

Madagascar's journey to DMPA-SC and self-injection scale-up

The Ministry of Public Health (MOH) in Madagascar has long recognized the opportunity for subcutaneous DMPA (DMPA-SC) to expand Malagasy women's access to contraceptives. In 2015 the MOH embraced DMPA-SC as part of a five-year plan to strengthen its family planning (FP) program and accelerate achievement of the country's FP2020 goals. DMPA-SC was first introduced in Madagascar via a small-scale pilot in 2015, which focused on distribution through community health workers and in public-sector facilities. Though there were some challenges with stockouts, women reported satisfaction with the product, and the community health workers and public-sector providers were responsive to the training and delivery of DMPA-SC.

Following the 2015 pilot, DMPA-SC was further expanded through a US Agency for International Development (USAID)-supported project focusing on community-based distribution and, to a limited extent, to outlets in the public, private, and social marketing organization sectors. However, DMPA-SC was not yet offered at scale, or through self-injection.

Family planning takes the stage

In December 2017, Madagascar adopted a new FP and reproductive health law. This law was a major win for FP advocates and FP users in the country, finally doing away with colonial-era policies that had prohibited contraception without spousal approval and recognizing the right of all citizens to reproductive health. The national law was also intended to align with other MOH health policies and build a regulatory environment that enabled access to FP information and services for all, in support of the country's FP2020 goals. At about the same time this pivotal law was passed, the Access Collaborative was formed, and Madagascar emerged as a promising pilot country for coordination and technical assistance around DMPA-SC scale-up and self-injection (SI).

In early 2018, the MOH reinvigorated its Family Planning Coordinating Committee to take advantage of this renewed interest, expertise, and support for FP and reproductive health. Through the coordinating committee, the MOH led development of a three-year DMPA-SC scale-up plan (2018–2020), which included targets for training providers, increasing supply, and expanding access to FP for more and more women.

Within three years, the MOH had made exceptional progress, with more than 19,000 providers (76 percent of plan targets) trained to administer DMPA-SC and 100% of public-sector service delivery points active in DMPA-SC provision. More than 3,600 providers (13% of plan targets) were equipped to train women who choose to self-inject, and 49% of all public service delivery points were actively offering SI.

Despite these significant accomplishments, engaging pharmacies and the private sector to offer the product has been challenging for a number of reasons. First, limitations on branding pose a challenge for the private sector and social marketing organizations to market and sell the same product that is free in the public sector in Madagascar. Second, import taxes on FP products effectively cut into the profit margin of the private sector. (A recent policy change, however, slashed these taxes, opening the door to broad benefits—particularly for FP services in the private sector.) Last, the wrap-up of key projects supporting private-sector introduction left a technical and financial gap for advancing DMPA-SC being offered in pharmacies, which remains to be addressed.

Contraception in Madagascar at-a-glance



- mCPR for all women ages 15–49: 35%
- mCPR for married women ages 15–49: 43%
- Unmet need for family planning among all women ages 15–49: 35%
- Unmet need for family planning among married women: ages 15–49: 18%
- Injectable share of modern method mix: 66%

FP2020 goals:

- Increase mCPR to 50% for married women
- Reduce the unmet need for family planning to 9%

mCPR: modern contraceptive prevalence rate
 mCPR source: *FP2020 Annual Report: The Arc of Progress 2019-2020*; unmet need, method mix source: *2018 MICS*

Changing perspectives on self-injection

In 2018, even as scale-up of DMPA-SC began, the MOH had reservations about introducing SI. Some health officials were concerned about the perceived lack of evidence around feasibility and acceptability, particularly in the Malagasy context. In addition, some community health workers were concerned about less-regulated access to the product. While the MOH acknowledged that it was open to SI in the future, even scheduling a feasibility study by Marie Stopes International, these concerns slowed progress.

Later that year, new developments changed the trajectory. First, an MOH delegation attended the Access Collaborative's [DMPA-SC Evidence to Practice meeting](#) in Nairobi, a multi-country convening at which participants shared the latest data on the safety, feasibility, and acceptability of DMPA-SC and SI and, based on this evidence, developed country action plans. Following the meeting, two high-level delegations from Madagascar traveled to Uganda and Burkina Faso to learn more about those countries' experiences with SI.

Addressing the needs of the underserved

Women seeking care in public-sector health facilities in rural Madagascar typically have limited access to contraceptives. As DMPA-SC and self-injection are introduced and scaled up, women in Madagascar—including those from remote, traditionally underserved populations—will have access to a wider range of modern contraceptive options.

This combination of global evidence and the opportunity to see and hear the SI implementation success stories of other countries proved pivotal in accelerating the MOH's enthusiasm for SI introduction (see Madagascar DMPA-SC and self-injection scale-up timeline on page 5). In fact, by early 2019, just months after the first Evidence to Practice meeting and study tours, the MOH had created a

new SI strategy, and the planned feasibility study was altered to become an operational study focused on scaling—rather than introducing—SI. Practical recommendations from this study, such as how many units to use for demonstration and/or practice during training, number of units to send home with a self-injector, and mechanisms for following up with women after they are trained, were incorporated into the national SI strategy.

By the middle of 2019, the national FP training curriculum for public-sector providers had been updated to include SI, and a costed plan was in place. A three-phased introduction of SI began in November 2019. In phase 1, SI would be introduced in a sample of 23 districts. Phase 2 would see expansion of SI

to health facilities in all 114 districts nationwide, and phase 3 would cover extension of SI to the community level. During the final months of 2019, 17 of the 23 phase 1 districts were trained using an orientation + job aid + supervision (OAS) approach (see Innovation Spotlight).¹

With the outbreak and spread of COVID-19, plans were necessarily revised. The MOH decided to accelerate SI to the entire country to provide women with more contraceptive options that reflected a self-care approach—in essence, making it easier for women to receive an advance supply of DMPA-SC for continuous contraception over several months at a time when access to services and facilities was constrained due to the outbreak. At the same time, the Access Collaborative worked with health officials to make components of OAS virtual in an effort to comply with COVID-19 restrictions on in-person gatherings and travel.

Key lessons and factors for success

1. **The MOH embraced and effectively used cross-country sharing of self-injection evidence, such as international conferences and study tours, to advance policy change.** Members of the Madagascar delegation attending both DMPA-SC Evidence to Practice meetings and study tours gained operational perspectives and familiarity with global evidence. These individuals were able to translate this evidence into action, introducing and bolstering high-level government commitment for DMPA-SC and SI. As a direct result, the MOH and national stakeholders were able to adapt the planned feasibility study to focus specifically on the existing learning questions for Madagascar—mainly, how to operationalize SI implementation. The insights from this study were a critical last step before the country proceeded to scale up SI.
2. **A willingness to test innovative approaches at the local level allowed for rapid adjustments to implementation, particularly in response to COVID-19.** With funding from the Clinton Health Access Initiative's Catalytic Opportunity Fund, John Snow, Inc. supported the MOH to test an alternative to classroom-based training of providers that involved rapid orientation, use of a job aid, and follow-up supervision (see Innovation Spotlight). Based on positive results, the MOH adopted this approach to scale up SI nationwide. When faced with COVID-19, the MOH was able to quickly pivot this methodology to virtual, including phone calls and text messages for training and supervision.
3. **Reinvigorating FP coordination ensured scale-up discussions occurred in the larger program context**

¹ An example DMPA-SC job aid is available at https://path.azureedge.net/media/documents/RH_sp_training_jobaids_providers.pdf.



Innovation spotlight

Thirty-five of Madagascar's 114 districts lack funding from nongovernmental organization implementing partners to conduct the country's six-day integrated family planning training for public health workers. To support these districts, the MOH, in collaboration with John Snow, Inc., piloted a new training method called OAS. This approach was supported through the Clinton Health Access Initiative's Catalytic Opportunity Fund, which supports low-cost, short-term opportunities to accelerate DMPA-SC scale-up. OAS featured a decentralized, three-step training model for injection-experienced providers:

- **Orientation:** Facility-in-charges were oriented on DMPA-SC basics during a routine monthly review meeting. They then "taught back" the information to family planning providers at their facilities.
- **Aide par fiche technique (job aid):** The training, along with follow-up activities, was guided by the DMPA-SC job aid, which was widely distributed in pilot sites.
- **Supervision:** Eight weeks after orientation, district management teams conducted supervision visits to all facilities included in the pilot.

An evaluation completed after the OAS training found that the training methodology was effective: during in-clinic observations, 81% of providers successfully completed the four critical steps to administer DMPA-SC correctly. Stakeholders were also satisfied. Based on these positive outcomes, the MOH adopted the OAS approach to scale up self-injection across the country.

Data management is another aspect of DMPA-SC, and particularly SI, stewardship in Madagascar. While working on an update to the national health management information system, DHIS2, the MOH created a separate but parallel system to collect SI data. This interim system is managed by the MOH and Access Collaborative for phases 1 and 2 of SI rollout. Looking forward, these SI data will need to be integrated into DHIS2 for the MOH to monitor the effect of SI on the overall FP program.

and helped strengthen policies and programming. In early 2018, the Family Planning Coordinating Committee was not meeting regularly. With support from the Access Collaborative, meetings with MOH and FP implementing partners were reinitiated. This ensured that the discussions of DMPA-SC scale-up always occurred in the context of the larger FP program. The result? The breakup of implementation silos and a more coordinated introduction effort. The group, for example:

- Coordinated FP advocacy efforts when the new Secretary-General of the MOH came on board, presenting not just one product, but the entire FP portfolio.
 - Built advocacy activities into the DMPA-SC introduction plan to support elimination of import taxes on FP products, which was achieved in early 2020.
4. **Planning for simultaneous introduction of provider-administered DMPA-SC and SI can result in a more impactful total market approach.** In the past, as the evidence base for SI was still growing, policymakers and partners were more comfortable scaling up provider-administered DMPA-SC first, and introducing SI later. This was true in Madagascar, where introduction of DMPA-SC was planned before there was broad support for SI, with a focus on provider administration through the public sector (see Madagascar DMPA-SC and self-injection scale-up timeline on page 5). This resulted in missed opportunities to think strategically about which channels could maximize access to SI—namely, the community level and pharmacies—and scale-up in these channels has been delayed. Though this is now a priority in Madagascar, it reveals a key lesson for others. Considering the full value proposition of DMPA-SC, including SI, early in the planning process can enable countries to maximize the reach of routine programming as well as prepare for crises like the COVID-19 pandemic where more self-care options are needed.

The way forward in Madagascar

Although COVID-19 has impacted training methods and approaches by limiting in-person meetings and travel, the MOH remains committed to ensuring the continuity and supply of critical FP products and services. In fact, the ministry recognizes that COVID-19 may create new opportunities to further prioritize women's self-care and autonomy. The MOH and implementing partners continue to expand SI to new districts through virtual training and supervision wherever feasible. In particular, the virtual OAS training methodology is being expanded to new districts, and this expansion will continue.

Expanding DMPA-SC more fully into the private sector is another frontier for DMPA-SC in Madagascar. USAID's IMPACT project has convened a technical working group on a total market approach for the FP program, with participation from the private sector. Now that FP products can be imported tax-free, next steps include defining in detail how FP services will be offered in this channel, such as the range of methods to be introduced at the pharmacy level, labeling and branding issues, supply chain strengthening, and how data will be reported.

Another area that will require focus is ensuring a continuous supply of product is available when and where it is needed. Current efforts are underway at the national level to strengthen the capacity to monitor the in-country supply of products as well as incoming shipments. This will need to be met with other efforts to strengthen in-country supply chains.

Key policies for DMPA-SC and self-injection scale-up in Madagascar



- ✓ 2014: DMPA-SC added to the Madagascar Essential Medicines List.
- ✓ 2017: New family planning and reproductive health law adopted.
- ✓ 2018: DMPA-SC registered by the national drug regulatory authority, the *Direction de l'Agence du Médicament de Madagascar*.
- ✓ 2019: Provision of injectable contraceptives by community health workers revitalized.
- ✓ 2020: Import taxes on FP products eliminated.

About the DMPA-SC Access Collaborative

The PATH-JSI DMPA-SC Access Collaborative provides data-driven technical assistance, coordination, resources, and tools to ensure that women have increased access to DMPA-SC self-injection as part of an expanded range of contraceptive methods, delivered through informed choice programming.

About PATH

PATH is a global nonprofit dedicated to achieving health equity. With more than 40 years of experience forging multisector partnerships, and with expertise in science, economics, technology, advocacy, and dozens of other specialties, PATH develops and scales up innovative solutions to the world's most pressing health challenges. Learn more at www.path.org.

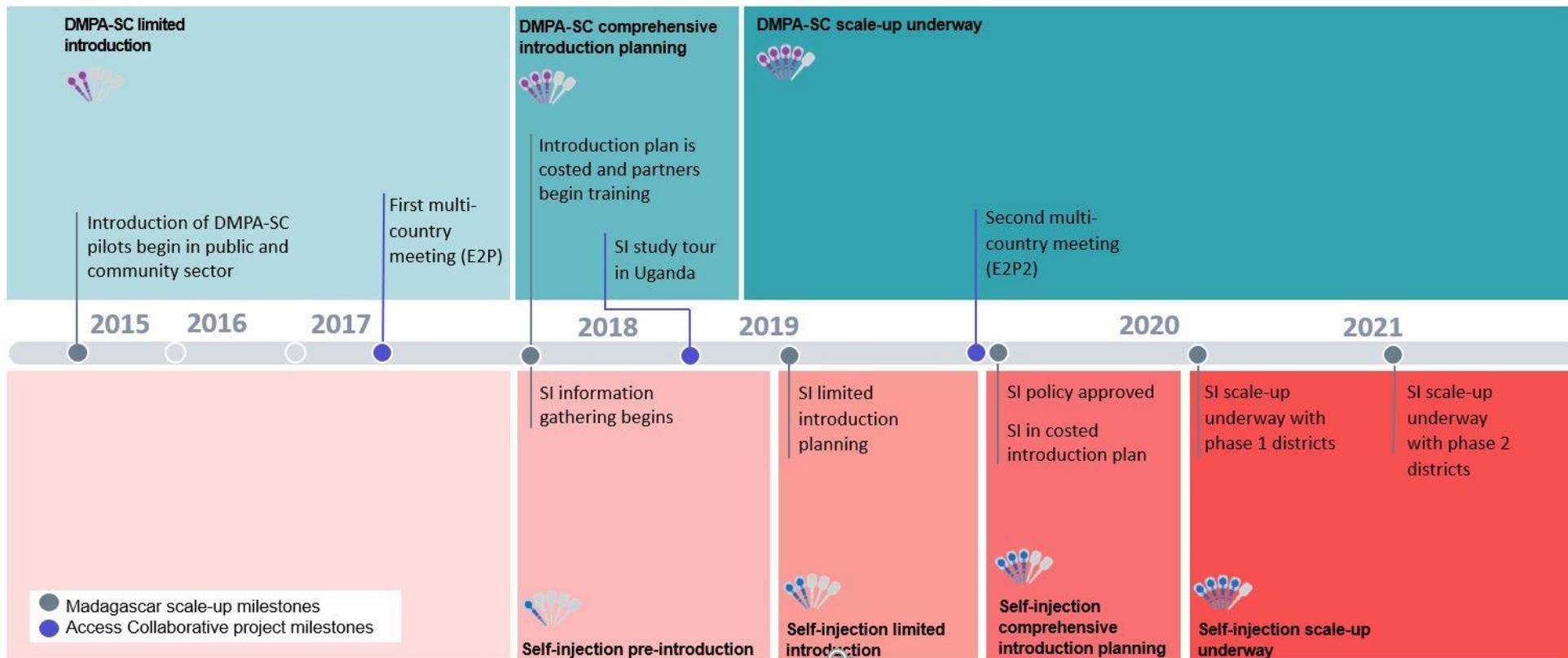
About John Snow, Inc.

JSI is dedicated to improving and promoting public health in the United States and across the globe. JSI works in more than 40 countries, partnering with clients to develop flexible, innovative approaches that solve complex public health problems, strengthening health systems to improve services—and ultimately, people's health. Learn more at www.jsi.com.

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Madagascar DMPA-SC and self-injection scale-up timeline



Abbreviations: CBD: community-based distribution; E2P: Evidence to Practice; FP: family planning; SDP: service delivery point; SI: self-injection

Introduction status definitions:

-  *DMPA-SC limited introduction: DMPA-SC has been introduced into the market for use on a limited scale, typically as a standalone project (e.g., research study or introduction at limited geographic scale in specific channels or regions).*
-  *DMPA-SC comprehensive introduction planning: partners and governments are working to develop and cost a comprehensive introduction and national scale-up plan that draws from earlier pilot studies or projects, as applicable.*
-  *DMPA-SC scale-up underway: DMPA-SC has been introduced into the market for wider use with the intention to scale the product country-wide. Governments are using a targeted, co-positioning, or transition strategy, or some combination of these strategies, and training consistent with the introduction/scale-up plan has been initiated.*
-  *Self-injection pre-introduction: the possibility of introducing SI is being discussed by the MOH and partners and/or groundwork is ongoing to create a favorable environment for SI.*
-  *Self-injection limited introduction: SI has been introduced on a limited scale, typically a standalone project (e.g. SI research study or introduction at limited geographic scale in specific channels or regions).*
-  *Self-injection comprehensive introduction planning: partners and governments are working to develop and cost a comprehensive introduction and national scale-up plan which includes SI and/or an SI plan is being developed separately, drawing from earlier pilot studies or projects, as applicable.*
-  *Self-injection scale-up underway: SI has been introduced for wider use with the intention to scale up country-wide, and training consistent with the SI introduction/scale-up plan has been initiated.*