The Strategic Pathway to Reproductive Health Commodity Security (SPARHCS), developed by the DELIVER, POLICY, and Commercial Market Strategies (CMS) projects (in collaboration with the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), and other donors and technical agencies), serves as an assessment, planning, and implementation tool to help countries address contraceptive security (CS) issues and to determine areas for strengthening and intervention. SPARHCS examines six key areas that factor into a country's CS situation: client utilization and demand, context, commitment, capital, capacity, and coordination. Moreover, it is a universal assessment tool that can be tailored to specific timelines, country contexts, or program objectives.

The following brief outlines the experience of using the SPARHCS tool in assessing contraceptive security in Madagascar. Use of SPARHCS enabled Madagascar to view contraceptive security through a comprehensive framework and gain a longer term vision of how to reposition family planning.

Documentation of the Use of SPARHCS: Madagascar

Introduction

Contraceptive security (CS) is achieved when individuals have the ability to choose, obtain, and use contraceptives and condoms whenever they need them. The Strategic Pathway to Achieving Reproductive Health Commodity Security (SPARHCS) framework provides countries with a tool to assess contraceptive security and to design plans for advancing it in both the short and long term.

From May–June 2003, with input from Malagasy key stakeholders, a team from POLICY, DELIVER, the United Nations Population Fund (UNFPA), and Partners for Health Reform plus (PHR*plus*) conducted a SPARHCS assessment in Madagascar. It was one of the first assessments conducted, and it served a dual purpose—to help stakeholders identify priority areas in order to initiate the strategic planning process and to pilot test SPARHCS as a framework and diagnostic guide. The assessment process launched a one-year effort to improve contraceptive security and build capacity for addressing broader health issues.

This brief describes the Madagascar CS context and SPARHCS assessment and also the findings, recommendations, lessons learned, activities, and progress made since the SPARHCS application.

CS Context in Madagascar

The SPARHCS team reviewed the demographic indicators, the history of donor financing of contraceptives, the family planning (FP) market, and the economic and political environment in Madagascar to understand the context related to achieving contraceptive security (Moreland et al., 2003b).

Demographic indicators.[1] During the last decade, the contraceptive prevalence rate (CPR) among married women of reproductive age (MWRA), ages 15–49, steadily increased from 17 percent in 1992 to 22 percent in 2003 (EDSMD, 1992; EDSMD, 2003/4). During that same period, the CPR for modern methods among MWRA increased from 5 percent to 14 percent. Despite these increases, modern contraceptive use is particularly low everywhere, and especially in rural areas, among lower socioeconomic groups, and among those with low education levels. Accordingly, the total fertility rate (TFR) is high at 5.2 lifetime births per woman (PRB, 2005).

History of donor financing of contraceptives. Since 1986, Madagascar has received donated contraceptive commodities mainly from USAID and UNFPA. Since 2001, USAID and UNFPA have been the only donors of contraceptive commodities in Madagascar. Until 2001, the International Planned Parenthood Federation (IPPF) provided small amounts of contraceptive commodities. Given the degree of donor involvement, Madagascar's method mix is, in part, determined by what donors are willing and able to provide, and donors conduct the contraceptive procurement, each using its own procurement system.

Currently, a portion of donated commodities is distributed to the commercial sector through the social marketing program, while the rest is distributed to public and select nongovernmental (NGO) FP sites. All NGOs received free commodities from donors until 2001, when the eight largest NGOs were asked to start purchasing contraceptives from the social marketing program.

[1] Madagascar's population is 17.3 million. Approximately 13 million (74 percent) people reside in rural areas. More than 4 million (24 percent) people are women ages 15–49. If Madagascar's 2.7 percent annual growth rate remains constant, the population will more than double by 2050, thus challenging economic and social development in the country (PRB, 2005).

FP providers and methods. Madagascar's predominant provider of contraceptive methods is the public sector, where 58 percent of MWRA FP users obtained their methods in 2003 (see Figure 1). The commercial sector—including private providers, pharmacies, and markets—serves 33 percent of FP users (mainly through social marketing). Finally, the NGO sector serves the remaining 9 percent of FP users (EDSMD, 2003/4; Steffen and Winfrey, 2004).

Among MWRA using family planning, 65 percent use a modern method (see Figure 2). The most commonly used modern methods are injectables (35%), oral contraceptives (13%), condoms (5%), lactational amenorrhea (LAM) (5%), sterilization (3%), IUDs (2%), and other methods (2%). The remaining 35 percent of FP clients use traditional methods. As previously noted, given the degree of donor dependence for contraceptive commodities, Madagascar's method mix is partially determined by donors (EDSMD 2003/4; Steffen and Winfrey, 2004).

Figure 1: Source Mix Among Current Users of Modern Methods in Madagascar (2003)

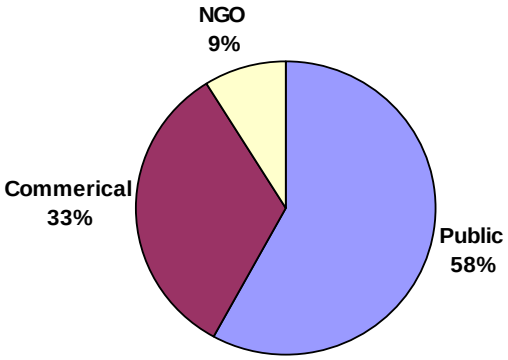
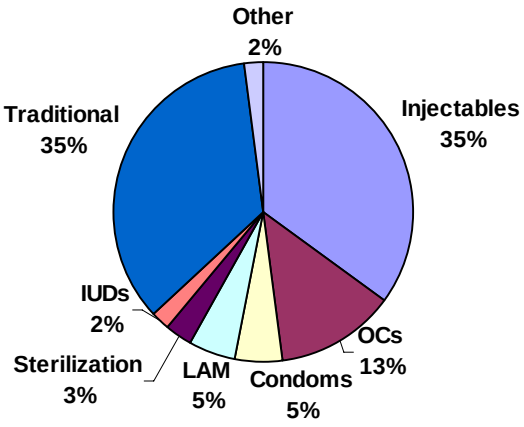


Figure 2: Method Mix Among Users of Family Planning in Madagascar (2003)



Economic and political environment. More than 70 percent of the population lives below the national poverty line, with nearly 30 percent living in extreme poverty (UNDP, 2003). Economic reforms are contributing to growth in gross domestic product (GDP). Still, Madagascar remains economically vulnerable. In 2002, the country experienced an economic crisis spurred on by social and political unrest following the disputed 2001 presidential election. In 2000, Madagascar qualified for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative, and since 2002 resources freed up from HIPC are directed toward improving access to health and education, improving infrastructure, and providing direct support to communities. Madagascar has a Poverty Reduction Strategy Paper (PRSP), and while it does not include funding for FP programs, it includes a goal to increase contraceptive use and an acknowledgement that women do not have sufficient freedom to choose their contraceptive methods (Borda et al., 2004).

Madagascar has provided reproductive healthcare and FP services to the population for over three decades via public, commercial, and NGO clinics, work-based programs, mobile clinics, and community-based distribution. Though national policy has supported the provision of family planning since 1990, political commitment has been sporadic. FP programming in the country has historically been donor-driven, but this is beginning to change and is being accompanied by strong political commitment. In 2003, the government of Madagascar (GOM) publicly affirmed its commitment to family planning. The MOH has since taken on a leadership role in managing the government's FP program and coordinating activities of the FP sector (including public, NGOs, donors, social marketing, and commercial entities). Therefore, the opportunity to make progress toward contraceptive security exists, despite the continued existence of a

colonial era anti-contraception law and the GOM's slowness in translating its reinvigorated commitment into financial investments or statements of intent.

The SPARHCS Assessment in Madagascar

The SPARHCS assessment, conducted from May 24–June 12, 2003, articulated the country's national objectives, including identifying critical strengths, weaknesses, and recommended interventions in contraceptive security; analyzing historical trends and future projections in contraceptive use; identifying actions to take to strengthen contraceptive security based on consensus-based priorities; assisting the GOM and its national and international partners to create a short-term action plan for improving contraceptive security; and presenting findings to key stakeholders to help initiate a long-term CS strategic plan.

Key players. A team of 14 Malagasy stakeholders, including individuals from participating ministries, donor agencies, and other public and private sector groups conducted the SPARHCS assessment in close collaboration with seven international consultants from POLICY, DELIVER, UNFPA, and PHR*plus*. Although being mainly country-driven, the assessment benefited from the technical assistance of international consultants, who guided working groups in data collection and helped with strategy development.

Information gathering. The assessment began with a national workshop attended by a multisectoral group of stakeholders involved in FP/RH and conducted by the Ministry of Health and POLICY/Madagascar. The workshop's objectives included renewing interest in contraceptive security, discussing Madagascar's current CS situation, and presenting the assessment's approach and aims. Workshop participants, including the international consultants, formed small working groups to gather information for the assessment. To build on previous work conducted in Madagascar by POLICY and JSI with the Ministry of Health, the working groups reflected the five major components constituting the country's existing CS framework: demography, policy, demand, service delivery, and finance. As a result, the SPARHCS diagnostic guide was reorganized around these five components.

During the following two weeks, the working groups performed a basic diagnosis of their respective components using several methodologies. Activities included data collection and analysis, document review and analysis, key informant interviews, focus group discussions, field visits, and meetings with high-level stakeholders. Each working group then created a presentation that summarized its findings.

Findings and dissemination of results. The working groups presented their findings at a second national workshop and identified priority areas for action and, when possible, recommendations for use in developing a CS strategic plan. The findings and workshop discussions allowed the stakeholders to help the GOM and its national and international partners produce a draft one-year CS action plan. The Ministry of Health accepted the draft plan at the conclusion of the workshop.

The team of international consultants prepared a full SPARHCS assessment report and a summary report and distributed them to key stakeholders, who planned to use the findings to develop the National Family Planning Strategy, within which contraceptive security would be a component. Both reports are available through POLICY upon request.

Evaluation of SPARHCS. Since the Madagascar SPARHCS application was a pilot test, it was important to evaluate the SPARHCS tool and process and make recommendations for improvements. Both the international consultants and key stakeholders participated in the evaluation. The consultants prepared a

"SPARHCS Field Test Evaluation Report" in English, which is also available through POLICY upon request.

The evaluation results indicated that in order to improve the overall process, it is important to ensure the appropriate selection of local counterparts and/or consultants; select and contact them in advance; allow sufficient time for preparatory work in-country; clarify the objectives and expectations of the assessment with participants in advance; and distribute the printed SPARHCS diagnostic guide before the initial workshop to improve participants' understanding of the assessment's purpose and their role in the process. The international consultants also suggested that involving a small group of highly experienced, local consultants for key technical areas, such as finance, would reduce the need for international consultants (Moreland et al., 2003a).

Regarding successes, the report noted that the stakeholders worked productively as a large team and in small groups; the SPARHCS process engaged stakeholders in FP/RH; the SPARHCS tool was effectively adapted to accommodate the existing CS framework in Madagascar; the assessment was conducted in partnership with local counterparts who took ownership of the process; and the SPARHCS process received significant support from the POLICY/Madagascar local office and USAID mission.

Overview of SPARHCS Findings

The SPARHCS working groups determined strengths and weaknesses in the following areas: policy, demand, service delivery, and finance (Moreland et al., 2003b). The working groups also identified priority areas for action, defined as the most important contraceptive security issues to address in the development of the National Family Planning Strategy.

Policy. The overall policy environment for family planning and reproductive health is favorable in Madagascar, evident by the existing national policies, strategies, and ratified treaties regarding family planning and reproductive health and by the multisectoral stakeholder interest in improving contraceptive security. The current GOM has made the provision of family planning a high priority in the context of economic and social development.

However, despite the favorable policy environment, it is important for government commitment to family planning to be accompanied by financial investment. In addition, interest in and commitment to family planning at lower levels of government are more limited, and few advocacy or watch dog groups exist to raise awareness about family planning among civil society and local government officials and to monitor the implementation of FP/RH policies. Furthermore, existing operational policies or the lack thereof hinder the effectiveness of FP/RH programs. For example, some policies inhibit product promotion and information dissemination, and there is an absence of policies or mechanisms to ensure equity between districts in the quality of service delivery, the training of staff, and the availability of commodities.

Demand. Only 14 percent of MWRA use a modern method, and the percentage is considerably lower among MWRA who are very poor or living in rural areas. Low level of demand for contraceptives is attributed to a lack of desire for contraception, a lack of accurate information about contraceptive methods and side effects, and limited access to services and products, particularly in rural areas.

However, there is some indication that the demand for contraceptive methods is growing. Since 84 percent of women ages 15–49 approve of diffusing information about FP methods via public channels, there is an opportunity to increase information, education, and communication (IEC) activities. Furthermore, evidence suggests that the price of contraceptives is not a major barrier to use and access (EDSMD, 2003/4). Accordingly, to expand the market for contraceptives, activities such as training and

IEC, behavior change communication (BCC), and mass media campaigns are being developed and implemented in both the public and NGO sectors, supported by donor funds.

Service delivery. The capacity of the country's decentralized health system to meet the population's healthcare needs, including family planning, is weak mainly because of limited access to facilities and low-quality service delivery. With 13 million people living in rural areas, ensuring access to health services is a challenge. However, both public and private sector efforts are expanding and strengthening FP services nationwide by tripling the number of FP service delivery sites between 1998 and 2004, using community-based distribution workers in rural areas, implementing adolescent-focused programs, and carrying out quality improvement initiatives.

The GOM is expanding the range of FP methods available in all public sector facilities. Health sector reforms attempting to make the healthcare system more responsive to local needs are promising. Technical assistance has led to improvements in the overall performance of the contraceptives distribution system. NGOs' skills in procurement and technical training have increased, and the social marketing program has worked to expand service availability by providing education to private doctors and pharmacies. Though these activities will help to achieve contraceptive security, coordination between the public and private sectors remains weak. In addition, there is no agreed upon method for forecasting contraceptive needs, and stockouts periodically occur in Ministry of Health facilities.

Financing. Madagascar's FP program continues to be dependent on donor financial, technical, and managerial assistance. Although the health budget has risen in recent years, government financial support for family planning has not increased, and little analysis has been conducted on the costs of a fully-funded FP program. Stakeholders anticipate that with the pending reinstatement of the user fee mechanism[2], which would charge fees in public sector facilities for the delivery of contraceptive methods, modest cost recovery could be achieved in the public sector. Still, given the required increase in funds for family planning and reproductive health because of population growth, more ambitious goals for contraceptive use, and the eventual decline in donor support, the GOM is faced with a growing financial gap for contraceptives and FP programming. The projected funding gap for contraceptives 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[3] (Moreland et al., 2003b).

Main Recommendations for Achieving Contraceptive Security

Stakeholders involved in the assessment process highlighted multiple priority areas for intervention in four of the existing components of the CS framework. The following recommendations informed the National Family Planning Strategy and will be used in future CS planning efforts:

- Expand the range of contraceptive products available in country.
- Ensure the availability of contraceptive products in both urban and rural areas.
- Reinforce the community-based delivery of contraceptive products and strengthen coordination between community health workers and health facilities.
- Increase training for those involved in logistics management.

[2] From 1999–2002, Madagascar's MOH implemented a user fee mechanism titled, Participation Financière des Usagers, or PFU, for essential drugs, including contraceptives. The PFU mechanism was suspended by a Presidential Decree in July 2002 but is scheduled to be reformed and reinstated.

[3] This is a rough estimate based on assumptions about changes in method mix and the future prices of contraceptives.

- Establish a resource targeting strategy for providing free family planning for those who cannot pay.

- Implement advocacy and IEC or BCC campaigns around family planning to improve contraceptive use and increase demand.

- Advocate for increased involvement of local or administrative authorities at all levels in family planning.

Lessons Learned Using SPARHCS in Madagascar

Important lessons emerged from Madagascar's SPARHCS assessment and evaluation that can be used to inform assessments in other countries.

Use SPARHCS to create a common understanding of contraceptive security. As a result of the SPARHCS assessment, contraceptive security received attention from high-level stakeholders at all levels in Madagascar. The assessment process successfully brought together a diverse, multidisciplinary group of stakeholders to discuss a multitude of CS-related issues, which ideally will lead to a successful strategic planning and implementation process. The assessment "sparked" interest and convinced stakeholders that contraceptive security is a priority issue.

Adapt SPARHCS locally to achieve a more effective application in the field. The diagnostic instrument served as a guide rather than a checklist or questionnaire. Key stakeholders adapted the SPARHCS approach by customizing the diagnostic guide to build on previous CS work, ultimately facilitating the data collection process for the working groups and the translation of findings into relevant recommendations.

Allow sufficient preparation time for a SPARHCS assessment. The assessment would have been improved if the Ministry of Health and/or POLICY/Madagascar had selected and contacted participants in advance; allotted sufficient time for preparatory work in-country; clarified objectives and expectations of the assessment phase with participants in advance; and provided the SPARHCS diagnostic guide in advance to improve participants' understanding of the assessment's purpose and their role in the process.

Solicit the participation of local counterparts as much as possible. The international consultants agreed that the SPARHCS findings and recommendations are more likely to influence CS strategic planning when there is local involvement in the assessment process. Involving a small group of highly experienced, local consultants in key technical areas, such as finance, would have reduced the need for international consultants. Note, however, that the assessment was conducted with local counterparts who took ownership of the process, and the assessment received significant support from the POLICY/Madagascar local office and the USAID mission.

Activities and Progress since the SPARHCS Application

The SPARHCS application in Madagascar marked the beginning of a one-year effort to improve contraceptive security and build capacity for addressing broader health issues. The POLICY and DELIVER projects provided technical assistance to these efforts. Using the SPARHCS tool enabled Madagascar to view contraceptive security through a comprehensive framework and gain a longer term vision of how to reposition family planning. More specifically, progress was made in expanding the range and quality of FP services and in creating a more enabling policy environment in support of contraceptive

security and FP issues overall. Please consult POLICY's full report titled "Using the SPARHCS Approach to Reposition Family Planning in Madagascar: A Success Story" for a more detailed description of progress made since SPARHCS in Madagascar (Aramati et al., 2006). Selected activities and progress include the following:

- In September 2003, as a direct result of the SPARHCS assessment, the World Bank reviewed Madagascar's contraceptive requirements based on the estimated annual increases in the CPR for 2003–2010 and agreed to make a financial contribution to help the Ministry of Health purchase contraceptives. Support from the Bank prevented an anticipated 2004 funding gap that would have resulted from an increase in the CPR coupled with a stagnant amount of donor-provided contraceptive commodities.

- An important outcome of the SPARHCS assessment was the inclusion of family planning within a broader framework of overall health and development, thus highlighting the importance of family planning in improving health and well-being of the population. This paradigm shift led to a change in the ministry's name from the Ministry of Health to the Ministry of Health and Family Planning (MOH/FP) and the creation of a specific directorate for family planning in January 2004. The MOH/FP committed to the expansion of FP programs, including financing contraceptives starting in 2005, and to the distribution of oral contraceptives by community health workers.

- With support from POLICY, which provided scenarios showing that introduction of a new implant contraceptive method would positively influence the CPR while keeping financing costs relatively lower than other methods, the GOM approved an additional contraceptive method (a three-year contraceptive implant) and national pharmaceutical authorities registered it for introduction into the commercial market in February 2004.

- With the assistance of POLICY and DELIVER, the MOH/FP prepared a three-year contraceptive procurement plan for 2005–2008. The Minister of Health presented the plan at a meeting in October 2004, which was held to confirm the commitment of donors and MOH decisionmakers to financing commodities.

- The GOM created a budget line item for contraceptives, with a modest $US150,000 allocated for 2006.

- The distribution of contraceptives has improved since the SPARHCS application—contraceptives have been incorporated into the country's essential drugs distribution system.

- POLICY and DELIVER facilitated additional activities, including baseline analyses, a willingness-to-pay study, a market segmentation analysis, the creation of provincial CS plans, and a workshop series—all of which guided policy and program decisions on contraceptive security and the new National Family Planning Strategy. Information from these studies has been crucial in informing advocacy efforts and has led to the mobilization of partners to help reposition family planning.

- A core group of individuals who participated in the SPARHCS assessment from the MOH/FP, other ministries, donor agencies, NGOs, and private sector stakeholders, with assistance from POLICY, created a national CS strategy, which built on SPARHCS findings and recommendations and served as the focus of the national family planning conference in December 2004. The CS action plan is now a component of the new five-year national FP

strategy. The President, the Minister of Health, and other ministers endorsed the strategy at the conference. The strategy focuses on increasing demand, increasing access, and strengthening the policy environment for family planning. Additionally, the President of Madagascar established the FP Executive Secretariat, which will ensure leadership, coordination, and monitoring of the FP strategy implementation.

- In November 2005, the SPARHCS tool was adapted by POLICY to assess Madagascar's progress in repositioning family planning since the SPARHCS assessment. POLICY/Washington staff conducted interviews with stakeholders and policymakers and reviewed key documents (Aramati et al., 2005).

It is clear that the SPARHCS framework made a lasting impression on government officials as a useful tool for multiple aspects of contraceptive security planning and implementation. The GOM used the assessment findings to inform CS planning efforts and in 2005, the MOH/FP suggested conducting a modified SPARHCS assessment in 2006 to assess the progress since the first assessment and determine areas for further strengthening. Given the strides Madagascar has made in engaging high-level government officials and garnering support for family planning and contraceptive security since 2003, the stage is set for and moving the country closer to the goal of CS—when every person is able to choose, obtain, and use contraceptives whenever she or he wants and/or needs them.

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