Selected Health Policy Issues :

Strategy and Plan of Action Regarding Contraceptive Security Calculations and Steps to Promote FP/RH Policy Dialogue Among Partners in Madagascar

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Strategy and Plan of Action Regarding Contraceptive Security Calculations and Steps to Promote FP/RH Policy Dialogue Among Partners in Madagascar

Antananarivo, November 2000

Context

The Government of Madagascar (GoM), specifically the Ministry of Health (MinSan), is strengthening and expanding its FP/RH services as the demands of the population increase for contraceptive services. To meet growing demands, it is necessary to strengthen forecasting and procurement procedures as key elements in contraceptive security. Several donor and technical assistance agencies are partnering with the MinSan to quantify as accurately as possible future needs for contraceptives relative as demand increases, to study potentially useful changes in the method mix, and to calculate resultant costs.

Initial reaction of the Secretary General of the Ministry of Health to the basic goal and approach of the proposed forecasting, coupled with strengthened policy dialogue about contraceptive security, has been positive. Reinforcing efforts to achieve contraceptive security and to place these efforts within a broad policy discussion of key health interventions in Madagascar while a strategy is developed for reducing poverty is quite timely according to the Secretary General

Estimates about contraceptive needs predict significant shortfalls in both contraceptive supplies and financing relative to projected demand in 2001. There is a consequent urgency to update these estimates immediately so that the implementing partners can place coordinated procurement orders before the end of 2000 and cover costs in accord with their respective roles and programs to meet demands during 2001.

Accurate estimates to be used by implementing partners require dependable data. Consequently, the data underlying these estimates need to be generally acceptable to partners. Thus, it is useful to have partners look at and agree on the underlying data to the extent that coordinated procurement move forward practically and rapidly. This approach is furthermore quite useful in developing a standardized forecasting methodology generally accepted by all and applied over the long term by implementing partners. Such standardization will assist materially to strengthening ongoing contraceptive security in Madagascar.

Enlarged Policy Dialogue

Practical and focused discussions by partners on data and the forecasting methodology can serve as a proximate, practical occasion to reinforce broader policy dialogue. Such a dialogue would ideally cover significant health issues and subsequent strategies adopted to resolve them as stated in the National Health Policy and National Population Policy with their respective Plans Directeur. What this paper proposes is that additional policy

dialogue be formalized for implementation in the months to come, perhaps using the immediate issue of contraceptive security as a springboard. It proposes that partners and other stakeholders enlarge the dialogue to consider in appropriate depth and detail selected policy issues. These can be explicit or as yet unexamined regarding major governmental reforms, as well as developments in the private sector and civil society affecting the health and well being of the whole population. The ultimate purpose of this policy dialogue is nothing other than to assist the efforts called for in the National Policies and Plans noted above. Principal efforts of these plans noted in general terms are: to strengthen and decentralize health service delivery for child and maternal health, adolescent health, communicable disease, STIs/HIV, among others; to assure public and private sector financing of health care; to eliminate poverty as expeditiously as possible; and, to promote sustainable human and economic development of all Malagasy peoples.

How to Select Elements of a Policy Dialogue Related to Contraceptive Security

What are some key elements of a useful and practical policy dialogue that could be developed by using the issue of contraceptive security as a springboard for broader policy discussions? One way of answering is to examine the National Health Policy to see what it cites as major, national health problems and corresponding strategies with actions specifying quantified targets for reductions of these problems.

Maternal mortality is cited in second place, after under-five mortality, and is targeted for reduction from 570 deaths per 100,000 live births to 285 by the year 2000. Data indicate that the two leading causes for maternal death in Madagascar are abortion, 40%, and complications of pregnancy and birth, 32%. Now, international data establish well the direct link between the reduction of abortions and the promotion and provision of accessible, high quality FP services. Likewise the link is well-established between women being well-counseled about FP, consequently freely choosing the number and timing of births thanks to accessible, timely FP services, and reductions in ill-advised pregnancies leading to death during pregnancy or during birth.

What comes to mind then is a wide range of relevant policies, especially operational policies, regarding the type, quantity and accessibility of health interventions that are chosen and applied in Madagascar to reduce maternal mortality, particularly, and as one priority, the provision of accessible, quality FP services. Thus, there is strong justification to use the immediate, focused discussion noted above to rationalize the purchase of contraceptives and long-term contraceptive security and to link it to a dialogue about implementation of additional operational policies governing interventions to reduce maternal mortality.

Long-term contraceptive security has a privileged place among these interventions. It contributes directly to reducing maternal morbidity and needs to be included in any policy dialogue about safe motherhood. Such policy dialogue is clearly necessary to achieve the synergies, cost-effectiveness, and sustainability of all the major health interventions selected to implement key national health strategies.

Additional Elements of an Integrated and Comprehensive Policy Dialogue

Other important elements of a dialogue regarding major health issues such as maternal health and strategies to improve it and other health issues in Madagascar are:

- The critical component of emergency obstetrical care (EOC) with essential elements of emergency transportation services, capabilities at referral centers in terms of trained staff, blood supplies and adequate equipment, and post-abortion care
- The National Health Policy for Adolescents and Youth in Madagascar with all that is required to implement it through: youth-friendly health care delivery system that is decentralizing; service delivery points with appropriate resources, education and awareness campaigns; discussion about the age of marriage; provision of contraceptive services and protection against STIs, etc.
- Prevention and treatment of STIs and HIV/AIDS as a major health need, especially if HIV becomes more prevalent in populations with already high rate of STIs
- Legal and regulatory barriers regarding elements supportive to expansion of FP/RH services, public or private sector, such as advertising and promotion of contraceptives, health services and products, particularly in the commercial sector
- Health care financing and allocation of resources in accord with priority health strategies and demonstrated effectiveness as appropriate in Madagascar; cost recovery mechanisms in the public health care delivery system, particularly in a decentralizing effort; coordination of approaches to the donor community

Two-Phased Action Proposal

Given the utility of strengthening a policy dialogue in Madagascar, the following proposal is offered as a result of a two-week mission by two specialists of the Futures Group International. They produced a forecast of FP needs based on multiple factors and suggested an approach for strengthening a discussion of associated FP/RH policy issues. Their SOW designed by JSI and approved by USAID was to produce a FamPlan-based calculation of contraceptive needs in the coming years. (see in Appendix 2 the Powerpoint presentation made and presented by the consultants during the mission to the various partners of JSI and the Futures Group International).This paper identifies some steps to engage key partners in a health and population policy dialogue. The two-phased proposal presents an 18-month plan of action, the first phase of which is to be completed before 31 December 2000. The key partners during both phases should include: MinSan, USAID, UNFPA, World Bank, INSTAT, ONP, JSI, CMS, and ASSONG, together with selected, additional stakeholders as determined particularly by MinSan.

Phase One: Forecasting Contraceptive Needs. November – December 2000

This phase responds to the urgent need to produce an accurate and generally accepted calculation of contraceptives required to meet demand during 2001 but which projects these growing needs to 2010. The calculation has been done using the Spectrum System of Policy Models, specifically its DemProj and FamPlan components. In consultation with several key in-country counterparts with reference to viable data and reasonable

starting points, the team developed projections showing contraceptive needs over 10 years by adjusting key variables including: contraceptive prevalence rates; expressed, unmet needs identified in household-based surveys; acceptable targets of contraceptive prevalence growth, potentially useful changes in method mix; and, associated costs for contraceptives. The chronology of activities to be undertaken is provided just below. The product will be a calculation of contraceptive needs generally accepted by discussants and contributory to donors' ability to complete a precise, coordinated purchase for 2001. A definable result will be the coordinated purchase of methods for 2001. A by-product will ideally be a standardized methodology applicable for the years to follow by all stakeholders and participating partners.

November, 2000

- JSI team meets key data personnel and selected stakeholders to confer on prevalence data available for the calculations of contraceptive needs
- Presentation of calculations at USAID and to Secretary General, MinSan

November-December, 2000

- Calculations circulate via JSI among key partners, donors and selected stakeholders
- MinSan, USAID, FNUAP, INSTAT, World Bank and JSI confer formally about calculations, suggest possible changes in the first assumptions made, and determine respective portions of financial coverage for purchase of contraceptive
- Standardized methodology for forecasting contraceptive needs generally adopted by partners (primarily by using and possibly revising the first FAMPLAN scenarios developed by the consultants)
- Agreement among key partners to purchase contraceptives to cover needs in 2001

Phase Two: Health Policy Dialogue and Strengthening Technical Capabilities
January 2001 – April 2002

The central goal of Phase Two is to implement a policy dialogue described above. The objectives are: first, to strengthen technical capabilities of selected MinSan personnel who are pertinent to, and can prepare for, an informed dialogue among key MinSan authorities and decision-makers, especially key representatives from all regions of Madagascar, as well as selected partners, about specific policy issues. The second objective is to conduct the dialogue through a limited number of well focussed and carefully prepared thematic national and regional workshops of two - three days each, highlighted near the end of the proposed period by a high-level meeting including regional representatives to determine progress made and a possible action plan for further policy work in a potential third phase. It may be desireable to add to the list of national authorities, partners, and stakeholders already cited, other interested institutions and parties such as the ONP, Schools of Medicine and Nursing, Parlementarians, professional associations, journalists and NGOs.

In addition, it may be necessary to engage selected technical advisors from within and without Madagascar. International advisors should have considerable experience, skills and tools in promoting, assisting and guiding in-depth policy dialogue.

The final choice of the thematic workshops should be made by the national authorities, specifically, MoH. This choice can be guided by existing policies, (e.g., Safe Motherhood, and within this framework contraceptive security) or it can concern new themes that the national authorities would like to explore and act upon (e.g., population and development, including negative impact of high fertility and population growth on full immunization coverage of children, school enrolment, etc..). The use of the different modules of Spectrum (Demproj, Famplan, etc..) should assist in that exercise, since they constitute incontrovertible decision making tools, for the various actors involved.

More generally, it should be emphasized that the content in each step of the dialogue needs to:

- concern a major health care intervention which is a priority and requires significant resources, which fact means that is likely in a competing position for these resources
- cover one or more policies concerning this major health intervention which are either non-existent or which exist but are deemed to be dysfunctional
- be open for examination and improvement in the short or near-term by authorities who are part of the dialogue
- form part of a coherent list of policies that, when examined and strengthened in their totality, will effect a measurable improvement in health care delivery.
- be confirmed by key partners and participating stakeholders as a priority matter to consider in accord with the preceding criteria

It is worth noting that, given the content of Phase One, essentially contraceptive security, the first content area for policy discussions would ideally be about this matter. Content could cover: relative role and weight ideally given to FP services in Madagascar to improve RH in accord with international data on effectiveness of FP as health intervention; its contribution to reduction in maternal mortality, particularly abortion; consequent efforts required to assure contraceptive security; legal and regulatory barriers regarding elements supportive to expansion of FP/RH services, public or private sector, such as advertising and promotion of contraceptives, health services and products, particularly in the commercial sector; importance of condom distribution throughout Madagascar for prevention of STIs and HIV in relation to condom distribution as part of the package of available FP methods.

The chronology of activities to deal with operational policies on this matter and others is proposed as follows:

January – March 2001

- JSI confers with selected MinSan authorities, decision-makers and regional authorities, as well as with key partners such as those noted several times above, regarding the list of relevant policy issues to be considered and objectives achieved. This proposal suggests below possible content for the first several meetings and workshops. Content focus on contraceptive security. After consideration of this proposal, selection made and schedule determined
  Discussants identified for first formal policy dialogue event in April 2001 in relation to subject chosen and objectives desired; discussants selected also in keeping with regional needs and decentralization efforts
- Technical personnel selected to prepare first policy dialogue content in accord with needs of discussants, overall policy issues selected, and stated objectives; dossiers prepared and disseminated for April meeting;. initial agreement reached on data to be used, on assumptions to be tested for policy makers, on both quantitative and qualitative objectives to be achieved in RH/FP within the framework of existing policies.

April – December 2001

- First two or three-day policy dialog workshop on contraceptive security in Madagascar during April 2001 occurs with 25 – 30 participants from MinSan, ONP, INSTAT, USAID, FNUAP and World Bank.
  Objectives: 1) confirmation of calculations on prevalence and projected increase by Malagasy experts 2) pledges by MinSan, partners and donors to cover increasing financial needs.
  Format of mini-presentations, small group work for analysis of operational policy issues and their solutions, and consensus on recommendations as part of guidelines and plan of action submitted to key authorities and decision-makers in MinSan and shared with partner organizations.

- Second policy dialogue workshop on contraceptive security in two provinces assisted by USAID occurs in July 2001.
  Objectives: 1) analyse experience in issues of contraceptive security such as level of demand, supply problems, user needs and behaviors, and male behavior. 2) draw conclusions for possible changes in service delivery by MinSan and other providers.
  Format of workshop, conference and focus group approaches.

- Third policy dialogue workshop on decision-making tools relative to contraceptive security. Held in same two provinces during October 2001 with participation of local managerial and technical personnel responsible for contraceptive security.
  Objectives: 1) training in the use of computer-based models so that local expertise is fully capable of accurate monitoring and forecasting

- Participants should be selected in accord with specific content but also to keep a certain level of continuity and overlap among participants, especially in relation regional and decentralization policies and needs

- During the last quarter of 2001 following the October dialogue meeting, preparations by selected technical personnel and advisors should take place in view of an enlarged two-day conference in January 2002 attended by high-level authorities, regional representatives and technical experts of Madagascar

January – April 2002

- High-level conference occurs in January to present findings and recommendation to date regarding policy improvements in view of their likelihood to assure contraceptive security and improve the delivery and effectiveness of selected health interventions.
- Top authorities and decision-makers from central and regional levels determine what further action steps will be taken and by whom in order to enact policy improvements
- A concertation meeting takes place in April to finalize all findings and recommendations reached during Phase Two, to decide in what manner policy dialogue activities should continue, and to plan for the follow-up
- Summary conclusions and recommended action plan disseminated as appropriate following the April concertation meeting

ANNEX 1

Activités récentes, besoins actuels et futurs en matière de SR/PF à Madagascar

Recent activities, current and future needs in RH/FP in Madagascar

by Jean-Pierre Guengant

The contraceptive revolution, i.e. the shift from uncontrolled fertility to controlled fertility was initiated in the 60's in many developing countries. The revolution came with the advent of "modern" contraceptive methods, especially pills and intra-uterine device. Developed countries also took part in this revolution. Indeed, couples in these countries moved from traditional methods to modern ones as more efficient methods appeared, thus going through their second contraceptive revolution *(1)*[1].

In Africa, the revolution was delayed for about twenty (20) to thirty (30) years due to numerous reasons (families prefer to have many children, services and programs were not available, couples were not informed). Therefore, the percentage of women in union using modern contraceptive methods was still low in the 90's, i.e. generally below 10%.

Progress of contraceptive utilization in Madagascar

Modern contraceptive methods services started developing in the country in the 80's. In 1990, Madagascar instituted its population policy entitled "National Population Policy for Economic and Social Development" under law # 90-030 *(3)*. The global strategy of this policy is to establish a coordinated program for access to non compulsory control of reproduction with an emphasis on maternal and child health and allowing each individual to choose the number of children he/she believes to be the best.

The different initiatives to provide family planning services rapidly increased the progress of modern contraceptive method utilization. As early as 1992, five percent of sexually active Malagasy women were using a modern contraceptive method *(4)*. The percentage increased to 9.9% in 1997 *(5)*, 13.0 in 1999 *(6)* and 11. 8% by mid 2000 *(7)*, giving an average annual increase of almost 1% of women in union using modern contraceptive methods

Despite these promising results, Madagascar is only at the beginning of its contraceptive revolution, like most countries of the African continent. As a basis for comparison, seventy to ninety percent (70% to 90%) of women use a contraceptive method, mostly modern ones, in the twenty countries with the highest contraceptive utilization rates *(2)*. The terms "The end of unwanted births" and "wanted babies" have become true and meaningful in those countries *(8 and 9)*. One thing to note is that some countries in the south hemisphere, mainly Asian countries are included in those twenty countries. They are China, Hong Kong, Singapore, Thailand, Brazil, Korea and Cuba. However, about half a dozen African countries have reached a contraceptive utilization

[1] In-bracket figures

rate above 50%. They are La Réunion, Tunisia, Algeria, Zimbabwe, Morocco, and South Africa. Next to those countries are those with a rate of 30 to 50% : Egypt, Botswana and Kenya. As for Madagascar, it ranks among the countries which have just achieved a rate above 10% of female users.

Over the last 20 to 30 years, modern contraceptive method utilization has increased by 1% or even 1.5% in these countries. With a rate of little less than 1% per year, Madagascar is at the intermediate level between this first group of countries and the group of countries where annual progress is lower than 0.5 per year (if these countries keep this pace, their contraceptive revolution will lag over more than one hundred years.)

Distribution of the Methods or Method Mix

The range of modern methods available is a key aspect in allowing individuals and couples to freely choose the method that suits their needs and their likes. A broader range of methods is often associated with a greater increase in contraceptive utilization in several countries.

Nonetheless, at the global level, it is observed that in one third of the countries for which data are available, there is a dominant method that at least half of the users resort. Sterilization is the dominant method in fourteen (14) countries, pills rank first in fifteen (15) other countries while the intra-uterine device has the first place in eight (8) other countries. Furthermore, in three (03) African countries with low prevalence (Burundi, Ivory Coast and Togo) the rhythm method remains the dominant method as it used to be in Madagascar according to the 1997 survey.

To summarize, the data show that the method mix varies a lot with no definite pattern emerging *(2)*. The situation of a given country or region results from intertwined and interacting factors. These factors include financial and operational constraints (such as the lack of facilities, medical and paramedical staff for certain methods) which prevents from providing certain methods at a large scale, and ease .in providing certain other methods. Factors also include legal and cultural barriers, either effective or assumed, to using some methods and , by contrast, the choice by users themselves or choices more or less dictated by the medical and paramedical staff.

The method mix varies according to the evolution of needs, that is as contraceptive utilization extends to new categories of the population, the evolution of users' choice as well as changes in supplying and availability of the different methods, whether those changes are accidental or wanted. Though it is observed in developing as well as in developed countries that users resort more and more to modern methods at the expense of traditional methods and female sterilization, there is no convergence towards one or even two or three types of specific method mix.

In Madagascar as in many other countries, a single method is being used by more than half of female users. The principal method is the injectable contraceptive (54%), the

second one being pills (25%). Eighty percent (80%) of users in total resort either to injectables or pills.

What could be the future method mix, especially with the sustained progress of modern contraceptive method utilization? Trends projection, based on the distribution observed in surveys done since 1992, shows an increased dominance of injectables and pills to the point that these two methods may make up 90% of methods used by 2010. Another way to explore the future is to observe how the method mix has changed in developing countries where there has been a marked increase of modern contraceptive method utilization in the last 20-30 years. We selected Bangladesh and Indonesia as examples.

The percentage of women in union using a modern contraceptive method in Bangladesh increased from 8.9% (1979) to 41.5% as shown by a survey done in 1996-1997., There were no marked difference between the proportions of women resorting to sterilization or using pills, respectively 37% and 40% in 1979, but between the two periods this distribution changed at the expense of sterilization. Indeed, pills had a dominant position in 1996-1997 with 50% of users while the proportion of sterilization was almost reduced by half at 21%. The reason for this change is quite obvious. At the beginning the program put the emphasis on women who already had many children and wished to have no more. This lead to massive sterilization. As contraception utilization was spreading in the population, the proportion of needs in matter of birth-giving ending contraception decreased and birth spacing contraception needs took over, leading to increased use of pills and reversible methods in general.

In Indonesia, the percentage of women in union using a contraceptive method increased from 17.3% to 52.1% between 1976 and 1994. In 1976, the dominant method was pills with more than two thirds of female users (67.1%). The next method was the intra-uterine device with 23.7%. In 1994, the method mix was more balanced with about a third of clients using pills, another third injectables and the last third intra-uterine device. This reflects a diversification of needs which occurs as contraception spreads in the population.

Based on these observations, the hypothesis for Madagascar is the diversification of methods provided and used as modern methods utilization increases in the country. A decrease of the proportion of injectables is assumed along with an increase of other methods. However, injectables will still be the dominant method as they are well-accepted by the population. The following distribution is projected by 2010: injectables, 37% (compared to 54% in 2000); pills 30% (compared to 25%); sterilization, 10% (compared to 7%), condoms 10% (compared to 5%), Norplant ® 8% (compared to 4%). Only the proportion of intra-uterine device users would remain the same at 4%. Though the hypothesis of method provision and utilization is based on a reasonable assumption, it remains an assumption and one should consider exploring other scenarios as programmatic options change.

Projection of needs by 2010

Future needs in contraceptives will depend on several factors, namely method utilization progress and method mix evolution. Those two factors are closely related since contraceptive provision diversification can speed up the spreading of contraceptive methods utilization in the population, as observed in several countries. From a programmatic point of view, a sudden change in modern contraceptive method utilization as well as in method mix is difficult to imagine unless some very exceptional event occur, because considerable time is needed for supplying delivery points, sensitizing and training service providers as well as informing, sensitizing, motivating, and overcoming the reluctance of new groups of people to using contraceptives in order to benefit from the advantages of this practice.

Projection of contraceptive needs was limited to the 2000-2010 period. It was assumed that the contraception utilization rate progress will remain one point per year (a little more than observed during the 1992-2000 period). The percentage of Malagasy women using modern contraceptive methods being estimated at 12% in mid-2000, the percentage would be 22% by 2010. It could also be assumed that the spread of contraception in the population would go faster and that the progress would reach 2 point per year starting in 2005, which will give a rate of women using modern contraceptive of 30% in 2010. For this hypothesis to become true, the different interveners in the family planning area will have to reach a consensus and a much stronger mobilization will be needed.

Therefore, using the FAMPLAN model designed by The Futures Group *(10)*, we projected the needs in contraceptive for the next ten years based on the trend hypothesis, that is to say one point of increase per year in modern contraception utilization, and obtained a rate of 22% of Malagasy women using modern contraception in 2010.

The combined effect of contraception utilization increase and increase of the number of women in union aged 15 to 49 during this period will result in a tremendous increase of users: 255,000 in mid-2000 to almost 640,000 in 2010, that is to say an increase by 2.5 times. The annual growth rate of the population using modern contraception and therefore the needs in contraceptive regardless of the methods will be about 10%. Under the hypothesis of a progression of two points per year starting in 2005, the projected number of users in 2010 will be 870,000, that is 3.4 times the number in 2000. The increase in contraceptive needs will be 13 to 14% per year.

In terms of amounts of products, the needs vary according to the method used and are estimated based on “conversion factors” which allows for calculation of amounts needed from the number of women using a given method. For instance, a pill users needs 15 cycles per year, a person who uses condoms for contraception will need 120 condoms per year and women using Depo-provera ® need 4 doses per year .

The increase in contraceptives needs between 2000 and 2010 calculated with those conversion factors depends on the hypothesis selected as regards the increase of

contraception utilization, the increase of the number of women in union, the hypothesis of method diversification (in the case of Madagascar, decrease of injectables and increase of other methods except intra-uterine device). Under the hypothesis of a one point progress per year in contraception utilization, the results are as follow: the number of sterilized women will increase by 2.5 times between 2000 and 2010; Norplant ® users by 3.6; IUD users by 2.3 (which reflects only the increase of women in union since the proportion of users does not change); and condom users by 5. One thing to note about this last method is that only the needs of couples using condoms as a contraceptive method were taken into account.

With these data and assuming that the purchase cost of contraceptives increases by 3% per year, the cost of corresponding supplies are estimated at 4.2 millions dollars in 2010 compared to 1.2 million in 2000, that is to say an increase by 4. This calculation is based on the set of hypotheses put forth above.

Conclusions

One should not give into excessive optimism when considering the good progress of modern contraception utilization recorded in Madagascar over the last years.

Indeed, on one hand the levels attained are quite modest and are not equally distributed over the country and social categories. On the other hand, there is no assurance that the recorded progress is sustainable.

In order to be sustainable, the Malagasy contraceptive revolution which started a decade ago requires that major efforts be carried out in terms of information, sensitization and motivation of many population categories, that contraceptives necessary to meet the needs be available, and that all population categories wishing to use contraceptives have full access to the contraceptives of their choice. This is a great challenge since only sustaining the current progress will result into an increase of needs of 10% per year in terms of amounts and an increase of almost 4 times in terms of supply costs between 2000 and 2010.

Implementing the national population policy put forth in 1990 and assuring fair and generalized access to freedom of choice in matter of reproduction for all couples implies great challenges.

Références

1) La seconde révolution contraceptive : la régulation des naissances en France de 1950 à 1985 / Henri Leridon, Yves Charbit, Philippe Collomb, Jean-Paul Sardon, Laurent Toulemon - Collection Travaux et documents / INED, ISSN 0071-8823 ; Cahier 117 - :

Institut National d'Etudes Démographiques : Presses Universitaires de France, Paris , 1987 (380 p)

2) United Nations, “ Levels and Trends of Contraceptive Use As Assessed in 1998 ”, /ESA/P/WP.155, 216 p., United Nations, New York, 1999.

3) MADAGASCAR, 1990,"Politique Nationale de Population pour le développement économique et social, Loi no. 90.030 du 19 décembre 1990" Antananarivo.

4) "Enquête Démographique et de Santé Madagascar 1992" -INSTITUT NATIONAL DE LA STATISTIQUE, DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, / MACRO International, Calverton, Maryland, USA, 1993.

5) "Enquête Démographique et de Santé Madagascar 1997" - INSTITUT NATIONAL DE LA STATISTIQUE, DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, MACRO International, Calverton, Maryland, USA, 1998.

6) INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DES MENAGES,août 2000,"Enquête prioritaire auprès des ménages 1999", rapport principal, Antananarivo.

7) Enquête MICS 2000

8) La fin des naissances non désirées" / Henri Leridon, Laurent Toulemon - dans Données sociales 1990.- Paris : INSEE, 1990.- pp. 293-296

9) Les enfants du désir : une révolution démographique" - Henri Leridon Paris Collection Pluriel, ISSN 0296-206, : Hachette littératures, 1998 (278 p.)

10) J.Stover, L;Heaton: " FAMPLAN, Version , 4 - A Computer Program fro Projecting Family Planning Requirements" - "The Policy Project", The Futures Group International, Washibnton D.C, December 1999 (127 p.).

ANNEX 2

Bibliography

Tananarive le 17 novembre 2000

From Jean-Pierre GUENGANT (Mission JSI/Futures Group International, à Madagascar du 6 au 17 novembre 2000)

Bibliographie Générale et Bibliographie extraite d'un document de Jim Allman sur la situation démographique à Madagascar

Bibliographie Générale

Banque mondiale, 1998 : " Rapport sur le développement dans le monde, 1998-1999 : Le savoir au service du développement " Oxford University Press, 252 p.

Banque mondiale, 1998 : " Madagascar, Un agenda pour la croissance et la réduction de la pauvreté ", Les rapports économiques de la Banque mondiale, Banque mondiale, Washington, D.C, 1999

Bongaarts J., 1982: "The fertility inhibiting effects of the intermediate fertility variables". Studies in Family Planning 13, no.67. New York, The Population Council.

Moreland S.et Guengant J.P., 1994 : " Striving for Mortality and Fertility Decline in Niger". Research Triangle Institute / The Futures Group, Research Triangle Park / Washington, 88p.

Ross J., Stover J., Willard A., 1999: " Profiles for Family Planning and Reproductive Health Programs " The Futures Group International, Glastonbury/Washington, 87p., plus Appendixes

United Nations, 1999 : " Word Population Prospects : The 1998 Revision , Volume I: Comprehensive Tables "- ST/ESA/SER.A/177, 627 pages, United Nations, New York, 1999.

United Nations, 1996 " Levels and Trends of Contraceptive Use As Assessed in 1998 ", /ESA/P/WP.155, 216 p., United Nations, New York, 1999.

United Nations, 1995 : " World Urbanization Prospects, The 1994 Revision ", New York, ST/ESA/SER.A150, 178 p.

Bibliographie Jim Allman (document sur la situation démographique à Madagascar) complétée par nos soins

ALLMAN J. et al., 2000, (à paraitre) "Fertility and Family Planning in Madagascar", Studies in Family Planning.

ALLMAN J. WILSON R., 1996, "Current and future trends in contraceptive prevalence in Madagascar, 1992-2002", APPROPOP/USAID, Antananarivo.

ALLMAN J. WILSON R., 1997, "L'utilisation des contraceptifs à Madagascar, 1992-2002", APPROPOP/USAID,Antananarivo.

ANDRIAMBOAHANGY B., 1973, "Confrontation de l'état civil avec un recensement: un exemple dans la préfecture d'Antsirabe" *Cahier d'ORSTOM* vol.10 (4), p.361-370.

CENTRE NATIONAL DE RECHERCHES SUR L'ENVIRONNEMENT, 1994, "Madagascar 1992, *Enquête Nationale Démographique et Sanitaire*/Demographic and Health Surveys" Antananarivo, Madagascar and Macro International, Calverton, Maryland, USA.

CHEVALIER L., 1952, "Madagascar, population et ressources".: Travaux et Document, Cahiers no. 15, INED/PUF, Paris.

COURBAGE Y. FARGUES P., 1979, "A Method for Deriving Mortality Estimates from Incomplete Vital Statistics." Population Studies vol.33 (1),p. 165-180.

FAMILY PLANNING ASSOCIATION OF MADAGASCAR, 1996, "Maternal and Child Health/Family Planning and Abortion in Madagascar", African Journal of Fertility, Sexuality and Reproductive Health vol.1 (1) mars p. 53-55.

GENDREAU F. 1969,"Quelques aspects de la recherche en démographie à Madagascar", Cahiers ORSTOM, série Sciences Humaines vol. 6 (4) p.93-127.

LACOMBE B., 1973, "Deux études sur l'etat civil de Madagascar." Cahier d'ORSTOM vol. 10 (4) p.343-370.

LACOMBE B., 1975,"Bibliographie Commentée des études de population à Madagascar", Initiations-Documentations techniques, no.27, ORSTOM,Paris.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE ET DE LA RECHERCHE ECONOMIQUE, 1966,"Enquête Démographique Madagascar 1966," août, Antananarivo.

MADAGASCAR, 1975,"Recensement 1975, Serie Etudes et Analyse, Guide Démographique", Antananarivo.

MADAGASCAR, DIRECTION GÉNÉRALE DU PLAN, UNITÉ DE POPULATION ET DÉVELOPPEMENT, 1988,"Etude sectorielle: Niveau, structure et tendence de la fécondite à Madagascar", Série Documents et études no.6, Antananarivo.

MADAGASCAR, 1990,"Politique Nationale de Population pour le développement économique et social, Loi no. 90.030 du 19 décembre 1990" Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DES MENAGES,1995, "Enquête permanente auprès des ménages", rapport principal, Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DES MENAGES,août 2000,"Enquête prioritaire auprès des ménages 1999", rapport principal, Antananarivo.

MADAGASCAR, MINISTERE DE LA SANTE, DIRECTION DES ETUDES ET DE LA PLANIFICATION, 1999, "Annuaire des Statistiques du Secteur Santé de Madagascar" 1999", Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, 1997, "Recensement Général de la Population et de l'Habitat, Août 1993, Resultats definitifs: analyse, Etat matrimonial et nuptialité", vol.II, (3), Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, 1997, "Recensement Général de la Population et de l'Habitat, Août 1993, Resultats definitifs: analyse, Fécondité et mortalité",vol. II, (4), Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE , DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, 1997, "Recensement Général de la Population et de l'Habitat, Août 1993, Migration" vol.II, (6),Antananarivo.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE, DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, 1993, "Enquête Démographique et de Santé Madagascar 1992",. MACRO International, Calverton, Maryland, USA.

MADAGASCAR, INSTITUT NATIONAL DE LA STATISTIQUE, DIRECTION DE LA DEMOGRAPHIE ET DES STATISTIQUES SOCIALES, 1998, "Enquête Démographique et de Santé Madagascar 1997",. MACRO International, Calverton, Maryland, USA.

MADAGASCAR, MINISTERE DE LA SANTE, 1996, "Politique Nationale de Santé", Antananarivo.

MADAGASCAR, MINISTERE DE LA SANTE, DIRECTION DES ETUDES ET DE LA PLANIFICATION, 1998, "L'aide exterieure à la santé," Antananarivo.

MIDI MADAGASCAR, 1998,"La reprise se confirme..." Samedi 7 novembre, p. 4.

RABETSITONTA T. RAKOTO G. DISAINE B. 1988, "Enquête sur la fécondite et les comportements en matière de procréation dans la capitale malgache", OSIPD, Antananarivo.

RATOVONDRAHONA P. VADANAIS D., 1999, "La capitale malgasche en transition demographiques", Demographic and Health Surveys, Macro International Inc.,Calverton, Maryland, USA.

RAMAROKOTO D. 1997, "Agriculture: enjeux et contraintes de la Liberalisation", Economie de Madagascar, no. 2, p. 7-12.

RAZAFIMANDIMBY L., 1997, "L'ajustment dans le secteur agricole", Economie de Madagascar, no. 2, p. 13-36.

RAZAFINDRAKOTO M., 1996, "Dynamique du secteur industriel moderne sur longue période ou comment se perdre en une décénnie?", Economie de Madagascar, no.1, p. 41-69.

RAZAFINDRAKOTO M. ROUBAUD F., 1997, "Les entreprisies franches à Madagascar", Economie de Madagascar, no. 2, p. 217-248.

ROUBAUD F., 1997, "La question rizicole à Madagascar: les résultats d'une décennie de libéralisation", Economie de Madagascar, no. 2, p. 37-61.

UNFPA, 1993, "Rapport d'analyse du programme et d'élaboration de la stratégie, Madagascar", no.35, New York.

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT MACRO INTERNATIONAL INC., 1998, Nutrition of Young Children and Thier Mothers in Madagascar", Calverton, Maryland, USA.

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT MACRO INTERNATIONAL INC., 1999, "Nutrition and Health Status of Young Children and Their Mothers in Madagascar, Findings from the 1997 Madagascar Demographic and Health Survey",Calverton, Maryland, USA.

WALTISPERGER D. CANTRELLE P. RALIJAONA O., 1997, "La Mortalité a Antananarivo de 1984 a 1995," Les Documents et Manuels du CEPED, no.7, Paris.

WORLD BANK, 1996, "Madagascar, Poverty Assessment", Washington, D.C.

WORLD BANK, 1998, "Rapport trimestriel, no.8 octobre-décembre 1997", Antananarivo.

ANNEX 3

Mission Futures Group

(Projet JSI/USAID)

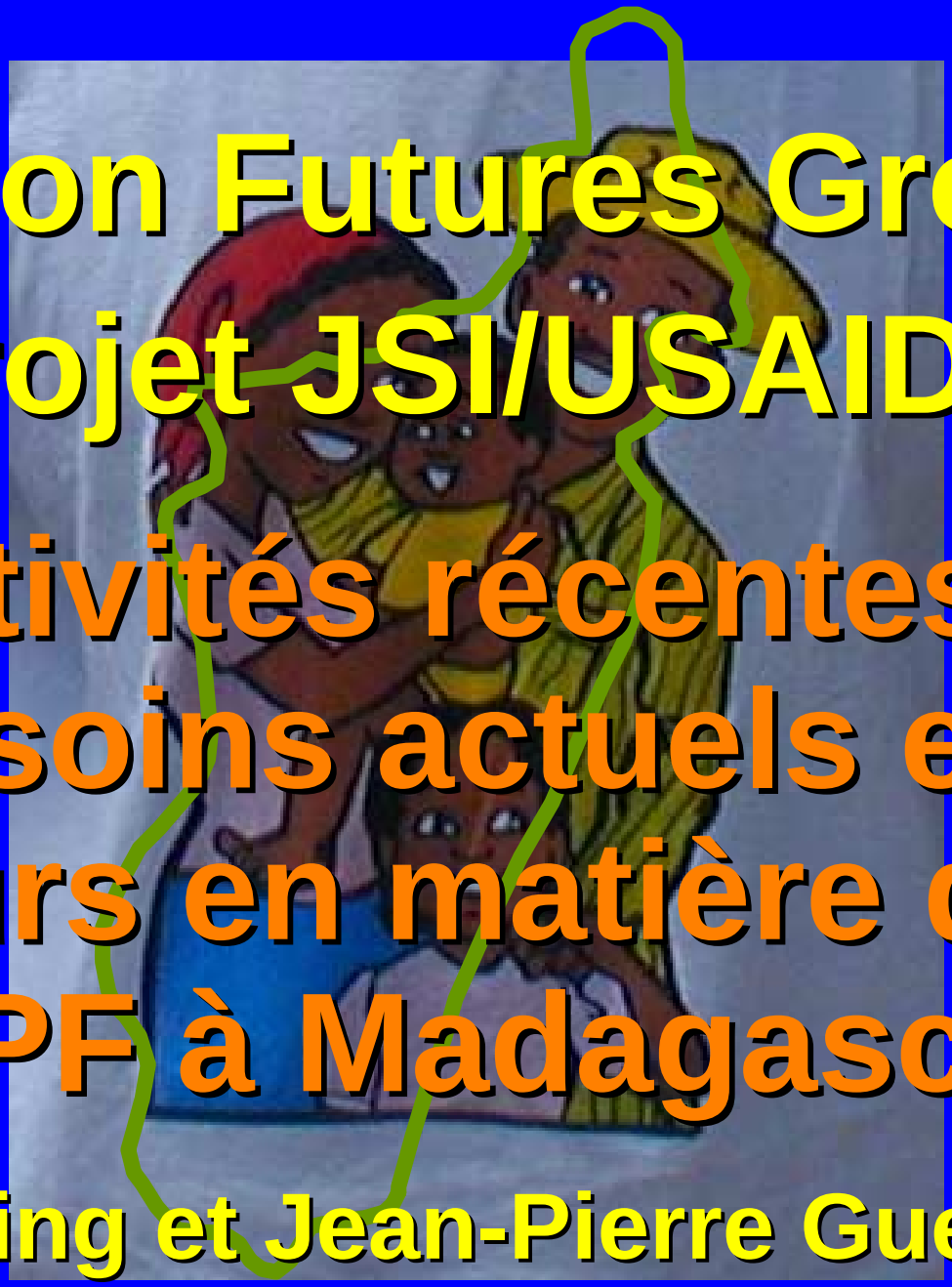
Activités récentes, besoins actuels et futurs en matière de SR/PF à Madagascar

Joe Deering et Jean-Pierre Guengant

Novembre 2000

(Diaporama)

Mission Futures Group (Projet JSI/USAID)



Activités récentes, besoins actuels et futurs en matière de SR/PF à Madagascar

Joe Deering et Jean-Pierre Guengant

Objectifs de la mission

1 - Analyser les activités passées en matière de SR/PF.

2 - Apprécier l'adéquation entre l 'offre actuelle et les besoins en la matière.

3 - Elaborer divers scénario d'évolution pour les années à venir (à l aide de FAMPLAN).

4 Répondre aux attentes de dialogue entre les partenaires actuels

Dynamique de la progression de l'utilisation de la contraception depuis 1990

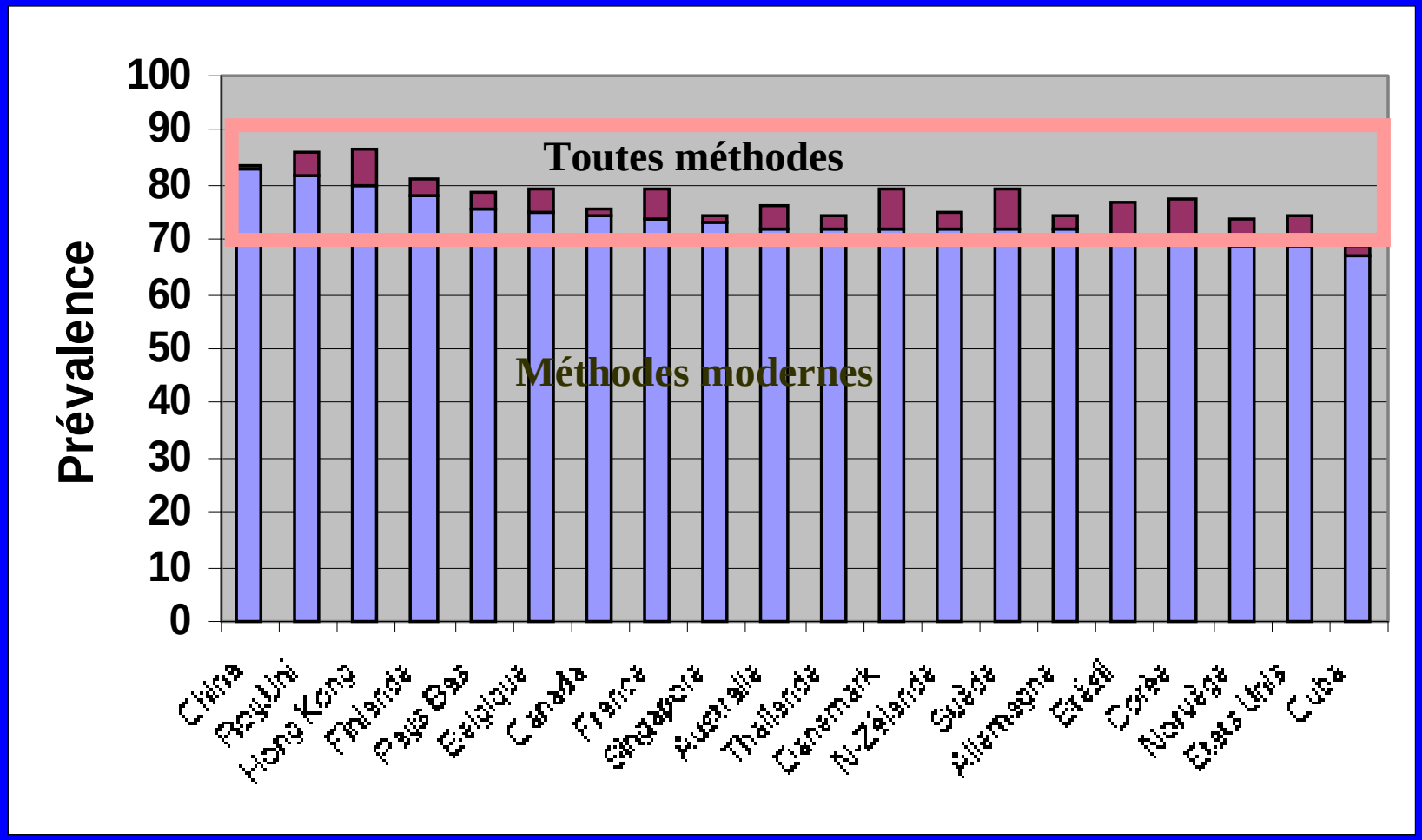
- **niveaux atteints,**
- **rythme de progression,**
- **comparaisons internationales.**

Utilisation des méthodes modernes de contraception depuis 1992

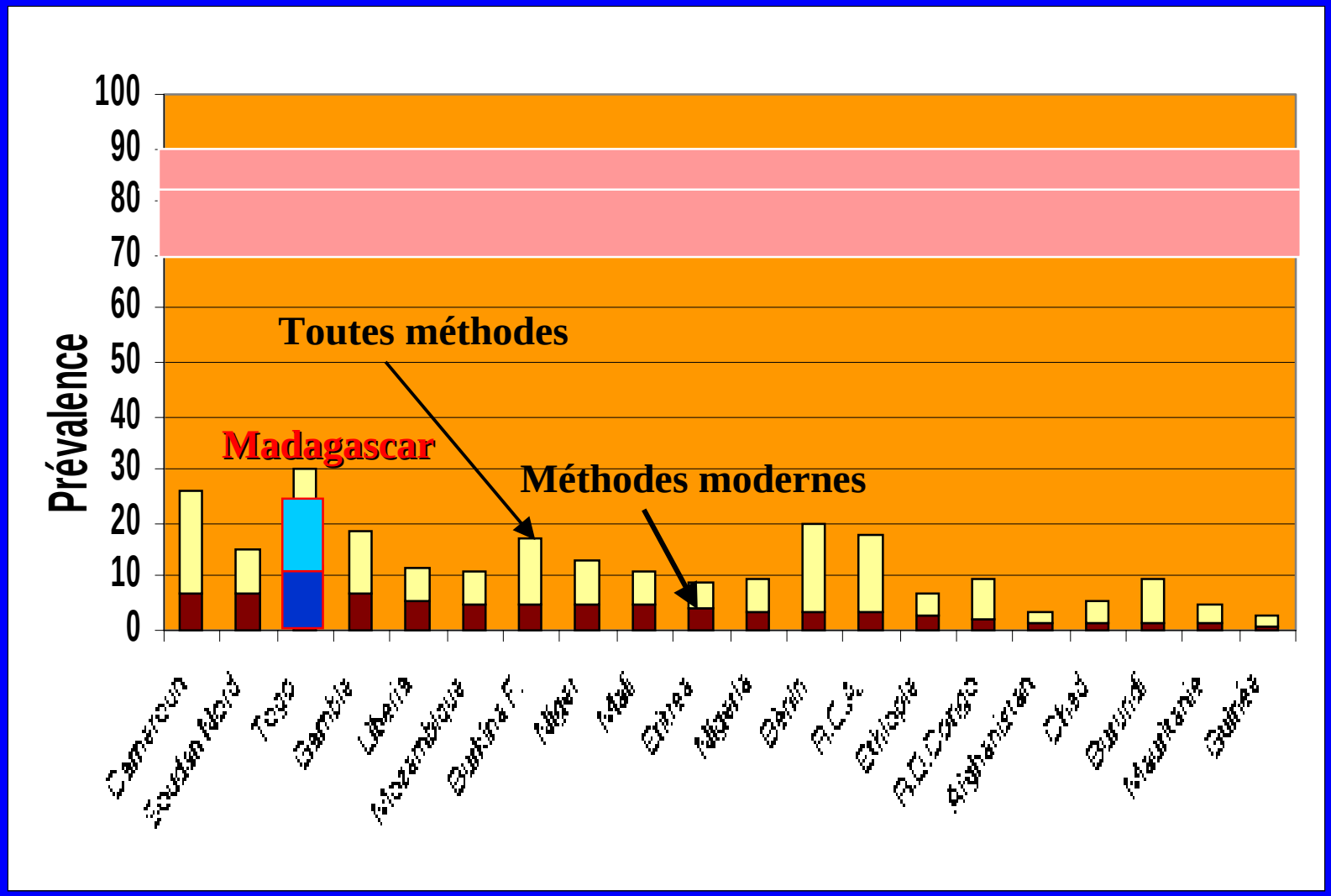
Femmes en union de 15 à 49 ans

Années	Méthodes modernes	Périodes	Croissance annuelle de la prévalence
1992	5,1		
		1992-1997	0,9
1997	9,9		
		1992-1997	1,6
1999	13,0		
	?	1997-2000	-1,6
2000	11,8		
		1992-2000	0,8
		Regression	
		1992-2000	0,9

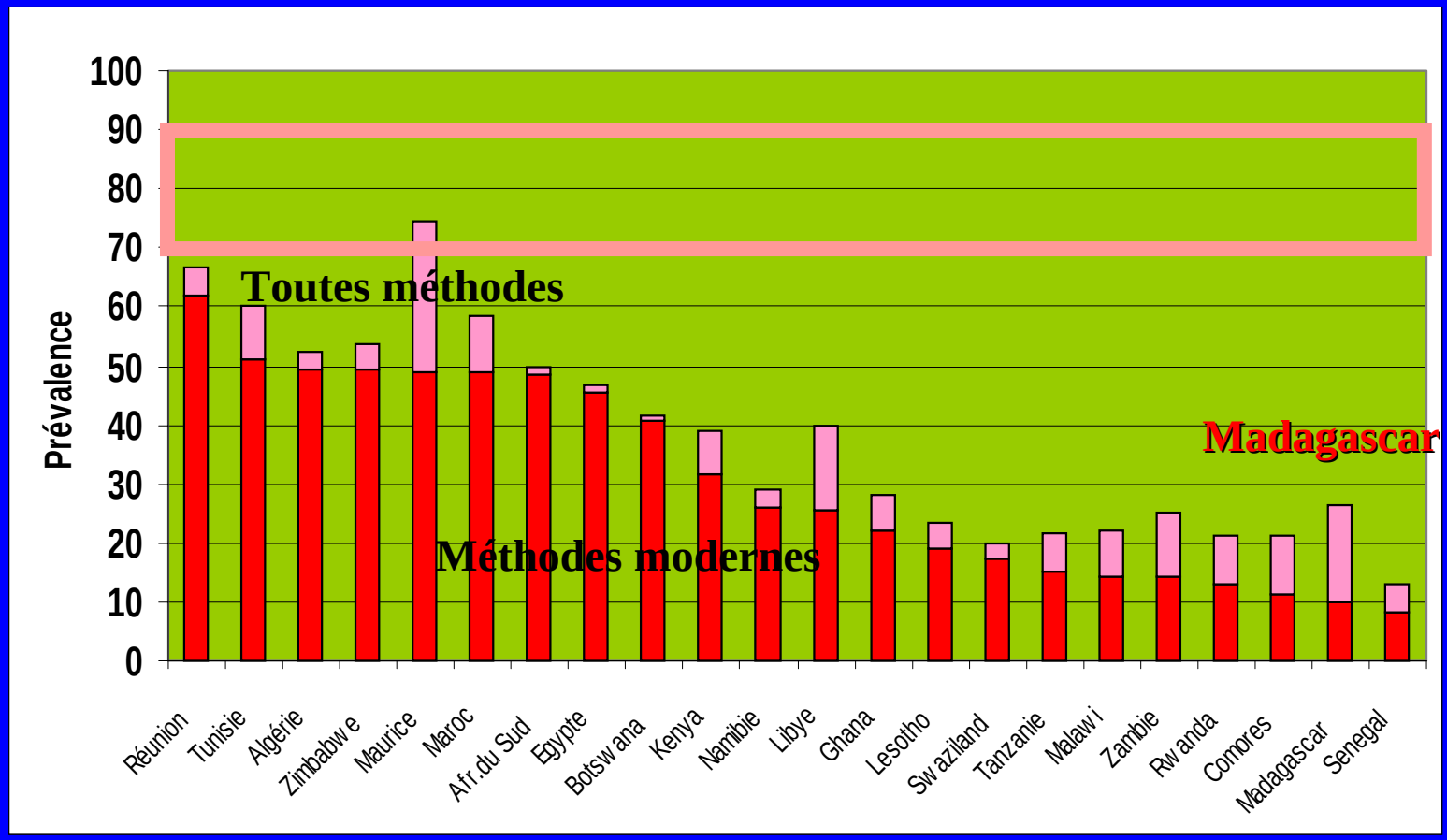
Les 20 pays ayant la prévalence la plus élevée (femmes en union)



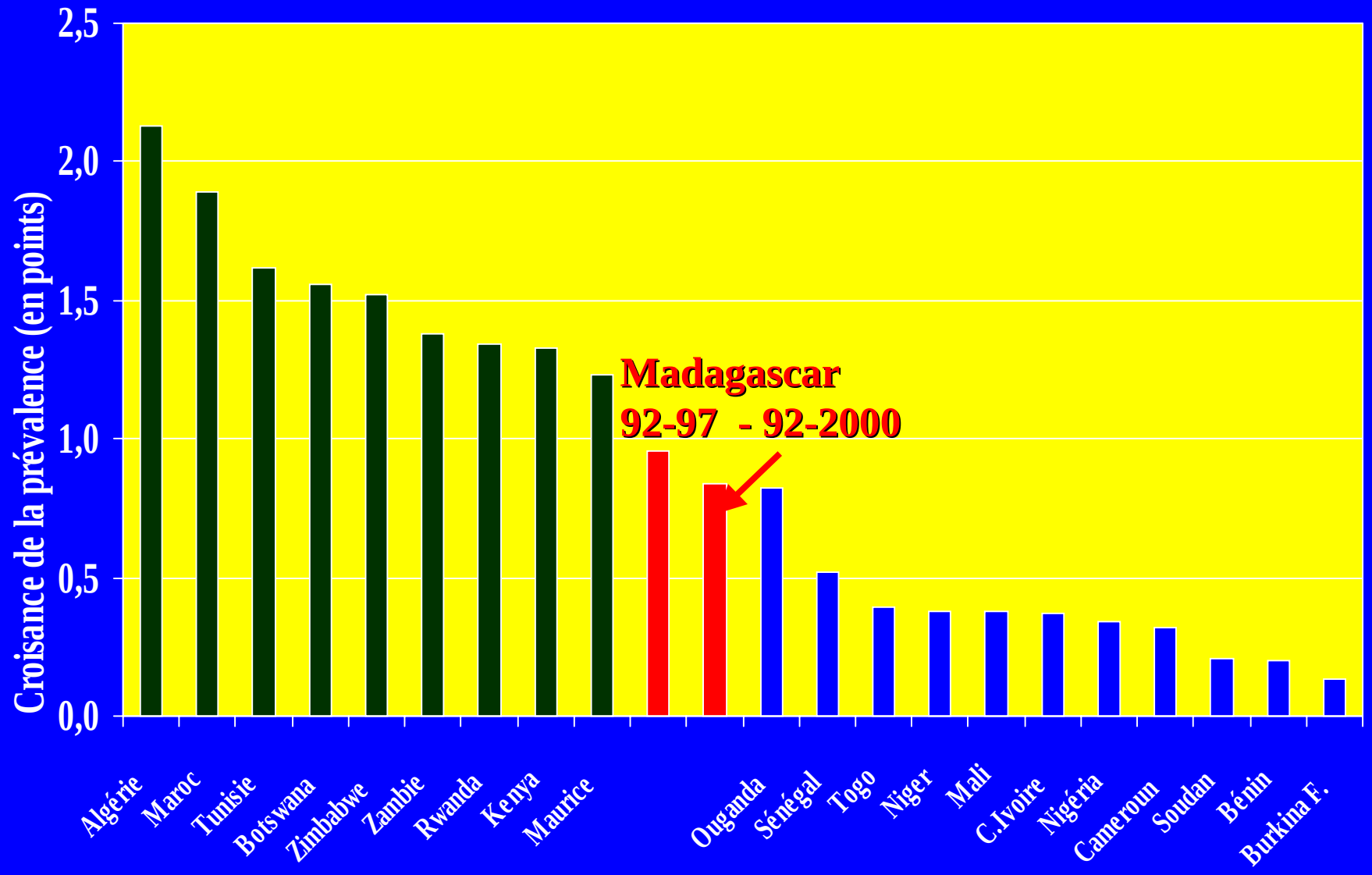
Les 20 pays ayant la prévalence la moins élevée (femmes en union)



Les 20 pays africains à la prévalence la plus élevée (femmes en union)



Points de croissance annuelle moyenne de la prévalence en Afrique



Moyens mis en œuvre pour garantir la sécurité contraceptive des utilisateurs

- **contribution de chacun des acteurs,**
- **contraintes, problèmes actuels,**
- **recommandations, actions à mettre en œuvre.**

La sécurité contraceptive: définition:

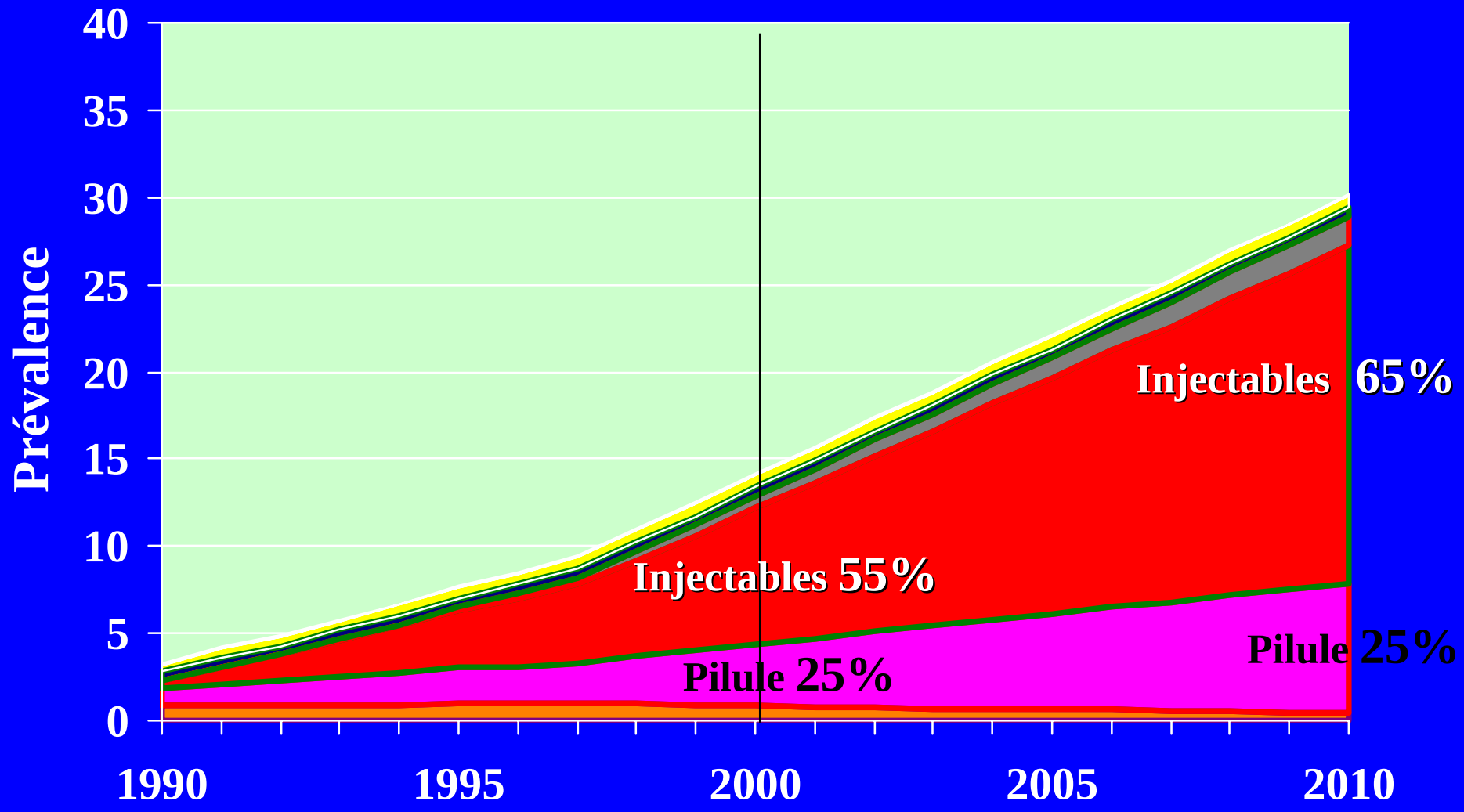
La sécurité contraceptive est l ’accés continu, aux meilleurs coûts, aux méthodes modernes de contraception dans l ’ensemble du pays.

- **Vision commune entre les partenaires,**
- **participation accrue du Gouvernement de Madagascar,**
- **développement du secteur privé**
- **participation accrue de nouvelles sources de financement.**

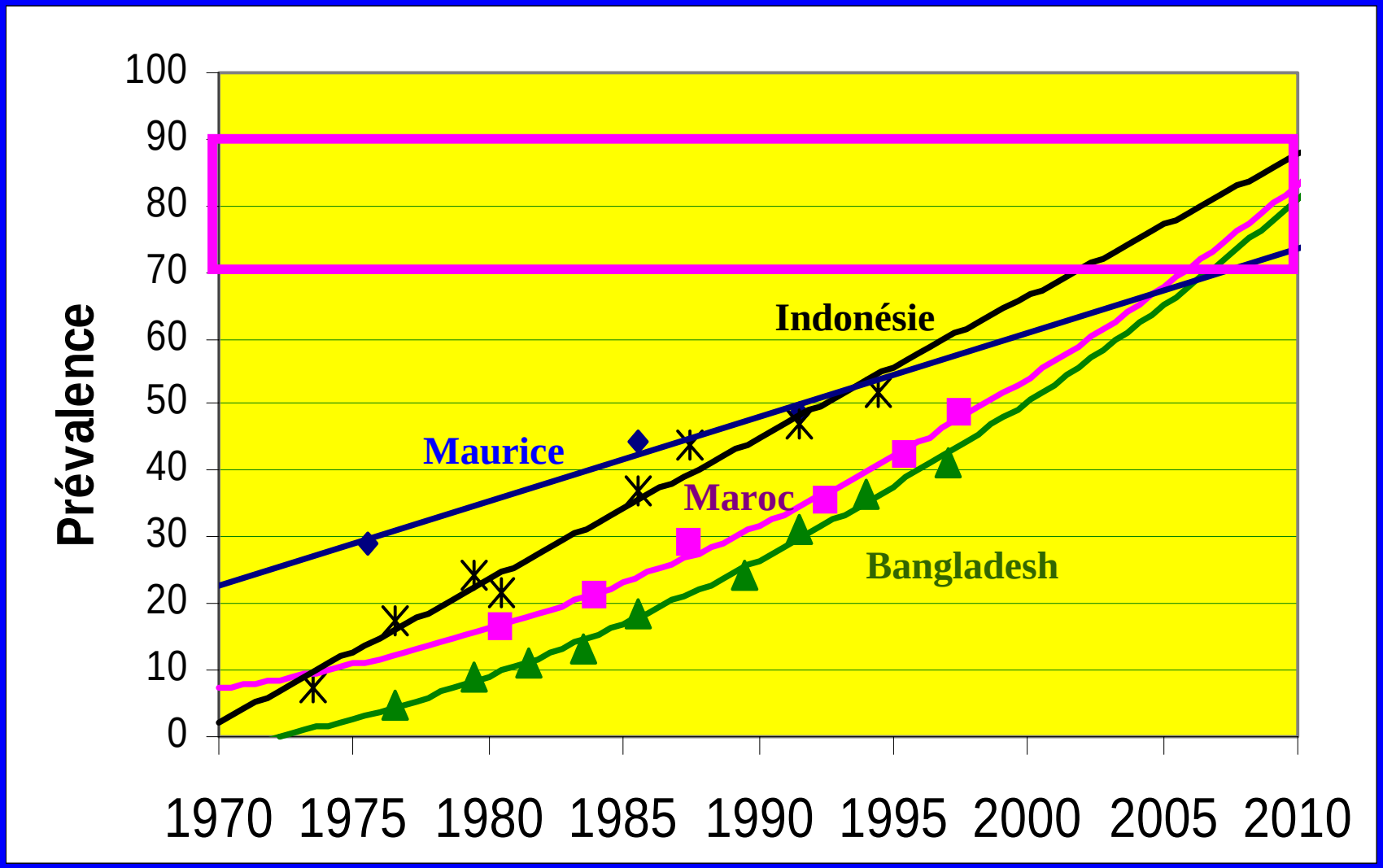
«Method mix»

- facteurs à considérer,
- comparaisons internationales,
- structure actuelle
- quelle évolution pour le futur ?

Evolution tendancielle du «Method mix» 1990-2010

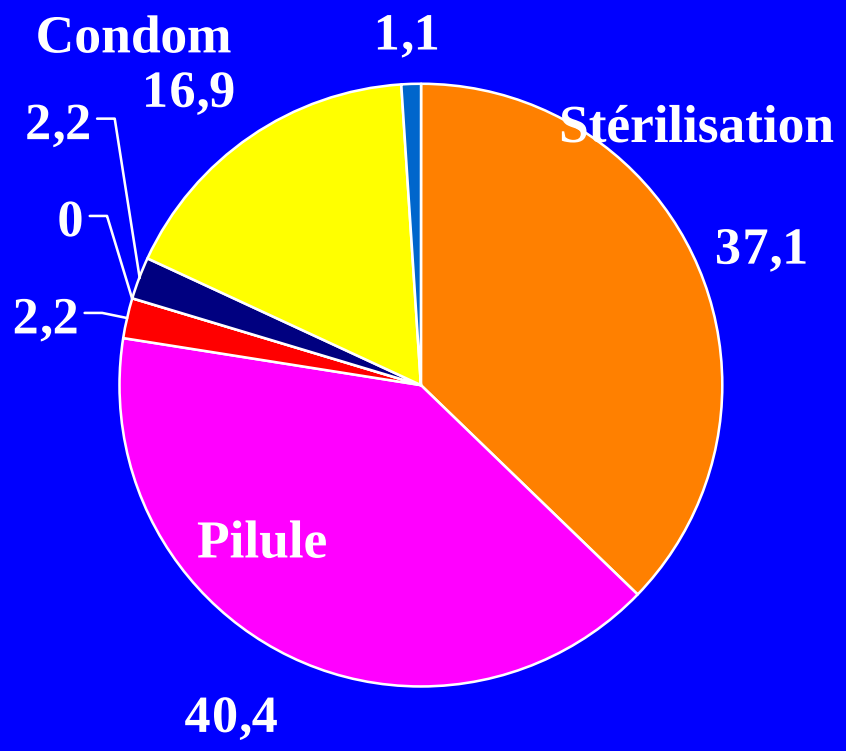


Evolution de la prévalence dans quelques pays (femmes en union)



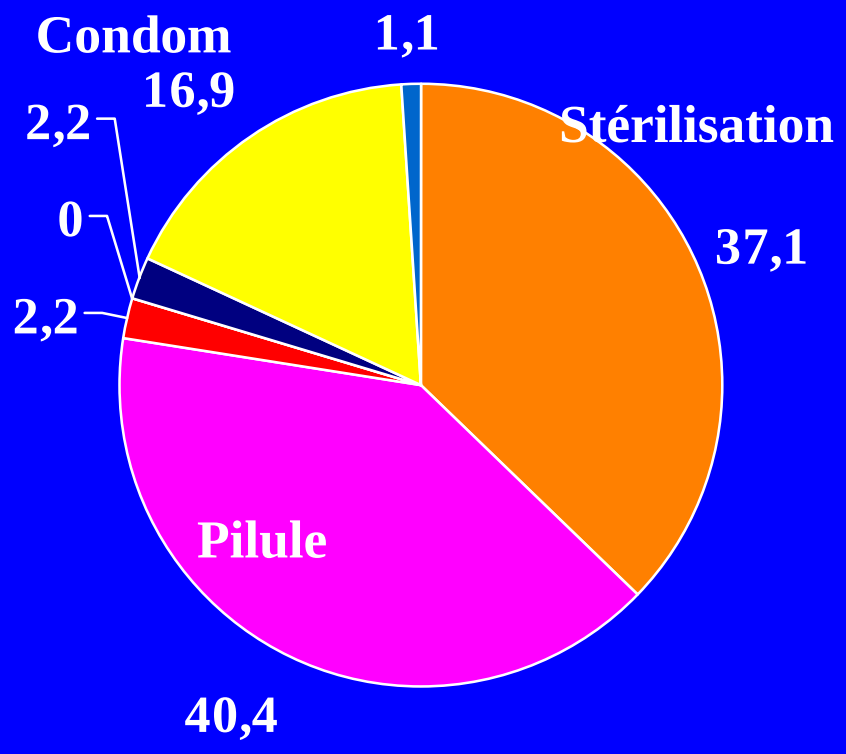
Evolution du « Method mix » au Bangladesh (femmes en union)

Bangladesh 1979
8,9%

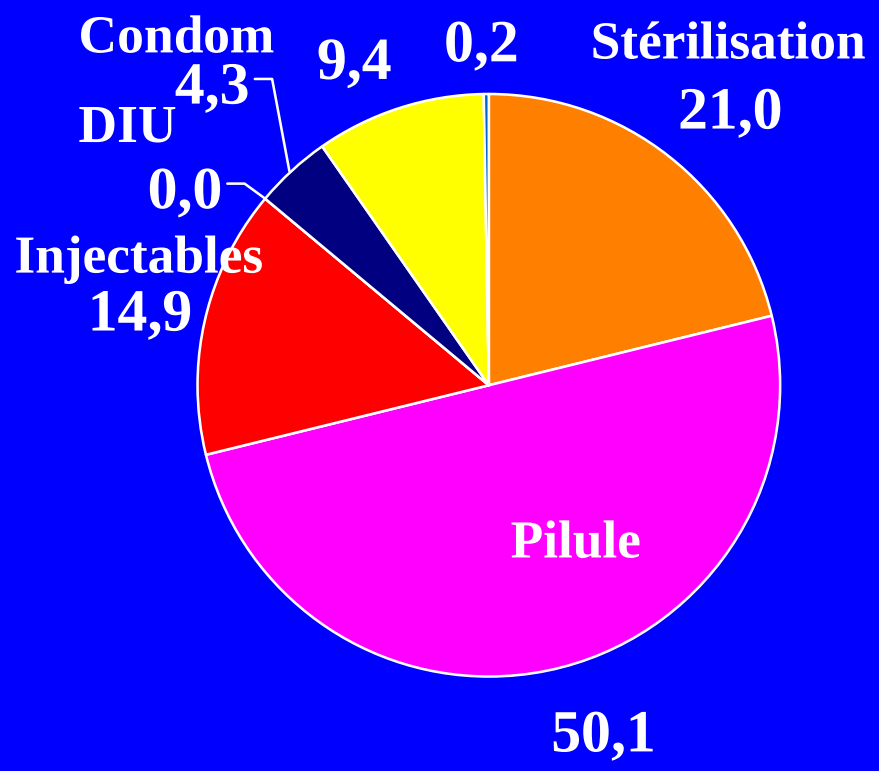


Evolution du « Method mix » au Bangladesh (femmes en union)

Bangladesh 1979
8,9%

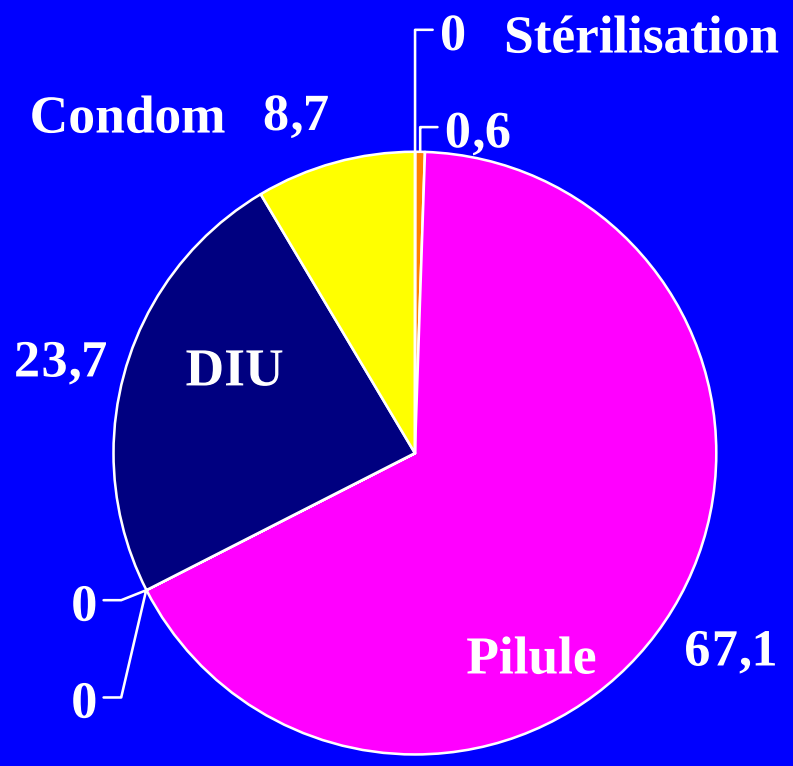


Bangladesh 96-97
41,5%



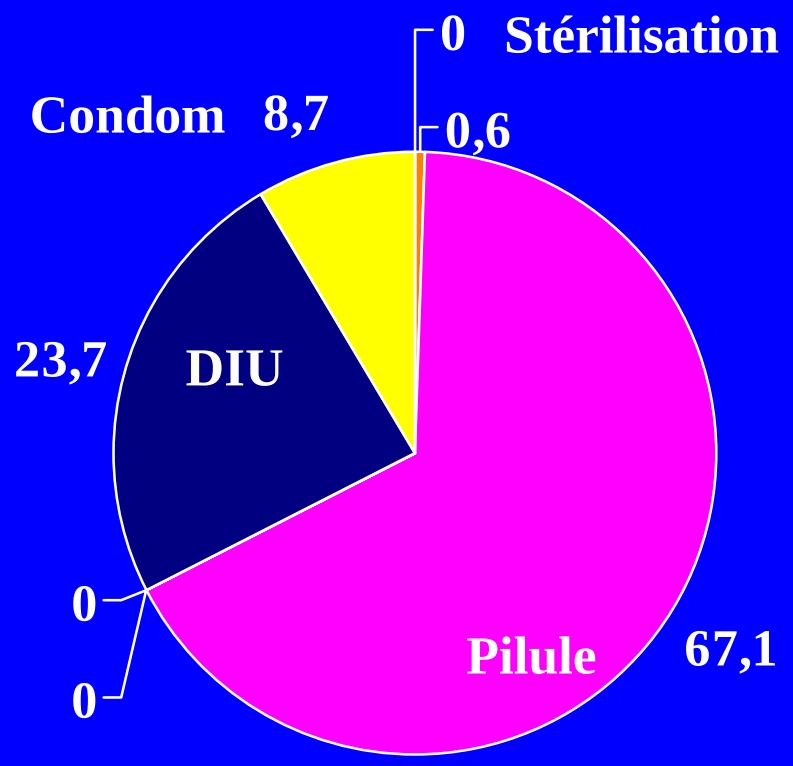
Evolution du « Method mix » en Indonésie (femmes en union)

Indonésie 1976
17,3%

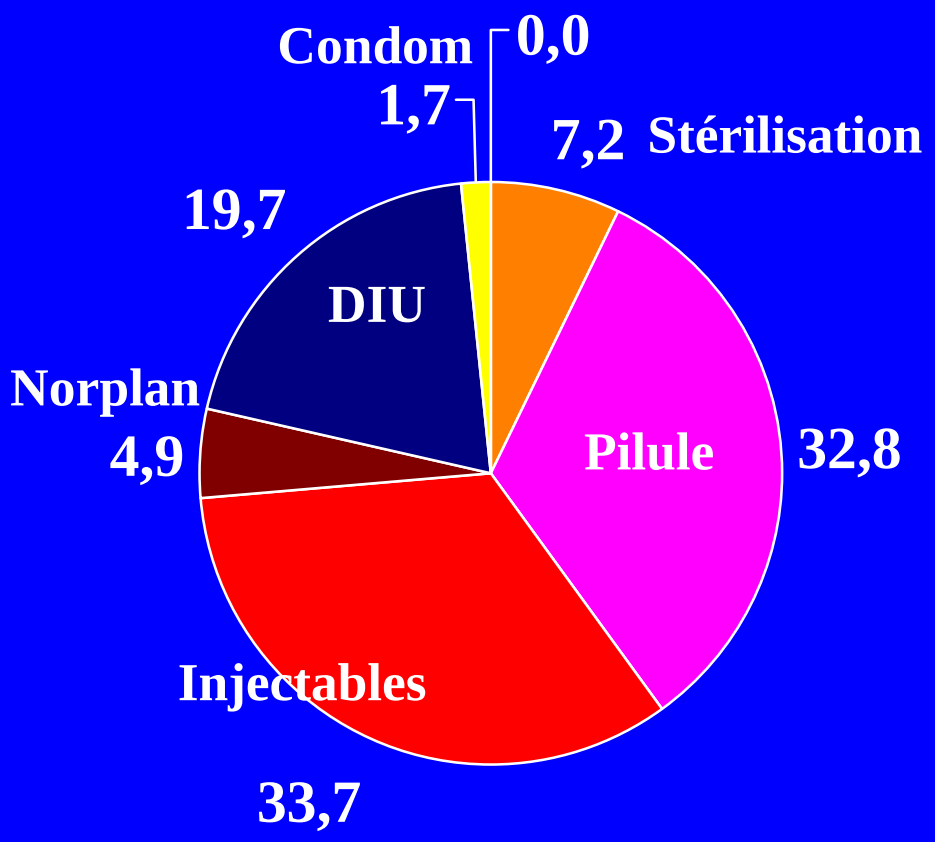


Evolution du « Method mix » en Indonésie (femmes en union)

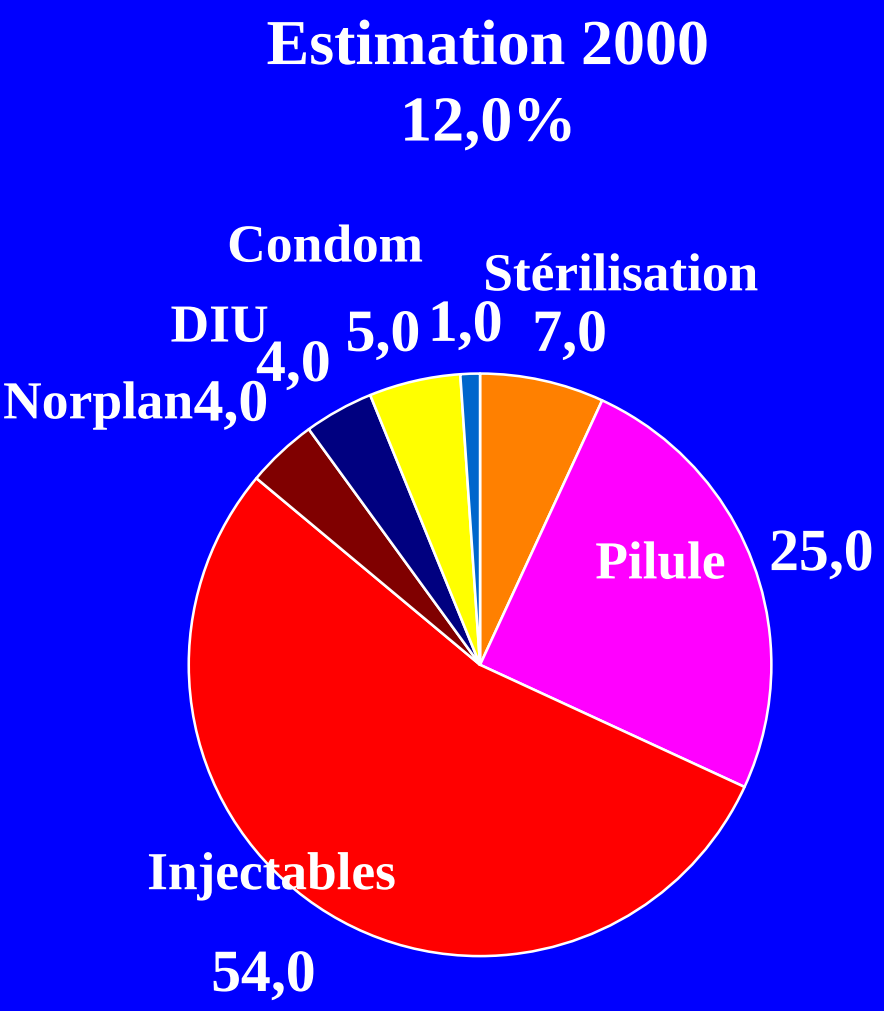
Indonésie 1976
17,3%



Indonésie 1994
52,1%

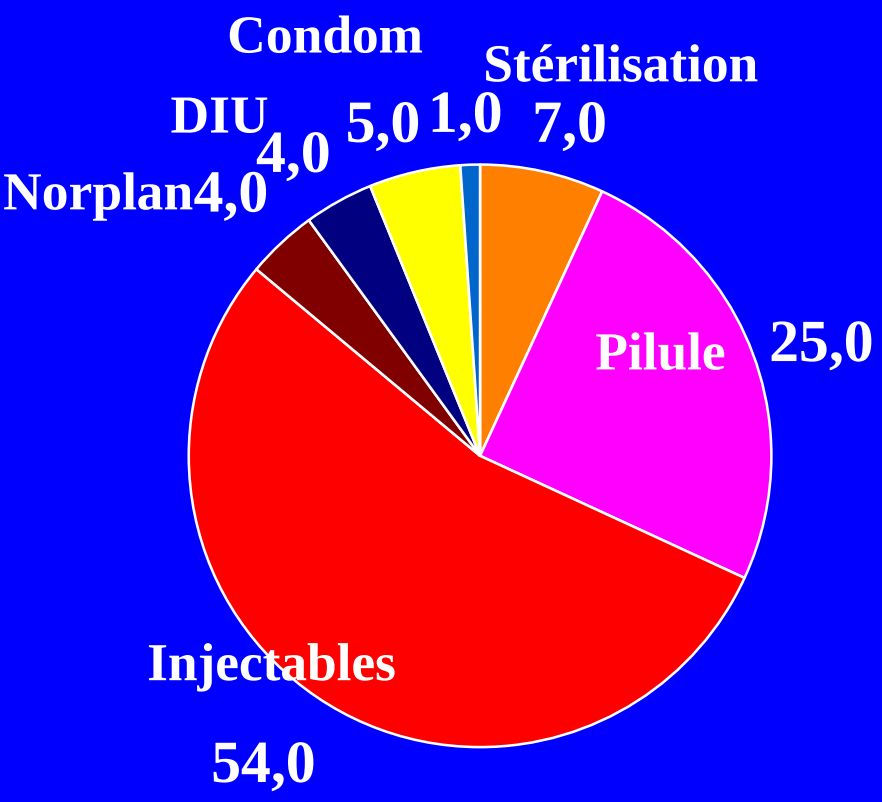


Projection du « Method mix » pour Madagascar (femmes en union)

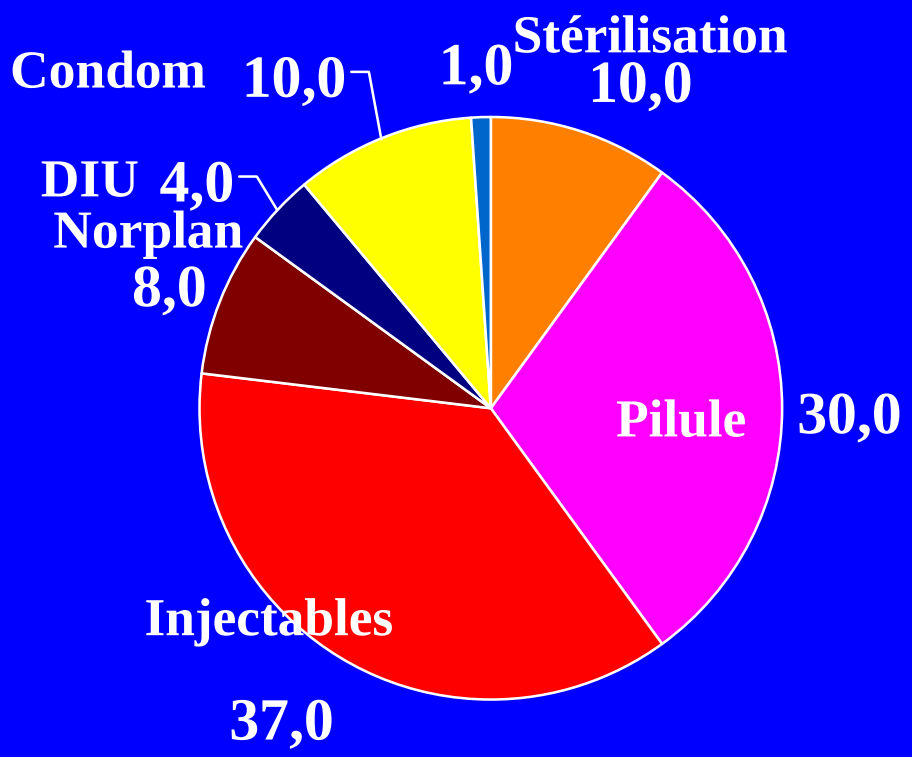


Projection du « Method mix » pour Madagascar (femmes en union)

Estimation 2000
12,0%



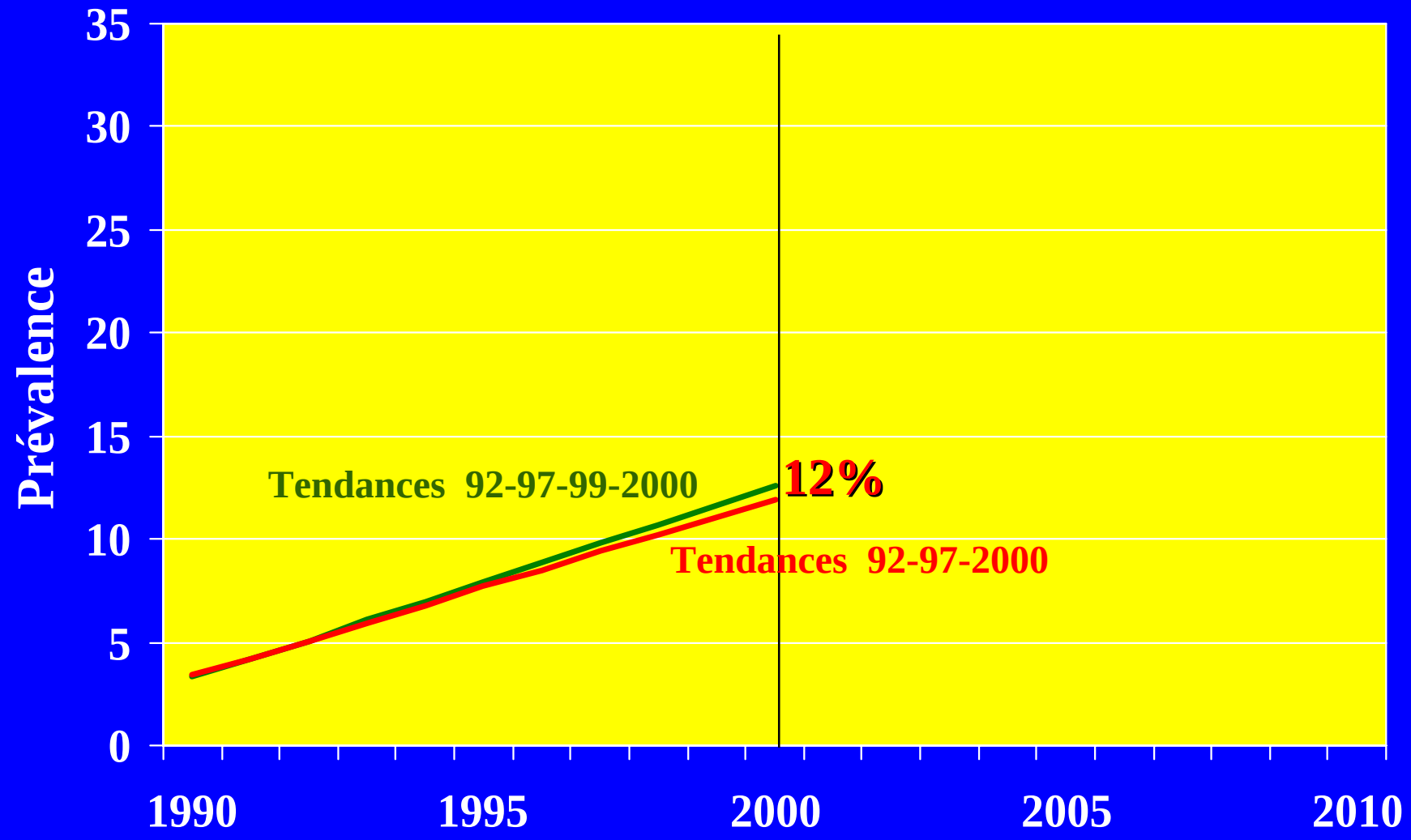
Projection 2010
entre 22 et 30 %



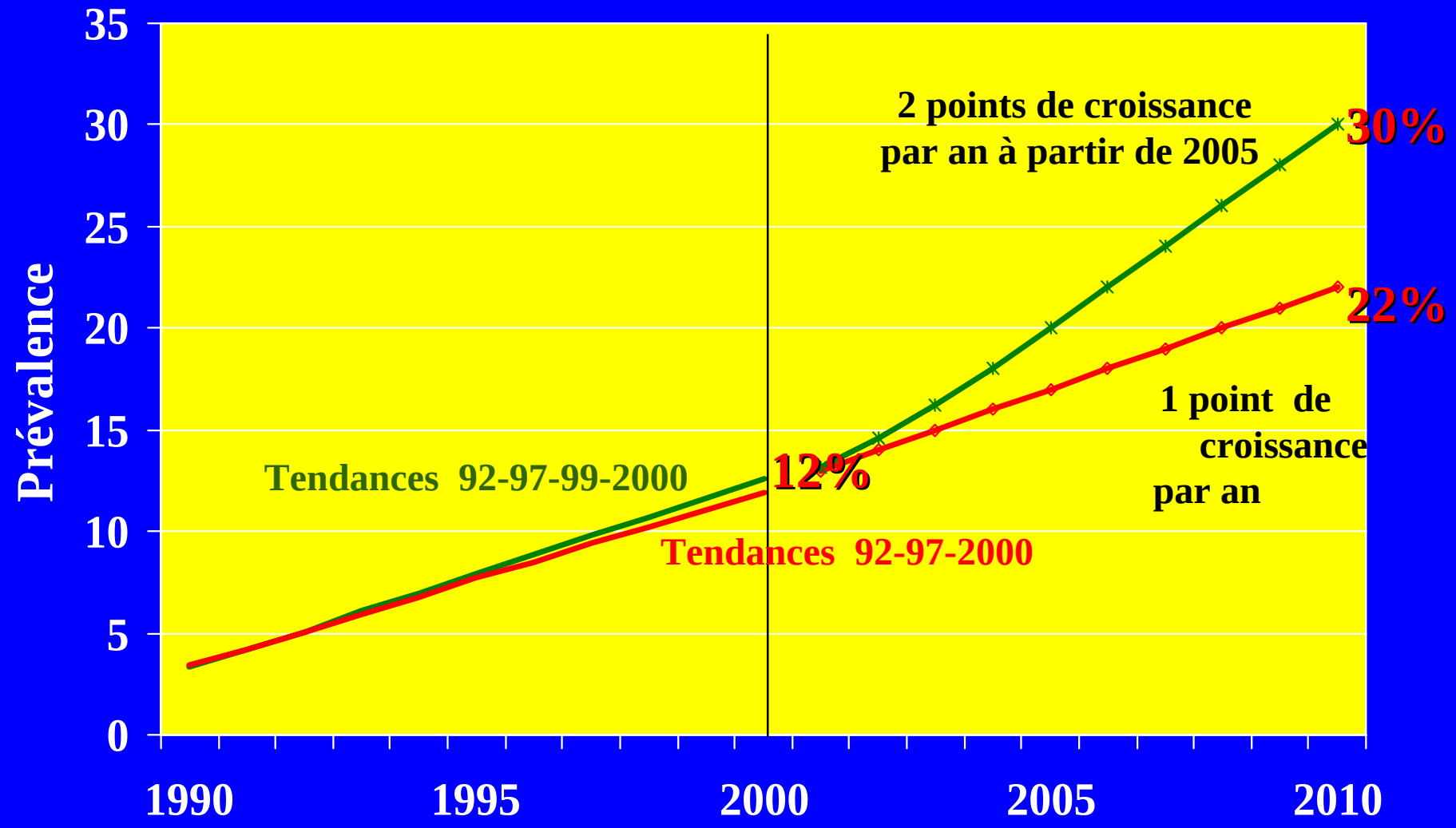
Scénarios d ’évolution pour chacune des 10 années à venir

- **progression de l’utilisation des méthodes modernes**
- **évolution du « méthod mix »**
- **coûts**

Hypothèses d'évolution de la prévalence contraceptive 2000-2010

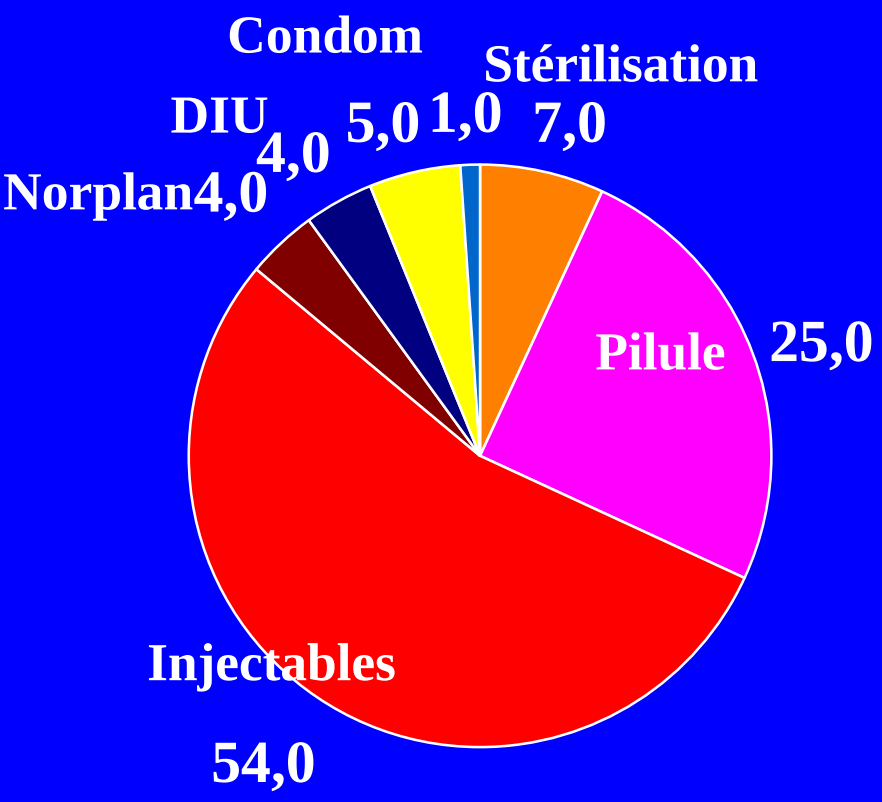


Hypothèses d'évolution de la prévalence contraceptive 2000-2010

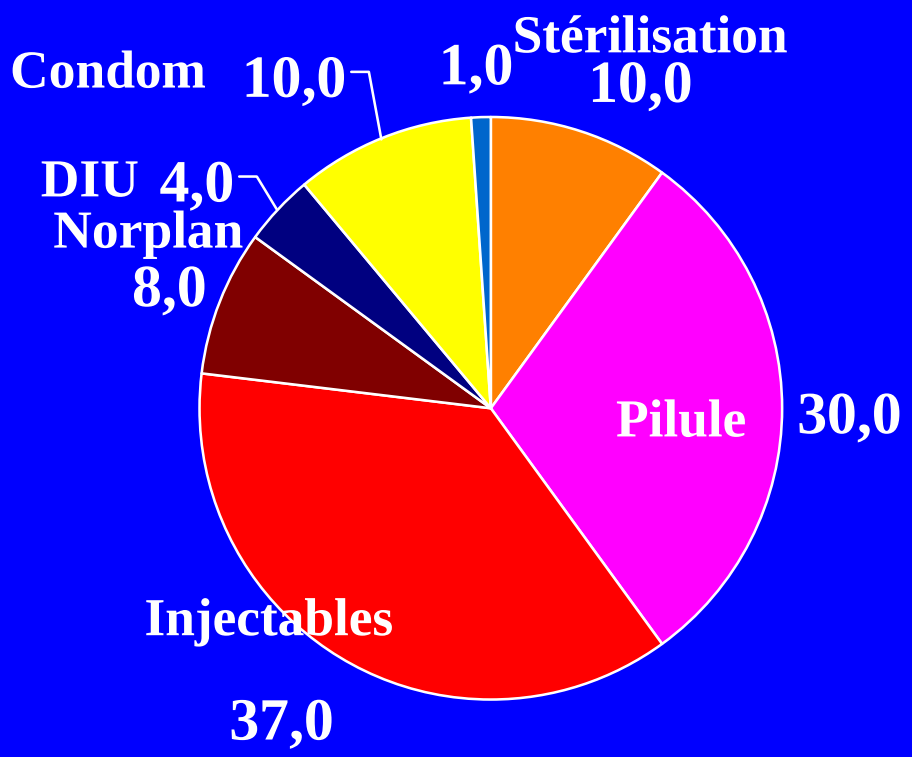


Projection du « Method mix » pour Madagascar (femmes en union)

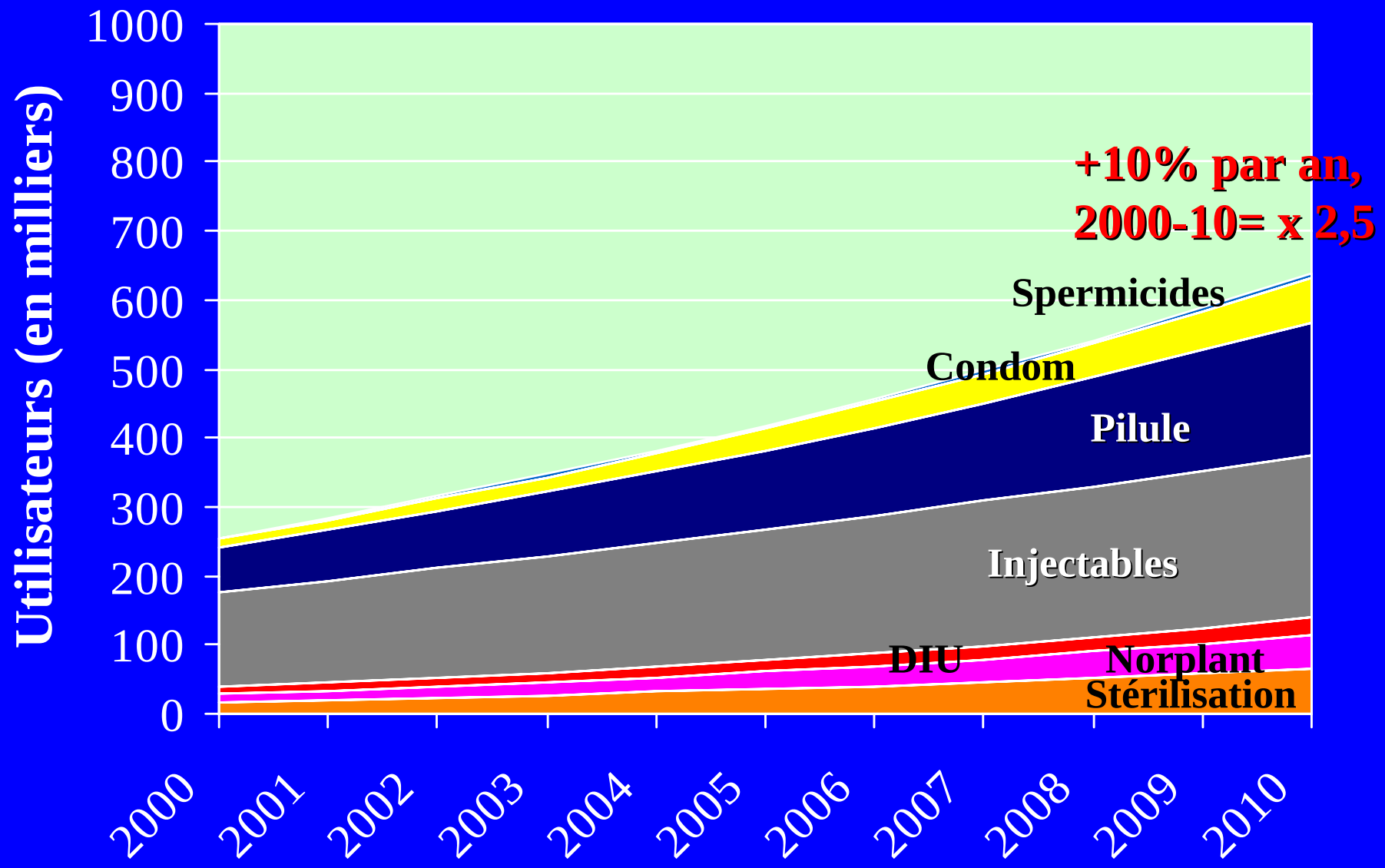
Estimation 2000
12,0%



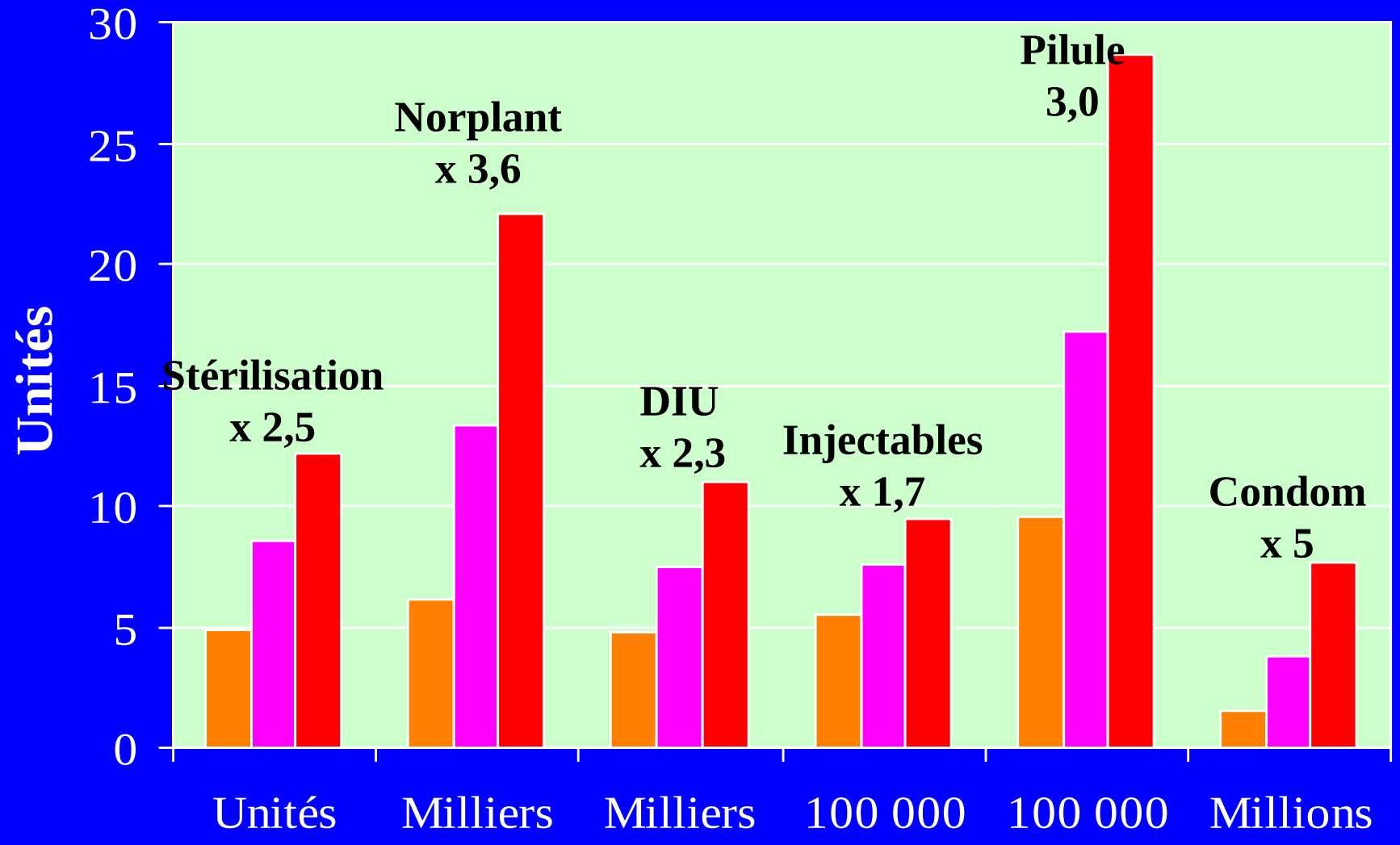
Projection 2010
entre 22 et 30 %



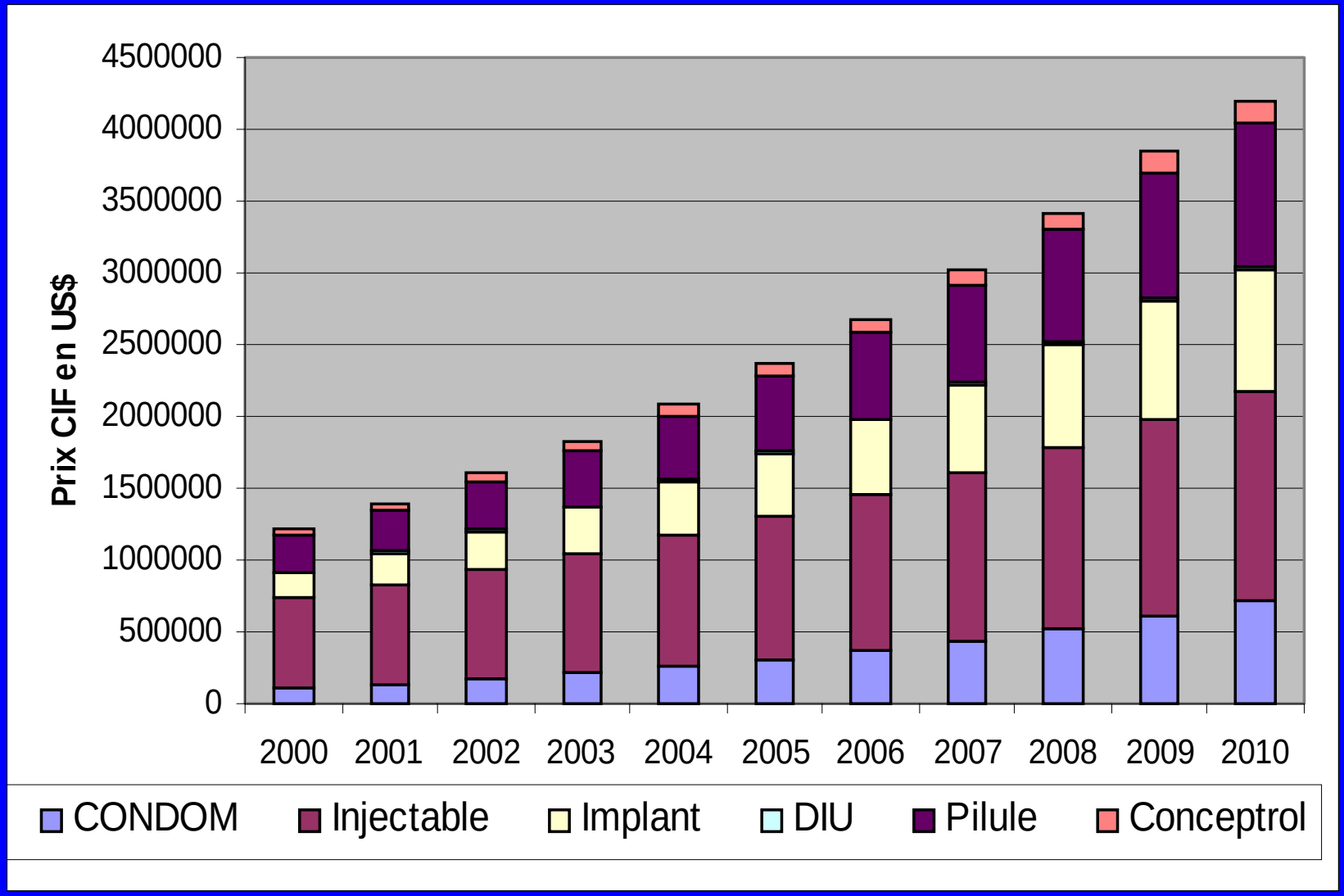
Evolution du nombre d'utilisateurs par méthode 2000-2010



Evolution des besoins en contraceptifs par méthode 2000-2010



Valeur d'achat des produits par année 2000:1,2 Mns $, 2010:4,2 Mns $



Conclusions: étapes suivantes

RENFORCEMENT DU DIALOGUE POLITIQUE SUR LA SR

- CE DIALOGUE S'EST INTENSIFIE RECEMMENT AU COURS DE LA REFORME DU SECTEUR DE LA SANTE

- LES GRANDS AXES DE LA POLITIQUE DE SANTE, TELS QUE LA MATERNITE SANS RISQUES ET LA DECENTRALISATION, DOIVENT SE BASER SUR DES POLITIQUES OPERATIONELLES DETAILLEES

IL EST ESSENTIEL D'HARMONISER CES POLITIQUES (SANTE ET DECENTRALISATION) ENTRE ELLES, ET LEURS GRANDS AXES

Plan d ’action proposé

POUR HARMONISER
LES POLITIQUES OPERATIONELLES

PHASE 1 - NOVEMBRE-DECEMBRE 2000

- **ANALYSE DES BESOINS EN CONTRACEPTIFS POUR LA PERIODE 2001/2003, ET MISE AU POINT D’UNE METHODO-LOGIE STANDARDISEE POUR L’ACHAT ET L’APPROVISIONNEMENT PAR LES PARTENAIRES**

- **FINANCEMENT AU COURT TERME**

PLAN D'ACTION PROPOSE

PHASE 2 - JANVIER 2001 – JUIN 2002

- **CHOISIR 4-5 VOLETS DES POLITIQUES PRIORITAIRES POUR UN DIALOGUE APPROFONDI**

- **FORMER LES EXPERTS ET LES TECHNICIENS A LA PREPARATION DES DOSSIERS**

PLAN D'ACTION PROPOSE

PHASE 2 - JANVIER 2001 – JUIN 2002 (Suite et fin)

- **REALISER UNE SERIE D'ATELIERS DE 2 A 3 JOURS TOUS LES TROIS MOIS AVEC LA PARTICIPATION DE DECIDEURS ET EXPERTS DU NIVEAU CENTRAL ET DES PROVINCES AUTONOMES**

- **ORGANISER UNE CONFERENCE DE CONCERTATION POUR EVALUER LES RESULTATS ET POUR PLANIFIER LA SUITE**

FIN