Madagascar

Total Market Initiative Project

INCREASING PRIVATE SECTOR PARTICIPATION IN FAMILY PLANNING IN MADAGASCAR

Final Report
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This project is supported by Program for Appropriate Technology in Health (PATH). The purpose of the Subgrant # GAT.1291-08456-GRT is to support Marie Stopes International (MSI) in building support in the public sector for a total market approach to the procurement of contraceptives in Madagascar. The Project will help the Reproductive Health Supplies Coalition (RHSC) meet its goals to mobilize public-sector and total-market resources at the country level and foster greater harmonization among stakeholders at the country level.

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Acronyms

DHS: Demographic Health Survey (EDS)
3DS: District Health Development Department
AMIT: Inter-Enterprise Medical Association
CDS: Social Development Committee
CPR: Contraceptive Prevalence Rate (TPC)
CRESAN2: Crédit Santé 2
CSB: Health Centre
CHD I: District Hospital Office (level I)
CHD II: District Hospital Office (level II)
DAMM: Drug Registration Authority of Madagascar
DPF: Family Planning Department
DRS: Regional Health Authority
FISA: Fianakaviana Sambatra (IPPF affiliate)
GoM: Government of Madagascar
GTZ: Deutsche Gesellschaft fûr Technisch Zusammenarbeit
KMS: Kaominina Mendrika Salama (Healthy and Deserving Municipality)
MLD: Long term contraceptive method
MOH: Ministry of Health
MSI: Marie Stopes International
MSM: Marie Stopes Madagascar
NGO: Non Governmental Organisation
OSTIE: Tananarive Inter-Enterprise Health Organization
PATH: Program for Appropriate Technology in Health
FP: Family Planning
PHAGDIS: District Wholesale Pharmacy
PHAGECOM: Community-run Pharmacy
PPP: Public Private Partnership
PSI: Population Services International
RHSC: Reproductive Health Supplies Coalition
SAF/FJKM: Development Service /Madagascar Protestant Church
SALFA: Lutheran Health Service
SSD: District Health Authority
SSPSR: Office for Reproductive Health Products Security
TVA: Value Added Tax
UNFPA: United Nations Fund for Population Activities
USAID: United States Agency for International Development
VIH: Human Immunodeficiency Virus

Preface

Marie Stopes International, Futures Group and UNFPA/Madagascar jointly conducted an evidence-based Total Market Initiative in Madagascar, using Round 2 funding from the Innovation Fund. The eighteen-month collaborative effort aimed at advocating for a successful public-private partnership to increase contraceptive security and prevalence in Madagascar with special emphasis on vulnerable and poor populations.

Activities conducted under this project include a market segmentation analysis, a literature review, and a stakeholders meeting to discuss strategies and next steps. The primary output of this project is a documented advocacy strategy plan with necessary policy changes, effective market segmentation and increased role of the private sector following a total market approach.

The researchers used the most recent Madagascar Demographic and Health Survey and supplemented this survey by collecting quantitative and qualitative data with the help of Marie Stopes International/Madagascar.

Acknowledgements

This draft report is the result of work undertaken by Marie Stopes International (MSI) and Marie Stopes Madagascar, with technical advice and feedback from the Government of Madagascar Ministry of Health and Family Welfare, the Futures Group, USA, UNFPA/Madagascar as well as other stakeholders in Madagascar.

Our special thanks go to Dr. WANOGO Dotian Ali, UNFPA-Madagascar and Ms. Margot Fahnestock, formerly with the Futures Group. The authors greatly acknowledge their time, support, comments, and suggestions provided to help improve this study. The authors would also like to thank the Futures Group for contributing the DHS 2009 Analysis and Soumitro Ghosh, MSI Head of Integrated Marketing, for revising the executive summary on short notice. Any errors or omissions remain the responsibility of the authors.

Executive Summary

Madagascar's population has grown rapidly since the 1950s. In 1955, the population was 4.8 million; by 2005, it had reached 18.5 million. At the current fertility rate of 4.8 children per woman, the population will continue to grow exponentially, putting a strain on resources and hindering economic development.

In recognition of this need to address rapid population growth, the Government of Madagascar has shown strong commitment to family planning (FP). In September 2007, the Government declared that all contraceptives would be provided free of charge to clients in the public sector. This has resulted in some impressive gains: total fertility rates have decreased, contraceptive prevalence has increased, and unmet need has decreased. However, the recent policy change also calls into question the sustainability of these achievements. ***Expanding the role of the private sector (commercial, NGO and other non-profit organizations) in the provision of contraceptives could have a significant impact in ensuring contraceptive security in Madagascar over the long-term.***

OPPORTUNITIES FOR INCREASING THE ROLE OF THE PRIVATE SECTOR

The 2007 policy change has resulted in a number of challenges for the Ministry of Health (MOH) in ensuring contraceptive security. Although the Government has a line item for procurement of contraceptives, the overwhelming majority of contraceptives are provided by donors. In addition, district authorities are still obligated to cover the costs of transporting contraceptives to health facilities but no longer have the funds to cover the costs, putting districts at risk of stockouts.

Figure 1:
Private Sector Contribution Has Shrunk as a Proportion of Total FP Market Share

Source: 2004 and 2009 Madagascar DHS Data

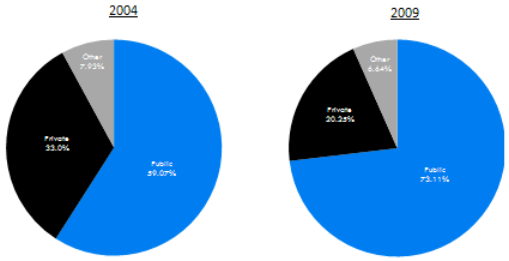
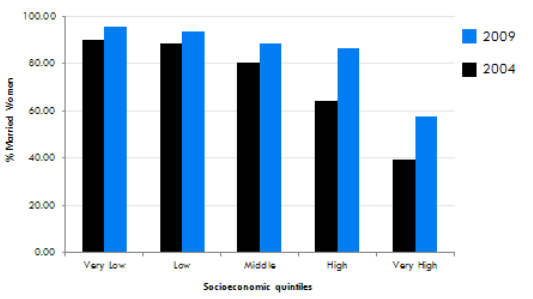


Figure 2: Public Sector Use for Injectables Increased among Higher Socioeconomic Groups

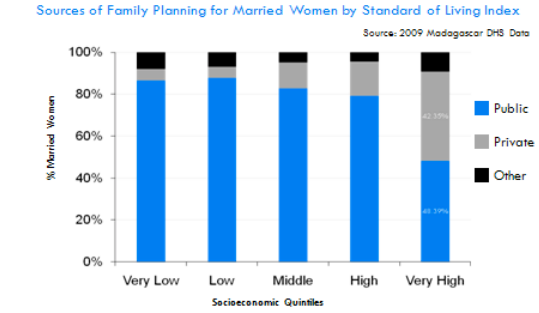
Source: 2004 and 2009 Madagascar DHS



In the past, the private sector contributed to over 1/3 of the total FP market share. The introduction of free contraceptives in the public sector has resulted in a decline in sales of contraceptive products in the commercial sector and a decline in distribution by private sector providers, resulting in greater reliance on the limited public sector resources (see Figure 1). The current situation in Madagascar presents a unique opportunity for the MOH to reengage the private sector in supporting the Government to reach its FP targets and ensure contraceptive security. Indeed, data from the 2009 Demographic and Health Survey show a clear role for the private sector in the FP market.

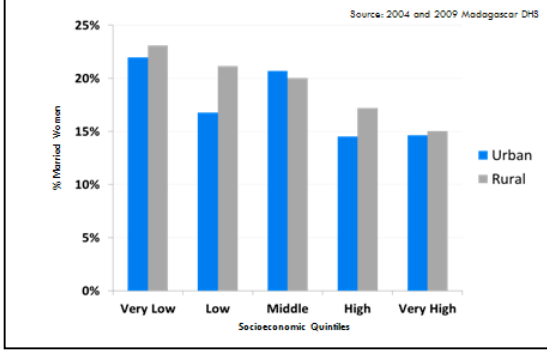
Clients who can pay use contraceptives provided by the public sector. With the introduction of free contraceptives in the public sector, the use of injectables—the most popular FP method—has increased in every socioeconomic group (see Figure 2). This growth is most dramatic in the two highest socioeconomic groups. Indeed, as Figure 3 shows, the public sector provides 48% of contraceptives for the highest socioeconomic group. Clients in the highest socio-economic groups could be targeted by the private sector, conserving public sector resources for those most in need.

Figure 3: Public Sector Still a Prominent Source in Highest Socioeconomic Groups



Unmet need for FP persists across all socioeconomic groups. Despite the introduction of free contraceptives in the public sector, there is still persistent unmet need across all groups—including among the highest socioeconomic groups, who could be targeted by the private sector.

Figure 4: Unmet Need Across All Socioeconomic Groups



CHALLENGES TO PRIVATE SECTOR EXPANSION

The private sector faces a number of challenges to entry in the FP market. These challenges must be taken into consideration in developing a plan to increase private sector participation.

Taxes on contraceptives: Under the current system, donors with bilateral agreements with the Government of Madagascar are exempt from taxes on FP commodities, but NGOs without such agreements are not, discouraging private sector participation. In addition, these taxes raise the prices of contraceptives in the private sector, decreasing demand and affecting contraceptive prevalence.

Public sector contraceptives are free: That public sector contraceptives are free discourages the scaling up of commercially-priced products. However, with targeted social marketing initiatives, the private sector can still be successful.

Inadequately segmented market: To appropriately target public sector resources to those who need them and private sector products to those who can pay for them, the MOH must understand how the market is segmented. This includes identifying current private sector contributions to FP, which are currently not disaggregated in national results.

ACTION PLAN FOR THE MINISTRY OF HEALTH

What are some steps the MOH can take towards improving contraceptive security through increasing the role of the private sector in the provision of contraceptives? Below are recommendations that were shared and agreed upon at an October 26, 2010 workshop with stakeholders from the MOH, Ministry of Finance, donor agencies and the private sector. The Total Market Initiative (TMI) Technical Advisory Group (TAG) will continue to provide support and guidance to the MOH in developing and implementing a detailed advocacy action plan for these recommendations.

Recommendation	Actions
Strengthen public-private partnerships (PPP).	• The MOH will invite TAG representatives to meet with the MOH Partnership Director to develop an action plan for strengthening PPP based on the recommendations made at the October 26 workshop. • The Partnerships Director will organize a regular meeting with FP NGOs to discuss ways to strengthen PPP. • The TAG will support the Partnerships Director to finalize a formal policy paper on PPPs for FP services.
Segment the market to appropriately target clients with public and private sector resources.	• The MOH must define the reporting systems required from FP NGOs. • Based on the TMI study and NGO activity reports, the TAG (including the MOH) will identify gaps in the current market segmentation to determine where to target and how to utilize public and private sector resources. The MOH will decide on a timeline for regular reporting on market segmentation so that resource targeting is adjusted as needed. • The MOH will work with NGOs providing FP to collect activity reports on a monthly basis so that they can be utilized by the MOH to determine gaps in market segmentation.
Remove taxes on contraceptives.	• The MOH Director of Safe Motherhood (DSM) will analyze the impact of taxation policies on contraceptive costs and Government revenue and develop recommendations to take to the Ministry of Finance. • The MOH (DSM) will meet with the Director of Finance and Budget to propose a law amendment and discuss the way forward (for example, aligning the definition of tax-exempt medicines with the MOH definition).
Promote social marketing initiatives.	• Prior to the Council of Ministers meeting, the Director of Safe Motherhood will frame the design of a draft social marketing policy. • The MOH will disseminate TMI results at the Council of Ministers meeting before end of 2010 to demonstrate the role of the private sector and potential for social marketing.
Increase public sector funding for contraceptive procurement and transportation to strengthen total market approaches.	• The MOH (DSM) will develop an action plan that outlines how increased public sector funding will facilitate total market approaches for FP. • The DSM will present an advocacy brief to the Director of Finance and Planning, for the MOH. • The MOH will develop objectives for funding – including line items for transportation costs related to supply of contraceptives to the CSB-level – that are in compliance with Ministry of Finance and Budget formats.

Chapter 1: Project Background, Objectives and Activities

Based on documented evidence collated by the proposed consortium consisting of Marie Stopes Madagascar (MSM), a clinical program of Marie Stopes International, the Futures Group, and the UNFPA country office in Madagascar, Madagascar has made impressive progress in promoting reproductive health and family planning. The Demographic Health Survey (DHS) shows modern method contraceptive use increased from 5.1% in 1992 to 18.3% in 2003. In addition, the Government of Madagascar's (GoM) national strategy has an objective of reaching 28% modern method prevalence by 2009. Since 2002 the GoM has shown strong commitment and demonstrated leadership in family planning and reproductive health. A Strategic Pathway to Achieving Reproductive Health Commodity Security Assessment conducted in 2003 resulted in a national family planning strategy. This strategy included policy and operational changes that increased collaboration between the public and private sectors, facilitated establishment of public-private-partnerships (PPP) in the procurement and distribution of contraceptives, and actions on the part of the public sector to target the distribution of free contraceptives. This represented the beginning of a targeted approach for improving contraceptive security by increasing the role of the private sector, including a sharing of costs by the public and private sector.

In 2007 the GoM changed course and determined that all public sector contraceptives were to be provided for free. Anecdotal evidence suggests that this action resulted in a decline in sales in contraceptives in the commercial sector and a decline in distribution by private sector providers. Currently, donors provide most of the contraceptives in Madagascar. The GoM has a line item in the health budget to procure contraceptives. While this represents a noteworthy achievement, it does not generate sufficient funding to meet the needs of the country. Reaching the objective of a 28% modern method contraceptive prevalence rate (CPR) will require significantly more resources on a sustainable basis. Prior to the 2007 decision, district authorities sold contraceptives on a cost-recovery basis. The money collected went into a fund used to cover the transport costs of the contraceptives from the central medical stores. A USAID-funded study into operational barriers to contraceptive security, conducted in December 2008 by JSI/Deliver and Futures Group HPI (Futures), found that with the loss of this income, district transport funds are close to depletion. This fund depletion could result in stock-outs of contraceptives at the point of service delivery. Another issue identified is that some districts had been using their previous income to procure contraceptives from social marketing organizations to avert stock-outs. The current situation in Madagascar points to a contraceptive supply that is highly vulnerable, but is one that offers an opportunity to influence policy change and increase the role of the private sector in meeting this challenge.

Though Madagascar's family planning program has been successful, showing significant increases in modern method CPR, the 2003/2004 DHS indicate significant disparities between rural and urban areas, by education levels and among different socioeconomic groups. According to PRB's 2008 World Data Sheet, 24% of married women in the richest quintile and only 2% of married women in the poorest quintile are using modern contraception. Unmet need is estimated at 25.6%. At the same time, a market segmentation study in Madagascar carried out by Futures in 2004 found that 25% of women accessing services from the public sector and 56% of women accessing subsidized services

from non-governmental organizations (NGO) were in the highest income segments. This information clearly indicates a gap in service provision to poorer women. Early indications of the results of the 2007 policy change make it reasonable to conclude that these disparities are regrettably increasing.
This proposal application is for an evidence-based advocacy project. When submitted in the previous round the proposal evoked valid concerns over the relevance of the project under the rapidly changing political situation in Madagascar from the review committee. The consortium, after consulting several partners in-country including the Ministry of Health and UNFPA, has established that major technical departments of the government are functioning and district-level resource personnel are not expected to change even with further political instability. Therefore, it will still be possible to implement and complete the project in a timely manner. The proposed market segmentation/equity analysis, which will provide essential input into the subsequent policy dialogue and advocacy efforts, is contingent on the availability of data from the 2008-2009 DHS. Thus, delays in finalizing the data collection under the DHS will inevitably result in delays in the implementation of the current proposal. MSM activities and partnership initiatives with government officials have been largely unaffected throughout the political crisis. However, appropriate risk management is needed to ensure project delivery in the light of further eventualities. As such, the project time frame is revised from originally proposed 9 months to a 15 month period, project start-up will coincide with the availability of DHS data, and a partnership with UNFPA is developed to complement and reinforce the consortium's advocacy capacity.

Project goal and objectives

Overall Goal

The goal of the project is to build support in the public sector for a total market approach to the procurement of contraceptives in Madagascar (Focus Area 1.1 and 3.2).

Objectives:

1. Demonstrate how increasing the role of the private sector can contribute to GoM's goal of increasing modern method CPR while reaching more of the country's vulnerable and poor populations, thus reducing disparities in family planning access.

2. Influence the political, programmatic, and country scene through the promotion of Total Market approaches through the sharing of relevant primary and secondary data from in country and global experiences.

3. Update and expand market based evidence prior to the 2007 contraceptive policy change and afterwards to influence proposed policy modifications.

Project activities

Summary of activities performed and results:

Date	Activities	Results
December 2009	Terms of Reference (TDR) preparation and tasks planned for MSM and Futures Group (meeting made by MSM and UNFPA).	- TDR developed with task distribution between MSM and Futures Group; - Contract Futures Group developed and signed; - Authorisation received from the Ministry of Health.
January 2010	- Development of questionnaires concerning market segmentation and equity achieved inquiry (for NGO, FP service providers, FP distributors and FP services in the Ministry of Health); - Organisation and realization of the inquiry by MSM.	- Questionnaire for data collection; developed, multiplied and distributed to stakeholders (16 institutions); - Data collection completed.
February - March 2010	- Survey on PF political change in Madagascar; - Arrival in Madagascar of Technical Advisors from MSI and Futures Group; - Organization and facilitation meetings held with the target FP stakeholders.	- TAG meeting with representatives of UNFPA, MoH Department of Safe Motherhood and Child Health, Taxation Directorate, FARMAD, Santénet2, USAID, PSI, ordre des pharmaciens, ordre des médecins, ordre des sages-femme; - Report and survey completed and made available by Futures Group concerning FP policy change.
April – mey 2010	(Technical Advisor Group) - Preparation of the first TAG meeting; - Realization of the TAG meeting.	- Meeting of TAG members conducted on 20 May 2010 (18 institutions represented, 45 participants at the meeting); - The TAG TDR is developed and validated.
July-August 2010	- Preparation and Presentation to the TAG members of the market segmentation and equity survey results produced and directed by MSM; - Share the first draft of the survey results during the meeting.	- Document partagé et présenté durant la réunion des membres du TAG à l'enceinte de l'UNFPA (02 August 2010).
August 2010	- Analysis of market segmentation and equity based on DHS data by Meghan Bishop of Futures Group; - Report-writing on the compilation of the results of the two surveys conducted by MSM and Futures Group; - Preparation for results dissemination.	- Report of the two surveys compiled by MSM.

September 2010	- Meeting with the TAG members for sharing the compiled document and collecting of their feedback.	- Meeting made at the MSM office on the 02 of September 2010. 10 TAG members were present).
October 2010	- Presentation of the study results during meeting of reproductive health partners organized by the Ministry of Health / Department of Safe Motherhood.	- A powerpoint prepared by MSM and presented by Dr Lucie Ramanandraibe, (expert on Reproductive Health – UNFPA) during the meeting of Reproductive Health partners on the 8 October 2010 (under the leadership of the MoH).
October 2010	- Preparation of the official final results dissemination of the study; - Soumitro Ghosh (MSI) and Meghan Bishop, Senior Policy Advisor (Futures Group) arrival for the official dissemination; - Group work with TAG members during the official dissemination workshop to complete development of the advocacy document.	- Official Dissemination conducted the 26 of October 2010 with the patronage by the Minister of Health; - Minutes of the meeting available; - Advocacy document finalised, made available and disseminated.
December 2010	- Advocacy document presented during the Reproductive Health coordination meeting organised by the MoH.	- Powerpoint prepared by MSM and presented by UNFPA (Dr Lucie Ramanandraibe).

Family Planning Environment in Madagascar

Since 2002, the Government of Madagascar has demonstrated a strong commitment to reproductive health and family planning. In 2003, Madagascar adopted its first National Strategy for Family Planning, with a goal to reach a contraceptive prevalence rate of 29.2% by 2008. This strategy included political and operational changes that helped improve collaboration between public and private sectors and facilitated the establishment of a public-private-partnership (PPP) in the purchase and distribution of contraceptives. In this sense, this strategy represented the beginning of a targeted approach to improve contraceptive security by increasing the role of the private sector, including cost sharing by the public and private. As a result, Madagascar saw great improvement in FP indicators, including an increase in the use of modern contraceptive methods increased from 5.1% in 1992, 18.3% in 2003 to 29.2% in 2008.

In 2007, demonstrating further commitment to improving FP, the Malagasy government declared that all contraceptives be provided free of charge to all clients served by the public sector. However, this action has resulted in some unintended negative impacts, especially for the private sector. For example, this policy change has resulted in a decline in sales of contraceptive products in the commercial sector and a decline in the distribution of contraceptives by private sector suppliers.

The Government faces several challenges to sustaining and improving upon contraceptive prevalence. Although the Government created a budget line for procurement of contraceptives, the bulk of public sector procurement is done by the donors. Prior to the 2007 policy change, authorities at the district level used a cost-recovery system to cover their cost of transporting contraceptives from the central warehouse to the district health service delivery points. District authorities charged a nominal fee on contraceptives, commensurate to the cost of transportation. However, a December 2008 USAID study on operational barriers to contraceptive security showed that with the policy change districts no longer have funds to the transportation of contraceptives, increasing the risk of product stock outs at delivery service points

Although contraceptive prevalence in Madagascar has steadily increased, thanks to the favorable FP policy environment, DHS data (2003/2004) demonstrates significant disparities in the use of modern contraceptive methods between rural and urban areas, levels of education and different socioeconomic groups. According to the World Population Reference Bureau (PRB) 2008 datasheet, 24% of married women in the highest wealth quintile and only 2% of married women in the lowest wealth quintile use modern contraception. Unmet need for family planning was estimated at 25.6% across all quintiles.

In addition, a study conducted by Futures Group in 2004 indicates that the FP market is sub-optimally segmented: 25% of women in the highest wealth quintiles were accessing public sector FP services and 56% were accessing services subsidized by non-governmental organizations (NGOs). This context suggests that the private sector could play a greater role in contraceptive distribution and provision of FP services to reduce disparities and to reduce reliance on the public sector by clients who can afford to pay for private sector services and products.

Market Segmentation Analysis Objectives

In line with the Government of Madagascar's efforts to address the issue of contraceptive security in the country, the MSI led consortium advocate a participatory process aimed at identifying appropriate roles for public, NGO, and commercial sectors in providing family planning products and services. The first objective of the market segmentation analysis, explained in more detail in this report to help identify opportunities for improving resource allocation in family planning in favour of promoting contraceptive security. Second, the analysis will serve as the common information source that feeds into the dialogue process among stakeholders. Finally, the market segmentation analysis and the accompanying dialogue process can facilitate collaboration among key stakeholders from public and private sectors.

Intended Use of Market Segmentation Analysis in Madagascar

The market segmentation analysis is supporting the policy process to improve resource allocation by addressing the contraceptive security challenge in Madagascar. This final report has been shared with key stakeholders from the public and private sectors; and has stimulated discussions about their respective roles, information needs, and interests in specific market segments.
The feedback obtained from stakeholders during the October 2010 market segmentation workshop has helped tailor the analysis to address specific information needs, and has also identified potential opportunities for each sector in particular for the private sector.
This final report should inform subsequent discussions among stakeholders about appropriate strategies to improve efficiency and effectiveness of the national family planning program. This collaborative approach will facilitate identification of appropriate roles for the public and private sector, allowing each sector to maximize its contribution and impact.

Applying Market Segmentation Analysis

Definitions

Market segmentation analysis is a useful analytic tool for donors, governments, and other stakeholders that are striving to achieve greater contraceptive security through a more efficient and effective allocation of resources. In its broadest sense, market segmentation analysis refers to the process of using survey data and statistical analysis to divide the reproductive health market into subpopulations whose reproductive health needs, characteristics (including ability to pay), or practices might require distinct service delivery or marketing strategies. Typically, a market segmentation analysis of the family planning market will include an examination of contraceptive

users by method, method source, and economic status (e.g., income quintile). By using that information, it will be possible to determine the extent to which the family planning market is *well-segmented*; that is, whether the contraceptive sources used by different economic groups are consistent with an efficient use of public and private resources.

Market Segmentation as a Policy Tool

In many countries, a limited resource for family planning is a primary obstacle to contraceptive security. Sources of funding for family planning include government, donors, and the private sector. The GOM contributes significantly to the national family planning program. What is the GOM's ability to meet the increased funding required as both contraceptive demand rises while donor funding decreases? Donor funding for contraceptives is declining. This means that the private sector needs to contribute significantly to meet the funding gap. In Madagascar, as in most developing countries, virtually all private sectors spending for family planning comes from households. The challenge is to increase payments from households without putting an unfair burden on the poor families of Madagascar. Therefore, an efficient use of resources means that payments from households reflect what those households are able to pay, as a way to maximize private sector resources. Such segmentation, however, requires coordination among public and private sector stakeholders.

When used as a policy tool, market segmentation analysis creates opportunities for various public and private sector stakeholders to coordinate their efforts to meet the country's family planning needs. This assumes greater significance in a resource scarce environment where such coordination is a necessity for achieving national program objectives. Given the different objectives of the public, NGO, and commercial sectors, it should be possible to identify each sector's complimentary roles in providing family planning products and services in a given country. In most countries, the initiation of the process inevitably coincides with planned donor phase out or an expected decline in donor supplied free contraceptives. However, several factors are important in implementing such a collaborative process that involves all the key stakeholders. Some key factors include continued commitment by the MoH to involve private sector stakeholders, existence of distinct market segments, and willingness of the private sector to invest resources needed for serving its target population.

It is important to recognize that with the growing demand for family planning in the country, a well segmented market will not necessarily reduce the role of any particular sector. In fact, the proposed collaboration will enhance the overall impact of the national family planning efforts and will enable efficient and equitable targeting of resources. This market segmentation analysis will provide data to key stakeholders to help them better understand the socioeconomic, demographic, and behavioural profile of the target population in terms of—

- use of contraceptive method mix
- use of contraceptive supply source mix
- unmet need for contraceptives
- reasons for non-use of contraceptives

Market Segmentation Methodology

Data

The present study relies on data from the Madagascar Demographic and Health Survey (DHS) 2009.

Wealth Index

The authors used the asset-based wealth index developed by ORC Macro and the World Bank to classify currently married women of reproductive age according to socioeconomic status.

The wealth index was developed explicitly for use with DHS data sets to compute a standard of living index for each woman in the DHS data set (Gwatkin 2000). The asset or wealth information is gathered using the DHS household questionnaire with questions typically posed to the head of the household concerning the household's ownership of a number of items, such as a fan, television, and car; dwelling characteristics that are related to wealth status, such as flooring material, wall material, and roofing material; type of drinking water source; type of toilet facilities; and other characteristics, such as electricity in the home.

A weight or factor score generated through principal component analysis is assigned to each household asset for which information was collected through the DHS. The resulting asset scores are standardized in relation to a standard normal distribution, with a mean of zero and a standard deviation of one. Each household is assigned a score depending on whether or not the household owns particular assets included in the asset index. The sample is then divided into population quintiles—five groups with approximately the same number of households in each group, with the first quintile being the poorest and the fifth quintile representing the wealthiest.

Analysis of Data

The family planning market can be segmented in a variety of ways, and there is no *best* approach. In this preliminary report, we used cross-tabulation to segment the family planning market, primarily along socioeconomic and geographic lines.

Chapter 2: Family Planning Policy Environment and Market Structure in Madagascar

Based on documented evidence collated by the proposed consortium consisting of Marie Stopes Madagascar (MSM), a clinical program of Marie Stopes International, the Futures Group, and the UNFPA country office, Madagascar has made impressive progress in promoting reproductive health and family planning. The Demographic Health Survey (DHS) shows modern method contraceptive use increased from 5.1% in 1992, to 18.3% in 2003, to 29.2% in 2008. The GoM's national strategy has an objective of reaching 28% modern method prevalence by 2009. Since 2002 the GoM has shown strong commitment and demonstrated leadership in family planning and reproductive health. A Strategic Pathway to Achieving Reproductive Health Commodity Security Assessment conducted in 2003 resulted in a national family planning strategy. This strategy included policy and operational changes that increased collaboration between the public and private sectors, facilitated establishment of public-private-partnerships (PPP) in the procurement and distribution of contraceptives, and actions on the part of the public sector to target the distribution of free contraceptives. This represented the beginning of a targeted approach for improving contraceptive security by increasing the role of the private sector, including a sharing of costs by the public and private sector.

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women accessing services from the public sector and 56% of women accessing subsidized services from non-governmental organizations (NGO) were in the highest income segments. This information clearly indicates a gap in service provision to poorer women. Early indications of the results of the 2007 policy change make it reasonable to conclude that these disparities are regrettably increasing.

The Policy Environment for Family Planning in Madagascar

Madagascar's national vision is to become a prosperous nation, with a high growth economy and a strong role as a competitor in the global marketplace. To achieve this status in the global economy, Madagascar understands that it must pay special attention to population growth and its negative impact on economic development and prosperity. Madagascar's population size has grown rapidly since the 1950s. In 1955, the population was 4.8 million; by 1985, the population had ballooned to 10.4 million. Twenty years later, in 2005, Madagascar's population had reached 18.5 million people; experts predict that that number will reach 78 million by 2050 at the current fertility level (4.8 children per woman according to the 2009 Madagascar Demographic and Health Survey).

Even with rapid population growth, Madagascar's family planning program has been highly successful; undoubtedly the population would have grown faster than it did in the last 10 years if the country had not made great strides in improving access to family planning services. The 1997, 2004 and 2009 Madagascar Demographic and Health Surveys (DHS) show that use of all contraceptive methods increased significantly from 19.4 percent to 27.1 percent to 39.9 percent of all married women of reproductive age. Madagascar's CPR is still relatively low, however, when compared with other sub-Saharan African countries. The Government of Madagascar expects that, given its recent efforts to strengthen and prioritize family planning, CPR among currently married women will continue to increase.

History of Family Planning Policy in Madagascar

In 1967, seven years after Madagascar gained independence, an affiliate of International Planned Parenthood, called Fianakaviana Sambatra (FISA) began offering family planning services. Despite the early availability of family planning services in the private sector, Madagascar's public sector family planning program wasn't created until 1986. In 1990 the country developed and adopted the first national Population Policy. The government further strengthened the family planning program with the development of norms, standards and guidelines for family planning services in 1992 and a national Reproductive Health Policy in 1993.

Beginning in 2002, Madagascar's government began to place a high priority on family planning to help address population growth. In fact, in January 2004, the Ministry of Health changed its name to Ministry of Health and Family Planning (MOHFP). The name change demonstrated the high level of political commitment to family planning. By December 2004, the ministry had launched its first National Family Planning Strategy for 2005–2009 and adopted a repositioning family planning initiative to increase demand for and access to family planning services and reduce the high unmet need for these services (23.6 percent of all married women expressed an unmet need for family planning services according to the 2004 DHS; in 2009 this number has decreased to 18.9 percent). In

September 2006, the Ministry began efforts to reposition family planning in Madagascar in view of the country's development plan, the Madagascar Action Plan (MAP). The ministry introduced the Plan Sectoriel en Planning Familial 2007–2012 (Sectoral Plan for Family Planning) in order to achieve the MAP's objectives through increased family planning. The ministry also created an Executive Secretariat for Family Planning within the ministry and a Family Planning Steering Committee.

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

These policy efforts have paid off for Madagascar: the country reported only 2 percent stockout rates for injectable contraceptives at service delivery points in 2007. Many stakeholders in Madagascar propose that the PAIS initiative greatly improved warehousing and distribution of all essential medicines, including contraceptives. In 2008, there were no stockouts reported for injectable contraceptives at service delivery points at the district level.f Injectable contraceptives continue to be the most popular modern contraceptive method (61% of all married women using modern contraceptives used injectable contraceptives, according to the 2009 DHS); thus, a low rate of stockouts is critical to maintaining a strong family planning program.

The Ministry coordinates forecasting and procurement of contraceptives through a logistics committee. For coordination issues regarding the family planning program, the Ministry hosts a family planning steering committee that consists of donors, implementing partners, nongovernmental organizations, Government and pharmaceutical industry members. As a commitment to the important of family planning in Madagascar, the Ministry has a budget line item to purchase contraceptives. Even though the amount is much smaller than the contribution from donors, the Government makes an annual government allocation of funds for contraceptives.

Public Sector Sources of Contraceptives

Since the September 2007 policy decision, women have been able to obtain all contraceptive methods free of charge. At the central level, Madagascar's central medical stores, SALAMA, procures and distributes essential medicines to the district level. SALAMA was created in 1996 to implement provisions of the Bamako Initiative. Madagascar's health system is decentralized, with seven health regions, 111 districts, and more than 1,597 communes within those districts. At the district level, women can obtain contraceptives at the Pha-G-Dis, or district pharmacy that is typically managed by an NGO; at the commune level, women can obtain contraceptives at the centre de santé de base (health center) that has a Pha-G-Com or pharmacy based at the health center. The public sector system provides injectable and oral contraceptives, intrauterine devices, spermicide, and CycleBeads. While condoms are available at the Pha-G-Dis and Pha-G-Com levels, the national family planning program does not consider them a family planning commodity. The study team learned that condoms

[f] SanteNet I Project, Public Sector Contraceptive Stockout Surveys for 2006, 2007, 2008.

are handled by the National AIDS Control Committee (Comité National de Lutte Contre le SIDA—CNLS) separately from the family planning commodity supply chain.

In 2007, the Programme d'Action pour l'Integration des Intrants de Sante (PAIS): Plan Strategique 2008 – 2012 was launched based on principles in the Madagascar Action Plan (MAP) and the Plan de Developpement du Secteur Sante et de la Protection Sociale (PDSSPS). The PAIS was meant to integrate commodities Madagascar's multiple distribution systems to avoid overstock, multiple logistics systems. Family planning was one of the first programs (along with STI treatment) integrated into the SALAMA procurement and distribution system. PAIS was also meant to control prices across the country – cites as on the benefits the opportunity to have the same product available for the same price across the country.

The PAIS also reinforced the FANOME system (Financement pour l'Approvisonment Non-stop en Medicaments), a system at the community level to which users participate financially created in 2004 to consolidate the Participation Financiere des Usagers (PFU) put in place in 1998 – this must be the cost recovery system for essential medicines. In 2005, Madagascar also created an equity fund for financing services for the poorest of the poor, funded by a portion of receipts from the FANOME system. Unfortunately, no strategy currently exists to best target the resources in the equity to the neediest.

Private Sector Sources of Contraceptives

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

Marie Stopes International's local affiliate, Marie Stopes Madagascar (MSM), has 15 clinics across the country that provide maternal and reproductive health services, including family planning. MSM has operated in Madagascar since 1992 and is known for increasing access to long-term and permanent family planning methods through an additional 11 mobile clinics with trained doctors and nurses who work through rural community health centers. In addition, MSM manages a social franchise of approximately 100 private reproductive health providers under the BlueStar brand. MSM obtains its contraceptive commodities from Marie Stopes International and directly from district health authorities.

The International Planned Parenthood Federation also has a local affiliate in Madagascar, called Fianakaviana Sambatra (FISA). FISA has operated in Madagascar for 45 years and as mentioned earlier was the first nongovernmental organization in Madagascar to provide contraceptives and family

planning services. Through its several clinics, FISA provides family planning services, treatment of sexually-transmitted infections, HIV testing and counseling, and post-abortion care. The organization does charge a small fee for contraceptives and family planning services and gets its commodities from the International Planned Parenthood Federation as donations, FARMAD, the central medical stores, PSI, and other sources.

Despite their contributions to increasing access to family planning in Madagascar, neither PSI nor FISA has tax-exempt status for importing contraceptives into Madagascar. USAID and United Nations agencies are both exempt from taxes for all pharmaceuticals, including contraceptives, imported into the country. Currently, PSI and FISA rely on their donors to pay the import taxes for any commodities imported into Madagascar. With different tax treatment between the public and social marketing sectors, organizations such as PSI may be required to account for this tax payment in the cost of their products. Only commodities imported for the Red Cross, organizations for orphans and vulnerable children and other nongovernmental organizations are free of duties and import taxes at the decision of the Director General of Customs.

Community-based Distribution of Contraceptives

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

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

The source for commodities for the community-based distribution program has changed to accommodate the new environment for development aid after the coup. Currently, USAID works closely with SanteNet2, PSI and local nongovernmental organizations to use private sector distribution channels to resupply the CSBs with contraceptives for community-based distribution.

Policies that Affect Family Planning Commodities

1. Plan d'Achat
2. Tax codes (Arrete from Ministry of Finance)
3. Purchasing permission for private sector from SALAMA (arête from MiniSante)

Taxes

- OPHAM pays a tax à l'importation (import/duty tax); the Government made a policy decision in 2007 to tax condoms and contraceptives (though FARMARD reports that this decision was made in 2005); the pharmacies heavily protested this policy, and now there's a government "tolerance" for not paying this tax.
- In the current system, for those donors such as UNFPA and USAID that have bilateral agreements with the Government of Madagascar to exempt them from taxes, the Ministry of Health must pay the Ministry of Finance for duty/customs taxes for family planning commodities. For those organizations (MSI, FISA) that import family planning commodities without a bilateral agreement, this taxation and barriers at the port in Tamatave can pose serious challenges.
- UNFPA even had challenges in 2009 when a stock of family planning commodities was stuck at Tamatave for six months because the Ministry of Health could not pay the tax amount to the Ministry of Finance. There were stockouts resulting from this shipment delay in three or four districts.
- Both UNFPA and SALAMA mentioned that they've been trying to advocate to the government that contraceptives be exempt from import duties/customs – this obviously hasn't been successful yet.

Transportation

- UNFPA is planning to conduct a study on the impact of transportation costs and logistics on the distribution system for family planning commodities in the public sector in Madagascar. What are the key problems and challenges?
- UNFPA is considering bringing family planning commodities all the way into the country and depositing them centrally at SALAMA (UNFPA may even reinstate some regional drugs deports for the public sector).
- UNFPA suggested to the Ministry that it pays for transport of family planning commodities to district and commune levels – this proposal hasn't yet been accepted.
- By contrast, the USAID SantéNet 2 Project – which works directly at the community level with community agents linked to public and private sector supply points for commodities – believes that "transportation is a non-issue" and "the [distribution] system is working".
- SALAMA contends that the problem of stockouts in the country has primarily been caused by delivery problems to the central level – which may be solved temporarily if UNFPA is successful in bringing commodities all the way to SALAMA, instead of to the port.
- UNFPA is also planning to incorporate private sector contraceptive logistics and distribution in a ''channel survey''.

District Purchasing

- Private sector providers and nongovernmental organizations are allowed to purchase contraceptive commodities directly from the PhaGDis (district pharmacy) level for all products that are not socially marketed (e.g., implants).
- UNFPA and others (including FISA), however, have been trying to advocate to the Direction of Family Planning that private sector organizations and NGOs should be able to obtain these products at the PhaGDis free of charge and sell them to consumers for a highly-subsidized price.

Government Purchasing

- The government's share of direct funding for contraceptive commodities is diminishing, though the Vice Primature (Ministry) of Health is still making an effort to provide its own funds for purchasing family planning commodities.
- In 2007 and 2008, the Ministry of Health and Family Planning purchased injectable contraceptives (DMPA called Petogen); in 2009, the Ministry purchased spermicide.
- Dr. Bako said that the government's participation in purchasing contraceptive commodities continues, but that the amount has "diminished".

Current Stock

- PSI and SantéNet 2 are collaborating at the community level to provide two sources of supply to community agents. Community agents can now provision/procure contraceptives from either a CSB in the public sector or a PSI supply point for socially-marketed contraceptives. PSI has apparently lowered its prices on oral and injectable contraceptives to equal the prices that the community agents are allowed to charge now for these products (100 Ariary for one pack of orals and 200 Ariary for one dose of DMPA).
- As USAID has "reprogrammed" its funding for contraceptives and essentially given what was formerly 50% of funding for contraceptives in the public sector to PSI, and UNFPA has taken over provision of contraceptives for the public sector, there may be approximately one and half times the amount of contraceptives in the country in 2010 as compared to 2009. No one seems clear about the impact of this increase in commodities.

Regulations

- OPHAM reports having to seek an autorisation de mise sur marché for all contraceptive products; this involves registering drugs with the AMM but there are only three pharmacy inspectors in all of Madagascar.

Policies that Affect Family Planning Services

1. Code de la Santé
2. Code de Deontologie Medicale
3. National Reproductive Health Policy
4. Sectoral Plan for Family Planning, 2007 – 2012

Regulations

- Ordre des Sage Femmes mentioned that matrons – or auxiliary midwives/traditional birth attendants – were providing much of the maternal care in Madagascar but that they were not regulated and not legal to provide these services. (The matrons may be an interesting cadre to consider providing family planning services – with the right training and supervision.)
- Sage femmes/midwives in Madagascar can be licensed to own their own private clinics – there are approximately 100 of these clinics in the country that provide family planning and other services, primarily in Antananarivo.

- Pharmacies must be owned by a pharmacist – which could be a barrier because of the lack of trained pharmacists currently in the country (though with the new pharmacy program in country, this will likely change).
- Dispensaires (or clinics that provide both services and drugs, which can include family planning) are typically run by a nurse or sage femme – which isn't legal but tolerated by the government because of a lack of doctors and pharmacists in rural areas.

Policy Issues/Barriers

- Free product/gratuité.
- SantéNet 2 believes that there is some ability to pay for contraceptives at the community level and that this demand is not as elastic as policy makers may have thought.
- Lack of involvement of private sector in any government-level decision-making and mechanism for coordination between public and private sector. Dr. Bako at the Direction of Family Planning admitted that sometimes private sector organizations such as FARMARD are forgotten from the planning and policy development process (though FARMARD specifically said that PSI always represents them in these venues, so leaving them out is somewhat understandable).
- Tax (value added) and/or customs issue; seems to be a big issue for non-bilateral donor organizations, except that UNFPA also had a problem last year with a shipment stuck for six months at the port in Tamatave.

The "shifting sands" of the policy/political environment; while program policy may not have changed for the health sector, it's still very unclear how government prioritizes family planning given the reorganization at the Vice Primature for Public Health and the elimination of "family planning" from the name of the health ministry. Dr. Bako did mention, though, that because of the government's acknowledgement of the need to attain the 2015 MDGs that it may emphasize family planning as a means to reduce maternal mortality.

In terms of a total market initiative, Madagascar's dominant public and social marketing sectors for family planning leave no room for a truly commercial sector for family planning; tax laws provide few incentives for local product manufacturing and the prices in the public/social marketing sectors (or lack thereof) discourages scaling up commercially-priced products and services.

Major barriers to new entrants to Madagascar's family planning market

- Lack of coordination between the sectors; no clear definition of public and private sector roles
- Onerous drug registration process; lack of enforcement of drugs that do enter the market; leakage from public sector
- No transparency or application of tax laws/policies
- Price of contraceptives and free provision in the public sector
- Labor laws (highly favorable towards employees, little labor reform)
- Restrictions on advertising contraceptives (which, because they require prescriptions, are regulated)

- Not a friendly business environment (especially in this business environment when business could be afraid of government appropriation of assets)

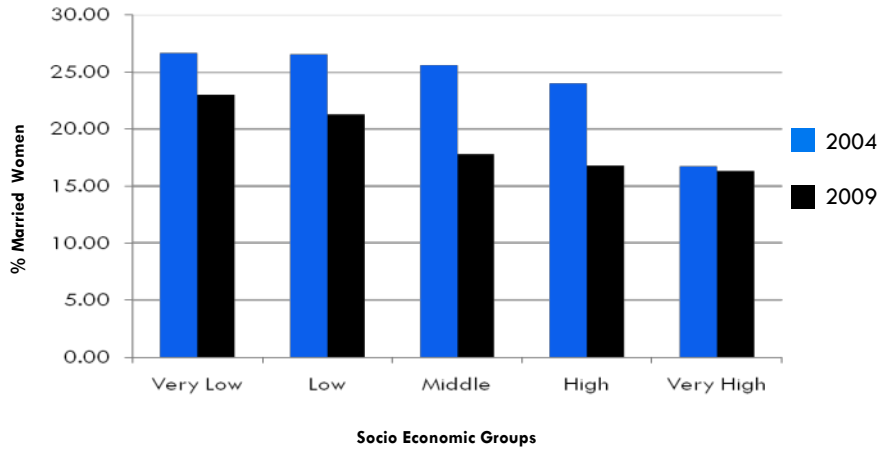
Chapter 3: Market Segmentation Opportunities

This section presents an analysis of findings from the segmentation study. The data indicate impact of change in FP policy in Madagascar and potential areas where clients' needs are not being fully met, where different sectors offer services to the same clients, or where the efficiency of resource allocation can be improved. The data also provide information on current and potential clients that each of the sectors can use to reach their target audiences more effectively. These findings are combined with the qualitative information from stakeholders who participated in the September 2010 workshop to review preliminary results from this market segmentation study. From the data and stakeholder input, the authors have developed a list of opportunities to improve the segmentation of the contraceptive market in Madagascar.

Impact of change of policy

Prior to September 2007, the government charged clients in the public sector for contraceptives—at amounts commensurate with the government's cost of procurement and transportation. In September 2007, GoM changed course and determined that all public sector contraceptives to be provided for free. As a result of change in policy, PAIS initiatives greatly improved warehousing and distribution of all essential medicines, including contraceptives. Unmet need also dropped substantially as well TFR levels dropped to 4.8.

Figure 1: Unmet Need among currently married women



Source: 2004 and 2009 Madagascar DHS

Figure 1: Unmet need comparison between DHS 2004 and 2009 clearly demonstrates that, there is a significant drop in unmet need across all socio economic groups.

Figure 2: Total Fertility Rate (TFR)

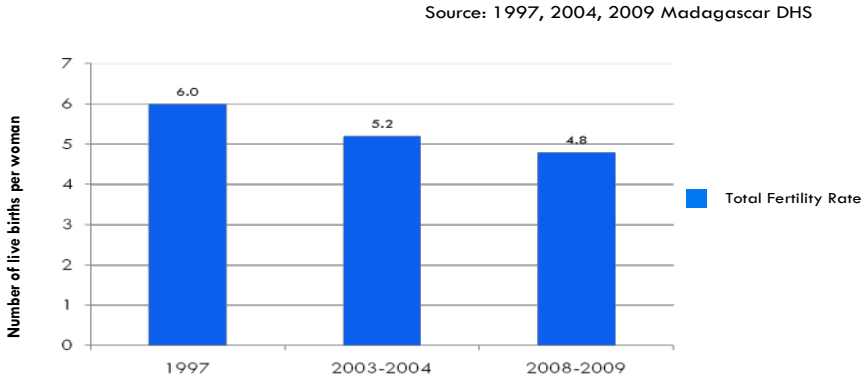
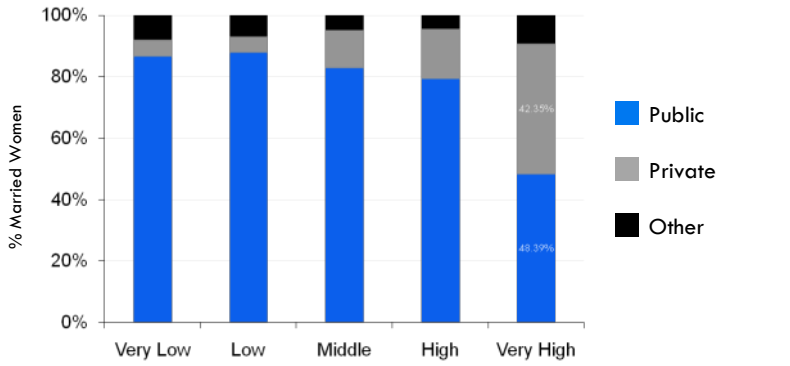


Figure 2: As a result of change in policy TFR levels also dropped to 4.8

Further analysis of DHS 2009 shows gaps in inequitable distribution of contraceptives across various socio-economic groups.

Figure 3: Sources of Family Planning for Married Women by Standard of Living Index

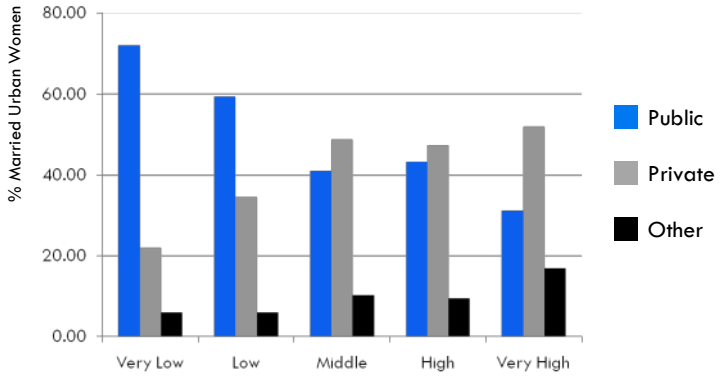


Source: 2009 Madagascar DHS Data

Figure 3, reflects that drop in TFR and reduced unmet need is achieved at the cost of increasing share of public sector and diminishing share of private sector across all socio-economic groups. Even “very high” (48.3%) wealth quintiles also use public sector for accessing contraceptives and equal section (42.3%) use private sector. This clearly demonstrates that FP commodities are not targeted well to the groups who need FP the most.

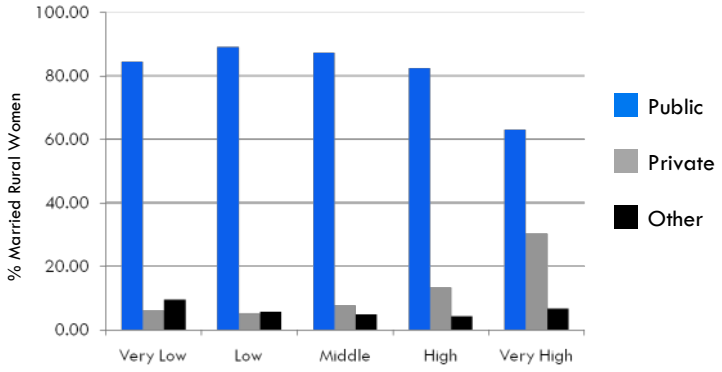
The case is similar in both urban (figure 4) and rural (figure 5) areas of Madagascar.

Figure 4: Sources of Family Planning for Married **Urban** Women



Source: 2009 Madagascar DHS Data

Figure 5: Sources of Family Planning for Married **Rural** Women



Source: 2009 Madagascar DHS Data

Implications: There is a substantial opportunity to increase acceptance to modern contraception among women with unmet need. Both the public and private sectors have a role in addressing this need. Because the need is substantial across quintiles, public and private sectors should divide the market according to the sector that can reach different groups within the target audience and has the comparative advantage to meet their needs.

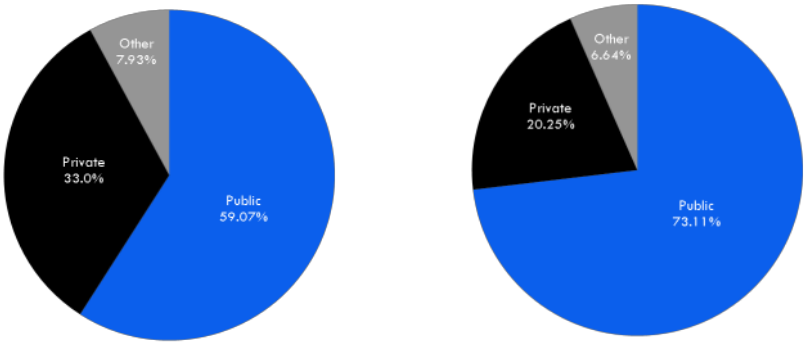
Although the recent policy change has undoubtedly contributed to improved access to FP contraceptives, it has also raised a number of unintended consequences which threaten contraceptive security.

First, ensuring contraceptive security will require substantially more resources than is currently budgeted for in the public sector. Although the Government has a budget line item for procurement of contraceptives, most contraceptives for the public sector are provided by donors (UNFPA and USAID). Second, prior to 2007, authorities at the district level charged a cost-recovery fee for the contraceptives they procured. This fee was used to cover the transportation costs of contraceptives to the district health delivery points, but now, without this revenue, district pharmacies will not have the funds to cover these costs but will still have the financial responsibility to transport contraceptives. This puts districts at risk of having stock-outs.

Finally, the fact that contraceptives are now available for free in the public sector has resulted in a decline in sales of contraceptive products in the commercial sector and a decline in distribution by private sector suppliers.

So, while the recent policy change has resulted in some exciting improvements, the concern is that in the long run, it will hurt access to contraceptives because health centers have no resources for transporting contraceptives from the district level and it discourages private sector entrants to the contraceptive market.

Figure 6: Comparison of Sources of Contraceptives 2004 vs. 2009



2004 2009

Source: 2004 and 2009 Madagascar DHS Data

Figure 7: The public sector wins largely in the rural sector

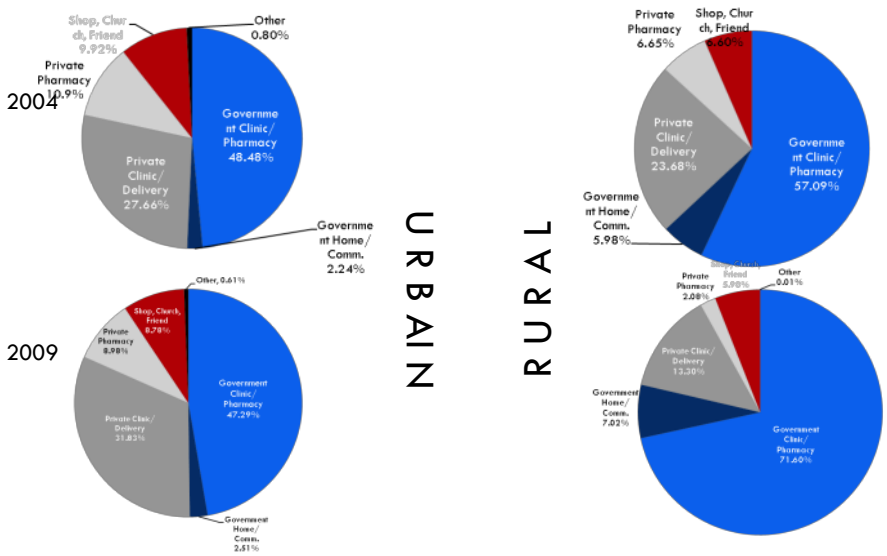
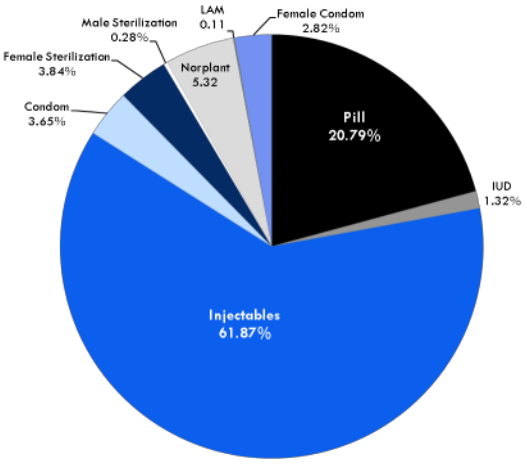


Figure 7, shows between 2004 and 2007 public sector in Madagascar has gained market share largely in rural Madagascar.

Opportunities for Increasing role of Private Sector in Madagascar

The current situation in Madagascar presents a unique opportunity for the private sector to support the Government in reaching its FP targets and ensuring contraceptive security.

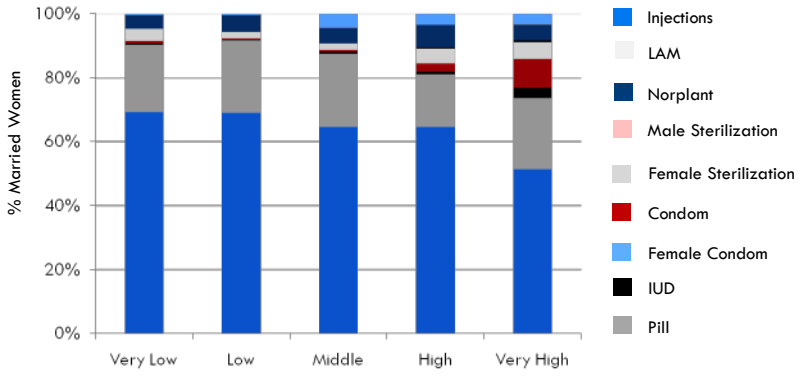
Figure 8: Modern Method Use by Married Women



Source: 2009 Madagascar DHS

Injectable contraceptive is the most dominant method, as this is freely available in public sector.

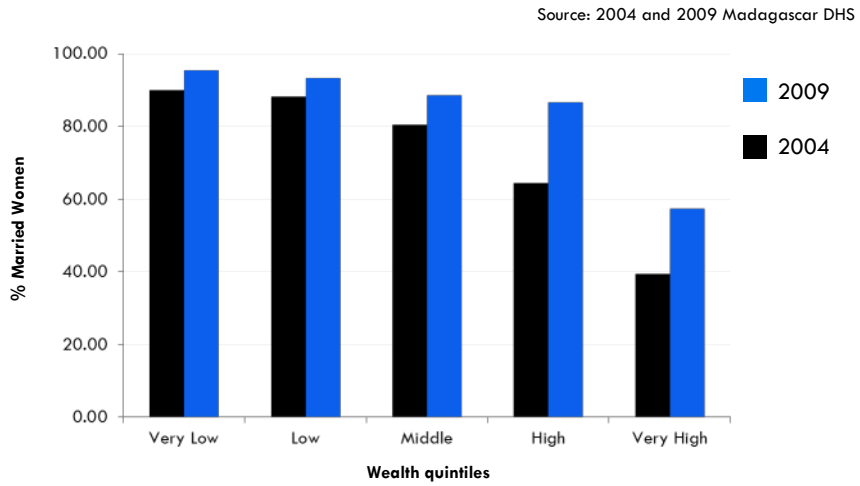
Figure 9: Modern Contraceptive Method Mix -2009



Source: 2009 Madagascar DHS

Injectables are still the most preferred contraceptive option across all the socio-economic groups, including wealthier women.

Figure 10: Public Sector Use for Injectables Increased among Higher Socioeconomic Groups



With the introduction of free contraceptives in the public sector, the use of injectables has increased in every wealth quintile – and the growth is most dramatic in the two highest wealth quintiles. These are the people who are most likely to have the means to pay for contraceptives.

Figure 11: Sources of Family Planning for Married Women by Standard of Living Index

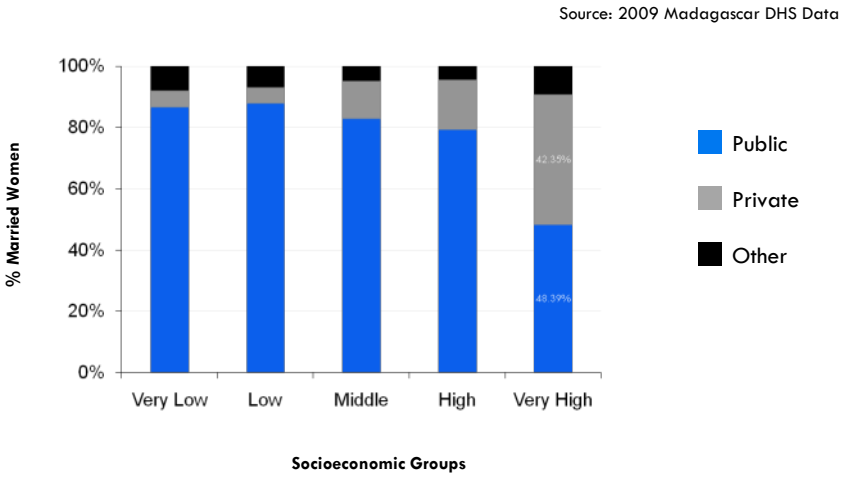


Figure 11: Public Sector is still a prominent source in highest socioeconomic groups: The public sector still provides 48% of the highest wealth quintile's FP methods. By comparison, the private sector's role in the highest and middle quintiles is rather small, although there may be clients within these quintiles who are willing and able to pay for FP. The customers in the lowest quintiles are least able to pay for contraceptives and should be targeted by the public sector.

Implications:

The market analysis shows that, with the introduction of free contraceptives in the public sector, many clients who can pay are now using public sector products. These are the people who could be served by the private sector and allow the public sector to better target its limited resources to those people who cannot afford to pay for contraceptives.

To understand how to increase private sector participation, we need to understand the challenges the private sector faces.

First, for private sector expansion to be successful and to help create a favorable policy environment for private sector participation, there must be a strong partnership with the public sector to ensure needs are being met and each sector it targeting the appropriate clients. But currently, there is no mechanism for coordination between the public and private sectors; and there is limited involvement of the private sector in any government-level decision-making.

Second, under the current system, donors with bilateral agreements with the GoM are exempt from taxes on family planning commodities, but other organizations without such agreements are not. This likely discourages private sector participation.

Chapter 4: Conclusions

Based on key findings and opportunities identified in the previous sections of the report, there appears to be a meaningful role for private sector that would help improve contraceptive security in Madagascar.

Following are the main conclusions that can be drawn from this market segmentation analysis.

First, for private sector expansion to be successful and to help create a favorable policy environment for private sector participation, there must be a strong partnership with the public sector to ensure needs are being met and each sector it targeting the appropriate clients. But currently, there's no mechanism for coordination between the public and private sectors, and there is limited involvement of the private sector in any government-level decision-making.

Second, under the current system, donors with bilateral agreements with the GoM are exempt from taxes on family planning commodities, but other organizations without such agreements are not. This is likely discourages private sector participation.

Third, registration of medicines and drugs are an onerous process in Madagascar. Providers must seek an authorization de mise sur marche for all contraceptive products; this involves registering drugs with the AMM, but there are only three pharmacy inspectors in all of Madagascar. This affects both the public and private sectors.

Fourth, and perhaps most obviously, public sector commodities are free – which discourages scaling up commercially-priced products. With appropriate targeting through marketing and advertising, the private sector can be successful, but there are currently restrictions on advertising for contraceptives.

In summary, the operating environment in Madagascar is not particularly conducive towards expanding private sector provision of contraceptives. Despite this, the GoM does acknowledge the legitimate role of private providers in expanding access to family planning services. The following recommendations have been developed between all members of the TAG, including active participation by relevant government departments.

Chapter 5: Recommendations

Strengthen public-private partnerships (PPP)

- The MOH to invite TAG representatives to meet with the MOH Partnership Director to develop an action plan for strengthening PPP based on the recommendations made at the October 26 workshop.
- The Partnerships Director to organize a regular meeting with FP NGOs to discuss ways to strengthen PPP. The TAG to support the Partnerships Director to finalize a formal policy paper on PPPs for FP services.

Segment the market to appropriately target clients with public and private sector resources

- The MOH must define the reporting systems required from FP NGOs.
- Based on the TMI study and NGO activity reports, the TAG (including the MOH) to identify gaps in the current market segmentation to determine where to target and how to utilize public and private sector resources. The MOH to decide on a timeline for regular reporting on market segmentation so that resource targeting is adjusted as needed. The MOH to work with NGOs providing FP to collect activity reports on a monthly basis so that they can be utilized by the MOH to determine gaps in market segmentation.

Remove taxes on contraceptives

- The MOH Director of Safe Motherhood (DSM) to analyze the impact of taxation policies on contraceptive costs and Government revenue and develop recommendations to take to the Ministry of Finance. The MOH (DSM) to meet with the Director of Finance and Budget to propose a law amendment and discuss the way forward (for example, aligning the definition of tax-exempt medicines with the MOH definition).

Promote social marketing initiatives

- Prior to the Council of Ministers meeting, the Director of Safe Motherhood to frame the design of a draft social marketing policy. The MOH to disseminate TMI results at the Council of Ministers meeting before end of 2010 to demonstrate the role of the private sector and potential for social marketing.

Increase public sector funding for contraceptive procurement and transportation to strengthen total market approaches

- The MOH (DSM) to develop an action plan that outlines how increased public sector funding will facilitate total market approaches for FP.
- The DSM to present an advocacy brief to the Director of Finance and Planning, for the MOH.
- The MOH to develop objectives for funding – including line items for transportation costs related to supply of contraceptives to the CSB-level – that are in compliance with Ministry of Finance and Budget formats.

Annex 1: Detailed DHS Analysis