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To access the capabilities of SIFPO, USAID missions and bureaus can buy into the cooperative agreement.

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EXECUTIVE SUMMARY

This case study documents the experiences in social franchising of the “Top Réseau” network of private health providers, implemented by Population Services International (PSI) in Madagascar. The methodology used to compile this document includes field visits, document reviews and interviews with various concerned parties including program and senior management, field managers and staff, outreach workers, network doctors, and a client. The case study also draws on the author’s extensive personal experience with the program having worked as Technical Services Director at PSI/Madagascar from 2000-2004 and then later as a Regional Technical Advisor to reproductive health programs from 2008-2010.

PSI is the leading non-profit social marketing organization in the world with programs in over 60 countries. Social marketing is the use of marketing techniques and principles to achieve positive social impact. Within PSI, the approach includes marketing products, behaviors or services to increase the health status of vulnerable populations. PSI prioritizes the use of research to design evidence-based programs.

Madagascar is one of the poorest countries in the world, with a growing population and myriad public health problems. PSI began social marketing in Madagascar in 1999 with family planning products and HIV prevention. In partnership with the Ministry of Health (MOH) in Madagascar, PSI has expanded its scope to work across a wide range of activities including maternal and child health, reproductive health, family planning, and STIs/HIV. Currently, the range of socially marketed products and services distributed and promoted by PSI/Madagascar include:

- Male and female condoms (Protector Plus and Feeling)
- Oral contraceptive (Pilplan) and a progestin-only pill (MicroPil)
- Three-month injectable contraceptives (Confiance)
- CycleBeads (Vakana)
- Copper-T 380A IUDs
- Implant (Implanon and SinolImplant)
- Emergency contraceptive pill (Unipill)
- Mosquito nets (SuperMoustiquaire)
- Safe Water Solution (Sur’Eau)
- Diarrheal treatment and Zinc (Hydrazinc)
- Top Réseau franchised network of private health providers

PSI/Madagascar launched the Top Réseau branded network of private providers and clinics in 2000. The focus of the network was originally on offering youth-friendly adolescent reproductive health services. Just over ten years after the launch, the network is adapting and responding to needs within the health market and capitalizing on emerging opportunities for integration of services and target groups.
Some key lessons learned by the program with respect to implementing a franchised network have been to prioritize the network, and in marketing terms, treat it as a "primary product". This translates to a consideration of the providers as a target group who merit the time and resources needed to cultivate a solid partnership.

Specific to the success of Top Réseau in Madagascar, PSI found that intensive lobbying and public relations before implementing the network in any given region was crucial. In addition, establishing good and ongoing communication with providers, medical associations and the MOH was equally important. Maintaining open lines of communication with providers as well as building strong demand-creation campaigns to increase demand for provider services were also essential elements of the program.

2. BACKGROUND

PSI/Madagascar officially launched the “Top Réseau” network of social franchised health care providers and clinics in 2000 in the eastern coastal region of Tamatave. Start-up funding for this youth-friendly reproductive health project was provided by the Bill & Melinda Gates Foundation but quickly supplemented by the U.S. Agency for International Development (USAID) and later expanded by other donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

At the time of the launch, HIV/AIDS rates in Africa were soaring and there was a deepening concern that the island country of Madagascar, with its apparently low prevalence of less than 1% but persistently high rates of STIs, would soon fall victim to the epidemic.¹ Youth were and are still considered a high-risk group for both STIs and HIV/AIDS, due to their risky and early sexual behavior as well as their limited access to reproductive health care.²

In addition, the population rate in Madagascar continued to rise and population experts were progressively more concerned about the devastating effects that overpopulation would have on a country where the majority eked out a living on less than a dollar a day³. The total fertility rate for women was around 6 at the time, with over a third of young women beginning their families by 19 years of age.⁴

These concerns led to the development of the Top Réseau project that aimed to increase access and use of youth-friendly reproductive health services for low-income Malagasy youth aged 15-24 years. Initial funding allowed the project to set up the network in the one region of Tamatave with 30 providers across 17 clinics; later funding expanded the project into an additional eight regions by 2011 with a total of 170 providers and 140 clinics. An additional 33 clinics affiliated with PSI/Madagascar are expected to join the Top Réseau network in 2011.

The core services offered by the network are STI prevention and treatment, family planning counseling and methods, and general reproductive health counseling. The Top Réseau providers are required as network members to offer among their range of reproductive health care products, those socially marketed products that PSI distributes, including short-term family planning methods (the pill "Piplan," the hormonal injection “Confiance,” the condom "Protector Plus") and the STI treatment kit for genital ulcers. Later, additional services were introduced as optional add-ons to the core package: HIV testing and long-term family planning methods. The network was designed to deliver youth friendly services with the following key attributes:

- Reproductive health services specialized and adapted for youth
- A warm and friendly welcome
- Confidential, affordable, high quality services

In exchange for upholding the key brand attributes and core services, and complying with PSI quality assurance and supervisory requirements, network members receive multiple benefits in the form of training and coaching, allocation of certain equipment and materials, promotional materials and signage, and adhesion in a close-knit community of professionals. They also benefit from PSI's multi-level communication campaign that aims at creating demand for services at the network.

At the clinic level, attractive signs with the Top Réseau rainbow logo identify the network members. These signs are affixed to the entryway of the clinic, with an additional sign indicating the way to the clinic located on the road leading up to it.

¹ USAID Madagascar HIV/AIDS Profile, September 2010.
² Ibid.
³ 2001 data from: http://apps.who.int/whosis/database/core/core_select_process.cfm
Outreach agents trained and supported by PSI refer clients to the network clinics in their catchment area, handing out flyers with addresses as well as personally accompanying interested clients. Inside the clinics, privacy screens and provider jackets, as well as other promotional materials, prominently display the Top Réseau logo.

From 2000-2008, the network kept closely to its original goals and objectives and contributed to increased modern contraception use, reductions in overall fertility and to keeping the HIV epidemic at bay. Although not entirely attributable to the project, Madagascar saw an increase in national contraceptive prevalence rate (CPR) from 18% in 2003 to 29% in 2009, a decrease in total fertility rate (TFR) from 5.2 to 4.8 in the same period, static HIV rates5, and a drop from 36% to 32% in the percentage of childbearing young women 15-19 years old.6

In addition, PSI TRaC studies from 2006-2010 show an increase in contraceptive prevalence in Top Réseau catchment areas from 26.1% to 39.6%.7

From January 2001 through June 2011, the Top Réseau network succeeded in meeting the needs of 730,839 youth. Of these, 226,684 clients accessed family planning services, 158,790 STI services, 190,442 received general counseling, and the rest accessed other reproductive health services. While STI services were most sought after at the debut of the Top Réseau network, demand for family planning and general counseling at the member centers has dramatically increased to date.

From 2008 through the present, the network has begun to change in scope. With an added emphasis on expanding the family planning method range to include long-term methods, PSI has begun to work outside the exclusive youth target group and instead include all women of childbearing age for its demand creation and referral activities. In 2009, a family planning method provider certification “ProFemina” was introduced as a way for clients to easily identify quality family planning network services, particularly with regard to long-term methods (LTM). Soon after, the “ProFemina” label was also extended as an umbrella brand for long-term family planning methods.

While useful as an umbrella brand for the socially marketed long-term family planning products, the certification of providers under the Profemina logo proved too complicated and cumbersome. Clients were confused about the difference between Top Réseau providers and Profemina providers, PSI’s supervision and monitoring systems were working inefficiently in parallel, and those Top Réseau providers who adhered to both the Top Réseau network and the Profemina providers were frustrated by the redoubling of supervisory visits and paperwork. This experience paved the way for the paradigm-changing strategy that has recently been developed: repositioning the

---

5 USAID Madagascar Family Planning Presentation, Kigali Rwanda, March 2010, Benjamin Andriamimotoa.
Top Réseau network in 2011 as a multi-health issue leader in quality services for low to middle income men and women of reproductive age. The Profemina network will cease to exist and instead the brand will figure as both an umbrella brand for all family planning methods and possibly as a certification indicator of long-term family planning services at participating Top Réseau clinics. Any Profemina network provider not yet a member of the Top Réseau network will be invited to join and be transformed into a Top Réseau clinic, provided they adhere to the conditions and offer all the core services.

3. CONTEXT

3.1 NATIONAL POPULATION AND HEALTH STATUS
Madagascar is one of the poorest countries in the world, ranked at 145 out of 182 by the UNDP, and possessing a growing population estimated at about 20 million. The island country has suffered through two major political crises in the past decade that have aggravated the precarious socio-economic situation. The most recent political crisis, which began with a coup d’état in early 2009 and installed a government still not recognized internationally, has resulted in significant aid reductions and trade embargos, making daily life even more difficult for the average Malagasy. The situation is especially strained, given the Malagasy population structure, which consists of a large proportion of dependents: 24% of the population is between the age of 10 and 19 years and at least 43% of the population is under the age of 15.

TABLE 3.1A: AGE AND SEX DISTRIBUTION FOR THE YEAR OF 2010:

Malagasy is host to multiple health challenges, especially related to maternal and child health. Maternal, child and infant mortality rates are particularly high. These rates are influenced by myriad symptoms of poverty: serious nutrition deficiencies, the prevalence of malaria and acute respiratory infections, insufficient use of appropriate birth spacing methods and a lack of sufficient hygiene and potable water sources. In addition, access to appropriate health care services is limited in rural areas where the majority of the population resides.

Recent statistics on the health force are lacking. As of 2000, there were approximately 1.6 doctors and 3.2 nurses and midwives per every 10,000 people living in Madagascar. The most recent Health Sector Development Plan put forth by the Ministry of Health for 2007-2011 outlines the number of recorded personnel in the public and private sector as of May 2005. The following table comes directly from this plan and draws on MOH reports and registers from the ONM and the National Order of Nurses.

TABLE 3.1B: MEDICAL PERSONNEL IN MADAGASCAR, MAY 2005

<table>
<thead>
<tr>
<th>Personnel Category</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist doctors</td>
<td>325</td>
<td>26</td>
<td>351</td>
</tr>
<tr>
<td>Surgeons</td>
<td>62</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Generalist doctors</td>
<td>2538</td>
<td>1348</td>
<td>3886</td>
</tr>
<tr>
<td>Nurses</td>
<td>2584</td>
<td>460</td>
<td>3044</td>
</tr>
<tr>
<td>Mid-wives</td>
<td>2497</td>
<td>76</td>
<td>2573</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>8</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Dental surgeons</td>
<td>161</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Medical aid workers</td>
<td>1050</td>
<td>0</td>
<td>1050</td>
</tr>
</tbody>
</table>

According to the analysis within the Health Sector Development Plan, there is a paucity of medical professionals in rural areas where the majority of the population resides. Over 70% of doctors are working in urban areas whereas 60% of paramedical agents are working in rural areas. In addition, the HSDP analysis shows that less than 65% of the population residues.
lives within 5 km of a health center.\textsuperscript{14} This presents a challenge for combating the multitude of health issues and problems that beset Madagascar.

Selected health and population statistics are detailed in Table 3.1c below.

**TABLE 3.1C: SELECTED POPULATION AND HEALTH STATISTICS, MADAGASCAR\textsuperscript{15}**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malagasy Population, 2009</td>
<td>19,625,000</td>
</tr>
<tr>
<td>Percent of population:</td>
<td></td>
</tr>
<tr>
<td>Under 15 years/15-24 years of age</td>
<td>43%/16%</td>
</tr>
<tr>
<td>Percent of population that is urban/rural, 2009</td>
<td>30%/70%</td>
</tr>
<tr>
<td>Gross National Income per capita (GNI), 2009</td>
<td>$420</td>
</tr>
<tr>
<td>Total Life Expectancy at Birth, 2009</td>
<td>61</td>
</tr>
<tr>
<td>Under 5 mortality rate (per 100,000), 2009</td>
<td>58</td>
</tr>
<tr>
<td>Infant mortality rate (IMR) per 1000 live births, 2009</td>
<td>41</td>
</tr>
<tr>
<td>Total expenditure on health per capita at exchange rate ($) (2009)</td>
<td>18</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>4.1</td>
</tr>
<tr>
<td>Private expenditure on health (PvtHE) as % of the THE (2009)</td>
<td>32.9</td>
</tr>
<tr>
<td>Private insurance as % of the PvtHE (2009)</td>
<td>15.1</td>
</tr>
<tr>
<td>Out of pocket expenditure as % of the PvtHE (2009)</td>
<td>67.8</td>
</tr>
<tr>
<td>Maternal mortality rate, 2009</td>
<td>498</td>
</tr>
<tr>
<td>Total unmet need for family planning, 2009</td>
<td>19%</td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate, 2009</td>
<td></td>
</tr>
<tr>
<td>All methods/Modern methods</td>
<td>39.9/29</td>
</tr>
<tr>
<td>Total Fertility Rate 1990/2009</td>
<td>6.3/4.6</td>
</tr>
<tr>
<td>Percent of births with skilled attendant, 2005-2009</td>
<td>44%</td>
</tr>
<tr>
<td>HIV prevalence rate (aged 15-49), 2009</td>
<td>0.2</td>
</tr>
<tr>
<td>TB rate</td>
<td></td>
</tr>
<tr>
<td>Malaria cases reported, 2009</td>
<td>299,094</td>
</tr>
<tr>
<td>Nutrition status indicators</td>
<td></td>
</tr>
<tr>
<td>• % of infants with low birth weight, 2005-2009</td>
<td>16%</td>
</tr>
<tr>
<td>• % of under-fives (2003-2009*) suffering from: stunting (WHO), moderate &amp; severe</td>
<td>50%</td>
</tr>
<tr>
<td>• % of children (2005-2009*) who are: exclusively breastfed (&lt;6 months)</td>
<td>53%</td>
</tr>
<tr>
<td>• % of households consuming iodized salt, 2003-2009</td>
<td>53%</td>
</tr>
<tr>
<td>Total adult literacy rate, 2005-2008</td>
<td>71%</td>
</tr>
<tr>
<td>Primary School net enrollment/attendance, 2005-2009</td>
<td>76%</td>
</tr>
</tbody>
</table>

\textsuperscript{14} Ibid.

Although HIV rates remain low, STI rates and birth rates are still high. Condom use remains modest and focused on commercial sexual relations. Birth rates, and particularly the spacing of births with reliable methods for appropriate intervals, remain a priority area of intervention. Under the Madagascar Action Plan developed by the government in power before 2009, the country set the objective of reaching a CPR of 30% by 2012. This was almost achieved in 2008 with a CPR of 29%. The current government is in the process of reviewing its strategic plan for 2011-2015 to meet unmet contraceptive need by 2015, as set in the Millennium Development Goals (MDGs). Reaching that goal would mean that Madagascar should reach a CPR of approximately 48% by 2015.

Preliminary results from a study conducted in 2010 indicate that PSI/Madagascar’s social marketing and franchising efforts contributed 34% of the contraceptives composing Madagascar’s CPR in 2009. The Malagasy Ministry of Health’s supply of contraceptives contributed to 60% of the CPR. The graph below illustrates the proportion of contraceptives contributing to the CPR by channel.

A major contributing factor to the increase in CPR from 2006-2008 was the government’s provision of free family planning services in public health centers that began in 2007. The Ministry of Health also made many improvements during that time to their contraceptive supply chain management. However, much of the momentum that was building under the last regime has slowed recently due to the political crisis. Training and expansion of long-term family planning methods in the public sector have halted. At present time family planning services in the public sector are still provided for free however discussions have started regarding the re-introduction of fees.

While the maternal mortality rate (MMR) decreased over the decade from 500 to 440 in 2007, there has recently been a slight increase to 498 deaths for 100,000 live births (2008-2009). The Millennium Development Goals call for a reduction in the MMR rate to 127 by 2015.

3.2 HEALTHCARE SYSTEM

There are 111 decentralized health districts in which exist three levels of health care. Each health district has approximately 10-15 basic health centers and one basic hospital center. According to the latest available MOH data from 2004, there are 448 2nd level health centers (CSB-2) and 117 1st level health centers (CSB-1), 22 2nd level hospitals (CHD-2) and 12 1st level district hospitals (CHD-1) throughout the country. The table below lists the levels and features of each.

<table>
<thead>
<tr>
<th>Level</th>
<th>Facility</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>CSB-1, CSB-2: Basic Health Centers</td>
<td>CSB-1 centers provide basic health care and are run by a para-medical agent. CSB-2 centers provide the same health care as a CSB-1, but there is a doctor attending.</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>CHD-1 and CHD-2: District level hospitals</td>
<td>CHD-1 centers provide basic hospitalization services. CHD-2 centers offer hospitalization and basic surgical facilities.</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>CHR: Regional Hospital Centers</td>
<td>CHRs are located at the regional level in 4 regions: Toamasina, Fianarantsoa, Antsiranana and Toliary. They offer hospital services and surgical facilities.</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>CHU: University Hospital Centers</td>
<td>UHCs are found at the national level. There are 16 UHCs (13 based in Antananarivo and 3 in Mahajanga). These are teaching hospitals that offer hospital services and surgical facilities.</td>
</tr>
</tbody>
</table>

17 Ibid.
18 PSI Madagascar, 2010.
19 NB: ONG= Non-governmental Organization.
Madagascar’s medical school has turned out hundreds of trained health professionals year after year. The public health care system does not have enough space to accommodate all of these professionals so many will start their own private practices. This has helped build a strong national market of private sector doctors, midwives and nurses. In 2003, there were a reported 2,347 public and 509 private CSBs. The data regarding the number of private doctors operating on their own is not available.

To legally practice medicine in Madagascar, it is required to be a member of the national medical professional organization, the National Organization of Doctors (ONM). This, and the other national provider organizations such as the National Order of Nurses and National Order of Midwives, have the authority to act as watchdogs over providers.

There exist two main types of health facilities in the private sector. The most prevalent type is the simple private practice clinic, which consists generally of one to two private providers. The second type is the health center, which is a larger facility with multiple providers and support staff including nurses and midwives. Often health centers will have some degree of surgical care in addition to primary care services. These health centers are owned and operated largely by NGOs, local associations, workplace initiatives and faith-based organizations.

For individual or small private medical practices, only doctors may open and run clinics. In order to be accredited and legally permitted to open a private clinic, private sector doctors must first submit their request to the ONM. Once they are accepted into the organization and their dossier has been approved, they must then apply at the district level MOH for legal approval. District level MOH officials are charged with visiting medical centers or offices before accreditation, however anecdotal evidence suggests that this step is often skipped in practice and accreditation granted sight unseen. The result of this is that the quality of services and facilities at private clinics is not assured and varies widely.

Private providers must remain members in good standing with the ONM in order to stay in practice. Membership is renewed on an annual basis, with an annual fee and assuming there have not been any serious infractions. The ONM is responsible for regularly auditing clinics and centers. In practice, there is little oversight and monitoring of private clinics. However, since the ONM and the MOH work at a decentralized level, they stay abreast of serious problems with private practitioners and intervene and disable those who are committing egregious medical malpractice.

Private health centers that are run by associations and faith-based organizations must request legal approval to open and offer medical services. The district level MOH receives their requests and conducts an exploratory visit before granting approval. All providers working at health centers must remain members in good standing with their respective national provider organization: National Organization of Doctors, National Order of Nurses and National Order of Midwives.

The general perception among health care clients is that the private sector, with its higher fees, provides higher quality services and products. In fact, many providers both public and private, lack opportunity for continuing education. They lack opportunities for ongoing collegial support and sharing lessons learned. The majority of private providers are simply struggling to earn a living and are serving clients who are in the same socio-economic situation.

A network such as Top Réseau can offer many potential benefits to private providers in this context, as well as contributing to the overall picture within a total market perspective. At the provider level, the Top Réseau network offers an opportunity to grow professionally through

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specialized training and opportunities for continuing education. In addition to training, providers benefit from certain essential materials for their clinics — that may have been out of their budgets — as well as ongoing capacity building in the form of supervision and evaluation. The network was designed so that each provider no longer works in isolation but benefits from regular interface, exchange and support from program team members such as regional supervisors, medical delegates, interpersonal communication agents. The member providers in each region have opportunities to meet and share technical ideas with their network colleagues on at least a semester basis. Starting in 2011, PSI plans to help keep members up to date on network goings-on and medical technology via a Top Réseau trimester newsletter.

An important and often remarked upon benefit of the network for members has been the creation of demand for their services. Whereas outside of the network all promotion of health services is legally forbidden, the promotion of the branded network is permitted with some restrictions. Benefitting from the brand recognition as well as links with IPC agents, the providers have seen increases in their client flows resulting from the intensive communication campaigns.

Finally, because network providers and their centers submit to heightened scrutiny and evaluation within the program, they benefit from a certain level of protection against claims of wrongdoing. In the past few years, there have been some cases of private providers being accused of misconduct and placed directly in jail with little due process. Providers belonging to the network are known to meet a certain quality standard and to be in favorable standing with the ONM. Providers have taken some reassurance in this level of protection as well as in the more stringent quality assurance measures for certain clinical services that PSI requires and audits.

With regard to a more comprehensive look at the private sector market for health services, the introduction of more stringent standards and monitoring of quality has led to better services for consumers. According to PSI/Madagascar program management, the ONM has been appreciative of the improvements that the network has produced in these areas. This is particularly applicable to the work that PSI has done with quality assurance for long-term family planning methods. In addition, the ONM has shared with PSI the observation of a diffusion effect: that other private providers are improving their quality standards as a result of the Top Réseau competition.

Few other examples of provider networks exist outside the Top Réseau network in Madagascar. The other networks are linked to religious organizations, workplace entities and international NGOs/associations like the IPPF affiliate and Marie Stopes International (MSI). MSI has had their clinics in place for over a decade. The biggest differences between Top Réseau and other networks pertain to scope and clinic ownership. The other networks are generally limited in number or by region and the clinics are owned and operated by an organization. Top Réseau has a greater number of autonomous clinics throughout the country. With the Top Réseau model in place and growing, the role for social franchising in this manner in Madagascar has been proven and the door opened to starting additional networks. In 2010, MSI began implementing their Blue Star provider network focused on expanding access to reproductive health and maternal care for all women of reproductive age.

3.3 REGULATORY FRAMEWORK FOR PRIVATE PROVIDERS

All medicinal drugs distributed in Madagascar must have authorization from the MOH to be in the market. This authorization, “Authorisation de Mise sur la Marché”, requires a lengthy process and rigorous review by the pharmaceutical division of the MOH. PSI/Madagascar has obtained the “AMM” for each health-related product that it distributes through social marketing.

The regulations on sales of medicine require distribution through the pharmaceutical chain of wholesalers and pharmacies; doctors are supposed to write prescriptions for medicine that patients will fill at the pharmacy, and return to the doctor for treatment as needed. In general, doctors are not allowed to dispense medicine from their clinics and centers. However for some essential medicines, doctors are free to stock and dispense directly to their clients.

23 Interview with Dr. Andry Nirina Rahajarison, Director of the Health Services Department, May 16, 2011.
24 Ibid.
PSI/Madagascar requested and received MOH authorization for private providers to directly sell certain socially marketed products: the contraceptive pill (Pilplan), the contraceptive injection (Confiance), the STI kits (Genicure and Cura7) and contraceptive implants. This is the case for all private providers, whether in the Top Réseau network or not. For the case of IUDs and condoms, these methods are not considered a medical product and not a drug, therefore with the proper “AMM” in hand, PSI is automatically permitted to distribute directly to providers who in turn are allowed to dispense from their clinics. PSI/Madagascar plans to request the inclusion of additional socially marketed products within the ministerial decree such as malaria treatment for children under 5 and oral rehydration therapy.

There has been a fine line to walk with advertising the Top Réseau network. Government regulations exist for advertising health care services and products; it is forbidden to promote a specific clinic or provider through mass media such as radio, TV and billboards. However, it is permissible, with some restrictions, to advertise a network through these channels, as well as through interpersonal communications and printed materials such as flyers and posters. It is also allowable for a health provider network or product to sponsor an educational message broadcast on mass media.

All of these permitted methods have been used to promote the Top Réseau network. Interpersonal communications, in the form of peer education, has been the predominant channel used by PSI. In each of the Top Réseau sites, youth peer educators are assigned to certain zones where they perform outreach activities to refer clients to the clinics. The peer educators distribute flyers outlining the services, attributes and locations of the network clinics.

Mass media has been used to complement the IPC efforts on the ground. Billboards that promoted the brand Top Réseau, with no indication of services or attributes, were approved by the Ministry of Health and set up in certain Top Réseau regions. In addition, a musical group, “Tearano” popular with youth, produced a song, music video and jingle for Top Réseau that was played on the radio and television. The jingle was used to frame educational radio and TV spots sponsored by Top Réseau.

PSI has always sought final approval from the Ministry of Health for communication materials and campaigns before implementing them in the field. Assuring that the MOH is aware of PSI’s activities and creating demand have been crucial elements of Top Réseau’s success; the trust and relationship building between the two entities has fostered support at central and local levels from the MOH for the network.

3.4 MARKET OPPORTUNITIES
While it is generally perceived that the private health sector provides better quality than the public sector in Madagascar, in fact quality standards and outputs are still often low and clients are not entirely satisfied. Private providers are also often limited in their scope of services and choices as well as expertise. Opportunities for private providers to access continuing education and technical knowledge are generally rare and expensive. In general, private providers are so focused on earning a living that they do not have time to branch out with new skills, services or products. The majority of private providers are obliged to rent clinic space or operate out of their own home to keep costs down. Most are working independently with no support staff.

The Top Réseau network has offered an opportunity to providers to expand their scope of skills and services offered, while simultaneously reinforcing and supporting their practices with targeted demand creation, as well as technical support and materials. The providers became trained experts in family planning, STI treatment and prevention and adolescent reproductive health. Some of the providers added on additional skills and services such as HIV counseling and testing and long-term family planning methods. The boost in quality and services offered within the growing network has also encouraged other providers and existing networks to increase the quality and range of their services, thereby encouraging a more vibrant market via competition and good role models.
The Top Réseau network also filled a void within the market. Until the network launch, youth-friendly providers were virtually unavailable in any region. Although there existed a few family planning networks with a limited number of member clinics, such as Marie Stopes International Clinics and the local IPPF clinics, none of these were specifically trained and equipped to offer services to adolescents. Malagasy youth were hesitant to seek reproductive health services at any clinic, either for STIs or for family planning, because of the judgmental attitudes and lack of confidentiality perceived as prevalent among private providers. The Top Réseau network helped to fill the gap in access to adolescent reproductive health services in every region where it has been launched. It presented a great opportunity to build capacity and competency among private providers for a new market segment of clients who desperately needed information, products and services.

For PSI, the network has offered a safe and reliable way to assure quality, access and availability for vulnerable target groups to the reproductive health services and products that they need. It has served as an additional, although extremely limited in scope, distribution channel for PSI socially-marketed products such as the short-term family planning methods (pill, injections, condoms), STI treatment kits, and in some cases maternal and child health products (mosquito nets, home water treatment solution, child malaria treatment).

4. BUSINESS MODEL

4.1 FRANChISOR

The business model for the Top Réseau franchised network allows for providers to remain independent while benefiting from network membership. Unlike other franchise models in the private sector, members do not have to “buy-in” to the network and lose their own identity. Top Réseau providers agree by contract to abide by certain conditions stipulated by PSI for membership and they pay a nominal annual fee of about $2.50. In exchange they will benefit from the branding, intensive demand creation, and technical provision such as continuing education and training, certain equipment, supervisory support and evaluation that PSI offers. Providers are free to continue their other activities and services outside the scope of the network as long as no conflicts exist. All financial decisions linked to the clinic, with the exception of keeping price ceilings on Top Réseau services for the target group, reside with the provider and PSI is not involved. Starting in 2011 the providers will even be permitted to fix their own prices with no maximum ceiling fee for all Top Réseau services except HIV testing and FP services for high-risk groups and youth. PSI will study this strategy carefully to assess if it will allow the network to continue to meet client access needs and equity.

A clinic will be branded as a Top Réseau clinic when the facility meets all the minimum membership requirements and at least one provider at the clinic has been approved and trained as per the membership criteria. The minimum criteria for provider eligibility to join and remain a member in the network are outlined as follows in Table 4.1a, “Minimum Criteria for Network Membership.”

Continued membership is contingent on unceasing adherence to the membership requirements and demonstration of quality service provision as evaluated by periodic supervisory visits and occasional mystery client studies. For those providers offering long-term family planning services, PSI also conducts an annual

<table>
<thead>
<tr>
<th>Categories</th>
<th>Minimum Criteria for Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of the health clinic/facility</td>
<td>• Convenient hours and location</td>
</tr>
<tr>
<td></td>
<td>• Ability to ensure confidentiality</td>
</tr>
<tr>
<td></td>
<td>• Comfortable setting for youth</td>
</tr>
<tr>
<td>Characteristics of providers and staff</td>
<td>• Specifically trained to serve youth</td>
</tr>
<tr>
<td></td>
<td>• Have tangible respect for youth</td>
</tr>
<tr>
<td></td>
<td>• Respect and maintain confidentiality and privacy</td>
</tr>
<tr>
<td></td>
<td>• Allow adequate time to receive clients properly and allow adequate exchange with customers</td>
</tr>
<tr>
<td></td>
<td>• Young men as well as women are received and served</td>
</tr>
<tr>
<td>Characteristics of the administrative system</td>
<td>• Information and appropriate contacts for references are available</td>
</tr>
<tr>
<td></td>
<td>• Prices are affordable</td>
</tr>
<tr>
<td></td>
<td>• Availability of a wide range of services</td>
</tr>
<tr>
<td></td>
<td>• Capable of welcoming customers who walk in for a visit and arranging their appointment rapidly</td>
</tr>
<tr>
<td></td>
<td>• Have educational materials available in the clinic that can be distributed to customers</td>
</tr>
</tbody>
</table>

quality assurance evaluation. A contract is signed between PSI and each provider at the beginning of membership; this contract is reviewed and renewed automatically on an annual basis if both parties agree. The main conditions stipulated within the contract, which are obligatory for continued membership, are outlined below in Table 4.1b, “Membership Conditions and Benefits.”

TABLE 4.1B: MEMBERSHIP CONDITIONS AND BENEFITS

<table>
<thead>
<tr>
<th>Conditions for Membership</th>
<th>Membership Benefits Received from PSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Offer high quality adolescent reproductive health services.</td>
<td>▪ Technical assistance: training and refresher courses for providers and their staff in counseling, STI management and treatment, family planning provision and others.</td>
</tr>
<tr>
<td>▪ Pay an annual membership fee.</td>
<td>▪ Documents and resources: IEC/BCC materials, network handbook, necessary support for community mobilization, marketing materials.</td>
</tr>
<tr>
<td>▪ Sign an agreement letter and contract with PSI.</td>
<td>▪ Monitoring and evaluation of quality assurance and support for assuring minimum standards and norms.</td>
</tr>
<tr>
<td>▪ Respect the overall norms of the network (specifically the minimum criteria cited above).</td>
<td>▪ Assistance with developing systems to collect and manage data.</td>
</tr>
<tr>
<td>▪ Respect the quality norms of Top Réseau (see Section 8 of this document).</td>
<td>▪ Regularly scheduled meetings to exchange ideas with other members and to build camaraderie within the network.</td>
</tr>
<tr>
<td>▪ Meet minimum requirements for equipment and space as stipulated in contract annexes (example: separate rooms for consultation and waiting/reception).</td>
<td>▪ Starter stock of socially marketed products such as: the pill, injectable, condoms, STI treatment kit and others.</td>
</tr>
<tr>
<td>▪ Engage at least one provider trained in ARH, FP and STIs who is certified by PSI.</td>
<td>▪ Condom use demonstration model and monthly sample stock of condoms.</td>
</tr>
<tr>
<td>▪ Assure that all personnel abide by the minimum network norms.</td>
<td>▪ Marketing materials: network branded signs for the exterior of the facility.</td>
</tr>
<tr>
<td>▪ Assure that there is always a sufficient stock of family planning methods, condoms and demonstration models for condom use.</td>
<td>▪ Promotion of services: communication and marketing campaigns for the network, which seek to increase demand for services at the network clinics.</td>
</tr>
<tr>
<td>▪ Assure sufficient stock of IEC materials.</td>
<td>▪ Certain promotional and medical materials as well as consumables provided for free: Branded prescription pads, privacy screens, trashcans with foot push, sterilization and disinfection equipment (disinfection tubs, autoclaves, treatment solutions), lights, examining tables and IUD insertion kits (for those providers offering LTM).</td>
</tr>
<tr>
<td>▪ Conform to other national and international norms and standards as applicable.</td>
<td>▪ Assistance with developing systems to collect and manage data.</td>
</tr>
<tr>
<td>▪ Attend Top Réseau meetings at least 75% of the time.</td>
<td>▪ Regularly scheduled meetings to exchange ideas with other members and to build camaraderie within the network.</td>
</tr>
<tr>
<td>▪ Follow the price ceiling fixed by PSI for Top Réseau clients.26</td>
<td>▪ Starter stock of socially marketed products such as: the pill, injectable, condoms, STI treatment kit and others.</td>
</tr>
<tr>
<td>▪ Affix prices in a clearly visible place for clients. 27</td>
<td>▪ Condom use demonstration model and monthly sample stock of condoms.</td>
</tr>
<tr>
<td>▪ Affix the network logo in a visible place.</td>
<td>▪ Marketing materials: network branded signs for the exterior of the facility.</td>
</tr>
<tr>
<td>▪ Accept that PSI conducts supervisions, evaluations and mystery client studies.</td>
<td>▪ Promotion of services: communication and marketing campaigns for the network, which seek to increase demand for services at the network clinics.</td>
</tr>
<tr>
<td>▪ Accept to fill in PSI MIS forms.</td>
<td>▪ Certain promotional and medical materials as well as consumables provided for free: Branded prescription pads, privacy screens, trashcans with foot push, sterilization and disinfection equipment (disinfection tubs, autoclaves, treatment solutions), lights, examining tables and IUD insertion kits (for those providers offering LTM).</td>
</tr>
</tbody>
</table>

PSI is an active partner with the franchised network. Regional coordinators and supervisors based in each region assure monthly contact with each provider; in some cases one regional office covers two Top Réseau regions. Sometimes there may be interaction multiple times per month with the franchised network members, depending on the needs of the provider. At a minimum, the regional coordinator or medical supervisor visits members each month for regular supervision. In addition, for providers which offer long term family planning methods or HIV counseling and testing services, the centrally based PSI quality assurance team will conduct a supervisory visit on a quarterly basis. Annual evaluations are conducted by both the regional supervisory team and, when appropriate, the quality assurance team.

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26 As of 2011 PSI will no longer fix prices other than some exceptions, but PSI does strongly advocate with providers to keep price levels as low as possible to ensure affordability to vulnerable groups.

27 Although stipulated within the Top Réseau manual, this is rarely done in practice.
The franchised network falls under the program management of the Health Services Department at PSI/Madagascar. The Director oversees a Senior Coordinator for Franchised Services, a Senior Coordinator for Capacity and Performance and a Coordinator of Medical Promotion. The Senior Coordinator for the Health Service Delivery Network (formerly called Senior Coordinator for Franchised Services) oversees the 9 regional coordinators who in turn oversee supervisors for IPC to youth and high-risk groups as well as medical supervisors who assist them in visiting and monitoring clinics. The Senior Coordinator for Capacity and Performance oversees a team of 3 quality assurance specialists; this team is actually employed by JHPIEGO but seconded to PSI and works exclusively within the program. The Coordinator of Medical Promotion oversees a team of medical delegates who work primarily with non-network providers but help to identify prospective members and provide community and paramedical trainings.28

Assuring a fluid communication between the franchise members and PSI has been an important element to successful retention of members. Network providers appreciate the bidirectional communication and responsiveness of the PSI social franchise team. The presence of a regional team has fostered an ongoing dialogue between PSI and the members, as well as a sharing of lessons learned among members. It has also allowed a spirit of partnership to grow, as the regional team is able to respond quickly with trouble-shooting challenges and championing successes.

4.2 FRANCHISEES
By the end of 2012, PSI intends to expand the network to include an additional 120 clinics, not including those transformed from Profemina to Top Réseau. The total number of clinics by the end of 2012 is projected at 293. This nearly doubling of the network is seen as meeting an unmet need among a broader target group for the variety of high quality services that the network will offer. Graphs 4.2a, 4.2b and 4.2c below show the dramatic increase in the quantity of services delivered since Top Réseau began in 2001.

28 Refer to annexes for the PSI/Madagascar organigram.
The Top Réseau network accreditation is linked to the doctor or doctors in each clinic and center. Certain health centers, nurses and midwives are also certified as providers within the network. All providers are accredited by the Ministry of Health and in good standing with the appropriate national association of health care providers. Member facilities range from a single doctor working in a one-room office to a multi-provider clinic with some surgical capacities; however, over 60% of clinics are single provider operated. The majority of Top Réseau providers are female.

All clinics are located in urban or peri-urban areas with catchment sites that cover all of the SES quintiles, with particular attention to the lower three. Providers generally work only at their private clinic but in certain cases, especially in very remote areas, some of them are supplementing their work as a public sector provider with a private practice on the side. Some providers are linked to workplace initiatives or NGOs like ASOS or IPPF, and others are led by Protestant religious organizations like SALFA and SAF-FJKM.

An important lesson learned with selecting provider members concerns the provider’s starting client flow. PSI/Madagascar found that providers with high client flows, although positioned to reach a large number of the target group and a logical choice for that reason, are actually too busy to adhere and excel within the network conditions. These providers are very interested in the beginning, but their interest wanes once the reporting and supervisory visits begin. In fact, the demand creation efforts are not even perceived as a benefit for them when their client flow begins to increase and exceed their capabilities. Dr. Leon Ratsimazafy Andriambololona, a highly popular provider in Antsirabe, upon taking on LTM service provision within the network stipulated to PSI that he would only take 2 IUD clients per week and limited those to Wednesdays.29

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29 Interview with Dr. Andry Nirina Rahajarison, Director of Health Services Department, May 16, 2011.
PSI has had the most success instead with providers who have a lower client flow but who are interested in the project. These providers have more available time, can quickly perceive and reap the benefits of increased client flow and are overall more appreciative and engaged in the collaboration with PSI. Dr. Muriel Rajaona Rakotonirainy, also offering Top Réseau services in Antsirabe but who joined as a provider just starting her practice, has noted with satisfaction that her client flow has increased because of the network affiliation. Now 90% of her clients are Top Réseau clients.

Within the new wave of recruitment for the network, PSI will be selecting providers who show promise and interest but are not yet extremely high in demand. The program will work to help these providers be more productive and expand their practice, as opposed to those providers who already have a thriving practice.

4.3 SCALABILITY
From one region to nine intervention areas, the Top Réseau model has proven to be replicable and allow for scaling up. The network has a national presence covering the most highly populated areas of the country. A key component to this scalability has been the preparatory work in each region prior to implementation. PSI has taken great care to build relationships, networks and support in each region before any activities begin. Lobbying and consensus building is done at the beginning of each regional implementation. This allows the network to start off with a certain amount of prestige, support and standing in the community.

Once a new region with a sufficient presence of private providers or large number of target groups has been pre-selected, either by demonstrated health need or donor interest or both, PSI contacts national level Ministry of Health and professional health provider organization representatives to discuss the feasibility of starting up the network in that area. When support for the extension has been built at the national level, regional level officials are contacted and meetings held to build partnerships and support. With this foundation, PSI holds a series of “town hall” type meetings with the various potential stakeholders, including potential private provider members, public sector health workers, community associations, youth groups and local leaders. The project is described in full and discussed in a forum setting; provider members from other regions assist in presenting the project with the experiences and benefits reaped in their respective regions. During the meetings with potential members, providers are invited to apply for membership if they are interested. An application form is distributed during the meeting and collected a few weeks later by a PSI/Madagascar medical supervisor. The medical supervisor will also conduct advocacy visits on an individual basis to potentially interested providers.

Interview with Dr. Muriel Rajaona Rakotonirainy, Top Réseau provider in Antsirabe, June 7th, 2011.
Until now expansion into new regions has been prioritized. Moving forward, extension will be focused within each region with the goal of adding new provider members to allow for increased coverage within each area of intervention. This will help maximize the efficient use of existing resources and simultaneously increase access to vulnerable groups.

TABLE 4.3: REGIONAL AND SERVICE EXPANSION OF TOP RÉSEAU BY YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Region</th>
<th>Service/Target group segmentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Tamatave</td>
<td>Core services</td>
</tr>
<tr>
<td>2001</td>
<td>Antananarivo</td>
<td>Core services</td>
</tr>
<tr>
<td>2003</td>
<td>Diego</td>
<td>Core services</td>
</tr>
<tr>
<td>2004</td>
<td>Fort Dauphin, Mahajanga</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>2005</td>
<td>All regions</td>
<td>CSW</td>
</tr>
<tr>
<td>2006</td>
<td>Morondava, Antsirabe</td>
<td>VCT</td>
</tr>
<tr>
<td>2007</td>
<td>All regions</td>
<td>MSM</td>
</tr>
<tr>
<td>2008</td>
<td>Fianarantsoa</td>
<td>LTM FP</td>
</tr>
<tr>
<td>2009</td>
<td>Moramanga</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Total</td>
<td>9 regions</td>
<td></td>
</tr>
</tbody>
</table>

As for adding in new services and commodities to the network, the fact that the network providers maintained their own basic health services and remained independent providers has been a significant advantage. Although the scope of the network was somewhat limited in services and target group, the providers were flexible enough and varied enough in their overall services to accommodate new activities. They were also able to benefit from their heightened image as high quality Top Réseau providers for youth to instill confidence in their clientele for additional services and products. Research has shown that the network providers have gained a highly varied clientele over the years and that PSI/Madagascar could build upon this existing pool of clients and demand for services without needing to reach out to new groups or invest extended resources into re-positioning efforts.

The planned strategy to shift from youth-centric services to a more comprehensive approach will draw upon the Top Réseau brand equity for its successful implementation. A recent study on perceptions of clients attending Top Réseau clinics showed that branding and marketing of services left a strong image among all ages. The study interviewed a range of ages including men and women of reproductive age (from below 25 years of age to 49 years), who shared their perception of Top Réseau as a clinic offering quality services (86%), family planning services (88%), STI treatment (83%) and serving youth (93%).

In effect, the planned shift is a response to current trends in client flow and client needs. As an example, a recent PSI study shows that 60% of all clients presenting at Top Réseau clinics are mothers with febrile children. Within the new broader branding scheme, there will be greater flexibility to add in new services and products. Providers will be able to add on to the basic core services according to their interests and motivation.

4.4 TARGET POPULATION

The Top Réseau project was initially designed to reach urban and peri-urban Malagasy youth aged 15 to 24 years old. From 2005, this target group was further expanded to include special high-risk groups such as MSM and CSWs. To reach youth and these high-risk groups, intensive lobbying and careful site selection of network clinics has been crucial.

During the pre-launch town hall meetings in a new region, PSI makes sure to emphasize the youth-focus of the network in order to assure that providers who sign up are truly aware and dedicated to the cause. A defining element of the network success is that providers are personally motivated to join and believe in the goals and objectives of the project. The PSI coordinators then visit the provider clinics that expressed interest and follow a checklist of site selection criteria including such variables as:

- Number of rooms in the facility (at least one room for consultation separate from an area dedicated to reception/waiting).
- Availability or presence of running water, electricity, examining table, scale, vaginal speculum and system of waste disposal.
- Situated in an area where youth are likely to seek services and of an acceptable distance (generally up to 30 minutes travel time for clients).
- Affordable price ranges for youth already in place or a sliding fee scale according to client ability to pay.

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33 PSI “Perceptions of Top Réseau” Study, 2010.
34 Refer to Annexes for the complete pre-selection criteria check-list.
Although these criteria are not necessary to grant eligibility to join the network, they must be in place before becoming an active member.

In addition to careful site selection, the Top Réseau network assures financial accessibility to youth. Network providers are obliged to keep prices for youth consultations within the affordable bounds of young people. PSI has conducted studies with youth that indicate their ability to pay about 1,500 to 2,000 ariary ($0.75 to $1.00) for a reproductive health consultation. Top Réseau network providers keep their fees for youth at or below this pricing ceiling, despite the potential profit loss.

PSI conducts ongoing formative research to determine which communication channels are the most effective in reaching youth. This research has led to the development of a multi-level communication campaign that promotes the network and behavior change through peer education, mobile video units and mass media.

Youth will visit a Top Réseau clinic because they can receive high quality, youth-friendly confidential services and counseling that they cannot get elsewhere. Anasthasie Rasoamalala Harivony, a peer educator in Tamatave, says that when she needed a doctor for contraception, Top Réseau was the only place she considered going. She did not try the network services before becoming a peer educator, but upon visiting the clinic she was entirely convinced of their appropriateness and benefit for youth.

Refined communications and interpersonal skills are the defining factors of youth-friendliness for the network. Providers are required to follow an intensive 4-hour training around communication, specifically targeted to youth. The training teaches providers how to interact in a non-judgmental, comforting and accessible way with youth. It also covers an overview of youth development and the kinds of special concerns that young people face. Providers who were interviewed for this case study particularly emphasized how important this training was for them and how it changed their whole approach to client interactions.

A recent research study among Top Réseau clients has shown that most youth clients are presenting for STI services, followed by family planning services and finally general youth counseling that ranges in topics from relationship issues to contraception counseling without method selection. This same study indicated that youth are interested and believe that Top Réseau clinics offer other high quality services outside the specific realm of family planning and STI care. Such additional services perceived by clients to be Top Réseau services include other types of reproductive health care, HIV counseling and testing, primary health care and maternal/child care.

Although Top Réseau clinics are well-known for providing youth-friendly services, a careful analysis of clinic client bases shows that a full range of age groups present at network clinics for a variety of reproductive health related and non-related issues. Interestingly, a PSI research study showed that in addition to youth aged 15-24 years feeling that Top Réseau was “designed for people like me,” even other age groups felt welcome at the network. Several different age groups including married men older than 25, women older than 35 years and mothers of children under 5 years felt a strong sense of belonging within the network.

35 Interviews with: Dr. Sandra Rabenja (former Top Réseau provider, current CRRPSS), Dr. Mino Andrianamananjara, and Dr. Muriel Rajaona Rakotonirainy.
37 PSI/Madagascar Perceptions of Top Réseau Survey 2010.
Starting in 2011, the network brand positioning has been broadened to include all men and women of reproductive age. The basic core services will be expanded to include maternal and child health care services as well as a larger scope of reproductive health services including cervical cancer testing, post-abortion care, emergency contraception and an extension of trained providers offering long-term family planning methods.

Overall, the providers are satisfied with the Top Réseau partnership. However, the low ceiling on consultation fees and the low-income population attracted to Top Réseau services means that providers sometimes suffer a profit loss. When asked in a recent survey to cite the top three solutions that would motivate them, the majority of providers requested an increase in the consultation fee ceiling point, the addition of financial incentives to providers and the provision of more materials and equipment for clinics. Dr. Mino Andrianamanjara of Tamatave says that although he is very satisfied with his membership in the network, he suggests that an improvement in the program would be to provide computers and other advanced equipment to providers. Although it is unlikely that PSI/Madagascar will be able to provide computers, the program is currently compiling a list of potential equipment and materials that will later be distributed as a means of motivating and supporting providers. PSI/Madagascar also plans to develop trainings to help providers grow and manage their practices.

4.5 FRANCHISEE RELATIONS
Legal contracts are signed with each provider before the provider is considered an official member. The contract specifies the conditions of the partnership and adherence to the membership. It is enforceable and renewable each year; in only one case has PSI had to cancel membership with a provider based on low quality performance or rejection of contract stipulations. In 2008, a provider was ousted from the network after being found inebriated on the job during a mystery client survey. Another provider was found to be falsifying reports on IUD insertions but was adhering to all the other quality criteria for Top Réseau; this provider was barred from providing IUD services under the Top Réseau/ProFemina brand but maintained as a Top Réseau provider.

With the onset of new activities and products to distribute, annexes are added on to the contract and signed by both parties. This has been crucial in the case of long-term method service provision and HIV counseling and testing. Given the more complicated and clinical nature of these services, PSI needed to assure quality standards and competency among participating network providers. The addition of a contract annex allowed PSI to insist and impose these high quality standards.

4.6 COSTS/BENEFITS OF ENROLLMENT
While the annual membership fee is nominal and symbolic at $2.50, there are other costs that providers will incur by being a member of the network. These costs can be measured in money, time and independence.

Some providers will have to invest in changes to their facilities before they can be admitted to the network. PSI does not provide financial support for facility upgrades; the provider must cover any costs to bring their center up to minimum standards.

Providers are required to undergo certain basic and initial trainings, which take time out of their usual schedule. PSI attempts to develop training calendars that work with provider schedules, such as half-day or weekend sessions, but some of the trainings can last up to 40 hours. If providers would like to add-on other services under the network umbrella, they will need to follow additional trainings with PSI. Although lodging and transportation are provided by PSI to those providers who must travel from out of town for a training, providers have complained about not receiving compensation during trainings to offset their temporary loss of productivity. PSI is considering providing a modest per diem to help address this issue.

38 PSI Provider Motivation Survey, 2010.
39 Interview with Dr. Mino Andrianamananjara, June 9th, 2011.
Fixed price ceilings for network services are another cost for many providers who find the limit too low for adequately gaining enough profit. Overall, providers have accepted the price ceilings although the issue has been discussed on an on-going and somewhat contentious basis with program management. Prices are agreed upon during regional network meetings and vary slightly by region. Some providers do not have a problem with the fee limits and these fit well into their regular fee program; others suffer a significant profit loss. However, those who lose money on the consultation price often make up their losses in increases in client load. In certain regions, the Regional Coordinators have had to negotiate with providers so that they accept the fixed price and continue with the network.40

In addition to potential losses from fixed consultation prices, providers who accept and receive vouchers for services must also wait for compensation until the end of each month. This is another hardship for providers who support themselves from day-to-day. Dr. Muriel Rajaona Rakotonirainy says that she often endures a delay in receiving payment for vouchers because of administrative procedures. This is her biggest complaint regarding network membership.

In addition, certain materials, equipment and job aids are provided by PSI to network members. Branded materials such as privacy screens and provider jackets are offered to member providers. A starter stock of PSI socially marketed products is provided to new members and to all providers when new products are added to the range. Providers who offer long-term family planning methods or HIV testing are provided with basic disinfection and sterilization equipment such as disinfection bins, autoclaves and chemical solutions.

Providers are equipped with multiple job aids and tools to assist them. Flip charts, checklists, posters and the patient register serve as tools for assuring client informed choice and following protocols and procedures. All supporting communication materials have undergone rigorous pre-testing.

4.7 FRANCHISEE RETENTION/ATTRITION
Overall franchisee retention has been relatively strong. The program management estimates that only 39 providers out of a total 250 in the past 12 years have left the network. Those that have left have done so principally because of financial motivation. These providers have not perceived the benefits of the network as outweighing the costs, particularly the price ceiling. This year, the network lost one provider to another.

Only 39 providers out of a total 250 in the past 12 years have left the network.

The loss of total autonomy may be the highest cost to providers. As members in the network, providers agree to allow PSI supervisors and evaluators visit their practice and give them feedback on a regular basis. While this can be seen as a positive aspect, providers also view it as a loss of independence. PSI has approached this issue with sensitivity by establishing set appointment times when possible for all visits, delivering feedback and evaluations with diplomacy and tact, building trust and relationships with each provider and engaging expert technicians for audits.

However, the costs associated with membership are balanced out by the myriad benefits.41 One of the biggest advantages of being a member in the network cited by providers is the opportunity to follow trainings. All providers receive a comprehensive training upon entry to the network covering reproductive health service provision and how to be youth-friendly. This training covers excellence in family planning counseling, including assuring informed choice and complete family planning counseling for each family planning client.

Another advantage of membership is the intensive communication campaigns built around the network that create demand. Providers benefit from being linked with peer educator teams who actively refer clients to the services. Mass media, mobile video units and signage also help orient clients to seek reproductive health services at their clinics.

40 Interview with Dr. Sandra RABENJA, Regional Coordinator in Tamatave.
41 PSI "Provider Motivation Study", 2010.
network, MSI’s Blue Star network. This provider left because he believes that the earning potential in the other network is greater than within Top Réseau.

As of yet, PSI has not developed any formal loyalty strategies for retaining franchisees. Although planned, there are not yet any non-monetary motivation schemes in place. However, on an informal level, the program has sought to showcase and reward motivated and talented providers by including them as co-facilitators in trainings of other providers. This has proven to be motivating for all providers as this type of recognition and participation is appreciated.

An additional informal structure, which likely contributes to member retention in at least a few of the regional sites, is the network notoriety. In a region like Tamatave where Top Réseau has been implemented for over 10 years with wide coverage, the network name has become synonymous with private sector independent doctors. This has presented a sort of social pressure on providers to join and remain members of the network. Dr. Sandra Rabenja, the Regional Coordinator in Tamatave, reports that one doctor approached her recently and asked to join the network because, according to him, clients will only visit a Top Réseau clinic. This sort of case is similar for other regions where coverage is high and the network has been firmly in place for several years.

The network has only lost one provider in the past 12 years due to a disciplinary issue. In general, the program has a policy of settling problems face-to-face with providers and trying to put in place a remedial plan to offer providers a chance to realign. PSI recognizes the independence of providers and does not want to impose too harshly upon them, even though it must assure adherence to network standards: this has meant walking a very fine line and using much diplomacy when problems do arise. The presence of local coordinators in each region, who are themselves doctors, has been extremely important for handling conflict with tact and in a collegial manner. Since many of the regional coordinators come from the same town where they work and have been private providers themselves, they are perceived as peers and insiders. Often, network meetings run by the regional coordinators have been safe forums to discuss problems.

5. MARKETING AND COMMUNICATIONS

Just as important as assuring the supply side of health services through the Top Réseau network, PSI also prioritizes increasing demand for these services. PSI employs a complementary mix of promotion and education to this end. The franchising department at PSI/Madagascar works in collaboration with several specialized internal teams to plan and implement appropriate communications for the project: the research department which collects essential data in the field for decision making, the social marketing advisor who helps manage the branding and marketing strategy, the communication department that oversees mass media and mobile video unit activities, and a training and IPC coordinator who helps manage all community-based and interpersonal communications.

Educational campaigns are developed following the results of ongoing operational research studies and campaign evaluations that are routinely conducted. The campaigns focus on changing the behavior and attitudes of the target group. Channels that are used to air campaign messages include radio, TV, peer education and mobile video unit teams. The youth-focused educational campaign supporting Top Réseau has found success through having its own brand: “Ahy ny Safidy” (It’s my Choice). This brand is used for radio, TV and peer education and is youth-centric. While the themes of the campaign vary from FP to HIV related messages, the campaign continues through its set channels and is easily identifiable by the brand. The format is educational while providing youth-focused entertainment, chosen by young people themselves.
Promotional efforts began with the development of a logo, brand name, and slogan for the network. These initial elements were developed through careful qualitative research to appeal to the target group and the health care providers. These identifying markers are used to advertise the network and the member clinics, through branded signs indicating membership at clinics and identifying paths to take to arrive at member clinics, and on billboards, flyers, brochures, posters and promotional materials inside each clinic. Additionally, a song was produced which aired on the radio and TV around the time of the first launch. In general, the network brand is not overtly promoted via mass media because of restrictions on marketing health services.

Interpersonal communications in the form of peer education has been particularly important both for communicating complex educational information and for promotion. Peer educator teams of about 10-15 work in each Top Réseau region, conducting dynamic educational sessions and linking clients to the network clinics. Some peer educators will refer as many as 50 clients per month to the network clinics. These referrals are tracked by vouchers, which are valid for clients only when accompanied by the peer educator. Olga, a 21-year-old client in Antsirabe, said that she would not have sought contraceptive services if it were not for meeting a Top Réseau peer educator, Narindra, who offered her a voucher to offset the consultation price.

**TABLE 4.8: BRANDING STRATEGY FOR TOP RÉSEAU 2010 AND 2011**

<table>
<thead>
<tr>
<th></th>
<th>2010 and earlier</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand target and positioning</td>
<td>Target group: youth and young adults 15-24 years of age</td>
<td>Target groups: men and women of reproductive age</td>
</tr>
<tr>
<td>Positioning statement: Top Réseau is the high quality network of youth-friendly medical providers for all your health concerns.</td>
<td>Positioning statement: For Bako, Top Réseau is the trusted neighborhood provider of effective and affordable clinical health services who cares about her and her family’s well being.</td>
<td></td>
</tr>
<tr>
<td>Brand personality</td>
<td>▪ Youthful ▪ Dynamic ▪ Modern</td>
<td>“The Reassuring Life-Long Family Friend” ▪ The well-known and well-respected neighborhood provider you’ve grown up with. ▪ He’s helped you through the tough times (e.g., surviving an illness) and celebrated with you during the good times (e.g., births). ▪ He’s practically a part of your family.</td>
</tr>
<tr>
<td>Brand execution</td>
<td>Slogan: Best choice for healthy youth</td>
<td>▪ Logo/Slogan: Adult &amp; serious (vs. young &amp; fun) ▪ Tone of Voice in media: soft, warm tones, familiar &amp; familial images &amp; sounds, overall positive &amp; reassuring ▪ Staff: ‘Living the brand’. They know client’s names, history, and families. They deliver on quality.</td>
</tr>
</tbody>
</table>

Interpersonal communication has been found to be a highly effective medium for building demand at Top Réseau clinics. IPC agent referrals account for the majority of all clients coming to Top Réseau. Among the tools used by the IPC

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**TABLE 5.1: REGIONAL CONSULTATION PRICES WITH AND WITHOUT TOP RÉSEAU VOUCHERS**

<table>
<thead>
<tr>
<th></th>
<th>With voucher (Ar)</th>
<th>Without voucher (Ar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamatave</td>
<td>1 500</td>
<td>2 000</td>
</tr>
<tr>
<td>Tanà</td>
<td>1 000</td>
<td>1 500</td>
</tr>
<tr>
<td>Diégo</td>
<td>1 500</td>
<td>2 000</td>
</tr>
<tr>
<td>Fort-Dauphin</td>
<td>500</td>
<td>1 000</td>
</tr>
<tr>
<td>Majunga</td>
<td>500</td>
<td>1 000</td>
</tr>
<tr>
<td>Antsirabe</td>
<td>500</td>
<td>1 000</td>
</tr>
<tr>
<td>Morondava</td>
<td>1 500</td>
<td>2 000</td>
</tr>
<tr>
<td>Fianarantsoa</td>
<td>1 000</td>
<td>1 500</td>
</tr>
<tr>
<td>Moramanga</td>
<td>1 000</td>
<td>1 500</td>
</tr>
</tbody>
</table>

NB: July 2011 value of the Malagasy ariary: 1,900 ariary= $1 USD.

PSI has successfully positioned the personality of the Top Réseau brand. Recent research shows that providers and clients perceive Top Réseau as offering high-quality reproductive health services to young adults. This image will change and broaden slightly as the branding strategy is adjusted in 2011.
agents are vouchers for reduced prices, which have proven to be effective but have had to be limited due to the lack of resources and questions around sustainability.

5.1 NETWORK LINKAGES
Interpersonal communication agents such as peer educators are employed by PSI and refer youth and women to the centers at the regional level. Referrals may be verbal, by voucher, or may include the agent physically accompanying the client to the nearest center. There is no payment due by the clinic for these referrals; it is an activity conducted and paid for by PSI as part of the comprehensive project.

For long-term family planning methods, IPC agent referrals have been extremely important for client flow. For these cases, referrals have accounted for nearly 90% of all client adoption. For youth client flow at the Top Réseau clinics, about 60% are referred by IPC.

For services not available at the network clinics, the providers refer clients as a courtesy per the referral lists provided by the Ministry of Health and PSI. They have a list that is location-specific and includes such issues as VCT and maternal care. In the case of complications from LTM insertions, PSI has specified a referral point for the client depending on the severity of the situation. A crisis communications plan and a chain of communication are also in place for the provider to use in the case of an adverse event. PSI takes on the financial responsibility as appropriate with adverse events.

6. SERVICES AND COMMODITIES

Initially, the Top Réseau network offered three main services targeting only youth: STI prevention and treatment, family planning services with short term family planning methods, and general youth counseling. This choice in services was based on the growing needs in reproductive health among youth. The estimated STI rates among youth were high while the HIV rate was low; there was concern that the STIs would set off an HIV epidemic. Family planning use was low among youth even though sexual relations and childbearing were starting before the age of 19. Additionally, formative research indicated that youth needed someone to talk with about reproductive health across more general themes like relationship issues, sexual health, and information about contraception. Over time, other services were deemed relevant and were added on, and the target group of youth was further broadened.

In 2005, the Top Réseau providers were trained in providing services for commercial sex workers (CSWs) of all ages. In 2007, services were further extended to specialize in serving all ages of men having sex with men (MSM) and CSW clients.

In 2006, PSI began to integrate HIV counseling and testing within certain interested and high-risk-location network clinics. These clinics were distinguished by the addition of a suffix to the brand network name, branded as “Top Réseau Plus”. The fact that Top Réseau had built an image of confidentiality and trust-worthiness facilitated the integration of this sensitive service. The service found a significant client demand that was driven solely by peer education outreach and referrals. From 2006-2011, there have been 40,477 persons tested for HIV across 21 provider clinics.

Also in 2006, USAID had a surplus of IUD and implant stock to be distributed. This presented an opportunity for Top Réseau to start piloting the integration of long-term methods into its offerings. PSI trained a selected number of interested Top Réseau providers on IUD and Implant service provision and supplied them with products. Actual long-term method insertions were low during this two-year trial period, as funding and prioritization was not focused toward demand creation. This lack of demand meant that most providers were unable to practice their new skills with enough frequency to maintain competency and motivation.
A more complete approach to integrating long-term family planning methods began in 2008 with funding from a private donor. This funding allowed for a comprehensive communication campaign supporting the services and creating demand. Trainings and quality assurance measures were put in place to support providers technically. The target group for these methods was expanded to women of reproductive age. Since Top Réseau was designed to cater to youth, a parallel network was devised to appeal to all women, “Profemina”. The Profemina branding on a member clinic signified that the provider had been certified and specially trained to offer high-quality family planning services including long-term methods. Nearly half of the Top Réseau providers signed on to provide this extra service. Another thirty-three providers outside of the network agreed to participate as “Profemina” certified providers. The experience proved to be successful and generated high IUD client numbers as there was intensive demand creation to accompany the improvements and investments on the supply side. From 2008-2010, PSI was able to offer long-term methods to 31,523 women through the Top Réseau and Profemina providers.

Moving forward in 2011 and beyond, PSI plans to dissolve the Profemina branding and focus solely on Top Réseau. The positioning of Top Réseau will be expanded to include a larger range of services and target a broader range of vulnerable groups. Top Réseau will consist of a network of clinics that offer services for all men and women of reproductive age. The basic package of services will be expanded to not only include the initial three core services, but also emergency contraception, post-abortion care, maternal and child health care, and cervical cancer testing. Providers will have the option to include add-ons such as: long-term family planning methods, HIV counseling and testing, and syphilis testing and treatment.

The integration of new services and new target groups has been largely welcomed by Top Réseau providers. With the exception of a certain number of providers who perceive these extensions as an added burden for which they will spend more time and lose more money, providers reported in a recent survey that they were most satisfied with the opportunity to gain new experiences and skills through growth of the network. The new strategy of increased services and target groups within the network is seen as a chance for increased client flow and greater technical expertise. Dr. Mino Andriamananjara, working in the Tamatave region, says that one of the most attractive aspects of the new strategy is the opportunity to evolve professionally and to expand into other services and target groups.

The biggest obstacle to integrating new services or addressing new target groups has been pricing. The ceiling price set by the network falls below the recommended minimum price of 5,000 ariary that the ONM recommends. The majority of providers have found that they ended up losing money on each individual Top Réseau client. Those that remained satisfied did so because they were able to recoup the losses through the increased client flow they benefitted from as network members or because of their humanitarian convictions. They also perceived the trainings, supervision and material assistance as important benefits offsetting some of the reduced earnings.

The latest policy that PSI/Madagascar is taking with the renewal of Top Réseau is to abolish the price ceiling and allow providers to fix their own rates for all services with the exception of those provided to high-risk groups or youth that present vouchers for family planning, STI treatment or VCT. While providers will be free to charge what they want, the network will continue to encourage them to keep prices reasonable for client access. Top Réseau providers have responded enthusiastically to this new policy coupled with the new overall network strategy.

44 Interview with Dr. Mino Andriamananjara, June 9th, 2011.
7. FINANCES

7.1 PRICES FOR COMMODITIES AND SERVICES
Adherence to the network has stipulated that providers must keep their fees for the target group within a recommended price range. The maximum price ceiling for consultations is about the equivalent of $0.75, which is less than many other private providers are charging and more than the public sector. The recommended price range is slightly lower than the Ministry of Health and ONM recommendations on consultation prices. Some clients still have difficulty meeting the low price at the network clinic. In these cases, peer educators are equipped monthly with a certain number of vouchers that provide a reduced fee with a small co-pay ranging from 500 - 1,500 ariary for consultation to the client depending on the region and the service requested. Top Réseau reimburses the provider at the end of the month for all vouchers received.

Although a gap exists between provider income needs and the consumer ability to pay, providers have accepted and appear to have mostly respected the price ceilings. In some areas the price is still reasonable for both the provider and the clients, in others providers feel the price is too low. Many providers report that the price ceiling causes them to endure a profit loss. Interviews with Top Réseau providers on this issue indicate that personal motivation for social action and the increased client flow helps to compensate for these individual losses.

PSI has verified adherence to price ceilings mostly through feedback from peer educators linked to clinics and mystery client surveys conducted on an irregular basis. Peer educator information has been provided ad hoc on this issue to the regional office and seems to indicate that providers in general do respect the pricing. This information may be biased by the close relationships that the peer educators have with network providers. In contrast, mystery client surveys have revealed discrepancies in price. For example in 2010 in Tamatave, at least one provider was charging nearly four times the fixed ceiling price. PSI has refrained from punishing or eliminating providers who commit infractions, but rather has tried to resolve issues through diplomacy and communications. Confronting these providers about their prices resulted in significant tensions between the providers and PSI regional coordinators. The providers lobbied for the freedom to fix their own prices, and PSI agreed to test the strategy in that region. At first, provider numbers went down when they raised their prices, but shortly thereafter their client flow resumed as usual. This convinced PSI both that the population could handle higher prices — although certain low-income clients might be left behind— and that the program could try applying the pricing strategy more broadly throughout the network.

With the new strategy starting in 2011, the fee ceiling point will be removed throughout the network and an analysis will be made of changes in client flow and provider satisfaction. After analysis, new pricing guidelines may be developed and put in place if deemed necessary. In such a case, PSI will likely only set a maximum service consultation fee for particular health services and will allow a flexible pricing strategy for the majority of health services. Nonetheless, providers will understand the expectation that network members assure prices remain affordable to lower income clients.

Member providers reap significant benefits from subsidies on commodities. Specifically, members of the network are able to procure PSI socially marketed products from the wholesalers at a reduced rate than at the regular detailer sales point. For certain products, such as the IUD, PSI sells directly to the providers at a price even more reduced than that offered by the Ministry of Health. No monetary incentives are provided to providers; non-monetary incentives and benefits include the donation of certain essential equipment, training and consumables that providers need to carry out their services.

Unfortunately, several network members have had difficulty recognizing the value of network benefits like the subsidies and non-monetary support. As a result, these providers have expressed dissatisfaction with the ceiling prices and lack of monetary support from PSI. PSI program management perceives the lack of “PR” regarding the subsidies and contributions to network providers and centers as a weakness in the strategy. In retrospect, highlighting these advantages and contributions might have resulted over the years in higher levels of overall satisfaction and less complaints.

Recognizing that the majority of the providers are focused on their basic material needs and making ends meet, it is difficult for most to look at the medium- and long-term gains that the network provides. Despite investments made by PSI to train providers on issues that add to the overall welfare of their
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In order to assure that Top Réseau clients can afford the consultation plus additional fees, PSI offers preferential pricing to network clinics on its socially marketed products. The majority of the products including short-term family planning methods, STI treatment kits, malaria treatment kits, mosquito nets and home water treatment solution, are available at the wholesaler price. The IUD is available directly from PSI at a subsidized price that is lower to members than through other available channels.

The network has also experimented with voucher schemes to assure that the most vulnerable clients are still able to access services. Top Réseau has been offering a certain number of vouchers per month in each region to clients in need of financial support. At first, the number of vouchers was unlimited, now there is a limit of 50 vouchers per peer educator per month. Generally there are at least 10-15 peer educators at each regional site.

7.2 PAYMENT SOURCES
The vast majority of clients in Madagascar pay out of pocket. The use of health insurance is not widespread; it is mostly limited to workplace-provided insurance policies. In most workplace insurance policies, clients are limited to a small pool of clinics that only cater to those covered by the insurance policy. None of the Top Réseau providers fall into this category; they are independent and expect payment at the time that services are rendered.

At the typical Top Réseau clinic, a client will need to pay a consultation fee and, in addition, a fee for any products or additional services rendered. The Top Réseau network has a cap set on consultation fees, but the client will sometimes have to pay more than this in order to receive the necessary treatment or product.

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The vouchers are distributed through the peer educators at their discretion. The regional coordinator or supervisor collects the used vouchers at each Top Réseau clinic at the end of the month. The regional office then reimburses the clinic for the full ceiling price of a consultation (about $0.75 to $1.00) per general voucher and $0.50 for a VCT specific voucher. Top Réseau supervisors and coordinators verify the vouchers that they pick up on a monthly basis from the clinic. This verification is generally limited to desk verification: they examine the provider register and make sure that there is an actual person recorded corresponding to the voucher details and they may also check with the IPC agent about the voucher.

PSI has encountered two difficulties with this system. The first issue is that the targeting of the vouchers has not been specific enough. Approximately 25% of clients with vouchers for family planning and 27% for STI services were in the highest socio-economic percentile and probably not the most vulnerable. The second issue is the case of at least one peer educator and Top Réseau provider acting in collusion to spin a profit off of turned-in vouchers with no actual client.

While these challenges have surfaced, the vast majority of vouchers have reached those in need simply because the vast majority of the population is living in extreme poverty. Many

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45 After lengthy discussions with the PSI program management team, she decided to stay in the network.
vouchers have been distributed without corruption and research shows that 26% and 20% of clients presenting with vouchers for family planning services and 21% and 29% of clients presenting for STI services were in the lowest to second lowest socio-economic quintile, respectively. To address the challenges but still support those in greatest need, peer educators have been trained on how to more carefully select and distribute vouchers to youth at high risk and high need.

During the two years when the Profemina certification and logo were used, PSI also employed a voucher scheme to help promote IUDs. This strategy allowed women to receive free or greatly reduced IUDs at the Profemina clinics; reimbursements to providers were made at the end of the month as done with Top Réseau. For a little-known product such as the IUD, this initial strategy was useful to break down some of the barriers to access and build demand. However this strategy was deemed costly and unsustainable, so it was gradually phased out completely.

PSI conducted a pilot project with vouchers for LTM services in the region of Antananarivo in 2010. The project was different and distinct from others that PSI had employed because it included the use of assessment tools by IPC agents to determine and filter vouchers to those women in greatest need. Potential clients were referred by their SES status to appropriate health centers, either in the public for free services or the private sector with voucher or for those with the financial means, the private sector with no voucher. These vouchers were valued at 2,000 ariary (about $1.00) and represented the cost for IUD insertion at the participating network clinic; PSI reimbursed the providers at the end of the month for each voucher received. Clients were still obliged to purchase the IUD at cost. PSI awaits the results of the research study that evaluated the pilot project to determine if the activities should be continued or not.

7.3 FRANCHISE FINANCES
PSI’s mid-term plans are to continue subsidizing services. There is significant pressure from certain donors to reduce the amount of subsidies on services, such as long-term family planning services. For this reason, vouchers are no longer distributed for LTM services outside of a limited number within the capital and are offered at a more restricted rate for youth and high-risk groups seeking short-term methods of family planning or STI/VCT services. Within the LTM service provision, PSI strives to achieve a CYP rate at $18.

Currently there is no cost-recovery plan envisioned. In the future such a plan may focus on increasing prices for treatment, as clients are more willing to pay higher prices for treatment as opposed to prevention. This might be applicable to STI treatment or the soon-to-be integrated services of treatment for malaria and acute respiratory infections.

7.4 DONORS
Top Réseau was initially financed by a grant from the GATES Foundation in 2000 for 2 years. Since then, follow-on funding for maintenance and extension has come from multiple sources such as supplementary grants from the GATES Foundation, the Global Fund (GFATM), USAID and a private donor. Currently, funding sources include USAID from 2008-2012 with 25.5 million dollars, of which 10.4 million is allocated to Top Réseau as well as funding from a private donor from 2010-2012 with 3 million dollars that will be used principally for provider training and demand creation. The GFATM contributes some funding to support demand creation within the project aimed at HIV/AIDS awareness and testing.

7.5 COST SUBSIDY PER UNIT
PSI currently has a cost per DALY of approximately $32; this figure is cross-cutting across all platform areas of health intervention, not just for Top Réseau. For long-term family planning method service provision, PSI tracks its cost for CYP and is currently at $18.

8. LOGISTICS

8.1 PROCUREMENT AND DELIVERY PROCESSES
PSI/Madagascar utilizes existing distribution channels to assure the flow of social marketing goods into the market. For short-term family planning methods and the STI
treatment kits, PSI uses the pharmaceutical chain, supplying first the pharmaceutical wholesalers who in turn supply retail outlets. For condoms, mosquito nets and malaria treatment, diarrhea treatment and home water treatment, commercial wholesalers are supplied who in turn supply retail outlets.

As a preferential benefit, Top Réseau network providers are linked via the PSI regional team to pharmaceutical and commercial wholesalers for supply of products instead of at retail outlets. For IUDs, Top Réseau providers procure the product directly from PSI, at a greatly subsidized price.

The PSI regional team verifies that the network providers always have a supply of at least the socially marketed family planning methods in stock. This is part of their regular monthly supervisory visit. Historically, PSI/Madagascar has not followed the flow of stock of these and the other PSI products. They have only followed the sales to youth, but not to other age groups. As a distribution channel with great potential, PSI missed the opportunity over the years for better tracking and possibly more optimization. This was not prioritized at the time at the risk of increasing paperwork and draining valuable time for the providers. However, starting in 2011, a new system will be put in place to follow up on the sales at network clinics, just as with any other distribution channel. It is expected that this monitoring will provide valuable information leading to better decision making about distribution strategies.

8.2 SALES AND INVENTORY MANAGEMENT

Sales and inventory management has been a weakness within the program. In fact, although network providers stock and sell many of PSI’s social marketed products, PSI has not yet put in place a mechanism to track these sales and their inventory at the clinic level. The only sales apart from the IUD that were monitored were those to the target group of youth, although product sales certainly were reaching other population groups. Since 2009, IUD sales and stock information has been followed and this information has been useful in following insertion trends and assuring sufficient stock levels at each participating clinic. The lack of sales monitoring for the other products has meant that this kind of valuable programmatic data has been lacking. Going forward in 2011, the program will be treating member clinics as an additional type of sales outlet, thus implementing a system to follow all product sales as well as inventory.

8.3 TECHNOLOGY

Up until now, the program has relied mainly on low-technology solutions. Most providers do not have access to computers so reporting is done on paper; for those few with access to computers, some will fill out their reports via a template. Generally, the providers fill out their hard copy reports, regional supervisors collect and enter the data, and this is sent by email to headquarters where all information is compiled and analyzed. In the future, the program is considering upgrading to data collection conducted through cellphone SMS systems.

There are two higher technology activities that the program does lead. One is an HIV/AIDS hotline that offers information and referrals to Counseling and Testing centers within and outside of Top Réseau. The program is considering expanding this hotline to deal with all health issues that Top Réseau will be covering from 2011.

The second activity is a branded youth-focused Facebook page. The youth communications campaign that supports Top Réseau is branded with the name and logo of “Ahy ny Safidy” which means, “It’s my Choice”. With 484 members to date, the webpage offers a forum for discussion among youth, peer educators and program staff on adolescent reproductive health issues. It is also a posting place for photos and videos of “Ahy ny Safidy” events and activities.

9. QUALITY ASSURANCE, MONITORING AND RESEARCH

8.1 QUALITY ASSURANCE

In terms of quality assurance (QA), the Top Réseau network has introduced norms and standards associated with providing youth-friendly reproductive health services. These are detailed in the Table 8.1 below. The Top Réseau norms and standards are monitored through regional supervisory visits, mystery client studies and rapid appraisals reviews by program staff. There have been no formal penalties or bonuses related to poor or superior performance; in cases of inferior performance, the program management team has chosen to work individually with the provider to develop
solutions rather than break the contract or inflict penalties. During trimester meetings, those providers who have shown exemplary service provision are recognized with small non-monetary gifts such as medical supplies, certificates or branded materials. This is done on an informal regional basis according to those providers who have made the most progress in improving their quality or those who have continuously done well during supervisory visits. Providers who have the best performance with relation to the norms and standards are invited to help co-facilitate trainings with new member providers.

<table>
<thead>
<tr>
<th>Categories of Quality</th>
<th>Sub-categories of Quality</th>
<th>Summary of Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Financial</td>
<td>All services should be affordable for the low-income clients, but should also be at prices that are acceptable and motivating for providers to offer the services of Top Réseau.</td>
</tr>
<tr>
<td></td>
<td>Geographic</td>
<td>Clinics should be situated in areas that are easy to reach but discreet.</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>The network should take into account local attitudes related to health services and assure that they are responded to appropriately.</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>Hours of the clinic should be convenient for clients and providers should assure that clients do not have a longer waiting time than 20 minutes.</td>
</tr>
<tr>
<td></td>
<td>Social</td>
<td>Providers should not restrict service provision based on age, sex, socio-economic class, religion, or any other social factor.</td>
</tr>
<tr>
<td>Norms</td>
<td>Technical</td>
<td>Providers should have appropriate technical aptitudes, knowledge and clinical competency to offer the services according to Top Réseau approved protocols.</td>
</tr>
<tr>
<td></td>
<td>Management</td>
<td>Providers should strive to collect appropriate client data, develop and improve stock management procedures, adequately attend to the upkeep of the facility and equipment, and train their personnel.</td>
</tr>
<tr>
<td></td>
<td>Security</td>
<td>Clients and providers in the network should feel safe: providers should assure that their locales are not dangerous (electric cords exposed, etc). Proper infection prevention procedures should be rigorously followed.</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>Appropriate referrals</td>
<td>Providers should know where to refer clients for high quality services that they are unable to offer and for resupply of medicine or health products (for example: resupply of pills or condoms).</td>
</tr>
<tr>
<td></td>
<td>At Top Réseau sites</td>
<td>Clients should be followed up with to assure that their needs are satisfied, that they are resupplying their medicine as appropriate, and that side effects are managed.</td>
</tr>
<tr>
<td>Information and</td>
<td>IEC/BCC</td>
<td>There should be an exchange of appropriate information in a simple, complete, concise and objective manner between the provider and the client. The client should be provided sufficient time to express his/her needs, worries, and expectations. The provider should use his/her knowledge and all available and appropriate IEC/BCC materials including Top Réseau materials.</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Informed Choice</td>
<td>Providers should assure that clients have the greatest variety of choices of family planning methods possible, including those not available at their clinic. The client should receive the method that she/he chooses.</td>
</tr>
<tr>
<td>Method Mix (Family</td>
<td>Intimacy</td>
<td>Providers must respect client intimacy at all moments, both sound and visual intimacy. Genital and pelvic exams must be done professionally, without comments, in an expedited manner focusing only on what is absolutely necessary. If possible, examinations of the body and especially the genitals should be done by a provider of the same sex as the client and should not be attended by assistants or other personnel. Intimacy and communication between provider and client should be assured during counseling as well.</td>
</tr>
<tr>
<td>Planning)</td>
<td>Interaction between</td>
<td>Providers must establish amicable rapport with clients, be polite and respectful, and avoid being judgmental, to allow clients to make informed decisions concerning their health.</td>
</tr>
<tr>
<td></td>
<td>provider and client</td>
<td>The Top Réseau sign and certificate should be clearly visible and well maintained in each clinic. Providers should work in a healthy, clean, and private environment, with interdiction to smokers, and assuring sufficient water and electricity. Strong attention should be given to assuring proper infection prevention controls.</td>
</tr>
<tr>
<td></td>
<td>Locale</td>
<td>All products should be stocked appropriately and resupplying should be done on a regular basis as needed.</td>
</tr>
</tbody>
</table>
With the introduction of long-term family planning methods in 2008, PSI developed a more intensive way of looking at quality assurance. The program developed a comprehensive QA plan based on norms, standards and protocols for service provision, in particular long-term family planning methods. These were based on national, international and PSI headquarters standards. Within the QA plan, PSI composed a dedicated QA team who train providers on long-term family planning method service provision, do follow-up supervision six weeks after trainings, conduct trimester technical supervision with providers, and annual evaluations. In addition, PSI conducts an external clinical audit every other year with each long-term family planning method provider. Up until now, this QA plan has been applicable only to those providers and clinics offering the long-term family planning services. However, PSI is adapting the QA plan to cover all network services and providers, in an effort to improve quality overall and apply more systematic and quantifiable standards. PSI has subcontracted with JHPIEGO to provide technical assistance in this domain.

8.2 MONITORING AND EVALUATION
PSI has a comprehensive monitoring and evaluation strategy for the Top Réseau network. On a monthly basis, regional supervisors and coordinators conduct supervisory visits with the provider and with IPC agents. On a semester and annual basis, rapid appraisal evaluations are made following a checklist reviewing provider-client interactions and facility standards; these evaluations are done through observation only and there is no interaction or feedback between the supervisor and the provider. Results are shared later on after analysis at the regional and headquarters level. Finally, every year or two, mystery client surveys are conducted within the network and the results are shared with the providers. As the network has grown, time and cost restraints have made it difficult to continue to conduct mystery client surveys at every provider center. To address this issue, PSI has adopted the use of LQAS sampling for the surveys. The latest round of surveys included 19 clinics throughout the country, from which PSI was able to share representative results to the providers.

For those providers who offer clinical services through the network such as long-term family planning methods or HIV counseling and testing, the PSI Quality Assurance team conducts a semester and annual quality assurance evaluation. In addition, an external team conducts a quality assurance audit every other year with a random sampling of provider clinics and a broad-reaching programmatic review.

Providers are enthusiastic about PSI’s shift to adapting the more stringent Quality Assurance plan measures to all Top Réseau providers. There has been some frustration with the evaluations done to date by observation only. Providers wish to have direct feedback, which is a key component of the procedures utilized by the QA team within the context of long-term family planning service provision. In addition, some providers perceive the extra attention to quality assurance as a means to improve technically and to excel among their peers.

PSI does not yet have a formal motivation scheme for network providers based on monitoring and evaluation results. With the onset of the new network strategy, PSI will be developing a set system to recognize providers who are doing good work.

8.3 RESEARCH
Operational research has guided programming for the franchised network. PSI/Madagascar has a highly capable in-house research team that has fostered a robust foundation of evidence-based programming. At the beginning of the project, a mix of quantitative and qualitative research was used to determine youth needs and expectations from youth-friendly clinics and providers, to develop the logo, slogan, and brand name and to establish and monitor baseline behavior change indicators.

Since 2005, PSI has conducted TRAC (Tracking Results Continuously) surveys every two years, which are targeted quantitative surveys that provide information on behaviors, attitudes and knowledge related to a specific health challenge. This allows PSI to tailor activities to most effectively have an impact on behavior change. It also provides a measurement tool for monitoring progress and impact across a range of variables.

Regularly scheduled mystery client studies provide feedback on provider performance and allow PSI to monitor and improve quality. This research methodology is applied primarily for general youth services. Initially the studies were conducted with each provider when the network was smaller; as it grew PSI has used LQAS sampling.

Communication campaign evaluations are conducted on a regular basis to help assess the results and better tailor ongoing
activities to the needs of the target groups. Additional research studies are conducted as operational challenges or questions arise: client and provider brand perceptions surveys and a client profile survey have helped with the network re-positioning strategy; a provider motivation survey helped examine key criteria for successful provider performance, new products and campaigns are pre-tested through target group research during the development process.

10. CHALLENGES AND OPPORTUNITIES

INTEGRATION OF NEW SERVICES
The biggest internal challenge that PSI/Madagascar has faced with implementing and maintaining the Top Réseau network has been to figure out how to best integrate more complicated services. When PSI started to seriously expand long-term family planning services for women of reproductive age, it began with creating a mostly parallel network, “Profemina” specifically for family planning. This resulted in a variety of programmatic difficulties, mainly due to the difficulty of coordinating two parallel but complementary networks. PSI struggled with a lack of efficiency and a redoubling of efforts by the franchise team. The majority of the doctors affiliated with Profemina were also Top Réseau members; regional supervisors were obliged to pass by the same provider twice in a month, once for the regular Top Réseau supervision and once for the Profemina visit. Providers were frustrated with the multiple visits and additional paperwork requested. Clients were confused about the difference between the two branded networks. The current re-positioning of Top Réseau and integration of all services under this branding will remedy the challenges cited above.

PRICING THAT ALLOWS FOR EQUITY OF SERVICE DELIVERY WITHOUT COMPROMISING PROVIDER PROFITABILITY OBJECTIVES
In terms of external challenges, the struggle to keep consultation prices low enough for consumers and yet allow for a sufficient profit margin for providers has been difficult. Many providers are at a profit loss with the ceiling prices set by the network. PSI has had to redouble its efforts to highlight other advantages and benefits offered by the network to offset the losses. Regional coordinators and supervisors have been asked to identify ways of communicating these kinds of benefits with the providers. The regional team has tried in some informal cases, to adopt a partner-type approach wherein they help assess the financial and client flow situation at each provider and troubleshoot problems. With help from the regional team, some providers have set their schedules to receive Top Réseau clients in usually low-frequented time spots; others have discovered that the increased client flow makes up for the lower individual consultation fee. The program plans to more formally train and engage the regional supervisors and coordinators as partners with the network providers; using interpersonal communication skills the regional team will try to better assist providers to weigh the real benefits and costs of network membership.

Although this helps the situation, it is not a solution: in 2011 PSI/Madagascar is piloting a strategy where providers are encouraged to keep prices low but are not bound by a ceiling point. The impact of this strategy on client access and equity across different socio-economic status levels will be assessed to provide for subsequent decision-making.

EQUITY OF SERVICE DELIVERY
Another important external challenge for the network is assuring equity of services. Currently, nearly all Top Réseau providers are located in urban areas and a few are in peri-urban sites. An increasing trend in the private sector is that the few providers located rurally are moving into the peri-urban and urban areas in search of better incomes. With the majority of the population living in rural areas and a growing paucity of private providers to collaborate with in these areas, reaching the majority of people in need is complicated.

BRAND REPOSITIONING
The upcoming challenge and biggest opportunity on the horizon for the network will be the re-positioning of the network brand. PSI will need to maintain the brand equity and repute that has been built up over more than 10 years, build upon this and expand its image. All indicators seem to point to the success of this upcoming strategy, but the true test will be implementation in the field.

With the new branding strategy, the network will be ripe for new services and products. It will be general enough in scope to allow for easy additions of other health issues. PSI globally is shifting more into service delivery and with PSI/Madagascar’s new strategy that reinforces their network and adds more flexibility; the network will serve as a good jumping board for even more continued extension.
Although this presents a great opportunity, there will be several challenges ahead to realizing the network potential. It will be important to coordinate with other organizations like Marie Stopes International, who are implementing similar types of franchised networks. This coordination will be essential to assure that the network activities complement and assure a greater coverage of the vulnerable population, as opposed to entering into direct competition with each other. In addition, now that Top Réseau will be adding new health themes to the repertoire of services, the network providers will be in increased competition with other private providers offering these other services. Finally, for a nation where the majority of the population resides in rural areas, the private sector trend is that providers are moving more and more towards urban areas. Rural areas have low market potential and are therefore being covered primarily by the public sector. To assure equity of services to the people who need it, PSI may need to innovate on ways to reach the rural population.

11. LESSONS LEARNED

11.1 PRIORITIZE SUPPORT AND PARTNERSHIPS
- It was extremely important for the success of the network to have top-level Ministry of Health support from the very beginning; this facilitated entry and buy-in from the decentralized government officials and among health professional organizations.
- The Top Réseau networks are firmly rooted in each region of implementation. Through the lobbying and series of public relations meetings and conferences held before implementation, PSI was able to assure community and stakeholder buy-in. This has proven essential to the stability of the network and its ability to weather the kinds of storms that inevitably arise with any program.

11.2 FOSTER GOOD COMMUNICATION AND CREATE DEMAND
- PSI has made significant efforts to maintain bi-directional communication with the providers. It has treated the providers as a partner and has been responsive to their needs and expectations when possible. This type of relationship building has been important to maintaining membership levels and satisfied partners.
- One of the key motivating elements for providers is the increased client flow that they perceive as a result of the PSI demand creation efforts. The multi-level campaign with complementary messages has helped get important behavior change messages out to the people who need it most, resulting in service-seeking behavior at the Top Réseau clinic. In contrast with the IUD experience from 2006-2008 when there was no supporting communications and virtually no demand for the services, demand spiked once intensive campaigns were put in place.

11.3 PRIORITIZE THE NETWORK WITHIN THE OVERALL PROGRAM
- The development of a strategic marketing plan for the network is very useful as a guide to keep programmatic strategy on-course. For several years, the network was considered a supporting product and thus was not accorded as much priority in overall resources as some of the socially marketed products. It is now recognized as important for prioritization and reaching service provision goals, to consider the network as a primary product.

11.4 PLAN FOR DATA COLLECTION AND ANALYSIS
- It is important to follow not only the service outputs but also the sales. For many years, PSI followed and recorded sales to the specific target group of youth. However, providers sold PSI’s socially marketed products to all ages. The lack of data on product flow and clientele makes it difficult to know the full potential of the clinics as a distribution channel, and to plan strategically.

11.5 UNDERSTAND AND RESPOND TO PROVIDER NEEDS
- Considering the providers as a target group is important. Since the provision of services is so dependent on the individual provider, it is crucial to assure the provider is competent, capable and motivated. Some of the products and services and conditions associated with the Top Réseau network have been innovative and different from the norm. As such, fully developed behavior change communications and advanced techniques in medical detailing are needed with the provider, to assure buy-in, comprehension, and competency.
- In addition, assessing and responding to ongoing training needs is important for maintaining quality levels. Finally, by studying and communicating with providers as a priority target group, PSI has been able to keep them motivated in their work with next-to-no attrition, despite significant challenges.
11.6 ALLOW FOR FLEXIBILITY

- A major key to success for the Top Réseau network was that membership did not mean that providers had to give up other activities. The Top Réseau network activities were not all encompassing and providers were encouraged to simply integrate them within ongoing offered services. This meant that providers were not limited in specialty and were not wholly dependent on the network for clientele. It has also meant that the Top Réseau clinics are perceived as being much more than just adolescent reproductive health services. This flexibility has allowed providers to flourish and has given PSI the opportunity to expand the types of services and products, as well as groups to target.

11.7 SELECT PROVIDERS CAREFULLY

- The program found that among the usual selection criteria for network membership (provider qualifications, facility standards, geographic proximity to the target group), another characteristic was very important: low to medium client flows. Those providers who entered Top Réseau with existing high client numbers were at first perceived as the ideal: a rapid way of reaching many people with targeted services. Yet, these providers quickly lost interest and motivation with the network; their time was stretched and increased client flow and reporting responsibilities were seen more as burdens than advantages. Instead, the program had more success with providers who were just starting out with their private practice or who had an established practice but did not yet have a high client demand. These providers were appreciative of the increases in client numbers and had sufficient time to participate more fully in the responsibilities of network membership including reporting and adhering to quality standards.

11.8 CLARIFY ROLES AND INTEGRATE INTERNALLY

- PSI’s experience with creating a parallel structure for the ProFemina network proved cumbersome, both externally and internally. The advantage of the new strategy wherein all services are integrated under the Top Réseau branded network allows for more clarity and less redundancy at the programmatic level. There will be one person at the regional level who is a focal point to providers for all technical areas, instead of several overlapping team members who address both one technical area and administrative/finance issues. This will mean more responsibility for regional supervisors and more opportunity for professional growth. At both the regional and the headquarters level, roles are better streamlined with division between administrative and finance team and technical issues to the program management.

11.9 START SMALL, AND THEN GROW

Starting off limited in scope allowed the program to develop a foundation from which to build upon later. PSI and the providers were able to develop a system for collaborating across a certain limited number of themes and for assuring a mutually beneficial partnership. The first few years presented a steep learning curve; Top Réseau was the first social franchise network in Madagascar. With this experience and base, PSI is in a position now where it can build and expand upon the network.

12. APPENDIXES

12.1 INTERVIEWS CONDUCTED

Antananarivo Region
Dr. Andry Nirina Rahajarison, Director of the Health Services Department
Dr. Mbola Razafimahefa, Coordinator of Social Franchising

Antsirabe Region
Dr. Dina Randriambololona, Regional Social Franchising Coordinator
Dr. Muriel Rajaona Rakotonirainy, Top Réseau Provider

Tamatave Region
Dr. Sandra Rabenja, Regional Social Franchising Coordinator
Dr. Mino Andriamananjara, Top Réseau Provider
Anasthasie Rasoamalala Harivony, Peer Educator/Outreach Worker
Olga (last name not requested to retain her confidentiality), Top Réseau client
FICHE D’ÉVALUATION DU CENTRE

Nom de l’Evaluateur: ________________________________________________
Titre : ____________________________________________________________
Date de l’évaluation: ________________________________________________
Nom du Centre : ____________________________________________________
Nom de l’interlocuteur: ______________________________________________
Fonction au sein du centre : __________________________________________
Adresse du Centre et Téléphone : _____________________________________

PARTIE I/ MOTIVATION ET DISPONIBILITE POUR LES FORMATIONS

Motivation à adhérer au réseau de prestation :
Prêt à mettre en place l’enseigne TOP Réseau au niveau du centre (à une place bien visible à l’extérieur du centre) oui non

Motivation à offrir les services IST/PF/Santé de l’enfant
oui non

Visite de Monitoring :
Accepte à recevoir des visites de support technique régulières de la part de PSI ? oui non

Norme de qualité :
Accepte de suivre et respecter les protocoles de prestation de service dans ces domaines oui non

Information :
Accepte de partager les résultats des données récoltées par votre centre en ce qui concerne nos domaines de collaboration, suivant un calendrier régulier oui non

Formations :
Disponibilité pour la formation initiale oui non

Disponibilité pour des renforcements de capacité périodiques oui non

Disponibilité pour les réunions d’échange périodiques du réseau oui non

En cas de « NON » à l’une de ces questions, ne continuez pas. Centre à exclure des centres potentiels

OFFRE DE SERVICES PF MLD :
1. Etes-vous intéressé à offrir des services de counseling, pose et retrait de méthodes Contraceptives de Longues Durée (DIU, Implants) dans votre centre en tenant compte du temps à passer (entre 30 et 45 minutes) avec une cliente pour cette prestation? (avec une moyenne de 4 à 6 clientes par jour)
□ Oui
□ Non

PARTIE II : REGULARITE DE LA SITUATION D’EXERCICE

Régularité de la cotisation annuelle en cours oui non

Avez-vous une autorisation légale d’ouverture du ministère de la santé et ONM oui non

En cas de non régularité, sous réserve de l’engagement du prestataire, on peut passer à la partie III

PARTIE III/ EVALUATION DU CENTRE
CRITERES DE NIVEAU 1 : INFRASTRUCTURE

Infrastructures existantes

<table>
<thead>
<tr>
<th>Salle de consultation et d’examen</th>
<th>Total de points</th>
<th>Points obtenus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Espace disponible et privé, le nombre total de salles (le nombre élevé de salles)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**12.2 PRE-SELECTION CHECKLIST FOR POTENTIAL TOP RÉSEAU PROVIDERS/CLINICS**

**Matériels**

- ☐ Eau courante
- ☐ Electricité
- ☐ Table d’examen
- ☐ Balance pèse-personne
- ☐ Spéculum vaginal
- ☐ Système de traitement des déchets

**TOTAL NIVEAU 1 : Infrastructure**

<table>
<thead>
<tr>
<th>CRITERES DE NIVEAU 3 : ACCESSIBILITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible à la population cible</td>
</tr>
<tr>
<td>Situé dans un lieu où la population cible viendra probablement chercher les services de soins et de santé</td>
</tr>
<tr>
<td>Centre financièrement accessible à la population cible : ont-ils une politique adaptée aux clients à faible revenu tel qu’un barème de prix décroissant suivant les capacités financières du client?</td>
</tr>
<tr>
<td>Moyenne mensuelle de clients par prestataire (moyenne mensuelle clientèle PF)</td>
</tr>
</tbody>
</table>

**TOTAL DES POINTS GENERAUX OBTENUS**
## 1. BUSINESS MODEL

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Proéminent</th>
<th>Discret</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Logo de la franchise</td>
<td>Attached convenablement</td>
<td>Non</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Heures d’ouverture affichées à l’extérieur</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>1.3</td>
<td>Médecin disponible ou notice d’absence affichée</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>1.4</td>
<td>Prix affichés</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>1.5</td>
<td>Manuel de qualité disponible</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>1.6</td>
<td>Certificat PSI exposé</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
</tbody>
</table>

TOTAL SCORE Grade

Instructions: 6/8 à classer grade “A” et 5/8 à classer grade “B”; 1.1 doit être inclus pour grade A ou B

## 2. REGISTRE DES CLIENTS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Oui</th>
<th>Non</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Système de registre de tous les clients disponible</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>2.2</td>
<td>Registre client jeune TR disponible</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>2.3</td>
<td>Registre Client à jour</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
</tbody>
</table>

TOTAL SCORE Grade

Instructions: 3/3 à classer grade “A” et 2/3 à classer grade “B”; 2.2 doit être inclus pour grade A ou B

## 3. PREVENTION DES INFECTIONS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Oui</th>
<th>Non</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Lieu pour se laver les mains : Savon et serviette en place</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>3.2</td>
<td>Décontamination des instruments médicaux appliquée</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>3.3</td>
<td>Désinfection des instruments appliquée</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>3.4</td>
<td>Dispose d’une méthode pour se débarrasser des aiguilles</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>3.5</td>
<td>Bac à ordure pour les autres matériels</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>3.6</td>
<td>Entreposage en sécurité des instruments</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
</tbody>
</table>

TOTAL SCORE Grade

Instructions: 6/6 à classer grade “A” et 5/6 à classer grade “B”; 3.1 doit être inclus pour grade A ou B

## 4. SALLE de CONSULTATION

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Oui</th>
<th>Non</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Rideau ou panneau séparateur disponible</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.2</td>
<td>Intérieure non vue de l’extérieur</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.3</td>
<td>bureau arrangé dans le coin</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.4</td>
<td>table d’examen</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.5</td>
<td>Electricité</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.6</td>
<td>Eau courante</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.7</td>
<td>Propreté</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
<tr>
<td>4.8</td>
<td>Préservatif disponible pour la clientèle</td>
<td>Oui</td>
<td>Non</td>
<td>Score</td>
</tr>
</tbody>
</table>

TOTAL SCORE Grade

Instruction: 6/8 à classer grade “A” et 5/8 à classer grade “B”; 4.1 et 4.7 doivent être inclus pour grade A ou B
12.3 RAPID APPRAISAL SUPERVISORY CHECK-LIST

### 5. SALLE D’ATTENTE

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Plus de 4 sièges disponibles</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>5.2</td>
<td>Inaudible par rapport à la salle de consultation</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>5.3</td>
<td>Radio ou télévision en sourdine</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>5.4</td>
<td>Propreté</td>
<td>Oui</td>
<td>Non</td>
</tr>
</tbody>
</table>

TOTAL SCORE | Grade

Instruction: 3/4 à classer grade “A” et 2/4 à classer grade “B”; 4.1 et 4.4 doivent être inclus pour grade A ou B

### 6. APPRO SUPPORT IEC

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Boîte à image IST disponible à portée des mains</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.2</td>
<td>Boîte à image PF disponible à portée des mains</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.3</td>
<td>Pénis en bois disponible</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.4</td>
<td>Kit de prévention</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.5</td>
<td>Préservatif de démo</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.6</td>
<td>Dépliants TOP Réseau</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.7</td>
<td>Bandes dessinées</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.8</td>
<td>Magazine 100% jeune</td>
<td>Oui</td>
<td>Non</td>
</tr>
<tr>
<td>6.9</td>
<td>autres (lister par nom)</td>
<td>Nom</td>
<td>Qté</td>
</tr>
</tbody>
</table>

TOTAL SCORE | Grade

Fréquence de la visite par le Superviseur de TOP Réseau

### 7. ATTITUDES du prestataire, PROBLEME GENERAL et COMMENTAIRES

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Motivé à rester dans le réseau</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>7.2</td>
<td>Augmentation de la clientèle</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>7.3</td>
<td>Autres avantages perçus par le médecin</td>
<td>+++++</td>
<td></td>
</tr>
</tbody>
</table>
| 7.4 | TOP RESEAU : positif pour les jeunes | PROBLEMES :
COMMENTAIRES :

TOTAL SCORE | Grade

MOIS de la supervision : | Nombre de clients SR du mois précédent :
GRADE mois précédent : | GRADE mois actuel :

RECAP actions à faire pour le mois prochain :
La présente Convention (ci-après la « Convention ») de mise en œuvre de réseau de centres de Santé de la Reproduction des Adolescents (ci-après «Franchise SRA ») a été établie ce ____________

Entre :

- ASSOCIATION MALGACHE DE MARKETING SOCIAL - POPULATION SERVICE INTERNATIONAL/MADAGASCAR, organisation non gouvernementale dûment enregistrée conformément aux lois de Madagascar, siégeant à l’Immeuble FIARO - Ampefiloha - Antananarivo 101,

représentée par ________________

ci-après dénommée « AMMS - PSI/MADA »

d’une part,

et

- _______________ dont le siège se trouve à ________________

représentée par ________________

ci-après dénommée « La Clinique franchisée »

d’autre part,

IL A ETE PREALABLEMENT EXPOSE QUE:

En septembre 1999, POPULATION SERVICES INTERNATIONAL, Inc. aux Etats-Unis (PSI), association mère de AMMS - PSI/MADAGASCAR (AMMS - PSI/MADA), a signé avec une fondation privée aux USA, une Convention de Coopération dans laquelle PSI a accepté d’utiliser son savoir-faire et ses ressources, ainsi que ceux de ses filiales réparties dans le monde, pour la prévention contre les Infections Sexuellement Transmissibles (« IST ») et le Syndrome de l’ImmunoDéficience Acquise (« SIDA ») dans les pays en voie de développement.

Aussi, sous les auspices et avec l’approbation du Ministère de la Santé Malgache, AMMS - PSI/MADA va développer un réseau de centres régionaux spécialisés dans les services (ci-après les Services) SRA, ci-après dénommé le Projet.

Il est entendu que la clinique franchisée a déjà franchi toutes les étapes nécessaires pour être admise en tant que membre du réseau de services SRA, tel que décrit dans le Manuel de franchise TOP Réseau, qui fait partie intégrante de cette convention. La clinique franchisée accepte de participer à la mise en place et au développement de ce réseau, pour cela il est convenu qu’elle offre des services de haute qualité respectant les normes et pratiques professionnelles en matière de SRA.

AMMS - PSI/MADA et La Clinique franchisée, chacune agissant par l’intermédiaire de son représentant dûment mandaté,

ONT CONVENU ET ARRETE CE QUI SUIT :

Article Premier : DE LA CONVENTION

Section 1.1 : Nature

La Clinique franchisée accepte de fournir des Services de Santé de la Reproduction conviviaux pour les jeunes dans les conditions spécifiées dans l’article II de la Convention et dans le Manuel de Franchise TOP Réseau.

AMMS - PSI/MADA accepte de fournir une assistance technique et en matière de gestion, les kits de prévention, ainsi que certains autres services de support, d’information, stipulés à l’article II de la Convention.
Section 1.2 : Date d'entrée en vigueur
La Convention entrera en vigueur dès sa signature par les deux parties.

Section 1.3 : Durée
La durée de la Convention est de une (1) année à partir de sa date d'entrée en vigueur.
Sur accord mutuel des parties, la durée de la Convention peut être soit prolongée conformément aux dispositions de la Section 4.6, soit écourtée selon les termes de la Section 4.10.

Article II : DES ENGAGEMENTS DE AMMS - PSI/MADA
Conformément à la politique nationale en matière de SRA, les engagements de AMMS - PSI/MADA sont définis comme suit :

Section 2.1 : Assistance Technique
Dans le but de renforcer la capacité des prestataires et afin d'améliorer la qualité des Services pour les jeunes, AMMS - PSI/MADA fournira au profit de La Clinique franchisée une assistance technique régulière et un suivi au niveau :
(A) De la formation et de la remise à niveau des connaissances du staff de La Clinique franchisée en matière de :
  • Counseling selon l’approche jeune,
  • Prise en charge des IST,
  • Prise en charge en matière de Planification Familiale ;
  • Autres formations considérées comme appropriées
(B) Du développement des documents et matériels :
  • d’Information, d’Education et de Communication (IEC),
  • de promotion,
  • de supports nécessaires pour la mobilisation de la communauté ;
(C) De la surveillance du respect des normes, de leur évaluation et de leur remise à niveau afin d’assurer la qualité. A cet effet, AMMS - PSI/MADA se réservera le droit d’utiliser les « Clients Mystères » et/ou des entretiens avec les clients actuels de La Clinique franchisée comme une des méthodes d’évaluation de la qualité des services offerts et un superviseur effectuera des visites régulières et périodiques au sein de La Clinique franchisée ;
(D) Du développement des systèmes de collecte et de gestion de données, comprenant les registres TOP Réseau, suivant le modèle donné à l'annexe 1 ;
(E) De la production de rapports périodiques sur toutes les activités du réseau SRA, incluant les rapports d’activités ;
(F) De la formulation des procédures d’organisation ainsi que de la stratégie à appliquer par La Clinique franchisée ;
(G) De la coordination des réunions périodiques entre tous les participants au Projet dans l’objectif de se communiquer les informations.
(H) AMMS - PSI/MADA dans l’exécution des activités de Suivi et d’Evaluation respectera et prendra en considération la disponibilité, la responsabilité et les obligations des prestataires envers les utilisateurs.

Section 2.2 : Supports divers
Conformément à la politique nationale en matière de SRA, AMMS - PSI/MADA fournira au profit de La Clinique franchisée, les outils suivants :
(A) Un Manuel de franchise complet et détaillé, faisant partie intégrante de cette Convention, traitant des normes standard relatives aux Services à fournir par La Clinique franchisée (ci-après dénommé le Manuel de franchise) ;
(B) Des kits de prévention IST que La Clinique franchisée distribuera au cours de la prestation des Services qu'elle va faire dans le cadre du Projet ;
(C) Les documents instructifs et matériels IEC pertinents, éducatifs et attrayants, à mettre à la disposition des clients du réseau pour qu'ils puissent les emporter ;
(D) Un modèle de pénis en bois et une certaine quantité mensuelle d’échantillon de préservatifs.
Section 2.3 : Actualisation des connaissances sur la Politique Nationale de SRA et des IST/SIDA
AMMS - PSI/MADA informera La Clinique franchisée à propos de toutes les politiques nationales en matière de SRA et IST/SIDA, et l’informerà également par écrit de tout changement dont ces politiques pourraient faire l’objet.

Section 2.4 : Le Logo
AMMS - PSI/MADA autorisera La Clinique franchisée à utiliser le Logo (ci-après le Logo) du réseau SRA suivant le modèle donné à l’annexe II, pendant la durée prévue par la Section 1.3 ci-dessus, en respectant les exigences prévues par les Sections 3.7 et 4.5 de la présente Convention.
A cet effet, AMMS - PSI/MADA fournira à La Clinique franchisée la(les) maquette(s) du Logo et donnera les instructions d’utilisation et d’affichage.

Section 2.5 : Promotion des Services
AMMS - PSI/MADA développera et exécutera des campagnes promotionnelles de marque et générique à travers le mass média, les pairs éducateurs et le ciné mobile pour stimuler la prise de conscience et l’intérêt pour ces Services ainsi que pour susciter leur utilisation.
AMMS - PSI/MADA plaidera en faveur de ces Services pour rechercher le soutien des institutions gouvernementales, du secteur privé, de la population en général et des organisations travaillant au bénéfice de la population.

Article III : DES ENGAGEMENTS DE LA CLINIQUE FRANCHISÉE

Section 3.1 : Généralités
La Clinique franchisée s’engage à fournir des Services de SRA dont elle sera responsable. Ces Services devront être de très haute qualité et en accord avec les exigences de la Convention, notamment en matière de relations avec la clientèle, d’assistance à la formation initiale des prestataires, ainsi que de respect des règles relatives à la confidentialité.
Les médecins de La Clinique franchisée s’engagent à payer la cotisation annuelle pour devenir membres du réseau. Cette cotisation doit être payée à AMMS - PSI/MADA après la signature de la Convention pour les nouveaux membres, et lors de la signature de la prolongation de la dite Convention pour les anciens membres.
Les médecins de La Clinique franchisée doivent approuver et signer la lettre d’agrément dans l’Annexe II du Manuel de Franchise TOP Réseau.

Section 3.2 : Respect des normes standard en matière de services
La Clinique franchisée réservera un cadre accueillant et confortable aux clients et respectera les normes standard en matière de Services, comme stipulé dans le Manuel de franchise.

Section 3.3 : Respect des normes de qualité en matière de Services
(A) La Clinique franchisée doit suivre les normes de qualité des soins stipulées dans l’Annexe III de cette Convention que AMMS – PSI/MADA se réserve le droit de faire les supervisions et les évaluations par des enquêtes
(B) La Clinique franchisée devra disposer de tous les équipements et de l’espace nécessaire et convenable pour une fourniture de Services de haute qualité et de maintenir ce niveau de qualité même en face d’une demande croissante des utilisateurs.
(C) L’équipement minimum et l’espace nécessaire exigés pour la fourniture des Services par La Clinique franchisée en conformité à la Convention seront détaillés dans l’annexe IV.
(D) Si La Clinique franchisée, pour une raison ou une autre, n’est pas en mesure de maintenir comme convenu la haute qualité des Services, elle doit en informer le Responsable de PSI le plus tôt possible.

Section 3.4 : Personnel adéquat
Stipulé dans l’annexe V : Personnel
La Clinique franchisée fournira au moins, un médecin formé en SRA, PF et prise en charge des IST par l’Approche syndromique, reconnu capable par AMMS - PSI/MADA, de réaliser les tâches décrites par la Convention.
Toutefois, pour assurer une meilleure qualité de service et d’accueil, il est recommandé que La Clinique franchisée recrute d’autres médecins ainsi qu’un ou plusieurs personnels paramédicaux et une personne chargée de l’accueil, tous formés et reconnus par AMMS - PSI/MADA.

Section 3.5 : Fourniture de Services de Santé de la Reproduction pour les jeunes
Afin de maintenir la plus haute qualité et l’uniformité au niveau des pratiques en matière de fourniture de Services pour les jeunes, La Clinique franchisée acceptera de:

(A) Faire en sorte que tout membre de personnel en relation, de quelque manière que ce soit, avec les utilisateurs du réseau SRA, respecte et applique les normes TOP RESEAU, notamment :
   • celles formulées par écrit sous forme d’instructions et de directives,
   • celles communiquées verbalement ou par écrit concernant l’éthique en matière de conseil aux utilisateurs,
   • les procédures et les engagements de confidentialité stipulés dans le Manuel de franchise, mais d’une manière non exhaustive ;

(B) Faire en sorte que tous les personnels paramédicaux participent à TOUTES les formations et à tous les ateliers organisés à leur profit par AMMS - PSI/MADA. Qu’ils respectent toutes les procédures relatives aux Services de SRA stipulées dans le Manuel de franchise et prescrites par AMMS - PSI/MADA ;

(C) Faire en sorte que les préservatifs, ainsi que les modèles de pénis en bois soient à tout moment disponibles à des fins de démonstrations ;

(D) Faire en sorte qu’un stock adéquat de produits pharmaceutiques du marketing social, notamment le PILPLAN, CONFIANCE, CURA 7 et GENICURE, soient à tout moment disponibles en cas de besoin

(E) Prendre en compte de façon objective les réclamations de l’utilisateur et les appliquer d’une manière effective ;

(F) Respecter tous les protocoles écrits, les directives et les algorithmes fournis par AMMS - PSI/MADA, concernant la prise en charge des IST ;

(G) Maintenir un stock suffisant de documents et matériels tels que ceux relatifs à l’IEC, et s’assurer qu’ils sont distribués aux utilisateurs ;

(H) Se conformer aux autres normes et exigences spécifiées par les lois et règlements du Gouvernement Malgache, ou les exigences pouvant être prescrites par le Ministère de la Santé ou l’Ordre National des médecins ;

(I) Participer activement à la réalisation et au développement du réseau TOP RESEAU, en s’acquittant des cotisations annuelles et en assistant, au moins, à 75% des séances de réunion périodique organisées par AMMS - PSI/MADA dans l’année ;

(J) Suivre les normes et standards mentionnés dans le Manuel de Franchise et le curriculum de formation.

Section 3.6 : Frais pour les Services SRA

(A) Pour la fourniture des Services, La Clinique franchisée fera payer aux utilisateurs des honoraires dont le montant est spécifié dans l’annexe VI selon l’accord des deux parties.

Etre disposée à fournir, à la discrétion du médecin, les services gratuitement ou à prix réduit pour ceux qui n’ont pas la possibilité ou ont des difficultés de payer ces honoraires .

(B) Le montant des honoraires pour les Services SRA devra être affiché d’une manière bien visible dans la salle d’attente et/ou dans la salle de réception des utilisateurs SRA.

Section 3.7 : Affichage du Logo

La Clinique franchisée affichera à l’extérieur dans un lieu bien en vue, et non loin des locaux affectés à la fourniture des Services, le Logo mis à sa disposition par AMMS - PSI/MADA, dans le cadre du Projet dont la dimension maximale ne doit pas excéder 45cm x 30cm.

La Clinique franchisée utilisera le Logo pour identifier toutes ses activités SRA.

Pour l’utilisation du Logo, La Clinique franchisée se conformera strictement aux exigences prescrites par AMMS - PSI/MADA, au nom du Projet.

Section 3.8 : Suivi, Evaluation, Tenue des dossiers

Pour maintenir et conserver le niveau de qualité des Services du TOP RESEAU, des activités de Suivi et d’Evaluation seront effectuées durant
l’année, de ce fait :

(A) La Clinique franchisée coopèrera pleinement à toutes les évaluations qu’effectuera AMMS - PSI/MADA concernant ces activités SRA. Pour ce faire, La Clinique franchisée autorisera AMMS - PSI/MADA à accéder à ses locaux et dossiers (sauf les dossiers médicaux des patients qui relèvent du secret Médical) ainsi qu’à s’entretenir avec le personnel pour permettre périodiquement à cette dernière de faire des observations et des évaluations ;

(B) La Clinique franchisée acceptera de:
1. Remplir le registre TOP Réseau pour chaque utilisateur jeune (15 à 24 ans), et/ou leur partenaire référé.
2. Remplir toute autre fiche dont AMMS - PSI/MADA pourra exiger l’établissement,
3. Soumettre toutes les fiches de suivi ou d’évaluation sus-mentionnées aux agents de AMMS - PSI/MADA.

Section 3.9 : Impôts et Taxes
La Clinique franchisée sera seule responsable du paiement de tous les impôts et taxes ou autres charges dues auprès des institutions gouvernementales malgaches concernant ses propres activités, dévolues et stipulées par la Convention, comprenant sans aucune limitation, les impôts des salariés ainsi que l’ensemble des taxes consécutives à l’exécution des Services ou autres, de sorte que AMMS - PSI/MADA ne puisse jamais être recherchée ou inquiétée à ce sujet.

Section 3.10 : Documents écrits et Publications
La Clinique franchisée se conformera aux directives de AMMS - PSI/MADA, concernant l’utilisation et la distribution des publications ou autres documents écrits qui lui sont fournis par AMMS - PSI/MADA.

Section 3.11 : Accès à la Communauté (participation aux activités communautaires promotionnelles du réseau SRA)

(A) A la demande de AMMS - PSI/MADA, La Clinique franchisée participera activement, selon sa disponibilité, à toutes les interventions d’Information Education et Communication telles que : les séances de sensibilisation, les événements spéciaux, les plaidoyers, les programmes radiophoniques, les spots télé, etc. du réseau SRA, quelle que soit leur envergure, locale, régionale ou nationale.

Article IV : DISPOSITIONS COMPLEMENTAIRES

Section 4.1 : Relations juridiques
La Convention n’a pas pour objet et ne peut avoir pour effet de créer une relation de dépendance ou une relation de société entre les parties ni vis à vis des tiers.
L’une ou l’autre des parties effectuera les communications et démarches appropriées et raisonnables pour clarifier le caractère purement contractuel de leurs relations auprès des autres individus et entités avec lesquels elles sont en relation. On ne peut opposer à l’autre partie tout agissement non conforme aux mœurs ou aux lois en vigueur à Madagascar.

Section 4.2 : Effet relatif
La présente Convention n’a d’effet qu’entre les parties contractantes.

Section 4.3 : Conformité avec les Lois en vigueur
Chaque partie se conformera entièrement aux lois et règlements en vigueur, applicables aux activités dévolues à chacune d’elles. Entre autres la conformité aux lois et règlements qui régissent l’interdiction des actes d’Interruption Volontaire de la Grossesse dans ce cadre, chaque partie devra pouvoir justifier, à tout moment, des éventuelles autorisations et licences nécessaires pour l’exercice de ses activités.

Section 4.4 : Confidentialité
Chaque partie se porte garant du caractère confidentiel de toutes informations émanant et concernant l’autre partie ou lui appartenant par ses employés et agents.
Chaque partie ne peut utiliser et dévoiler de telles informations, que dans les cas mentionnés ci-dessous :

(A) S’il existe une autorisation écrite de l’autre partie ;

(B) Si elle y est contrainte en vertu de dispositions légales ou de décisions judiciaires ;

(C) Si celles-ci sont devenues publiques, d’une manière autre que par violation par l’une ou l’autre partie des dispositions de la Convention.

Section 4.5 : Propriété intellectuelle

(A) PSI détiendra d’une manière exclusive, tous les droits relatifs à ses propriétés intellectuelles, y compris sans limitation, les marques déposées, les marques de service, les noms de marques, les droits d'auteur et de copie et les patentes (« PI ») que PSI aura mis à la disposition de La Clinique franchisée aux fins d’utilisation dans le cadre exclusif de la Convention.

PSI détiendra d’une manière exclusive les droits de propriété intellectuelle, plus particulièrement et sans limitation, sur le nom, le Logo, le Manuel de franchise, les matériels didactiques et tous les matériels IEC ou promotionnels mis à la disposition par AMMS - PSI/MADA de La Clinique franchisée pour leur utilisation dans le cadre exclusif de la Convention.

(B) AMMS - PSI/MADA délivrera à La Clinique franchisée les autorisations nécessaires pour l’utilisation dans le cadre exclusif de la Convention, de tels droits de propriété intellectuelle détenus par PSI.

La Clinique franchisée ne pourra ni revendiquer l’exclusivité d’utilisation de ces droits de propriétés intellectuelles, ni les transférer ou céder à des tiers.

(C) Cette clause ne peut avoir pour effet de permettre à La Clinique franchisée d’utiliser les droits de propriété intellectuelle de AMMS - PSI/MADA, postérieurement à l'expiration de la Convention.

Section 4.6 : Amendements

La Convention pourra à tout moment, faire l'objet de modifications par avenant écrit signé par les représentants autorisés des deux Parties.

Section 4.7 : Cession

Ni la Convention, ni aucun des droits ou obligations qui en découlent ou qui y sont liés, ne peuvent être cédés par l’une ou l’autre partie sans le consentement écrit et préalable de l’autre.

Section 4.8 : Indemnisation

La Clinique franchisée maintiendra PSI, AMMS - PSI/MADA et toute entité juridique du groupe PSI ainsi que leurs directeurs, cadres et employés à l'abri de toutes réclamations, obligations et/ou dommages pouvant être engendrés par elle ou par les éventuelles actions de ses filiales, directeurs, cadres et employés ou contractants.

Si le cas se produit, La Clinique franchisée s'engage à indemniser PSI et AMMS - PSI/MADA pour les dommages causés.

Section 4.9 : Conditions interférant avec l'exécution des obligations

Chaque partie notifiera à l’autre par écrit la survenue de tous événements et/ou de leurs effets pouvant interférer ou susceptibles de le faire sur l'exécution complète, opportune et effective des droits et obligations qui lui ont été conférés selon les termes de la Convention.

Section 4.10 : Résiliation de la Convention

(A) Chaque partie peut résilier la Convention, à tout moment, sous réserve d'avisé l’autre partie par écrit de sa décision trois mois à l’avance.

(B) AMMS - PSI/MADA peut résilier la Convention à tout moment, avant sa date d'expiration, si La Clinique franchisée manque de se conformer à l’une quelconque de ses obligations matérielles et/ou ne satisfait pas les conditions et normes spécifiées par la présente et/ou le Manuel de Franchise et omet de réparer un tel manquement dans les 15 jours qui suivent la réception d’une lettre de mise en demeure émanant de AMMS - PSI/MADA.

Section 4.11 : Loi régissant la Convention
En cas de litiges quant à l’application ou l’interprétation de la Convention, et/ou des droits et obligations en découlant, ceux-ci seront traités par un arbitre désigné par les parties, ou à défaut d’accord entre elles, par le Président du Tribunal de Première Instance, conformément aux dispositions de la loi n° 98-019 du 11/11/98.

Section 4.12 : Notifications
Sauf dans les cas d’exception expressément spécifiés, toute notification émanant de l’une vers l’autre partie dans le cadre de la Convention, devra être faite par écrit, et transmise en personne, ou par la poste avec accusé de réception, et sera considérée donnée ou envoyée dès sa transmission vers les adresses suivantes :

A AMMS - PSI/MADA
Population Services International/ Madagascar
Immeuble FIARO - Escalier D 2ème étage
Ampéfiloha - 101 Antananarivo ou
Tél. (261) 20 22 629 84
Fax (261) 20 22 361 89
A __________

Section 4.13 : Accord complet
A partir de sa date d’entrée en vigueur, la Convention constitue l’accord complet, exclusif et final des parties concernant le sujet spécifié. Elle remplace et annule tous accords ou arrangements antérieurs qui auraient pu intervenir entre elles, qu’ils soient verbaux ou écrits.

Le Représentant de La Clinique franchisée
AMMS - PSI/MADA
12.5 ORGANIGRAMS: PSI/MADAGASCAR SENIOR MANAGEMENT AND HEALTH SERVICES

ORGANIGRAMME GÉNÉRAL

* En orange - les positions proposées, En vert - les positions existantes