Using the SPARHCS Approach to Reposition Family Planning in Madagascar: A Success Story

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CONTENTS

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ABBREVIATIONS

BCC	Behavioral change communication
CA	Cooperating Agencies
CBD	Community-Based Distribution
CNLS	National AIDS Committee
CPR	Contraceptive prevalence rate
CRESAN	Second Health Sector Support Project – World Bank
CS	Contraceptive Security
DELIVER	DELIVER Project (John Snow International)
DHS/EDS	Demographic and health surveys
EMAD	District Management Team
FISA	Fianakaviana Sambatra (Family Planning Association in Madagascar)
FP	Family planning
GOM	Government of Madagascar
HIPC	Heavily Indebted Poor Countries Initiative
IDA	International Development Association (World Bank)
IEC	Information, education, and communication
IMCI	Integrated Child Illness Management
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LTM	Long-term method
LTPM	Long-term and permanent method
MOH/FP	Ministry of Health and Family Planning
MOU	Memorandum of understanding
MTCT	Mother-to-child transmission
NFPS	National Family Planning Strategy
NGO	Nongovernmental organization
Pha-G-Dis	Wholesale District Pharmacy
POLICY	POLICY Project (Futures Group International, LLC)
PRSP	Poverty Reduction and Strategy Paper
PSI	Population Services International
RH	Reproductive health
RHCS	Reproductive Health and Commodity Security
RFP	Repositioning family planning
SALAMA	Central Drug Purchase Department (NGO)
SanteNet	SanteNet (Chemonics)
SDP	Service delivery point
SM	Social Marketing
SSD	District Health Services
SPARHCS	Strategic Pathway to Achieving Reproductive Health Commodity Security
STI	Sexually transmitted infection
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank

EXECUTIVE SUMMARY

In June 2003, a process was launched to strengthen Reproductive Health Commodities Security (RHCS) in Madagascar. An assessment was conducted using a methodology known as SPARHCS—the Strategic Pathway to Achieving Reproductive Health Commodity Security. SPARHCS provides a framework and diagnostic guide to help countries develop a strategic commitment and a funded RHCS action plan using consensus-based priorities as determined by a multisectoral group. The 2003 assessment of RHCS was conducted to identify critical strengths, weaknesses, and opportunities; analyze historical trends and future projections; identify immediate follow-up actions; assist the government of Madagascar (GOM) and its national and international partners to produce a one-year immediate plan of action; and present findings to key stakeholders and facilitate discussions on a long-term RHCS strategic plan.

Following the SPARHCS assessment, technical assistance was provided to the government of Madagascar (GOM) to implement a strategic plan for RHCS. More than two years after this process was launched, Madagascar has made great strides in engaging high-level government officials, garnering support for RHCS, and moving the country closer to the goal of RHCS — *when every person is able to choose, obtain, and use contraceptives and other essential reproductive health supplies whenever she or he wants and/or needs them.* This assessment provides a follow-up to the SPARHCS assessment conducted in Madagascar between May 24 and June 12, 2003, to document the SPARHCS experience, and the impact of SPARHCS on Repositioning Family Planning (RFP) program efforts in Madagascar.

The leadership role and commitment of USAID/Madagascar, in collaboration with the GOM, NGOs, and other partners, were critical to the success of the SPARHCS process and provided a positive policy environment for RFP. As an example, the Memorandum of Understanding initiated by USAID/Madagascar and signed in an official ceremony in March 2003 played a significant role in the collaborative efforts among the Ministry of Health and Family Planning (MOH/FP), USAID, UNFPA, and the Central Drug Purchase Department (SALAMA) to improve the availability of contraceptives. In addition, as the results of SPARHCS were being described, it was clear that SPARHCS sparked the process and was used as a tool for Repositioning Family Planning.

The success of the RHCS work in Madagascar, while noted by the USAID community and its implementing partners, has not been well documented. This assessment provides documentation and a clear description of the country's success in using the SPARHCS process to strengthen RHCS and reposition the FP program. These results can be seen as a success story for RFP and may be used as guidelines for countries currently planning for, or implementing, RHCS and RFP strategies. The RFP initiative is based on the premise that, with increased political commitment for financial and human resources for FP, strengthened participation and coordination among donors and partners, and more effective programming of resources toward technically sound programs, it will be possible to expand access and meet unmet need for family planning.

This assessment documents the SPARHCS process, and its results, challenges, and recommendations for raising awareness of the FP program in Madagascar. The sources of

information for this paper were the result of in-depth interviews with key stakeholders and a review of documents. The information presented in this paper highlights the success story of family planning and how the SPARHCS process contributed to repositioning family planning in Madagascar, and reports on the major results achieved thus far.

SPARHCS Results toward Repositioning Family Planning

Significant and promising changes and events relative to family planning and reproductive health (FP/RH) have taken place in Madagascar as a result of the SPARHCS process and through the leadership and commitment of USAID/Madagascar, and the government of Madagascar (GOM). These events include the following:

- A change in name from the Ministry of Health to the Ministry of Health and Family Planning on January 5, 2004
- Financial support for the procurement of contraceptives provided by the World Bank during 2004 and that led to the delivery of commodities in Madagascar purchased at the request and under the authority of the GOM
- Completion of a series of studies and analyses recommended by the SPARHCS assessment to make the case for increased actions and political support to achieve RHCS
    - Contraceptive stocks survey at the service delivery point (SDP) level:
        - Recommendations to improve the distribution system, and a baseline from which to monitor the functioning of the system
        - Data to prepare forecasting, procurement, and financing plan
    - Market studies:
        - Market segmentation study based on the 2003/2004 Demographic Health Survey (DHS) that provided an assessment of the market to enable decisions for the design of the FP strategy
        - Willingness to pay study in the public sector that indicated a willingness to pay for contraceptives to ensure appropriate contraception by users
- Culmination of USAID support through its various CAs (the bilateral SanteNet Project as well as the POLICY and DELIVER projects) for strengthening FP/RH in a series of workshops on FP/RH, and a December 2004 national workshop that included participation by Madagascar President Marc Ravalomanana and five key government ministries (This is proof of increased political commitment.)
- Definition of a new National FP Strategy: this strategy is the most important result of the political commitment that was developed during the SPARHCS process to reposition FP in Madagascar
- Planning by the MOH/FP, in collaboration with donor agencies and USAID as requested/instructed by President Ravalomanana, to respond to unmet need for family planning as presented at the December conference, and to raise national consciousness regarding the benefits of FP
- Initiation of a program to “reposition family planning” to insure both improved access to FP services and achievement of the GOM’s contraceptive prevalence goals
- Establishment of the Executive Secretariat for Family Planning, initiated by President Ravalomanana; the Executive Secretariat of the FP program ensures leadership,

coordination, and monitoring of the implementation of the National Family Planning Strategy

- Launching of the IUD program through the workshop on "Revitalization of IUDs as a Long-Term Method." The workshop was held in November 2005 and was opened by the GOM's Minister of Health and Family Planning, who stated that the government and MOH/FP have included among their priorities the expansion of family planning to the entire population

I. METHODOLOGY

The POLICY Project proposed to assist USAID in publicizing the SPARHCS experience in Madagascar and raise awareness about the benefits that SPAHRCS can bring to a country for RFP. Using the SPARHCS diagnostic instrument, POLICY identified and assessed the extent to which the challenges and opportunities identified in the SPARHCS assessment have been addressed since its launch. A POLICY/Washington staff member met with key leaders who have been active in the RHCS strategy development and implementation, such as the MOH/FP, other participating ministries, donor agencies, NGOs, and private sector stakeholders to identify the extent to which commitment, leadership, and coordination have changed as a result of SPARHCS. In addition, the POLICY Project assessed the strengths of the SPARHCS process, as well as some of the challenges faced during the recent implementation of the newly defined FP national strategy.

This report documents the process, results, challenges, recommendations, and the keys to success in raising the profile of the FP program in Madagascar. The sources of information for this paper were the result of in-depth interviews with key stakeholders (see Appendix 1) and document reviews (see Appendix 2). In-country interviews were conducted from October 25 to November 6, 2005. A list of questions was prepared in English and French (see Appendix 3). The results of the interviews are presented in the report section titled "Findings Based on the Interviews."

II. COUNTRY BACKGROUND

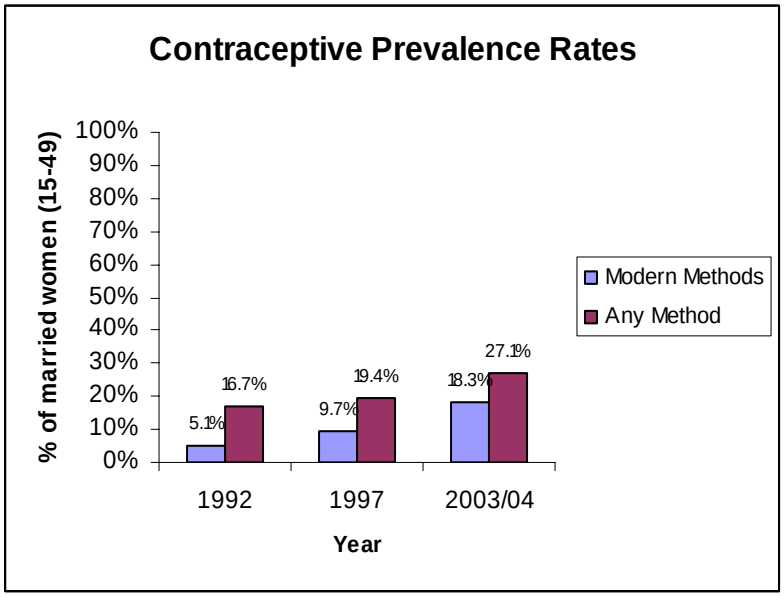
Family Planning Environment in Madagascar

Demographic indicators.[1] In the last decade, as shown in Figure 1, the contraceptive prevalence rate (CPR) for women in the 15–49 age group in Madagascar has slowly but steadily increased from 17 percent in 1992 to 19 percent in 1997 to 27 percent in 2003/4 (DHS 1992; DHS 1997; DHS 2003/4). CPR for modern methods has increased from 5 percent in 1992 to 10 percent in 1997 to 18 percent in 2003/4 (DHS 1992; DHS 1997; DHS 2003/4). Despite overall increases, modern contraceptive use is still low and disparities exist between rural and urban areas, among socioeconomic groups, and between those with low versus higher education levels (EDS 1992, 1997, MICS 2000). Accordingly, the total fertility rate (TFR) in Madagascar is 5.68.

Donor financing of contraceptives. Since its inception in 1986, the government of Madagascar's (GOM) FP program has been dependent on donor funding, mainly from USAID, UNFPA, and IPPF. GOM financial support for the FP program has not increased, despite increases in the health sector's budget. Donors provide fund for the vast majority of program-specific costs of the FP program, the bulk of which are for the procurement of contraceptives at the central level.

[1] Madagascar's population is measured at 17.5 million inhabitants. Approximately 13 million people (74%) reside in rural areas. More than four million (24%) of Madagascar's inhabitants are women of reproductive age. Assuming that its 2.8 percent annual growth rate remains constant, Madagascar's population will triple by 2050, thus challenging economic and social development in the country (PRB 2004 World Population Data Sheet).

Figure 1.



Source: DHS

In the mid-1990s, the GOM assigned the main donor agencies providing support to the health sector in Madagascar to specific provinces to enable donor agencies to focus their assistance in designated geographic areas and decrease overlap. Additionally, each of the donors supplied different methods centrally or at the provincial level—UNFPA provided implants (Norplant) and injectables (Depo-Provera); and USAID and IPPF supplied condoms (no logo and Protector/Protector Plus), pills (Lo-Femenal and Ovrette), IUDs (TCu-380A), injectables (Depo-Provera), and Conceptrol Foaming Tablets. Since 2001, however, USAID and UNFPA have been the only donors and the main suppliers of contraceptives and condoms in Madagascar.

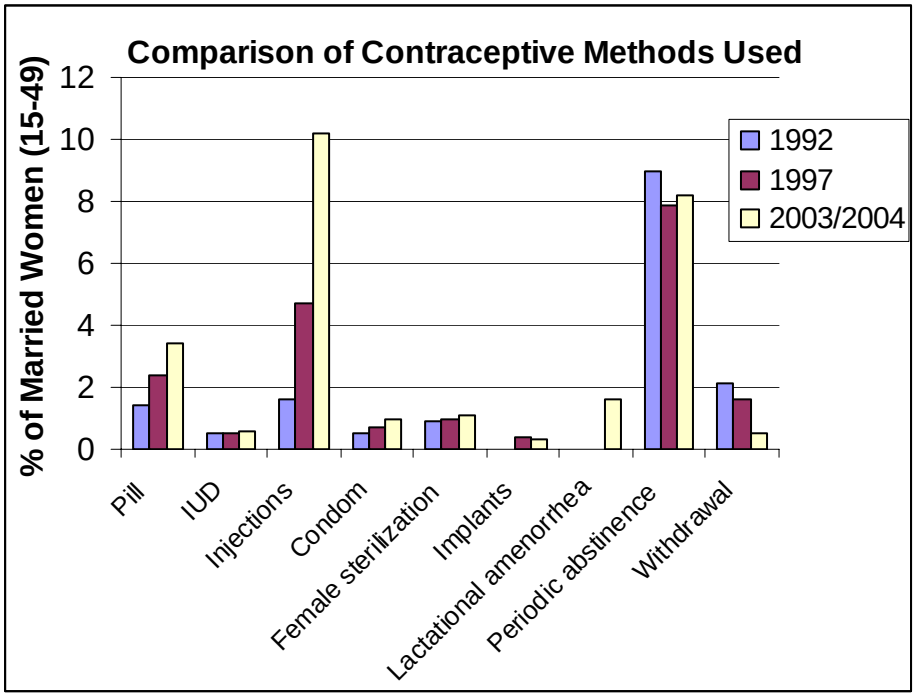
Family planning providers and methods. Madagascar's most important provider of FP products is the public sector, where 58 percent of FP users obtain their methods. The commercial sector follows, composed of private providers, pharmacies, and markets, serving 33 percent of FP users, mainly through social marketing. The NGO sector serves the remaining 9 percent of FP users.

As shown in Figure 2, the most common FP methods among married women are injectables (1.6 % in 1992, 4.7% in 1997, and 10.2% in 2003/2004); periodic abstinence (9% in 1992, 7.9% in 1997, 8.2 percent in 2003/2004); oral contraceptives (1.4% in 1992, 2.4% in 1997, 3.4% in 2003/2004); condoms (0.5% in 1992, 0.7% in 1997, 1% in 2003/2004); lactational amenorrhea (1.6% in 2003/2004); female sterilization (0.9% in 1992, 1% in 1997, 1.1% in 2003/2004); and IUDs (0.5% in 1992 and 1997, 0.6% in 2003/2004) (DHS 1992, DHS 1997, DHS 2003/2004). Given the degree of dependence on donors for FP programs, Madagascar's method mix is, in part, determined by what donors are willing and able to provide. Contraceptive procurement is conducted by the donor agencies, with each using its own procurement systems.

Economic and political factors. More than 70 percent of the population lives below the poverty level, with nearly 30 percent living in extreme poverty. While economic reforms are contributing to GDP growth, Madagascar remains economically vulnerable. In 2000, Madagascar qualified for debt relief under the Heavily Indebted Poor Countries Initiative (HIPC), and resources freed up from HIPC are or will be 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 family planning, it states a goal to increase contraceptive use and acknowledges that women do not have sufficient freedom in their choice of contraceptive methods.[2]

Figure 2.



Source: DHS

While FP has long been supported through policy, it has not always been matched with political commitment and funding. FP programming has been primarily donor driven, a situation that is now changing. In 2002, Madagascar experienced an economic crisis spurred by social and political unrest following the disputed 2001 presidential election. A democratically elected government was inaugurated in 2002, providing a major impetus for a change in FP programming. The new government supports a reform agenda. As a result, the political environment since 2002 has been open to change and is a significant factor in the renewed government commitment to family planning. Recently, through the close collaboration and leadership by USAID/Madagascar and the MOH/FP, the GOM has publicly affirmed its commitment to family planning and has taken a leadership role. The SPARHCS process has helped to spark the GOM's commitment toward RPF in Madagascar.

III. THE SPARHCS PROCESS IN MADAGASCAR

Madagascar was one of the first countries to undergo a SPARHCS assessment to study RHCS. The 2003 assessment of RHCS was conducted to identify critical strengths, weaknesses, and opportunities; analyze historical trends and future projections; identify immediate follow-up actions; assist the GOM and its national and international partners to produce a one-year immediate plan of action; and present findings to key stakeholders and facilitate discussions on a long-term RHCS strategic plan.

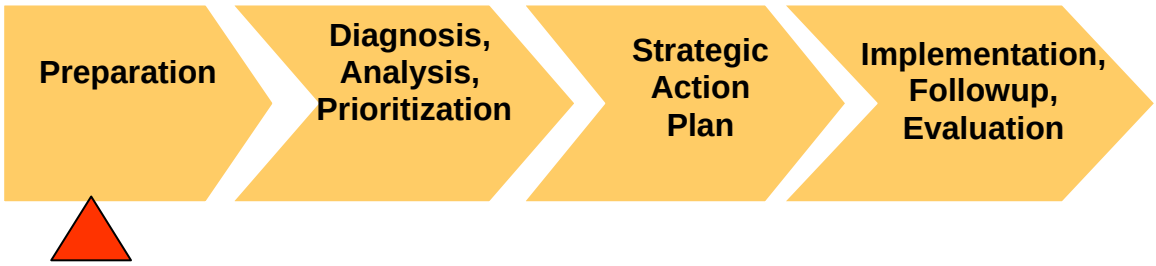
SPARHCS provides a framework and diagnostic guide to help countries develop a strategic commitment and a funded RHCS action plan. During the Madagascar assessment, a

[2] Borda, M., C. Shepherd, and W. Winfrey. 2004. *POLICY ISSUE: How do Poverty Reduction Strategy Papers Address Family Planning?* Washington, DC: Futures Group/POLICY Project. Draft.

multisectoral team of consultants and country partners formed working groups that reflected the five major components of the RHCS framework relevant to Madagascar and adapted earlier from SPARHCS: demography, policy and political environment, demand, service delivery, and finance. Each working group used some combination of document review and report analysis, secondary data analysis, computer-based modeling, key informant interviews, focus group discussions, field visits, and group work (in and out of workshops). The dissemination of assessment findings fed into the development of a one-year draft plan of action designed to move Madagascar towards its goal of contraceptive security. The one-year plan was accepted by the MOH at a national conference.

The workplan, implemented over a 16-month period, supported additional analysis and fostered dialogue that culminated with a national FP conference in December 2004. This conference, which was preceded by a series of technical and strategic workshops (November-December 2004), provided for the adoption of a new national FP strategy.

SPARHCS PROCESS



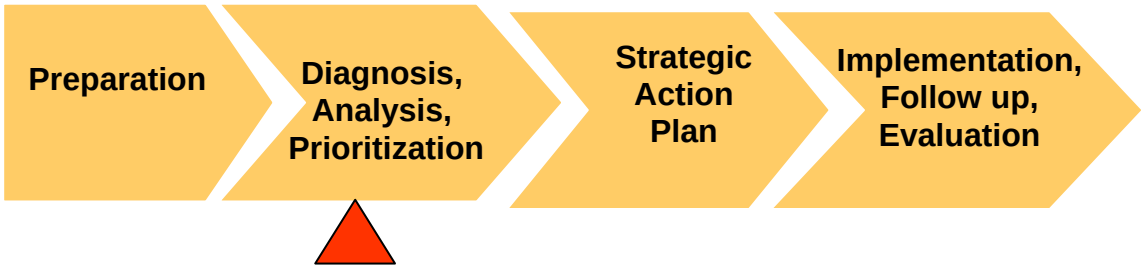
Preparation

- Participation in the RHCS Regional Workshop held in Abidjan, Nigeria, June 2002

- First reproductive health, contraceptive security workshop in Madagascar held November 2002:
  - definition of the five axes/components of RHCS: (demography, environment and policy, demand, service delivery, and finance)
  - presentation of the first prevalence situations as related to world experience

- USAID/Madagascar initiated a Memorandum of Understanding (MOU) among the MOH, SALAMA, USAID, and UNFPA to improve the availability of contraceptives
  - MOU was signed during an official ceremony held in March 2003 under the auspices of the MOH

- In May 2003, the Minister of Health met with SPARHCS partners in Washington, D.C., and approved the preparation for the RHCS diagnostic process in Madagascar

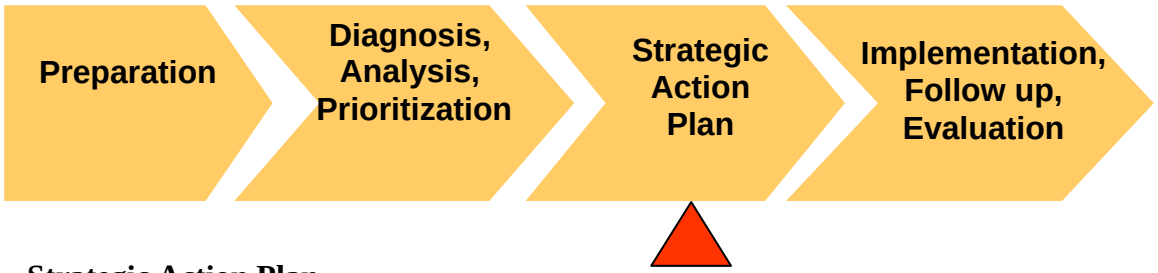


Diagnosis, Analysis, Prioritization

- Workshop held in Antananarivo, Madagascar, May 27, 2003:
  - Introduction to the SPARHCS process in Madagascar
  - Confirmation of working groups according to the research axes previously defined in November 2002
  - Launching of the diagnostic phase of SPARHCS

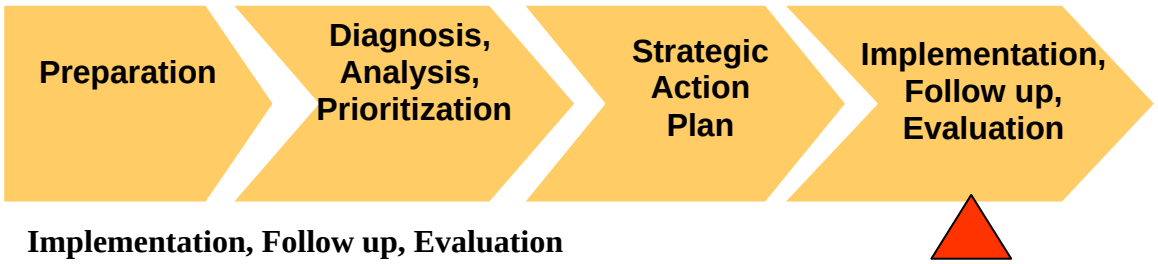
- SPARHCS workshop held in Antananarivo, Madagascar, June 10-11, 2003:
  - Feedback on the diagnostic phase
  - Prevalence projection consensus reached
  - Creation and adoption of a one-year workplan to prepare the National SPARHCS Strategy

- National Reproductive Health Workshop held in Antsirabe, Madagascar, December 2003:
  - Action Plans for the following components: Family Planning, Youth and Adolescent Reproductive Health, Safe Motherhood, and Obstetric Emergency Care



Strategic Action Plan

- Workshops (end of 2003 and beginning of 2004):
  - Initiated the dialogue between the public and private sector to define respective responsibilities and collaboration regarding the promotion and provision of FP services within the governmental strategy of the four P's (Public Private Population Partnership)
  - Studies conducted to guide MOH/FP leaders in making policy and programmatic decisions regarding the following:
    - Contraceptive stock status survey
    - Willingness to pay for contraceptives by clients attending public sector health facilities
    - FP market segmentation study based on new DHS 2003/2004 results
- Preliminary results of DHS-MD3 (2003/2004) November 2004:
  - Results used to update CPR scenarios
- Adoption of a New National FP Strategy for Madagascar (November and December 2004)
  - The new strategy was defined during a series of mini-workshops and validated during a National Conference attended by the President of the Republic of Madagascar, heads of major state bodies (i.e., Parliament) as well as church leaders
  - The strategy was adopted, along with a five-year action plan



Implementation, Follow up, Evaluation

- Confirmation of the national government's commitment:
  - Creation of an Executive Secretariat for FP linked to the president
  - Establishment of an FP steering committee in collaboration with government partners
  - Expansion of the WB/IDA budget to include the provision of US$3 million for family planning
  - Creation of a new budgetary line in the national budget allocating US$150,000 in 2006 for contraceptives
  - Change in the regulations to integrate contraceptives into the list of essential medicines and thus eliminate taxes on contraceptives
  - Existence of a new FP strategy

- Public-private partnership:
  - Agreement between the GOM and Organon to introduce Implanon®
  - The social marketing organizations and private doctors to work in close collaboration with the MOH

- Operational implementation of the new FP strategy defined in December 2004:
  - Reinitiating long-term methods (LTM), training of service providers in IUD insertion and removal, piloting of the Implanon®
  - Work on norms and standards
  - Reinforcement of contraceptives stock levels in the districts to reduce risks of stock-outs

IV. FINDINGS BASED ON THE INTERVIEWS

The interviews conducted with senior stakeholders in the public sector, NGOs, and donor/partners focused on four themes: the FP environment before SPARHCS, the results of SPARHCS, current challenges facing policymakers in family planning, and recommendations for the future of the FP program in Madagascar.

Family Planning Environment before SPARHCS

The FP situation in Madagascar prior to the SPARHCS process was characterized by all interviewees as severely lacking. The system for supply and distribution of contraceptives had logistical problems, compounded by insufficient government commitment and no clear direction for attaining contraceptive security as described in the country background section.

Results of SPARHCS: Summary of Interviews

The introduction of the SPARHCS process in Madagascar was very successful. SPARHCS was utilized as a tool to reposition family planning. The process initiated important changes in the level of involvement of the public sector in family planning and in the relationships between the public sector, NGOs, and partner communities. One of the changes was that President Ravalomanana, through the MOH/FP, established the Executive Secretariat of Family Planning. This decision was based on the importance of family planning for the country's economic development and for poverty reduction, so as to "improve the well being of Malagasy families, and to ensure that couples have access to information and quality family planning services." As such, the two key elements were the well-being of families (decreased maternal mortality), and the potential impact of family planning on the country's economic development.

Table 1 presents a summary of the interviewees' perceptions of the results of the SPARHCS process. Interviewees' responses are divided into four categories: Policy and Political Environment, Demand, Service Delivery, and Finance; these are the components of the SPARHCS process as applied in Madagascar. Similar responses are shown cutting across the columns horizontally.

Table 1. Results of SPARHCS Process Toward RFP in Madagascar: Summary of Interviews

SPARHCS Component	Public Sector	Partners	Nongovernmental Organizations
Policy & Political Environment	o Personal commitment by President Ravalomanana to FP		
	o Name of Ministry of Health changed to Ministry of Health and Family Planning		o NGOs participate in FP coordination meetings o SALAMA becomes a member of the FP logistics working group
	o FP Executive Secretariat established in President's office o New FP strategy	o USAID initiates SPARHCS process o FP added to Madagascar PRSP	o President's office conducts a survey on institutions working in FP
	FP steering committee created with public sector, NGO, and donor members		
Demand	o Government and private physicians collaborate on social marketing o Revitalizes interest in long-term & permanent methods (LTPM)	o FP IEC/BCC committee created to increase demand among specific groups o UNICEF integrates FP into its IMCI & MCT programs to promote birth spacing.	
Service Delivery	o Contraceptives added to SALAMA's list of essential drugs o GOM and Organon reached agreement for pilot introduction of Implanon® (Implants)		o Shift from free generic commodities (donor supplied) to subsidized procurement of social marketing products
	o Joint condom forecasting with National AIDS Committee (CNLS) o Training of service providers in IUDs o Reinforcement of the minimal/maximum contraceptive stocks at the district level to reduce risks of stock-outs o Workshop on FP SSD/Pha-G-Dis o Activities on Norms and Standards o Range of contraceptive products expanded from 4 to 6 (IUD and implants added)	o Under new FP strategy, partners will work to train midwives on complete range of contraceptive methods	
Finance	o Creation of line-item in national budget for contraceptives o US$150,000 allocated by GOM for 2006 o Addition of US$3million into CRESAN's budget for FP (WB/IDA funds)		
	o Equity fund for poor established		

Policy and Political Environment. Interviewees from all sectors mentioned changes in the context, coordination, and commitment of the policy and political environment. The renaming of the Ministry of Health to the Ministry of Health and Family Planning (MOH/FP) was mentioned by both public sector and partner interviewees. The renaming occurred by presidential decree in 2003. With a new decree (n°2004-001) in January 2004, the MOH/FP organigram was adapted with two general directorates. A specific directorate for family planning was created whereas before it was subsumed under the Preventive Medicine department.

Figure 3. Madagascar's New FP National Strategy

Goal

Guarantee couples access to information and high-quality FP services

Intermediate Objectives

1. Increase FP demand
2. Improve access to FP services
3. Create a favorable environment toward family planning, including a policy framework

Specific Objectives (2005/2009)

1. Increase the contraceptive prevalence rate from 18% to 28% (2 points / year):
   a. Increase the population's knowledge of various existing contraceptive methods and the importance of family planning
   b. Increase access of users to information about various contraceptive methods, as well as services of choice
   c. Increase the proportion of health facilities offering FP services from 71% to 100%
   d. Increase the proportion of health centers offering the full range of contraceptive methods from 7% to 14%
2. Establish a program coordination entity at the central level
3. Insure that FP/MCH programs are financed by 50% of the regions
4. Increase the CPR by 2 percentage points per year
5. Increase users' access to methods of their choice

This new ministry title reflects a greater commitment to family planning at the national level. With the newly created FP Directorate placed under the direct authority of one of the two general directors, it is expected that family planning will be more actively promoted and brought to the attention of decisionmakers at the highest level of the MOH/FP. While many factors contributed to this decision, among them was USAID's effort in promoting and financing FP activities in Madagascar over the years. This effort includes the SPARHCS activities conducted under the leadership of POLICY. These activities helped to influence the government to commit to the expansion of family planning.

Public sector interviewees noted both the establishment of the FP Executive Secretariat and the new FP strategy. What was supposed to be a focused process to define a national RHCS strategy evolved into a broader policy dialogue that permitted discussion and definition of a new National FP Strategy with political commitment at the highest level. The goal of the new strategy is to ensure access to information and high-quality FP services, with the specific aims of increasing the demand for family planning, improving access to FP services, and establishing a favorable policy and overall environment for family planning. The specific objectives of the strategy are outlined in Figure 3. This strategy contributed to repositioning family planning in Madagascar.

All three sectors lauded the creation of an FP steering committee, which fosters coordination between the public sector, NGOs, and partners. An additional result commented on only by the partner interviewees was the addition of family planning to Madagascar's PRSP.

Interviewees affiliated with NGOs tended to mention only those changes that were directly relevant to their sector. These changes included the inclusion of NGOs in FP coordination meetings, SALAMA becoming a member of the FP logistics working group, and the fact that a survey of institutions working in the FP field was conducted by the President's office.

Another result of the SPARHCS process mentioned by interviewees was the increased commitment on the part of the President of Madagascar. After the December 2004 National Conference, the President called for increased participation toward FP strengthening. He called for an immediate partners meeting with the GOM to assess donors' potential participation in achieving FP national goals. This resulted in the addition of UNICEF as a new partner in the FP Program.

Demand. The demand component of the SPARHCS framework concerns contraceptive users and non-users, the services available, and expanding the contraceptive market. All sectors noted changes in this area. Public sector interviewees noted an increase in GOM collaboration with private physicians in social marketing of contraceptives, as well as a renewed interest within the government for long-term and permanent methods (LTPM). The NGO interviewees also noted the recognition of social marketing and a shift in commodities procurement. The growing public-private partnership is evidenced by the government's official recognition of the social marketing program. This permitted Population Services International (PSI) to introduce new products (STI treatment kits), which were officially launched with the participation of the MOH/FP. The dialogue among the GOM and NGO's was re-launched during a workshop organized by POLICY and DELIVER. Subsequent to this initiative, the MOH/FP sent out an official "note de service" that established the distribution channels for NGOs. The approach limited access to Pha-G-Dis (Wholesale Districts Pharmacy)—free distribution—to small local NGOs only. This permitted the MOH/FP officially to reorient large NGOs toward the private sector to provide social marketing products. This initiative represents the beginning of a targeted approach toward contraceptive security in Madagascar by increasing private sector cost sharing. As a practical result, the FP commodities distribution system was redesigned during 2004.

Partner interviewees noted that FP information, education, communication/behavioral change communication (IEC/BCC) committees were created to increase contraceptive demand among specific groups. In addition, UNICEF is incorporating family planning into its integrated child illness management and mother-to-child transmission programs, to help promote birth spacing.

Service Delivery. Interviewees noted numerous changes in the FP service delivery structure that occurred as a result of SPARHCS. Both public sector and partner interviewees mentioned the addition of contraceptives to SALAMA's list of essential drugs. In addition, both cited the new partnership between GOM and Organon to pilot the implant Implanon®.

The initiation of new dialogue among MOH/FP, USAID, and PSI resulted in a specific regulatory change: an MOH/FP waiver modifying the "code de deontology" to allow private

doctors to sell socially marketed FP products and STI pharmaceutical products (pre-packaged kits) directly to their clients.

Finance. In order for changes in the policy and political environment, demand, and service delivery to be sustained, there must be a commitment to increase available funding. Public sector and partner interviewees remarked on three main changes in the financing commitment that resulted from the SPARHCS process: creation of a contraceptive line item in the national budget, US$150,000 allocated by GOM for contraceptives in 2006, and the addition of US$3 million dedicated to family planning from CRESAN (World Bank health project).

Although the specific part of the national budget dedicated to family planning remains very low, it should be noted that the GOM and the World Bank agreed on increasing the specific envelope for family planning in the loan for health (CRESAN Project). This resulted in the first procurement of contraceptives by the GOM using IDA money. Although the MOH/FP mentioned the possibility of using HIPC funds to finance FP activities, the decision has not yet been finalized. Indeed, although the awareness of FP has evolved dramatically at the highest level of the administration in Madagascar, decisionmakers with limited budgets continue to give priority to treatment rather than prevention.

Current Challenges: Summary of Interviews

The recent success in FP programs demonstrates the excellent collaboration among all sectors; however, the interviewees noted several challenges that remain in making contraceptive security a reality. With all the demographic successes to date, the use of modern contraception is still low at 18 percent, (although higher than its 1997 level of 10%), and fertility levels remain high at an average of 5.2 births per woman. Although this represents an important improvement in contraceptive use, the DHS indicated an unmet need for contraceptives of 24 percent. Fertility rates are highest among the most inaccessible populations. Most of the country's population (75%) resides in rural areas of the country, some of which are inaccessible all year long. Literacy rates are still quite low among rural women, and malaria is a leading killer of children under five. Since the GOM has set a goal for CPR of 28 percent to be achieved by 2009, the national FP program will face a number of challenges in the coming years. The following challenges were noted by interviewees.

Table 2. Challenges to RFP in Madagascar: Summary of Interviews

SPARHCS Component	Public Sector	Partners	Nongovernmental Organizations
Policy & Political Environment	o No strategy to reach the poorest, despite establishment of equity fund	o Lack of clarity in approach to young people's needs o Roles of FP coordination committee & FP Executive Secretariat unclear	
Demand	o Poorest groups cannot afford services and government resources are not available o High rates of illiteracy among women	o High fertility is perceived as a sign of wealth o Married men unwilling to accept contraception	
Service Delivery	o Only 60 percent of health facilities provide FP services		o NGO use of non-social marketing commodities is not accounted for in Pha-G-Dis' forecasting
	o High level of unmet need	o Problems supervising sales revenue o Service providers and EMAD do not use management tools o Relocation of FP trained health workers o Community workers attracted to HIV/AIDS activities due to higher pay	
		o Poor quality guidelines	
Finance	Sustainability issues	o GOM-provided resources are not adequate o No resources to air FP spots	

Recommendations: Summary of Interviews

During the interviews, several recommendations in the areas of policy, demand, service delivery, and finance were proposed. The recurring theme was that SPARHCS is a tool for RFP and is a continuing process. As such, it was recommended by all parties that a SPARHCS follow-up assessment be conducted at the end of 2006.

Table 3. Recommendations for RFP in Madagascar: Summary of Interviews

SPARHCS Component	Public Sector	Partners	NGOs
Policy & Political Environment	o Continuation of SPARHCS process with technical assistance		
	o Conduct SPARHCS exercise in 2006	o Renewal of the MOU between MOHFP, SALAMA, and donors	
	o Study tours or exchanges with other countries	o Clarify the role of the FP Executive Secretariat, as well as its partners	o Standardize guidelines between the public and NGO sectors
Demand		o Reinforce mass awareness-raising and communication regarding FP o Reinforce awareness-raising in under-served populations o Conduct a feasibility study on how to reach remote areas	
Service Delivery	o Expand the range of contraceptive products o Reinforce the community-based approach and coordination between CBD workers and health facilities o Authorize NGOs (e.g., FISA) to get supplies directly from SALAMA to avoid stock-outs		o Provide appropriate equipment to health facilities to ensure quality services o Reinforce collaboration to improve bottom-to-top transmission of order-related information o Allow NGOs to get their supplies from Pha-G-Dis so they can offer their products at the same price as in the public sector o Reinforce training in logistics management at SSD level o Involve SALAMA's staff in training o Integrate FP with other health programs
	o Reinforce integration of FP and HIV/AIDS (single supply system) o Training in logistics management at national level and for FP committee members in charge of logistics o Establish a pool of trainers/supervisors for contraceptive logistics management o Increase from 6 to 9 months the maximum stock at the Pha-G-Dis level o Install database software at district, provincial, and central levels to improve M&E of FP o Insure the supply of LTPM (IUD) to increase CPR from 18 to 34 percent o Ensure that all CSB in Madagascar are covered with 100 percent of FP products o Update norms and standards in relation to MTC and malaria prevention at the health facility level o Provide 12 cycles of oral contraceptives	o Improve/update needs forecasting and share with partners o Periodic and regular supervision of health facilities in districts and of SALAMA distribution channels o Translate messages and guidelines into Malagasy o Establish collaboration between NGOs and SALAMA for transportation of products to remote areas o USAID and UNFPA should work together to present forecasting tools o Train midwives on complete range of contraceptive methods	
	o Ensure availability of contraceptive products		
Finance	o Ensure funding		
	o Subsidize FP services for the poorest		

V. CONCLUSION

During a September 2005 visit from USAID/Washington, team members concurred that GOM and USAID/Madagascar have made great progress in meeting the need for FP based on the 2004 DHS results indicating a contraceptive prevalence rate of 18 percent, which was increased from 1997 when it was 10 percent. The GOM has become increasingly interested in the role of family planning to accomplish the country's broader development agenda. They also reported that high-level commitment to achieving health and development goals related to reproductive health and meeting the unmet need for family planning are evident in the actions and dialogue of the Malagasy MOH/FP. According to the team, this commitment, coupled with the wealth of technical expertise within the mission and among its partners, provided the potential for creating a positive policy environment for repositioning family planning.

The repositioning of the national FP strategy, as formalized in December 2004, is currently faced with challenges; however, the program to reposition FP is being implemented with the aim of increasing access to FP services as well as achieving the GOM's goal to meet the CPR of 28 percent. The program will focus on reaching hard-to-reach populations, expanding the range of methods available in Madagascar, and removing obstacles and barriers, and by establishing the Executive Secretariat for family planning. The Executive Secretary of family planning will ensure leadership, coordination, and monitoring of the FP strategy implementation.

Utilizing the results of the interviews, the following suggestions for next steps may add value regarding current needs for repositioning family planning.

Policy

- Renew the Memorandum of Understanding among the MOH/FP, USAID, UNFPA, PSI, and SALAMA to improve the availability of contraceptives
- Formalize the structure of the Executive Secretariat of Family Planning and the steering committee and disseminate the terms of reference
- Conduct a SPARHCS assessment at the end of 2006 based on the 2004 DHS numbers that will include a series of workshops to assess the implementation of the new strategy per component (demography, policy, demand, service delivery, and finance) under the umbrella of the three goals of the new strategy

Financing

- Ensure viability of funding to ensure FP program is sustainable in the public and private sectors
- Increase FP services availability to the poor through the adoption of a means-tested card—the possession of which entitles the user to FP services
- Undertake an analysis/mapping of the NGO sector's utilization of family planning, services provided, types of clients, payment mechanisms for purchasing contraceptives, and user fees

Logistics

- Build the local capacity for contraceptive procurement at the central level (SALAMA)

- Continue strengthening the capacity of logistics management (including forecasting, procurement, monitoring) at the central, district, and SDP levels
- Strengthen collaboration between MOH/FP and the private sector (including the social marketing program) to clarify to the NGOs the complementarities of distribution schemes for public and private sectors
- Increase the maximum stock level at the district level from six to nine months in order to minimize the risk of stock-outs.
- Clarify the system for NGOs to obtain contraceptive supplies, especially long-term methods

Service Delivery

- Revise and update the Norms and Standards document (which is a good document) as soon as possible; the current one is perceived as a barrier to achieving contraceptive security
- Integrate HIV/AIDS and FP; FP clinics can be used as service delivery points for the distribution of condoms as a method choice for family planning and prevention of HIV/AIDS
- Conduct a feasibility study and/or operational research to identify barriers to providing FP in remote areas
- Based on results of study, strengthen and expand delivery of contraceptives
- Quality Improvement: Promote FP through a quality improvement campaign. For example, MOHP clinics participate in the Gold Star program in Egypt and could receive a gold star if they meet quality standards for six months and undergo two supervisory visits. Often clients want to go to a Gold Star clinic after seeing a TV advertisement
- Enhance the utilization of pharmacists (private sector) as service delivery points for promoting FP. For example, in Egypt, the program was titled "Ask and Consult." The pharmacists were trained in CS. The program also was used in a marketing campaign to direct clients to obtain FP services at the pharmacy

Advocacy

- Broadcast TV and radio spots for FP. For example in Egypt, the Minister of Information and the Minister of Health and Population signed an agreement to promote FP without payment, as a social responsibility
- Strengthen advocacy groups to promote FP to parliamentarians, religious groups, and community leaders at the regional and district levels. In a recent similar effort, POLICY, in collaboration with regional partners, conducted workshops with Francophone West African parliamentarians to prepare an RH legislative and regulatory reform guide to be used by workshop participants and others to advocate for policy change
- Promote Madagascar's participation with regional working groups such as Repositioning FP in West Africa, and share lessons learned and best practices
- Reinforce collaboration and communication across all stakeholders

USAID/Washington additional recommendations based on USAID Team Trip Report—Madagascar, September2005

- Expand use of IUDs as per the new WHO guidelines
- Expand the role of CBDs to include Depo-Provera and the standard days method

- Introduce pregnancy checklist and screening tools to increase uptake of family planning as indicated
- Develop a monitoring and evaluation plan so that the current approach to poverty reduction can be documented and progress or the lack thereof can be tracked and appropriate changes made to the plan as indicated

TIMELINE

Year	Activity
1960	Established Independence
1967	FISA (IPPF affiliate) began offering FP services
1985	Strengthening of Social Marketing Program for high risk pregnancies
1986	Public Sector FP program began
1990	Opposition parties legalized
1990	National Population Policy adopted
1991	New FP Project introduced (USAID)
1992	Norms and Standards for FP services introduced
1993	Population Program 2000: Reproductive Health Policy adopted
1993	Introduction of the initiative for Baby Friendly Hospitals (including breast feeding as a contraceptive method)
1997	National Symposium on RH
1998	National Health Policy adopted
2000	National Policy of RH adopted
June 2002	SPARHCS meeting in Abidjan
July 2002	New Madagascar government inaugurated
Nov. 2002	First workshop on RHCS in Madagascar
March 2003	Signature of MOU between SALAMA, USAID, UNFPA ,& MOH
May 2003	Minister of Health meets with SPARHCS partners in Washington, DC
June 2003	SPARHCS Diagnosis and second workshop in Madagascar
Oct. 2003	SPARHCS workshop in provinces
Dec. 2003	National RH Workshop held
Nov. 2004	National Coordination Workshop on RH
Nov. 2004	Mini-workshops for the development of a new FP National Strategy
Dec. 2004	National Conference on FP
Dec. 2004	Implementation of new FP strategy

APPENDIX 1. List of Interviewees

Name	Title	Organization
Wendy BENAZERGA	Team Leader, Health Population and Nutrition Office	USAID
Benjamin ANDRIAMITANTSOA	Child Survival, Family Planning and Nutrition Program Manager	
Lynne GAFFIKIN	Population Leadership Program Fellow, Health Population Environment	
Dr. Paul BLUMENTHAL	Advisor to MOH/FP	
Dr. Perline RAHANTANIRINA	Directeur de la Santé de la Famille	MINISTERE DE LA SANTE ET DU PLANNING FAMILIAL
Dr. Bako Nirina RAKOTOELINA	Chef de Service de la Santé de la Reproduction et de la Maternité Sans Risque	
Rigobert Arsène RAFIRINGASON	Chargé des Affaires de Partenariat	
Dr. Josué Lala ANDRIAMANANTSOA	Directeur des Etudes et de la Planification	
Volkan CAKIR	Directeur des Programmes	SANTENET
Dr. Nirina RANAIVOSON		
Avotiana RAKOTOMANGA	Responsable de l'Appui au Système de Gestion pour la Santé	
Dr. Paul Richard RALAINIRINA	Coordonnateur National	Projet CRESAN
Hajarijaona RAZAFINDRAFITO	Adjoint du Secrétaire Exécutif Chargé des Stratégies et Opérations	Comité National de Lutte contre le VIH/SIDA (CNLS)
Masy HARISOA MAHEFA HARINAIVO	Conseillère en Santé de la Mère et de l'Enfant	OMS
Victor RAKOTO	Assistant au Représentant	FNUAP
Dr. SOLOMANDRESY	Responsable Santé de la Reproduction	
Mr. LAZA	Responsable base de données	
Tahina ANDRIANJAFY	Directeur Général par intérim	SALAMA
Dr. Jeannine RAZAFIARISOA	Attachée de Direction Commerciale	
Douglas CALL	Représentant Résident	PSI MADAGASCAR
Dr. Andry Nirina RAHAJARISON	Coordinateur de marque PILPAN/CONFIANCE	
Dr. Macrine RAZAFINDRASENDRA	Délégué Médical	
Manitra ANDRIAMASINORO	Directeur Exécutif	FISA
Isabelle RANDRIAMBOLAMANANA	Chef de Service Logistique	
Dr. Julia Emilia RANAIVOSON	Médecin	Clinique TOP RESEAU Isotry
Dr. Eliane RASAMBAINARIVO	Médecin Chef	AMIT
Dr. Haja RAKOTONDRAFARA		CMS JIRAMA
Dr. Rija ANDRIAMIHANTANIRINA	Administrateur Adjoint Programme Survie	UNICEF
Dr. Norolalao RAKOTONDRAFARA	Directeur de la Direction Régional Santé	Direction Régional Santé Analamanga
Dr. SAHONDRA	Responsable Pha-G-Dis	
Service de Santé de District Antananarivo Atsimondrano	Monsieur le Médecin Inspecteur et son équipe	
Dr. Clarisse	Chef de Service de la Santé	SAF/FJKM

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APPENDIX 3. Interview Questions (English & French)

English

Questions to Guide Discussion of the SPARHCS Process in Madagascar
Background:

In June 2003, a process was launched to strengthen Reproductive Health Commodities Security (RHCS) in Madagascar. An assessment was conducted using a methodology known as SPARHCS – the Strategic Pathway to Achieving Reproductive Health Commodity Security (also known as SPSR in Madagascar). Following the assessment, USAID provided technical assistance to the Government of Madagascar and its national and international partners to prepare and implement a FP strategy.

More than two years after this process was launched, Madagascar has made great strides in engaging high level government officials, and garnering support for family planning and reproductive health commodity security. Much of this success can be attributed to a political shift that is taking place in Madagascar but it is also important to document the influence that the SPARHCS process may have had in influencing political commitment and repositioning family planning in Madagascar. Documenting lessons learned in Madagascar will be important for other countries that are working to achieve similar results.

In documenting the Madagascar experience, the following questions will be used to guide discussion regarding the outcomes of the SPARHCS process.

1. Evaluation of SPARHCS activities

a) Implementation of SPARHCS draft plan of action:
In the one year action plan a number of activities were cited as priority. Can you tell me the status of these activities and whether or not they were completed?

1. Assessment of the condom program by CNLS, USAID, and UNFPA
2. Action planning at the regional levels – were the plans finalized? Implemented? Did the national action plan integrate the provincial plans?
3. Did the studies done by POLICY and DELIVER (i.e. market segmentation and willingness to pay) help inform the development of the FP strategy?
4. Describe the process in which the national FP strategy was finalized. ex. Who was involved? How did organizations reach consensus?

In 2003 the government and its partners were promoting a number of strategies to increase the uptake of FP services by:

- making pills and condoms available in 100 percent of primary health care sites by the end of 2005
- expanding distribution through community-based distributors (*I think oral contraceptives are now distributed through community based agents. Were they not doing this before? why not?)*
- expanding access for youth through Ministry and FISA youth educators
- improving quality of services by providing standard guidance, training and equipment
- studying the role of Malagasy men in influencing the use of FP services (FISA)
- initiating an HIV/AIDS program for marginalized youth.
-

What is the status of each of these?

b) Influence of SPARHCS process and FP Strategy development:
Was the SPARHCS assessment report helpful when designing the FP strategy? (i.e. do you remember using it to get information about program strengths and weaknesses, etc.)

Did the SPARHCS Process help in gaining commitment from all sectors to participate?

Did the SPARHCS process contribute to successful arguments for funding?

Did the SPARHCS process contribute to problems in design or implementation or help resolve problems?

Was the SPARHCS process useful in developing an FP strategy?

2. Policy environment

Can you give me a very brief overview of how political commitment for FP has changed in the last 5 years.

In your opinion, how did the SPARHCS process influence the policy environment for FP?

Are there any materials that have been published that indicate changes in political support for FP? *(if so get copies)*

What led to the creation of a ministry of health and family planning and what is the significance of this change? Who was involved in making this change?

Which bodies demonstrate leadership responsibility for FP? (for example donors, MOH)? How has this changed in recent years?

Are there any policy champions or advocacy groups working to increase awareness of FP? Please describe.

How has structure of the FP program changed in recent years? Does this new structure support or undermine the goals of the FP program?

Have there been any changes to official health, population, and development policies at national and operational levels in the last 5 years that have influenced FP services and commodities? For example:

- increase in funding, creation of line items, subsidies from (Gov OR donors, client's financial participation)
- product quality, access or choice of contraceptives? introduction of a new product, a new brand?

Decentralization

Has decentralization helped increase or decrease attention to FP at the national level? Subnational level?

3. Collaboration and Coordination

Has there been a change in the way organizations collaborate on FP issues in the last 5 years, either formal or informal? (negative or positive)

- Among donors
- Within government
- Between donors and government
- Among service providers in different sectors
- Between government and service providers
- Between government and civil society organizations
- Among cooperating agencies

Did the working group that was formed to work on an FP strategy change the way organizations worked together?

I understand a number of coordination bodies (both informal and formal) have recently been formed. Could you please update me on the status including those listed below and others you can think of?

1. National population program
2. The partners' forum
3. health partners meeting
4. contraceptive task force
5. IEC task force? UNAIDs theme group? Other?

4. Repositioning Family Planning

Does the FP strategy link FP to other programs such as child survival, maternal health, adolescent RH or male involvement and to other sectors?

Apart from the national FP strategy and the creation of the Ministry of Health and Family Planning, are there any other initiatives in place to reposition FP either as an important component of RH or as an important national and international development issue?

For example, in the health sector:

- Advocacy efforts to promote joint FP activities with other donors, (EU, European and other bilaterals, private foundations, UNFPA, DFID, CIDA, KFW, World Bank)
- Increased attempt to link FP and child survival programming, eg. promotion of increased birth intervals, promotion of breastfeeding, etc.)
- Increased focus on promoting clinical contraceptive methods through updating of service provider skills , increasing number of sites offering clinical methods, changes in policies,
- Increased focus on adolescent FP programs, (ex. Top Reseau program by PSI, youth pair educators, formal education system)
- New or renewed focus on male involvement in FP

Is RH/ FP included in the PRSP? MDGs?

Were the FamPlan scenarios (Jean-Pierre Guengant) helpful in making the link between family planning and economic development in the country?

Describe how SPARHCS has helped to reposition FP in Madagascar's HIV/AIDS programs and policies.

- Has participation by CNLS in the SPARHCS process contributed to any changes in the way FP is integrated in HIV/AIDS services? Or vice versa?
- Are condoms for HIV/AIDS included in forecast projections for FP programs?

Are FP information and services an integral part of VCT and MTCT programs? When did this begin?

Communication and Advocacy Strategies

Has coverage of FP in the media changed in the last 5 years? Please describe.

Has the quality of information changed? (for example, in newspaper articles, mass media)

Has Madagascar developed an advocacy or communication strategy for FP?

Has Madagascar developed advocacy materials to reposition FP in the donor and international community? (ex. presentations, print material, etc.)

6. Finance

a) Funding Sources for FP

- Has national MOH funding for FP (not including WB loans) increased since 2002? Is this expected to change in the future?
- Has national MOH funding for FP through the World Bank loan increased since 2002? Is this expected to change in the future?
- Has donor funding increased? USAID? UNFPA? DFID? (use chart below if necessary)

Funding Source for FP	Before June 03	June 03	now	Future
National MOH (excluding WB loan)				
National MOH (including WB loan)				
UNFPA				
DFID				
USAID				
KFW				
Other Donor: _____				
Commercial (for profit) Sector				
NGOs (funding independent of donors)				
Other International Funding Sources:_____				
TOTALS:				

What percentage of the health budget is going to FP? How has this changed in recent years?

What percentage of the family planning budget is used for contraceptives? How has this changed in recent years?

Are government resources being focused on the poorest of the poor?

Has there been any attempt to reintroduce the cost-recovery system? (PFU) Describe.

Has there been any attempt to redistribute resources (material and financial) to districts on a more equitable basis?

b) Alternative Financing Mechanisms
Has there been any recent change in alternative financing mechanisms that cover FP? (move to cover certain methods under health insurance schemes, community financing schemes, etc.)

c) Current and Future Funding
Are the social marketing organizations and NGOs more or less dependent on donor subsidies than they were in 2002? Is this changing, and if so, how?

What are the government and donors doing to address the funding gap for FP?

7. Private sector involvement
Do you recall the involvement of the private sector in the SPARHCS workshop/process? (NGOs, commercial sector, providers, pharmaceutical companies etc.)

Did the private sector remain engaged in the activities after the initial SPARHCS workshop? (for example, were they present in the strategy development meeting, regional meetings, working groups etc.)

Have there been any policy changes that have improved the environment for private sector? Ex. Price controls, restrictions on distribution, taxes, duties, operational policies, brand advertising, etc.

What are some of the obstacles that hinder involvement of private sector today? Are these issues being addressed?

8. Other Questions:

A présent selon vous quelles sont les contraintes qui ont pu entraver certaines decisions, certains processus?

Selon vous quelles-sont les priorités à donner pour que la nouvelle stratégie nationale du Planning Familial soit mise en œuvre correctement et que les objectifs fixés soient atteints.

- Pour la Politique
- Pour la coordination
- Pour l'accessibilité physique et financière des services et des produits
- En ce qui concerne le financement (subventions d'Etat et des donateurs, participation des utilisateurs)
- Pour une meilleure information des familles, des femmes et des hommes sur le Planning Familial

In general, has the SPARHCS process helped to strengthen political support for FP in Madagascar ?

French

Questions pour guider les discussions sur le processus de Sécurité des Produits de la Santé Reproductive à Madagascar

Contexte

En juin 2003, un processus a été lancé à Madagascar pour y renforcer la Sécurité des Produits de la Santé Reproductive (SPSR). Dans ce cadre, une évaluation a été menée selon la méthodologie *Strategic Pathway to Achieving Reproductive Health Commodity Security*, connue sous le nom de SPSR dans le pays. A l'issue de cette évaluation, l'USAID a apporté une assistance technique au Gouvernement Malgache et à ses partenaires nationaux et internationaux pour préparer et mettre en œuvre une politique de Planification Familiale (PF).

Plus de deux ans après le début du processus, Madagascar a réalisé de grandes avancées en termes d'engagement des responsables gouvernementaux de haut niveau et en termes de mobilisation des appuis pour la PF et la SPSR. Si une grande partie de ces succès sont dus au changement politique qui se produit actuellement dans le pays, il n'est pas moins important d'étudier dans quelle mesure le processus SPSR a pu influer sur l'engagement politique et sur la planification du repositionnement de la PF à Madagascar. Constituer une base documentaire des résultats de cette étude est important pour les autres pays qui oeuvrent en faveur de résultats similaires actuellement.

Les questions suivantes seront utilisées pour guider les discussions sur les résultats du processus SPSR.

1. Evaluation des activités SPSR

a) Mise en œuvre de la version préliminaire du plan d'action SPSR

Dans le plan d'action d'une durée d'une année, un certain nombre d'activités ont été relevées comme étant prioritaires. Pourriez-vous me dire où nous en sommes actuellement avec ces activités ? Ont-elle été achevées ?

1. Evaluation du programme condom par le CNLS, l'USAID et le FNUAP
2. Elaboration de plans d'action au niveau régional : est-ce que les plans ont pu être finalisés ? mis en œuvre ? Est-ce que le plan d'action national a intégré les plans régionaux ?
3. Décrivez le processus qui a permis de finaliser la stratégie de PF – i.e. qui y ont pris part ? comment est-ce que les organisations sont arrivées à un consensus ?

En 2003, le Gouvernement et ses partenaires ont fait la promotion d'un certain nombre de stratégies pour augmenter l'utilisation des services de PF. Il s'agissait de :

- assurer la disponibilité du condom dans 100 pour cent des centres de santé de base à la fin de 2005 ;
- élargir la distribution à travers des réseaux de distributeurs à base communautaires (*Je pense que les contraceptifs oraux sont actuellement distribués par les agents communautaires. Est-ce que cela ne se faisait pas avant ? Pourquoi ?)*
- améliorer l'accès des jeunes à la PF par les éducateurs de jeunes du Ministère et de la FISA ;
- améliorer la qualité des services à travers des directives, des formations et des équipements standards ;
- étudier le rôle des hommes malgaches dans l'utilisation des services de PF (FISA) ;
- lancer un programme de VIH/SIDA pour les jeunes marginalisés.

Où en sommes-nous avec chacune de ces stratégies ?

b) Influence de la SPSR et élaboration de la stratégie PF

Est-ce que le rapport de l'évaluation SPSR a été vraiment utile pour l'élaboration de la stratégie PF ? (est-ce que vous souvenez d'avoir exploité le rapport pour vous informer sur les points faibles et les points forts du programme, etc.)

Est-ce que le processus SPSR a contribué à obtenir l'engagement de tous les secteurs à participer ?

Est-ce que le processus SPSR a contribué à offrir des arguments solides pour le financement ?

Est-ce que le processus SPSR a apporté des problèmes dans la conception et la mise en œuvre ou est-ce qu'il a contribué à résoudre les problèmes ?

Est-ce que le processus SPSR a aidé dans l'élaboration de la stratégie PF ?

2. Environnement politique

Est-ce que le rapport SPSR a été utile dans la conception de la stratégie PF ?(est-ce que vous souvenez en avoir tiré des informations sur les points forts et les points faibles du programme ?)

Selon vous, en quoi ou dans quelle mesure le processus SPSR a-t-il influé sur le cadre politique de la PF ?

Y a-t-il un ou des documents qui ont été publiés et qui témoignent de changements dans les appuis politiques à la PF ? (Si oui, demandez-en un exemplaire)

Qu'est-ce qui a amené à la création d'un ministère de la santé *et* du planning familial ? Quelle est la portée de ce changement ? Qui ont été impliqués dans ce changement ?

Quelles sont les entités qui assurent un leadership en matière de PF (par exemple, Ministère, bailleurs) ? Quels ont été les changements observés dans ce domaine ces dernières années ?

Existe-t-il des « défenseurs » de la politique ou des groupes de plaidoyer qui oeuvrent pour une plus grande prise de conscience par rapport à la PF ? Veuillez les décrire.

Quels ont été les changements observés dans la structure du programme de PF ces dernières années ? Est-ce que cette nouvelle structure va dans le sens du programme de PF ou est-ce qu'elle l'entrave ?

Y a-t-il eu ces cinq dernières années des changements dans les politiques officielles de santé, de population ou de développement au niveau national ou opérationnel qui ont eu une influence sur les services et les produits de PF ? Par exemple :

- accroissement des financements, création de nouvelles rubriques budgétaire, subventions (du gouvernement OU des bailleurs, participation financière des usagers)
- qualité des produits, accès aux contraceptifs, choix, introduction d'un nouveau produit, d'une nouvelle marque

Décentralisation

Est-ce que la décentralisation a contribué à accroître ou à réduire l'attention accordée à la PF au niveau national ? au niveau sub-national ?

3. Collaboration et coordination

Y a-t-il eu des changements dans la façon dont les organisations collaborent sur les questions de PF dans les cinq dernières années ? (ces changements peuvent être formels ou informels – négatifs ou positifs)

- au niveau des bailleurs
- au sein du gouvernement
- entre bailleurs et gouvernement
- au niveau des prestataires de services dans les différents secteurs
- entre le gouvernement et les prestataires de services
- entre le gouvernement et les organisations de la société civile
- entre les agences de coopération

Est-ce que la création du groupe de travail Stratégie PF a amené des changements dans la façon dont les organisations travaillent ensemble ?

Je crois savoir qu'un certain nombre d'organes de coordination formels et informels ont été créés récemment. Pouvez-vous me dire où ils en sont ? Je vais vous donner la liste des organes que je connais mais vous pouvez en rajouter si vous en connaissez d'autres.

1. Programme national de population
2. Le forum des partenaires
3. La réunion des partenaires de la santé
4. La task force Produits contraceptifs
5. La task force IEC ? Le groupe thématique d'ONUSIDA ? d'autres ?

4. Repositionnement de la planification familiale

Est-ce que la stratégie de PF met la PF en relation avec d'autres secteurs ou d'autres programmes comme la survie de l'enfant, la santé maternelle, la SR des adolescents ou l'implication des hommes ?

Mis à part la stratégie nationale de PF et la création d'un Ministère de la Santé et du Planning Familial, est-ce qu'il y a d'autres initiatives pour repositionner la PF en tant qu'une composante importante de la SR ou en tant que question de développement importante tant au point de vue national qu'international ?
Par exemple, dans le secteur santé :

- Efforts de plaidoyer pour promouvoir des activités conjointes de PF avec les autres bailleurs (UE, bilatéraux, fondations privées, FNUAP, DFID, CIDA, KFW, Banque mondiale)
- Renforcement des activités allant dans le sens d'une mise en relation de la PF et des programmes de survie de l'enfant (par exemple, promotion de l'espacement de naissances, promotion de l'allaitement maternel, etc.)
- Renforcement de la promotion des méthodes contraceptives cliniques à travers la mise à jour technique des prestataires de services, l'augmentation du nombre de sites offrant ces méthodes, des changements dans les politiques,
- Renforcement des programmes de PF ciblant les adolescents (par exemple, Top Réseau de PSI, pairs éducateurs, système éducatif formel)
- Renforcement de l'implication des hommes dan la PF.

Est-ce que la SR/PF figure dans le DSRP ? MDG ?
Est-ce que les scénarios du FamPlan (Jean Pierre Guengant) ont aidé à mettre la PF en relation avec le développement économique du pays ?

Dites comment la SPSR a contribué au repositionnement de la PF dans les programmes et les politiques de VIH/SIDA du pays.

- Est-ce que la participation du CNLS dans le processus SPSR a contribué à des changements en termes d'intégration de la PF dans les services de VIH/SIDA ? ou inversement ?
- Est-ce que les condoms pour la prévention du VIH/SIDA sont inclus dans les projections des programmes de PF ?
- Est-ce que les informations et les services de PF font partie intégrante des programmes de CTV et de PTME ? Quand est-ce que cela a commencé ?

5. Stratégies de communication et de plaidoyer

Est-ce qu'il y a eu des changements dans la couverture médiatique de la PF au cours des cinq dernières années ? Veuillez les décrire.

Est-ce que la qualité des informations a changé ? (par exemple, dans les articles de journaux, dans les mass médias)

Est-ce que Madagascar a élaboré une stratégie de communication ou de plaidoyer pour la PF ?

Est-ce que Madagascar a élaboré des supports de plaidoyer pour le repositionnement de la PF au niveau de la communauté des bailleurs et de la communauté internationale ? (par exemple, présentations, supports imprimés, etc.)

6. Aspects financiers

a) Sources de financement pour la PF

Est-ce que le financement de la PF par le MinSan/PF a augmenté depuis 2002 (crédits de la Banque mondiale exclus) ? Est-ce que l'on peut s'attendre à des changements dans ce domaine à l'avenir ?
Est-ce que le financement de la PF par le MinSan/PF par le biais des crédits de la Banque mondiale ont augmenté depuis 2002 ? Est-ce que l'on peut s'attendre à des changements dans ce domaine à l'avenir ?
Est-ce que les financements par les bailleurs ont augmenté ? USAID ? FNUAP ? DFID ? (Vous pouvez utiliser le tableau ci-après).

Sources de financement pour la PF	Avant juin 03	Juin 03	A présent	A l'avenir
MinSan/PF (crédits BM exclus)				
MinSan/PF (crédits BM inclus)				
FNUAP				
DFID				
USAID				
KFW				
Autres bailleurs : _____				
Secteur commercial				
ONG (financement indépendant des bailleurs)				
Autres sources internationales de financement				
Totaux				

Quel pourcentage du budget de la santé est affecté à la PF ? Quelles ont été les évolutions dans ce domaine ces dernières années ?

Quel pourcentage du budget de la PF est affecté aux produits contraceptifs ? Quelles ont été les évolutions dans ce domaine ces dernières années ?
Est-ce que les ressources de l'Etat sont allouées prioritairement aux plus pauvres parmi les pauvres ?
Est-ce qu'il y a eu des tentatives de rétablir le système de recouvrement de coûts (PFU) ? Veuillez décrire.
Est-ce qu'il y a eu des efforts pour redistribuer les ressources (matérielles et financières) vers les districts pour plus d'équité ?

b) Mécanismes alternatifs de financement

Quels sont les changements récents en ce qui concerne les mécanismes alternatifs de financement de la PF ? (passage à des programmes d'assurance médicale, programme de financement communautaire, etc.)

c) Financement actuel et à venir

Est-ce que les organisations de marketing social et les ONG sont actuellement plus ou moins dépendantes des subventions des bailleurs par rapport à leur situation en 2002 ? Quelles sont les évolutions dans ce domaine ?

Qu'est-ce que le gouvernement et les bailleurs font pour traiter de la question du manque à financer pour la PF ?

7. **Implication du secteur privé**
   - Est-ce que vous vous souvenez avoir relevé la participation du secteur privé dans les ateliers ou le processus SPSR ? (ONG, secteur commercial, fournisseurs, sociétés pharmaceutiques, etc.)
   - Est-ce que le secteur privé a continué à être impliqué dans les activités après l'atelier SPSR ? (par exemple, est-ce qu'il était représenté dans la réunion d'élaboration de la stratégie, dans les réunions régionales, les groupes de travail, etc.)
   - Y a-t-il eu des changements dans les politiques qui ont contribué à améliorer le cadre de travail du secteur privé ? (par exemple, contrôle des prix, restrictions sur la distribution, taxes et impôts, règlement opérationnel, marque et publicité, etc.)
   - Quels sont les obstacles qui entravent l'implication du secteur privé actuellement ? Qu'est-ce qui est fait pour résoudre ces problèmes ?

8. Autres questions

A présent selon vous, quelles sont les contraintes qui ont pu entraver certaines décisions, certains processus ?

Selon vous, quelles-sont les priorités à donner pour que la nouvelle stratégie nationale du Planning Familial soit mise en œuvre correctement et que les objectifs fixés soient atteints ?

- Pour la Politique
- Pour la coordination
- Pour l'accessibilité physique et financière des services et des produits
- En ce qui concerne le financement (subventions d'Etat et des bailleurs, participation des usagers)
- Pour une meilleure information des familles, des femmes et des hommes sur la Planification Familiale

De manière générale, est-ce que le processus SPSR a contribué à renforcer l'appui politique à la PF à Madagascar ?