AWARENESS Project
Madagascar Country Report
2004–2007

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Georgetown University
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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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Acronyms

ADRA	Adventist Development & Relief Agency
AMCM	Association of Catholic Doctors of Madagascar
BCC/IEC	Behavior Change Communication/Information, Education, and Communication
CBD	Community-based Distributor
DHS	Demographic and Health Survey
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
INSPC	Malagasy National Institute of Public Health
IRH	Institute for Reproductive Health
LAM	Lactational Amenorrhea Method
MIS	Management Information System
MOHFP	Ministry of Health and Family Planning
SAF/FJKM	Protestant Faith-based Organization
SALAMA	National Logistics System
SALFA	Lutheran Faith-based Organization
SDM	Standard Days Method®
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund

The AWARENESS Project

Expanding Family Planning Choices Worldwide

Country Program Summary
Madagascar

November 2007

Country Context

Madagascar is one of the lowest-income countries in the world, with 49 % of its population subsisting on less than one US dollar per day. In 2006, it had an estimated population of 18.3 million, growing by 2.7% per year. The median age of the population in 2005 was 17.8, and the government is concerned about high fertility among adolescents.[1] According to the 2003–2004 Demographic and Health Survey, contraceptive use by women in union was 27%, with 2% using the Lactational Amenorrhea Method (LAM) and 8% using periodic abstinence. Unmet need for family planning is an estimated 23.6%, of which 11.3% is for birth spacing.[2] The USAID- funded SanténNet project (managed by Chemonics with IRH as a partner) implemented the majority of program activities in Madagascar—focused on integrating the SDM into existing services—between 2005 and 2007. Additional support was provided by the AWARENESS Project.

Approach

- Create conditions for optimal integration of the Standard Days Method® (SDM) into services through public- and private-sector reproductive health services
- Build capacity and commitment for full integration of the SDM into the national programs.

Approach/Key Activities

- Leveraging resources to advance SDM integration and other family planning activities through the SanténNet program. (In May 2004, the SanteNet project was awarded to the Chemonics consortium, including IRH, with the goal of assisting to achieve USAID/ Madagascar Strategic Objective 5: Use of selected health services and products increased and practices improved.)
- Conducting research to guide scale-up planning with the Ministry of Health and Family Planning (MOHFP).
- Developing service delivery and research partnerships with a range of nongovernmental and faith-based organizations (NGOs and FBOs) and USAID cooperating agencies.
- Building capacity of public- and private-sector organizations to offer high-quality SDM services.

Research

Six-month pilot study: This study, conducted by the Malagasy School of Public Health, assessed the feasibility and acceptability of integrating the SDM into 30 family planning service sites. Key results:

- Over 550 women chose the SDM as their method. This was achieved without extensive information, education, and communication (IEC) campaigns.

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- Half the women who chose the SDM reported never having used a contraceptive method before.
- Most of the couples interviewed (90%) had not used any method in the two months before using the SDM.
- Most users reported that learning to use the method was easy.
- Most women interviewed (92%) could use the method correctly.

SDM Integration

Based on results fo the pilot assessment, the MOHFP decided to integrate the SDM into the national reproductive health program. The SDM now is included in official norms and the list of essential medicines; and a forecast for 70,000 CycleBeads® has been included in the annual contraceptive procurement table. The MOHFP also partnered with SanténNet and IRH in planning for scale-up and training trainers. Although the MOHFP has included CycleBeads in its national contraceptive procurement plans, no donor has yet agreed to purchase them.

The SDM also was integrated into multimethod IEC materials; family planning promotional campaigns; in-service training curricula; national management information reporting forms; and internal reporting systems of partner NGOs and FBOs.

Lessons to Guide Future Programming

- Working with the Malagasy MOHFP, which is a strong advocate for family planning, was instrumental.
- Addressing SDM integration within the context of the broader SanténNet project was critical to success, allowing considerable leveraging.
- Integration of the SDM took place because the method was a SanténNet Project deliverable. (IRH has found elsewhere that, if the SDM is not specifically included as a deliverable in USAID-funded projects, implementing groups are reluctant to spend project resources on it).
- Given the importance to potential and actual clients of community-based services, IRH is planning with Population Services International and SanténNet to integrate the SDM as one of the methods offered by over 6,000 community-based distributors throughout the country.
- Additional attention is needed to obtain donor support for CycleBeads.
- The potential for reinvigorating LAM services with an emphasis on the transition to other methods should be explored.

> *It's easy to use [the SDM], but you have to be very mature about it. You can't forget to move the ring each day, but I haven't had any problems*
>
> ***SDM User, Tamatave***

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[1] UNFPA. Population Health and Socio Economic Indicators/Policy Development. Website: http://www.unfpa.org/profile/madagascar.cfm?Section=1

[2] Population Reference Bureau. DataFinder Madagascar. http://www.prb.org/DataFind/

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I. Introduction

Source: CIA World Factbook 2008

Madagascar is one of the poorest countries in the world, with 49% of its population subsisting on less than one US dollar per day. In 2006, it had an estimated population of 18.3 million, growing by 2.7% per year.[1] The median age of the population in 2005 was 17.8 and the government has growing concern about the 1.7% HIV/AIDS infection rate and high fertility among adolescents.[2] The fertility rate per woman 15–49 is 3.7 in urban and 5.7 in rural areas.[3] Unmet need for family planning is an estimated 23.6 percent, of which 11.3% is for birth spacing.[4] Health disparities between rural and urban populations are pronounced.

According to the 2003–2004 Demographic and Health Survey (DHS), contraceptive use by women in union was 27%, with 2% using the Lactational Amenorrhea Method (LAM) and 8% periodic abstinence.[5] However, it is unclear if these women are using LAM and periodic abstinence correctly and consistently.[6]

Furthermore, there is an unmet need for family planning of 23.6 percent, of which 11.3% is for spacing.[7] Responses to this unmet need must involve expanding the options available to Malagasy women and couples. Increasing the accessibility of natural methods of family planning that are not widely offered now represents one viable strategy for expanding choice.[8] Despite the existence of a significant potential demand for natural methods in Madagascar, access to these methods is limited.

II. Objectives and Strategy

In May 2004, the SanténNet Project was awarded to the Chemonics consortium with the goal of assisting to achieve USAID/Madagascar's strategic objective 5 – Use of selected health services and products increased and practices improved. Chemonics subcontracted the Georgetown University Institute for Reproductive Health (IRH) through the SanténNet program to provide primary support for key elements of family planning, specifically the integration of the Standard Days Method® (SDM) into programming.

SanténNet—including IRH—and the Ministry of Health and Family Planning (MOHFP) agreed that after six months of SDM integration into 30 service delivery sites, the Malagasy National

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[1] Population Reference Bureau. DataFinder Madagascar. http://www.prb.org/DataFind/
[2] UNFPA. Population Health and Socio Economic Indicators/Policy Development. Web site: http://www.unfpa.org/profile/madagascar.cfm?Section=1
[3] Population Reference Bureau. 2006 World Population Data Sheet. http://www.prb.org.
[4] Population Reference Bureau. DataFinder Madagascar. http://www.prb.org/DataFind/
[5] The 2003-2004 DHS defines traditional methods as periodic abstinence, withdrawal, and other "popular" methods.
[6] INSTAT and Measure DHS+. July 2004. Enquête Démographique et de Santé EDSMD III: Rapport Préliminaire. Calverton, MD:ORC Macro.
[7] Population Reference Bureau. DataFinder Madagascar. http://www.prb.org/DataFind/
[8] Mane, B., CEFOREP and Institute for Reproductive Health. 2000. *Augmenter l'Acceptation et l'Usage de la Planification Familiale Naturelle: Une Étude Diagnostique.*

Institute of Public Health (INSPC) would conduct an assessment and the MOHFP would make a decision as to the suitability of integrating the SDM into family planning services. The results of the pilot effort were positive, and national scale up is underway in two phases. Phase 1 saw the integration of the SDM into 13 USAID-supported zones, and Phase 2, which has begun, will integrate the SDM into the remaining nine zones.

The objectives of the SanténNet project vis a vis the SDM fit well with the AWARENESS Project's objectives. However, given the breadth of SanténNet and its limited resources, IRH also allocated AWARENESS funds to support research, evaluation, and capacity building activities for the SDM in Madagascar.

III. Activities and Accomplishments

During the first 18 months of the project, SanténNet/IRH, the MOHFP, and partners conducted advocacy with potential pilot study partners and initiated a six-month study to assess the feasibility and acceptability of integrating the SDM into family planning services offered to the Malagasy population. In addition to MOHFP, four service delivery organizations were identified: Sampan'asa fahasalamana/Fiangonan'I Jesoa Kristy eto Madagasikara: SAF/FJKM (Protestant), Sampan'Asa Loterana momban'ny Fahasalamna: SALFA (Lutheran), Adventist Development & Relief Agency: ADRA (Adventist), and Association des Médecins Catholiques de Madagascar: AMCM (Catholic). The project trained providers and health animators (promoters) to offer the SDM at five sites of each partner organization (including SanténNet) for a total of 30 sites in the USAID focus areas (named Commune Mendrika "champion communities"). The project also trained CARE staff at this time, even though their sites were not included in the pilot study.

Because of the limited scope of the intervention, behavior change communication/information, education, and communication (BCC/IEC) activities were limited to the training of community health animators to raise awareness in the pilot catchment areas and the distribution of a poster produced by SanténNet. Nonetheless, in February 2006, approximately six months after the SDM introduction, there were 517 registered users with a high proportion among the faith-based organizational partners.

Following a positive assessment of the project, the MOHFP decided to integrate the SDM into its national family planning program. IRH and partners unsuccessfully attempted to identify donors to finance the countrywide scale up. Lacking funds to scale up nationally, SanténNet/IRH and the MOHFP decided on a limited scale up of the method in the Commune Mendrika areas. At the same time, the MOHFP pursued scale-up opportunities with other donors.

Table 1: Partners, Roles, and Accomplishments

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's role	Accomplishments
SanténNet	• Pilot study • Integration into USAID catchment areas	• Service delivery • Poster production • Office for point person	• Training • Technical assistance • Point person • CycleBeads® donation	• High acceptance of SDM • Scale up in USAID zones

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health and Family Planning (MOHFP)	• Pilot study • National integration	• Service delivery • Integration into national in-service training program. • SDM training in existing family planning centers through in-service training.	• Training • Advocacy • Technical assistance • CycleBeads® donation	• High acceptance of SDM • SDM in official Norms and Procedures documents • CycleBeads® on list of Essential Medicines • CycleBeads® in annual procurement table • SDM included in in-service curricula • Included in monitoring and management information systems (MIS) • 166 trained providers
SAF/FJKM (Protestant)	Pilot study	Service delivery	Training	• High acceptance of SDM • Six trained providers
SALFA (Lutheran)	Pilot study	Service delivery	Training	• High acceptance of SDM • Six trained providers
ADRA (Adventist)	Pilot study	Service delivery	Training	• High acceptance of SDM • Two trainers trained
Catholic Relief Services/AMCM (Catholic)	Pilot study	Service delivery	Training	• High acceptance of SDM • 18 trained providers
CARE	Training of community-based distributors (CBDs)	Service delivery	Training	154 trained CBDs
Malagasy National Institute of Public Health (INSPC)	• Pilot study • Adolescent study	Research	Technical assistance	Reports

A. Research

In March 2006, the INSPC, with assistance from IRH/SanténNet, undertook the assessment of the pilot project. The assessment addressed the following specific service delivery issues:

- feasibility of offering SDM in government service delivery settings as well as through faith-based programs and NGOs
- user acceptance, satisfaction, and continuation
- profile of clients who elected to use the SDM
- male involvement and couple communication among SDM users
- providers' and supervisors' willingness to continue offering the method, and
- providers' skills in offering the method

The INSPC found that the method was well accepted by supervisors, providers, and users and, as a result of the assessment, the MOHFP decided to integrate the SDM nationally into the reproductive health program. Other notable findings included:

- In the first six months of the pilot, over 517 women in service delivery sites chose the SDM as their method. This was achieved without extensive BCC/IEC campaigns.

- Half the women who chose the SDM were new users of family planning who reported never having used a method in the past. Other methods used were the injectable, pill, and other natural methods.
- Many of the couples interviewed (90%) had not used any method in the two months before using the SDM.
- Most users reported that learning to use the method was easy.
- Most women interviewed (91.8%) could use the method correctly (i.e., abstain from unprotected intercourse during the fertile period).

Results from the pilot study assessment indicated a strong potential for the SDM to fill unmet need for family planning in Madagascar. Consequently, the MOHFP decided to encourage partners and donors to scale up the SDM into the reproductive health services countrywide. This decision was made in July 2006 and the MOHFP and partners have already made progress towards this goal.

> *"I had stomach aches when I was using the pill, so I went to the health center and I saw that the SDM was the best method for me."*
> **– SDM user, Tamatave**

The MOHFP has included the SDM in the official Norms and Procedures as well as the list of Essential Medicines. The MOHFP and SanténNet have also begun to train trainers and plan for scaling up the method. The MOHFP forecasted a need for 70,000 CycleBeads and has included this number in their annual contraceptive procurement table.

B. Building awareness of and support for SDM

SanténNet and the MOHFP have been key actors in raising awareness of the SDM within the reproductive health community. INSPC's assessment of the pilot and the subsequent meeting to share study results generated enthusiasm for SDM scale up. Piloting the method in both public and private (religious and secular) sites also offered the opportunity for stakeholders to learn about the method and its merits and limitations.

SanténNet produced an SDM poster in Malagasy and French and provided it to the pilot clinics. IRH/SanténNet also worked to place the SDM on the Ministry multimethod poster, and IRH assisted in the development of an SDM flyer. The SDM was also integrated into the *Samia Mitondra Telo* ("one family planning user brings three") campaign which encouraged family planning users to bring friends to services. This campaign promoted all methods, including the SDM. The program trained health animators to raise awareness of the method and refer clients to clinics offering use instruction.

Since the pilot, IRH has hired one of the SanténNet staff as the point person for SDM activities. Having a dedicated person within the major family planning cooperating agency in Madagascar has been indispensable to further method integration. This person has monitored progress and provided timely technical assistance to encourage and oversee the integration of the method into relevant systems, including the official Norms and Procedures, the list of Essential Medicines, and in-service training curricula.

C. Developing the capacity of local organizations

Table 2. Local organization capacity building June 2005 to August 2007

Name of Organization	Number of Providers Trained	Number of Sites with Trained Providers	Number of Trainers Trained	Number of SDM Acceptors	Percentage of new SDM acceptors who are new FP users
MOHFP	162	151	6 central 14 regional 40 districts	712	46
ADRA	NA	NA	2	NA	NA
AMCM	18	7	2	181	62
SAF/FJKM	6	5	2	149	46
SALFA	6	6	2	143	36
CARE	154 CBD	48 villages in 5 Communes	11 CBD trainers	-	-
Ave Maria	1	1	1	25	36
TOTAL	**347**	**218**	**80**	**1,210**	

IRH/Africa staff from the Democratic Republic of Congo and Rwanda and two SanténNet staff completed the initial training of twelve trainers from all partner organizations. SanténNet then followed a cascade training system to train providers and community health promoters. Table 2 above shows the capacity built within each partner organization to date.

Following the MOHFP's decision to scale up the SDM, SanténNet trained 77 MOHFP district supervisors/trainers in three waves by province. The district supervisors/trainers then trained providers and community health promoters from 153 sites. The use of district supervisors to both train and supervise providers helped ensure that providers and community promoters offer good quality SDM services. The MOHFP integrated the SDM training curricula into in-service training programs so that the SDM is now part of refresher training programs.

The SanténNet program provided resources and funding for all training costs, including the reproduction of training materials and costs for all training participants. Although some of these trainings covered a variety of methods, many focused specifically on the SDM.

D. Incorporating SDM into reporting systems

The latest version of the MIS reporting form now includes the SDM. This new reporting form is slowly being introduced into clinic and reporting systems. Until these forms are widely available in zones where the SDM is offered, providers will continue to mark SDM users in the natural method column on the current forms. In the meantime, efforts are being made to ensure that providers specifically record *Collier du Cycle* users so that statistics will not be lost. NGOs have integrated the SDM into their internal reporting systems and provide this information to the SanténNet Project on a quarterly basis.

E. Generating commitment of resources to SDM by governments, NGOs, or donor agencies

The Malagasy MOHFP has shown a great deal of interest and support for the integration of the method into countrywide service delivery systems. This effort will require both a national plan and the participation of a range of donors and partners. The MOH is planning collaboratively with various sectors and the international donor community to: train sufficient numbers of trainers, supervisors, providers, and community health workers on the method in both rural and urban areas for national coverage; conduct a national BCC/IEC campaign to raise awareness and promote the method as an additional family planning choice; make commodities available; and ensure that providers and supervisors are reporting information on SDM users.

MOHFP providers who offer the SDM

F. Incorporating SDM into the logistics system

During the pilot study, SanténNet directly provided CycleBeads, the visual tool that supports SDM use, to the clinics involved. This allowed partners to be resupplied as needed but was not a large-scale sustainable strategy. Since then, the SanténNet program integrated CycleBeads into the distribution system and has begun to scale up the SDM into all its clinics. The country logistics system, SALAMA, is functional; it should be possible to integrate another method into the existing system. However it is still unclear who will purchase CycleBeads for the program. Although the MOHFP has included CycleBeads in its national contraceptive procurement table, no donor has yet agreed to purchase them. If necessary, the MOHFP may use World Bank funds to purchase supplies.

G. Summary of experience of SDM introduction and expansion

Integration of the SDM took place because the method was a deliverable in the SanténNet Project. IRH has found elsewhere that, if the SDM is not specifically included as a deliverable in USAID-funded projects, implementing groups are reluctant to spend project resources on it. The short six-month pilot timeframe allowed sufficient time to collect information related to acceptability, while informing decision makers about the method and advocating for SDM integration. The partnership with SanténNet has leveraged significant resources and expertise to integrate the method into the family planning system. The presence of committed actors on the ground already working with the MOHFP has greatly facilitated the introduction of the method into Madagascar's family planning system.

Involving the MOHFP and National Public Health Institute from the beginning encouraged buy-in and facilitated advocacy with other health authorities. Piloting the method in private and public sites afforded different communities the time needed to learn about the method first hand and to experience, on a limited scale, the benefits of integrating a new method into their services.

The SDM has now been integrated into national Norms and Procedures, the list of Essential Medicines, in-service curricula, monitoring and information systems, and the national contraceptive procurement table.

IV. Challenges

In an effort to gain support for national scale up, the Minister of Health and Family Planning wrote a letter to the United Nations Population Fund (UNFPA) in Madagascar to request the purchase of 70,000 sets of CycleBeads for national scale up. Unfortunately, UNFPA denied the request, stating that the SDM was neither a modern method nor on their commodity list. The MOHFP continues to seek other funding sources for the scale up of SDM integration and, as a short-term strategy, is working with IRH and the SantéNet program to integrate the method into 630 public and private service delivery sites.

V. Lessons Learned

Working with a capable partner in the field has been invaluable to the success of the project. SantéNet has been a strong advocate for the SDM with the MOHFP and partners since the start of the pilot program. The project was the main driver behind the introduction of the method into the country's reproductive health care system.

A second important aspect of the Madagascar program was the involvement of the very capable MOHFP, which has a strong focus on family planning. Once the program sensitized the MOHFP to the method, it provided the necessary support and personnel to ensure that the SDM was systematically introduced into the system. The MOHFP also identified an internal point person to work closely with SantéNet/IRH and the Ministry to integrate the method.

VI. Future Plans

IRH has already begun discussions with Population Services International (PSI) and SantéNet to integrate the SDM as one of the methods offered by over 6,000 community-based distributors throughout the country.

IRH/SantéNet has made significant progress in integrating the method into SantéNet/USAID zones and some surrounding areas. Future activities should focus on reinforcing the integration in these zones and expansion into other non-USAID zones. This will ensure that the method is available throughout most of the country. Future programs should also continue to support the MOHFP in advocating for support from other donors including the African Development Bank, the World Health Organization, the United Nation Children's Fund, and the UNFPA.

Advocates should also explore the possibilities of partnering with environmental organizations to increase access in areas with limited health services, such as communities surrounding national parks. In the past, IRH has worked with the Jane Goodall Institute to integrate natural family planning activities into its work in the Eastern Congo.

Throughout the scale-up process, results of the project and research should be presented and disseminated to key stakeholders as needed to inform strategies needed to ensure a sustainable program.