declines and does not fall below 3 until after 2040. Under the medium variant TFR

falls somewhat faster and reaches 3 in 2036. Under the most ambitious scenario of 3% annual increase in the CPR we see that the TFR falls to replacement level by 2028. This in turn has an effect on the total population growth rate and size of the population, as shown in figure 10. Under the most optimistic scenario, the population will increase to 37 million by the year 2050; under the medium variant scenario, population will increase to 49 million; and under the scenario which projects the lowest increase in CPR (0.5 percent per year), the population would increase to 57 million by the year 2050.

Figure 9. Total Fertility Rate under the Three Proposed Scenarios

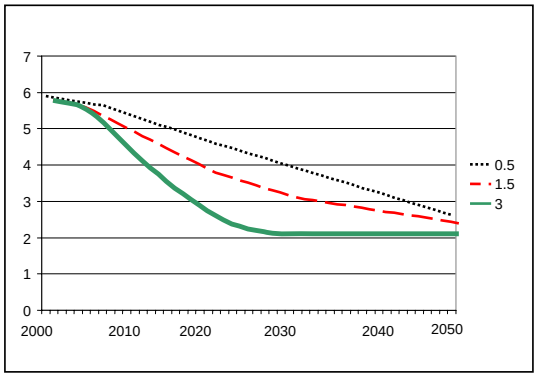
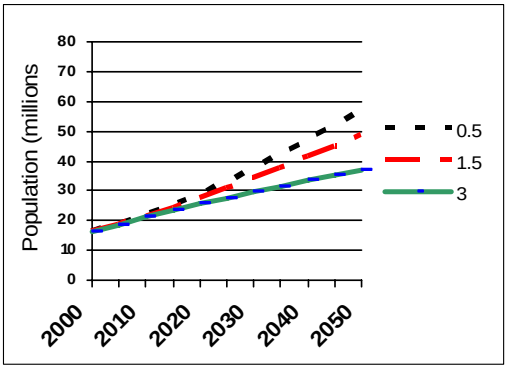
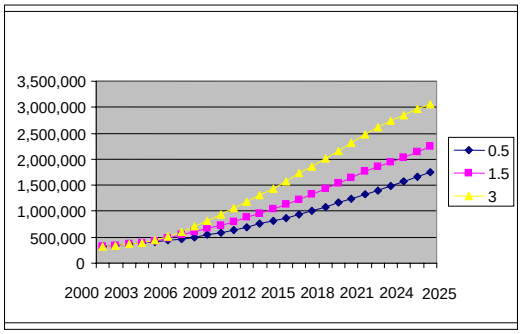


Figure 10. Total Population Rate under the Three Proposed Scenarios



The team also projected the number of users and the number of contraceptive commodities required, as a result of these three scenarios. Figure 11 shows the numbers of users up until the year 2025. It can be seen that even under the lower growth scenario the number of expected users will increase from under 500,000 in 2000 to approximately 1.75 million by 2025, while under the most optimistic scenarios the number of users will increase to over 32 million. The projected commodity requirements are shown in the Finance section of this report.

Figure 11. Projected Users under the Three Scenarios



7. Service Delivery

The Service Delivery Component of SPARHCS is intended to examine the overall access, availability, affordability and quality of services for the target population for FP/RH commodities. During the basic diagnosis, the service delivery team looked at the family planning products and services, forecasting and procurement, and distribution of contraceptives.

7.1 Situational Analysis:

7.1.1 History of FP/RH Service Delivery:

Reproductive health and family planning services have been offered in Madagascar for over three decades, through various sources including public, private and NGO clinics, workplace-based programs, mobile clinics and community based agents. The public sector began integrating these services into health centers in 1986; after this time family planning services expanded rapidly throughout the 1990s, in the public, private and NGO facilities and in the early 1990s, STI treatment centers were installed. The majority of RH services function within the health care structure. complying with the principles of integrated reproductive health that are outlined in the national reproductive health policy, which sets forth that all clinics at the community and CSB levels must offer a minimum packet of reproductive health services, including family planning services and products.

In the family planning domain, the USAID bilateral project, under the Jereo Salama Isika Project, as well as UNFPA, and GTZ, have provided support in contraceptive logistics management and various activities aimed at increasing access to and use of family planning services in the public and private (NGO) sectors. Activities include trainings, supervision, IEC/BCC, and mass media campaigns. USAID also supports an extensive social marketing program implemented by Population Services International (PSI).

Comment [s1]: We need to add a few sentences about what other donors are doing so it doesn't look so USAID focused.

7.1.2 Overview of the Health Sector:

It is important to address issues related to family planning and reproductive health services in the larger context of health service delivery, especially now that services are, for the most part, integrated into Madagascar's health care system. Health centers are often characterized by poor quality of care, where contraceptives and drugs are rarely available. Facilities and laboratories are not equipped with adequate infrastructure or health care personnel.[ix] [xviii]The interim poverty reduction strategy paper proposed that by the end of 2003, over 2,100 basic health centers (excluding cyclone-damaged centers) should be operational with the appointment of sufficient personnel, doctors and assistants. Materials will be granted , buildings rehabilitated, and 12 additional district hospitals will have been equipped to cater for common surgical interventions. Currently, large disparities in quality exist between levels of the health system, as well as between rural and urban regions. For example, only 49 percent of doctors in the public sector serve the rural zones where 80 percent of the population resides; those in the private sector work primarily in the urban areas, serving 20 percent of the population.

In the mid-1990s, the government assigned provinces to the main donor agencies providing support to the health sector in Madagascar to enable them to focus their assistance. USAID provides support to the provinces of Antananarivo and Fianarantsoa, UNFPA to Antsiranana, Toamasina, and Toliary, and GTZ to Mahajanga.

Recent reforms have attempted to make the system more responsive to local needs by redefining roles and responsibilities and by shifting more responsibility from the central to the district levels. The decentralized structure promotes multisectoral and community participation, with the aim of improving planning, management, and supervision and strengthening health service delivery by building capacity and monitoring quality.[8] However, the ability to take on these new responsibilities varies across districts.

Madagascar's decentralized health system is divided into three levels. The Ministry of Health oversees six health regions, which are responsible for coordinating, supervising and supporting health districts; planning for the needs of the region; developing a health information system; and ensuring quality of service delivery. Personnel at the intermediate level facilitate the integration of MOH priorities at the district levels and are responsible for mobilizing resources, tracking utilization of resources, and also monitoring cost recovery, when it is in place.

There are a total of 111 districts, each serving 112 000 habitants on average, with one district management team (EMAD); one district hospital (CHD) or primary care center; 17 Basic Health Centers (CSBs); a health committee; and in some jurisdictions, private clinics.[vi] The EMAD is responsible for coordinating all health programs within the district.[vi]

The findings from the supply assessment are divided into three headings: Family Planning Products and Services, Forecasting and Procurement, and Distribution.

7.1.3 Family Planning Products and Services:

Family planning services are offered through public, non-governmental and private-commercial service delivery points. The public and NGO sectors offer a similar package of services. Social marketing has played an important role in engaging the private sector in providing family planning through training and certification of private family planning providers and has a strong advantage in the distribution of re-supply methods like condoms and oral contraceptives.

The Ministry has been concentrating its efforts on supplying oral contraceptives, injections and barrier methods at the primary health care level and expanded barrier and oral contraceptive distribution through community based distribution. The practical approach of making a few methods widely available was successful in increasing contraceptive availability in public sector primary health care facilities to 46 percent. The government's stated role is to make these three methods available in 100 percent of its primary health care facilities.

Referral for and availability of long-term and permanent contraception in the public sector is generally weak although there have been successes through campaign approaches. The larger non-governmental organizations, particularly FISA and Marie Stopes International, provide a large percentage of tubal ligations and most of the IUD insertions nationally (as well as Norplant) , and these may also include referrals from the public sector.

The government and its partners are promoting a number of strategies to increase the uptake of family planning services. These include:

- Making pills and barrier methods available in 100 percent of primary health care sites by the end of year 2005;
- Expanding distribution through community-based distributors;

[8] see appendix

- Expanding access for youth through Ministry and FISA youth educators ("Jeunes Pairs Educateurs" – to date, there are 120 such educators);
- Improving quality of services through providing standard guidance, training and equipment;
- Studying the role of Malagasy men in influencing the use of family planning services (FISA);
- Initiating an HIV/AIDS program for marginalized youth.

Overall, the public sector employs over 1,600 service providers trained in family planning offering services in approximately 1,453 sites (2003) representing 47 percent of available sites. (This should be re-formulated given that the 1,453 sites include part if not all NGO sites. This figure provided by the MOH comes from the HMIS to which NGO's report.) While there is enthusiasm for community based distribution at the central level, it is unclear how many trained community based distributors are currently active. Some study of the real importance of their contribution and the factors for success (or discontinuation) of community based distribution in the public and NGO sectors of Madagascar should be required before proposing expansion of these programs. The resources of the public sector are spread thin over a large territory, and so its ability to provide supervision, refresher training and other services designed to maintain quality is limited.

The NGO sector employs over 400 service providers trained in family planning through approximately 250 service delivery points (estimated in 2000). In addition, FISA manages more than one hundred youth educators. Some NGOs have put a particular emphasis on developing their training capacity, both for internal staff development and as a service to other organizations and should be considered as a potential source of technical assistance when training activities are being developed.

The social marketing program has been working to expand service availability in the private sector by providing education to private doctors and pharmacies. Their "TOP Réseau" (pilot program, mentioned in the Demand section of this report) trained 30 doctors working in 17 health centers. In addition, sales of condoms in the market exceeded 20,000 units in 2002.

The three sectors were historically dependent to different degrees on the sale of contraceptives. In 2000, when public sector sales of contraceptives were legal, they generated less than three percent of the family planning program budget. As another comparison, sales were generating less than 10 percent of commodities cost including distribution. Although cost was not indicated as a barrier to family planning clients, under the new administration, the public sector was prohibited from charging for contraceptives in 2002. It is anticipated that with the re-establishment of cost sharing system –at a date that remains to be determined- the modest revenues generated by the sales will be used to cover activities like transportation, procurement of expendable tertiary supplies essential to service delivery, and possibly incentives for service providers.

The importance of sales for the NGOs varies, but according to FISA's annual report in 1999, these sales represented an important 28.9 percent of their revenue. FISA, along with 9 other large NGOs have recently been converted to the social marketing program for their source of supply for orals, condoms and injectables. This constituted something of a fiscal shock for the NGOs that had been accustomed to receiving donated commodities. For its part, FISA seems to have weathered the transition. For those smaller NGOs that have not transitioned to the social marketing program, the MoH has agreed on the principle of resupplying their SDP's through the PHA-G-Dis. Some already do. However no formal strategy has been developed to accompany this re-orientation yet. The NGOs that have been re-oriented to Social Marketed products also need to develop a sustainable strategy for assuring re-supply long-term methods like implants. While IUDs are not much used by public sector clients, NGOs like Marie Stopes International serve modestly increasing numbers of acceptors.

The social marketing program depends on donated commodities. Depending on the product, the social marketing program recovers between 50 percent and 100 percent of packaging and insert costs from their

sales. Looked at another way, sales to distributors return between eight and thirty-eight percent of the costs of the commodities. This is shown in table 6.

Table 6. Social Marketing Prices to distributors (Pharmad, Salama)

	Social Marketing Sale Price		USAID Purchase Price	% recovered
Product	FMG	US$	US$	
Injectables	1,000	0.17	0.95	18%
Pills	500	0.08	0.2166	38%
Condoms x3	80	0.01	0.1755	8%

There is currently no plan for them to recover commodity costs as the focus of the program is expanding the market and the level of cost recovery is considered sufficient at the present moment. Future research may reveal whether target populations are willing and able to pay more for contraception.

7.1.4 Forecasting and Procurement:

The method mix is, in part, determined by what donors are willing and able to provide, and contraceptive procurement is conducted by the donor agencies, each using their own procurement systems. This "push" system may have contributed to some stock imbalances recently with 3-month injectables. For example, a donor that had committed to providing Depo Provera was faced with a manufacturing shortfall from its supplier that significantly delayed scheduled deliveries. The Ministry, being dependant upon the donors and the donors' suppliers, was not in a position to research alternative suppliers to meet its demand.

There are a number of strong points in the system. First of all, the national policy is in line with international standards in that the government of Madagascar's policy is to assure a mix of contraceptive commodities. Second, historical consumption information has been collected and is available for a number of products. The quality and availability of this data is good, up until the year 2000. However, there is a need to improve the use of this data, by USAID and the MOH, in order to more effectively make decisions about procurement and distribution. The third strong point is the capacity of the staff at SALAMA. Since they already have the skills to procure drugs, they can be easily trained to conduct contraceptive procurement in the near future. Finally, Coordination between the donors and the Ministry for the purpose of procurement planning continues to evolve, and there is good will on all sides.

Starting in 2003, under the public sector distribution system, the procurement services provider for the Ministry of Health, SALAMA, will take over responsibility for the logistics and costs related to the storage and distribution of public sector commodities. The POLICY project will continue to provide forecasting technical assistance to SALAMA that was formerly provided by the Jereo Salama Isika project. Donors will continue to be responsible for the procurement of contraceptives and the transportation of these contraceptives to the central warehouse.

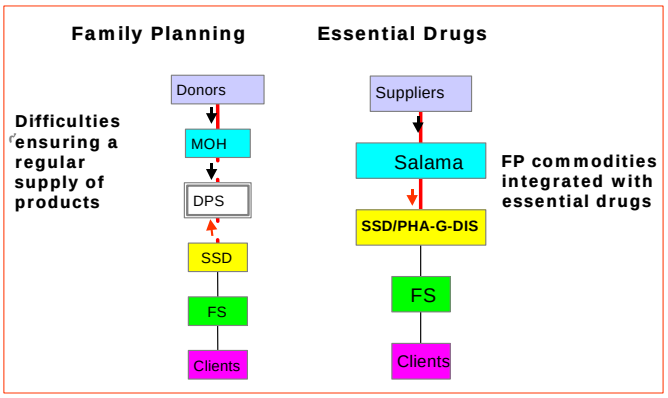
7.1.4 Distribution

A portion of the commodities received from donors is distributed to the commercial sector through the social marketing program while others are distributed to public and NGO family planning sites. At present, there are three main distribution channels for commodities received from donors. From the central level, commodities for the public sector are stored and distributed by USAID and, to a lesser extent, the Ministry of Health; commodities for the NGO sector by the National Association of NGOs (ASSONG); and for the commercial sector by the social marketing program. In the public sector, donors have distributed the vast majority of commodities from the central to the provincial and district levels as well.

Distribution and logistics management information were given significant technical support during the two USAID phases (APPROPO/PF & Jereo Salama Isika Projects). Improvements were made that led to iing to improvements in the overall performance of the distribution system: stock cards are now available at all levels; appropriate locations for stock are maintained at all levels;management procedures are well-defined; and designated personnel have been assigned stock management responsibilities.

Starting in 2003, contraceptive products for the public sector will be distributed through a decentralized, integrated system that will provide national essential drugs, including contraceptives, to service delivery points. The Memorandum of Understanding has been signed by the government, USAID, UNFPA, SALAMA, (the central procurement agency), to implement this new distribution system. However, at the time of the assessment the new distribution system was not yet in place.

Figure 9. Comparison between former contraceptive distribution strategy and the essential drug distribution



Integration of family planning products in the essential drug distribution system in 2003 will allow for direct distribution from the central level to the districts, reducing the pipeline. The differences between the old contraceptive distribution strategy and the essential drug distribution strategy are illustrated in figure 12. Removing stock management responsibilities from the departmental level is an important step that shortens the period of time between when products arrive in Madagascar and the time that they can be made available to FP clients.

7.2 Key findings:

Strengths:

- The service delivery system is diverse and complementary in that reproductive health services and products are available through public, private, NGO and social marketing channels;
- The Government has demonstrated commitment to making a manageable number of family planning methods available through 100 percent of public sector service delivery points;
- NGOs' capacity to supply long-term methods and provide technical training is high;
- Some historical consumption information is available for a number of products;
- The staff of SALAMA have developed skills and experience in drug procurement, and this can be transferred to contraceptive procurement;
- The LMIS is in place in the public sector and procedures are well-documented.

Comment [s2]: The highlighted bullets need to be "sharpened" – we want to be careful not to just state the obvious – can you expand on these?

Weaknesses:

- The referral system in the public sector is weak, making it difficult to make long-term and permanent contraception available;
- Import requirements have not been met prior to shipment, particularly tax exemption paperwork for donated commodities;
- Logistics data has not always been completed accurately or promptly;
- Distribution to and communication with the more peripheral service delivery points has in the past, been weak;
- Financing for communication and transportation, as well as management tools (for example, stock cards and registers) has been weak;
- The system remains extremely donor dependent on specific aspects of the logistics system, for example LMIS forms and registers. The MOH has limited capacity for updating forecasts and procurement plans on a regular basis;
- Financial continuity for contraceptive procurement, especially for the NGOs is uncertain;
- Communication is poor between the central level and the service delivery points.

Comment [s3]: What kind of capacity? HR training?

Comment [s4]: Please expand on this – is it becasue government does not have this in the budget???

Comment [s5]: Please elaborate

7.3 Priority areas for action

During the June 10 workshop, participants made the following general recommendations for improving Family Planning Service Delivery, Forecasting and Procurement, and Distribution:

Capacity Building:

- Maintain and supplement the personnel of the existing Logistics Unit so as to transfer to appropriate Malagasy institutions, particularly SALAMA and appropriate departments of the MOH, knowledge and skills required to carry out RH/FP commodities forecasting, procurement and logistics supply. Ongoing training, (both formalized and on-the-job training) should focus on building capacity of staff as they analyze trend data on consumption, write contraceptive specifications, and produce international tenders for RH commodities;
- Facilitate the development of a quality assurance system for contraceptives
- Improve maintenance of the re-supply calendar to assure the delivery of the contraceptives to the service delivery points;
- Strengthen supervision to improve reporting rates;
- Improve procedures for monitoring supplies: The MOH and other stakeholders have to focus on improving completeness and timeliness of data for monitoring performance and estimating requirements;
- Provide support in drafting a five-year forecast of commodity needs based on national data and validated data extrapolated from provinces not heretofore covered by USAID-assisted projects, including updates of contraceptive procurement;
- Provide reinforcement training of counterparts in use of forecasting tools for commodities, i.e., with personnel from SALAMA and MOH and selected, private sector agencies. This would increase reliability of logistics data, particularly consumption and stock on hand data, through a strong LMIS and improvement of reporting rates;
- Continue providing support to the ICC in order to clearly define roles and responsibilities and improve logistics management functions of the EPI program. (It is important to note that though the MoH decided to subcontract the supply function to SALAMA and NGO's (district pharmaceutical warehouse level (PHA.G.DIS)), the administration remains extremely present in the validation of orders at each level.

Access:

- Address problems related to difficult access by strengthening the network of community based distributors to serve clients. Research studies should be conducted to determine strategies for reducing discontinuation by the CBDs. These studies should be done in collaboration with activities aimed to stimulate demand for contraceptives;

- Improve sensitization and IEC/BCC programs to combat rumors about the safety and efficacy of methods held both within the general population and among service providers that may discourage them from offering a complete mix of contraceptive choices. This will have an impact on stimulating demand for a broader range of methods;

- Identify focal persons and key stakeholders who will advocate for supply-related issues like tax exemptions and financial continuity. This will help ensure that all import requirements are met prior to shipment, particularly tax exemption paperwork for donated commodities;

Collaboration and Coordination:

- Improve coordination mechanisms between partners to monitor product availability, ensure financial continuity and improve logistics operations. Ongoing communication between stakeholders will be required in order to assure financial continuity for these requirements in the short term, and some plan for financing of commodities needs to be developed for the future;

- Encourage public/private collaboration, monitoring the impact of programs like TOP Réseau – the program targeting adolescents;

Research:

- Conduct in-depth evaluations of the following: baseline indicators for the supply component (service provision, forecasting and procurement and distribution); required resources (human and financial) to achieve desired growth in contraceptive prevalence; evaluate IEC/BCC approaches and extend those that have been effective;

Long-term goal:

- Expand family planning services to 100 percent of public health centers in order to meet the objectives outlined in the national "Business Plan". In order to do this stakeholders will need to develop work plans and budgets that extend coverage consistent with the Business Plan.

8. Finance

8.1 Situational Analysis :

8.1.1 Overall health sector financing:

It is important to look at financing of the family planning program within the context of overall financing for the health sector. The total health budget impacts the level of funding available for all health service areas and programs, which often compete for limited resources.

Over the last five years, the health budget has increased by approximately 47 percent (from $57 million in 1998 to $83 million in 2003). From 1998-2001, actual expenditures on health increased by over 60 percent, reflecting both an increase in the budget and the proportion of budgeted funds spent. Table 7 shows the total health budget and actual expenditures (if available) over the last five years.

Table 7. Overall Health Budget and Expenditures, 1998-2003 (in millions of current US$)[9]

	1998		1999		2000		2001		2002	2003
	Budget	**Actual Exp.**	**Budget**	**Actual Exp.**	**Budget**	**Actual Exp.**	**Budget**	**Actual Exp.**	**Budget**	**Budget**
Total Expenditures	**56.7**	**43.1**	**62.5**	**52.1**	**79.9**	**73.6**	**70.9**	**69.5**	**67.1**	**83.1**
Recurrent	**31.0**	**26.4**	**31.1**	**28.7**	**37.5**	**33.3**	**35.1**	**33.7**	**40.2**	**49.5**
Personnel	15.4	11.3	15.0	14.4	18.1	18.1	19.4	17.9	22.0	25.1
Goods and services	15.6	15.1	16.1	14.3	19.4	15.2	15.7	15.8	18.2	24.3
Investment (PIP)[10]	**25.7**	**16.7**	**31.4**	**23.5**	**42.4**	**39.2**	**35.7**	**35.7**	**24.6**	**32.8**
GoM	7.0		8.4		8.8		10.0		5.5	4.9
Donor Funds	10.9		12.4		21.7		15.6		11.7	12.5
Loans	7.8		10.6		12.0		10.1		5.1	14.6
HIPC Credit									**2.3**	**0.8**

Source: Ministry of Planning for investment budget and HIPC, World Bank report for recurrent budget (report data from Ministry of Health (1998) and Ministry of Finance (1999-2003)

Both recurrent and investment expenditures increased from 1998-2001, by 27 and 214 percent, respectively. The doubling of investment expenditure was due largely to an increase in the amount of investment program (PIP) funds spent over this period. While the recurrent budget is financed from general government revenue, the vast majority (75 percent) of the investment budget is financed by external sources – approximately 44 percent by donors and 31 percent through loans over the past four years.

In 2000, Madagascar became eligible to receive debt relief under the enhanced World Bank/IMF-supported Heavily-Indebted Poor Countries Initiative (HIPC II). Exceeding 100% of GDP for most of the 1990s, Madagascar's high level of external debt has impacted the amount of discretionary funds available. Since 2002, the health sector has benefited from the funds freed up through the HIPC Initiative, receiving $2.3

[9] For the table of Consumer Price Index (CPI) conversion factors used to convert all financial data presented in this section to 2003 U.S. dollars, see: http://oregonstate.edu/Dept/pol_sci/fac/sahr/cv2003.xls

[10] The investment (PIP) budget does not include USAID support to the health sector. All other donor support should be included in the investment budget, but further financial analysis is needed to verify the accuracy of the donor figures in the central budget.

million in 2002 and $0.8 million in 2003.[11] In Madagascar's Poverty Reduction Strategy Paper, which sets forth how HIPC funds will be used, one of the priority health objectives noted is to strengthen the family planning program and increase the contraceptive prevalence rate from 12 to 25 percent by 2005. At the time of the assessment, however, it was unclear whether some of the HIPC funds channeled for the health sector were earmarked and/or used for the family planning program.

Total government expenditures, including external funds, translated to per capita health expenditures of approximately $4.35 in 2001, up from $2.98 in 1998.[12] Health expenditures fluctuated between 5 and 8 percent of total public expenditures, and 1 to 1.7 percent of GDP between 1998 and 2001.

8.1.2 Financing of family planning services

While the health budget has risen over the past five years, government financial support for the family planning program has not increased, as mentioned previously. Donors finance the vast majority of program-specific costs of the family planning program, of which the bulk is for the purchase of contraceptives.

Table 8 presents a breakdown of expenditures on the direct costs of the family program by funding source for the period 1999-2003. It should be noted that only direct program costs are included – costs that would be incurred in the absence of the family planning program, such as general facility operating costs or salaries for staff that provide a variety of health services, are not captured here.

Over three-quarters of total expenditures on the family planning program over the last four years were for the purchase of hormonal contraceptives and condoms for the public and private (NGO and social marketing) sectors. All costs related to the purchase and shipment of these commodities have been paid for by donors, with the exception of 1999 and 2000 when the International Planned Parenthood Federation (IPPF) also contributed contraceptives.

The second largest share (8 percent) of program expenditures has been for the training of health facility staff and district health officials in family planning methods and services. In addition, USAID provided public and private sector grants (AAPS) - directly to health districts and through the bi-lateral Jereo Salama Isika (JSI) Project to NGOs - to carry out family planning activities, including trainings and supervision, as well as other health activities not included in the above figures.[13]

The figures for non-commodity costs of the family planning program, however, should be interpreted with caution. Due to the increasing level of integration of family planning activities into other related reproductive health activities, it is often difficult to separate out the direct, non-commodity costs of the family planning program.

Each of the current sources of financing for the family planning program and their relative importance are discussed in more detail below.

[11] HIPC funds are considered a separate source of funding within the investment budget.
[12] Health expenditures per capita were calculated using constant 2003 US$.
[13] Disaggregated AAPS expenditure data was not available at the time of the assessment.

Table 8. Estimated Expenditures on the family planning program, by funding source, 1999-2003 ('000s of current US$)[14,15]

Cost Category	Central Gov't	USAID[16]	UNFPA[17]	GTZ	IPPF	Total	% of Total
Recurrent costs (excluding salaries)	20	-	-	-	-	20	0.2%
Contraceptives	-	5,949	2,532	-	215	8696	79%
Training	-	513	343	27	-	883	8%
Supervision	-	51	38	39	-	128	1%
IEC	-	131	106	11	-	248	2%
Contraceptive logistics	-	242	-	2	-	244	2%
Medical Equipment	-	-	115	-	-	115	1%
Public sector AAPS[18]	-	484	-	-	-	484	4%
Private sector AAPS (NGO Support)[19]	-	185	-	-	-	185	2%
Technical assistance	-	-	-	-	-	-	-
Total	***20***	***7555***	***3134***	***79***	***215***	***11,003***	
% of Total	***0.2%***	***69%***	***28%***	***1%***	***2%***	***100%***	***100%***

Sources: Ministry of Health, USAID, UNFPA, GTZ, DELIVER
** USAID, UNFPA, and GTZ provide short and long-term technical assistance

Central Government

[14] USAID, UNFPA, and GTZ provided estimates of expenditures directly related to the family planning program. IPPF expenditures only include expenditures on contraceptives. At the time of the assessment, data was not available on the non-commodity costs of the family planning program paid for by IPPF.
[15] Central government and UNFPA support are included in the health budget presented in Table 1. It is not clear whether GTZ and IPPF support is captured in the investment budget presented in Table 1.
[16] Includes PSI trainings and IEC activities related to the provision of family planning products and services.
[17] UNFPA support to NGOs is distributed among the different types of activities.
[18] Public sector grants (AAPS) were given directly to USAID districts under the USAID b-lateral JSI Project to fund child survival and reproductive health activities, including family planning. The AAPS funding included in Table 3 is the portion used for the family planning program, the majority of which was used for trainings.
[19] Private sector grants (AAPS) were given to a number of NGOs under the USAID bi-lateral JSI Project. The AAPS funding included in Table 3 is the portion used for the family planning program.

The main family planning program costs covered by the government are for the portion of the operating costs of the Ministry of Health's Reproductive Health Division (RHD) used to provide central-level support to the family planning program.[20] Table 9 presents the total recurrent budget (not including salaries) for the RHD, of which 15 percent is estimated by the RHD to be spent on the family planning program. After a significant increase in its share of the total MOH recurrent budget (excluding salaries) from 1998 to 1999, the RHD budget's share has remained relatively constant at approximately 0.14 percent of the recurrent budget.

[20] Most RHD staff spend a small minority of their time on family planning activities. However, one RHD staff person is estimated to spend the majority (up to 80 percent) of time on family planning activities. This staff person's salary could be considered a direct program cost, but the starting date of her employment and salary information was not available at the time of the assessment.

Table 9. Central-level budget allocations to reproductive health and family planning (in current US$)

	1998	1999	2000	2001	2002
Total MOH recurrent budget (excluding salaries)	15,609,702	16,114,501	19,426,487	15,726,403	18,207,358
RHD Recurrent budget	13,225	24,525	23,185	22,923	23,059
% of total recurrent budget	0.08%	0.15%	0.12%	0.15%	0.13%
Recurrent budget for FP (within RHD budget)	1,984	3,679	3,478	3,439	3,459
% of RHD recurrent budget	15%	15%	15%	15%	15%
% of total MOH recurrent budget	0.01%	0.02%	0.02%	0.02%	0.02%

Source: Ministry of Health

While the central government does not fund a large percentage of the direct costs of the family planning program, it does pay for related costs, such as district and health facility level operations, including personnel salaries, maintenance and overhead costs, and basic supplies, as well as some building costs. It is difficult to estimate the portion of these costs that are incurred for family planning services - there is limited data on which facilities are providing family planning services, as well as wide variation in the dates that facilities started providing services, the range of services provided, and amount of time spent on the family planning services. However, given the low use of modern contraceptives in the country, the family planning program portion of these costs paid for by the government, while a key contribution, is likely relatively low.

As mentioned previously, a new, decentralized public sector distribution system is scheduled for implementation in 2003 which will provide essential drugs, including contraceptives, to service delivery points. Under the Memorandum of Understanding signed by the government, USAID, UNFPA, and SALAMA to implement this new distribution system, the government has agreed to pay the taxes and customs duties of the commodities procured, as well as begin the process of purchasing contraceptive products in 2003.[21]

Donors and International Organizations

Donor funding for contraceptives

Contributions from donors come in various forms, though one of their main contributions has been the procurement and delivery of hormonal contraceptives and condoms to the central level. Since 2001, USAID and UNFPA have been the only donors and main suppliers of contraceptives and condoms in Madagascar.[22] Each of the donors supplies different methods: from 1999-2003, UNFPA provided implants (Norplant) and injectables (Depo-provera); USAID and IPPF supplied condoms (no logo and Protector/Protector Plus), pills (Lo-Femenal and Ovrette), IUDs (Copper T 380), injectables (Depo-provera), and Conceptrol Foaming Tablets.

[21] Memorandum of Understanding between the Ministry of Health, USAID, UNFPA, and the central procurement agency "SALAMA" for Improved Contraceptive Availability and Coverage, Dec. 2002

[22] A very small percentage of the supply of condoms sold at commercial outlets is not donated. Exact figures were not available at the time of the assessment.

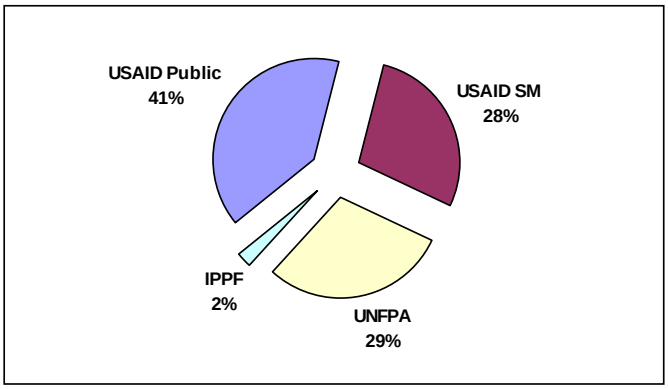
Table 10 presents the annual cost of contraceptives received between 1999 and 2003 in Madagascar by funding source. The variation in cost from year to year reflects external factors such as fluctuations in donor funding and delivery time, as well as internal factors, such as the need to replenish low stocks in 2001. Therefore, to assess each donor's contribution to the supply of contraceptives, it is better to look at total contribution over the past four years.

Table 10. Trends in funding for contraceptives, 1999-2003

	1999	2000	2001	2002	2003*	Annual average	Total 1999-2003	% of Total
USAID – Public	$1,596,675	$121,154	$1,051,198	$141,308	$595,983	$701,263	$3,506,317	41%
USAID – SM	$51,412	$782,552	$992,004	$562,360	$54,784	$488,622	$2,443,112	28%
UNFPA	$960,899	$-	$1,051,198	$141,308	$378,417	$506,364	$2,531,822	29%
IPPF	$164,234	$50,565	$-	$-	$-	$42,960	$214,798	2%
TOTAL	$2,775,219	$956,270	$3,096,401	$846,978	$1,031,187	$1,741,211	$8,696,049	100%

Source: JSI logistics management database (Pipeline), JSI (for 2001-3 commodities for the social marketing sector)
* Projected costs of products scheduled for delivery in 2003

Figure 10. Funding Sources for Contraceptives, 1999-2003



As shown in Figure 13, the largest donor for family planning commodities is USAID, which provided approximately 70 percent of all contraceptives supplied to the public and private (NGO and social marketing) sectors from 1999 to 2003. UNFPA funded approximately one-third of all commodities received over this time period.

A portion of the commodities received from donors is distributed to the commercial sector through the social marketing program while the rest are distributed to public and NGO family planning sites. Donors cover all procurement and shipping-related costs, delivery of the commodities to the central level, and the vast majority of the storage costs. Under the new public sector distribution system, SALAMA will cover the costs related to the storage and distribution of public sector commodities (using money generated by the cost sharing system) and donors will pay for the procurement and transportation of commodities to the central warehouse. However, the end user will ultimately pay for the costs of distribution from the central to district and health facility levels.

Donor funding for the non-commodity costs of the family planning program

Table 11 shows the financial support provided by USAID, UNFPA, and GTZ for the non-commodity costs of the family planning program.

Table 11. Trends in donor expenditures on non-commodity costs of FP program, 1999-2003

Year	USAID	UNFPA	GTZ	Total
1999	$57,654	$58,877	$11,575	$128,106
2000	$334,769	$118,787	$16,971	$470,527
2001	$772,796	$211,386	$8,031	$992,213
2002	$330,307	$141,504	$5,314	$477,125
2003	$179,342	$71,152	$37,150	$287,644
TOTAL	***$1,674,867***	***$601,707***	***$79,041***	***$2,355,615***

Sources: USAID, UNFPA, GTZ

Excluding contraceptive supplies, the majority of USAID's assistance to the health sector between 1999-2003 has been through the bi-lateral JSI Project and the social marketing program. Over this period, USAID expended an estimated $1.7 million on activities that directly supported the family planning program. Table 11 presents the amount expended by year, which does not include expatriate salaries or short-term technical assistance provided through the bilateral or other USAID-funded projects. The increase in USAID support from 2000-2002 reflects the use of public sector grants to fund district family planning-related activities. The main public sector grant-making period was from December 2000 – October 2001.

UNFPA provides direct funding to the Ministry of Health to conduct trainings and supervision activities, purchase basic medical supplies and carry out other complementary activities in three districts where it focuses its support. A large portion of UNFPA's fourth country program in Madagascar (1999-2003) was earmarked for family planning trainings. In early 2000, however, the Ministry of Health ended all formal, multi-week family planning trainings and created a policy that all in-service training be done using self-learning techniques (Auto-Apprentisage Assisté or AAA). As a result, a significant amount of UNFPA funds programmed for family planning activities were not used from 2000-2001, during which time the AAA training modules were being developed. Total UNFPA expenditures on the non-commodity costs of the family planning program between 1999-2003 are estimated at approximately $607,000.

GTZ supports a more limited program of reproductive health and family planning activities in the province of Mahjanga. GTZ's family planning activities include trainings, supervision, distribution of commodities, and IEC. Total GTZ expenditures from 1999-2003 on the family planning program are estimated at $79,000.

Private Sector

Madagascar has an extensive NGO sector providing reproductive health and family planning services. All NGOs received free commodities from donors until 2001 when the eight largest NGOs[23] were asked to start purchasing contraceptives from the social marketing program. The other NGOs continue to receive free contraceptives through ASSONG, or sometimes the public sector district warehouses.

[23] The 8 largest NGOs are: AMIT, BNI/CL, FISA, JIRAMA, MSI-MSM, OSTIE, SAF-KJKM, and SALFA

In addition to commodities, many of the NGOs providing health services receive extensive support from USAID (through private sector grants under the JSI Project) and UNFPA for their family planning activities, including service provision, trainings, and IEC. In addition, FISA, the local IPPF affiliate, receives support from IPPF. Due to time constraints, the assessment team was not able to collect information on all possible sources of financing for every NGO.

Some for-profit providers offer family planning services, though there is little information on the size of the for-profit private sector. Under current Malagasy laws, private providers cannot sell hormonal contraceptives to clients. Since family planning services tend not to be as lucrative as other services, many small for-profit providers do not offer these family planning services.

There is a very small commercial sector. Most traditional commercial sector outlets sell primarily socially-marketed products.

Household Contribution

Total household expenditures on family planning commodities are a significant source of financing. Between 1999 and 2002, total household expenditure was roughly estimated to be over $2 million.[24] Table 12 shows estimated total household expenditures on contraceptives by sector and year. Table 13 details household expenditures, by product and sector, from 1999 to 2002.

In 1999, a cost recovery system (Participation financière des usagers or PFU) was established in the public sector for all essential drugs, including contraceptives, which were added to the essential drug list that same year. Prior to 1999, separate fees were charged for contraceptives. The cost recovery system was suspended by Presidential Decree in July 2002 and is scheduled to be reformed and re-implemented in the near future. The suspension of the program by the new president was intended to increase access to health services following the crisis. Therefore, from July 2002 until the time of the assessment, no user fees were charged for contraceptives in public facilities. This is taken into account in the estimation of fees collected in 2002 in Tables 12 and 13, as reflected in the drop in public sector household expenditures in 2002.

Table 12. Estimated household expenditures on contraceptives by sector, 1999-2002 (Current US$)[25]

	1999		2000		2001		2002	
Public sector	$179,938	36%	$222,645	40%	$150,275	30%	$136,049	25%
8 largest ASSONG NGOs	$127,878	26%	$25,601	5%	$98,572	20%	$47,361	9%
Other NGOs	$26,629	5%	$99,699	18%	$26,037	5%	$17,826	3%
Social Marketing	$161,595	33%	$209,291	38%	$221,946	45%	$337,254	63%
USD Total	$496,040		$557,234		$496,829		$538,490	
FMG Total ('000s)	2,664,919		2,074,545		2,300,478		1,826,413	

[24] Public sector household expenditure estimates are based on JSI data on actual public sector consumption in 1999 and estimates of consumption in 2000-2002. NGO estimates are based on ASSONG consumption data collected from its NGO members. PSI estimates are based on PSI sales figures.

[25] Does not include the cost of related family planning services.

Table 13. Household expenditures on contraceptives by product and source, 1999-2002 (Current US$)

Method	Public Sector	8 largest NGOs	Other NGOs	Soc. Marketing	Total
Lofemenal (pill)	$202,151	$132,807	$79,249	--	$414,207
Ovrette (pill)	$29,497	$10,581	$6,103	--	$46,182
Depo Provera (inject.)	$494,098	$145,667	$79,584	--	$719,349
IUD	$19,432	$2,967	$1,714	--	$24,112
Conceptrol	$0	$2,095	$813	--	$2,908
Condom	$7,085	$5,294	$2,728	--	$15,107
Norplant (implant)	$4,668	--	--	--	$4,668
Pilplan (pill)	--	--	--	$213,380	$213,380
Confiance (injectable)	--	--	--	$112,739	$112,739
Protector/Protector Plus (condom)	--	--	--	$603,966	$603,966

Under the former cost recovery system, there was no systematic way of tracking the use of funds - and the limited data available suggest that there was wide variation in how the funds were used. Therefore, it is difficult to know to what extent the fees collected for contraceptives were used to support the family planning program. In theory, the funds could have been used to motivate health workers providing family planning services, or to refill the facility's stock of contraceptives.

Under the new public sector distribution system, 25 percent of the user fee charged at the health facility level (for all essential medicines) will cover the costs of storage and distribution of essential drugs (including contraceptives) at SALAMA and at the district pharmaceutical warehouse (PHA.G.DIS) level. The remaining 75 percent will be held at the health facility level. At the time of the assessment, the policy detailing how the fees collected at the facility level will be used had not been developed.

There is limited data available on how funds collected through the sale of contraceptives are being used at NGOs. In the case of PSI, a large portion of their sales revenue is used to package socially-marketed commodities. Therefore, while household expenditures on contraceptives are substantial, more studies are needed on how the funds collected are used, and to what extent their use supports the family planning program.

Nevertheless, the high level of expenditures on contraceptives in the private sector (which represented 47 percent of contraceptive sources used by women in 1997[26]) seems to suggest that some consumers are willing to pay higher prices for contraceptives. Further investigation is needed to better understand the profile of these consumers and why they are obtaining commodities in the private sector. Table 14 shows the cost of a year's supply of contraceptives to households for each method offered in Madagascar. The cost of contraceptives per household ranges 0.5 to 1.6 percent of average annual income, as measured by gross domestic product (GDP) per capita.

[26] 1997 DHS

Table 14. Cost of an annual supply of contraceptives to households, by method and sector, 2003 (US$)

	Public	% of GDP pc	NGO	% of GDP pc	Soc. Marketing	% of GDP pc
Public/NGO Sector Products						
Pill	$1.23	0.5%	$2.46	1%		
Injectable (Depo Provera)	$0.84	0.3%	$1.13	0%		
IUD	$0.82	0.3%	$1.23	0%		
Condom	$1.23	0.5%	$2.46	1%		
Norplant	$2.81	1.1%	$4.22	2%		
Socially-marketed Products						
Pilplan (pill)					$2.46	1.0%
Confiance (injectable)					$1.15	0.4%
ProtectorPlus (condom)					$4.10	1.6%

Alternative financing mechanisms

There do not appear to be any significant alternative funding mechanisms for the family planning program. Private insurance coverage, including employer-based insurance, is very low. At present, most insurance does not reimburse the cost of family planning services. Community-based financing for health has been introduced on a very small scale in a handful of pilot sites. Information on the outcome of these pilots, or the feasibility and sustainability of community-based financing was not available at the time of the assessment. Further investigation could be done to assess the feasibility and potential of alternative financing mechanisms for family planning services, including community and employer-based insurance.

Comment [s6]: Private insurance coverage is so low that it was difficult to collect information on the potential of employer-based insurance.

8.1.3 Future funding for the family planning program

Funding for contraceptives

The current contribution of donors to the purchase of hormonal contraceptives and condoms is not sufficient to meet projected future demand for family planning. Under the medium variant scenario, in which CPR increases by 1.5 percent per year, the cost of contraceptives is estimated to double from $2.3 to $4.6 million over the next five years, as shown in figure 14.

Figure 11. Annual cost of contraceptives for medium variant scenario (+1.5% CPR/year), 2003-2010

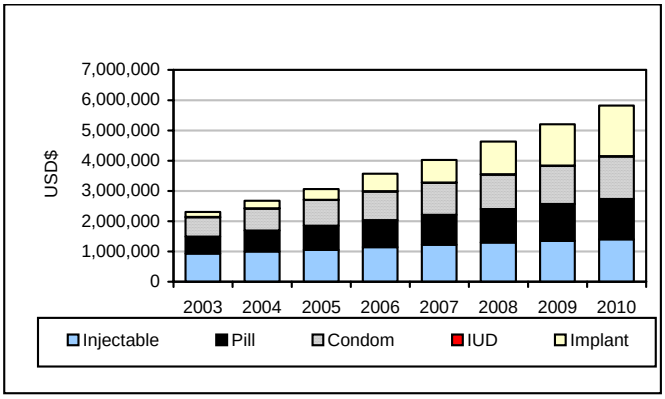
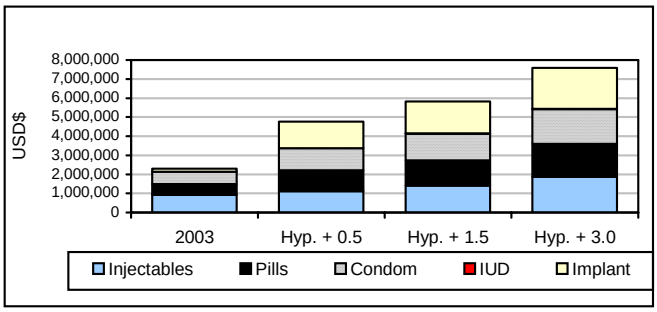


Figure 15, on the next page, presents the total cost of contraceptives in 2010 under each of the different scenarios. Even under the most modest scenario of a 0.5 percentage point increase in contraceptive prevalence, the cost of contraceptives will more than double between 2003 and 2010.

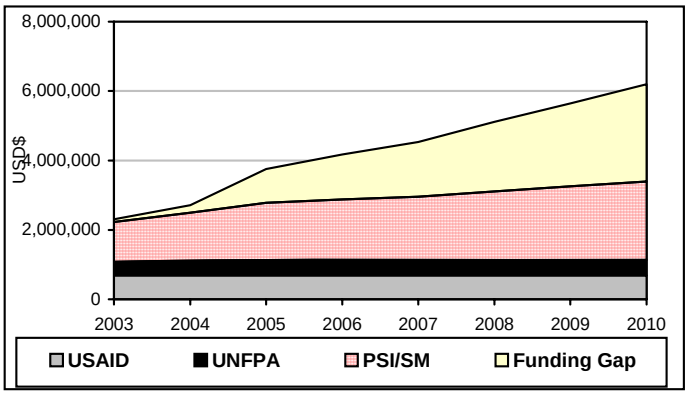
Figure 12. Cost of contraceptives in 2003 and by CPR increase scenario in 2010



Shortfalls in funding may jeopardize contraceptive security in Madagascar in the very near future. Figure 16 shows the growing gap between donor funding and total funding needed to meet moderate increases (1.5 percentage point annually) in demand. As shown in the graph and detailed in the Table 15, USAID and UNFPA's contribution to the supply of contraceptives to the public sector and smaller ASSONG NGOs are assumed to remain roughly equal to that of the past few years.

The estimated contribution of the social marketing program to the supply of contraceptives includes the current level of contraceptives and condoms being supplied by USAID to the social marketing program, as well as additional supplies to meet the PSI-forecasted demand for social marketed commodities. Therefore, it should be noted that the contribution of the social marketing program may be overestimated.

Figure 13. Cost of contraceptives by funding source according to intermediate scenario of 1.5% increase in CPR, 2003-2010



The projected funding gap is estimated to increase from approximately $79,000 in 2003 to almost $3 million in 2010, which represents 0.1 to 3.4 percent of the 2003 total health budget. As noted above, this is a rough estimate based on assumptions about changes in method mix and future prices of contraceptives. The gap was calculated by subtracting the total quantity needed to meet the demand for each method and subtracting the quantity of each method that is expected to be supplied by USAID (for the public and social marketing sectors) and UNFPA. To estimate the cost of filling the funding gap, the cost per method is estimated to be the average of the cost currently paid by UNFPA and USAID for that particular method. In the future, the projected funding gap will be affected by the country's ability to negotiate lower prices for commodities. Household expenditures are not accounted for in the financing gap since at the time of the assessment, it was not clear to what extent the fees paid by

consumers were used to pay for commodities. This was discussed in section 8.1.2 of this report under household expenditures.

Table 15. Estimated levels of funding by funding source, 2003-2010

Funding source	2003	2004	2005	2006	2007	2008	2009	2010
USAID	689,260	689,260	689,260	689,260	689,260	689,260	689,260	689,260
UNFPA	391,177	431,491	442,531	442,531	442,531	442,531	442,531	442,531
USAID/Social Marketing	1,143,600	1,372,320	1,646,784	1,745,606	1,824,537	1,974,554	2,123,985	2,257,168
Funding Gap	***78,793***	***218,851***	***972,451***	***1,298,393***	***1,573,381***	***2,008,211***	***2,387,330***	***2,801,143***
Gap as % of 2003 Health Budget	0.1%	0.4%	1.2%	1.7%	2.2%	3.0%	3.7%	4.4%

Given that USAID and UNFPA funding for contraceptives is not expected to increase, it is critical that a strategy be developed to cover the entire funding gap. The Ministry of Health is considering using World Bank funds under the CRESAN2 project to fill the funding gap, though no formal decision had been made at the time of the assessment.

Funding for family planning activities

With the exception of commodities, there is very limited disaggregated data on the cost of – or expenditures on – the family planning program. There is no mechanism in place at the central level to track donor expenditures and the assessment team was not aware of any costing studies that attempted to estimate the costs of program activities, including trainings, supervision, service delivery, IEC/BCC, and basic medical supplies and equipment. The data presented above on donor expenditures were provided by each of the donors individually.

8.1.4 A Benefit-Cost Analysis of Family Planning:

The Government of Madagascar is aware that a rapidly increasing population will jeopardize the socioeconomic development and environment of the country. Family planning has become a high priority for the Government but a significant amount of financial commitment is yet to be made. The Minister of Health has expressed the importance of identifying the financial benefits of investing in family planning, in addition to the social benefits. In order to help stakeholders understand how investments in family planning can impact other sectors, the team performed a financial benefit-cost analysis using an Excel-based model developed during the assessment.

Many public services provided by the government are closely related to population size. For example, if elementary school education is compulsory, as it is in Madagascar, then the number of students enrolled each year will depend on the number of children in the age group 6 to 12. As the size of this group of children changes, demand for classrooms, teachers, books and other supplies, changes. Successful family planning programs that lower the TFR will therefore lower the number of children who need to be educated, thus lowering the costs of education. Similarly, the costs of child survival interventions are affected by population size; a smaller population of infants will result in a lower demand for vaccinations to protect against childhood diseases, thus lowering costs for child survival interventions.

The assessment team performed an analysis to compare the financial costs of investing in family planning with the financial savings that would result in education and child survival interventions, as a result of providing the same services to a smaller group of people. The team found that every Malagasy Franc invested in family planning commodities alone will result in savings of 1.7 Malagasy Francs (FMG) on education and child-survival interventions by the year 2025. The team chose 2025 as the time span in order to reflect savings that would not necessarily be apparent in a short time span such as five years. The results are illustrated in the following figures and accompanying table.

The potential savings in public sector service expenditures, like education and immunization, that result from lower population growth, can be viewed as a direct benefit of successful family planning programs. If one also calculates the costs of the family planning programs these can be compared to the monetary value of the benefits. Resources "saved" in education and child-survival programs could theoretically be used to improve the quality of those services. However, despite the importance of evaluating the financial benefit-cost analysis, this analysis addresses only the financial implications of investing in family planning commodities and should not, on its own, be the basis of policy formulation. It merely suggests that investing in family planning would alleviate the burden of providing the same services, as well as other social services to an ever-increasing clientele and would give the government an opportunity to improve the quality of services using the savings generated from having to reach a smaller population.

Figure 17 shows that if CPR rises by 0.5 or 1.5 percentage points per year, as proposed in the scenarios presented in section 6, then the total cumulative costs of contraceptives will be 1,254,280 and 1,519,697 respectively by the year 2025. This makes sense since under the higher CPR scenario more users will require more contraceptives. The difference in costs between these scenarios is 265,415 Malagasy Francs. This is the additional amount of money that the Government, or donors, will have to spend in order to meet the growing demand for contraceptives.

Figure 14. Expenditures on FP commodities, according to the two hypotheses of CPR increase

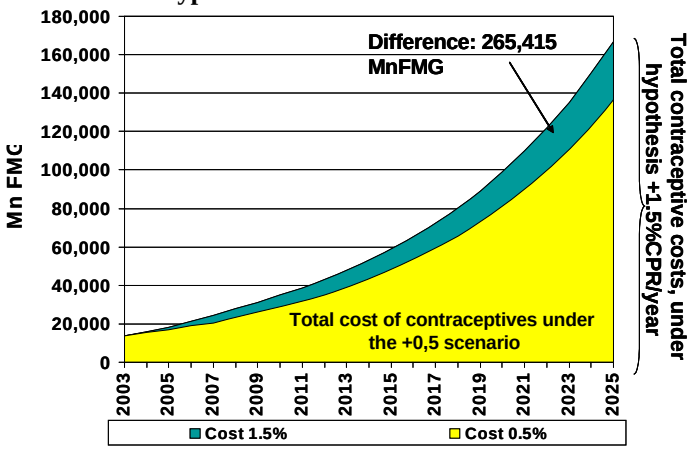
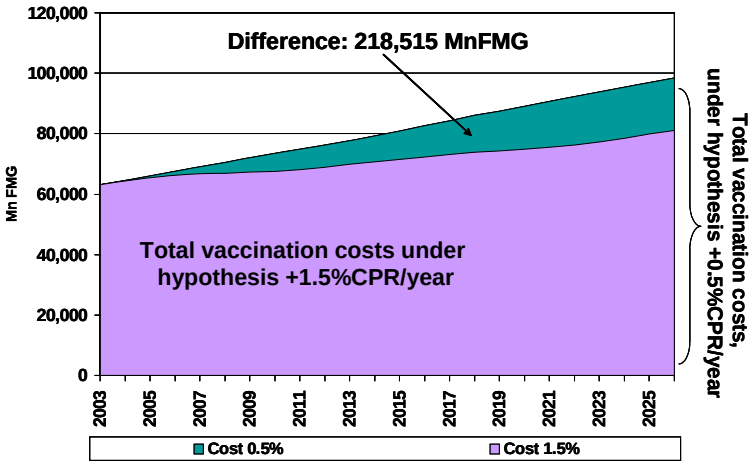


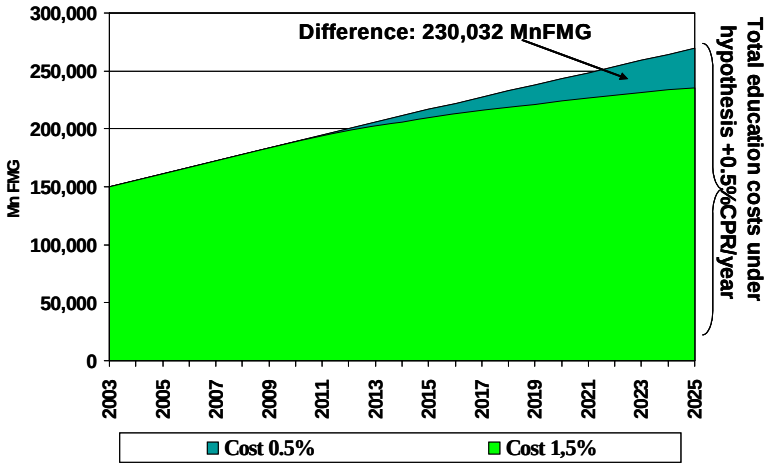
Figure 18 illustrates that investments in family planning will result in savings for child survival interventions.

Figure 15. Expenditures on vaccinations according to the two hypotheses of CPR increase



If CPR increases by 1.5 percent per year, a smaller population of 0 to 1 year olds in the year 2025 would result would need to be vaccinated before their first birthday, compared to the scenario where CPR continues to increase by 0.5 percent per year. Under this low scenario, the cumulative cost of these vaccinations would be higher than it would be under the medium variant scenario, which results in a smaller population. The cumulative difference in vaccination costs between these scenarios is 218, 515 Malagasy Francs by the year 2025, as shown in figure 18. Thus, increases in CPR result in decreased expenditures for vaccinations alone. This analysis could also be performed to identify savings in other health interventions, as a result of investments made in family planning.

Figure 16. Expenditures for primary education according to two different scenarios of increasing CPR.



Similarly, when comparing expenditures for primary education, the scenario under which CPR increases by 1.5 percent results in a smaller population of children of primary school age, when compared to the population of children born under the lower scenario. Comparing these two scenarios, the more aggressive increase in CPR will result in cumulative savings of 230, 032 Malagasy Francs by the year 2050.

Table 16 summarizes these calculations. It shows that increasing the CPR growth rate by 1 percent per year, (from 0.5 percent to 1.5 percent), will require 265,415 Malagasy Francs to be spent on reproductive heath commodities by the year 2025. This investment in family planning would result in savings of 448,637 Malagasy Francs for primary education and child survival interventions combined. The net savings to the Government will be 183,225 Malagasy Francs. Viewed another way, every Malagasy Franc the Government invests in family planning commodities will result in a savings of 0.87 Malagasy Francs for vaccinations and 0.82 Malagasy Francs for primary education, resulting in an overall return of 1.69 Malagasy Francs for both interventions. This makes a clear argument that family planning, a service that often competes for limited public resources, is a good investment financially, as well as socially.

Table 16. Cumulative Savings in Vaccination and Primary Education Costs as a Result of Investing in Family Planning, 2003 to 2025.

	Cumulative FP Commodity Costs (Mg FMG) (2003-2025)	Cumulative Savings (Mg FMG) (2003-2025)	Savings as a Result of Investing 1 Mg FMG in FP Commodities (2003-2025)
FP Commodities	265,415		
Vaccinations for infants<1year		230,032	0.87 Mg FMG
Primary Education		218,605	0.82 Mg FMG
Total	265,415	448,637	
Total Savings		**183,225**	

Other services that are affected by population size and distribution include other health interventions, secondary and tertiary education, food subsidies, social welfare, housing, utilities, and infrastructure. Some of the relationships between these programs and family planning are direct and immediate, while others become apparent only after long delays, such as housing programs. Further analyses could be performed to identify additional cost-benefit relationships that result from investing in family planning, in both the short and long-term. This preliminary analysis illustrates the broad impact investments in family planning can make and further analyses such as these would be useful advocacy tools for repositioning family planning in Madagascar. The Minister of Health has expressed interest in developing a better understanding of the cost-effectiveness of family planning and the role family planning has in overall development. In recent years, resources for family planning have become scarce and resources have been directed toward competing interventions and programs, HIV/AIDS being one example.

In order to garner more support from donors and the Government, stakeholders will need to better understand how family planning affects other development outcomes, especially health outcomes. For example, a global study showed that birth spacing and postponement of first childbearing can reduce infant and child mortality by as much as 25 percent. Prevention of unplanned pregnancy, postponement of first childbearing, and birth spacing can lower rates of maternal mortality by as much as 20 percent.[xix] Another noteworthy study looked at the impact of family planning on the prevention of mother to child transmission of HIV (PMTCT). The findings suggest that adding family planning to PMTCT programs can save the lives of thousands of women and children and significantly reduce the number of orphans.[xx] Although the PMTCT study did not include Madagascar, the findings can be applied globally. In Madagascar child mortality and maternal mortality rates are high, at 88 and 488 respectively; country specific information could help Malagasy counterparts project the impact of family planning on health outcomes and help build the case for increased funding for family planning.

8.2 Key Findings:

Strengths:

- The Government has shown a renewed interest in and commitment to the family planning program. This is demonstrated in the Ministry of Health Business Plan and the PRSP, which include increasing the contraceptive rate as a priority objective.
- The Government has also made an increased financial commitment to the family planning program in the Memorandum of Understanding for the new distribution system signed by the government, USAID, UNFPA, and SALAMA.
- Efforts are being made to improve the cost recovery system in the public sector to ensure that funds collected are used effectively and to improve overall management of the system.
- The Government is also considering the use of World Bank funds to purchase contraceptives in the future.
- Donor support for the family planning program is strong.
- Investing public dollars in family planning programs results in net savings in other social programs.

Weaknesses:

- The family planning program continues to be very dependent on donor financing, as well as on donor technical and managerial assistance;
- The current contribution of donors to the purchase of contraceptives is not sufficient to meet projected future demand for family planning, thereby jeopardizing contraceptive security in Madagascar;
- Very little analysis has been conducted to-date on the non-commodity costs of a fully- funded family planning program. Due to the division of the country into different donor areas of focus, the range and level of activities varies significantly by province, as well as by health district. Greater efforts should be made to ensure equity in the financing of family planning services;
- Very little information is available about consumer's willingness to pay for contraceptives.

8.3 Priority areas for action:

- Develop a national strategic plan to ensure the availability of funds to cover the projected gap between current donor funding and projected financing needs for contraceptives.
- Conduct studies to estimate the non-commodity costs of the family planning program in order to generate a comprehensive financing plan for all aspects of the family planning program, including training, supervision, and IEC/BCC activities;

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- Re-implement the PFU system, including a clear policy on how funds collected are to be used and a mechanism to track the use of funds. As stated previously, the PFU system should also include exemptions for those who are unable to pay for health services;

- Advocate for the inclusion of family planning and reproductive health services in private insurance plans;

- Assess the feasibility of alternative financing mechanisms, such as community-based financing or prepayment schemes, as a means of increasing financial access to family planning and reproductive health services;

- Conduct a willingness to pay study in order to examine the relationships between price and demand in order to maintain a balance between financial sustainability and coverage goals.

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Next Steps

The following activities will build upon the findings of the assessment and facilitate the development of a long-term strategy for achieving contraceptive security. Some of these activities have already been initiated in Madagascar.

- Establish and support the functioning of a national commodity security coordinating committee composed of the Ministry of Health; Ministry of Finance; SALAMA/Pha-G-Dis; Office of National Strategy for the Campaign Against HIV/AIDS (CNLS); National Institute of Public and Community Health; INSTAT; donor agencies, including USAID, World Bank, UNFPA, and others; selected USAID Cooperating Agencies; NGOs; faith-based organizations; the media; and commercial sector representatives;

- Disseminate results of rapid SPARHCS assessment to stakeholders and build consensus around priority issues to be addressed within the one-year framework;

- Draft a multisectoral strategy, policy and action plan for FP/RH commodity promotion and distribution, which is consistent with the FP/RH objectives of the Ministry of Health. Recommended elements of this plan, among others, include:
    - Periodically estimated FP/RH commodities needs projections
    - Procurement, stocking and distribution systems
    - Financing needs and sources of support
    - Operational policy barriers analysis
    - Market segmentation analysis to assist in determining need for user fees or their modification/elimination
    - Willingness to pay study
    - Monitoring and evaluation procedures for strengthening RH/FP commodities procurement and logistics competencies and skills.

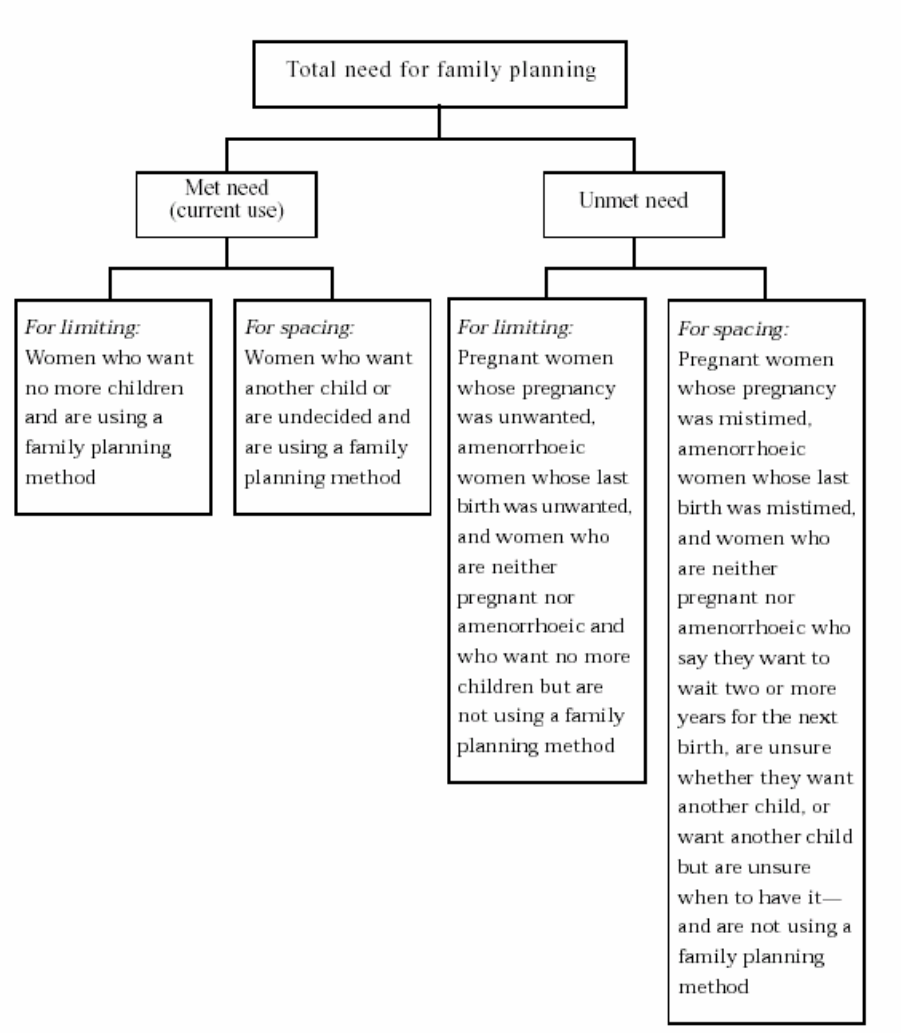
Appendix A

Action Plan for the development of the National Strategic Plan for Reproductive Health Commodity Security (RHCS) in Madagascar.

Activity	Organization	Date
Establish an RHCS working group	MOH and other partners	June 2003
Review SPARHCS assessment report	RHCS working group	May - July 2003
Diagnostic de la programmation des condoms	Groupe travail SPSR, CNLS, UNFPA, Projet Policy	Before the end of August 2003
Finalization of the SPARHCS assessment report	U.S-based consultants	July 30, 2003
Disseminate report	U.S.-based consultants/ RHCS working group	May-August 2003
Develop initial plans for developing strategic action plans at the provincial level	RHCS Working Group, POLICY Project Madagascar	September 30, 2003
Facilitate the development of the provincial strategic action plans	RHCS Working Group	October – December 2003
Begin conducting studies that will provide documentation and inform the strategic plan	RHCS Working Group POLICY Project, DELIVER	August 2003 – February 2004
Develop draft strategic plan for RHCS, integrating the provincial plans	RHCS Working Group	February 1, 2004
Present and discuss the draft strategic plan at a national workshop	MOH and other partners	February 28, 2004
Revise the strategic plan	RHCS Working Group	March 1, 2004
Present and validate the national strategic plan	MOH and other partners	March 30, 2004

Appendix B

Classification of the Need for Family Planning



source: Rhada Devi, D., Rastogi, S.R., Retherford, R.D. *Unmet Need for Family Planning in Uttar Pradesh*

Appendix C

SPSR Diagnostique

Composante 1: Démographie

Catégories	- 10 ans	- 5 ans	Année en cours	Projections + 5 ans	Projections + 10 ans
Population totale					
% population urbaine					
% population rurale					
Revenu par habitant					
Taux d'accroissement de la population					
Nombre de femme en age de procréer					
Femme en age de procréer					
% Eduquées					
% Non éduquées					
Taux de fécondité (TF)					
Prévalence du VIH					
Mortalité infantile					
Mortalité maternelle					
Autre indicateur de PF					
Autre indicateur de PF					

Composante 2: Offre de Services

A. Offre de services

Est ce que tous les clients qui veulent ou ont besoin de contraceptifs y ont accès ?

. Si non, où et quels sont les principaux problèmes rencontrés (secteur, niveau, zone géographique etc.)

. Avec quelle fréquence est-ce que les clients sont refusés ou doivent se diriger vers d'autres centres de prestations parce que les services de base (définis par les normes et les standards) ou les produits ne sont pas disponibles ?

Dans quelles mesures est-ce que l'accès et la disponibilité affectent l'utilisation des services de PF ?

Quel est le taux d'abandon ? Quels sont les motifs d'abandon de l'utilisation de contraceptifs (manque de satisfaction, difficultés d'accès ou manque de produits) ?

Dans quelle mesure est-ce que la satisfaction du client et un choix informé influence l'utilisation des services et des produits ?

B. Prestations de Service

Quelles methodes offre chaque source de prestations (publique, commercial, marketing social, ONG)?

Est-ce que le « Method Mix » dans le secteur publique fortement orienté vers la réapprovisionnement ?

Quelles sont les implications/effets de l'actuelle « association de méthode » *« méthode mix »* sur la sécurité contraceptive ?

Y a-t-il eu des ruptures de stocks de produits de PF pendant la dernière année ? Si oui, quels produits, dans quel secteur et à quel niveau ?
Les prestataires de service pensent ils avoir les contraceptifs nécessaires pour effectuer leur travail ?

Y a-t-il eu des quantités significatives de produits contraceptifs expirés au cours de la dernière année (dans tous les secteurs, à tous les niveaux) ?

C. Sources des Contraceptifs

Sources des contraceptifs	**- 10 ans**	**- 5 ans**	**Année en cours**	**Projections + 5 ans**	**Projections + 10 ans**
% DONNES					
% ACHETES					
-- à travers les fonds du gvt.					
-- à travers des emprunts					
VENTES					
--publiques					
--ONG					
-- marketing social					
-- secteur commercial					
--autres					

D. Distribution

Les capacités actuelles ont elle une incidence sur le système de distribution public :

- Combien de niveau y a t'il dans la reseau de distribution?
- Quelle est la longueur du *reseau de distribution*? Comment peut elle être réduite ?
- Les conditions de stockage de tout le systèmes sont elles adaptées à la gestion du volume de produits ?
- Les moyens de transports sont ils adaptés à tous les niveaux ?
- Le plan de distribution est il approprié ?
- Les données sur l'état des stock et la consommation sont elles collectées et utilisées pour passer les commandes et acheminer les produits à tous les niveaux ?
- Existe t'il des instructions / un système mis en place pour la gestion des produits expirés ou défectueux ?

Quelles sont les capacités futures du système public de distribution?

- Les infrastructures nécessaires pour la distribution des produits de la SR s'améliorent elles ou se détériorent-elles ?
- Les demandes dans le secteur publique tendent-elles à augmenter ? Le système peut il absorber une augmentation de ces demandes ?
- La faiblesse des infrastructures (infrastructures routières en mauvais état, insuffisance de grossistes) limite-t-elle la disponibilité des produits de la SR dans le secteur privé ?

E. Produits et services de PF

Pour le secteur commercial, quelle est la place des produits de PF selon l'analyse des paramètres suivants :

- Quel est le pourcentage de revenus dérivés des produits de PF ?
- Quel est l'investissement dans les produits de PF (marketing, innovation, augmentation des capacités) ?
- Quelles sont les perspective d'expansion des capacités de production ou de distribution des fournisseurs locaux ?

Pour les ONG et organisations de marketing social, quels sont les projets d'expansion des services de PF et d'intégration des produits dans leurs programmes ?

Quel est le marché projeté existant ou prévu pour chaque fournisseur de service de PF ?

Le secteur commercial a-t-il la volonté et le potentiel pour envisager une expansion ? Quelle sont les obstacles à cette expansion (coûts de transports, coût de travail et/ou promotion/publicité aux consommateurs) ?

F. Achat des produits

Qui est responsable de l'achat des contraceptifs ?

- Quelle sorte de formation aux achats ont-ils reçu?
- Existe-t-il des mécanismes de coordination entre le personnel de la logistique et celui des achats ?

Quelles données sont utilisées pour preciser la quantité à acheter ?

Quelles sont les procédures d'achat (appel d'offre, évaluation des offres, suivi des performances des fournisseurs)?

Les procédures d'achat sont-ils transparents?

Les produits fournis répondent ils aux besoins estimés ? Permettent ils d'éviter les ruptures de stock ?

Quelles sont les procédures en place qui garantissent la qualité des produits ?

G. Compétences des prestataires

Quel est le niveau de compétences des prestataires par secteur *source* ?

- La formation des prestataires à tous les niveaux inclus t'elle les volets : choix raisonné d'une méthode contraceptive, logistique/réapprovisionnement ainsi que l'acquisition de compétences techniques (Pose de DIU, etc..) ?
- Les services sont ils approvisionnés avec les contraceptifs adaptés au niveau de compétences du personnel de santé afin de dispenser des méthodes respectant des standards de soins ?
- Y a-t-il des préférences pour la promotion de certaines méthodes chez les prestataires ? Si oui, quelles sont les implications dans la mise à disposition de la gamme complète de contraceptifs ?

Les superviseurs vérifient ils la qualité du travail des prestataires et font ils de la formation continue pour améliorer leurs compétences en matière de stockage, préparation des commandes, relevé de données, etc.… ?

Le personnel est il formé à faire les taches logistiques appropriés pour leurs niveaux dans le système?

Composante 3: Contexte et Politique

A. Politique

Existe-t-il une politique officielle en matière de population ou PF ?

- En quoi contribue elle au renforcement de la sécurité des produits de la santé reproductive (SPSR) ?
- Comment sont elles soutenues par des programmes adaptés et fiancées ?
- Comment les directives et les programmes ont-ils été mis en oeuvre ?
- Quelles en ont été /sont les implications pour la sécurité contraceptive ?

La politique de lutte contre le VIH/SIDA est elle directement liée à la politique de population/ PF ?

- La politique du VIH/SIDA mentionne t'elle explicitement la nécessité de garantir un approvisionnement adapté en préservatif et autres produits ?

Quelle politique/directives influencent la qualité des produits ?

- Un contrôle qualité des produits existe-t-il ?
- Est il obligatoire ?

Les contraceptifs sont ils sur la liste des médicament essentiels ? Lesquels ?

Existe-t-il des directives et des restrictions pouvant limiter le choix et l'accès aux contraceptifs ?

Quelles politiques /réglementation affectent le secteur privé ?

- Y a-t-il un contrôle des prix ?
- Y a-t-il des limitations dans la distribution ?

- Y a-t-il des taxes et contributions/impôts qui affectent le secteur privé (taxes d'importation, TVA, exonérations) ?
- Existe-t-il d'autres contraintes opérationnelles ou réglementations qui affectent positivement ou négativement le secteur privé ?
- Existe-t-il une interdiction ou restriction sur la publicité des marques ?

Quelles réglementations ou directives opérationnelles affectent le fonctionnement des services de PF ?

- Existe-t-il des restrictions sur les demandes de licences ou des réglementations pour la dispensation ?
- Existe-t-il des restrictions ou contraintes concernant la qualification des personnes habilitées à dispenser les prestations de PF ?
- Existe-t-il des directives et réglementations concernant le système d'information pour la gestion ? (SIG)

Les directives donnent elles la capacité aux prestataires de services de PF de fournir des contraceptifs ?

- Est-ce que les manuels de procédures des prestataires, les protocoles, les normes, les procédures et normes d'assurance qualité définies incluent des principes logistiques simples en ce qui concerne les commandes, le suivi, le stockage, la manutention etc… des contraceptifs ?
- Quelles sont les formations requises pour les prestataires (avant et pendant leur activité) spécifiques à chaque méthode ?

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Les directives et réglementations assurent elles une répartition équitable et transparente des fonds ?

- Existe-t-il des réglementations concernant le budget (procédures pour définir le financement annuel, niveau et répartition, flexibilité, gestion financière) ?
- Existe-t-il des directives qui restreignent ou régulent les prix des services et contraceptifs (niveau, exonérations) ?
- Existe-t-il des directives pour la gestion financière (procédures de récolte des fonds générés par la participation des usagers, gestion des fonds, facilités de payement, achats locaux) ?

B. Secteur santé

Dans le secteur publique, les services de santé reproductive (SR) sont ils inclus dans le PRSP (Strategie sur la réduction de la pauvreté)?

Quel est l'impact de la réforme du secteur santé sur la SPSR (décentralisation, intégration, financement, implication du secteur privé) ?

- Les décisions concernant la sélection, les prévisions, le financement, les achats sont elles prises au niveau central ou local ?
- Quel est le rôle du secteur privé dans les prestations de services de santé dans l'approvisionnement en contraceptif ?

Quelle est la part de marché pour chaque secteur en matière de PF ? Quelle est la répartition entre le secteur public et privé pour l'offre de services de PF ?

En quoi la stimulation de la demande affecterait cette répartition ?

C. Coordination

Quels sont les différents partenaires devant coordonner leurs activités (donateurs, gouvernement, prestataires de services, ONG, agences de coopération, secteur commercial, autres secteurs) ?

Quels sont les mécanismes formels et informels de coordination fonctionnant entre les partenaires ?

- Parmi les donateurs
- Au sein du gouvernement
- Entre les donateurs et le gouvernement
- Parmi les prestataires de services des différents secteurs
- Entre le gouvernement et les prestataires de service
- Entre le gouvernement et les organisations de la société civile
- Entre les agences de coopération

Quelles sont les conséquences de la coordination ?

- Existe-t-il une volonté de coordination entre les ministères du gouvernement et les organisations partenaires ?
- Quels sont les canaux d'information (horizontaux versus verticaux, à double sens versus sens unique) ?
- Quelles sont les activités de coordination existantes, telles que la collaboration dans le financement ou la dispensation de produits et services ?

Les partenaires sont ils impliqués dans l'élaboration des politiques ? Lesquels ? Dans quelle mesure ?

Existe-t-il une stratégie commune de SPSR ?

- Si oui, est elle incluse dans une stratégie plus large ou est ce une stratégie à part entière ?
- Qui a été impliqué dans sont élaboration ?
- Si non, les partenaires ont-ils la capacité de développer une stratégie de SPSR ?
- Ont-ils les capacités d'effectuer le suivi des progrès en SPSR? De procéder à des réajustements?

D. Engagement

Quel est l'engagement politique en matière de sécurité contraceptive?

- Qui sont les chefs de file *décideurs*, – formels et informels ? A quel niveau - présidentiel, *directeur de cabinet*, Ministère de la santé, Ministère des finances, local ?
- Comment les décideurs suscitent, supportent ou freinent les efforts pour parvenir à la SPSR ?
- Les décideurs sont ils engagés ou opposés à l'utilisation des fonds du gouvernement pour soutenir la SPSR ? Y a-t-il une ligne budgétaire pour les contraceptifs ? Les fonds gouvernementaux pour les contraceptifs et services annexes subissent ils des baisses et hausses permanentes ?
- Existe-t-il des *champions* de la SPSR au sein de la structure des décideurs ?
- Existe-t-il des organisations de la société civile mobilisées autour de la santé reproductive et de la sécurité contraceptive ?

Existe une volonté/capacité de favoriser/encourager la coordination parmi les partenaires ?

- Le Ministère de la santé communique t' il et coordonne t'il ses actions avec les partenaires « clef » y compris les donateurs, Agence d'exécution agences de coordination, les ONG, le secteur privé, les autres ministères et le publique en général ?
- La stratégie de SPSR est elle généralement connue et soutenue par le Ministère de la santé et organisations « clef » ? Dans la communauté plus large des partenaires?

En ce qui concerne les produits de PF, comment les décisions sont elles prises et qui est impliqué?

De quelles données contraceptives/produits, financières les décideurs "clefs" disposent ils ? Comment les utilisent ils ?

En ce qui concerne les produits VIH/SIDA, comment les décisions sont elles prises et qui est impliqué ?

Composante 4: Demande

A. Utilisateurs de contraceptifs

Catégories	- 10 ans	- 5 ans	Année en cours	Projections + 5 ans	Projections + 10 ans
TPC toutes méthodes					
TPC méthodes modernes					
Pilule					
DIU					
Injectables					
Méthodes vaginales					
Préservatif					
Sterilisation. Feminine					
ZONE GEOGRAPHIQUE					
RESIDENCE					
Urbain					
Rural					

Quelle est la répartitions actuelle des utilisateurs de contraceptifs ?

- Par niveau de vie ou revenus
- Par lieu de résidence rural/urbain (se référer au tableau)
- Par niveau d'éducation
- Par répartition géographique (se référer au tableau)
- Par méthode (se référer au tableau)
- Par source

Quelle participation des utilisateurs pour les contraceptifs ? En fonction du niveau de vie, urbain/rural, méthode, source.

- Quel est le tarif appliqué dans le secteur public par visite ?
- Quel est le tarif appliqué dans le secteur privé par visite ?
- Quelle est la capacité/volonté à payer dans le secteur public ?
- Quel est la capacité/volonté à payer dans le secteur privé ?

Quel est le profil actuel des clients du secteur publique et privé ?

- Quel est leur age ?
- Réparition par sexe ?
- Quels sont leurs revenus, niveau de vie ?
- Ont-ils accès au secteur privé (ratio urbain/rural) ?
- Quelles sont leurs intentions en SR (espacement, limitation des naissances) ?
- Quelles méthodes préfèrent ils ?
- Quel est leur niveau d'éducation ?

B. Non utilisateurs de contraceptifs

Catégories	**- 10 ans**	**- 5 ans**	**Année en cours**	**Projections + 5 ans**	**Projections + 10 ans**
Besoins non satisfaits					
--pour l'espacement					
--pour la limitation					
% de naissances mal planifiées					
% naissances non désirées					
AGE					
<15					
15-19					
20-49					
RESIDENCE					
Urbain					

Catégories	- 10 ans	- 5 ans	Année en cours	Projections + 5 ans	Projections + 10 ans
Rural					
ZONE GEOGRAPHIC					
EDUCATION					
Non éduqués					
Niveau primaire non achevé					
Niveau primaire completé					
Secondaire et plus					

Quelle est la répartition des non utilisateurs ?

- Par Niveau de vie ou revenus
- Par lieu de résidence rural/urbain (se référer au tableau)
- Par répartition géographique (se référer au tableau)
- Par age (se référer au tableau)
- Par niveau d'éducation (se référer au tableau).

Quelles sont les intentions pour les besoins non satisfaits ?

Quel est le pourcentage de non utilisateurs qui souhaitent espacer ou limiter les naissances ?

Quel est le pourcentage de ceux qui ont l'intention d'utiliser des contraceptifs ?

Quel est le pourcentage d'utilisateurs de méthodes traditionnelles ?

C. Extension du marché

Comment les activités en cours pour augmenter l'utilisation des services ont une incidence sur la sécurité contraceptive ?

- Quelles sont les activités « clef » prévues par intervenant ?
- Quel est l'impact attendu de leurs activités ?
- Quels sont les résultats obtenus jusqu'à présent ?

Comment les activités planifiées/futures pour augmenter l'utilisation des services pourraient avoir /auront une incidence sur la sécurité contraceptive ?

- Quelles sont les activités prévues pour chaque intervenant ?
- Quel est l'impact attendu des activités qu'ils ont proposé et est ce réaliste ?

D. Prévisions

Les besoins en contraceptifs sont ils prévus 2 à 5 ans à l'avance ?

Quelles données sont utilisées pour prévoir les besoins (données logistiques, consommations, sorties de stock, pertes/ajustements, données de vente, données démographiques, statistiques des services)?

- Ces données sont elles fiables?
- Quelle est la fréquence de mise à jours des prévisions?

Qui est responsable des prévisions et quelles compétences ont ils et quelle formation ont-ils reçu?

- Ont-ils besoin de l'assistance des donateurs pour effectuer leurs prévisions?

Les données prévisionnelles sont elles utilisées pour la mobilisation des ressources?

Composante 5: Financement

Sources de financement pour les contraceptifs

Sources de financement pour les contraceptifs	**- 10 ans**	**- 5 ans**	**Année en cours**	**Projections + 5 ans**	**Projections + 10 ans**
MINSAN (à l'exclusion des financements à travers les bailleurs tels que la Banque Mondiale)					
MINSAN (financements à travers les bailleurs tels que la Banque Mondiale à l'exclusion des donateurs)					
UNFPA					

Sources de financement pour les contraceptifs	- 10 ans	- 5 ans	Année en cours	Projections + 5 ans	Projections + 10 ans
DFID					
USAID					
KFW					
Autre donateur: _____					
Autre donateur: _____					
Secteur commercial à but lucratif					
ONG (financements indépendant des donateurs)					
Autres financements internationaux Sources:_____					
TOTALS:					

B. Financement par le gouvernement

Quel est le montant actuel de financement disponible pour les contraceptifs ?

- Quelles sont les dépenses annuelles pour les contraceptifs ?
- Quelle est la place de la SR/PF/contraceptifs dans la santé (dans les comptes nationaux et les dépenses de santé) ?
- Le pourcentage destiné à la SR dans le budget national global de santé.
- Le pourcentage destiné à la PF dans le budget national de SR
- Le pourcentage destiné aux contraceptifs dans le budget national de PF

Quelles sont les sources de financement pour les contraceptifs et quel pourcentage des dépenses totales de SR et contraceptifs chacune représente t'elle ?

- Quel est le montant des dépenses du gouvernement central ? du gouvernement local, de la sécurité sociale ?
- Comment les fonds sont ils utilisés ?
- Les ressources du gouvernement sont elles destinées aux plus pauvres d'entre les pauvres ?

C. Financement par les ménages

Quel est en pourcentage le montant de dépenses en contraceptifs à débourser par rapport au revenu par habitant ?

- Par niveau de vie ou revenu ?
- Par origine rurale et urbaine ?
- Par méthode ?
- Par source?
- Par zone géographique?

Quel est le pourcentage de dépenses en services de SR à débourser par rapport au revenu par capita ?

- Par niveau de vie ou revenu ?
- Par origine rurale et urbaine ?
- Par méthode ?
- Par source?
- Par zone géographique?

C. Mécanismes alternatifs de financement

Quels sont les tierces parties /systèmes d'assurance santé y compris les systèmes de sécurité sociale et d'assurances privées?

- Quelles sont les principales tierces parties impliquées dans le financement *(des contraceptifs)* ? Qui couvrent elles? Combien dépensent elles? Quelles méthodes fournissent elles?
- Quelle la couverture des services de PF et des produits offrent t'elles ?

Quels sont les mécanismes alternatifs de financement disponibles pour mobiliser des ressources ?

- Y a-t-il un système de recouvrement des coûts en place –dans le secteur publique, marketing social, secteur commercial - ? Comment fonctionnement ces systèmes et comment les fonds sont utilisés ?

D. Financements actuels et futurs

Le mode de financement actuel est il adapté?

- Quel est le déficit actuel dans le financement ?
- Quel est le degré actuel de dépendance des organisations de marketing social, des ONG et autre, des subventions du gouvernement et des donateurs ?

Quels sont les changements significatifs attendus dans le mécanisme de financement – source et type ?

Quelles sont les sources de financement attendues et quel montant est prévu pour chacun d'elle ?

Quelles sont les dépenses prévues ? En contraceptifs, pour les activités, en renforcement de capacités ?

Quel est le déficit attendu ?

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