

***2005-2006 Baseline Assessment
for the CRTU Program:
Reproductive Health and
Family Planning in Madagascar***

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Executive Summary

Introduction

FHI was awarded the Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU) by USAID in 2005. The CRTU's goal is to expand the range and increase the use of safe, effective, acceptable, and affordable contraceptive methods and reproductive technologies, delivered through high-quality family planning and reproductive health services in developing countries. By concentrating its resources in a few carefully selected countries, the CRTU strives to maximize the public health impact of its work. FHI is identifying and prioritizing local research and program needs within these selected focus countries; developing and implementing country work plans that address those needs; fostering collaborative partnerships with local groups; and facilitating the translation of research into practice.

For many reasons, Madagascar was selected as one of the CRTU's focus countries. Demographically, Madagascar exhibits clear reproductive health needs. Organizationally, FHI was already engaged in a number of activities in the country. Through our provision of technical assistance in revising national reproductive health norms and procedures, FHI had previously developed a strong relationship with the Ministry of Health and Family Planning (MOHFP), as well as other local stakeholders; this positioned us well to affect additional change under the CRTU.

This report on the reproductive health and family planning program in Madagascar is intended to serve two primary purposes: 1) as a resource for CRTU staff and colleagues who are working together on research, research utilization, and other reproductive health activities in Madagascar under the CRTU; and 2) as a tool to facilitate documentation of changes in Madagascar over the course of the five-year CRTU program.

This assessment compiles information from key resource documents and synthesizes the most recent qualitative and quantitative data on family planning and reproductive health in Madagascar, with special attention paid to the integration of HIV and family planning services. In addition, this report summarizes ongoing work under the CRTU, as well as results of a family planning assessment conducted in March 2006, in which the MOHFP, partner cooperating agencies (CAs), and health providers identified opportunities for improvement and areas in which best practices can be applied. These priority areas, coupled with the CRTU's own goals and outcomes and shaped by partnerships and funding realities, will inform and influence the future course of work in Madagascar under the CRTU.

Highlights of Current Family Planning and HIV/AIDS Trends and Issues in Madagascar

- Knowledge of contraception is fairly high; approximately 84.2 percent of currently married Malagasy women know of at least one modern family planning method.
- Contraceptive use has increased substantially in Madagascar over the past 15 years. Overall prevalence (all methods) has risen from 17 percent in 1992 and 19 percent in 1997 to 27 percent in 2003-2004. Use of modern methods among women in union has

almost doubled from one national survey to the next, from 5 percent in 1992 to 10 percent in 1997 and 18 percent in 2003-2004.

- Success in family planning (FP) is not equally distributed between urban and rural areas. While the overall use of modern methods among women in union in the 2003-2004 Demographic Health Survey (DHS) was 18 percent, this figure is actually a combination of the 27 percent use in urban areas and 16 percent use in rural areas.
- Almost half of Madagascar's population is under the age of 15 years. This means that a large cohort will soon reach reproductive age, adding to the demand for family planning, HIV prevention, and reproductive health services.
- The current national family planning method mix is heavily weighted toward short-term contraceptive methods. Longer-term methods are especially scarce in rural areas of Madagascar, where 75 percent of the population resides.
- Injectable contraceptives are the most widely used method by married women. They are also the method that has experienced the greatest increase in use in Madagascar between the 1997 and 2003-2004 DHS surveys (10-point increase). Efforts to further expand access to injectables via community-based health workers are underway.
- The Madagascar MOHFP's *Reproductive Health Norms and Procedures – 2nd Edition 2006* was drafted in September 2006 to include an updated set of eligibility requirements and procedures for the appropriate delivery of hormonal and other contraceptive methods to women. To a large extent, they mirror the *WHO Medical Eligibility Criteria Guidelines*, although some exceptions are noted in this report.
- As of January 2007, there were six ongoing subprojects in Madagascar led by FHI Research (formerly the Institute for Family Health). Of these, three are subprojects supported by the CRTU, one is funded by CONRAD, one by the University of North Carolina (UNC), and one by the National Institutes of Health (NIH). More information about these subprojects is contained in Table 3 of this report.

Integration of HIV/AIDS and Family Planning Services

- Madagascar's HIV epidemic is relatively nascent compared to most countries in mainland Africa, though prevalence rates are increasing. The national adult prevalence is estimated to be 0.95%. On the other hand, STI rates remain alarmingly high. Active syphilis prevalence is estimated to be 3.8 percent among the general adult population according to 2003-2004 DHS, which translates into nearly 300,000 infected people.
- While Madagascar has had success in coordinating national HIV efforts through a sophisticated, decentralized administrative structure that includes regional and local coordinating bodies, the country needs a unified and well-coordinated integration strategy for HIV/AIDS and family planning services. Antiretroviral treatment (ART), voluntary counseling and testing (VCT), and prevention of mother-to-child transmission (PMTCT) services remain inadequate and are not yet integrated into family planning services.
- Despite progressive national policies mandating the provision of family planning methods in post-abortion care settings, it is not clear whether care is comprehensive in practice.

Adolescent Reproductive Health

- Given that adolescents are such a significant proportion of Madagascar's population (nearly half are under 15 years of age), research and reproductive health programs need to include special consideration for this group. Policies that pertain to youth are in place.
- Inadequate access to reproductive health information is a concern for youth in Madagascar. In a population where almost 78 percent of the population has either no education or attends only primary school, basic reproductive health is not taught until the last year of middle school (Source: 2003-2004 DHS). Meanwhile, sexuality education is included only in high school curricula.
- Less than 8 percent of sexually active women aged 15-19 years are currently using any form of family planning.
- Malagasy youth engage in high-risk sex, defined as having multiple partners and unprotected intercourse. Only 12 percent of males and 5 percent of females aged 15-24 years reported condom use with a non-regular sex partner during the 2003-2004 DHS survey.
- Among Malagasy youth the prevalence of sexually transmitted infections, particularly syphilis, is extremely high. Among youth aged 15-24 years, 7.5 percent of females and 3.9 percent of males had syphilis at the time of the 2003-2004 DHS survey.

USAID and Other Key Organizations in Madagascar

- The USAID program in Madagascar includes four strategic objectives that address access to quality healthcare, increased rural incomes, improved natural resource management, and effective governance. USAID's financial support for health programs has remained stable between 2004 and 2006. Links to key USAID planning documents are contained in this report.
- Over the past five years, FHI Research has worked with several other CAs and local reproductive health organizations in Madagascar, including SantéNet, the Adventist Development and Relief Agency (ADRA), Joseph Ravoahangy Andrianavalona CHU (Central University Hospital), the Laboratoire National de Reference (VIH/MST), and the University of North Carolina at Chapel Hill.
- Numerous government entities play a role in the conduct of reproductive health work in Madagascar. These include, but are not limited to, the National Institute of Public and Community Health; Administration of Family Health; Administration of Emergencies and Infectious Disease; the Administration of Health Promotion; and the National HIV/AIDS Control Committee (CNLS).
- As of February 2007, Serge Raharison was appointed project director to manage FHI's research and program portfolio in country. Robbyn Lewis serves as the senior program officer for Madagascar and provides administrative backstopping from FHI's North Carolina headquarters. Coordinating travel and CRTU activities with FHI/Madagascar staff is not only required but also beneficial given the staff's in-country experience and expertise.

Priority Setting

Priorities, as identified among family planning and reproductive health stakeholders in Madagascar, are listed at the end of this report. Recurring themes include strengthening national logistics management systems; revising and updating the national *Reproductive Health Norms and Standards* document; expanding the role of community-based distributors to provide Depo-Provera and teach clients how to use the standard days method; and introducing innovative approaches such as the pregnancy checklist and systematic screening to increase uptake of family planning methods.

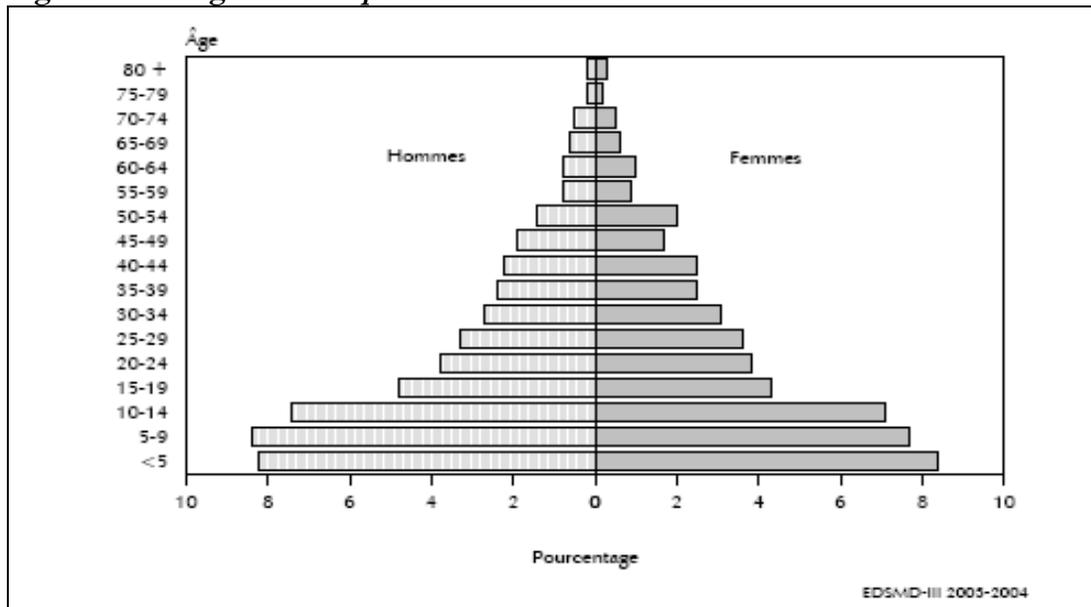
Ultimately, it is necessary to marry the realities of limited resources – human and financial – with both the priorities identified by all stakeholders, and with the outcomes that the CRTU is striving to achieve. This document serves as a resource to those developing and implementing CRTU activities in Madagascar, in addition to providing a baseline against which to measure changes over time and a tool with which to help prioritize future activities.

Land and Population

Madagascar is an island nation located in southern Africa off the coast of Mozambique, occupying a total land area of 587,401 sq km.¹ The country is geographically diverse, with narrow coastal plains, high plateaus, and mountains at its center.

Madagascar's population totals 18,595,469.² Its population density (nearly 32 people per square kilometers) is higher than that of its neighbor Mozambique (25) but considerably lower than that of nearby Tanzania (42), Comoros (318), and Mauritius (611).

Figure 1: Madagascar's Population Distribution in 2004



Source: [Enquête Démographique et de Santé, Madagascar 2003-2004](#)

Madagascar's population profile (Figure 1) is typical for a developing country, in which relatively high birth and death rates contribute to the country's very young population; nearly 45 percent of its people are under the age of 15 years.³

The people on the island belong to 18 major ethnic groups, which have cultural and historical ties both to Africa and Asia.⁴ Other groups include French, Indian, Creole, and Comoran people. The country's official language is Malagasy, though French is used in educational and administrative settings.

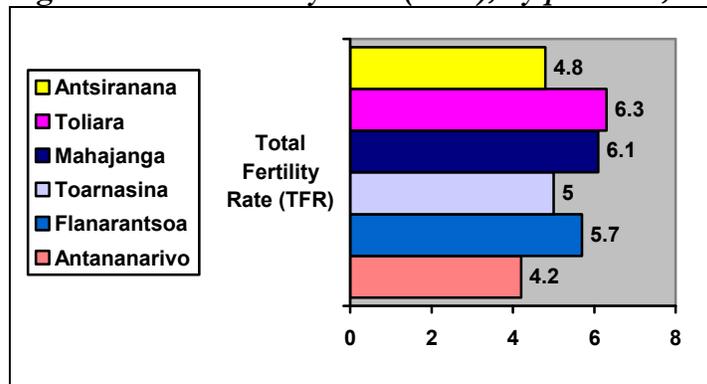
In the 1990s, at the suggestion of the International Monetary Fund (IMF), Madagascar began to adopt policies of economic privatization and liberalization.⁵ Since then, the country has experienced slow and steady economic growth. However, despite the relative gains, the new economic strategy has resulted overall in rising inequality between the rich and poor and has had only a moderate impact on poverty.⁶ Indeed, Madagascar remains a very poor country, with a per capita gross national income (GNI) of US\$ 290 in 2005.⁷ The country was ranked extremely low in the United Nation Development Programme's 2005 Human Development Report (146th out of 159 countries)⁸ and 143rd out of 177 countries in the 2006 report.⁹ Government corruption and environmental degradation continue to be major challenges to development.

Madagascar's main industries are fishing and forestry, and most of the population engages in subsistence agriculture.

Reproductive Health Demographics

Women of reproductive age (15-49 years) make up 46 percent of the female population in Madagascar.¹⁰ While the country's total fertility rate (TFR) remains quite high at 5.2 births per woman, this represents a decline in fertility from 6.0 births per woman in 1997.¹¹ The TFR varies considerably across Madagascar; the average is 3.7 in urban areas and 5.7 in rural areas. Total fertility is highest in the southern province of Toliara (Figure 2.)

Figure 2: Total Fertility Rate (TFR), by province, Madagascar, 2004



Source: Demographic and Health Survey (DHS) Key Findings Report, Madagascar 2003-2004

Adolescent pregnancy is common in Madagascar. Among women aged 15-19 years, 34 percent have already begun childbearing.¹² Nevertheless, a sign of improvement over time has been the median age at first birth. Among women aged 20-49 years at the time of the most recent DHS survey, median age at first birth was 20.4 years, up from 19.5 in 1997.¹³

For more information about reproductive health demographics in Madagascar, refer to:

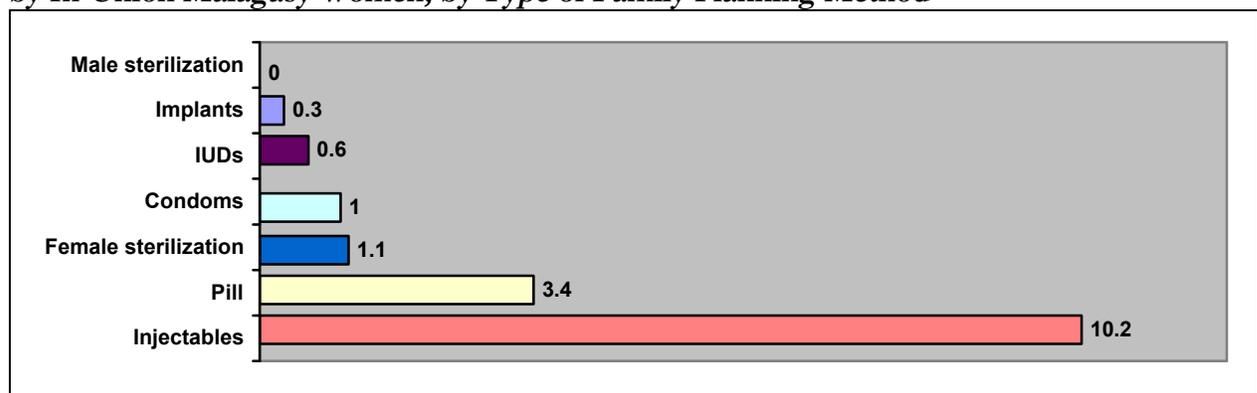
- Chapters 4-7 of the [Enquête Démographique et de Santé, Madagascar 2003-2004](#) (Translation: “Demographic and Health Survey, Madagascar 2003-2004”), which is the full report in French; or
- The [2003-2004 Madagascar DHS Key Findings Report](#), which includes selected findings in English.

Family Planning Knowledge and Use

Knowledge of family planning is fairly high in Madagascar. As evidenced by the 2003-2004 DHS, 84.2 percent of in-union Malagasy women know of at least one modern contraceptive method. Injectables (78.2 percent) and the pill (76.5 percent) are the best-known methods among in-union women, followed closely by the male condom (72 percent).¹⁴

This relatively high degree of knowledge, however, is not reflected in the country’s contraceptive prevalence. Indeed, only a reported 31.3 percent of Malagasy women have ever used a modern family planning method. Meanwhile, only 18.3 percent of in-union Malagasy women were using a modern family planning method at the time of survey, compared to 22.3 percent of sexually active unmarried women.¹⁵ The difference in use between in-union and single women is mainly attributable to higher rates of pill and condom use among unmarried women (6.9 and 5.8 percent, respectively), as compared to those of in-union women (3.4 and 1.0 percent).¹⁶ Figure 3 displays the distribution of current use of modern family planning methods among in-union women.

Figure 3: Percent Distribution of Current Use of Modern Family Planning Methods by In-Union Malagasy Women, by Type of Family Planning Method



Source: [Enquête Démographique et de Santé, Madagascar 2003-2004](#)

Overall contraceptive prevalence in Madagascar has increased significantly in recent years: from 17 percent in 1992 to 19 percent in 1997, and to 27 percent in 2003-2004.¹⁷ Use of

modern methods has also risen dramatically, from 5 percent in 1992 to 10 percent in 1999, to 18 percent in 2003-2004. Despite these gains, nearly one quarter (24 percent) of women in Madagascar have an unmet need for family planning.¹⁸

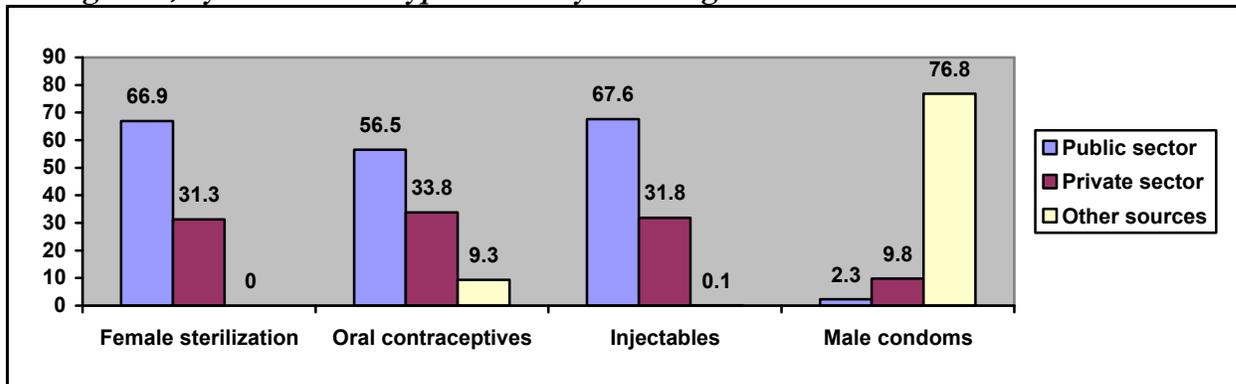
Nonuse of Contraception

Among in-union women who were not using contraception at the time of the survey, 38 percent said they intended to use it in the future, while 47 percent of women did not intend to use it in the future.¹⁹ The in-union women who were not using a method of contraception at the time of the survey and who said that they had no intention of using one in the future were asked the main reason for not doing so. Overall, the most commonly cited reasons were desire for children (20 percent), fear of side effects (18 percent), and difficulty conceiving (13 percent).²⁰

Sources of Contraceptives

At the time of the 2003-2004 DHS survey, the public sector was the most important source of contraceptives for family planning users. Over half (54.7 percent) of users obtained their methods from public facilities, which include government hospitals, health care centers, and family planning clinics. Meanwhile, private facilities (private clinics, hospitals, and pharmacies) were reported as sources by just under one third (31.5 percent) of current users.²¹ Other sources (community health workers, shops, religious institutions, or friends and relatives) accounted for nearly all of the remaining (8.9 percent) modern contraceptive users. The source of contraception varied according to the method, as indicated in Figure 4.

Figure 4: Percent Distribution of Source of Modern Family Planning Methods in Madagascar, by Source and Type of Family Planning Method



Source: [Enquête Démographique et de Santé, Madagascar 2003-2004](#)

It is important to note that oral contraceptives (OCs) are classified as over the counter (OTC) in Madagascar. According to Douglas Call, Director of PSI/Madagascar, OCs are sold, along with condoms, at many non-medical/non-pharmaceutical sales points such as shops, kiosks, by door-to-door sales people, and via community-based agents. National coverage is very good, Call reports, although better in urban areas. Coverage becomes increasingly irregular the more rural the area and the farther away from the cash economy (i.e., subsistence farming).²²

For more information about family planning knowledge and use, refer to Chapter 5 of the [Enquête Démographique et de Santé, Madagascar 2003-2004](#).

Family Planning Program and Guidelines

National Reproductive Health Strategies

The Government of Madagascar has indirectly supported family planning through national policies since 1976 and directly supported the effort to provide access to contraceptives since 1986.²³ After the Cairo conference of 1994, components of reproductive health were defined in the context of Madagascar at a national symposium held in Toamasina. The first national reproductive health policy was then developed in March 2000, serving as a reference for reproductive health interventions nationwide. Current policies related to family planning and reproductive health include:

- ***Programme de Planification Familiale: 2005-2009 Pour La Mise en Ouvre de la Nouvelle Strategie***²⁴ (Translation: “Implementation Plan for the New Family Planning Program Strategy, 2005-2009”) This document outlines the Ministry of Health and Family Planning’s overall objective (“to respond to the demand for family planning information and service with quality information and service provision in a friendly and supportive environment”) and three strategies proposed to meet this objective. These strategies include: 1) increasing the demand for family planning services, 2) improving service provision, and 3) creating a supportive environment for family planning, both financially and politically. The Ministry of Health and Family Planning has set an ambitious goal of increasing the overall contraceptive prevalence rate from its current 18 percent to 28 percent by 2009. The total cost of this five-year plan is estimated at around US\$ 47 million, with 53 percent of the budget reserved to procure contraceptive products, 11 percent to generate demand, 25 percent to improve the service delivery, and 11 percent to promote an enabling environment.
- ***Feuille de Route Pour la Reduction de la Mortalite Maternelle et Neonatale a Madagascar 2005-2015***²⁵ (Translation: “Roadmap to Reducing Maternal and Newborn Mortality in Madagascar 2005-2015”) The proposed interventions for this two-phased effort include defining a minimum package of services at each level of the health system to include:
 - providing family planning services and commodities;
 - revising national policies’ norms and protocols for maternal and neonatal health and FP using international evidence-based standards of care;
 - upgrading health services to ensure greater accessibility, acceptance, and quality of care;
 - implementing all standards of emergency obstetric care;
 - updating pre-service training curricula in medical training settings;
 - establishing radio communication systems linked to a transport system;
 - strengthening health information;
 - promoting male involvement; and
 - establishing community committees for maternal and neonatal health.
- ***The Madagascar Action Plan (2007-2012)***²⁶ is a five-year plan that sets national priorities, including a set of eight commitments by the national government, to fight

poverty. Family planning and HIV/AIDS interventions are clearly identified as key strategies in the plan.

Family Planning Guidelines

In September 2006, the Ministry of Health and Family Planning released a draft of its *Reproductive Health Norms and Procedures – 2nd Edition 2006*,^{*27} which contains an updated set of eligibility requirements and procedures for the appropriate delivery of hormonal and other contraceptive methods to women. In the sections on IUD, implants, injectables, and oral contraceptives, the document advises health care staff, where applicable, to follow the eligibility requirements described in the WHO consultation chart.

Table 1 displays a summary of facts about contraceptive eligibility in Madagascar, as excerpted from the *Norms and Procedures*. The table also shows results of an analysis conducted to compare Madagascar's *Norms and Procedures* with those of the [WHO's 2004 Medical Eligibility Criteria for Contraceptive Use \(MEC\)](#).²⁸ The comparison shows that the Madagascar family planning guidelines are, for the most part, consistent with the WHO MEC, with the exception of a few areas. The most noteworthy inconsistencies include:

- In terms of eligibility requirements, the Madagascar norms and procedures document does not distinguish between combined oral contraceptives and progestin-only contraceptives, when in reality the requirements for the two methods differ substantially. This represents the largest discrepancy between the Madagascar and the WHO guidelines.
- The WHO MEC does not require following up with a patient one week after insertion of an IUD.

* Note: Further revisions of this document are underway; it is currently available in draft form only from the Ministry of Health and Family Planning.

Table 1: Summary of Key Facts about Contraceptive Methods in Madagascar’s National Guidelines and Comparison to WHO Guidelines

Method	Madagascar age guidelines	Other limitations	Comparison to WHO Guidelines
Intrauterine Devices (IUDs)	No age guidelines specified.	<p>IUDs can be provided if the woman is:</p> <ul style="list-style-type: none"> • in the first 12 days of her cycle; • within the first 48 hours after childbirth or up to 4 weeks after childbirth; • post-abortion; can be provided immediately if conditions permit; • at any time during her cycle if one is reasonably sure she is not pregnant. 	Madagascar requirements are consistent with WHO MEC.
Implants	No age guidelines specified.	<p>Implants can be provided if the woman is:</p> <ul style="list-style-type: none"> • in the first 7 days of her cycle; • postpartum; • breastfeeding exclusively and is either having or not having her period six months after childbirth; • is not breastfeeding on the 21st day after childbirth; • post-abortion; can be provided immediately; or • at any time during her cycle if one is reasonably sure she is not pregnant. Conduct patient follow-up one week after insertion. 	<p>WHO requirements are more clear than Madagascar guidelines about implants for postpartum women:</p> <p>Postpartum and breastfeeding:</p> <ul style="list-style-type: none"> • Implants can be inserted starting at 6 weeks postpartum (before 6 weeks it is Category 3[†] according to WHO) • Between 6 weeks and 6 months postpartum, implant can be inserted any time if protected from pregnancy by lactational amenorrhea (LAM); no additional protection needed. <p>Postpartum, but not breastfeeding:</p> <ul style="list-style-type: none"> • Implants can be inserted any time within the first 21 days postpartum; no additional protection needed • After 21 days postpartum. Additional protection needed for 7 days. <p>WHO does not require following up with patient one week after insertion.</p>

[†] The WHO’s criteria classify contraindications to contraceptives using four categories: Category 1 - a condition for which there is no restriction for the use of the contraceptive method; Category 2 - a condition where the advantages of using the method generally outweigh the theoretical or proven risks; Category 3 - a condition where the theoretical or proven risks usually outweigh the advantages of using the method; and Category 4 - a condition which represents an unacceptable health risk if the contraceptive method is used.

Combined Oral Contraceptives (COCs)	No age guidelines specified.	<p>Oral contraceptives can be provided if the woman is:</p> <ul style="list-style-type: none"> • in the first five days of her cycle; • postpartum; • breastfeeding and > six months after childbirth; • not breastfeeding 21 days after childbirth; • post-abortion; can be given immediately; or • at any time during her cycle if one is reasonably sure she is not pregnant (Provide counseling on abstinence or use of another method for 7 days.) 	<p>Madagascar requirements are consistent with WHO MEC.</p> <p>Counseling on abstinence or use of another method for 7 days is recommended by WHO only if woman initiates OCs more than 5 days after start of period.</p>
Progestin-Only Pills (POPs)	No age guidelines specified.	<p>(Madagascar guidelines do not distinguish POPs from COCs in terms of eligibility requirements.)</p>	<ul style="list-style-type: none"> • WHO recommends additional protection for 2 days (not 7, as with COCs) if POPs are initiated after day 5 of menstrual cycle. • For postpartum women (breastfeeding and non-breastfeeding), recommendations are the same as for implant but not the same as for COCs.
Injectables	No age guidelines specified.	<p>Injectable contraceptives can be provided if the woman is:</p> <ul style="list-style-type: none"> • in the first five days of her cycle; • postpartum; • breastfeeding exclusively and is not having her period six months after childbirth; • breastfeeding exclusively and is having her period six weeks after childbirth; • breastfeeding and > six months after childbirth; • not breastfeeding 21 days after childbirth; • post-abortion; can be given immediately; or 	<p>The first injection can be given within the first 7 days (not 5 days, as indicated in the Madagascar guidelines) of her cycle without any additional protection.</p> <p>WHO requirements are more clear than Madagascar guidelines about injectables for postpartum women:</p> <p>Postpartum and breastfeeding:</p> <ul style="list-style-type: none"> • injection can be given starting at 6 weeks postpartum (before 6 weeks it is category 3 according to WHO) • between 6 weeks and 6 months, insert any time if protected from pregnancy by LAM; no additional protection needed. <p>Postpartum, but not breastfeeding:</p> <ul style="list-style-type: none"> • injection can be given any time within the first 21 days, no additional protection needed • after 21 days postpartum additional protection needed for 7 days

Injectables (continued)		<ul style="list-style-type: none"> at any time during her cycle if one is reasonably sure she is not pregnant (Provide counseling on abstinence or use of another method for 7 days.) 	Counseling on abstinence or use of another method for 7 days is recommended by WHO only if woman initiates injectables more than 5 days after start of period.
Male Condoms	No age guidelines specified.	Male condoms should be provided as needed by clients. (No eligibility requirements noted.)	For latex condoms, allergy to latex is a Category 3 condition.
Female Condoms	(No guidelines provided for female condoms.)	(No guidelines provided for female condoms.)	No eligibility restrictions for female condom in WHO MEC.
Emergency Contraceptive Pills (ECPs)	No age guidelines specified.	Provide emergency contraception within five days following unprotected sex.	Women taking combined oral contraceptives for emergency contraceptive purposes are subject to the same eligibility requirements as those initiating combined oral contraceptives (see above).
Male Sterilization	No age guidelines specified.	(No eligibility requirements noted.)	<p>As this is a permanent method, extra caution required for young people due to possibility that they could later regret the decision.</p> <p>Some conditions result in the delay of the procedure (e.g., scrotal skin infection, active STI, epididymitis or orchitis, systemic infection, gastroenteritis, etc.)</p>
Female Sterilization	No age guidelines specified.	<p>Female sterilization surgery can be provided if the women is:</p> <ul style="list-style-type: none"> at any time during her cycle if one is reasonably sure she is not pregnant; within the first seven days after childbirth or after six weeks postpartum; post-abortion; can be provided immediately if conditions permit. 	<p>As this is a permanent method, extra caution required for young people due to possibility that they could later regret the decision.</p> <p>Some conditions result in the delay of the procedure (e.g., postpartum/post-abortion infection, current deep venous thrombosis, current ischemic heart disease, current PID or purulent cervicitis, active hepatitis and some others)</p>

Sources: Draft *Reproductive Health Norms and Procedures – 2nd Edition, 2006*, September 2006 and [WHO's Medical Eligibility Criteria for Contraceptive Use](#), 2004 edition.²⁹ Comparison provided by FHI's Irina Yacobson, Assistant Medical Director, 2007.

The national guidelines were finalized in early 2007 after a final technical review and inclusion of feedback from various partners. The document was duplicated in February 2007, and a distribution plan was developed with the participation of the major stakeholders, including UNFPA, WHO, UNICEF, USAID, FHI, and SantéNet. The training curricula for family planning were also revised to include the new technical components. All new health care sites opened in 2007 will receive updated directives.

Facilities and Services

Madagascar comprises 6 provinces and 111 districts. Health administration is organized into a three-level system, which includes basic health centres (CSB) and district hospitals (CHD) at the primary level, regional hospitals (CHR) at the secondary level, and university hospitals (CHU) at the national level.³⁰

Types of basic care facilities include *dispensaire, post sanitaire, post d'infirmierie*, and *Centres de Soins de Santé Primaire (CSSP)*.³¹ A typical district contains 10-15 of these basic or primary care facilities and one hospital.³²

Statistics from 2005 about health facilities in Madagascar are provided by the Ministry of Health and Family Planning's National Statistics Service and are included in Appendix 1 of this report.

The draft *Reproductive Health Norms and Procedures – 2nd Edition, 2006* outlines the level of service that each type of health care facility and staff person can provide. The three main levels of care include:

- **community level** (providers include community-based health agents, traditional midwives, etc);
- **primary care level** (providers include paramedical and other health care staff at CSBs and many CHDs); and
- **hospital-level providers** (providers include physicians and other medical staff of regional and university hospitals).

At the community level, community-based health agents can counsel clients and provide a range of products, including oral contraceptives (also used as an emergency contraceptive), spermicides, and condoms. Although part of the National Strategy aimed at increasing accessibility to FP services, provision of injectable contraceptives by community-based health agents still encounters some skepticism from many health professionals. Medical staff at the other two levels of care can provide those methods, as well as IUDs and implants. Only medical staff at hospitals provide female sterilization. Male sterilization, while extremely rare, is also provided only in the hospital setting.

As for private providers, *Fianakaviana Sambatra* (FISA), the Malagasy affiliate of the International Planned Parenthood Federation, works throughout the country in 9 clinics and 70 other sites.³³ [Population Services International \(PSI\)](#), a nonprofit social marketing organization, estimates that approximately 850 health care facilities (pharmacies, clinics, etc., nearly all private) distribute their (PSI's) contraceptive mix. SantéNet, through its Champion Community initiative, estimates that 1820 community-based distribution agents work in its targeted communities as of September 2006.

Method Mix

According to Madagascar's draft *Reproductive Health Norms and Procedures*, a wide array of family planning methods are available in Madagascar through public health care facilities (Table 2).

Table 2: Modern Family Planning Methods Available in Public Sector Health Care Facilities in Madagascar, September 2006

Method Type	Family Planning Method
Hormonal family planning methods	<p><u>Oral Contraceptives*</u>: COC: <i>Lo féminéal</i> POP: <i>Ovrette</i></p> <p><u>Injectable</u>: Combined and progestin-only are available. Brands not specified.</p> <p><u>Implants</u>: <i>Norplant</i> and <i>Implanon</i></p>
Other modern, non-hormonal family planning methods	<p>IUD: <i>TCU 380 A</i> Condoms: Brands not specified. Spermicides: Brands not specified.</p>
Natural family planning methods also discussed in family planning counseling sessions	<p>Lactational amenorrhea Withdrawal method Ovulation method (cervical mucus) Standard days method</p>
Voluntary surgical contraception	Male and female sterilization
Emergency contraception	<p>COC: <i>Lo féminéal</i> POP: <i>Ovrette</i> IUD: <i>TCU 380 A</i></p>

Source: (Draft) *Reproductive Health Norms and Procedures*, September 2006³⁴

* Note: In Madagascar, oral contraceptive pills are classified as over-the-counter drugs.

Through [PSI's social marketing program](#), *Protector Plus* condoms, *Pilplan* low-dose combined contraceptive pills, and *Confiance* three-month injectables are available at heavily subsidized prices:

- *Protector Plus* condoms are 100 Ariary (approximately US\$.05) for a pack of three.
- *Pilplan* oral contraceptives are 200 Ariary (approximately US\$.10) for a single-cycle blister pack.
- Depo injectables (*Confiance* brand) are 400 Ariary (approximately US\$.20) per dose.

Contraceptive Supply

With the arrival of Madagascar's first democratically-elected government and its reform agenda in 2002, interest in reproductive health commodity security (RHCS) was renewed.³⁵ This movement led to a nationwide assessment of RHCS in 2003, the establishment of a national stakeholder working group, and the development of a strategic plan to improve RHCS in Madagascar.

Prior to these events, the family planning situation in Madagascar was severely lacking. The country was ranked 7th lowest (out of 57 countries) on the [2003 Contraceptive Security Index](#), which includes indicators related to supply chain, policy, finance, and access. According to the [report](#)³⁶ from the 2003 RHCS assessment, “the system for supply and distribution of contraceptives had logistical problems, compounded by insufficient government commitment and no clear direction for attaining contraceptive security...” Researchers at Cornell University, in a 2000 report called [Education and Health Services in Madagascar: Utilization Patterns and Demand Determinants](#),³⁷ stated that “the major shortcoming in public health facilities (in Madagascar) is the lack of medicines.”

Since the implementation of the strategic plan, however, the country has succeeded in increasing the method mix from four to six contraceptive methods;[‡] placing contraceptives on the country’s list of essential drugs; redesigning the commodities distribution system to integrate contraceptive products into the distribution system of essential drugs; and giving the private sector a larger role in national family planning provision.³⁸ For more information, refer to the 2005 POLICY Project report [Using the Strategic Pathway to Achieving Reproductive Health Commodity Security \(SPARHCS\) Approach to Reposition Family Planning in Madagascar: A Success Story](#)³⁹ and the [USAID Repositioning in Action e-bulletin](#) from March 2006.

In recent years, Madagascar’s contraceptive security has experienced substantial improvements. According to the USAID/Madagascar mission, the proportion of service delivery points with stockouts dropped from 14 percent in 2004 to just 4 percent in 2006. In 2006, the number of facilities reporting stockouts of any contraceptive commodity offered was only 86, out of a 2150 facilities.⁴⁰ These improvements may be related to a new policy created by the Ministry of Health and Family Planning, which now requires all district-level pharmacies to carry a six-month supply of contraceptive commodities.⁴¹

Since 2001, USAID- and UNFPA-supported agencies have remained the main suppliers – and USAID and UNFPA the only donors – of contraceptives and condoms in Madagascar.⁴²

Community-Based Distribution (CBD)

Because more than 75 percent of women in Madagascar live in remote rural areas, far from the urban and suburban facilities where family planning services are provided,⁴³ CBD programs have the potential for enormous impact. Indeed, nearly 80 percent of male condoms and 9 percent of oral contraceptive pills⁴⁴ are obtained from Madagascar’s estimated 2300 CBD agents.⁴⁵ Further expansion of community-based distribution is a key governmental strategy to improve Madagascar’s family planning service coverage in the coming years. For more information about this national strategy, refer to the *Programme de Planification Familiale 2005-2009 Pour La Mise en Ouvre de la Nouvelle Stratégie*.⁴⁶

The adoption of FHI’s pregnancy checklist by Madagascar’s Ministry of Health and Family Planning in 2006 has made possible the initiation of additional family planning methods in

[‡] Required method mix in every public health center (includes *Centres de Santé de Base*, such as clinics, as well as district and regional hospitals) in Madagascar had included pills, condoms, injectables, and spermicides. This has been expanded to include IUDs and implants. For more information, refer to Draft *Reproductive Health Norms and Procedures – 2nd Edition*, 2006.

community settings. Since May 2006, FHI has led a CRTU-supported pilot activity to assess the feasibility of providing DMPA injections, a service previously provided only by clinicians in urban and suburban health facilities, through an existing network of community-based health workers.

Madagascar has a relatively long history of CBD programs. Other CBD efforts underway in Madagascar include [insecticide-treated bed nets](#) via a USAID-supported project, [anti-malarial treatment kits](#) by Population Services International (PSI), and contraceptives by *Fianakaviana Sambatra* (FISA), the Malagasy affiliate of the International Planned Parenthood Federation.

For more information about CBD programs in Madagascar, refer to:

- a 2003 article published by the Guttmacher Institute, [Using Network Analysis to Understand Community-Based Programs: A Case-Study from Highland Madagascar](#),⁴⁷ and
- a 2004 report by the BASICS II project [Improving Family Health Using an Integrated, Community-Based Approach: Madagascar Case Study](#).⁴⁸

Provider Knowledge of Family Planning Methods

Little data are available on provider knowledge of family planning methods in Madagascar. However, some information related to general medical knowledge and capacity of health professionals exists. A report entitled [EPI Training Needs Assessment in 12 African Countries \(2002-2004\)](#)⁴⁹ points out that, despite being included in the curricula of all medical training institutions in Madagascar, the coverage of epidemiology content is inadequate. Knowledge and skills among Malagasy health professionals in specific areas such as vaccine management were also found to be low.

According to a July 2000 Knowledge, Attitudes, and Practice (KAP) study⁵⁰ conducted in the antenatal health care centers and the hospital of Tamatave, scientific knowledge about transmissibility of HIV infection among health care providers is lacking.

Opportunities to improve providers' knowledge of family planning methods remain numerous in Madagascar, as evidenced by a major recommendation from the first annual Maternal and Child Health Week meetings, which took place in November 2006. The recommendation was to make every public health center in Madagascar a family planning service delivery point (as of 2006, 70 percent of these centers provided FP services). The MOHFP, assisted by its major partners (USAID and UNFPA), hopes to achieve this objective by April 2007, when the second Maternal and Child Health Week is slated to take place.

Family Planning in the Context of HIV

HIV Statistics

Madagascar's HIV epidemic is considerably smaller than the concentrated and generalized epidemics of many countries in mainland Africa. However, trend analyses indicate that HIV prevalence has begun increasing in Madagascar, as evidenced among women attending

antenatal clinics. HIV prevalence in this population rose from 0.065% in 1995 to 1.1% in 2003.⁵¹

The [UNAIDS 2006 Epidemiological Fact Sheet](#)⁵² for Madagascar reports that the adult (ages 15-49 years) HIV prevalence rate is 0.5 percent, with an estimated 47,000 adults living with HIV at the end of 2005. Of those, an estimated 13,000 were women. Madagascar's Ministry of Health and Family Planning estimates the prevalence to be much higher: 1.8 percent among adults at the end of 2005. Heterosexual intercourse is the primary mode of HIV transmission in Madagascar.⁵³

According to UNAIDS, 2900 adults and children died of AIDS in Madagascar in 2005. A total of 13,000 children (ages 0-17 years) orphaned by the HIV epidemic were living in Madagascar in 2005.

A [study published in 2003](#)⁵⁴ on knowledge about HIV among adult patients in Antananarivo showed that HIV and AIDS awareness is high, but knowledge of how HIV and AIDS is and is not transmitted and the use of condoms in prevention is limited.

Given the association between circumcision and the decreased risk of contracting HIV, it is important to note that male circumcision is very common in Madagascar. According to a 2004 [article](#) in the Kaiser Family Foundation's Daily HIV/AIDS Report, "almost 100% of boys in Madagascar are circumcised by puberty."⁵⁵

For more information about HIV in Madagascar, refer to:

- [USAID's Madagascar HIV/AIDS profile](#),⁵⁶
- [HIV InSite's Madagascar profile](#),
- [2003 research on HIV- and AIDS-related Knowledge, Awareness, and Practices](#),⁵⁷ and
- [UNAIDS' 2006 Epidemiological Fact Sheet for Madagascar](#).

Madagascar has some of the highest rates of sexually transmitted infection in the world.^{58 59} Incidence of other STIs, particularly syphilis, concerns many experts who believe that HIV infection rates could become catastrophic without effective national prevention strategies. "A major HIV epidemic can still be averted in Madagascar but effective STI control is needed nationwide," concludes a [2003 study published in Tropical Medicine and International Health](#).⁶⁰

For more information about STIs in Madagascar, refer to:

- [May 2002 research rummary by the HORIZONS Project](#),⁶¹
- [March 2003 study](#) published in *Sexually Transmitted Diseases*, which found high STI rates in among males living in rural areas;⁶²
- [2005 article](#)⁶³ published in *Sexually Transmitted Infections* regarding a randomized trial of male condom promotion among Madagascar's sex workers; and
- [2005 article](#)⁶⁴ published in *Sexually Transmitted Infections* regarding continued high STI prevalence in rural populations.

Madagascar's National AIDS Policy

The *Comité National de Lutte contre le VIH/Sida (CNLS)*, chaired by Madagascar President Marc Ravalomanana, is the nation's multisectoral AIDS program. The CNLS developed the current [National 2001-2006 HIV Strategic Plan](#), which is laid out in three parts:

- **the national response**, which advocates for political and religious leadership and the engagement of the community, and discusses private sector implications;
- **the legal and legislative response**, including HIV/AIDS laws and guidelines related to anti-discrimination and voluntary counseling and testing; and
- **the service delivery response**, in which improving access to treatment is discussed as an effective way to encourage testing and prevention.

Additionally, the plan provides guidelines as to how HIV/AIDS efforts will be coordinated and decentralized, and how training, operational research, education, and evaluation will be managed.

The 2007-2012 HIV Strategic Plan was designed to be in line with the [Madagascar Action Plan \(MAP\)](#) to fight poverty. Its three main goals are to:

- reverse the current trends in HIV/AIDS prevalence;
- reduce by half the current STI prevalence; and
- ensure quality of life for people living with HIV/AIDS (PLHA).

This next five-year plan is based on four strategies:

- promoting a multisectoral framework for collaboration in combating STI/AIDS;
- improving access to information and primary prevention methods;
- ensuring quality services for individuals, families, communities, and institutions; and
- ensuring the establishment and operationalization of an M&E system that assists in planning, impact assessment, and resources mobilization.

[The National Policy on Voluntary Counseling and Testing \(January 2005\)](#) (*scroll down on Web page to header "Policy Reports and Papers"*) aims to reach its goal of reducing HIV/AIDS incidence through counseling and testing by:

- promoting an friendly environment that reduces barriers to testing;
- strengthening capacity and infrastructure needed to provide VCT; and
- reinforcing a system for continued follow-up of tested clients.

National Integration Strategies

The *Comité National de lutte contre le VIH/Sida (CNLS)* coordinates all national HIV programs in Madagascar. According to information on [UNAIDS' Madagascar profile](#), good coordination exists between the CNLS and the Ministry of Health. The committee includes governmental partners, civil society members, and the private sector. As part of decentralization of the HIV-control effort, regional control committees have also been

established, with regional coordinators appointed in each of the 22 regions. Local AIDS-control committees exist in 745 of Madagascar's 1557 communes.

Despite Madagascar's apparent success in coordinating its HIV efforts, the country lacks a unified and well-coordinated national integration strategy for HIV/AIDS and family planning services. Anti-retroviral treatment (ART), prevention of mother to child transmission (PMTCT), and voluntary counseling and testing (VCT) services remain inadequate and continue to be vertically managed.

Neither the [2001-2006 HIV Strategic Plan](#) nor the new 2007-2012 plan directly mentions family planning or contraception. Meanwhile, the draft *Reproductive Health Norms and Procedures – 2nd Edition, 2006* discusses HIV only briefly in three places: 1) STI counseling conducted during family planning intake exams, 2) in the context of appropriate measures for sterilizing needles, and 3) in discussing the STI training required for community-based health agents and family planning providers. Despite the HIV counseling that is offered, referral systems for VCT and PMTCT do not appear to be in place. HIV test kits are not included on the required family planning supplies list for health facilities.

While integrated services are not yet available in public health care settings in Madagascar, some integration is occurring in the private sector. *TOP Réseau*, PSI's franchised network of reproductive health service providers aimed at youth, is offering integrated STI prevention/treatment and family planning services "to meet the unique needs of adolescents whose behavior typically puts them at risk for both unwanted pregnancies and STI transmission." According to [PSI's Web site](#), VCT is offered in five *TOP Réseau* sites and will continue to be further integrated into other health activities.

Target Areas for Improvement

In June 2003, the POLICY Project conducted an assessment to assist USAID in documenting the use of methodology called Strategic Pathway to Achieving Reproductive Health Commodity Security (SPARHCS) in Madagascar. Their [December 2005 report](#)⁶⁵ outlines significant and promising changes made by the Government of Madagascar in regard to repositioning family planning and recommends next steps. Among their many recommendations (see Appendix 2 for the full list), the assessment team suggests that the Government of Madagascar should integrate HIV/AIDS and family planning services.

Social Marketing

As [USAID's Web site](#) points out, social marketing in Madagascar requires creativity: "The inaccessibility of much of Madagascar's population to health education and information is a major challenge - over three-quarters of people live in rural areas, and only six percent of all households have a television. Among young women, aged 15 to 24, approximately two-thirds have no access to any form of mass media."

Population Services International has been working in Madagascar since 1998 and leads national social marketing efforts in family planning and HIV prevention through its own brands of socially-marketed contraceptive products and a network of family planning and STI treatment clinics for youth.

PSI's mobile cinema project delivers health messages to rural communities in Madagascar through a social marketing tool called [Cinemobiles](#). Cinemobile teams consist of three young men and women trained to be facilitators, audio-visual equipment including a transportable movie screen, and an all-terrain vehicle. Facilitators engage the audience with discussions, games, and demonstrations. Locally developed soap operas that address issues of responsible sexual behavior, condom use, STI treatment, and living with HIV/AIDS are projected onto the movie screen.

For more information about social marketing in Madagascar, refer to:

- PSI's report [Changing Youth Behavior Through Social Marketing: Program Experiences and Research Findings from Cameroon, Madagascar and Rwanda](#),⁶⁶ and
- PSI's 2005 report [Improving the Health Status of the Malagasy through Social Marketing of Hormonal Contraceptives and Maternal and Child Health Products](#).⁶⁷

Integration of Family Planning through Other Services

Post-Abortion Care (PAC) Services

Abortion is illegal in Madagascar except in instances where the procedure would save the pregnant mother's life. According to a [paper published in the African Journal of Fertility, Sexuality and Reproductive Health](#),⁶⁸ studies have revealed that "despite the legal restrictions on abortion, a huge number of Malagasy women resort to abortion to get rid of an unwanted pregnancy. Most of these abortions are done in secret, with the help of traditional doctors, medical practitioners or paramedics, and still others try to manage abortion all by themselves. In 1998, there were 8934 recorded cases of induced abortion treated in public hospitals, with an abortion ratio of 58.3/1000 live births. Some women used abortion as a substitute for birth control methods. Factors like inaccessibility of family planning services and low level of knowledge about modern contraceptive methods contributed to the prevalence of abortion in Madagascar." Complications due to unsafe abortion remain one of the most important causes of Madagascar's high maternal mortality.^{§69}

Madagascar's 2006 draft *Reproductive Health Norms and Procedures* names post-abortion clients as a priority target group for contraception. Post-abortion counseling, provision of family planning methods, and referral to other reproductive health services are among the document's five main elements of post-abortion care. Hence, policies provide for the integration of PAC and family planning services in Madagascar, although it is not clear whether this reflects realities in practice.

Voluntary Counseling and Testing (VCT)

According to the [National Policy on Voluntary Counseling and Testing \(January 2005\)](#),^{**70} there are five main public VCT testing centers in Madagascar, one each in five of the nation's six provincial capitals. All were opened in 2003 and 2004. The policy document also

§ [WHO's 2006 Health System Fact Sheet](#) reports that 550 women die per every 100,000 live births in Madagascar.

** From this link, scroll down to bottom of Web site to section entitled "Policy Reports and Papers."

estimates that 21 NGO-operated (private) HIV testing centers provide VCT across the country. An example of such a private provider is the faith-based organization [Catholic Relief Services](#).

As outlined in the draft *Reproductive Health Norms and Procedures*, health providers in public facilities must offer VCT during family planning counseling sessions, at pre-natal and post-natal consultations, and as an integrated service provided with other reproductive health services. To combat some of the barriers to getting tested, the government has made the service available free. [Malagasy government officials are also actively working to break down the stigma](#) associated with the HIV test.⁷¹ Demand for VCT is rising. Numbers tested have increased from 2082 people in 2003⁷² to 240,000 tested between February and November 2006.⁷³

According to [PSI's Web site](#), PSI will soon launch youth-friendly VCT services in its *Top Réseau* clinic franchise in Madagascar.

Prevention of Mother-to-Child Transmission (PMTCT) Services

HIV prevalence is rising in Madagascar, as evidenced among pregnant women in antenatal clinics. Between 1995 and 2003, prevalence in this population rose from 0.065 percent to 1.1 percent.⁷⁴ [UNICEF](#) estimates that 110 people living with HIV in Madagascar in 2005 had been infected via mother-to-child transmission.

PMTCT programs in the public sector are few, though [efforts](#) to improve the current situation are underway. Mr. Sétou Kaba, UNAIDS country coordinator for Madagascar, states that as of December 2006, 536 facilities were established to offer PMTCT services in Madagascar. Of those, only 228 are operational.⁷⁵

Demand for these services remains low. [UNAIDS' 2006 Epidemiological Fact Sheet](#) states that at the end of 2005, no women were receiving treatment to reduce mother-to-child transmission. Mr. Kaba reports that by end of December 2006, only three pregnant HIV-positive women were on ART prophylaxis. For more information about PMTCT in Madagascar, refer to the [UNAIDS' Madagascar country profile page](#)

Anti-Retroviral (ARV) Treatment Services

Access to ARV treatment remains inadequate in Madagascar. [IRIN PlusNews' Madagascar profile](#)⁷⁶ reports that anti-retroviral therapy is only available at 6 sites in Madagascar through the public-sector treatment program.

The level of unmet need for ARV treatment in Madagascar is substantial. [USAID's February 2005 Health Profile for Madagascar](#) estimates that as of September 2004, only 30 of an estimated 17,000 adults in need of treatment for advanced HIV were receiving antiretroviral therapy. The 2005 figures in the UNAIDS 2006 Epidemiological Fact Sheet on Madagascar are much lower, reporting an estimated 6500 adults [range 2400 – 13,000] living with HIV who remain in need of ARV treatment. At the end of 2005, only 600 people were receiving ARV treatment in Madagascar.⁷⁷

Adolescent Reproductive Health

Sexually Transmitted Infections (STIs)

The prevalence of STIs, particularly syphilis, among Malagasy youth is alarmingly high. Among youth aged 15-24 years, 7.5 percent of females and 3.9 percent of males had syphilis at the time of the 2003 DHS survey. For more information, refer to Chapter 13 of the [Enquête Démographique et de Santé, Madagascar 2003-2004](#).

Despite high rates of syphilis, HIV remains relatively low in this population. Of young people aged 15-24 years, 0.5 percent [range 0.2 – 1.3] of young men and 0.3 percent [range 0.1 to 0.6] of young women were estimated to be infected with HIV at the end of 2005. For more information, refer to the [UNAIDS 2006 Epidemiological Fact Sheet](#).

Knowledge, Attitudes, and Behavior

Madagascar's youth begin having sex at a relatively young age. By age 15, 15 percent of young Malagasy women are already sexually active. By age 20, this jumps to 77 percent. The median age at sexual debut is 17.5 years for females aged 25-49 years, as compared to 18.0 years among young men aged 25-59. This statistic has not changed substantially since the 1997 DHS, in which median age at sexual debut was 16.9 years among women and 17.8 for men aged 20-49 years.

Despite the young age at which they begin having sex, youth in Madagascar are not very knowledgeable about contraceptive methods. Only 62.7 percent of young women aged 15-19 could name a modern method of family planning. Knowledge increases substantially (to 86.5 percent) among those aged 20-24 years; however, by that time, the majority of these young women have been pregnant.

Most Malagasy women continue to have their first children at a young age, though less so than in the past. While over half (56 percent) of 18-year-olds were pregnant or had at least one child at the time of the 1997 DHS survey, this dropped to 48 percent in the 2003-2004 survey. As would be expected, rural residence and low educational level are factors that increase the likelihood of early childbearing in Madagascar.

While no data are available to indicate young people's knowledge of fertility cycles, the 2003-2004 DHS provides a clue. Among all ages of women surveyed (15-49 years), 48 percent had no idea of the existence of a fertile period. This may also indicate a low level of knowledge among younger women.

Indeed, [2004 research](#) about the determinants of women's HIV knowledge and behavior indicated that older women are significantly more knowledgeable about HIV prevention than women aged 15-20 years.⁷⁸ Among young people aged 15-24 surveyed during the [Enquête Démographique et de Santé, Madagascar 2003-2004](#), only 75 percent had heard about HIV and just 60 percent of youth knew that any methods existed to prevent infection. In fact, only 16 percent of males and 19 percent of females could correctly identify two ways of preventing the sexual transmission of HIV and correctly reject three misconceptions about HIV transmission.

The 2003-2004 DHS also detected Malagasy youths' negative attitudes toward people with HIV. Only 56.7 percent of young women and 53.9 percent of young men would be accepting of someone in their family who had HIV.

Malagasy youth engage in high-risk sex, defined here as having multiple partners and unprotected intercourse. A survey of 15- to 24-year-olds in a mining region found that 72 percent of respondents had more than two sexual partners in the previous year. Only 12 percent of males and 5 percent of females of ages 15-24 years reported condom use with a non-regular sex partner during the 2003 DHS survey.⁷⁹

For more information about reproductive health knowledge, attitudes, and behavior among youth in Madagascar, refer to:

- 2006 article in *Sexuality in Africa Magazine*, [Preliminary Findings on Youth, Sexuality and Marriage in Selected African Countries](#);⁸⁰
- 2004 PSI Research Brief, [Franchised Youth Clinics Motivate Behavior Change in Madagascar](#);⁸¹
- Research published in 2005 in the *Journal of Biological Science* entitled, "Determinants of Condom Use Among Youth in Madagascar";⁸² and
- [Enquête Démographique et de Santé, Madagascar 2003-2004](#).

Youth-Centered Policies in Madagascar

An April 2000 document by the Ministry of Health, [Politique Nationale de Sante des Adolescents et des Jeunes a Madagascar](#)^{††83} (National Youth and Adolescent Health Policy in Madagascar), outlines the national guiding principles on health for Malagasy youth. The overall objectives of the policy are to:

- 1) encourage adolescents and youth to adopt healthy behaviors;
- 2) offer quality services adapted especially for adolescents and youths;
- 3) encourage adolescents and youth to adopt responsible behaviors related to sexuality and reproduction;
- 4) support harmonious relationships between adolescents and youth and their environment; and
- 5) prepare adolescents and youth for being responsible family members and citizens.

The policy's strategy for achieving these objectives revolves around five "axes":

- **Information:** to disseminate appropriate information regarding health, behavior, and development to youth and their parents through the appropriate channels.
- **Advocacy:** to advocate to policy-makers and community leaders the importance of ensuring youth/adolescent access to reproductive health services and HIV/AIDS prevention education.
- **Service delivery:** to encourage research on issues related to youth and adolescents and to improve their access to reproductive health services.
- **Jobs:** to ensure technical training and job skills at every level of education and to develop capacity of youth to become independent and functioning citizens.

†† Note: This online text contains characters outside the standard character set supported by Microsoft Internet Explorer on an English-centric installation of Microsoft Windows. Because of this, all non-English characters display incorrectly.

- **Education:** to support girls' education, to develop capacity among teachers to engage and listen to youth, and to make reproductive health curriculum in schools mainstream.
- **Research:** to dedicate funds for research on topics related to youth including violence, sexually transmitted infections, abortion, and others.

Youth-Friendly Health Services

The single largest youth-focused reproductive health program in Madagascar is the USAID-supported [Top Réseau](#), a franchise of youth-friendly clinics started by PSI in 2001. The purpose of *Top Réseau* is to prevent STIs and unintended pregnancies among sexually-active youth by promoting correct and consistent condom use and by increasing young people's use of medical professionals for treatment of STI symptoms. A complementary media campaign has promoted the clinics, endorsed condom use for dual protection, encouraged treatment of STIs, and taught skills for condom negotiation and sexual abstinence.

From the PSI Web site:

In 2001, [PSI/Madagascar](#) launched a franchise network of youth-friendly private clinics branded *Top Réseau* with the support of the Gates Foundation in one large city. Subsequently, PSI received additional support to expand the social franchise program to four other urban areas: Antananarivo, Antsiranana, Tolagnaro, and Mahajanga. The project aims at preventing STI transmission and unwanted pregnancy by improving STI case management, and promoting consistent condom use and modern family planning methods among sexually active youth. *Top Réseau* clinics are promoted among young people looking for confidential, quality, affordable, and youth-friendly services. To date, PSI/Madagascar has trained and incorporated 184 doctors from 123 existing private clinics to provide STI curative and family planning services. PSI encourages effective STI prevention counseling through continuous provider training and a variety of educational tools. The *Top Réseau* network is supported by a strong youth peer educator program to attract new clients. In 2005, *Top Réseau* clinics reported more than 41,000 clients. With PSI/Madagascar support, in 2006, selected providers will begin offering voluntary HIV counseling and testing.

For more information about *Top Réseau* clinics in Madagascar, refer to:

- USAID's article [Improving Sexual and Reproductive Health for Malagasy Youth](#),⁸⁴ and
- PSI's article [Franchised Youth Clinics Motivate Behavior Change in Madagascar](#).⁸⁵

Sexuality Education

While basic reproductive health is taught during the last year (*3eme* grade) of middle school in Madagascar,⁸⁶ a [2004 article from Sexuality in Africa](#) reports that sexuality education is included only in high school curricula.⁸⁷

[A 2005 case study](#) argues that, due in part to unmet need for sexual education and contraceptives, "many young Malagasy women are unaware of the fact that their body and their fecundity are things they can control."⁸⁸ The paper highlights [research conducted in the 1990s by Lesley Sharp](#), which demonstrates how young women have little or no access to sexual information.⁸⁹ The researcher points out that one of the few occasions during which

young Malagasy women are likely to receive modern and scientific sexual education is at high school. Unfortunately, over 20 percent of people in Madagascar have never been to school, and only 5.3 percent have completed secondary school.⁹⁰ “Rural youth often leave school before they have completed primary school, so sexuality education at school is irrelevant as far as they are concerned.”⁹¹

Some sexuality education is provided to younger girls, although only in specific cases, such as the Ambassador’s Girls’ Scholarship, a mentorship project implemented in Madagascar by [John Snow, Inc.](#), which reaches approximately 1000 school-age girls per year.

Youth-Focused Reproductive Health Programs

SantéNet, a USAID-funded technical assistance agency, works in collaboration with [Health Communication Partnership \(HCP\)](#) to implement an HIV prevention education program for youth. The program, called *Ankoay*, which means eagle in Malagasy, brings together members of Madagascar’s boys’ and girls’ scouting organizations to promote youth leadership in HIV/AIDS activities. According to SantéNet’s 2005-2006 Annual Report,⁹² 166 scout troops were trained between October 2005 and September 2006, and 80 among them completed all activities and graduated as *Ankoay* scout troops. The 80 scout troops represent approximately 2400 boy and girl scouts. As part of the *Ankoay* model, each scout is required to reach out to 10 non-scout youth. The total number of youth reached by the first year of *Ankoay* was 24,000. The model is being expanded to reach a larger number of young people through junior high schools (*Ankoay Schools*) and sports clubs (*Ankoay Sports*).

For more information about youth-focused reproductive health and social marketing programs in Madagascar, refer to:

- section on page 23 of this assessment entitled “Social Marketing”;
- USAID’s Success Story, [Youth Fight AIDS in Madagascar](#);⁹³
- 2006 article [USAID Supports the Expansion of Top Réseau Health Clinics into Antsirabe and Morandava](#);⁹⁴
- PSI’s report [Changing Youth Behavior Through Social Marketing: Program Experiences and Research Findings from Cameroon, Madagascar and Rwanda](#);⁹⁵ and
- PSI’s 2005 report [Improving the Health Status of the Malagasy through Social Marketing of Hormonal Contraceptives and Maternal and Child Health Products](#).⁹⁶

PEPFAR and USAID Funding Restrictions on Reproductive Health Activities

USAID’s anti-prostitution policy from the [Acquisition and Assistance Policy Directive](#) of 2005 prohibits USAID funds to be used “to promote the legalization or practice of prostitution or sex trafficking,” and requires that recipients adopt a policy “explicitly opposing prostitution and sex trafficking.”⁹⁷ Further provisions advise recipients “to not endorse or utilize a multisectoral approach to combatting HIV/AIDS, or to not endorse, utilize or participate in a prevention method or treatment program to which the organization has a religious or moral objection.”

Madagascar is not one of the 15 PEPFAR countries and is therefore not affected by its funding restrictions.

FHI Ongoing and Planned Reproductive Health Activities in Madagascar

Table 3: FHI's Research Activities in Madagascar, as of January 2007.

Subproject Title	Project or Award	FCO	Tech Monitor	Div	Total Approved Budget	Start Date	Projected End Date	Subproject Objective
UNC: A Phase III Equivalence Trial of Azithromycin vs. Benzathine Penicillin for the Treatment of Early Syphilis	University of North Carolina (UNC)	1735/12096	L. McNeil	CRD	\$388,547	10/02/01	10/31/08	To demonstrate that the rate of cure for treatment of early syphilis with azithromycin is equivalent or superior to that obtained with penicillin as measured at six months after initial treatment. Equivalence will be defined as an observed azithromycin cure rate no worse than 12% below the cure rate observed for penicillin.
CONRAD: Monitoring for Studies of Diaphragm Acceptability Among STI Patients in Madagascar	CONRAD	12017	G. Pittman	CRD	\$38,571	04/12/05	2/28/07	To provide monitoring support to two CONRAD/CDC studies carried out in Madagascar. One investigated the acceptability of diaphragms among women of low socio-economic status at high risk for sexually transmitted infections. The second recruited from an existing study cohort of women seeking care for STIs in the public clinics of four communities. This randomized study was intended to lead to a larger randomized controlled trial of safety and acceptability of the diaphragm used with various vaginal products.

Formative Research to Determine the Feasibility of Recruitment for "True Efficacy" Trials	USAID	116104	A. Corneli	BASS	\$297,359	09/09/05	3/31/08	To identify characteristics of women who are most likely to participate in a one-month, placebo/no method-controlled contraceptive efficacy or effectiveness trial; and to develop strategies to recruit women willing to join the study.
Enhanced Country Program Implementation	USAID	113117	T. Nutley	FITS	\$2,809,915	09/08/05	4/28/10	1) To identify and prioritize local reproductive health research and program needs in focus countries; and 2) to facilitate efficient, effective implementation and utilization of reproductive health research and programs in the focus countries.
Introductory Trial of Community-based Distribution of DMPA in Rural Madagascar	USAID	124103	T. Hoke	HSR	\$100,019	05/16/06	12/31/07	To assess the feasibility of providing DMPA through an existing network of community-based distributors in rural Madagascar, and to determine the programmatic inputs required for successful implementation and scale-up of this service delivery model.

UAB: Effectiveness of the Diaphragm for the Prevention of Gonococcal & Chlamydial Infections in Women at High Risk in Madagascar	NIH - National Institutes of Health	12094	L. McNeil	CRD	\$393,510	02/09/06	10/31/08	To investigate the effectiveness of the latex ALL-FLEX® diaphragm to prevent N. gonorrhoeae or C. trachomatis in women at high risk of STIs in four cities in Madagascar. The time to initial incident chlamydial or gonococcal infection will be compared among women assigned to use the diaphragm, together with male condoms, with the time to initial chlamydial or gonococcal infection among women assigned to use male condoms only. <i>Note: Due to uncertainty about a conflicting trial, which was being developed at the designated study sites, NIH placed this trial on hold in November 2006 until further notice.</i>
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Source: Electronic Information System (EIS), *Family Health International*, accessed January 2007

USAID's Family Planning, Reproductive Health, and HIV Programs

USAID Strategies in Madagascar

USAID's strategy in Madagascar is fourfold:

- to strengthen civil society and government institutions;
- to increase rural incomes;
- to improve natural resource management; and
- to increase access to quality healthcare.

For more information, refer to [USAID/Washington's Madagascar page](#) and the [USAID/Madagascar Mission](#).

USAID's total budget in Madagascar has changed very little between 2004 (US \$20.7 million) and 2006 (US \$20.4 million). Global Health made up 49 percent of the 2006 budget. Of Madagascar's 6 provinces and 22 regions, 4 provinces (Tana, Fianar, Toamasina, and Toliara) and 16 regions are targeted by USAID.⁹⁸

For more information about USAID's activities and funding in Madagascar, refer to the [2006 Congressional Budget Justification](#) and the [2005 USAID/Madagascar annual report](#).

Other Country Information

Donors

According to USAID's [2006 Congressional Budget Justification](#), the World Bank, the United Nations and the European Union are Madagascar's largest multilateral donors, followed by France, the United States and Japan at the bilateral level. Donor coverage and priorities by sector are as follows: World Bank (governance, institutional development, public finance, judicial reform, gemstone trade, maternal/child health, HIV/AIDS, environment, education, privatization, agriculture, food security, rural development, micro-credit); European Union (public finance, judicial reform, environment, agriculture, rural development, food security, transportation infrastructure); United Nations (governance, maternal/child health, family planning, environment, rural development, food security, disaster mitigation); France (judicial reform, public finance, maternal/child health, family planning, environment, rural development, food security, micro-credit, agriculture, urban development); and Japan (collaborates with USAID in health and behavioral change activities). Governance and institutional development are the central themes of World Bank and International Monetary Fund support. The World Bank is the lead HIV/AIDS and education sector donor in Madagascar. Madagascar also receives funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccinations and Immunizations (GAVI), and the MacArthur Foundation.

By the end of 2005, the Global Fund had approved a total of eight grants to Madagascar, including three for HIV/AIDS.⁹⁹

Government Entities and Other Organizations Relevant to FHI's Work

The [Ministry of Health and Family Planning](#) includes 17 departments and divisions. Of those, the four that are the most relevant to FHI's work include:

- **National Institute of Public and Community Health** (biomedical, social, and operational research; application of research results in service delivery settings)
- **Administration of Family Health** (includes nutrition, vaccinations, youth/adolescent health, reproductive health, and safe motherhood services)
- **Administration of Emergencies and Infectious Disease** (tuberculosis, leprosy, malaria, and emergent epidemics)
- **Administration of Health Promotion**

A full list of divisions and directors is available on the Madagascar Ministry of Health and Family Planning Web site's [Responsables page](#). For a list of all ministries in the government of Madagascar, refer to the [Government of Madagascar Web site](#).

Contact information for the *Comité National de lutte contre le VIH/Sida (CNLS)*, Madagascar's national HIV control program can be found on the [Global Fund's Madagascar page](#).

Other organizations working in Madagascar include:

- [Population Services International \(PSI\)](#)
- [Management Sciences for Health \(MSH\)](#)
- [SantéNet](#)
- [Catholic Relief Services](#)

For a full list of USAID grantees in Madagascar, refer to the [USAID/Madagascar Mission partners](#) page.

Ongoing Microbicide and HIV Vaccine Research

[One formative study on Acidform gel](#) used with a diaphragm was conducted in Madagascar by the University of North Carolina's School of Public Health (Principal Investigator Frieda Behets, Ph.D., Associate Professor of Epidemiology at the UNC-CH School of Public Health), in collaboration with Madagascar's National Institute of Public and Community Health and the Institute Pasteur in Madagascar.¹⁰⁰ The formative study is finished and results will be presented at the International Society for Sexually Transmitted Diseases Research Conference in Seattle, WA in July 2007.¹⁰¹ A follow-up clinical trial will begin in Madagascar in late 2007.

Up-to-date information about microbicide trials is available at the [Alliance for Microbicide Development](#) Web site.¹⁰² For more information about specific trials, refer also to the [Microbicides Development Programme \(MDP\) Web site](#).¹⁰³

Research Ethics Requirements in Madagascar

Family Health International conducts research in Madagascar with the approval of the ethics committee at the National Institute of Public and Community Health (*Institut National De Santé Publique et Communautaire, Ecole de Médecine, Antananarivo, Madagascar*). The head of this committee is Professor Justin Ranjalahy Rasolofomanana.

Ethics committees also exist at the [Laboratoire National de Référence](#) (National Reference Laboratory) and the [Ministry of Health and Family Planning](#) in Antananarivo, though no additional information could be located about these.

Evidence of the Impact of FHI Research

FHI's research results and good working relations with both cooperative agencies and the Ministry of Health and Family Planning (MOHFP) contributed to the MOHFP's decision to update its national reproductive health guidelines to reflect evidence-based research findings.

Early in 2006, the MOHFP indicated its interest in piloting the USAID's *Best Practices Package*, a set of evidence-based practices developed in partnership with FHI and other collaborating agencies. In March 2006, a team comprised of representatives from USAID, FHI, the Adventist Development and Relief Agency (ADRA), and the MOHFP conducted an assessment to identify which of these best practices could be applied to Madagascar. The team recommended that Madagascar adopt FHI's pregnancy checklist and an evidence-based practice known as systematic screening as standard practices for all clinical and community-based health providers. The team presented its findings to senior-level policymakers in the Ministry in April.¹⁰⁴

In May 2006, the MOHFP held a workshop on family planning norms and standards. Taking into account the recommendations of the assessment team, policy-makers at the workshop made two critical changes related to national family planning service provision:

- to pilot the implementation of the *Best Practices Package*, and
- to drop menses as a requirement for contraceptive initiation.

Over the years, FHI has also made substantial contributions to the clinical and behavioral knowledge base surrounding the female condom in Madagascar. As a result, reproductive health program managers in Madagascar are considering results of an FHI-led trial that assessed the impact of introducing male and female condoms among those at highest risk for HIV and other STIs.

As excerpted from the 1995-2005 Contraceptive Technology Research Program's (CTR) [Final Results Briefs](#),¹⁰⁵

- Beginning in 1999, FHI conducted studies in Bangladesh, Kenya, Madagascar, Mexico, and Tanzania to assess the impact of introducing the female condom among high-risk populations of commercial sex workers (CSWs). The studies sought to determine if the introduction led to more protected sex and if female condom use substituted for male condom use... The Madagascar study found good evidence of an association between female condom introduction and reduced STI rates... STI prevalence declined from an aggregate of 49% prior to female condom introduction to 40% after 12 months of female condom promotion. The extent of the reduction varied depending on site, intervention group, and participant characteristics.
- Introducing the female condom to these high-risk populations led to reported increased use of protection... Increased protection levels at these sites were attributable primarily to use of the female condom with regular, paying

clients...After introducing the female condom in Madagascar, the proportion of study participants reporting protected sex acts with all clients rose from 78% following six months of male condom promotion to 88% at 18 months...However, these studies also found that a “condom gap” of unprotected sex still existed with emotional partners (boyfriends).

- In Madagascar, interpersonal support offered by peer educators was sufficient to encourage significant increases in use of protection with female condom availability. No evidence suggested that added benefit was derived from supplementing peer promotion of female condoms with clinic-based counseling.

Research and Administrative Capacity

Though FHI’s Madagascar field office closed in 2003, a small number of FHI staff continue to work full time in Madagascar. Project Director Serge Raharison manages FHI’s research and program portfolio in-country. Contract employee Kelsey Lynd is an associate program officer working on the Introductory Trial of Community-based Distribution of DMPA in Rural Madagascar (FCO 124103/144100). Robbyn Lewis serves as the senior program officer and country monitor for Madagascar, providing administrative backstopping from FHI’s North Carolina headquarters.

Research organizations which FHI’s former Institute for Family Health has worked with in Madagascar during the past five years include the CHU Joseph Ravoahangy Andrianavalona (Central University Hospital), the Laboratoire National de Reference (VIH/MST), and the University of North Carolina at Chapel Hill.¹⁰⁶ All three research organizations collaborated with FHI on the *Impact of Female and Male Condom Promotion* study led by Theresa Hatzell-Hoke.

Dissemination

Some specific women-targeted magazines, such as *Femina Santé* Magazine, are available in Madagascar and are well situated to cover reproductive health and HIV topics. However, coverage appears to be limited and magazines are not affordable for the average Malagasy woman. Newspapers, radio, and TV broadcasts remain the most effective methods of advocating and promoting family planning, reproductive health, and behavior change for HIV prevention—even though journalists and audio-visual professionals in Madagascar still require substantial training and technical support to be able to provide appropriate, accurate messages.

The MOHFP issues a quarterly magazine called “Bulletin *Ezaka*,” which targets health professionals and RH/FP program managers at different levels. The content includes new guidelines and provides updates on current activities and innovative approaches.

For more information about the media in Madagascar, refer to the [BBC News’ Madagascar profile](#),¹⁰⁷ which includes a list of the country’s newspapers, television channels, and radio stations.

FHI Web Activity

Of its 459,382 total online visitors between January 1 and March 31, 2006, the FHI Web site received 222 visitors from Madagascar.¹⁰⁸

In-Country Networks

The National Reproductive Health and Family Planning Working Group is led by the MOHFP. Main partners include UNFPA, UNICEF, WHO, USAID and its collaborating agencies, and JICA. The working group organizes a large-scale annual workshop to share experiences, define overall plans, and make decisions on future directions. Additionally, thematic workshops are carried out throughout the year, and systematic quarterly follow-up meetings are regularly organized to track progress and update the agenda.

Stakeholder Perspectives

In March 2006, an assessment team - whose members consisted of staff from USAID, FHI, the Adventist Development and Relief Agency (ADRA), and the MOHFP - convened stakeholders in Madagascar to discuss USAID's *Best Practices Package*. The group identified which best practices could be applied to Madagascar and observed needs and opportunities for improving the national family planning program on three levels:¹⁰⁹

Policy and Environment

- Complete the process of updating the norms and standards.
- Disseminate new norms and standards broadly and orient RH service delivery staff throughout the system to ensure that they understand the changes.
- Operationalize plans developed on strategy level to improve service delivery, communications, and health management information systems.
- Establish an ongoing process of systematic review and updating of the norms and standards in order to stay current with international service provision standards.

Clinic-based Services

- Augment the capacity of clinic personnel to provide RH services. Specifically, improve orientation on Madagascar's norms and standards document for service provision. This is especially important once the document is updated to reflect the current WHO MEC/SPR.
- Encourage service providers to inform clients about the full range of contraceptive methods, including methods like long-acting and permanent methods (LAPMs) that may not be available at a particular service site, but which are available elsewhere in the service delivery system.
- Improve the capability of clinic-based providers to offer integrated services so that clients can get the most out of their visits to the clinic. A relatively large proportion of the population has poor access to clinic services, and visits to a facility are costly in terms of time and effort to clients of limited means. Ensuring that clients are offered multiple priority services (e.g., FP, child vaccination, and STI diagnosis and treatment) at each visit, at least in clinics with the capacity to provide services, would increase uptake of priority interventions and increase the efficiency of clinic visits.

- Strengthen mechanisms for circulating program-related information throughout the system.
- Continue efforts to prevent stockouts of family planning commodities (and other consumable commodities).
- Provide additional support to information, education, and communication activities and to Health Management and Information Systems (HMIS) functions.
- Strengthen the overall RH supervision system. This would be a significant step in institutionalizing change, both to consolidate gains already made and to solidify any changes that might be forthcoming.

Community Outreach Services

- Where applicable, take measures to reduce variance in skills of community outreach workers, which vary by agency and by site. Given the uniform training structure, variability should raise a note of caution.
- Support increased responsibility and improved performance of community outreach workers with improved training, supervision, and eventually performance incentives.
- Ensure strong relationships between the clinics and the outreach workers, and explore mechanisms for involving service delivery personnel in capacity-strengthening activities and supervision for community outreach workers.
- Ensure that community outreach workers at all sites have the health education materials and job aids they need to be successful. This seems relatively easy to remediate given that the materials exist and could be built into efforts to improve the quality and uniformity of training at this level.

For more information about stakeholder perspectives in Madagascar, refer to:

- the April 2006 assessment team's full report, *Mission to Assess the Potential for Introduction of Evidence-based Family Planning Practices in Madagascar*,¹¹⁰ and
- the [December 2005 POLICY Project assessment team report](#)¹¹¹ on contraceptive security in Madagascar, including Appendix 2 of this report for the team's recommendations.

Appendix 1:

Health Facility Statistics Provided by the National Statistic Service (2005)

Basic health centers (CSBs): These number 2609 in all. This includes 2181 in the public sector, 373 in the private sector, and 55 known as “para-public” (i.e., the CSB remains public but is managed by an NGO or faith-based organization). There are two types of CSBs:

- CSB-1s (numbering 1146 in 2005) that provide basic health care services (curative and preventive) and are run by a paramedical officer.
- CSB-2s (numbering 1403 in 2005) that provide the same health care services as above but also include urban dispensaries and mother and child health care centers and are run by a physician. Significant efforts are being made by the government to equip the CSBs with medical doctors, so the number of CSB-2s is expected to increase.

District hospitals (CHDs): These number 124 in all, including 100 in the public sector, 21 in the private sector and 3 para-public. There are also two types of CHDs in the public sector:

- 74 CHD-1s that provide hospital cares to medical cases.
- 50 CHD-2s in 2005 that also provide standard surgical operation facilities.

Hospital bed capacity per province is as follows - Antananarivo: 1046 beds; Antsiranana: 653 beds; Fianarantsoa: 829 beds; Mahajanga: 404 beds; Toamasina: 633 beds; and Toliary: 595 beds.

University hospitals (CHUs) are operated at national level. These number 16 in all, including 13 in Antananarivo and 3 in Mahajanga. These hospitals provide full service health care, impart initial and continuous training, and conduct some research. At the secondary level, there are four regional hospitals (CHRs), one each in Toamasina, Fianarantsoa, Antsiranana, and Toliary. Bed capacity in the CHUs/CHRs per province is as follows - Antananarivo: 1502 beds; Antsiranana: 300 beds; Fianarantsoa: 309 beds; Mahajanga: 195 beds; Toamasina: 335 beds; and Toliary: 242 beds.

Appendix 2:

Recommendations Provided in December 2005 POLICY Project Assessment Team Report¹¹² on Contraceptive Security in Madagascar

Policy

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

Financing

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

Logistics

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

Service Delivery

- Revise and update the norms and standards document (which is a good document) as soon as possible; the current one is perceived as a barrier to achieving contraceptive security.
- Integrate HIV/AIDS and FP; FP clinics can be used as service delivery points for the distribution of condoms as a method choice for family planning and prevention of HIV/AIDS.
- Conduct a feasibility study and/or operational research to identify barriers to providing FP in remote areas.
- Based on results of study, strengthen and expand delivery of contraceptives.

- Quality improvement: Promote FP through a quality improvement campaign. For example, MOHP clinics participate in the Gold Star program in Egypt and could receive a gold star if they meet quality standards for six months and undergo two supervisory visits. Often clients want to go to a Gold Star clinic after seeing a TV advertisement.
- Enhance the utilization of pharmacists (private sector) as service delivery points for promoting FP. For example, in Egypt, the program was titled “Ask and Consult.” The pharmacists were trained in contraceptive services. The program also was used in a marketing campaign to direct clients to obtain FP services at the pharmacy.

Advocacy

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

USAID/Washington additional recommendations based on USAID Team Trip Report—Madagascar, September 2005

- Expand use of IUDs per the new WHO guidelines.
- Expand the role of CBDs to include Depo-Provera and the standard days method.
- Introduce pregnancy checklist and screening tools to increase uptake of family planning as indicated.
- Develop a monitoring and evaluation plan so that the current approach to poverty reduction can be documented and progress or the lack thereof can be tracked and appropriate changes made to the plan as indicated.

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