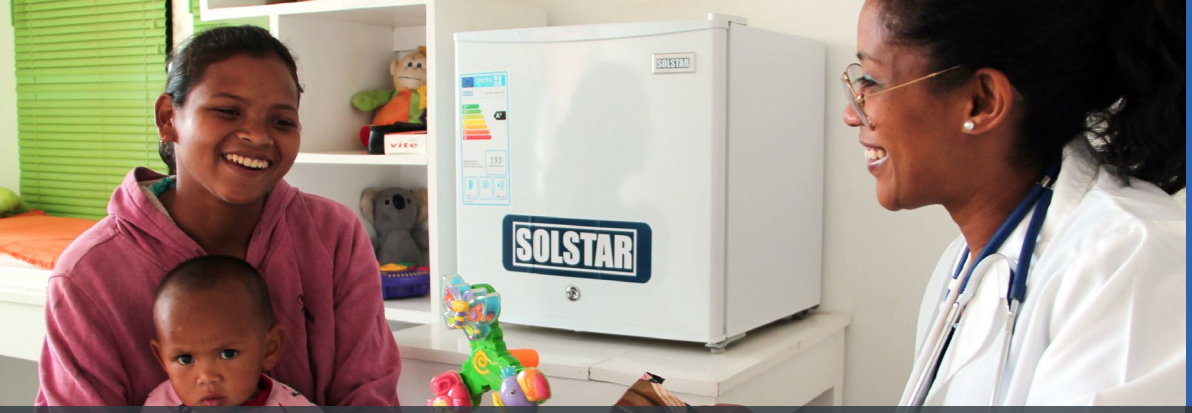

HP+ POLICY *Brief*
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The Legal, Regulatory, and Policy Environment for Integrating Family Planning into Universal Health Coverage Schemes in Madagascar

Authors: Elise Lang and Erin DeGraw

Introduction

As countries make progress toward the 2030 Sustainable Development Goals' health agenda, especially to achieve universal health coverage (UHC), family planning should be integrated into all relevant efforts. As one of the best buys in healthcare, increased access to family planning can have positive impacts on other health and development indicators as well as help deliver broader socioeconomic gains, including the demographic dividend (Health Policy Plus, 2018). Yet, after an era of significant increases, external funding for family planning programming has plateaued and become inconsistent (FP2020, 2019; IHME, 2019). Continued progress to achieve universal access to family planning under the Sustainable Development Goals is at risk, and one of the key reasons is the expectation of continued declines in financing. Continued progress for family planning programming depends on unlocking stable long-term financing from domestic sources. Family planning will need to be well integrated into country-level UHC-related and health financing reform agendas to increase access to quality essential services and reduce out-of-pocket spending.

To improve integration of family planning within these reforms, most family planning decisionmakers will need a deeper understanding of how family planning financing is impacted by the legal, regulatory, and policy environment and how it should be managed within that context. The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), developed a framework and corresponding checklist that serve as a guide to identify critical barriers and enablers to improving access to family planning services within the legal, regulatory, and policy aspects (referred to collectively as "policy instances") of health financing arrangements aimed at achieving UHC. The framework was then applied through a comprehensive review of policy instances in Madagascar, a country now embarking on a review of its UHC agenda and drafting a health financing strategy for adoption in 2021–2022. This policy review aimed to provide information to decisionmakers in Madagascar to use to ensure adequate financing for family planning as the country embarks on health sector reform and scale-up of future health financing schemes toward UHC.

The Framework

The framework is based on the intersection of the outcomes of *USAID's Vision for Health Systems Strengthening*, which aims to achieve universal access to affordable, high-quality essential health services, with the roles of health financing actors (USAID, 2015). This intersection can be conceptually viewed as a matrix, with the health system strengthening outcomes (population coverage, responsiveness, and financial protection) as rows, and the health financing actors (payers, providers, and family planning users) as columns (see Table 1). Each cell in this

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Table 1. Framework Summary

Dimension	**Payer:** Policy instances that govern how services are paid and by whom	**Provider:** Policies that govern how and where services must be delivered and what can be paid for them	**Family Planning User:** Policy instances that determine whether and how an individual can demand and receive high-quality and culturally appropriate family planning services
Population coverage of family planning services	Examining across these crosscutting dimensions allows countries to understand how the policy instance is affecting the healthcare system, which stakeholders are affected, and what aspect of UHC it impedes or enables. The framework allows stakeholders to: 1. Examine each policy instance for enablers and barriers 2. Identify contradictions between policy instances 3. Anticipate how major structural reforms will affect family planning		
Responsiveness of family planning services provided, including the range of methods and ancillary services included in the package of services covered by the health financing system			
Financial protection offered in delivery of these services			

matrix, corresponding to a specific outcome of interest in achieving universal health coverage (row), and a specific actor (column), can be related to different country policy instances. The framework therefore guides the user toward the identification and analysis of the health system policy instances that benefit or impede family planning. The full framework and description can be seen in a related HP+ document: *Guide for Examining the Legal, Regulatory, and Policy Environment for Family Planning Inclusion in Universal Health Coverage Schemes*.

The framework was developed specifically to examine the legal, regulatory, and policy implications for financing high-quality family planning services. It is not intended to provide a generalized or broader review of the enabling environment for family planning as a whole. As it was developed as a tool that could be used across different country and legal contexts, the existence and content of each policy instance will differ from country to country. However, across all contexts, the framework allows users to identify relevant policy instances and conduct a content review to understand whether each of the clauses or articles in the policy instance support or inhibit population-level coverage and access, increased responsiveness and method choice, and financial protection in seeking family planning services.

Methods

For the Madagascar case study, the application of the framework and the analysis were developed in three stages: desk-based review, stakeholder consultation, and revision and validation. HP+ used the framework and checklist to organize the review of policy instances and collected three main sets of documents. The first set included high-level policy instances related to family planning and reproductive health. Family planning was often included as part of broader reproductive health policy instances, most importantly within a 2018 reproductive health and family planning (RH/FP) law and it's supporting 2020 RH/FP decree. These policy instances therefore were included as part of the analysis. The second set of documents related specifically to the provision of family planning services. This set included clinical guidelines, rules on registering new commodities, facility stock-keeping standards, guidelines defining which cadres of healthcare workers can provide family planning methods, reporting requirements, and import tax regulations related to the donation or procurement of commodities. The third set of documents related to the health financing context, such as laws related to Madagascar's equity fund, civil servant medical reimbursement scheme, and formal private sector schemes, which govern

who is eligible, what benefits are included, and how services are purchased. The documents were mostly available through online searches of government websites and online newspaper sites, though some were obtained through key informants (see Box 1 for examples). While HP+ reviewed a variety of documents, the RH/FP law was key. Because Madagascar's nascent health financing system has produced few related policy instances, the RH/FP law provides a significant proportion of the framing for financing family planning.

Local stakeholders were consulted via virtual meetings to discuss the enabling and barrier policy instances found in the initial desk-based review by sharing of initial and revised results. Stakeholder consultation for Madagascar was conducted with the support of the FP2020 Secretariat and the FP2020 focal points in-country. Stakeholders in-country included government officials from the Ministry of Public Health, USAID staff, United Nations Population Fund staff, and implementing partner representatives. Stakeholder consultation helped uncover informal rules and norms around how policy instances are interpreted or implemented in-country. This contribution helped to further contextualize and define the enablers and barriers.

Box 1. Examples of Documents Reviewed

- Reproductive health and family planning law
- Reproductive health and family planning policies
- Annual finance law
- Community health policy
- Essential medicines list
- General customs code
- Decree on providing health insurance to formal private sector workers

Madagascar Context

Madagascar is a low-resource country with long-term challenges in raising government fiscal capacity. It has struggled to develop its healthcare system, particularly since the political and economic crisis from 2009 to 2013. However, the country has still made some progress in family planning (Lang et al., 2018). The modern contraceptive prevalence rate for married Malagasy women 15–49 years of age increased from 32.7 percent in 2012 to 41 percent in 2018 (INSTAT, 2013; UNICEF, 2019). The Madagascar government showed its commitment to family planning when it passed a new RH/FP law in 2018. This law replaced the dated 1920 law from the French colonial period which restricted access to family planning information and methods. The 2018 law provides a universal right to access reproductive health and family planning and sets the stage for creating a more enabling environment. However, the health financing system has not matured at the same pace. As a result, financing schemes remain nascent and public financing of health services is low in total volume and as a proportion of need. While Madagascar has mechanisms for offering financial protection for health to the poor, civil servants, and the formal sector, they are inefficient and there are few mechanisms that offer financial protection to the 70 percent or more of the population that works in the informal sector. In total, less than 10 percent of the population has access to health insurance (Lang et al., 2018). The absence of certain types of policy instances, such as those regulating health insurance schemes, creates more barriers to family planning financing than the implications of policy instances that do exist.

Madagascar's Legal, Regulatory, and Policy Environment Affecting Family Planning Financing

The 2018 RH/FP law promotes universal access to family planning services and a diverse range of methods regardless of age, marital status, or other potential forms of discrimination (Présidence de la République, 2017). However, while the law provides a base for a strong enabling environment for family planning, various legal, regulatory, and policy barriers continue to limit population coverage, responsiveness, and financial protection of family planning services.

Population Coverage

Examining policy instances from a population coverage perspective provides insights into the enablers and barriers for individuals to access family planning services. This section highlights some key policy instances related to population coverage; a complete summary can be seen in Table 2.

The RH/FP law explicitly states that individuals have a right to information, education, communication, and provision and referral of reproductive health and family planning services regardless of age, sex, or marital status. While the RH/FP law supports universal access to family planning, additional policies are needed to better support vulnerable and underserved population groups. For example, while the law should promote access among adolescents, there are social and cultural sensitivities around adolescent access to family planning services and it is unclear what repercussions exist if providers were to refuse access to adolescents. The country's National Adolescent and Youth Health Policy does insist on implementation of the RH/FP law, explicitly calling for reproductive health for adolescents. However, while the policy promotes access to all health services for adolescents and youth, it does not explicitly mention adolescent- and youth-friendly services for family planning.

To ensure family planning access to youth and adolescents, polices should include directives to train and mentor providers to deliver respectful, non-judgmental, and quality counseling on family planning services and methods for young people in the context of informed choice. Sustainable investment in youth-friendly health services is also critical to meet the needs of adolescents and youth. However, these investments remain a challenge. Adolescent and youth family planning programs are almost exclusively financed by external funders. The limited investment by the government of Madagascar has restricted the country's ability to improve access to high-quality, affordable family planning services for youth. As a result of these funding challenges, the country has been unable to reach its 2016 projections calling for adolescent and youth-friendly services to be available at 400 primary healthcare centers by 2020. To date, only 171 primary healthcare centers have been upgraded to be youth-friendly facilities. To improve family planning services for adolescents and youth and ensure adequate funding to meet the country's goals, policies should explicitly require investment, including for youth-friendly health services, in family planning programs for youth. Lack of data for adolescent and youth health indicators may contribute to the inadequate funding for adolescent and youth family planning services; the RH/FP law calls for multiple research studies to address this critical data gap. One of the studies to be conducted aims to understand the bottlenecks for adolescent and youth access to family planning services. The results from this study, once completed, will further inform policies, programs, and funding requirements to improve family planning access for adolescents and youth.

The RH/FP law also states that every public and private health facility as well as reproductive health and family planning providers have the obligation to provide quality reproductive health and family planning services. This law suggests that trained providers must provide family planning services; however, there is no explicit mention of a policy instance allowing or barring conscience-driven opt-out for facilities or providers. Nor is it clear whether resources are allocated to ensure that providers have the means to support policy implementation. So overall, while the legal framework is supportive of universal access to family planning, the RH/FP law is broad and there are gaps in the language that without additional regulations could allow for varied interpretation and implementation.

Responsiveness

Examining policy instances from a responsiveness perspective provides insights into the enablers and barriers to accessing different family planning methods and high-quality services. This section highlights some key policy instances related to responsiveness; a complete summary can be seen in Table 3.

The RH/FP law and related policies allow for diverse cadres of workers to provide family planning services based on their training and qualifications (République de Madagascar,

Table 2. Policy Enablers and Barriers Related to Population Coverage

Payer-Level: Enabling Policy Instances	• The RH/FP law permits and requires the government to mobilize the necessary resources to enable the provision of family planning services and to support awareness-raising, promotion, and publicity of family planning services. • The RH/FP law grants universal access to family planning, prohibiting all forms of discrimination. • The Procedures Manual for Logistical Management of Health Commodities requires a two-month minimum stock for basic health centers and district hospitals and a three-month minimum stock for higher-level specialist hospitals.
Payer-Level: Barrier Policy Instances	• No overarching policy instance requiring family planning in insurance benefits exists. • Universal health coverage strategy does not explicitly include family planning. • No UHC law or health financing strategy exists. • No law earmarking funding for family planning exists. • No government policy for results-based financing of rights-based family planning exists.
Provider-Level: Enabling Policy Instances	• Community health policy does not allow and legally protect diverse health worker cadres to provide a range of methods, but the RH/FP law and decree do. • The national reproductive health policy states that districts should ask for a new contraceptive order when stock nears a four-month level to maintain a minimum two- or three-month stock level. • Reproductive health and family planning policies stipulate that family planning should be integrated alongside other health services, including postpartum and post-abortion care. • No policy instance allowing conscience-driven opt-out to providing family planning exists. • The RH/FP law requires all health structures (public and private) and their reproductive health and family planning providers to provide family planning services. • No laws forbid the use of public funds to pay certain providers. • No policy instance requiring unnecessary medical barriers for family planning exists.* • No regulations that restrict reimbursement for providers exists. • Madagascar has developed a national plan and operational guidelines to scale up DMPA-SC across the country, allowing for self-injection.
Provider-Level: Barrier Policy Instances	• Family planning policy states emergency contraception requires a prescription.
Family Planning User-Level: Enabling Policy Instances	• Reproductive health and family planning policies include constructive male engagement strategies. • No law restricts family planning eligibility based on parity. • No policy instance requiring unnecessary administrative barriers to family planning services (e.g., law requiring partner, marital, or parental consent) exists. • The RH/FP law provides universal access without discrimination based on age, gender, wealth, skin color, religion, ethnicity, marital status, or any other situation.

* For example, requiring Pap smears, pregnancy tests, or tests for sexually transmitted infection when not medically necessary to receive the chosen method.

2000; République de Madagascar, 2008). For example, community health workers are allowed to provide all the methods World Health Organization (WHO) guidelines recommend, except emergency contraceptive pills. Access to emergency contraception remains limited, as it requires a prescription and cannot be provided by community health workers or pharmacists as WHO recommends (Présidence de la République, 2017; WHO/RHR and CCP, 2018). While the 2020 RH/FP decree explicitly allows community health workers to provide injectables, this option was not always available (Ministère de la Santé Publique, 2019) (see Box 2).

Availability and affordability of a diverse mix of contraceptive methods link back to rules around commodity importation. For many years, there has been a 20 percent value-added tax applied on the importation of contraceptives regardless of whether they were donated or bought through the private sector. According to the Ministry of Finance's 2015 customs tax rules, contraceptive methods are not tax exempt, despite being on the 2008 and newly revised 2019 Essential Medicines List (Ministère de Finance et du Budget, 2015). Import taxes can affect downstream responsiveness and financial affordability. First, they add to costs faced by the payer, in this case the external funder, when procuring the commodities, and hence limit the total volume of methods and potentially the types of methods procured. Second, they reduce the choice of providers. Private wholesale importers of family planning commodities would pass on the tax in the prices they charge to retailers, who would pass this on to the family planning user. The user would then make a choice to either accept this price, discontinue use, or choose not to seek services.

According to key informants, the private sector has been largely uninterested in investing in the contraceptive market in part due to the 20 percent value-added tax. As a result, contraceptives are generally unavailable in private drug stores or pharmacies. Those available are sold at high prices and cater to those socioeconomically better-off. With the lack of private sector investment, there is an over-reliance on public facilities to meet the country's family planning demand. Forty-eight percent of family planning users seek services in the public sector, where contraceptives are free to the user; only 15 percent seek services in the private sector (INSTAT, 2013). As a result, the public sector suffers from frequent stock-outs that restrict access to family planning services and limit method choice for family planning users. The elimination of the 20 percent value-added tax would offer an incentive for private sector investment in family planning and allow private sector providers to offer services and commodities

Box 2. Access to Injectable Contraceptives in Madagascar

The recent revision of the National Community Health Policy did not mention community-based distribution of family planning methods (Ministère de la Santé Publique, 2017). Due to concerns about injectables being used inappropriately to fatten hogs, the Ministry of Public Health temporarily suspended community-based provision of injectables in 2018 and therefore the provision was not included in the finalized policy documents. However, almost half of married women in Madagascar who chose to use family planning in 2018, chose to use injectables (UNICEF, 2019). The sudden and temporary halt to community-based distribution restricted women's access to a preferred method. However, in April 2019, the Minister of Public Health signed a policy note confirming the revitalization of community-based distribution of injectables (Ministère de la Santé Publique, 2019). The note references a guide developed by family planning stakeholders to ensure quality service provision, supervision, and monitoring and evaluation of community-based distribution of injectables. The policy note allowed community health workers to restart their provision of injectables. In addition, in December 2019, the Council of Ministers passed the RH/FP decree, which was signed into law by the prime minister in January 2020. The decree now protects community health workers providing the service and increases access and choice.

Table 3. Policy Enablers and Barriers Related to Responsiveness—Method Choice and Service Quality

Payer-Level: Enabling Policy Instances	• The national essential medicines list contains a diverse method mix. • The RH/FP law requires the provision of all family planning methods. • The RH/FP law and clinical guidelines include a rights-based approach that emphasizes voluntarism and informed choice and includes comprehensive counseling. • No policy instance prohibits the sale of any family planning method including emergency contraceptive pill. • The RH/FP decree permits the sale of all methods in the public and private sector. • No import policies prevent certain methods from entering the market. • National FP/RH guidelines meet WHO standards for quality assurance/ quality improvement.
Payer-Level: Barrier Policy Instances	• Twenty percent import tariff imposed on donated commodities is not yet eliminated, restricting overall access and method choice. • No existing safe drug law that addresses quality of family planning methods. • No standard insurance policy that requires certain methods to be included in insurance benefits packages. • No established policy to determine whether results-based financing programs follow a volunteerism, informed choice, and rights-based approach to family planning (Boydell et al., 2018).
Provider-Level: Enabling Policy Instances	• Family planning policy includes standard supervision and reporting guidelines. • Family planning policy allows for community-based distribution of oral and barrier contraceptives and injectables, and the RH/FP decree allows for community-based distribution of condoms, standard days method, spermicides, oral pills, and injectables. • No specific law prevents certain cadres from providing certain family planning methods, which their skills/training would otherwise allow (except for emergency contraception).
Provider-Level: Barrier Policy Instances	• Family planning policy requires a prescription to access emergency contraception and the RH/FP decree states that community health workers and pharmacists cannot provide emergency contraception, contrary to WHO recommendations.
Family Planning User-Level: Enabling Policy Instances	• No policy instance barring self-injection (DMPA-SC) exists. • The RH/FP law permits and requires government financing for the advertisement of family planning services and methods. • The National Adolescent and Youth Policy provides for access to adolescent- and youth-friendly services. It explicitly calls for the implementation of existing reproductive health laws, including the RH/FP law, as they relate to rights for adolescents and youth.

at a lower cost. Lower costs, in turn, would benefit family planning users with the ability to pay and who prefer to access services in the private sector, and ultimately reduce the burden on the public sector.

There are signs that the government is taking steps to remove the tax to encourage private sector investment in family planning; however, conflicting policy instances continue to perpetuate the issue. The 2020 Rectified Finance Law lists contraceptives as exempt from value-added tax for the first time (République de Madagascar, 2020b), and this tax exemption was subsequently included in the 2020 General Tax Code (République de Madagascar, 2020a). Yet, the 2020 Customs Tax Code still includes a 20 percent value-added tax (République de Madagascar, 2020c), directly contradicting the previous exemptions for contraceptives. Without harmonization of these policy instances, it is unlikely Madagascar will be able to secure long-lasting tax exemption for contraceptives to improve responsiveness and affordability, limiting the potential for a total market approach to funding family planning in Madagascar.

Financial Protection

Examining policy instances from a financial protection perspective provides insights into the enablers and barriers to affordable family planning services and commodities. This section highlights some key policy instances related to financial protection; a complete summary can be seen in Table 4.

Article 19 of Madagascar's constitution provides each citizen with the right to healthcare: "the State recognizes and guarantees to every individual, from birth, the right to health through the organization of public health services, whose free of charge delivery results from a capacity for national solidarity" (Ministère de la Santé Publique, 2016).[1] The RH/FP law then explicitly states that the government is obliged to mobilize the necessary resources to allow for the provision of quality, effective, and continuous reproductive health and family planning services as well as to implement campaigns for awareness-raising, promotion, and publicity of reproductive health and family planning. From a payer perspective, this means that the government has a responsibility to fund family planning service provision and communication. However, the RH/FP law does not say how or with what mechanism the government will fund the services.

Public Sector

In September 2007, the government decreed that all contraceptives would be free at the point of service at public facilities (UNFPA, 2012). In addition, each basic health center (centre de santé de base) provides a standard minimum package of services, including family planning. All consultations at public basic health centers are free of charge and patients only pay for certain medications (Lang et al., 2018). A specific provision for free access to contraceptives is also included in the RH/FP decree (Ministère de la Santé Publique, 2020a, 2020b). These policies and regulations minimize out-of-pocket spending for those visiting the public sector. However, free services must be realized by providers able and willing to provide them, which means both that healthcare professionals be adequately trained to provide the available methods and that contraceptives are in stock. Truly free services also require that no informal or under the table payments are requested or required from clients. Yet, informal fees for healthcare services, including family planning, are common in Madagascar. This situation puts increased financial burden on many family planning users (Razafiarimanana, 2019). Additionally, past studies indicate that only 41 percent of health professionals at basic health centers were trained in contraceptive logistics and there were contraceptive stock-outs in 9 to 22 percent of health centers. Stock-out variations resulted largely from poor quantification and ad hoc distribution of commodities across the country. Many facilities have inadequate transportation mechanisms to ensure sufficient and consistent supply distribution (Republique de Madagascar, 2017; Diallo et al., 2015). As a result, while contraceptives should be free in public facilities, they are not always available.

[1] Translated from French: "L'Etat reconnaît et organise pour tout individu le droit à la protection de la santé dès sa conception par l'organisation des soins publics gratuits, dont la gratuité résulte de la capacité de la solidarité nationale."

Health Insurance

Although Madagascar's reproductive health and family planning policies and law suggest the presence of an enabling policy environment for family planning, the broad health financing-related legal framework of the country does not provide support for enhanced population-level access and coverage, responsiveness of services, or financial protection. Because there is no UHC-related law or national or social health insurance scheme in Madagascar and the private health sector and private health insurance is weakly regulated, there are no policy instances requiring family planning to be included in health insurance benefits. In the absence of an overarching policy instance, there is no legal support related to ensuring a diverse method mix, adequate reimbursement to providers, or affordable or equitable access to family planning within pre-payment schemes such as insurance.

While there is not a national health insurance scheme, Madagascar has four health financing schemes that offer limited and non-standardized forms of financial protection to a small percentage of the population (see Box 3). The Equity Fund offers an opportunity for the poor to access services at public facilities that they otherwise would not be able to afford. However, the fund is underutilized and, as family planning services are already free at public facilities, it does not offer any additional protections. Civil servants benefit from a scheme that allows them to be reimbursed for health services at public and select private facilities. The scheme offers additional choice for civil servants seeking family planning services. The limited documentation on the medical business services' benefits packages suggests that most of the formal sector health insurance schemes, which cover a very small proportion of workers, cover family planning and offer services without requiring a co-pay. Decree N°2003-1162 requires the benefits package to include some service categories including preventive medical care but the decree is vague and there is no list of specific health services that the schemes must offer (République de Madagascar, 2003).

The government as the budget-financed payer does provide family planning at no cost to users at public facilities. However, the lack of scaled-up health insurance or pre-payment schemes to protect poor and marginalized populations and the lack of regulation related to family planning integration in formal sector health insurance schemes limits a family planning user's options of where they can seek and obtain high-quality, affordable family planning services.

Box 3. Financial Protection Mechanisms in Madagascar

1. **Equity Fund** (Fond d'équité): The fund is managed by each basic health center and available to finance the healthcare of the poorest population. Established through Decree n°2003-1040 in 2003, its respective legal texts allocate a proportion of the margin on drugs sales to be used to fund the healthcare of the poorest population.
2. **Civil servants scheme** (La caisse de sécurité sanitaire des fonctionnaires et agents non encadrés de l'État): Established under Decree N°94-077, the reimbursement scheme provides civil servants with access to medical and hospitalization services free of charge.
3. **Formal private sector scheme through medical business services** (Les services médicaux interentreprises): Decree N°2003-1162 requires all companies with more than 1,500 employees to adhere to a medical business service that must offer certain services, including preventive healthcare; the benefits package varies by medical business service.
4. **Community-based health insurance** (mutuelles de la santé): Madagascar has more than 40 years of history of operating small community-based health insurance schemes. However, there is no standard benefits package and, as most are subsidized by international donors, they remain small and unsustainable.

Table 4. Policy Enablers and Barriers Related to Financial Protection

Payer-Level: Enabling Policy Instances	• Family planning consultations and methods are provided free of charge at public facilities. • The RH/FP law and decree require contraceptives to be free at public facilities. • No policy instance stipulates that user fees differentiate by method.
Payer-Level: Barrier Policy Instances	• Twenty percent import tariffs that affect financial protection and that are imposed on private sector commodities are not yet eliminated. • No government policies regulate co-pays for certain methods under health insurance schemes. • Most private facilities require out-of-pocket payment for family planning services.
Provider-Level: Enabling Policy Instances	• The Health Code requires pharmacist controllers to respect and enforce the pricing of medications at all public and private pharmacies and drug depots.
Provider-Level: Barrier Policy Instances	• Family planning policy states that certain methods (sterilization, implants, and IUD insertion and removal) are only available at hospitals or basic health centers with trained staff, thus limiting the number of facilities providing these services and increasing travel costs and time. • Insurance-related policies do not explicitly include or exclude the removal of long-acting reversible contraception from benefits packages. • No law sets a maximum fee or prevents providers or service delivery points from charging informal fees.

Discussion and Conclusion

Madagascar has a strong enabling environment for family planning provision. Yet, the environment for sustainable financing is underdeveloped, consistent with the nascent state of health financing schemes. Government budgetary financing of family planning commodities is limited. The government commits to affordable services at public facilities, with mostly externally financed commodities, but stock-outs do occur. As an overarching framework, the RH/FP law provides a solid foundation for access, responsiveness, and financial protection for family planning services. There are still limitations to accessing emergency contraception and to ensuring adolescent- and youth-friendly services, but the major challenge is the absence of family planning's explicit inclusion in health financing mechanisms. Considering Madagascar's health financing system, it is not surprising that family planning is not included explicitly in the policy instances; the current health financing structure is fragmented and under-resourced. Madagascar faces inadequate protection of standards of quality and affordability, particularly in the private sector, and limited options to ensure sustainable and affordable services for the poor outside of the government budget, which currently cannot adequately finance the full need.

It will be important for Madagascar to consider the implications to family planning as it undertakes future health financing reform aimed at UHC and develops candidate benefits packages that include essential health services. If insurance-based financing is scaled up, family planning should be appropriately included, especially to continue access to long-acting reversible and permanent methods that generate facility-based service delivery costs. Decisionmakers in Madagascar should develop a "policy action plan" that can be used as an advocacy tool for how these priority issues can be best addressed within health sector reform. The plan should address the development of a health financing policy and thereby create space for effective legal, regulatory, and policy-level change.

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CONTACT US

Health Policy Plus
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
www.healthpolicyplus.com
policyinfo@thepalladiumgroup.com

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