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THE LEGAL ENVIRONMENT FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH IN MADAGASCAR

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INTRODUCTION

"*Miteraha fito lahy, fito vavy*" (may you have seven sons and seven daughters). This quote from a traditional wedding benediction succinctly encapsulates the culturally ingrained view in Malagasy society that children are a blessing. For the poor, the dominant value of children remains economic. Large families provide labor for livelihoods and the household, and a safety net in the event of parental illness and the inevitability of old age. For better off groups, children are cherished for a mix of personal, religious, and familial reasons. For the nation, children represent the country's future human capital for development and prosperity. However, the population needs to be managed to advance well-being and reduce poverty. Population growth, reproductive health, maternal and child health, and family planning in Madagascar are critical issues, which health statistics have demonstrated the need to address. According to World Bank and World Health Organization statistics for 2013, the country's annual population growth rate remains high at 2.8 percent, maternal mortality is at 440 per 100,00 live births, and the contraceptive prevalence rate is 39.8 percent.

The government of Madagascar took its first formal policy steps to address the population issue with the passage of Law No. 90-030 of December 19, 1990, which established the National Population Policy for Social and Economic Development. Prior to this law and since then, government officials have participated in numerous international conferences, signed international protocols, developed additional policies and programs, and elaborated a variety of strategic sector plans. Implementation progress has been slower than anticipated, and the health ministry and its international partners have sought to detect and analyze causes and influences, and develop remedies.

Among the factors singled out is the legal environment and the extent to which it enables or impedes provision of family planning and reproductive health services for women and youth. This report provides a rapid, targeted overview and assessment of the legal context for these services, with the aim of clarifying the role of laws and policy and of identifying both positive and constraining features. The study, conducted by the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), supports the HP+ Madagascar team and government partners in their efforts to improve the enabling environment for equitable and sustainable health services, supplies, and delivery systems. Given the targeted focus of the study, laws related to ministerial and functional mandates, or to administrative arrangements, and those concerning importation and procurement of family planning commodities were not investigated. Relevant analytic sources on these laws can be found in Razafinarivo et al. (n.d.) and Health Policy Initiative and Deliver Project (2010).

RESEARCH QUESTIONS AND METHODOLOGY

To improve understanding of the legal and policy context for family planning to inform HP+ activities, the study explored the following research questions:

- What are key features of the legal, regulatory, and policy context that have an impact on family planning service delivery, access, and use?
- How are laws and regulations implemented and enforced?
- What socio-cultural and informal factors influence attitudes about, access to, and use of family planning services?

- To what extent do citizens seek to utilize judicial procedures (formal or informal) to address health and/or family planning service issues?
- Who are the key stakeholders and influential societal actors important to family planning and related policies, practices, and services?

The study team discussed the research questions, the field interview guide, the rapid assessment methodology, and a draft analytic framework with the HP+ Madagascar country team during the months of October through December 2016. Final versions were validated at a December 2016 meeting of a technical committee composed of representatives of various units within the health ministry (MINSANP). During this period, a local consultant, Olga Indriamihaja, was engaged to contribute to the interview guide and methodology, develop a list of relevant interview candidates, and initiate contacts ahead of the planned January fieldwork.

The assessment methodology consisted of two components. The first was document review and analysis. Derick Brinkerhoff, Alyson Lipsky, and Christin Stewart carried out this component. Document categories included the following:

1. Laws related to family planning services, rights, and obligations; civil marriage; youth and adolescence; and relevant criminal statutes and penalties
2. International conventions, charters, treaties, and conference declarations
3. Ancillary legislation and regulation; and family planning/reproductive health policies, services, and programs, including annual/strategic plans and national health sector development plans
4. Research reports and studies on Madagascar's legal system, health and family planning policies and services, socio-cultural norms and practices, and the role of religion in family planning

The study's second component consisted of in-country data collection via interviews and focus group meetings. Derick Brinkerhoff and Olga Indriamihaja conducted the fieldwork in Madagascar from January 15–28, 2017. Several additional interviews were carried out in February due to lack of availability of key informants while Derick Brinkerhoff was in Madagascar. The Madagascar study team was supported by HP+ Madagascar's staff: Nirina Ranaivoson, Annick Ranirisoa, and Rivo Noelson. The study team met with USAID/Madagascar health office staff at the start of the fieldwork, and prepared an exit briefing presentation that, due to scheduling constraints, was delivered on February 22, 2017. The study team circulated a draft of the report for review and comment, and finalized it in June 2017.

Analytic Framework

The study team's operational definition of the legal context considers family planning laws, regulations, and policies as those statements and documents that define, regulate, and standardize which varieties of family planning services and products are delivered within a particular country, to what user populations, and under what conditions (Bertrand and Escudero, 2002). These statements and documents shape government intentions and actions related to family planning, and to the extent that they are elaborated in operational guidelines, they establish systems and procedures for family planning service delivery in the public, private, and nonprofit sectors.

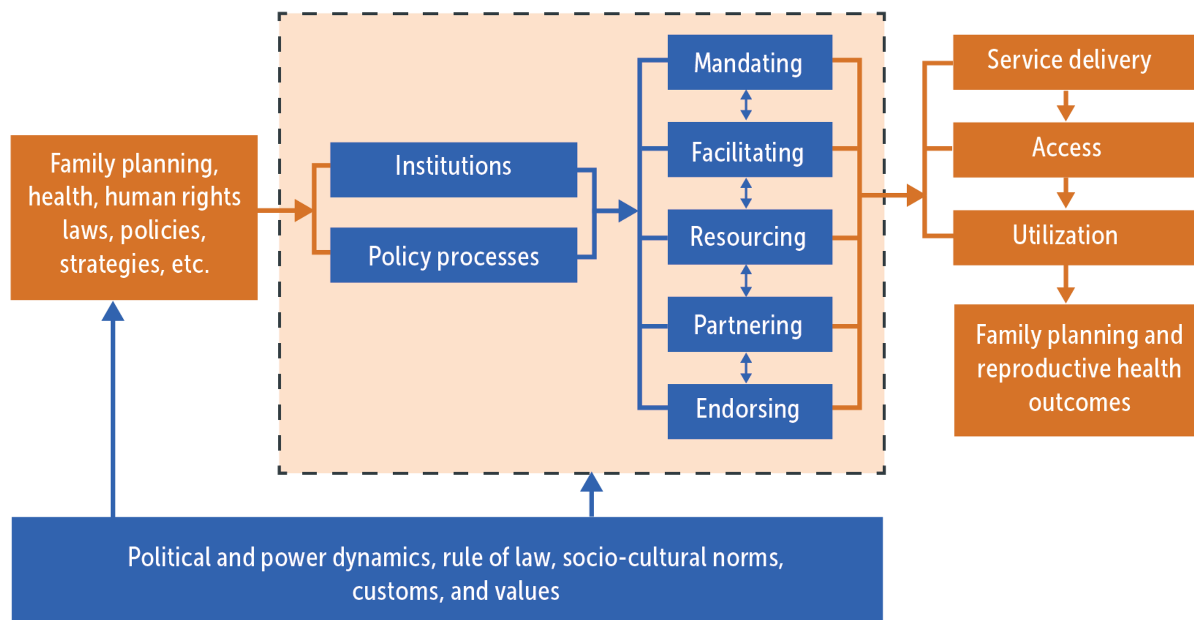
This assessment looks beyond family planning and reproductive health laws, policies, strategies, etc. It also reviews human rights laws and conventions to which Madagascar is a

signatory and examines both what is provided for in laws and regulations, and how these are implemented.

The term "enabling environment" is subject to a variety of definitions, ranging from all-encompassing to narrow. A typical general definition is that: "An enabling environment is a set of interrelated conditions—such as legal, bureaucratic, fiscal, informational, political, and cultural—that impact on the capacity of … development actors to engage in development processes in a sustained and effective manner" (Thindwa, 2001, pg. 3). Our focus on the legal context leads us to concentrate on the actions of government in fostering an enabling environment, since governments have the constitutional and statutory responsibility to pass and enforce laws and decrees, develop and apply regulations, enter into international agreements, monitor compliance, and apply sanctions. However, effective legislative, policy, and regulatory processes engage governments, both national and sub-national, with citizens and civil society, technical experts, policy analysts, and professional groups. So, while government may be in the lead role, it is not the sole actor.

Enabling can be categorized as consisting of the following actions: mandating, facilitating, resourcing, partnering, and endorsing (Brinkerhoff, 2007). This definition highlights the systemic nature of the concept of an enabling environment. Figure 1 seeks to illustrate this systems perspective graphically, and presents our conceptualization of the legal enabling environment for family planning and reproductive health. The figure demonstrates that the extent to which enabling actions focused on laws and regulations strengthen service delivery capacities and results is mediated by institutions and policy processes. The institutions, policy processes, and enabling actions are subject to broader societal factors, such as distributions of power, politics and the structure of the state, the quality of the rule of law, and a range of socio-cultural influences. The arrows in the figure indicate direct connections between a positive enabling environment, service delivery improvements, and family planning and reproductive health outcomes. However, in reality, the causal pathways are more complicated and contingent than our analytic framework can easily display.

Figure 1. Model of the Legal Enabling Environment Affecting Family Planning and Reproductive Health



THE LEGAL ENVIRONMENT FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH

This section reviews features of Madagascar's legal environment, beginning with a brief overview of the legal system. It is followed by an assessment of the laws, policies, and plans specific to family planning based on a document review of relevant literature.

Madagascar's Legal System

The constitution establishes Madagascar as a unitary republic, functioning according to democratic principles, with a bicameral legislature. The executive is led by a president elected by popular vote, and a prime minister, selected by the majority party in parliament. The president is the head of state, and the prime minister leads the government. The constitution and the body of organic laws that derive from it define Madagascar's legal system, which is based on the Napoleonic code. Alongside the formal legal system is traditional law and custom, elements of which have over time been integrated with the French-derived official legal corpus. For example, traditional rules governing disputes related to property, inheritance, and local resource use, known as *dina*, continue to be applied, and have in some cases have been given formal legal status (Pillay and Zimbris, 2015).

With successive regimes, constitutional revisions have generally reinforced the power of the executive—and of the president in particular—at the expense of parliament and the judiciary. These powers included presidential authority to name the prime minister, dissolve the national assembly, and rule by decree without parliamentary approval. Although the 2010 constitution sought to restore more power to parliament, the office of the president dominates Madagascar's governance (Pillay and Zimbris, 2015; Ravaozanany et al., 2014).

Parliament consists of the Senate and the National Assembly. The former ratifies international treaties and conventions, and is charged with overseeing their implementation in national law. The National Assembly plays the dominant role in primary legislation, that is, statutes that outline broad principles and powers relative to the issue being addressed (Clarke, 2016). The Assembly operates through a set of sectoral and technical commissions and committees, overseen by a Presidential Conference and a Secretariat. As summarized in Ravaozanany et al. (2014), the legislative process consists of six steps: 1) submission of a draft law to one or the other houses of parliament, 2) inscription in the agenda of the Presidential Conference and assignment to the appropriate commission, 3) review by the commission and selected external experts, 4) first reading and debate in plenary session in the Senate, 5) assuming adoption in the fourth step, second reading and vote of adoption in the National Assembly, and 6) presidential promulgation.

Below primary legislation developed and passed through parliamentary channels is secondary legislation, which elaborates the technical and operational procedures, structures, and details needed to put primary legislation into practice. Secondary legislation can include regulations, ministerial decrees, rules, orders, policy directives, and/or bylaws (Clarke, 2016). These do not require parliamentary approval, based on the premise that the issuing entity has the statutory mandate and the requisite technical expertise to exercise this form of legal authority. In the health sector, the health ministry and related public agencies are the major sources of secondary legislation.

Implementation and the Rule of Law

Laws, regulations, and policies can neither serve as enablers nor fully achieve their intended results unless they are applied, enforced, and accepted as valid and legitimate by a majority

of citizens. The shorthand concept for legal implementation is the rule of law, which captures the extent to which governments, private entities, and citizens are held accountable; laws are clear, just, and impartially applied; and legal institutions and processes are fair, accessible, ethical, and timely. For many countries, meeting these standards continues to be a challenge. The World Justice Project conducts an annual global review of country performance on an eight-dimension scale of the elements of the rule of law. The dimensions that the index rates include: constraints on government powers, absence of corruption, open government, fundamental rights, order and security, regulatory enforcement, civil justice, and criminal justice (World Justice Project, 2016).

Madagascar's global ranking in 2016 places it 90th out of 113 countries, which indicates that the country faces some serious constraints in operating in accordance with the rule of law. However, its score closely reflects those of other low income sub-Saharan African countries, falling in the middle of this group (10th out of 18 countries), so Madagascar is not alone in confronting implementation problems, and shares similar patterns with others in the region.

Such aggregate ratings cannot capture the specifics of the legal issues related to individual sectors, such as health or family planning. However, they provide a rough indicator of the ability of government to use laws and regulations to support and achieve intended policy and program outcomes. In the case of family planning and reproductive health, HP+'s analysis and interviews confirmed problems with unclear and contradictory statutes, partial enforcement, weak dissemination, and limited reach of formal law in comparison with customs and traditional practices. All these factors pose constraints on the degree to which the legal environment can serve as an enabler of family planning and reproductive health policies and services.

Laws, Policies, and Plans Related to Family Planning and Reproductive Health

Madagascar has a long history of government commitment to family planning and reproductive health, going back to various international conventions. Law No. 90-030 of December 19, 1990, referred to in the introduction, constituted formal recognition of the country's population growth problem, and the need to consider demographic issues as closely connected to socio-economic development. The 1990 law addressed the problem from the perspectives of a) a definition of health that moved beyond simply the absence of illness, and b) women's rights. By including family planning in its provisions and programmatic agenda, it made family planning legal, although it left a 1920 law prohibiting promotion of family planning in place (see Table 1).

International commitments

The government of Madagascar is a signatory to multiple international treaties that are relevant for family planning and reproductive health, all of which signal some degree of high-level government intent and political commitment. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR, signed by Madagascar in 1970), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, signed in 1980), and the Convention on the Rights of the Child (CRC, signed in 1990). These treaties promote the right to health, especially maternal and child health, and affirm women's right to reproductive choice.

Between 1994 and 2000, the government signed consensus documents agreed to at international conferences, including the Programme of Action adopted at the International Conference on Population and Development, the Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women, and the United Nations Millennium Declaration adopted at the General Assembly Millennium Summit. These documents call on

states to prioritize the provision of healthcare services, including reproductive health and family planning services.

Most recently in 2015, the government signed on to the FP2020 commitment to expand access to voluntary, rights-based, high-quality family planning through specific policy, financial, and program and service delivery pledges. The government agreed to increasing the contraceptive prevalence rate to 50 percent and to decreasing by half the unmet need for family planning, lowering it to 9 percent by 2020.

The evolution of Madagascar's legal landscape for family planning and reproductive health

The early foundational laws in the legal landscape discouraged policy attention to family planning. A 1920 colonial-era law prohibited publicity for contraception in any form, and designated criminal penalties for abortion. Article 317 of the 1960 Penal Code enumerated penalties for three categories of abortion-related crimes: the practice of abortion by a third party, the practice of abortion by the pregnant woman herself, and the offering of advice about the practice of abortion when the advisor is a member of the medical profession (Rakotomalala, n.d.).

As various documents and our interviews attest, these laws have rarely been enforced and have been widely ignored. In many cases, citizens are unaware of their existence or uniformed regarding their provisions. A 2007 study of clandestine abortions, for example, found that while 60 percent of women interviewed who resided in Antananarivo city said that they were aware of the existence of criminal penalties for abortion, this percentage dropped to 45 percent for women in other municipalities, and to 36 percent for rural women (Focus Development Association, 2007, pg. 24). However, the study concluded that lack of awareness of the 1920 family planning law, which prohibits abortion, did not necessarily encourage women to seek abortions. A small group of parliamentarians launched an effort in the late 1980s to draft and pass a law (Law No. 03/88 PL) to abrogate the 1920 law, but the initiative died during the political turmoil facing the Ratsiraka government in 1991 (Razafinarivo et al., n.d.).

As noted previously, the legal landscape took on a more positive orientation with the passage of Law No. 90-030 in 1990, which recognized the need for family planning for Madagascar's development and the well-being of its citizens, and laid out the policy framework for family planning. Subsequent policy statements and operational plans have built from this foundational policy that legitimized and encouraged the provision of family planning services.

The marriage law of 2007, mentioned by almost all our interviewees, is important in that it provided a legal loophole for child marriage, which is a well-recognized issue for maternal and child health, family planning, and youth and women's rights. Also relevant to family planning and reproductive health is the 2015 law on national youth policy, which updated the 2004 youth policy. This law anticipated some of the rights language in the draft law on family planning recently voted on by the National Assembly. Its text called for expanded access to a full range of health services for youth, which it defined as people falling within an age range of 14 to 29. The draft family planning law, however, does not specify an age range for youth, but leaves such determination for later application decrees.

Table 1 offers an assessment of the laws, policies, and plans reviewed for this study. The table highlights issues related to achieving family planning and reproductive health objectives, and notes positive and negative aspects along with gaps and contradictions related to these laws, policies, and plans.

Table 1. Summary of Family Planning/Reproductive Health-Related Laws, Regulations, and Policies

Law, Regulation, or Policy Statement	Responsible Authority	Assessment and Status	Comments and Issues
FP2020 Commitments	President/Prime Minister, MINSANP	The international commitment document specifies family planning targets to be achieved by 2020: increase contraceptive prevalence to 50% and cut by half unmet need for family planning, decreasing to 9%.	Serves as useful motivation for public statements of commitment. However, family planning targets are ambitious.
Roadmap to Accelerate Reduced Maternal and Neonatal Mortality in Madagascar 2015–2019	MINSANP	The roadmap identifies two major challenges: 1) the low utilization of maternal and neonatal health services, and 2) service supply problems including geographic coverage, lack of resources, low quality, and insufficient demand generation. Its focus is on emergency obstetric and newborn care. Family planning falls under preventive and promotional activities, targeted at teenagers and youth.	The roadmap frames family planning within a broader policy domain focused on maternal and neonatal health. The plan calls for reinforcement of maternal and neonatal health institutional, legal, management, and organizational capacities at all levels, and strengthening leadership, coordination, and partnerships.
Integrated Strategic Plan for Family Planning and Contraceptive Security 2016–2020	MINSANP in the lead	Highly detailed action plan with targets and indicators and a recognized maternal mortality roadmap component. The plan takes a multisectoral approach, including other ministries (justice, youth and sports, population, and communication), plus nongovernmental organizations and donors.	This plan is the most concrete and specific assessment and plan for family planning and reproductive health among the various policy documents reviewed. If it is used to track and manage implementation, this could be an effective means of making progress. The evaluation of the previous plan noted problems with ministry capacity, including information monitoring and dissemination.
National Health Policy, draft, 2015–2019	MINSANP	This document elaborates the challenges facing the country in the health sector, noting the negative impact of the political crisis, leadership weaknesses, and resource and capacity gaps. It identifies key priorities as universal health coverage, maternal and neonatal health, human resources for health, and partnerships. Among the policy targets are improving maternal, child, and youth health. The policy recognizes the important role of local communities and advocates for greater participation and decentralization.	The policy updates the 2005 national health policy and the 2007-2015 health sector development plan. Family planning is not mentioned specifically, but clandestine abortions are called out as a problem. Among the policy's key performance indicators is increased contraceptive prevalence. The document expresses government commitment.

Law, Regulation, or Policy Statement	Responsible Authority	Assessment and Status	Comments and Issues
Madagascar 2009 National Policy on Community Health	MINSANP	This policy has three strategic objectives: empower communities to take action in their locality, optimize community use of priority health and social protection services, and harmonize socio-health interventions. Has a strong focus on maternal and child health, but does not specifically address family planning except in the annexes. Annex 5 lists family planning services among the functions of community health workers. Annex 7 contains a sample job description for community health workers, which mentions Depo-Provera injections.	A revision is underway (started in 2016 and to be finalized and validated in the near future). Community health workers are key actors in family planning service delivery and are the link between the health system and the community. Roles and legal status of community health workers were under-defined in the 2009 policy, but are clearer in the revised version.
Draft Law on General Rules Governing Reproductive Health and Family Planning	MINSANP, Ministry of Justice, Ministry of Population, Social Protection, and the Advancement of Women, Ministry of Youth and Sports, National Assembly	As of the time of writing this report, the National Assembly voted to approve the law, which goes to the Senate next. A therapeutic abortion clause was removed before review by the Council of Ministers but was reinserted by the National Assembly's health commission prior to the vote. Chapter II specifies rights to information and reproductive health and family planning services, and the obligations of the State to protect citizens' rights and provide services. Chapter III clarifies the services to be provided. Chapter IV addresses the sale of contraceptives, the determination of products to be made available, and authorizes public information and promotion of family planning methods and products.	The Senate appears likely to pass the law with the therapeutic abortion amendment. The law will be a useful and important public signal of government commitment to a rights-based approach to family planning. It will need a public promotion campaign, and on the legal side, further work will be needed to develop application decrees. Implementation will involve clarifying and harmonizing the new law with other decrees and regulations.
Law No. 2007-022 on Marriage and Matrimonial Property Regimes	Ministry of Justice	The law specifies the legal age of marriage is 18, but allows for an exception if parents obtain a waiver from a local official. The other provisions in the law deal with divorce, the rights and obligations of married couples, and common versus individual property acquired prior to and after marriage.	This law is not a strong entry point for reducing child marriage and/or early pregnancies given the article allowing exceptions. Most marriages are traditional, not civil.

Law, Regulation, or Policy Statement	Responsible Authority	Assessment and Status	Comments and Issues
Law No. 2015-038 Amending and Supplementing Certain Provisions of Act No. 2004-028 of September 9, 2004, on National Youth Policy	Ministry of Youth and Sports	The law specifies 14–29 as the age range qualifying as youth. The law also specifies a range of youth rights to benefits and services, including rights to develop their potential and to be protected from exploitation and harm. Health is noted in the introduction as a neglected priority. Health as a right is specified in terms of availability, access, acceptability, and quality. The law mentions the legal framework specifically as the means to eliminate barriers to youth access and utilization of health services, and to guarantee youth rights in health.	The legal definition of a minor is not addressed in this law, which interviewees noted as important for open access by youth to family planning. Parental approval remains an issue. According to interviewees, many youth, particularly girls, seek family planning services secretly, or rely upon their peers for advice.
French Law of 1920 Made Applicable to Madagascar by the Decree of May 30, 1933, and Promulgated in Madagascar by Government Decree of July 18, 1933	Ministry of Health during colonial period	Law prohibits any advertising or publicity in favor of contraception and abortion. Law prohibits abortion, referencing criminal penalties.	The law is referred to in many documents as a barrier for family planning, although various studies and most interviewees noted that it has not prevented Madagascar from establishing family planning policies and programs for many years.
Law No. 2011-002 of July 15 on the Health Code	MINSANP	Book 6 of the law concerns family health and includes maternal and child health and family planning, youth, and adolescents. Book 8 enumerates service provider responsibilities, including a duty to offer advice on avoiding unwanted pregnancies. Article 267 mentions availability of abortions in relation to pregnancy complications.	The law provides broad and detailed statements of services to be made available and responsibilities and duties of providers in various categories. The code makes no mention of mechanisms or resources to implement or enforce the code.
Article 317, Order No. 60-161 of 03-10-60, Penal Code	Ministry of Justice	Code states that any person caught performing or attempting to perform an abortion is subject to penalties such as imprisonment or a fine. Medical personnel are subject to suspension for a minimum of five years to life.	The code adds to ambiguity for service providers given the general lack of enforcement of laws. It contradicts articles in the Health Code and the Code of Ethics.

Law, Regulation, or Policy Statement	Responsible Authority	Assessment and Status	Comments and Issues
Decree No. 98-945 on the Medical Profession Code of Ethics, December 4, 1998	MINSANP	Article 40 in the decree permits abortion if it protects the health of the pregnant woman and it is determined by a physician that her life cannot be saved by any other means. Abortion is only permitted if two additional physicians are consulted, one of whom must be taken from a list of experts provided by the court. Article 41 names the physician as the sole judge of what is in the interests of the mother and the child.	The code establishes a high bar to meet for legal abortion, effectively creating a barrier to accessing this service, especially in rural areas. Women who need a therapeutic abortion are more at risk of negative health consequences or death since rural facilities have only one physician.

PERSPECTIVES ON THE LEGAL ENVIRONMENT: INTERVIEW FINDINGS

This section reports on the findings from interviews with government officials, health service providers, donor-funded project staff, and civil society organizations (see Annex 1 for a list of interviewees). Responses are presented according to our research questions listed previously.

Key Features of the Legal, Regulatory, and Policy Context Affecting Family Planning

Most respondents commented on the existence of the 1920 colonial-era law on family planning and its restrictive and punitive elements. However, following that acknowledgment, they all indicated that the law has not prevented the government from establishing family planning policies and pursuing programs over decades that make contraceptives and reproductive health services available. While from a narrow interpretation, the old family planning law may have posed a barrier—some interviewees observed that the country's family planning programs could be said to operate illegally—in practice the law has been largely ignored as the government has recognized the severity of the country's population problem and has taken steps to address it.

Among respondents, though, there was near unanimity on the need to abrogate the old law and replace it. Two main reasons were cited. First, the 1920 law has created uncertainty for service providers regarding whether and how any of its provisions may or may not be enforced. Second, given the government's international commitments in support of family planning and its national policies and programs that provide family planning and reproductive health services, the old law stands out as contradictory and inconsistent. The following quote from a senior official sums up this latter point:

> *One could say that we're operating illegally regarding the 1920 law. But that's not my perspective. Yes, we have this old law, that's a reality, but we also have Law No. 90-030 on the national population policy for social and economic development ... We also have our national policy on reproductive health, and there are roadmaps—our latest from 2015—and the signing of FP2020. So these demonstrate the Madagascar government's commitment to FP [family planning].*

Respondents familiar with the new draft law on family planning that has been under development over the past year expressed positive views. These were mostly officials from the ministries of health, population, and youth, and representatives from family planning civil society organizations who have participated in the technical commission on the law. According to them, the chapters in the draft reflect a legal orientation that deemphasizes prohibitions in favor of specifying rights and inciting positive practices and behaviors. This shift offers an opportunity for the new law to serve as a positive factor in encouraging family planning and in implementing the policies and programs already in place. For example, a senior MINSANP official said, "this new law is not to penalize people, but rather to educate and motivate them."

MINSANP officials and their national and international partners that were interviewed all remarked upon the various policy statements and planning documents that support family planning and reproductive health. At the international level, Madagascar's FP2020 commitments were cited as a positive contextual factor, providing a clear statement of the government's aspirational intentions. At the national level, respondents highlighted the maternal and neonatal health roadmap, and the 2016–2020 integrated strategic plan on

family planning and contraceptive security as framing the context for policy and action, not just within the health sector but across government ministries. In particular, the strategic plan was cited as a primary document that lays out targets and elaborates indicators.

Several respondents mentioned the marriage law (Law No. 2007-022) in relation to child marriage and early-age pregnancies. These interviewees cited two points. First, while the law specifies 18 years as the legal age of marriage, it provides an exception through obtaining a waiver from local authorities. Second, most marriages in Madagascar, particularly in remote regions, are traditional unions and are not treated as subject to formal civil law. As a tool for advancing family planning and reproductive health, those respondents who commented on the marriage law deemed it relatively weak. In the words of one interviewee:

> *The law says that 18 is the legal age for marriage, but it's the community and customary practices that encourage early marriage … Mayors accept that parents come before them and sign, indicating that their child is a minor and they want them to marry. So they don't have authorization for FP [family planning], but they do for early marriage. You can see the contradiction in all this.*

Interviews with officials at the Ministry of Youth and Sports revealed several contextual factors related to legal issues. The government's national youth policy (Law No. 2015-038) specifies 14–29 as the age range that constitutes youth; however, the law does not offer a legal definition of a minor. Informants recounted that through the various ministry programs that provide youth-related services, they have identified access to family planning as something that youth are concerned with, not just in urban areas but rural ones too. For family planning providers, questions regarding who is a minor and who needs parental consent to seek services are a source of uncertainty. Many youth seek services clandestinely without informing their parents.

Respondents noted the positive effect of Madagascar's FP2020 commitment in highlighting the importance of increased access to family planning services by youth, and in giving prominence to the sections of the national youth policy that concern rights to health and elimination of barriers to services. FP2020 has contributed to promoting the ministry's youth health services and programs at youth facilities (*centres amis des jeunes*). The latter are funded by the United Nations Population Fund, among whose activities are awareness building and increasing access to information for young people on family planning and reproductive health.

A legal gap identified by interviewees whose work focuses on service delivery at the community level is the ambiguous legal status of community health workers (*agents communautaires*). These workers are the core modality for outreach to deliver family planning and reproductive health services to women in peri-urban and rural areas. They receive supervision, training, and family planning product kits to carry out their work, but they do so on a voluntary basis and do not receive payments or stipends, although they can generate a small return from the authorized mark-up on contraceptive sales.

However, they do not have any legal protection should there be some sort of problem as a result of the services they provide. The legal status issue has arisen recently from a controversy regarding which family planning methods community health workers should be able to provide (see the discussion in the next section on community health workers and injectable contraceptives). Projects that support community-based family planning services are worried; as one staff member said, "if the ability to provide injectables is taken away from ACs [community health workers], for our project and the country, this will be a big step backwards." In the opinion of some members of the medical profession, since family planning services involve provision of medicines through medical procedures, and since community health workers are not officially designated medical service providers, they

should not be allowed to operate at all. This viewpoint is not widely shared; particularly at local health centers, staff recognize that community health workers decrease their workload and increase access to family planning for their catchment areas.

Application and Implementation of Laws and Policies

The main point made by interviewees was the fact that laws related to family planning have been incompletely applied. As most noted, the 1920 family planning law has been largely unenforced. Interviewees noted the prevalence of clandestine abortions as an indicator of lack of enforcement. They also cited the uncertainty that this situation has created for service providers who have sought to respond to women and youth seeking services in cases where they do so without informing spouses or parents. As one provider summarized:

> *According to local customs, parents want their female children to marry young and then have children. So they don't want their children to have access to FP [family planning]. This puts us, the providers, in a contradictory situation. If we're providing FP to a young person who is independent and not afraid of his/her parents, then we're ok. But if it's a situation where the young person is still dependent and coming to us secretly, then we need to be very careful because the old law is still in place.*

Discussions surfaced legal application and implementation issues arising from the lack of availability of physical copies of laws, decrees, regulations, and policies. This absence of hard copies applies to health sector officials, local government officials, providers, and citizens. Official documents of any kind are rarely made available, although some may be found on government of Madagascar websites. Outside of large urban areas, however, web access is quite limited and few people have computers, tablets, or smart phones. And in remote parts of the country, a visit to a government office can involve hours of travel, so rural citizens have little possibility to obtain information even if they were inclined to do so. These factors contribute to widespread ignorance on the part of most citizens of laws and regulations related to family planning and reproductive health, and very limited knowledge among many local officials as well.

An example of the extent to which family planning information fails to penetrate beyond a small coterie of policy and professional specialists emerged from a focus group discussion with community health workers interviewed at the primary health center (*Centre de Santé de Base*) in Anjeva Gara. The women were unaware of any of the laws related to family planning, either the old 1920 law or the draft new law. Several indicated that they had heard of a law issued by the Vatican that prohibits family planning (a reference to Pope Paul VI's 1968 encyclical, *Humanae Vitae*), but then added that although they are Catholic, they provide family planning services in their communities.

Few citizens take any sort of legal recourse related to health issues, such as lodging a complaint about provider mistreatment or malpractice. Further, and especially the case for rural and remote residents, few citizens use the formal legal system at all. Factors such as limited access and distance, unfamiliarity, costs involved, education, and literacy levels all play a role, as does a cultural norm of conflict avoidance and non-confrontation. Several interviewees mentioned examples of parents complaining to a local official about a health service provider who gave contraceptive products to their adolescent child. The study team was unable to determine if these were isolated cases or not.

The other example of problems with family planning that elicited a legal response was the accusation that volunteer community health workers were diverting the Depo-Provera injectable contraceptive, which contains the hormone progestin, for use in fattening hogs. This led to calls for increased regulation of community health workers and pharmacies, as well as the suggestion in some quarters that community health workers be barred from

delivering Depo-Provera to their clients, which, given that injectables are the preferred contraceptive for women in rural areas, would result in negative impacts on access and utilization. As with the story of parental complaints regarding contraceptives for minors, interviewees did not have any empirical details regarding how widespread this problem might be.

Socio-cultural and Informal Factors

As the quote that opens this report—which several interviewees repeated to us—reveals, Madagascar is a strongly pronatalist society for a mix of cultural, social, and economic reasons. Traditional families follow gender norms that lead them to exert pressure on their girls to marry early. Most marriages, as noted, are customary unions without standing in formal law. Family planning campaigns have sought to sensitize people on the dangers of early pregnancy, but as the interviewees collectively recounted, such efforts have yet to generate a significant impact.

Interviewees noted that, in general, Malagasy societal attitudes regarding sexual relations, gender roles, women's equality, and youth are conservative. Sexuality is not a topic that most people feel comfortable discussing openly, particularly where women or adolescents are concerned. Family planning is often viewed as promoting infidelity among married women and promiscuity among youth. Informants in the Ministry of Youth and Sports indicated that while their main sex education and health awareness campaigns and curriculum development are targeted toward youth, they also promote programs for parents in an effort to influence societal norms.

However, despite these widespread conservative attitudes, interviewees concurred that family planning is viewed positively by growing numbers of people, including husbands and parents, and its role in contributing to a healthy population is increasingly recognized. A study of family dynamics and use of contraceptives confirms the viewpoint of the interviewees (see Hajason et al., 2013). Providers interviewed said that there appears to be a pattern that once a woman (or a girl) has her first child, interest in, and openness to, family planning increases.

One socio-cultural factor where interviewees' perspectives differed was the role of religion in attitudes toward family planning and reproductive health. On the one hand, several interviewees cited Catholic opposition to family planning and abortion specifically as a barrier, and expressed the opinion that Catholics, both members of the church organization itself as well as of congregations, have been opposed to family planning and especially to abortion (see ANAPV and SRI, 2014). These groups are likely to look unfavorably at the provisions in the new law that elaborate rights and open access to family planning for adults and youth. However, others felt that the automatic presumption of religiously based opposition is unwarranted and not as widely reflected in practice as commonly perceived. While some methods may be rejected as inappropriate or undesirable (e.g., long-term methods for youth), for the most part, church organizations and their congregations accept the need for family planning.

This view emerged strongly from the two church-sponsored health services units visited, both of which offer some family planning services. Representatives of SAF/FJKM (Department for Development/Church of Jesus Christ in Madagascar) and SALFA (Malagasy Lutheran Health Department) noted that their religious and ethical doctrines treat the appropriate realm of sexual relations to be married couples only, and thus the message transmitted to youth is to practice abstinence until they marry. Both SAF/FJKM and SALFA, however, indicated that if youth who are sexually active outside of marriage visit one of their facilities they are not turned away, but are offered counselling on safe sex and a limited range of family planning products. Both have participated in programs throughout Madagascar to

promote youth life skills development, including health, in which family planning is included as one element of awareness campaigns.

A serious societal constraint, both on utilization of family planning and reproductive health services and on the use of legal measures to promote such services, is the strength of Madagascar's oral culture. Some of this relates to illiteracy and lack of education, and some to the limited access to written materials of any sort. People tend to learn about family planning, reproductive health, and sexuality from discussions with their peers, family members and relatives, friends, and health providers. Interviewees spoke of a range of widely believed rumors about the negative effects of family planning in general (e.g., spousal infidelity) and of particular family planning methods (e.g., fears of the risk of cancer).

Stakeholders Important for Family Planning and Reproductive Health

Interviewees' views on key stakeholders for laws, regulations, and policies for family planning and reproductive health were very similar. All highlighted the critical leadership roles of the Ministry of Public Health (MINSANP) and Ministry of Population, Social Protection, and the Advancement of Women (MPPSPF), and mentioned the importance of the youth and education ministries as key partners in a multisectoral approach. Both public and private sector family planning/reproductive health service providers were mentioned. Particularly given the legal ambiguities surrounding services for minors, and debates over what products should be provided to youth, these stakeholders have a direct interest in passage of the new family planning law and in the details of subsequent application decrees and regulations. International Planned Parenthood-Madagascar (FISA) and Marie Stopes Madagascar—nongovernmental organizations (NGOs) with a long history of family planning advocacy and service delivery, as well as participating in the technical discussions of the draft family planning law—were noted by everyone as major stakeholders. These NGOs noted that youth groups themselves are important stakeholders. Community members who participate in family planning/reproductive health service delivery are significant as well. These include community health workers as well as various health peer-partners in schools and youth centers.

Interviewees were unanimous in citing churches as stakeholders: Catholics, evangelical Protestants, and Lutherans. However, as noted previously, viewpoints differed on the extent to which these stakeholders are obstacles to, or supporters of, wide availability, access, and utilization of family planning, and of achievement of FP2020 objectives. Some felt that the popular presumption of their opposition is inaccurate, while others expressed worry that they would indeed be opposed, particularly the Catholic Church. Family planning NGOs and providers interviewed felt that the nature of religious-based opposition needs to be understood in terms of specific family planning services, products, and issues; for example, what types of contraceptives and awareness programs are appropriate for youth, availability for unmarried women, early-age pregnancy issues, and the "hot button" topic of therapeutic abortion.

A few interviewees, mostly those associated with field-level family planning service delivery, noted the role of local commune officials as stakeholders. Particularly in relation to community health workers, who are connected administratively to the decentralization ministry and managed at the commune level, these officials would be concerned with the local service delivery implications of the new family planning law and its provisions for increased access to services.

Another stakeholder group relevant to community health workers are doctors. As the interview with the National Order of Physicians revealed, there is some opposition to community health workers providing services that medical professionals see as requiring

medical training and skills. This apprehension is a well-recognized issue in task shifting debates around the world.

Summary Assessment: Opportunities and Constraints

Table 2 offers a summary of the positive and negative forces at play in the legal enabling environment for family planning and reproductive health that emerged from the interviews. Most of these points confirm findings from previous analyses, which increases our confidence in the inferences and analysis of our rapid assessment (for example, see the conclusions in MINSANP, n.d.).

The summary table reveals a relatively encouraging situation for progress despite the challenges on the negative side of the table. The presence of political will and the government's public commitment to family planning and reproductive health provide a firm foundation for implementation of the maternal and neonatal health roadmap and the 2016–2020 integrated family planning strategic plan. The rights-based and positive framing in the provisions of the new family planning law open the door to motivating increased access and service provision to groups that have had difficulties in obtaining family planning/reproductive health services in the past. As one interviewee said:

> *I see the new law as an expression of the willingness of the State to take a step toward modernization of its family planning regulations, and this will motivate citizens to consider more openly questions of family planning as legal dispositions become clearer.*

The negative forces identified offer potential avenues for advocacy, interventions, and reforms to counter their adverse effects on making progress on family planning and reproductive health. The National Assembly, and the health, population, and decentralization ministries are well positioned to address resource gaps and questions of distribution, as well as taking steps to rationalize laws and regulations. Government, NGOs, civil society, providers, religious groups, and donor partners are all potential actors in awareness building and education campaigns.

Table 2. Positive and Negative Forces Related to Family Planning, Reproductive Health, and the Law

Positive Forces	Negative Forces
• Political will among key public health officials and partner organizations to pursue family planning and reproductive health objectives • Public commitment to international protocols and agreements (e.g., FP2020), and national policy statements • Strategic plans with targets, timelines, and assigned responsibilities in place and agreed upon • A new family planning law with strong a chance of adoption, passage, and promulgation • Positive orientation of the provisions of the new law, and related laws and policies, as opposed to a coercive and punitive one	• Insufficiency and maldistribution of financial and human resources necessary to implement family planning and reproductive health policies and programs at sufficient scale • Ambiguity and incoherence in the accumulated body of law and regulations that affect family planning and reproductive health • Lack of availability and dissemination of laws, regulations, policies, and basic technical information on family planning and reproductive health, resulting in widespread ignorance • The strength of customary and traditional practices relative to the formal legal system • Persistence of conservative attitudes and resulting limited engagement of women and youth in family planning and reproductive health decision-making

The Law's Role in Promoting Family Planning and Reproductive Health

This study has shown the limitations of relying solely upon the coercive power of the law to change attitudes and behaviors related to family planning and reproductive health. Effective coercion depends upon a widespread recognition that first, transgressors face a strong probability that they will be caught and punished; second, the purpose of the law and the legal sanctions it imposes are justified; and third, the state has the willingness and the capacity for enforcement. In the case of family planning and reproductive health in Madagascar, these factors do not hold, which leads to considerations of other roles that the law can play in promoting family planning and reproductive health. This section focuses on the enabling role of the law in shaping attitudes and behaviors—that is, serving as a "signpost" to coordinate actions in a desired direction; and in inducing compliance through increasing awareness, acceptance, and legitimacy of rules, regulations, and policies (World Bank, 2017).

As the model of the legal enabling environment presented in Figure 1 graphically illustrates, governments—and citizens—can use laws to help policymakers and public institutions engage in the functions of mandating, facilitating, resourcing, partnering, and endorsing. These, in various combinations, make up the constituent elements of an enabling environment (Brinkerhoff, 2007). This section defines some specific actions, presented according to these five enabling functions, that could enhance the legal environment for family planning and reproductive health in Madagascar. These are offered as inputs for future collaborative programming by the HP+ team and government partners.

Mandating is the function that most immediately comes to mind in thinking about the legal enabling environment. It refers to drafting, enacting, and applying both primary and secondary legislation, all the way from basic constitutional principles and rights to procedural determinations of what sectoral services and products are provided, how, and for whom. A critical, but on occasion forgotten, aspect of mandating is setting up monitoring systems to track progress and diagnose problems. These systems work best when both government entities and civil society are involved (Cottingham et al., 2010).

For laws to achieve their objectives, governments need to provide facilitating measures. These can include positive incentives and capacity-building for public agencies to implement laws, regulations, and policies. Another vital facilitating action is to make information on them available to the relevant public sector actors, NGOs, service providers, and citizens (both as individuals and in civil society organizations) in readily understandable language and easily accessible formats. Transparency is important both to increase knowledge that can lead to more utilization of family planning and reproductive health services, and to creating a basis for accountability for public officials and providers.

As many interviewees stressed, the new family planning law will require a nationwide dissemination and awareness campaign. In the words of one source:

> *In my view, nothing works better than community dialogue ... We need to explain the new FP [family planning] law, because what it contains and what it means is not evident to the average person. FP is something that is quite nebulous for many people. Further, the law is linked to institutions and the State. Ordinary people are afraid of the State, so we need to come down to their level, and talk to them in ordinary and simple language.*

Resourcing involves direct public funding, establishing financial incentives that encourage availability of products and services, and assuring appropriate levels and quality of human resources. In the developing world, where governments may be relatively resource

constrained, public funding is limited and international donor agencies' resources can provide an important supplement.

Partnering is a function that brings government agencies into relationships with other relevant public sector actors, NGOs, the private sector, and civil society in ways that capitalize on the comparative advantages of the partners. Critical to contributing to the enabling environment are government actions that establish mechanisms and procedures that allow public sector actors in the executive and legislative branches of government to enter into partnerships with actors outside of government. An example would be where a government agency enables a policy advocacy NGO and/or a professional association to participate in establishing regulatory standards and/or in policy outcomes monitoring. In the legislative branch, members of parliament can bring in civil society to collect data on policy issues, conduct polls of their membership, and/or participate in committee hearings and deliberations.

Endorsing refers to actions that explain, legitimize, and publicize policy objectives; reinforce government commitment to policies and legal agreements; and encourage citizens and civil society groups to change attitudes and engage in supportive actions (see World Bank, 2017). Examples include policymakers publicizing the role of family planning in achieving development objectives, contributing to fulfilling women's rights, meeting international commitments, and so on. Engaging with the media is an important mechanism for communicating endorsements.

The following table offers illustrative actions according to each of the five functions in the enabling environment model in Figure 1. Several of these actions are ones that the government of Madagascar and partners have already undertaken, or plan to do so in the near future. However, some of these could benefit from more attention and more coordinated action among stakeholders, while others represent actions that have not been pursued.

Table 3. Legal Enabling Environment Functions and Illustrative Actions

Function	Illustrative Actions
Mandating	• Passage of family planning and reproductive health laws and regulations • Development of application decrees and procedures • Issuance of policies and associated strategic plans • Monitoring to track progress and compliance
Facilitating	• Family planning product procurement procedures and systems • Dissemination of family planning/reproductive health laws, regulations, policies, and plans • Awareness and education campaigns, including sex education in schools • Training for providers and community health workers • Building capacity of public officials to foster citizen participation
Resourcing	• Tax and importation laws for family planning products • Public funding of family planning/reproductive health services • Staffing public health agencies and facilities • Mobilizing donor funding
Partnering	• Formation of service delivery partnerships with NGOs, faith-based groups, the private sector, and communities • Multisector family planning/reproductive health planning and programs across ministries • Creation of public arenas and forums for shared policy dialogue and awareness campaigns • Involving providers, civil society, and NGOs in parliamentary committees, blue-ribbon task forces, etc.

Endorsing	• Publicizing government commitment to family planning and reproductive health for all, including youth • Recognizing contributions of service providers and communities • Encouraging media reporting on family planning, reproductive health, and youth

RECOMMENDATIONS

The following are some suggested actions for HP+, government partners, and USAID/Madagascar to consider. These recommendations are derived from both the document review and assessment, and the findings from in-country interviews.

- Support advocacy and awareness campaigns for the new family planning law. The interviewees and many of the studies reviewed mentioned the lack of information about family planning and stressed the importance of outreach, dissemination, and demystification of the new family planning law and existing policies and programs. Multiple communication avenues should be pursued, such as media (print, television, and radio), as well as dialogue forums throughout the country. Civil society groups should be actively engaged.
- Mobilize support coalitions to ensure sufficient resources for family planning and reproductive health, so that the provisions of the new law and the action plans in place can be implemented. Pay attention to geographic coverage to assure availability of family planning products, staff, technical assistance, and financing for facilities in zones that have gaps and insufficiencies in these areas.
- Encourage public officials at all levels to express their commitment to the provisions of the new law in public forums and via media. The new law talks about universal access to family planning and reproductive health services, but avoids explicit mention of youth and minors, so government commitment to expanding access and utilization will be important to convincing societal groups that have reservations about, or are resistant to, the changes. Facilitate connecting public sector actors who are considered family planning "champions" to coalitions that can expand support and acceptance. Medical professional groups need to be on board, as well as NGOs already committed to family planning and women's reproductive health rights, and providers in the public, private, and NGO sectors.
- Promote and support the elaboration and dissemination of application decrees and guidelines for the new family planning law. The provisions of the new law are written as broad statements of rights and obligations and basic principles of universal access. Details, such as defining clearly who has access to which services at what age, will be important. To be applied effectively and according to the rule of law, all of these provisions will require the development of secondary legislation, much of it at the ministerial level. These measures too will need awareness campaigns and broad dissemination among public officials, providers, local governments, communities, and citizens.
- Support secondary legislation (decrees, regulations, etc.) that address current gaps related to: 1) legal definition of minors; 2) ambiguities regarding parental permission for youth and minors for family planning and reproductive health products and services; 3) clarification of what products and services are available to minors and youth; and 4) legal status of, and legal protections for, community health workers. Work with the youth and education ministries to coordinate with their outreach and education programs related to family planning and reproductive health.

- Encourage review of prior legislation to address inconsistencies; for example, between the medical code of ethics and the health code, and Article 317 (see Table 1). Support abrogation of the 1920 family planning law.
- Encourage wider enforcement of the marriage law's prohibition of marriage under the age of 18 through ongoing awareness building regarding the health danger to girls of early pregnancies and the societal costs to Madagascar.
- Support monitoring of progress related to actions that contribute to the legal enabling environment (mandating, facilitating, resourcing, partnering, and endorsing), and track progress on the impacts on family planning/reproductive health service delivery access and uptake, behavior change, societal attitudes, and stakeholder perceptions. Publicize progress made.
- Consider a subsequent assessment of laws and regulations on importation, sale, and distribution of family planning and reproductive health products. This present study was not able to include these in the review, but interviews revealed confusion around tax rules and exemptions for products, the circumstances that determine when and whether family planning products are freely available or subject to sale, and so on. The terms of reference for this investigation could be to update the findings of a 2010 study conducted by the Health Policy Initiative and Deliver Project.

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ANNEX 1. PERSONS INTERVIEWED

Ministry of Public Health

Office of the Secretary General

- RATSIRARSON Joséa, Secretary General
- RANDRIAMAMPIANDRA Hasindrainy, Attorney, Department of Legislation and Regulatory Affairs
- RAZAFY Sylvain, Technical Advisor
- RANDRIANARISON José Clement, Technical Advisor

Family Health Directorate (DSFa): Departments of Family Planning (SPF) and Adolescent Reproductive Health (SSRA):

- RAVONIARISOA Georgette, Directorate Head
- RAMANANJANAHARY Haingonirina, Department Head, SPF
- RAZAFINDRAVELO Angeline, Department Head, SSRA
- RASOANANDRASANA Vololoniaina, Technical Assistant, SPF
- RAKOTOSON H. Patricia, Database Manager, SPF
- ANDRIATSIMAMETRA Veroniaina, Manager, Community Activities, SPF

Regional Health Directorate, Analamanga

- RAKOTOARIVONY Mamy, Directorate Head
- RATOVONOMENJANAHARY ROVA, Managing Physician, Reproductive Health Services
- RASOARIMANANA Vololona, Managing Physician, Family Planning Services

Primary Health Center, Level 2, Anosy Avaratra

- MAHEFA Altensio Gernie, Chief Physician
- RAZAFIARIMAMY Antoinie, Midwife
- ANDRIAMIRADOVOLA Maminiaina, Manager, Youth Center

Primary Health Center, Level 2, Anjeva Gara, and Center-affiliated Community Health Workers (*agent communautaire*)

- RAKOTONOEL Harimbolamena, Chief Physician
- RAMALALATIANA Annie, Physician
- RAKOTOSON Holimboahanginirina Lalainaharintsoa Annick, Midwife
- RAVONIARIMANANA Lucienne, agent communautaire
- RASOARIMANANA Marthe, agent communautaire
- RAVELOARIMANANA Charlotte, agent communautaire
- RAVOLOLOARIMANANA Malalasoa, agent communautaire
- RABAKOMALALA Euphrasie, agent communautaire
- RAZAFINDRAMBOLO Joséphine, agent communautaire
- RATSIMBA Marie Angeline, agent communautaire
- RANDRIANATOANDRO Sahondra, agent communautaire
- RAVAONASOLO Raharimalala, agent communautaire
- RASOAZANANY Mariette, agent communautaire
- RAVELOARINIRINA Miguelle Odette, agent communautaire

Ministry of Youth and Sports

Reproductive Health Program for Adolescents and Youth (SRAJ)

- RAKOTOSEHENO Noro Haingo, National Coordinator, SRAJ
- RAJAOARINARIVO Tiavina Jean, Database Manager, SRAJ
- RAKOTONDRAMANANA Samy Naina, Technical Advisor, SRAJ

Ministry of Population, Social Protection, and Women's Promotion
Population Directorate • NDREMANA Philémon, Directorate Head • JOHNSON Roland, Technical Advisor • RAMANDASOA Erika, Head, Department of Legislation and Regulatory Affairs • RADESA Franck, Technical Advisor
Central Purchasing Agency for Essential Medicines and Medical Equipment (SALAMA)
• Dr RAZAFIARISOA Jeannine, Director of Vertical Programs
National Assembly
Health Commission • Dr RAJAOBELINA Lova Herizo, Assembly Member, President of the Health Commission
United Nations Population Fund
• RAHELINIRINA Faramala, Family Planning Manager • RAKOTOMANGA Karine, Supply Manager
Nongovernmental Organizations and Donor-Funded Projects
International Planned Parenthood-Madagascar (FISA) • RAFITOSON Ketakandriana, Lawyer and volunteer • RAZANAMAHANDRY Vololona, Coordinator of the Management Committee • RAZAFINDRAFARA Larissa Malala, Manager, National Programs Marie Stopes Madagascar • ANDRIAMASY Eugene, Partnership Coordinator • Dr HANITRINIAINA Odile, National Research Coordinator • RAKOTOMALALA Fanja, Manager, Administration and Human Resources • Dr RAHAJARISON Feno, Clinical trainer • Dr RAVALITERA Jocelyne, Clinical trainer Private health center, Marie Stopes Madagascar • Dr RAHARIMALALA Léa, Physician USAID Project: MAHEFA MIARAKA • CHUA-OON Chuanpit, Chief of Party • RAHELIMALALA Robertine, Senior Advisor, Community Health USAID Project: MIKOLO • RALIDERA Onisoa Rindra, Family Planning Specialist PSI • RAFALIMANANA Elisohasina, Coordinator, Family Planning, Adolescent Reproductive Health and Gender Program • NOFIARILALA Volatiana, Manager, Top Réseaux Health Centers Network

Faith-based Nongovernmental Organizations
SAF/FJKM • RANAIVOARISON Voahangy, Health Specialist • RANDRIAMBAHOAKA Mampianina, Health Program Coordinator SALFA • RASAMIMANANA Nirina, Health Program Coordinator • RASOLOMANANA Lalaina, Manager, Monitoring and Evaluation
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