



USAID
FROM THE AMERICAN PEOPLE



Integrated Social Marketing Program (ISM)

USAID Annual Report FY January-September 2013

Submitted November 25, 2013

PSI Madagascar
Immeuble FIARO, Rue Jules RANAIVO
ESCALIER D, 2ème Etage
BP 7748; Antananarivo 101
Madagascar
Phone: + 261 20 22 629 84
Fax: + 261 20 22 361 89

Table of Contents

List of Acronyms and Definitions	i
Introduction	1
Intermediate Result One: Increased Adoption and Maintenance of Healthy Behaviors	4
Intermediate Result Two: Improved Quality of Selected Health Services in the Private Sector	10
Intermediate Result Three (IR3): Increased Availability of Life Saving Health Products and Services	18
Cross Cutting Issues: Research, M&E, Gender and Environmental Standards	27
Annex A: Work Plan Activity Status Update (Attached)	
Annex B: Results Framework and Quarterly Activity Results (Attached).....	
Annex C: Distribution Graphs (Attached)	
Annex D: Family Planning Compliance Plan (Attached)	
Annex E: Environmental Mitigation and Monitoring Plan (Attached).....	
Annex F: Participant Training Information (Attached).....	
Annex G: Success Story (IUD) (Attached).....	
Annex H: Gender Assessment Report (Attached)	
Annex I: Research Reports (Attached)	
Annex J: Budget Analysis.....	

List of Acronyms and Definitions

ABM	<i>Acces Banque/Madagascar</i>
ACT	Artemisinin Based Combination Therapy
ALU	Arthemeter Lumefantrin
AMM	Autorization to Market (<i>Autorisation de Mise sur le Marché</i>)
AOR	Agreement Office Representative
ASAQ	Artesunate Amodiquine
BCC	Behavior Change Communications
COAG	Cooperative Agreement
CHW	Community Health Worker
CNC	National Coordination Committee (<i>Committee National de Coordination</i>)
CROM	Regional Body of Doctors (<i>Conseil Regional d'Ordre des Medecins</i>)
CU5	Children Under 5
CYP	Couple Years of Protection
DAM	Medical Drugs Agency (<i>Direction de l'Agence de Médicaments</i>)
DHIS	District Health Information System
DQA	Data Quality Assurance
DTK	Diarrhea Treatment Kits
EMMS	Environmental Mitigation and Monitoring Statement
ETL	Education through Listening
FGD	Focus Group Discussion
FoQus	Framework for Qualitative Research in Social Marketing
FP	Family Planning
FY	Fiscal Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HF	Healthy Family

HIM	Health Images of Manhood
HNI	Human Network International
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment – Pregnancy
IR	Intermediate Result
ISM	Integrated Social Marketing
IUD	Intra-Uterine Device
LFP	Learning for Performance
LLIN	Long-Lasting Insecticide Nets
LMIS	Logistics Management Information System
LTM	Long Lasting Method
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MIS	Monitoring and Information Systems
MIS	Malaria Indicator Survey
MOH	Ministry of Health
MVU	Mobile Video Unit
NGO	Non Governmental Organisation
NMCP	National Malaria Control Program
OPQ	Optimizing Performance and Quality
PA	Supply Point (<i>Point d'Approvisionnement</i>)
PAMF	<i>Premiere Agence de Microfinance</i>
PE	Peer Educator
PHC	Primary Health Care
PMI	Presidential Malaria Initiative

Q	Quarter
QA	Quality Assurance
RDT	Rapid Diagnostic Kit
RH	Reproductive Health
SAF	<i>Sampan' Asa Fampandrosoana/Fiangonan' I Jesosy Kristy eto Madagaskara</i>
SALFA	<i>Sampan' Asa Loterana momban'ny FAhasalamana</i>
SMS	Short Message System
STI	Sexually Transmitted Infection
TA	Technical Assistance
TBD	To be determined
TIPS	Trials for Improved Performance
TraC	Tracking Results Continuously
TOT	Training of Trainers
TV	Television
UN	United Nations
USAID	US Agency for International Development
WASH	Water, Sanitation and Hygiene
WHP	Women's Health Project
WRA	Women of Reproductive Age

Introduction

In December 2012, PSI/Madagascar was awarded the Cooperative Agreement (COAG) No. AID-687-A-13-00001 for the Integrated Social Marketing (ISM) Program in Madagascar. The award is for a total of \$36,823,053. The ISM Program runs from January 1, 2013 through December 31, 2017.

The goal of this program is to improve the health of the Malagasy people -- especially women of reproductive age (WRA), children under five (CU5), youth 15-24 years old and those living in rural and underserved areas -- through an increasingly sustainable social marketing program that delivers essential health products and services with a focus on reaching rural and underserved areas. PSI/Madagascar and its partners Intrahealth, Banyan Global, Human Network International (HNI), SAF and SALFA – all together referred to as the ISM Team -- will apply its expertise in social marketing, social franchising and behavior change to bring more users into the Malagasy health market. By the end of this program, the Malagasy people will see improvements in their health status with regard to Family Planning (FP), Reproductive Health (RH), Maternal and Child Health (MCH), and Malaria.

The ISM Program is organized along three Intermediate Result (IR) areas, as summarized below.

- IR 1: Increased adoption and maintenance of health behaviors
- IR 2: Improved quality of selected health services in the private sector
- IR 3: Increased availability of life saving health products and services

During Fiscal Year (FY) 2013, PSI/Madagascar reports important achievements towards promoting healthier behaviors and increasing access to and use of effective health products and services. This annual report covers the period January 1st 2013 through September 30, 2013¹, and highlights key achievements during the Fiscal Year. Activities, achievements and challenges from the last Quarter (Q) -- July-September 2013 or Q4 -- are also described in this report.

Activities and achievements to particular note for FY 2013 include the following:

- On February 28th, PSI/Madagascar senior staff presented the ISM Program to a dozen editors and journalists at the Media Center. The USAID Development, Outreach and Communications Officer had organised the meeting, in which the ISM Program's Agreement Office Representative (AOR), Mr. Sixte Zigirumugabe, also participated. Interviews were broadcasted on national television and radio channels.

¹ As per the COAG, no separate quarterly report will be submitted to cover activities during the last Quarter (Q4) of FY 2013 (July-September 2013). Activities and achievements/challenges during Q4 are hence specifically mentioned in this annual report.

- On March 15th, PSI/Madagascar organized a launch workshop with the Mission Director, the Health, Population and Nutrition (HPN) Office Director and the ISM program AOR of USAID/Madagascar, teams from the Santenet2 and MAHEFA community health projects, and new local sub-grantees in which each partner gave a brief overview of main activities under the ISM project.
- Technical assistance from a PSI global marketing and communication advisor based in Johannesburg and a local creative consultant to develop and finalize the Healthy Family integrated communication campaign. A detailed communication plan was developed that includes messages for the main target groups across the various health areas. Recruitment is underway for script writers and a production agency to help develop the first four episodes of the Healthy Family communication campaign.
- Several coordination meetings and a training of trainers were held with the USAID bilateral health project MAHEFA to discuss integration of the ‘*education through listening*’ approach in Community Health Worker (CHW) interpersonal communication (IPC) work, and to develop the concept for the mother-father model as part of the Healthy Family integrated communication campaign.
- In February and March 2013, contracts were developed and negotiated with the new international partners (Intrahealth, HNI and Banyan Global) under the ISM project. Contracts with local partners SAF and SALFA were signed in July 2013. The Intrahealth and Banyan Global local staff have all been recruited and trained up for their roles under the ISM by their respective managers/supervisors.
- PSI/Madagascar secured 622,980 Couple Years of Protection (CYP) (147% of the FY target) through the distribution and promotion of socially marketed contraceptives.
- PSI/Madagascar reached its distribution targets for all products with the exception of *Viasur* Diarrheal Treatment Kit (DTK) and *Pneumostop*, the pneumonia treatment kit, both of which experienced stock outs due to procurement delays and/or the long and complicated Malagasy pharmaceutical product registration processes.
- PSI/Madagascar developed the overall strategy for a new youth-focused campaign, “*Tanora 100%*” or “*100% youth*”.
- In collaboration with SAF and SALFA, 16 rural clinics were integrated into the *Top Reseau* franchise, and their providers trained on Family Planning (FP) and Integrated Management of Childhood Illnesses (IMCI).
- PSI/Madagascar received several key technical assistance (TA) visits during FY 2013 including from a community supply chain expert, Mr. Yves Cyaka; and a PSI/Washington supply chain expert, Ms. Nicole Seiver.
- Several technical and/or managerial assistance visits took place during FY 2013 both by Banyan Global (Ms. Nhu-An Tran) and Intrahealth (Ms. Laura Hurley), including Senior Technical Advisor for Gender Equality (Ms. Maryce Ramsey) and the Senior Clinical Training Advisor (Dr. Boniface Sebikali).
- With assistance from the Intrahealth Senior Technical Advisor for Gender Equality, a gender assessment was conducted in the field and recommendations are used for communication and training activities.

- PSI/Madagascar continued the planned expansion of supply points in MAHEFA zones. Supply point (*point d' approvisionnement* or PA) training was conducted and a total of 281 PAs and 11 '*relay*' PAs in MAHEFA zones trained in FY 2013.
- With the new Primary Health Care (PHC) project just off the ground and not working in 100% the same areas as the former Santenet2 project, PSI/Madagascar and USAID agreed that PSI/M would for now continue to supply existing supply points in the former Santenet2 zones and encourage them to maintain linkages to the CHWs to the extent possible (see Annex C: Distribution graphs). Future coverage will need to be determined in consultation with MAHEFA, PCH and USAID.
- The last quarter of FY 2013 saw busy preparation for the October 2013 mass distribution campaign of 2.7 million free long lasting insecticide treated nets (LLINs). The campaign prioritized the same 28 districts that were covered by the 2010 campaign. All pre-campaign activities were completed.
- PSI/Madagascar's research team completed the Focus for Qualitative Research in Social Marketing (FoQus) study on rural youth, and conducted small group discussions with urban youth on a new youth-positioned condom in Antananarivo and Tamatave. The team also completed a client satisfaction survey among youth and older *Top Reseau* clients, and a *Top Reseau* provider motivational study.

Intermediate Result One: Increased Adoption and Maintenance of Healthy Behaviors

Key Expected Results:

Key expected results to demonstrate impact on the adoption and maintenance of healthy behaviors over the life of the ISM Program are summarized below.

Expected Results	Baseline	2013/2014 Result	2017 Target
Increase contraceptive prevalence rate nationally	29.2% (DHS ²)	34.8% (TRaC ³ FP 2012/2013)	40.2%
Increase in the % of target who know of two ways to prevent diarrhea	58.6%	TBD: TRaC IMCI 2014	70%
Increase in the % of caregivers with knowledge on ways to prevent pneumonia in CU5	0%	TBD: TRaC IMCI 2014	12%
Increase in the % of children under five who slept under an ITN the previous night ⁴	76.5%	62% (Malaria Indicator Survey 2013)	80%
Increase in the % of target group who perceive ACTs including ASAQ and ALU as an effective treatment for malaria in CU5 ⁵	19% (ASAQ only)	32% (ACTs including ASAQ and/or ALU) (Malaria Indicator Survey 2013)	55% (revised in Sept 2013 at the request of USAID)

² DHS stands for Demographic and Health Survey

³ TRaC stands for Tracking Results Continuously.

⁴ Findings from the 2013 Malaria Indicator Survey place the level of this indicator at 62%, a reduction from the baseline % of 77%. PSI/Madagascar will maintain the target of 80%.

⁵ The indicator included in the 2013 Malaria Indicator Survey (MIS) reads as follows: *Percentage of women aged 15-49 who cited Actipal, ACT, ACTm or ASAQ as an effective treatment for malaria for CU5*. Findings from 2013 place this indicator at 32%, well above the baseline of 19% and above the 2017 target of 29%. PSI/Madagascar proposes to use the indicator going forward, to be aligned with the MIS wording, and has revised the 2017 target to 55% as requested by USAID. This is also been revised in the ISM Performance Framework.

Key Illustrative Activities for IR1:

- Promote integrated family health through an overarching BCC campaign.
- Expand the “*Education Through Listening*” IPC approach for IPC agents linked to franchised clinics.
- Develop positive role models of rural mothers and fathers to be used in BCC.
- Tap into community-based groups to better reach youth.
- Harmonize BCC and other delivery activities.

Context: During FY 2013, PSI/Madagascar re-assessed its ongoing BCC work and initiated discussions with staff from the MAHEFA project to introduce new and improved approaches to CHW IPC work. Findings from the Intrahealth-led gender assessment indicate that, despite large increases in contraceptive use in urban areas, women’s role in decision making on FP remains weak especially in rural areas, and there is a need for positive male and female role models to reinforce optimal health behaviors. Despite high coverage of LLINs following mass campaigns with pre- and post-campaign messages, findings from the 2013 Malaria Indicator Survey (MIS) indicate that behaviors are not consistently maintained, and continually focused BCC is required. At home behaviors, conducive to better child health and care-seeking behavior for malaria, diarrhea and pneumonia prevention and treatment also continue to constitute large challenges in converting BCC into actual, measurable changes in behavior.

Overview of Key Activities during FY 2013:

Cross Cutting Communication: Building on the DELTA marketing plans and the results from a technical assistance visit from a marketing and communication expert in April 2013, PSI/Madagascar developed an integrated communication plan for a mass media communication campaign that will cover a variety of health areas called “the Healthy Family”. The Health Family campaign will consist mainly of radio drama episodes and Mobile Video Unit (MVU) spots that will be diffused in rural areas. This campaign will be rolled-out over the entire life of the project.

With support from the technical advisor, the campaign’s concept was fully developed including the preferred channels to use for a rural communication campaign, the definition of target groups⁶, and the key messages across the different health areas. A local ‘creative consultant’ was recruited to support the creative aspects of the campaign and in particular to help with the story line for the 175 drama episodes and three short films that will be produced. Findings from the gender assessment will feed into the development of the campaign’s story line to ensure gender issues are addressed. In Q4, tenders were launched for episode writers and a video production agency. The first four episodes will be developed and pre tested in Q1 of FY 2014. Subsequent episodes (up to 93 in all) will be produced in segments of six throughout the remainder of FY 2014 and part of FY 2015 (Q1 and Q2). Interpersonal

⁶ The campaign’s primary target groups are women of reproductive age with children under five; youth 15 to 19 years old and their partners. Its secondary target groups are mother s-in-law and community leaders.

communication tools for CHWs will be finalized and disseminated through the two USAID bilateral health projects in Q3 and Q4 of FY 2014. The MVU component (a mini film of 78 minutes) will be finalized at the end of FY 2014, for use in FY 2015⁷.

Several meetings were held in May and June 2013 with the USAID supported MAHEFA project team to discuss coordination around IPC activities for CHWs in MAHEFA zones. Discussion topics included: 1) development and introduction of a ‘model mother and father’ IPC strategy to support CHWs in their community activities. This strategy will build upon the “TIPS” (Trials for Improved Practices) approach that MAHEFA is currently using to enhance the adoption of healthy behaviors at community level; and 2) introducing the “education through listening” IPC technique to help CHWs in their outreach and interpersonal activities.

To this end in Q4, a training of trainers was organized on the ETL technique, with 15 MAHEFA NGO staff, 3 staff from SAF, 3 from SALFA and 2 trainers from PSI/M. Furthermore, a concept-note for the model mother and father strategy was developed and presented to MAHEFA for discussion and finalization in Q1 of FY 2014. Also in Q4, the communication team worked with MAHEFA to determine the technical specifications for signboards that would be installed at CHW homes to increase the visibility of their presence/work. More than 6,000 signboards will be ordered and installed in FY 2014.

Key Challenge: The “Healthy Family” integrated campaign will cover key messages in five health areas, which in and of itself is a big challenge. In addition, the male-focused campaign for FP will also be part of the Healthy Family campaign. It will be a challenge to the script writers to make sure the drama and the other campaign audio-visuals will be entertaining *AND* educational, and to bring (and keep) the campaign’s characters to life over a four-year period. Moreover, messages will need to be consistent and concise, and as such, harmonized with communication activities under the MAHEFA and PHC projects.

Gender issues: The local Intrahealth Gender Coordinator participated in the DELTA Youth Planning Process and emphasized the importance of collecting gender-disaggregated data. The IntraHealth Senior Technical Advisor for Gender Equality has since provided additional guidance on gender analysis of data from the completed rural Focus on youth survey, further enhancing the understanding of Malagasy youth. The results of this analysis will be key inputs for future marketing and communication plans for ISM youth programming. As part of the introduction of the new youth condom for dual protection, findings from the gender assessment were used during the condom DELTA planning process to make sure that the developed strategies explore ways to be gender transformative. The gender assessment also echoed the community needs for a positive deviant that could model healthy behavior and those findings influenced the development of the ‘father and mother role model’ approach with emphasis on promoting key messages on equitable behaviors.

⁷ This schedule is likely to evolve as it depends on many factors and outside actors/contractors/intermediaries. A detailed planning is available, should USAID like to see this, and will be regularly updated to reflect any changes to the detailed timeline for conception, production, pretest and delivery of HF campaign tools.

Intervention Area 1.1: Family Planning and Reproductive Health

During Quarter 3 of FY 2013, PSI/Madagascar organized an internal ‘DELTA’ marketing workshop to develop a marketing plan for urban and rural youth. The “*Tanora 100%*” or ‘*100% youth*’ campaign will focus on modern contraceptive method use to avoid unwanted pregnancies; seeking STI treatment from qualified providers; and voluntary counseling and testing for HIV. Two strategic priorities were identified for the youth campaign: i) reinforcing the quality of youth-friendly services delivery in the *Top Réseau* clinics; and ii) strengthening demand creation for services and products through various communication channels. The campaign “*Tanora 100%*” will be linked to the overarching Healthy Family campaign.

In September 2013, PSI/Madagascar organized a one-week workshop with regional IPC supervisors to improve current IPC and supervision systems, tools, and approaches according to the “*Tanora 100%*” strategic priorities. Field tools used for IPC activities, data recording sheets, MIS, and feedback loops were also reviewed. IPC workers will be trained to use the newly adapted forms and tools in Q1 FY2014.

Using the findings from the client satisfaction survey among youth *Top Réseau* clients, and the Foqus on rural youth study, PSI/Madagascar developed the concept for the pilot introduction of the youth loyalty scheme in one urban *Top Réseau* site following the design of the “*Tanora 100%*” youth program. The concept will be finalized and implemented towards the end of Q1 FY2014.

The qualitative Foqus study with 145 young men and young women in three sites (April 2013, c.f. Annex I for full study report) indicated, for example, that strong misconceptions remain about side-effects from modern methods, especially related to infertility, and that the preferred/most often practiced method by youth is the calendar method even if they are aware of its unreliability. The research uncovered large and important knowledge gaps, and it revealed that rural youth have very little to no exposure to information about modern contraceptives. Findings will help the communication and program teams in developing appropriate messages and channels to reach rural youth with messages about preventing unwanted pregnancy. One such strategy may be to work with SAF and SALFA clinic staff and outreach workers on youth-friendly RH/FP services and information provision.

Over the course of the Fiscal Year, PSI/Madagascar continued the diffusion of the mass media FP communications to promote the use of FP methods. The mass media FP campaign included TV and radio programs, and TV and radio spots that were broadcasted nationally. A total of 883 radio spots, 2,034 songs, 681 radio shows, 96 TV spots, 175 TV songs, and 172 MVU sessions were held on FP. Mass media FP communications that were aired during this period included TV spots and brief reports, MVU clips, and radio spots. Main messages focus on women’s self efficacy to use short term methods, social support for modern FP methods and social norms for IUD. Communications on long term FP methods, and in particular IUDs, were financed by the Women’s Health Project (WHP) private foundation donor.

The mass media FP campaign was supported by outreach activities with youth peer educators (PEs), FP and maternal health counselors, and MVU sessions. During FY 2013, 120 youth PEs were trained to provide FP information to youth, and to refer youth to *Top Reseau* clinics.

Intervention Area 1.2: Maternal and Child Health

The Maternal and Child Health-specific activities that were implemented in FY 2013 mainly consisted of radio broadcasting of existing communication messages developed under the previous social marketing COAG. These current messages promote treatment seeking behavior for IMCI interventions with particular attention given to creating demand for, and correct use of maternal and child health products and to reinforcing knowledge of ways to prevent the multiple diseases that affect children under five. The team worked with the USAID-funded projects MAHEFA to harmonize messages that were disseminated in FY 2013 through radio and other channels (IPC with health workers).

Due to product stock out for some MCH products and the delay in the start-up of the rural *Top Reseau* clinics (cf. Annex A: Work Plan Status), some planned communication and promotional activities did not take place. During the FY, 1,908 radio spots with generic (non-branded) child survival messages were aired on national and local radio. The team produced sales and promotion incentives for child survival products (*Pneumostop* syrup and the *Viasur* DTK) for distribution at community and pharmaceutical level, in anticipation of the planned distribution in FY 2014 once the product arrives.

PSI/Madagascar worked with the youth scouts program, WaterAid and *Tily eto Madagasikara* to support the dissemination of sanitation and safe water use messages. These partnerships help to increase awareness of and promote correct/consistent use of *Sûr'Eau* for diarrheal prevention and *ViaSur* for case management. Other examples of local partnerships and small events that were conducted during FY 2013 include: participation in the five day long national meeting of the FJKM Antsirabe 'Sunday Schools' branch where the three key messages on WASH were shared with 1,500-1,800 participants - the large majority of them children - by the MVU team, and flyers were distributed; participation with a stand and peer educator activities during the National Women's Football Championship in Antananarivo (September 2013); and water treatment awareness raising at the *Sampana Tily* FJKM temple with scouts to sensitize communities near Ranomafana on point-of-use water treatment.

Intervention Area 1.3: Malaria

The FY saw good collaboration between the IEC/BCC unit at the National Malaria Control Program (NMCP) and PSI/M toward the development of basic messages for malaria control strategies including case management with Rapid Diagnostic Kits (RDTs), ACTs, and IPTp, and malaria prevention strategies using LLINs and indoor residual spraying. During coordination meetings, priority strategies and messages were determined and the malaria communication plan (including messages on malaria during pregnancy and use of RDTs) was developed. The plan will be updated in FY 2014 to be in line with the National Malaria Strategic Plan (2013-2017).

During FY 2013, the following main activities were completed:

- Radio spots on malaria during pregnancy/ IPTp and on use of RDTs were produced and disseminated⁸;
- PSI/Madagascar participated in Malaria World Day celebrations in May 2013 in Anjiamangirana, Antsohihy district; and
- Messages and artworks/scripts for job aids and radio spots (2) were produced to support continuous net distribution under the NETWORKS project in Tamatave II.

⁸Broadcasts were suspended in Q3 following an official communication from the Ministry of Health. Broadcasting recommenced in Q4 following negotiations with the MOH that allowed PSI/Madagascar to reinstate its mass media communications.

Intermediate Result Two: Improved Quality of Selected Health Services in the Private Sector

Key Expected Results:

The table below presents key expected results to demonstrate changes for activities with *Top Réseau* franchised providers and their client communities over the life of the ISM Program.

Expected Results	Baseline	Results End FY 2013	2017 Target
% of <i>Top Réseau</i> providers reaching minimum service quality standards for FP and IMCI services	35%	n/a	80%
# of <i>Top Réseau</i> health clinics offering integrated services in at least 3 health areas (FP/RH, IMCI, malaria)	Urban: 213 Rural: 0	Urban: 213 Rural: 16	Urban: 233 Rural: 40
# of <i>Top Réseau</i> providers trained in business management & financial management	Urban : 0 Rural : 0	Urban: 108 Rural: 0	Urban : 270 Rural : 30
# of new <i>Top Réseau</i> providers who have received quality training	Urban: 0 Rural: 0	Urban: 10 Rural: 15	Urban: 20 Rural: 40

Key illustrative Activities for IR2:

- Expand the number of private sector health providers in the *Top Réseau* franchise (c.f. table above).
- Increase access to finance for *Top Réseau* providers in partnership with Banyan Global.
- Modernize existing data collection using SMS technology in partnership with HNI.
- Build the business management capacity of *Top Réseau* providers with support from Banyan Global (c.f. table above).
- Enhance the medical training approach of the *Top Réseau* franchise with support from Intrahealth, resulting in improved client satisfaction and improved minimum standard scores.
- Enhance provider behavior change using results from provider motivational surveys, provider network meetings, and building on Intrahealth's experience in this area.

- Institutionalize capacity building targeting high-performing franchise providers by making them peer trainers.
- Pilot demand-side financing rural community mechanisms with support from Banyan Global.

Context: PSI/M launched the *Top Réseau* franchise in 2000 as a network of private and independent clinics initially focused on delivering reproductive health services to adolescents. This focus was later expanded to include prevention of Sexually Transmitted Infections (STIs)/HIV among high-risk groups, long term contraceptive methods (LTMs) and IMCI, cervical cancer screening and referral, post abortion care counseling and referral, and most recently nutrition (for selected providers only). At the start of FY 2014, PSI/Madagascar now directly supports 215 network clinics in 46 out of the 112 districts across Madagascar.

In FY 2011, PSI/Madagascar decided to expand the positioning of *Top Réseau* to include additional target groups, while maintaining its activities for youth and high risk groups, and to incorporate new health areas. All newly recruited providers receive training in a basic package that includes short term FP, IMCI, and diagnosis and treatment related to sexually transmitted infections. For qualified and motivated providers, PSI/Madagascar offers training and supervision in LTM methods, cervical cancer screening, basic maternal health care, and HIV testing and counseling⁹.

Intervention Area 2.1: Expanding Access to Quality Services at Private Health Clinics

Following the signatures of the subcontracts with SAF and SALFA, and the development of the expansion strategy (Q2 of FY 2013) – which considered a variety of criteria¹⁰ -- 16 clinics (eight SAF and eight SALFA) in rural areas were identified and recruited for inclusion in the *Top Réseau* network. A total of 27 providers from these clinics received training in the basic service package (FP/RH, STI management, and IMCI) during the last Q of FY 2013.

All 16 clinics received support to improve their equipment and facilities. PSI/Madagascar conducted a training of trainers (TOT) for SAF and SALFA technical and IPC supervisors to train and support their IPC agents in the ‘*Education through Listening*’ approach. These supervisors will lead in their turn training for their IPC workers – consisting of Community Health Workers (CHWs) -- who will ensure demand creation for the clinics

In addition, nine new *Top Réseau* clinics located in/around Antananarivo were recruited in Q3 of FY 2013. The new *Top Réseau* clinics were upgraded and providers received initial training from PSI/Madagascar trainers and medical supervisors in Q4.

⁹ With support from SIFPO. Under the ISM Program, no HIV specific funding is included.

¹⁰ Selection criteria for the first batch of new rural SAF and SALFA clinics included: rural zone with a non functioning/non existing CSB, population catchment area, epidemiological data, accessibility, provider motivation and any other information SAF and SALFA may have regarding the clinic’s functioning/collaboration with the local staff.

Challenges: Working with new local partners takes time, as trust and confidence need to be built slowly. While the collaboration with SAF and SALFA is off to a good start, it is clear that the local partnerships will require close monitoring, support and ‘nurturing’ throughout the life of the project. It is also clear that there will be no perfect rural clinic that will meet all selection criteria, hence the importance of conducting the site visits as the expansion continues into FY 14, to make sure that a proper balance is struck between PSI/Madagascar supervision, data reporting and other programmatic requirements and the local reality in the field – some clinics even lack basic commodities like running water, for example.

Following the assessment visits and the two local launches in Q4 2013 in Ejeda (district of Ampanihy in the Atsimo Andrefana region) and Nosy Varika (Vatovavy Fitovinany region), PSI/Madagascar is now actively exploring optimal supervision and reporting modalities, as difficulties in scheduling regular supervision visits and receiving monthly client data in time are anticipated¹¹. One proposed solution -- that is being tested following training of the providers by partner HNI -- is the use of mobile technology via SMS, to allow the providers to rapidly send data on activities conducted during the month to PSI/Madagascar. Results from this will be shared in FY 2014, and if successful and where possible, this model will be adopted and expanded to future rural *Top Reseau* clinics.



Photo 1: Launch of Top Reseau activities in Nosy Varika.

¹¹ As such, PSI/Madagascar will initially not provide training and support for long term FP methods, which require close support and supervision and immediate follow up in case of complications/adverse events.

Network Promotion: All of 120 youth peer's educators (PE) planned in this project have been recruited and trained during Q4. The initial training session focused on the ETL communication technique, RH/FP, promoting Top Réseau clinics and referring youth clients for services. During FY 2013, PSI/Madagascar continued to promote *Top Réseau*-- using already existing radio spots for women, youth and the Malagasy family -- with messages tailored for urban and rural targets.

Quality Assurance (QA): During this first year, IntraHealth focused its efforts in building the local team that joined the PSI/Madagascar ISM implementing staff. IntraHealth Senior Program Manager, Laura Hurley, traveled to Madagascar twice during this period to work with PSI/Madagascar to recruit IntraHealth local staff. All the activities designed and implanted during this period aimed at sharing IntraHealth's concepts and approaches. Two successive STTA were provided by IntraHealth headquarters to assist local staff in primary IntraHealth interventions on the project. Efforts to mainstream gender into the program has made great strides through various processes such as DELTA Marketing, internal programming and capacity building due to a series of trainings on gender for PSI/Madagascar staff. From June 21 to July 7, Maryce Ramsey, with the support of the PSI research team and the local gender coordinator, conducted the gender assessment. From June 24 to July 5, Dr. Boniface Sebikali provided support for the review and design of all training curriculum and supervision tools. He also conducted an orientation session on Optimizing Performance and Quality (OPQ) and the Learning for Performance (LFP) approach for the key staff of the ISM project. Twelve SALFA and fifteen SAF rural clinic providers received trainings using the Learning For Performance approach.

During FY 2013, ISM partner Intrahealth recruited three new staff who will support QA activities under the ISM IR2. Positions are for the FP/RH Clinical Training Advisor; the MCH/Malaria Clinical Training Advisor; and the Quality Assurance Technical Advisor (filled in Q4).

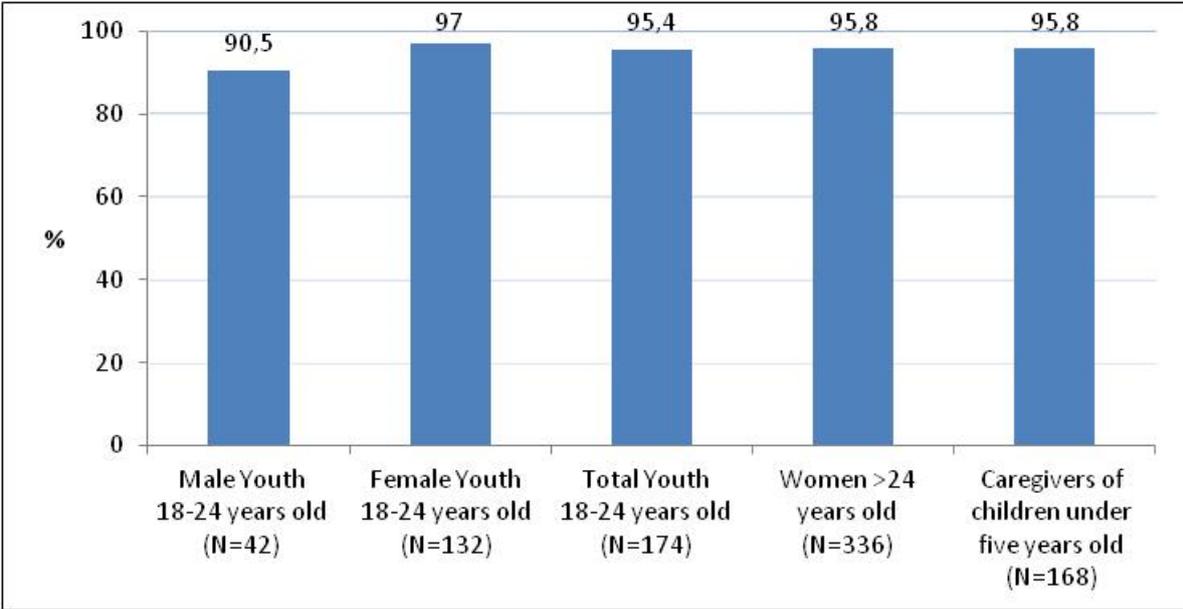
In Q3, Intrahealth's Senior Clinical Advisor, Dr Sebikali, provided short term technical assistance to two of the newly recruited staff (the FP/RH Clinical Training Advisor and the MCH/Malaria Clinical Training Advisor) as well as to PSI/Madagascar's medical team. The team focused on the review and update of the existing QA and training tools. A key component of this review was to ensure that training methods and content (for FP/RH, child survival, malaria and nutrition) are compliant with international best practices while respecting national norms and standards. Dr. Sebikali also conducted a one-day orientation on Optimizing Performance and Quality (OPQ), supportive supervision, and the Learning for Performance (LFP) approach for five technical staff members.

During Q4, the FP/RH Clinical Training Advisor and the MCH/Malaria Clinical Training Advisor conducted a total of 2 training sessions with 27 providers (new SAF and SALFA providers) using pre-final versions of the training curricula and the supervision tools. The team brought in several experienced external trainers (SAF/FJKM and SALFA co trainers) to elicit their feedback on the curricula and tools. Final versions of these materials will be shared

with Dr. Sebikali for validation early in FY 2014. A training plan for new providers in the basic/standard package has been developed and guides the team and the local medical supervisors in planning training and supervisory activities. Towards the end of FY 2013, the team began exploring the inclusion of training activities in new health areas for e.g. nutrition and maternal/neonatal health, and will take this work forward in early FY2014.

Client Satisfaction Study: In July 2013, PSI/Madagascar conducted the first of two rounds of client satisfaction studies planned during the life of project. A total of 76 *Top Réseau* providers in three sites were selected for the study (45 providers in Antananarivo, 25 in Toamasina and 11 in Fianarantsoa). A total of 678 clients¹² were interviewed. Data from the survey indicate that more than 98% of *Top Réseau* clients were satisfied with the overall quality of services obtained from the provider and that 90% or more intend to recommend *Top Réseau* services to other people as illustrated in Graph 1 below (c.f. Annex I for the full study report). The project aims to further reinforce this notion through close supervision, regular training, bi-annual meetings with all providers, and by addressing, to the extent possible, any concerns providers may have about the tasks they are performing to improve the non clinical and clinical skills in their consultations.

Graph 1: Clients’ intention to recommend *Top Réseau* services to other people by demographics, in 3 *Top Réseau* Sites (Antananarivo, Fianarantsoa and Toamasina), 2013



Provider motivational study: As part of its activities to support and strengthen the social franchise’s overall performance (in terms of access, quality, product/service portfolio, equity etc), PSI/Madagascar is continuously looking for ways to improve its provider motivational strategy. The motivational strategy – in general -- aims to recruit potential providers into the network, to maintain well performing providers in the TR network and to make them high

¹² The breakdown of clients was as follows: Male youth 18-24 years old: 42; Female youth 18-24 years old: 132; Women more than 24 years old: 336; Caregivers of children under five: 168.

performers. Under the ISM, PSI/Madagascar will explore ways to maintain and improve provider motivation and quality of service delivery. The first of two planned provider motivational studies was conducted in July 2013; the second one is planned for FY 2015. The current study involved all *Top Reseau* providers from all sites grouped into distinct performance related categories¹³.

The study was designed to examine *Top Reseau* providers' motivation, as well as knowledge and attitudes with regards to IUD insertion among FP providers (TR or non TR). Findings from the study will feed into improved support and supervision systems to ensure optimal provider performance. The study provided useful information on how to motivate providers to deliver quality services to target clients, how to increase their collaboration and commitment to adhere to required quality standards and norms, while delivering essential health services to as high a client number as possible. Key findings from the study show that:

- 1) To the providers, trainings and meeting support are the most valued attributes of belonging to the network; humanitarian/community values come second, and belonging to a quality network/visibility of the network and increase in client flow and profits are ranked third and fourth, respectively. The attributes did not vary by performance levels.
- 2) The providers ranked barriers – assigning a score between 1 and 4 -- associated with belonging to the network with mean scores in order of 'severity' as follows: pricing problems due to the fact that most clients are low income (3.81), being asked to work in technical they were not familiar with (3.22), reporting challenges (2.91), time consuming (2.79), and time consuming training/meetings (2.27). These barriers also did not vary by performance levels.
- 3) Provider knowledge scores on IUDs showed that only 4.6% providers (TR and non TR, no significant difference exist between the groups) scored at least 75% on a series of facts/issues on the IUD. The study further found that *Top Reseau* providers had more positive attitudes and beliefs towards the IUD compared to their non-*Top Reseau* counterparts, and they exhibited stronger levels of confidence in their ability to insert IUDs (97%) compared to non *Top Reseau* providers (80%).

Based on these findings, the FP and health service delivery teams will continue to provide high quality training and supervision, as these activities are highly valued by providers. They will continue to reinforce information provision and capacity building on IUD insertion and removals with network providers to increase provider knowledge and to maintain their confidence levels.

Intervention Area 2.2: Capacity Building

Banyan Global officially launched the implementation of its work plan during Q3 of FY 2013. Banyan Global's work under the ISM focuses on three areas, namely: improving access to finance for *Top Reseau* providers and selected supply points (where feasible); improving

¹³ Performance of *Top Reseau* providers was defined according to the number of clients registered in the Management Information System database from January to June 2013. Performance is categorized into low (less than 25 clients per month), medium (between 25 and 70 clients per month) and high (71 clients and more per month).

business management capacity for *Top Réseau* providers and selected supply points (where feasible); and piloting demand-side financing for rural communities.

Key accomplishments during FY 2013 include:

- The PSI/M research team collected rapid data on financing needs and experience with micro financing schemes among 100 *Top Réseau* providers and 134 supply points in Quarter 2 of FY 2013 to better understand their interest and perceived barriers to accessing credits;
- Completion of two training curriculum for *Top Réseau* providers: “Access to Finance” and “Simplified Accounting”;
- 42 *Top Réseau* providers were trained in Access to Finance and 66 *Top Réseau* providers trained in Simplified Accounting;
- Selection of two partner financial institutions for a pilot lending program to *Top Réseau* providers: *Premiere Agence de Microfinance* (PAMF) and *AccesBanque Madagascar* (ABM); and
- 37 supply points (PAs) participated in a pilot session of the Simplified Accounting course.

Business Training for TR Providers: Banyan Global organized three sessions of the Access to Finance course (on July 9, 16, and 23), and four sessions of the Simplified Accounting course during Q4 (on September 13, 23, 24, and 27). A total of 42 TR providers participated in the former and 66 TR providers participated in the latter course. In addition, a Training of Trainers (TOT) on both courses was conducted for three PSI/Madagascar regional supervisors and seven medical staff.

Pilot lending program: During the Access to Finance course, participants were asked to complete a short questionnaire regarding their financing needs and their potential interest in obtaining a loan. Out of the 42 providers that completed the questionnaire, Banyan Global selected 13 providers that expressed a need for credit in the short term, have spousal support for the loan, and possess sufficient collateral. This list was submitted to both PAMF and ABM for their consideration. At the end of FY 2013, one loan had been approved and disbursed, and two applications were in the final negotiation process.

Demand-side Financing: In Q4, Banyan Global conducted interviews to recruit a short-term consultant to lead the work on demand-side financing. A final candidate has been identified and is expected to start in November 2013. A follow-up meeting was conducted with AFAFI in Q4 FY 2013 to further discuss potential ways to partner with PSI/Madagascar and Banyan. AFAFI stated that out of the 85 medical practitioners in their network, about 15 are TR clinics. The selection of clinics is primarily based on where clients are currently obtaining their service. In addition, AFAFI looks at criteria such as volume of business and quality-to-price ratio.

AFAFI prefers to offer their insurance schemes through existing groups (associations, borrowers of a MFI, etc.) since this enlarges the risk pool, minimizes the administrative cost of collecting premium, and facilitates the sensitization process (AFAFI also uses a model of

peer educator like PSI/Madagascar). Furthermore, group members should be self-selected and relatively homogeneous, i.e. from same fokontany or village, same level of socio-economic status, etc. A minimum of 50 members per group is required, membership in the health mutual is mandatory for an initial period, after which members can opt out.

Given these pre-conditions for adhering to AFAMI's mutual insurance scheme, more analysis is needed to decide whether this is a feasible option for PSI/Madagascar and the clients of TR clinics.

Finally, on August 3rd and 5th 2013, Banyan Global conducted a short training curriculum on basic bookkeeping/accounting for the PAs selected to be in the Airtel VPP. A total of 37 PAs participated from two zones (Mandritsara and Ambanja).

Challenges: The feedback from the Accounting course has been very positive and the majority of TR providers appreciate that the training gives them some concrete learning about a technical topic. The challenge will be to ensure that providers have the appropriate tool to apply what they have learned in the course. Post-training follow-up and individual coaching will be crucial in the coming year(s).

Helping TR providers to better define their financing needs and conceptualize a project for financing will be another challenge. While many providers say they have an interest in getting a loan, there remains some reticence about getting into debt, especially given the uncertain economic and political situation in the country. While Banyan Global will continue to work with providers on access to finance, the priority will be on strengthening providers' recordkeeping and financial management system: once providers have a good picture of their financial situation, it will be easier to help them plan their future growth and expansion.

Intervention Area 2.3: Promotional Support

In the last Quarter of FY 2013, PSI/Madagascar started the development a loyalty scheme to attract new adolescent users in urban and rural areas to *Top Reseau* services. This loyalty system will target youth for FP/RH services and will help attract and maintain new and current users. The card will be piloted in one-two zones in FY 2014.

Youth PE teams continued to promote services for young users in *Top Reseau* sites. More than 370,000 peri-urban youth were reached with information on *Top Reseau*. Mass media (radio) was also used to promote *Top Reseau* services for the Malagasy family: A total of 80 radio spots were diffused in FY 2013. Lastly, the *Top Reseau* communication and marketing plan was updated in FY 2013.

Intermediate Result Three (IR3): Increased Availability of Life Saving Health Products and Services

Key Expected Results:

Key expected results to demonstrate impact on the increased availability of life saving health products and services over the life of the ISM Program are summarized below.

Expected Results	Baseline	Results End FY 2013	2017 Target
Increased # of social marketed products distributed	See Results Framework, Table 1	See Results Framework, Table 1	See Results Framework, Table 1
% of community supply points trained and serving MAHEFA and the new Primary Health Care project zones that report no stock-outs of social marketed products in the last month	80%	n/a ¹⁴	90%
# of community distributors distributing social marketed products	870	1,088	1,200
Increased coverage of social marketed products	See Results Framework, Table 2	See Results Framework, Table 2	See Results Framework, Table 2

Context: While social marketed products and services have had a significant health impact in Madagascar, especially during the past four years of socio-political crisis, access is neither uniform nor optimal, especially in rural areas. Coordinated efforts under the previous USAID-funded Santénet2 program and the current MAHEFA program have made important progress in getting health products out to more rural and isolated areas, but supply chain challenges remain. Under the ISM Program, PSI/Madagascar and the USAID-funded bilateral health projects will continue to collaborate and coordinate closely; to ensure products reach trained community health workers and their communities with the least possible delays; and to avoid stock outs of essential products where possible.

Given the remoteness of some of the areas where PSI/Madagascar intervenes with product distribution, the lack of timely reliable data for reporting, forecasting and other uses continues to challenge more efficient distribution. With support from partner HNI and some innovative work with Airtel, PSI/Madagascar is making good progress to reduce data reporting problems. At the same time, PSI/Madagascar is committed to improve internal planning and to reinforce relationships with the Malagasy Drug Regulatory Agency (DAM); PSI/Madagascar is

¹⁴ Training for supply points using the *Datawinners* system took place in September/October and data on stock out will be collected as of November 2014. If possible, PSI/Madagascar will report on this indicator in the first quarterly report of FY 2014.

working to increase efficiency in product procurement and registration, and to provide regular updates on any related challenges to USAID.

Key Activities for IR3:

- Review and finalize the entire portfolio of socially marketed products.
- Enhance private sector (commercial and pharmaceutical channels) distribution.
- Enhance community-based distribution.

Intervention Area 3.1: Product Procurement and Branding

3.1.1 Family Planning and Reproductive Health

In FY 2013, PSI/Madagascar (PSI/M) continued to promote and distribute its large range of FP products and services including: *Pilplan*-branded pills, *Confiance*-branded injectables, *Rojo*-branded cycle beads, Implants (*Implanon*) and intra-uterine devices (IUDs). During Q4, PSI/Madagascar achieved 246,237 couple years of protection (CYPs), exceeding the FY 2013 annual target by 147% with 622,980 CYPs (condoms excluded, cf. Annex A: Work Plan Status).

Several factors have contributed to this high performance including a significant increase in sales of *Pilplan*-branded pills and *Confiance*-branded injectables through the pharmaceutical distribution channel as the result of a distribution strategy that focuses on selecting high performing pharmaceutical wholesalers. The increase of *Rojo*-branded cycle beads sales was mainly due to CHW starter stocks distributed in March, July and August 2013 by MAHEFA. A total of 1,500 units of *Zarin*-implant were sold to Marie Stopes/Madagascar in February and July 2013. Finally, mass media broadcasts and demand generation through IPC activities led to increases in IUD sales.

In Q4, PSI/Madagascar began the brand development process and foil artwork preparation of a new youth-positioned, dual-protection purpose, male condom. This activity was initiated based on a feasibility survey conducted among urban youth in Tanà and Tamatave, and the marketing plan for youth condoms. The brand pretest is ongoing; the final selection of the new youth-focused condom product and the brand development planning is to be finalized in Q1 FY 2014, and the youth-condom will be launched in Q3 of FY 2014.

3.1.2 Maternal and Child Health

Diarrhea Program

PSI/M reports the following updates for the distribution of its diarrhea products:

Diarrheal treatment kits (DKTs): A total of 84,934 DKTs have been distributed since the beginning of the project, which corresponds to 46% of the annual target. This low achievement is due to the stock out of *Viasur* since May 2013. An air shipment was expected in September, however, due to longer than anticipated procedures this shipment was received in the second week of October.

Sûr'Eau: 1,642,191 bottles of *Sûr'Eau* 150ml and 333,231 bottles of *Sûr'Eau* 40ml were distributed since the beginning of the ISM project. This amounts to 2,596,578,900 liters of

water treated. After launching a call for bids for the production of *Sûr'Eau*, PSI/Madagascar identified two new potential local producers (not including current producer SIGMA). Contracts were signed with New Area and ECO Clean to test their products and production capacities. Once the samples are tested and validated, these new suppliers are able to join and compete with SIGMA as *Sûr'Eau* alternate suppliers.

Pneumonia Program

Pneumostop syrup: On September 21st 2013, PSI/Madagascar received 25,000 units of *Pneumostop* syrup air shipped by the supplier. Product distribution started on September 23rd, and will continue in Q1 FY 2014. The remaining batch (108,000 units) is coming by sea and is expected to be available in country by the end of November. Due to the late arrival of the product, FY 2013 distribution targets were not met. PSI/Madagascar is processing follow-on orders (additional 97,200 units) to avoid any discontinuation of product availability in FY 2014 and FY 2015, given the increasingly challenging procurement and “authorization to market” (AMM) processes.

Pneumostop tablet: This product was not launched in FY 2013 due to ongoing registration processes with the DAM. PSI/Madagascar received product samples from the supplier on October 23rd and submitted a second round of registration documents on October 31st. Following negotiations with the DAM Director, it was agreed these registration documents will only be examined by the DAM team without needing to pass through the Registration Committee for validation. The AMM notification will likely not be received before the end of 2013 as there are some new technical questions on the dossier that need to be resolved with the supplier. Product arrival in-country may be delayed into early 2014 (March/April 2014). PSI/M is grateful for the support provided by USAID (Dr Jocelyne Andriamiadana) in negotiating with the DAM.

The table below summarizes the stock movements and situation per product at the end of FY 2013.

Health Area	Product	Opening Balance	Quantity In	Quantity Out	Ending Balance	Ordered
DIARRHEA	<i>Sur'Eau 150 ml.</i>	537 718	1 242 000	1 642 191	137 527	500 000
	<i>Sur'Eau 40 ml.</i>	143 380	235 000	333 831	44 549	100 000
	<i>Hydrazinc.</i>	0	50 790	50 790	0	12 4000
	<i>Viasur</i>	34 149		34 149	0	75 000
PNEUMONIA	<i>Pneumostop syrup</i>	24 949	25 000	24 949	25 000	108 000
MALARIA	<i>Super Moustiquaire White</i>	150 144		133 911	16 233	
	<i>Super Moustiquaire Blue</i>	162 773	1 546	146 875	17 444	
	<i>ACT</i>	93 001	889 413	761 144	221 270	
	<i>RDT</i>	325 777	1 139 000	805 012	659 765	

FAMILY PLANNING	Pilplan	2 151 655	4 173 739	2 279 000	4 046 394	
	Confiance	965140	1 700 000	1 313 688	1 351 452	
	Rojo	21210	22 200	23 351	20 059	
	IUD Copper T MIUD	34173	2 995	24 082	13086	
	Implanon	6120	4 000	2 165	7955	
	Implant Zarin	2 236	26	1 666	596	

Intervention Area 3.2: Supply Chain Management

To deal with the various challenges in the supply chain process, a supply chain action plan was developed. A committee composed of the supply chain manager, the Director of Distribution and a technical assistant updates the action plan every two weeks. The committee analyzes the data on the situation of stocks at different levels: international procurement; PSI/Madagascar central and regional warehouses; wholesalers and retailers; supply points (PA) and CHW levels. PSI/Madagascar's implementing partners are informed of the current situation during the various coordination meetings.

3.2.1 Enhance private sector (commercial and pharmaceutical channels) distribution

During Q4 of FY 2013, PSI/Madagascar benefited from the assistance of a consultant pharmacist to help improve pharmaceutical distribution activities. The consultant recommended that PSI/Madagascar adjust its statutes to be more coherent with Malagasy health codes. She also recommended that PSI/Madagascar recruit a pharmacist to address the technical issues pertaining to product registration and procurement. Based on this suggestion, PSI/Madagascar has initiated the recruitment process of hiring a pharmacist.

In the development and implementation of the rural *Top Réseau* clinics, PSI/Madagascar and SALFA signed a distribution contract to facilitate the supply of products to all operational SALFA's clinics. The purpose of the agreement is to insure the availability of products and allow neighboring CHWs to refer complicated cases to rural SALFA clinical centers. Urban clinics are supplied directly by NIPHAR to avoid intermediaries that increase the price to the target population. Pharmaceutical wholesalers that have reached their distribution objectives at the end of each quarter receive a commission as stipulated in their contract.

As for the commercial distribution channel, four "super" wholesalers were identified for commercial distribution in the regions of Diana, Boeny, Atsinanana and Analamanga. They will serve as pilots while the extension to the High Matsiatra and Atsimo Andrefana regions is scheduled for the end of Q1 FY 2014. PSI/Madagascar's goal is to transfer the commercial distribution to five to ten large distributors throughout the country; this is to enable the sales team to focus their time and resources on the community based distribution system.

3.2.2 Enhance community-based distribution

During FY 2013:

- PSI/Madagascar's warehouse in Antsohihy became operational and a distribution team including a distribution agent and a distribution assistant are now based there to better serve the MAHEFA areas. The availability of a four-wheel drive vehicle and a motorbike to reach remote and inaccessible zones in the region of Sofia has improved efficiency of PA re-supply.

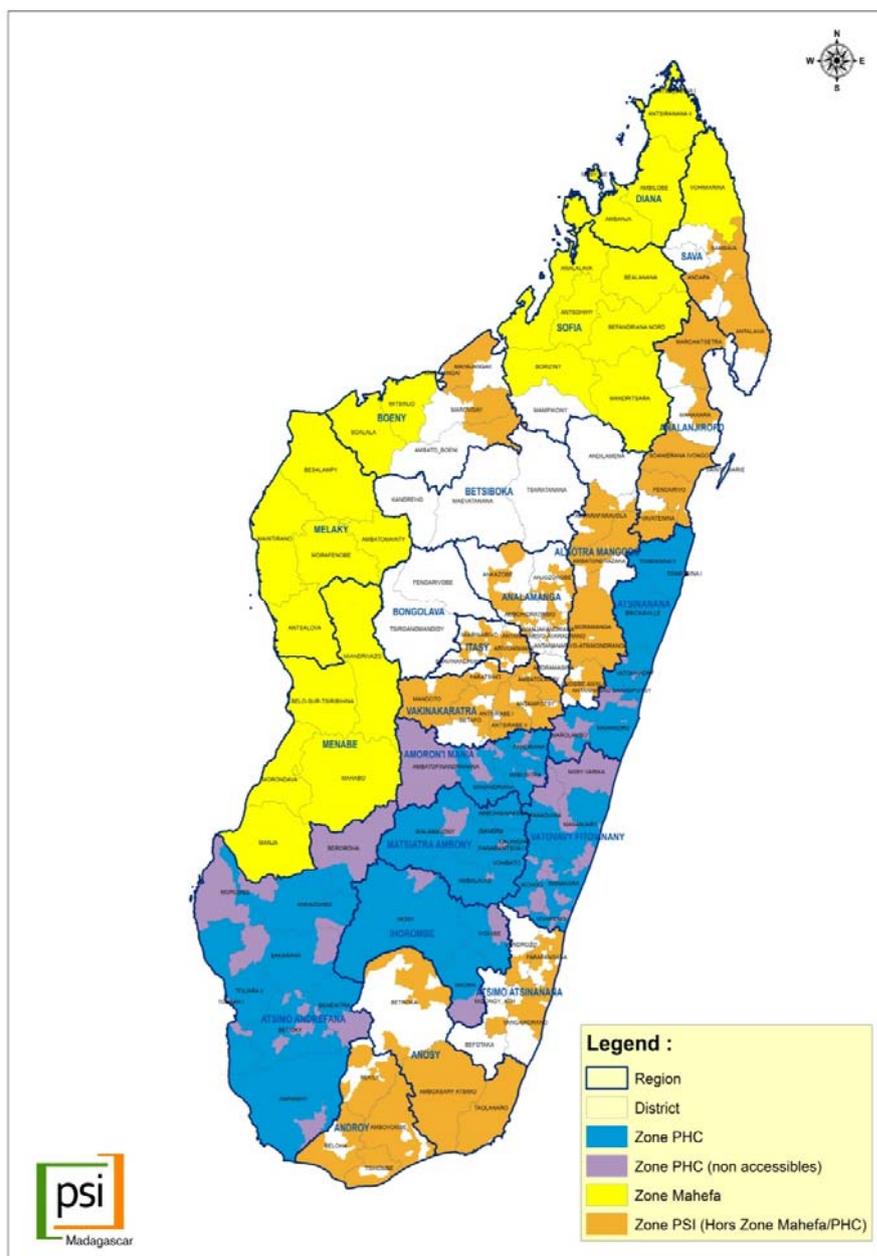
- In August 2013, 14 PAs located in the districts of Besalampy and Miandrivazo, considered as the most difficult areas to access in the MAHEFA zone, were trained. A total of 281 PAs and 11 'relay' PAs in MAHEFA zones have been trained so far.
- 92 commodity cabinets for PAs were delivered and another batch of 128 is being ordered. Currently, 94 PAs have received cabinets.
- Communes in the selected pilot districts of Mandritsara and Ambanja were identified as either being covered or not by the cell phone company Airtel network. PSI/Madagascar and Banyan Global are negotiating with Airtel that PAs located in communes not covered by the Airtel network can acquire phone equipment under the Village Phone project.

As agreed with USAID in February 2013, PSI/Madagascar has continued to distribute social marketing products for community based distribution in areas where there are no CHWs working with USAID-funded community health projects, but where there are functional PAs and NGOs supervising CHWs. The map below illustrates the CBD coverage indicating the different zones where PSI/Madagascar intervenes with CBD activities vis-à-vis the presence of USAID bi-lateral health projects (see Map 1: Community Based Distribution).

Challenges:

- FY 2013 distribution targets for *Pneumostop* syrup were not reached due to procurement delays resulting in late product arrival in late September, which was originally scheduled to arrive in August. Distribution of the 25,000 bottles of *Pneumostop* syrup that were sent by air started in October and will continue in Q1 of FY 2014.
- FY 2013 distribution targets for DTK *Viasur* were not met due to procurement delays; the air shipment of 25,000 kits arrived during the second week of October. Distribution of the *Viasur* kits began in third week of October, with an additional 50,000 kits expected to arrive via sea shipment at the end of November.
- As the rainy season typically begins in December, good stock forecasting for PAs located in difficult-to-access areas is required. The major challenge is the financial ability of PAs to buy enough stock to cover 4-6 months, and the reduced access for supervision and direct assistance from PSI/Madagascar.

COMMUNITY BASED DISTRIBUTION CHANNEL



Intervention Area 3.3: Malaria Campaigns

In October 2013, a mass distribution campaign of 2.7 million free long lasting insecticide treated nets (LLINs) took place in Madagascar to maintain the national coverage rate. This campaign prioritized the same 28 districts that were covered by the 2010 campaign. Mass distribution campaigns are broken down in three phases: pre-campaign; per-campaign; post-campaign. This FY 2013 report covers only the pre-campaign phase. The actual campaign and the post-campaign period will be covered in the first Quarterly report of FY 2014.

The table below gives an overview of the pre-campaign activities in FY 2013.

Month	Pre-Campaign Activities	Targets	Responsibility
January-March	-Develop campaign strategic plan (gap identification, implementation scheme)	-Action plan developed by each sub-committee of the CNC	PSI & partners
June	- Conduct training (at all levels) including campaign coaches and sub awardees: assessment and of distribution strategy; advocacy plan, social mobilization, campaign messages and logistical needs assessment in line with the distribution strategy; development of the micro positioning plan of the LLINs based on census results	-Targets: 72 key players of the campaign understand the strategy of the campaign execution and are equipped to execute it.	PSI
	-Lead sub-grantee recruitment and training process:	-Subcontracting for campaign execution	PSI
June -September	- Monitoring of training (TOT at all levels)	- Targets: 8 Regional Managers and 24 districts managers received supervision/training on the census and on the overall campaign process.	PSI
August	- Lead the procurement process: transporters, logistical and promotional tools production (except LLINs)	- Contracting with transporters for micro plan execution	PSI
	- Campaign macro logistics (transport, storage, macro-plan)	-Targets : 2.700.000 MID transferred to 28 districts	PSI
	- Campaign micro logistic (transport, storage, micro plan)	- Census in the 3425 fokontany of the 28 districts	NMCP
		-Development of 24 the micro positioning plan of the LLINs based on census results	PSI & partners
September	- Pre campaign BCC : distribute/disseminate campaign logistic tools and promotional materials: conception and production of IEC materials and radio spots	-2,498,300 LLIN transferred to the 28 districts *targets : validation of art work for the production of 11,285 vests for CHWs, 7,398 sensitization guides, 52,722 sensitization posters, 1,295 localization posters, 320 banners	PSI

In the latter part of FY 2013, PSI/Madagascar activities focused on the preparation of the mass distribution campaign, with support from the Presidential Malaria Initiative (PMI) under the ISM Program in 28 districts, as follows:

- *Coordination and action plan:*
 - With support from PMI and the National Coordinating Committee (CNC), the strategic plan for the campaign was revised¹⁵ through weekly coordination meetings.
 - The action plan and timeline were finalized. The distribution dates were set from September 30 - October 6, 2013.
 - The M&E plan was finalized. The CAMPMID¹⁶ database was updated, simplified, and approved by the CNC.
- *Training:*
 - The training manual and the training curriculum for CHWs were validated by the CNC.
 - PSI/M organized a training of trainers at central level in June 2013: 20 PSI/M staff was trained.
 - TOT at central and regional level was conducted in July 2013: 8 Regional Managers and 24 districts managers received PSI/M supervision/training on the census and on the overall campaign process.
 - A total of 11,285 CHWs were trained in 320 communes.
- *Sub-contractor recruitment:*
 - 11 sub-contractors were selected to ensure implementation of the campaign in the 28 districts. The sub-contractors trained the CHWs, and mobilized distributors and warehouse managers at site level, and supervisors at regional, district and communal levels during all phases of the campaign.
 - During the sub-contractors' recruitment process, PSI/M realized that one of the subcontractor chosen (NGO ACADRID for Lot 3) was unable to reach the campaign objectives and did not have a sufficient understanding of mass campaign implementation. PSI/M decided to terminate the agreement with this sub-contractor and to re-open the contracting process. The new submissions did not reach the selecting committee's expectations, so the committee decided that Lot 3 will be covered by NGOs operating around the Lot 3 areas and will be postponed to November. Lot 3 was divided into two parts:
 - Lot 3A: Implemented by ODEFI (Maintirano, Ambatomainty, Antsalova) and
 - Lot 3B : Implemented by GOLD (Morafenobe)
- *Communications (pre campaign):*
 - The communication plan was finalized and approved by the CNC. Campaign materials were pretested with target groups (CHW vests, flyers, radio spots in local dialects, etc.)
 - The conception and production of IEC materials and activities started as planned: this included the production of 11,285 vests for CHWs; 7,398 sensitization guides; 52,722 sensitization posters; 1,295 localization posters; and 320 banners. The production was completed except for the vests that were produced only at 50% because of the failure of suppliers to deliver the products on time (861 of 7,000 previous vests were not delivered on time by the supplier).
- *Procurement process (except LLINs):* The procurement plan was established for transporters (at district level) and for production of promotional tools.
 - PSI sub-contracted with the transporters with funding from ISM.

¹⁵Revisions covered areas such as: Implementation scheme; communication plan; priority areas to be served by the first campaign in 2013; and re-organization of the CNC.

¹⁶ CAMPMID is the name of the software for data collection and management of the LLIN mass distribution campaign.

- These contractors transported **2,498,300** LLINs.
- *Campaign macro plan logistics:*
 - The procurement process for LLINs was handled by DELIVER.
 - A total of **2,699,750** of **2,700,000** LLINs from PMI arrived in country.
- *Campaign micro plan logistics:*
 - Development of the micro positioning plans of the LLINs based on NMCP census results. The quality of the census data, however, was deemed unreliable, and a specific additional amount was assigned to each district to anticipate LLINs gaps for some districts.
 - **2,498,300** LLINs were delivered to the 28 districts.

201,450 LLINs remain after distribution to the 28 districts. Based on PMI's decision, 50,000 of the remaining LLINs will be designated for emergency distribution, while the remaining balance will be designed to cover any gaps during the upcoming GFATM mass campaign.

Challenges:

- Mass campaign monitoring by trained coaches in remote areas;
- Ensuring data completion with CAMPMID by each sub-contractor;
- Managing post campaign activities before the rainy season starts in December 2013;
- Finalizing all per campaign activities including the Lot 3 situation, where distribution has been postponed until November;
- Ensuring traceability of LLINs distributed and remaining nets at the distribution sites;
- Ensuring timely and complete collection and analysis of point-of-delivery data sheets at community level to verify mass campaign distribution to the end users.



Photo 2: USAID 2013 Mass Campaign Distribution

Cross Cutting Issues:

Research, Monitoring and Evaluation, Gender and Environmental Standards

PSI/Madagascar conducted the following research and program improvement activities during FY 2013:

Quantitative Research/Program Improvement:

- *Provider motivational study (Quarter 3-4):* As mentioned earlier in this report, PSI/Madagascar encourages TR providers to adopt a series of ‘desired behaviors’, which are:
 - 1) Efficiency (provision of services according to quality standards);
 - 2) Performance in terms of productivity (number of customers); and
 - 3) Good collaboration with PSI/Madagascar (assiduity on reporting, meetings and training, availability for supervision, availability to receive clients referred by agents, improving the clinic according to PSI/Madagascar recommendations).

PSI/Madagascar’s research team conducted a survey in July 2013 among all *Top Réseau* providers (N=223) to detect their level of motivation, and according to their level of performance, assess what characteristics of the network appeal to them most and least. Findings indicate *Top Réseau* providers are motivated to perform according to the above three criteria when there is high quality training & supervision, as well as a humanitarian/social cause related to their work.

- *Client satisfaction survey (Quarter 3-4):* Client exit interviews were conducted at 76 selected *Top Réseau* clinics in three sites (Antananarivo, Toamasina and Fianarantsoa) in July 2013. Clients include male and female young people (18-24 years of age), female clients who are older than 24 years, and mothers of children under five in urban areas. Results show that 98% of *Top Réseau* clients were satisfied with overall services obtained from the *Top Réseau* providers. While this is encouraging, the program team is recognizant of the importance of maintaining high quality standards in the network, and will continue its regular support and supervision visits, network meetings and quality audits.

Qualitative Research /Program Improvement

- *FoQus on Segmentation Rural Youth (Quarter2-3):* A qualitative study using in depth interviews and focus group discussions was conducted among 145 male and female youth in three sites (Miarinarivo, Ihosy and Antsohihy). Findings from this study highlight major knowledge gaps and misconceptions regarding modern contraceptive methods and the need to bring correct information to rural youth.
- *Pretesting of malaria campaign new IEC materials:* In support of the 2013 LLIN distribution campaign, a pretest of all campaign related communication materials

was conducted among CHWs and household members in Tsiroanomandidy. All the materials were used during the 2013 campaign.

The team further began preparations for the pretest of the brand name and packaging of the new condom youth and the Healthy Family campaign drama¹⁷.

MANAGEMENT INFORMATION SYSTEM

During FY 2013, PSI/Madagascar completed the following activities related to MIS:

- **Clinic-level Monitoring:** Following the integration of new clinical services through the *Top Réseau* private clinics (cancer screening and treatment at selected sites; components of the IMCI approach including nutrition), PSI/Madagascar modified its client visit data collection tools and broader management information systems (MIS) to allow for monthly reporting on relevant program data. Current levels of information through routine MIS will be maintained (number of visits per clinic, client profile, type of visit per health area, etc.). In addition, information for new health areas and information coming from the new SAF and SALFA rural clinics will be included on data collection tools and systems, and collected for analysis/reporting and for feedback to providers
- **Monitoring & Evaluation (M&E) and MIS Systems:** The improved decentralized M&E system, developed in FY 2011/2 and rolled out in headquarters and regional offices, is fully operational. The system collects information across PSI/Madagascar's five key intervention areas, namely: 1) supply chain and distribution; 2) capacity building; 3) BCC (IPC, MVU and mass media); 4) service delivery; and 5) sub-recipients. Activities in FY 2013 included refresher training for central and regional M&E focal points. Focal points received training on data collection tools, storage/protection, and routine data quality assurance, in accordance with an M&E handbook and the first version of the Data Quality Assurance (DQA) Manual.
- **Continued refresher training for staff:** Workshops were held with regional teams to reinforce their capacity in Data Quality Assurance. The workshops included practical exercises on routine DQA using real data related to the key intervention areas listed above, and development of an action plan for data quality improvement. A total of 24 regional workshops were held in FY 2013.
- **Data Quality Assurance supervision:** Routine DQA supervision visits were conducted in nine regional sites. Representative samples of data were selected and checked. In addition to the routine DQA, refreshing trainings on general M&E, database management, Quality Assurance as well as maintenance of the database system were given to regional staff.

¹⁷ These pre tests were planned for Q4 of FY 2013 but data collection has been postponed to Q1 of FY 2014 for the youth condom and for Q2 for the pre test of the Healthy Family campaign materials.

- **MIS for LLIN campaign implementation:** CAMPMID is the name of the software for data collection and management of the LLIN mass distribution campaign. Data collection tools were adjusted and a new version of CAMPMID software was developed based on experiences of the 2012 campaign. All the sub-recipients' staff in the 28 districts were trained on the MIS system for the LLIN 2013 campaign in Quarter 4 of FY 2013.

Additionally, PSI/Madagascar performed on activities in the three cross cutting areas, namely gender, capacity building and environmental impact mitigation, as follows:

Gender: Efforts for gender mainstreaming in the ISM project during this first year focused on integrating gender into training curricula development and revision. Five trainings for PSI staff were conducted that covered gender concepts, donor requirements and positive male engagement in gender equity.

A gender assessment was completed during this FY that will guide gender transformative work in the upcoming FYs. The assessment showed that contraceptive use is negotiated through a lens of '*marriageability*' based on what FP use or potential use says about the partners involved and the quality of the relationship. Global research has demonstrated the connection between aspects of relationship quality such as intimacy, commitment and duration and contraceptive use. Those studies show a transition from condoms to hormonal methods as relationship quality increases. This transition was not readily apparent from the ISM focus group discussions where young people talked primarily about "counting days" and condom usage. One possible explanation is the strong perception that hormonal methods are not appropriate for unmarried women or women who have not already given birth.

Among married couples contraceptive use is negotiated through a lens of mistrust where partners interpret FP use or non-use in terms of marital infidelity. Given the levels of mistrust and the potentially devastating impact on the couple, all of the focus groups discussed hidden contraception as a viable option for women who are not able to convince their partners to use family planning or for whom such a conversation would be problematic. While unmarried young people talked primarily about the calendar method and condoms, married couples primarily discussed hormonal methods. Studies have shown that injectables are the most popular method for those hiding contraceptive use. As with young people, fear of side effects remains a barrier to modern contraceptive use.

While all of the FGDs revealed men and women fulfilling traditional gender roles, those same FGDs all provided glimpses into a Malagasy culture in transition particularly in those places where women have access to employment and income. Yet even in the rural areas men are more involved in the health and daily lives of their wives and children and in more non-traditional ways than might have been expected. This makes it a very opportune time to launch the BCC on Model Fathers and Mothers, and Healthy Families that offer positive images of masculinity and

encourage these men who are stepping out of traditional roles or who would like to be more involved in their families but do not know how.

Using the finding of this assessment, a draft work plan has been designed. One key activity informed by this report is the adaptation of the Healthy Images of Manhood (HIM) that will tackle the issues that hinder men from supporting their partner to use family planning, especially rumors and myths. This model of male involvement is based on three pillars: men as clients of services, men as equal partners and men as agents of change.

Subsequent to the gender assessment, integration activities began with the participation of the Intrahealth local gender coordinator in the DELTA planning process (see IR 1 above) and integration into the training curriculum for the youth peer educators. Integration into the curriculum focused on enabling youth peer educators to understand the effect of gender inequality on their work and what can be done to address and transform negative gender norms and reinforce positive gender norms.

Working with youth peer educators provides an opportunity to ensure that messages on equitable gender norms arrive at the right time in young people's lives and can be both discussed and modeled by trained youth peer educators. Gender integration in the curriculum emphasizes empowering young women to seek better healthcare, to wait to have children until they are ready, and teaching young men that risk-taking and violence do not define masculinity.

- **Capacity Building and Results Sharing:** Building capacity of our staff and local partners remains a pillar of PSI/Madagascar's approach in Madagascar. As an organization with experienced staff and resources in programmatic, financial, M&E and other areas, PSI/Madagascar regards the sharing of these skills with partners as an essential component of our work. Some examples of FY 2013 capacity building efforts include:
 - a) Collaboration around distribution and product promotion with MAHEFA and the new Primary Health Care project partners, and exploring a prospective partnership with the US Peace Corps (Quarter 4). To this effect, meetings took place regularly with MAHEFA in FY 2013 -- and will commence with PHC -- and a first meeting was organized between the PSI/Madagascar Country Director and the US Peace Corps Country Director in Quarter 4 to discuss possible ways of collaboration.
 - b) Training and strengthening the capacity of SAF and SALFA private clinics in rural areas, which includes working with providers as well as IPC agents. For example: SAF and SALFA community supervisors received a training of trainers in '*Education through Listening*', an innovative BCC technique and 48 of their IPC agents will subsequently be trained.
 - c) Regional network meetings for *Top Reseau* providers -- with a total of 23 such meetings held in FY 2013 - where providers come together to discuss progress, challenges and areas for further/continued support.

- d) Ongoing training of trainers for PSI/Madagascar's health service delivery work among the growing pool of local *Top Réseau* doctors.
- e) Business and finance training for PSI/Madagascar staff working with *Top Réseau* providers, continuous learning from partner Intrahealth on quality assurance in training and supervision, and exposure to international experts in a variety of domains (e.g. communications, supply chain management, gender, and performance based financing).

PSI/Madagascar also considers critical the continued enhancement of the skills of its own staff. Technical assistance for the PSI/Madagascar operational and program teams was provided throughout the first Quarters of this FY in a range of areas including: supply chain management, gender (training and assessment techniques), communications/creative design, quality assurance, and business and finance training. Moreover, many of PSI/Madagascar's national staff have and will travel abroad to participate in international meetings or workshops, to present PSI/Madagascar's work in areas such as FP/RH, IMCI, malaria prevention or service delivery. In Q3 of FY 2013, for example, the MIS coordinator attended an overseas training to learn about improved data quality management and reporting using the District Health Information System Version 2.

In August 2011, in partnership with HNI, PSI/Madagascar started using the *DataWinners* SMS system to collect data on commercial sales (in addition to selected outreach activities for FP), which allows for an accurate performance measure of commercial outlets' activities. In FY 13, PSI/Madagascar finalized its contract with HNI building on the *DataWinners* project and has begun expanding this approach to community-based distribution where the timely availability of data is crucial to make operations even more efficient. The project site, included on the global *DataWinners* website, includes stock levels for each supply point, product sales and the number of days of stock out, if any. PSI/Madagascar and MAHEFA started working with HNI to capture data from CHWs on product sales and services provided to clients. Supply point and CHW data are to be synchronized and presented in a single dashboard.

PSI/Madagascar's collaboration with HNI for PA data collection continued to expand in new areas. After testing in four pilot districts the previous year (Ambatolampy, Moramanga, Ambatondrazaka, Mahabo), PSI/Madagascar's selected and began implementation with 309 PAs in 17 new districts. HNI provided a training of trainers to the PSI team which then provide direct training to PAs during their periodical supervision visits. 27 PAs received training on data collection during FY 2013.

In collaboration with the phone company Airtel, PSI/Madagascar started exploring the possibility to provide supply points in rural areas with mobile phone equipment to allow them to send reports by SMS when there is no commercial network coverage. The village phone project involves a variety of partners including Banyan Global, MAHEFA (and in future, the Primary Health Care project), the microfinance institution PAMF and HNI. In order to further improve PA efficiency and

sustainability, PSI/Madagascar and Banyan Global collaborated to provide training to 38 PAs in the districts of Mandritsara and Ambanja; the PAs received training in business management, with topics including “simplified accounting” and "cash management".

The use of Village Phone project (VPP) equipment was introduced during the training led by Banyan International and PSI/Madagascar’s. Four communes in the district of Ambanja and three communes in the district of Mandritsara are not covered by the Airtel network and therefore were candidates for the use of VPP. The equipment could be purchased by the PAs through a loan from the local microfinance network. PSI/Madagascar and Banyan Global were responsible for facilitating the acquisition of equipment from Airtel and the loan from the microfinance organizations. Because of these negotiations with Airtel, PAs are now able to pay a total cost of 250,000 Ar, which includes a 150,000 Ar bonus of call credit available for three months of operation. This arrangement allows the PAs to buy the equipment at 100,000 Ar and to start working with a call credit of 150,000 Ar.

Environmental Standards: PSI/Madagascar continued activity-specific environmental mitigation activities as detailed in the Environmental Mitigation and Monitoring Statement (EMMS) as part of its efforts towards minimizing the environmental impact of its programs. The EMMR is included as an Annex to this report.

Annex A: Work Plan Activity Status Update (Attached)

Annex B: Results Framework and Quarterly Activity Results (Attached)

Annex C: Distribution Graphs (Attached)

Annex D: Family Planning Compliance Plan (Attached)

Annex E: Environmental Mitigation and Monitoring Plan (Attached)

Annex F: Participant Training Information (Attached)

Annex G: Success Story (IUD) (Attached)

Annex H: Gender Assessment Report (Attached)

Annex I: Research Reports (Attached)

Annex J: Budget Analysis (Attached)

Annex A

**WORK PLAN ACTIVITY STATUS
UPDATE**

PSI/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intermediate Result 1: Increased adoption and maintenance of healthy behaviors									
Cross cutting communication									
	P25	Apply BCC framework on a larger scale to integrate existing communication campaigns, tools and messages into an overarching Healthy Family campaign that will address all three health areas outlined in the RFA by linking various healthy behaviors with relevant products and services							
		<i>Produce 3 DELTA marketing plans (Family Planning / Reproductive Health ; Child Survival ; Health Services) to develop the Healthy Family ("HF") campaign strategy</i>						Completed	
		<i>Organize communications technical assistance to support PSI/M in designing and executing the "HF" communication plan</i>						Completed	
		<i>Renew communication equipment (video station, camera) to improve the production capacity of video tools</i>						Completed	
		<i>Prepare pre-production of the "HF" radio spot and mobile video unit (MVU) film</i>						Completed	
		<i>Prepare production of the "HF" radio spot and MVU film</i>						Postponed to Q1 FY 2014	
	P27	Using the youth archetype for urban and rural areas, develop a youth-focused campaign, indirectly linked to the Healthy Family campaign for urban and rural youth (linking in with voucher and loyalty card systems)							
		<i>Produce a youth DELTA marketing plan that includes rural and urban youth profiles, communication objectives and key messages targeting youth, using results from the FoQus study and the gender assessment</i>						Completed	
		<i>Produce a youth communication plan linked to the "HF" one and detailing communication channels, tools, budget and media plan</i>						Completed	
		<i>Adapt and broadcast existing radio programs and spots targeting urban youth</i>						Completed	
		<i>Develop the youth loyalty scheme and produce the loyalty card for young FP/RH services at Top Réseau</i>						Postponed: To be completed in Q1 FY14	
		<i>Plan for an educational event targeting youth in collaboration with community-based groups and youth clubs</i>						Completed	
	P28	Shift to supporting USAID-funded community-health projects in generic IPC messaging conducted by CHWs							
		<i>Prepare and discuss with Mahefa and Santénet2 (and the new PHC project) the strategy to help CHWs enhance their IPC activities</i>						Ongoing	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future)
		<i>Prepare pre-production of communication tools (linked to the "HF" campaign) that will help communities identify CHWs as health providers (e.g. advertising signs) and that will help CHWs conduct IPC and create demand for social marketing products (e.g. brochures, booklets, flyers, social franchising brochures to help CHWs refer clients to Top Réseau)</i>						Ongoing	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future)

PSI/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intermediate Result 1: Increased adoption and maintenance of healthy behaviors									
		<i>Produce and distribute the communication tools mentioned above to NGOs working with Mahefa and Santénet2 (and the new PHC project)</i>						Pending progress on the above activities	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future)
	P28	Explore with Mahefa and Santénet2 (and the new PHC project) development of a model mother and model father program for rural communities to support CHWs in their community sensitization and IPC work							
		<i>Develop and present to Mahefa and Santénet2 (and the new PHC project) the model mother and father program strategy</i>						Ongoing: A concept-note has been developed and presented to MAHEFA for discussion and finalization	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future), Intrahealth
		<i>In collaboration with Mahefa and Santénet2 (and the new PHC project), finalize the program strategy and develop an operationalization plan for the program (for FY 2)</i>						Ongoing	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future), Intrahealth
		<i>With the aim to support the "HF" larger communication activities, prepare pre-production of BCC tools (TBD) that will help rural role models tell their stories</i>						Pending progress on the above activities	NGOs in Mahefa and Santénet2 areas (and in new PHC areas in the future), Intrahealth
	P28	Coordinate with Mahefa and Santénet2 (and the PHC project) to build in/expand/improve IPC and gender training modules into existing CHW training, for all health areas and products						Ongoing: a ToT on Education through Listening was completed	PSI/M, Mahefa, Santénet2, PHC project
	P27	Continue integrating mid-media activities (community events and MVU sessions) to support the Healthy Family campaign							
		<i>Launch the "HF" concept during a community event (e.g. Malaria Day on April 25th)</i>						Postponed until the first episodes have been finalised	PMI
		<i>Renew the MVU equipment (videoprojector, screen, loudspeakers, PDA) to organize the MVU sessions that will be a mid-media component of the "HF" campaign</i>						Ongoing. The new equipment should be fully installed at the start of FY 2014	
	P28	Leverage existing PSI global relationship with the US Peace Corps Volunteers (PCV) in support of BCC capacity building efforts working with PCV in communes in rural Mahefa and Santénet2 areas							

PSI/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intermediate Result 1: Increased adoption and maintenance of healthy behaviors									
		<i>Prepare and sign a Memorandum of Understanding (MoU) with the US PC to officialize their support to BCC capacity building efforts in rural communities where Mahefa and Santénet2 operate</i>						Ongoing: A first meeting was held in Q4 and a follow up meeting to discuss operational details is planned for mid/late Nov	PVCs
	P29	Harmonize existing USAID and USAID-funded community health projects (Mahefa and PHC) BCC efforts, along with other relevant stakeholders							
		<i>Organize a BCC workshop with USAID, Mahefa and Santénet2 to a) present the content of the ISM's IR1, b) propose a ToT for Yr2 (Training of Trainers) for the ETL (Education through Listening) IPC technique for CHWs, c) harmonize PSI/M's, MAHEFA and Santénet2's BCC efforts (and include PHC in future)</i>						a) BCC workshop with Mahefa & SN2 to present the content of the ISM's IR1 : Completed b) ToT on ETL: Completed (for MAHEFA) c) Harmonize BCC efforts : Completed/ongoing (not yet for PHC)	Mahefa, Santénet2 and PHC
		<i>Actively participate in the Communications Working Group (CWG) led by USAID and in the BCC subcommittee for net campaigns</i>						Ongoing /periodical meetings	Mahefa, Santénet2, PMI, PHC
	P27	Train all IPC agents linked to <i>Top Réseau</i> clinics in the use of the ETL ("Education through Listening") IPC technique across health areas	# of IPC agents trained					Postponed until Q1 and 2 of FY 2014	
Intervention Area 1.1: Family Planning/Reproductive Health									
1.1.1	P27	Increase the focus on men in radio media, IPC and community mobilization efforts for FP/RH, working with SAF, SALFA and other local partners						Ongoing	
		Develop a creative brief for the "Men" campaign using results from the gender assessment						Completed	
		Produce the communication plan, related messages and materials (radio novel primarily) for the campaign focusing on men, using the results from the gender assessment and strategy						Completed	
1.1.2	P19-20	Work with CHWs from NGOs in Mahefa and Santénet2 areas for the referral of women to rural <i>Top Réseau</i> clinics for FP and in particular LTMs, as the <i>Top Reseau</i> networks starts to extend to rural areas (and include PHC in future, as relevant)	# of women referred to rural TR by CHWs for FP					Starting in FY 2014	Mahefa, Santénet2, PHC
1.1.3	P50	Recruit new IPC workers in urban <i>Top Reseau</i> sites to promote LTMs including with a voucher for subsidized services (Antananarivo) (with WHP funding)	120 youth PE recruited					Completed	
1.1.4		Continue placing existing mass media for the promotion of FP (and in particular LTMs with funding from the Women's Health Project)						Completed	
Intervention Area 1.2: Maternal and Child Health									
1.2.1	P28	Expand the successful youth scout program from urban to rural areas to leverage WASH (Sanitation and Safe Water use) messages							
		<i>Develop a strategic plan with WASH partners to expand the youth scouts program from urban to rural areas</i>						In progress	Scouts Program, WaterAid
		<i>Participate in selected scout outreach activities and events</i>						Completed/ongoing as per relevant activities	Scouts Program, WaterAid

PSI/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intermediate Result 1: Increased adoption and maintenance of healthy behaviors									
		<i>Disseminate WASH educational and promotional materials through scout activities</i>						Completed/ongoing as per relevant activities	Scouts Program, WaterAid
1.2.2	P19-20	Orient CHWs from NGOs in Mahefa and the new PHC project areas for referral of women to rural <i>Top Réseau</i> clinics for IMCI	# of women referred to rural TR by CHWs for IMCI					Starting in FY 2014	Mahefa, Santénet2, PHC
1.2.3	P24	Continue broadcasting existing child survival messages through national and local radio stations	1908 messages were broadcast					Ongoing	
1.2.4	P24	Produce sales and promotion incentives for existing child survival products						Completed/Ongoing	
Intervention Area 1.3: Malaria- P7									
1.3.1	P29	Harmonize malaria communications with other donor efforts							
		<i>Develop a malaria communication plan in line with the National Malaria Strategic Plan and in collaboration with the RBM</i>						Process began, communication plan development is continuing	Roll Back Malaria Committee
		<i>Monitor the implementation of the PSI/M's component of the malaria communication plan</i>						Ongoing	Roll Back Malaria Committee
1.3.2	P25	Conduct IPTp-focused communication to promote the importance of four ANC visits and the importance of IPTp for pregnant women in <i>Top Reseau</i> zones							
		<i>Develop a brief communication plan for IPTp related communications detailing key messages and radio media plan</i>						Completed/Ongoing	RBM, PMI
		<i>Produce and start broadcasting the IPTp-related radio spot in Top Reseau zones</i>	# IPTp spots broadcast					Not achieved: to commence in FY 2014	RBM, PMI
1.3.3	P25	Conduct RDT-related communications emphasizing that diagnosis with RDTs must be a precursor to treatment							
		<i>Extend communication emphasizing RDT use through collaboration with FIFA by developing a MOU</i>						Ongoing	RBM, PMI
		<i>Organize workshop with FIFA to develop 2014 activity workplan</i>						Starting in FY 2014	RBM, PMI
		<i>Organize event with RDT use as main message with partners such as FIFA, MAHEFA,</i>						Starting in FY 2015	RBM, PMI
		<i>Update RDTs message radio spot</i>						Completed	RBM, PMI
		<i>Broadcast radio spot related to RDTs use</i>	390 spots were broadcast					Completed	RBM, PMI

PS/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Indicator	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intermediate Result 2: Improved quality of selected health services in the private sector									
Intervention Area 2.1: Expanding access to quality services at private sector health clinics									
2.1.1		Expand <i>Top Réseau</i> network by adding at least 15 additional outlets in rural areas and 8-10 additional outlets in urban areas	16 clinics added in rural and 13 in urban area						
		<i>Sign subagreements with SAF and SALFA</i>						Completed	PSI/M, SAF, SALFA
		<i>Identify and recruit 15 additional SALFA and SAF clinics in rural areas</i>						Completed	PSI/M, SAF, SALFA
		<i>Upgrade the 15 additional clinics to conform to minimum quality standards</i>						Ongoing	PSI/M, SAF, SALFA, Intrahealth
		<i>Provide refresher training to SAF and SALFA clinic staff in FP/RH, STI management, and IMCI</i>	2 refresher trainings given					Completed	
		<i>Identify and recruit 11 new Top Réseau clinics in urban areas</i>	13 clinics recruited					Completed	PSI/M, SAF, SALFA, Intrahealth
2.1.2		Continue to promote <i>Top Réseau</i> services through radio with messages tailored for urban and rural targets, peer education (with vouchers for referrals), mini launch for rural <i>Top Réseau</i> , advertising signs for new rural <i>Top Réseau</i> clinics							
		<i>Select existing radio spot promoting Top Réseau services for urban and rural targets</i>						Completed	PSI/M
		<i>Broadcast existing radio spot in rural and urban areas</i>	80 spots broadcast					Completed	PSI/M
		<i>Recruit and train 120 youth peer educators to promote Top Réseau clinics and distribute vouchers for youth in urban areas</i>	120 youth PEs trained					Completed	PSI/M
		<i>Train at least 30 community agents for SAF and SALFA to promote new rural Top Réseau clinics and distribute vouchers in rural areas</i>	# of SAF and SALFA community agents trained					Postponed to Q2 FY 2014	PSI/M
		<i>Launch Top Réseau in 2 selected rural sites (NB. these would be symbolic launches in strategic locations as the budget doesn't allow for 15 clinic level launches)</i>						Postponed to Q1 FY 2014	PSI/M
2.1.3		Broaden the <i>Top Réseau</i> service package for qualified, motivated providers to include new health areas (e.g.: nutrition, maternal & neonatal health, ANC/PNC, post partum IUD; permanent methods) through training and supervision							
		<i>Develop training plan for new Top Réseau providers on basic service package, long term FP and nutrition</i>	46 providers trained (urban, rural)					Completed	IntraHealth, PSI/M
		<i>Explore the possibility to integrate new health services (maternal & neonatal health, ANC/PNC, post partum IUD and permanent methods) for selected urban and rural clinics</i>						Ongoing	IntraHealth, PSI/M
2.1.4		Increase and intensify training on Long Action Methods among new rural <i>Top Réseau</i> members							
		<i>Train new Top Réseau providers in rural areas on long acting methods</i>	# of providers trained on LTM					Not achieved: this is planned for FY 2014	SAF, SALFA, PSI/M, IntraHealth
2.1.5		Pilot demand-side community savings mechanisms in 2 <i>Top Réseau</i> sites (peri-urban)							
		<i>Consumer demand-side survey of current financing methods and feasibility of different options (savings, insurance, pre-payment schemes, etc.)</i>						Postponed to Y2	Banyan
		<i>Design pilot program (using one or more of the identified options)</i>						Postponed to Y2	Banyan
2.1.6		Review and update the existing quality assurance system for the <i>Top Réseau</i> franchise with a particular focus on new health areas and new members in rural areas							
		<i>Review and support in updating, as needed, the existing QA system for all health areas, including all tools, for the franchise, with a particular focus on new members and new health areas, while incorporating IntraHealth's Optimizing Performance and Quality, Learning for Performance, and other approaches, best practices/international and national standards</i>						Postponed to Q1 & Q2 FY14	IntraHealth
		<i>Critically assess past and ongoing training of providers to ensure conformity with international best practices, the compliance with the national standard and considering the the context in private sector</i>						Postponed to Q1 & Q2 FY14	IntraHealth

No.	Cf. COAG Page #	Activity	Indicator	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intervention Area 2.2: Capacity-building									
2.2.1		Build capacity and motivation of high performing <i>Top Réseau</i> providers by making them co-trainers to assist in cascading training activities for other providers							
		<i>Develop selection criteria of high performing Top Réseau providers</i>						Completed	IntraHealth, PSI/M
		<i>Invite at least 2 Top Réseau providers for a peer-training activity</i>	# of providers trained as co-trainers					Postponed to Q2 FY14	IntraHealth, PSI/M
2.2.2		Support the development of a database on provider quality (training scores-pre and post; supervisory feedback scores; quality audits, etc)							
		<i>Review the existing database</i>						Postponed to Q1 FY14	IntraHealth, PSI/M
		<i>Develop the provider quality database (training scores-pre and post; supervisory feedback scores; quality audits)</i>						Postponed to Q1 FY14	IntraHealth, PSI/M
2.2.3		Invest in provider motivation, supportive supervision and provider focused communication							
		<i>Using the results of the provider motivation study, develop a strategy to maintain and increase provider motivation, for both urban and rural providers</i>						Ongoing	PSI/M
2.2.4		Enhance the training approach for <i>Top Réseau</i> providers, upgrading current practices; incorporating adult learning techniques, real-life case studies and practice components; and skill transfer to PSI/M medical supervisory staff							
		<i>Assess and review existing training process and training tools, and enhance their content</i>						Completed	IntraHealth
2.2.5		Ensure gender is mainstreamed throughout the program (for providers, clients, staff; looking at equity of access, use, quality, ...)							
		<i>Use the findings from the gender assessment and implement the gender strategy as relevant for Top Réseau (see tab M&E and gender)</i>						Ongoing	IntraHealth
2.2.6		Develop and roll out business management, financial and other non health training for <i>Top Réseau</i> members							
		<i>Rapid needs assessment of Top Réseau members to identify business knowledge and skills needed</i>						Completed	Banyan
		<i>Develop training course and materials tailored to Top Réseau needs</i>						Completed	Banyan
		<i>Pilot the training course on selected providers and refine materials, for roll out in FY 2014</i>							Banyan
2.2.7		Increase access to finance for <i>Top Réseau</i> providers							
		<i>Conduct a financing needs assessment among selected providers</i>						Completed	Banyan
		<i>Conduct a financial sector assessment to identify potential institutions with whom the project could partner</i>						Completed	Banyan
		<i>Design a program to expand access to finance for providers including a DCA guarantee if feasible</i>						N/A	Banyan
2.2.8		Conduct exchange meetings among <i>Top Réseau</i> providers (each region will have at least 1 network meeting)						Completed	PSI/M
2.2.9		Train 40 community agents from SAF & SALFA in BCC innovative techniques (ETL technique)							
		<i>Review and update training curriculum on BCC</i>						Completed	PSI/M, SAF, SALFA
		<i>Conduct ToT for IPC supervisors from SAF & SALFA</i>						Completed	PSI/M, SAF, SALFA
		<i>Train SAF and SALFA community agents</i>	# of SAF and SALFA community agents trained					Postponed to Q2 FY 2014	PSI/M, SAF, SALFA

No.	Cf. COAG Page #	Activity	Indicator	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
Intervention Area 2.3: Promotional support									
2.3.1		Develop and pilot a loyalty scheme to attract new adolescent users in urban and rural areas to <i>Top Réseau</i> services	# of youth coming with a loyalty card for TR services					Postponed until Q2 FY 2014	PSI/M
2.3.2		Recruit and train peer educators in urban areas (youth, male and female) to promote FP/RH services at <i>Top Réseau</i> clinics	120 PE trained					Completed	PSI/M
2.3.3		Continue mass media and other promotional activities to benefit <i>Top Réseau</i> providers (urban and rural) and CHWs that create demand for their services	80 mass media spots aired					Ongoing	PSI/M
2.3.4		Review marketing, branding and communication plan for <i>Top Réseau</i>						Completed	PSI/M
2.3.5		Develop and distribute promotional items for <i>Top Réseau</i> network providers as part of provider focused BCC						Ongoing	PSI/M
2.3.6		Work with the National Doctors' Association (ONM) and their regional offices (CROM) to maintain and expand their support to the <i>Top Réseau</i> franchise and other franchised clinics in Madagascar							
		<i>Hold an introduction meeting with the local CROM in the new Top Réseau sites</i>						Completed	PSI/M, ONM, CROM
		<i>Present ONM and CROM 2013 workplan and Top Réseau achievements</i>						Completed	PSI/M, ONM, CROM
		<i>Support CROM through participation in local promotional events</i>						Ongoing	PSI/M, ONM, CROM

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
		<p>Following DAMM communication on August 12, PSI to prepare new application, including:</p> <p>1) <u>Authorization to Market Registration Fee</u>: the registration fee must be paid again and the original letter requesting authorization to market the product needs to be updated.</p> <p>2) <u>Intruction notice and artwork</u>: The Iris proofs with revised artworks were received from Erica on August 9 (2 days after planned due date).</p> <p>3) Administrative dossier: PSI requested the following documents again from Erica on August 12:</p> <ul style="list-style-type: none"> renewed GMP renewed Certificate of pharmaceutical product renewed pharmacist commitment <p>4) <u>Produce & Ship product samples (including notice)</u>: Following production of final sample artwork, Erica is to ship a sample batch of 20 blisters of 6 pills each with the final artwork and a new batch analysis certificate.</p>						Completed: new application submitted the first week of oct	
		<i>Submission of new application to DAMM</i>						Completed	
		<i>Conduct high level advocacy with the DAM to speed up the registration process once documents have been received from the manufacturer</i>						Ongoing	
		<p>1) The DAMM required that these samples be available for the review of the new dossier. => PSI tried to negotiate a waiver for this but it was rejected.</p> <p>2) In addition, DAMM procedure is to conduct an analysis of sample products received. This step typically takes 2 months, and during this time the process is on hold. => PSI will try to negotiate for a waiver with the DAMM for the sample analysis, but there is no guarantee that we will succeed.</p> <p>3) The DAMM meets once a month as a committee to review new applications. review took place the 4th => PSI will request a special meeting before this date, but cannot guarantee that we will get an earlier date.</p>						Completed	
		<i>Ensure that the technical product specifications follow national program requirements</i>						Completed	
		<p>Final Test Report, Production and Shipping: The goods will be inspected and samples sent to an independent test lab for quality testing before PSI Procurement (HQ) authorizes the shipment</p>						This is planned for FY 2014	
		<i>Distribute 67,500 PTKs</i>	24,949 kits distributed					Not achieved: Stock out of product. Air shipment received in third week of September.	
		<p><i>Pneumostop suspension:</i> On August 8, PSI was informed that the manufacturer had to re-schedule sampling dates from August 2 to August 19, as two batches failed the manufacturer's in house testing. The third batch was tested the week of August 19. Product passed the test and was both air and sea shipped in September.</p>						Completed	
3.1.6	P34	Continue to promote Sûr'Eau safe water treatment (big 150 ml and small 40 ml bottles)							
		<i>Distribute 180,050 40ml bottles for the community channel and 1,633,500 150ml bottles for the commercial channel</i>	333,231 (40ml bottles) and 1,642,191 (150ml bottles) distributed					Completed	
		Malaria							
3.1.7		<i>Distribute free non branded RDTs (with safety box & gloves) through community based distribution (quantity to be determined) in Santénet2 and Mahefa areas</i>	878,378 RDTs distributed					Ongoing	PSI/M
3.1.8		<i>Continue to promote GF funded malaria treatment and prevention social marketing products by distributing 300,000 Super Moustiquaire and 850,000 ACTs in calendar year 2013 (N.B. this objective is not part of the ISM's distribution objectives)</i>	760,831 ACTs and 279,240 SuperMoustiquaire distributed					Ongoing	
		HIV/STIs							

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
3.1.9		Distribute with funding from the GF, 8,603,095 Protector Plus-branded condoms, 3,651,670 generic condoms targeted at clients of female sex workers and 40,000 Feeling-branded female condoms targeted at female sex workers in calendar year 2013 (N.B. this objective is not part of the ISM's distribution objectives)	7,732,396 Protector Plus condoms and 943,872 generic condoms distributed. 37,155 Female condoms distributed					Ongoing	
3.1.10		Continue to distribute with support from SIFPO 2 STI treatment kits : 180,484 Cefidoxal-branded kits and 50,000 Genicure-branded kits in calendar year 2013 (N.B. this objective is not part of the ISM's distribution objectives)						N/A	
Intervention Area 3.2: Supply chain management									
3.2.1	P37	Continue to train community supply points, pharmaceutical/commercial wholesalers, pharmacies/retailers on socially marketed products							
		Produce and distribute management tools to supply points that are going to be trained in stock management	4,300 management tools produced					Completed	
		Organize 1 refresher stock management training for already operational supply points and 1 initial stock management training for newly recruited supply points	146 PA trained					Completed	
		Conduct post-training assessment to adjust for future trainings						Completed	
		Organize on-going visits of pharmaceutical and commercial wholesalers during which capacity building in and demand creation for socially marketed products will be conducted						Completed	
		Produce materials for supply points and advertising signs for retailers to improve their functioning						Completed	
3.2.2	P37	Expand the community-based network of supply points							
		Secure 3 additional regional warehouses (Maintirano, Antsohihy, Bekily)						Completed	
		Add additional supply points in Mahefa and the new PHC project zones						Completed	
		Work with Mahefa and the new PHC project to institutionalize coordination meetings at the regional levels and continue to actively participate in coordination and commodity quantification meetings/workshops at the central level						Completed	
3.2.3	P37	Train a small group of key community supply points in financial and business management and pilot access to credit for key supply points (focusing on female operated supply points where possible)							
		Conduct a rapid needs assessment for supply points & identify business knowledge and skills needed by supply points						Completed	Banyan
		Develop training materials & develop business curriculum for supply points						Completed	Banyan
		Conduct Training of Trainers (ToT) with PSI/M's team of trainers/promoters (for rollout to the broader network of supply points)						Completed	Banyan
3.2.4	P36	Enhance the current pull system through the private sector (commercial and pharmaceutical channels)							
		Organize for a FY 2 consultant evaluation of the pull system to document lessons learned and to improve the system						Postponed to FY 2	
		Revise pricing structures based on evidence						Postponed to FY 2	
3.2.5	P36	Improve the pharmaceutical distribution channel							
		Provide non monetary prices to highly performing wholesalers and to Niphar						Ongoing	
		Develop merchandising efforts by tightening the links between pharmaceutical wholesalers and pharmacies (through regular visits) and by producing promotion and advertising tools for existing pharmaceutical products (for wholesalers only)						Completed	
3.2.6	P39	Continue active participation in the supply chain working group in partnership with USAID						Completed	MAHEFA, the new PHC project
3.2.7	P36	Explore potential synergies with existing large beverage distribution network(s) to expand product commercial coverage of rural areas							
		Identify key potential beverage distributors and develop selection criteria and terms of reference						Postponed to FY 2	
		Organize visits to large beverage distributors and assess their interest in partnering for distribution of socially marketed products							
3.2.8	P37	Continue to distribute products directly to supply points in communes accessible by car and start distributing products directly to supply points in communes accessible by motorbike (particularly in Mahefa zones)							
		Identify # of communes and supply points accessible by car and # of communes & supply points accessible by motorbike						Completed	MAHEFA, the new PHC project
		Purchase motorbikes for distribution assistants						Completed	
		Directly deliver socially marketed products to supply points in Mahefa and new PHC project zones						Completed	MAHEFA, the new PHC project
3.2.9	P38	Develop (with STTA) a community supply chain procedural manual, enhance the supply points training curricula and reporting tools and liaise with HNI for the roll out of a LMIS (Logistics Management Information System) including data collection and product forecasting							
		Organize supply chain technical assistance to support PSI/M in community supply chain management						Completed	HNI, Mahefa, the new PHC project
		Work in tandem with the supply chain technical expert and with partners to develop a draft LMIS, a draft of procedural manual and to initiate revision of supply points' working tools						Postponed to Q1 FY 2	HNI, Mahefa, the new PHC project
3.2.10	P37	Using SMS technology, enhance forecasting and data collection to decrease the risk of stock out. Additionally, set up an LMIS with HNI and by coordinating with Mahefa and Santénet2 projects, to report data on products distributed by CHWs to end users							
		Draft and finalize HNI's Terms of Reference						Completed	HNI, Mahefa, the new PHC project

No.	Cf. COAG Page #	Activity	Indicator (cumulative)	Year 1				End of FY 2013 Status	USAID Partner Involvement
				Q1	Q2	Q3	Q4		
		<i>Work with HNI to pilot use of SMS technology in order to help supply points place orders, report on stock levels and forecast needs</i>					Completed	HNI, Mahefa, the new PHC project	
		<i>Modernize existing distribution data collection efforts (sales data, stock forecasting/tracking and monitoring, periodic activity)</i>					Completed	HNI	
3.2.11	P33-39	Continue to revise and improve the existing incentive system for PSI/M distribution staff to encourage optimal attention to and supervision of the community supply chain							
		<i>Prepare and finalize the revision of the existing incentive system (NB. this does not include top-ups)</i>					Completed		
		<i>Move to the new incentive system for PSI/M distribution team</i>					Completed		
3.2.12		Train the distribution team in key distribution issues (strategic distribution goals, sales techniques, PA supervision, DELTA+ distribution). Training will be conducted by the Distribution Director, the Marketing TA and potentially a distribution consultant					Completed		
Intervention Area 3.3: Malaria campaigns									
3.3.1	P39	Conduct campaign related advocacy workshops in the USAID campaign districts (61 districts nationwide between GF & USAID)							
		<i>Develop campaign strategic plan (gap identification, implementation scheme)</i>					Completed	campaign sub grantees	
		<i>Contribute to CNC re-organization</i>					Completed		
		<i>Conduct weekly coordination meetings with mass campaign stakeholders</i>					Ongoing		
		<i>Develop campaign action plan & timeline</i>					Completed	partners involved in the LLIN campaigns	
3.3.2	P39	Develop all tools necessary for all phases of campaign implementation (household registration data collection and summary forms, LLIN distribution data collection and summary forms, hang up data collection and summary forms, supervision and monitoring tools)							
		<i>Validation of the campaign M&E plan</i>					Completed	partners involved in the LLIN campaigns	
		<i>Monitoring of the campaign M&E plan implementation</i>					Ongoing	partners involved in the LLIN campaigns	
3.3.3	P39	Train LLIN CHWs for activities pre, during and post campaign							
		<i>Development of training manuals</i>					Completed		
		<i>Monitoring of training (TOT at all levels)</i>					Ongoing		
		<i>Conduct training (at all levels) including campaign coaches and subawardees</i>					Ongoing		
3.3.4	P39	Campaign implementation						partners involved in the LLIN campaigns	
		<i>Campaign macro logistics (transport, storage, macro-plan)</i>					Completed		
		<i>Campaign micro logistic (transport, storage, micro plan, distribution)</i>					Completed		
		<i>Campaign BCC (pre, per and post): distribute/disseminate campaign logistic tools and promotional materials</i>					Ongoing		
		<i>Lead sub-grantee recruitment and training process</i>					Completed		
		<i>Lead the procurement process: transporters, logistical and promotional tools production (except LLINs)</i>					Completed		
		<i>Supervise all post campaign activities</i>					Ongoing		
		<i>Campaign evaluation (objectives, approach, data assesment, survey report)</i>					Ongoing		

PSI/M Annual Implementation Plan for FY1: January - September 2013 (Q2-4)

No.	Cf. COAG Page #	Activity	Year 1				End of FY 2013 status	USAID Partner Involvement
			Q1	Q2	Q3	Q4		
Research, M&E								
		Start preparing for an acceptability study for the introduction of a new youth positioned male condom for dual protection purposes (pending approval from USAID)					Completed	
		Conduct a FoQus on rural youth study to constitute a rural archetype that will help design communication strategies for rural youth on FP/RH messages					Completed	
		Conduct a baseline client satisfaction survey for older and younger FP/RH clients at a selection of <i>Top Réseau</i> clinics					Completed	
		Conduct a provider motivation study for <i>Top Réseau</i> franchised providers					Completed	
		Pre-test new malaria campaign IEC materials					Completed	Partners involved in the LLIN campaigns
		Assist with the gender assessment through FGDs and interviews with PSI/M staff, partners, beneficiaries, Top Reseau providers, etc.; data analysis and interpretation					Completed	IntraHealth
		Conduct routine program MIS for all health areas and all activities (communications; distribution; training, clinical service delivery)					Ongoing	
		Conduct routine data quality assessment and quarterly supervision on MIS					Ongoing	

No.	Cf. COAG Page #	Activity	Year 1				End of FY 2013 status	USAID Partner Involvement
			Q1	Q2	Q3	Q4		
		Develop and implement the sub-recipient unit MIS network					Ongoing	
		Conduct refreshing training on M&E among selected PSI/M staff					Completed	
		Continuously upload new information on Intranet and maintain & reinforce PSI/M staff use of Intranet, through training, regular updates, bulletin postings etc.					Ongoing	
Gender Activities								
		Recruitment of a gender coordinator (local INTRAHealth personnel)					Completed	IntraHealth
		Conduct a gender assessment					Completed	IntraHealth
		Using findings from the gender assessment, orient and train PSI/M staff in gender issues					Completed	IntraHealth
		Develop a gender strategy for relevant program activities within PSI/M					Completed	IntraHealth
		Ensure that training curriculum and BCC messages, including for youth and the male campaign and the healthy family campaign, are updated according to the gender strategy (NB. This will continue into 2014)					Ongoing	IntraHealth
General								
		Conduct ISM Launch Workshop with new subs and key partners					Completed	USAID and Partners

Annex B

**RESULTS FRAMEWORK AND
QUATERLY REPORT ACTIVITY
RESULTS**

Quarterly Reports Results Framework

ISM Program

PSI/Madagascar (2013-2017)

I-Impact level indicator

Output	Data source	Indicator	Indicator's definition	Baseline		FY13		Targets				Frequency of data collection
				Year	Value	Achievement FY13	Target FY13	FY14	FY15	FY16	FY17	
G1	DHS	Total Fertility Rate (per 1,000)	The average number of children that would be born to a woman over her lifetime	2009	163	N/A	N/A	130	N/A	N/A	108	5 years
G2	MDG 2012/2013	Under Five Mortality Rate (U5MR) (per 1,000) NB. Included in USAID Standard Indicator List	Number of all-cause deaths among CU% in a given year, as a proportion of the number of live births in the same year	2009	72	N/A	N/A	60	N/A	N/A	55	5 years
G3	MDG 2012/2013	Maternal Mortality Ratio (MMR) (per 100,000) NB. Included in USAID Standard Indicator List	Number of deaths in women aged 15-49 years that occurred during pregnancy, delivery or within two months of delivery as a proportion of the number of live births	2009	498	N/A	N/A	469	N/A	N/A	440	5 years
G4	MDG 2012/2013	Modern Contraceptive Prevalence Rate (among women in union) NB. Included in USAID Standard Indicator List	Number of women in union who use modern contraceptives as a proportion of all women in union	2009	29.2%	N/A	N/A	34.2%	N/A	N/A	40.2%	5 years
G5	MDG 2012/2013	Death rate associated with malaria, all cases under 5 mortality rate in endemic area (per 100,000)	Number of child under five died by malaria expressed as a proportion of all child under five in endemic area per one hundred thousand	2009	72‰	N/A	N/A	47‰	N/A	N/A	35‰	5 years

Quarterly Reports Results Framework

ISM Program

PSI/Madagascar (2013-2017)

2-Outcome Level Indicator

Output	Data source	Indicator	Indicator's definition	Baseline		FY13			Target				Frequency of data collection
				Year	Value	Achievement FY13	Target FY13	Achievement % FY13	FY14	FY15	FY16	FY17	
SO1	TRaC FP 2014-2015	Modern Contraceptive Prevalence Rate among women in union (in urban and rural, by age and by method) NB. Included in USAID Standard Indicator List	Number of WRA 15 to 49 years old and 15 to 24 years old who use modern contraception as a proportion of WRA 15 to 49 years old in union and 15 to 24 years old in union in rural and urban areas	2012	15-49: National: 37.9% Rural: 36.7% Urban: 43.9%	N/A	N/A	N/A		15-49: 42.9%			2-3 years
					15-24: National: N/A Rural: 29.6% Urban: N/A	N/A	N/A	N/A		15-24: 34.6%			
SO2	TRaC IMCI 2014-2016	Percentage of households who treated their drinking water prior to consumption in last 24 hours (including chlorine, boiling, filtering, etc.) (urban and rural)	Number of households who treated their drinking water prior to consumption in the last 24 hour (including chlorine, boiling, filtering, etc.) as a proportion of all households in urban and rural areas	2011	32.4%	N/A	N/A	N/A	38%		42%		2-3 years
SO3	TRaC IMCI 2014-2016	Percentage of CU5 with diarrhea in the last two weeks who received combined ORS & zinc treatment (urban and rural)	Number of CU5 with diarrhea who received combined ORS & zinc treatment as a proportion of all CU5 with diarrhea in urban and rural areas	2011	3.6%	N/A	N/A	N/A	8%		12%		2-3 years
SO4	TRaC IMCI 2014-2016	Percentage of CU5 with cough and rapid breathing in the last two weeks who received the recommended antibiotic (urban and rural)	Number of CU5 with cough and rapid breathing who received the recommended antibiotic (Cotrimoxazole and Amoxicilline) as a proportion of all CU5 with cough and rapid breathing in urban and rural areas	2011	50.9%	N/A	N/A	N/A	55%		60%		2 years
SO5	MIS survey 2013-2015	Percentage of pregnant women who slept under an LLIN the previous night	Number of pregnant women who slept under an LLIN the previous night as a proportion of all pregnant women in urban and rural area	2011	71.5%	National: 61.4% Rural: 61.0% Urban: 67.1%	75%	81.9%		75%			2 years
SO6	MIS survey 2013-2015	Proportion of CU5 who slept under an insecticide-treated net (ITN) the previous night (urban and rural) NB. Included in USAID Standard Indicator List	Number of CU5 who slept under an ITN the previous night as a proportion of all CU5 in urban and rural areas	2011	76.5%	National: 61.5% Rural: 60.7% Urban: 74.8%	80%	76.9%		80%			2 years

Output	Data source	Indicator	Indicator's definition	Baseline		FY13			Target				Frequency of data collection
				Year	Value	Achievement FY13	Target FY13	Achievement % FY13	FY14	FY15	FY16	FY17	
SO7	MIS survey 2013-2015	Proportion of households with at least one insecticide-treated nets (ITN) (urban and rural)	Number of households who have at least one LLIN as a proportion of all households in urban and rural areas	2011	80%	National: 67.9% Rural: 66.8% Urban: 79.5%	85%	79,9%		80%			2 years
SO8	MIS survey 2013-2015	Percentage of CU5 who received an RDT (proxy: finger or heel prick) to diagnose malaria among those who had a fever in the past two weeks[1] (urban and rural)	Number of CU5 with a fever in the past two weeks who received an RDT (proxy: finger or heel prick) to diagnose malaria as a proportion of all CU5 who had a fever in the past two weeks	2011	National: 6.2% Rural: 6.1% Urban: 8.6%	National: 13.4% Rural: 13.6% Urban: 9.1%	n/a	n/a		20%			2 years
SO10	Program MIS	Couple Years of Protection NB. Included in USAID Standard Indicator List	Number obtained according to USAID standard calculations	2012	561 510	622 980	423 600	147%	1 020 775			2 766 341	Semester
SO11	Program MIS	DALYs averted	Number obtained according to PSI Global standard calculations	2012	0	303 881	243 450	125%	392 775			1 263 918	Semester

During the MIS 2011, this indicator was not included yet. In the 2013 MIS, the indicator did not specifically ask about RDTs but focused on a blood test. Results reported here refer to CU5 who had a blood test to detect malaria. The indicator will be reworded to be more precise for RDTs in the 2015 MIS; the 2015 target is set based on the result of the 2013 MIS.

Quarterly Reports Results Framework
ISM Program

PSI/Madagascar (2013-2017)

3-Output Level Indicator

Output	Data source	Indicator	Indicator's definition	Baseline		Area	Sex	Age	FY 13			Target				Frequency of data collection	
				Year	Value				Achievement FY13	Target FY13	Achievement % FY13	FY14	FY15	FY16	FY17		
FPI.1	TRaC FP 2014 – 2015	Percentage of WRA reporting no myths or misconceptions regarding modern FP methods (urban, rural, and by age)	Number of WRA 15 to 49 years old and 15 to 24 years old reporting no myths or misconceptions regarding modern FP methods as a proportion of all WRA 15 to 49 years old and 15 to 24 years old in urban and rural areas	2012	National: 16.6%	National	Female	15-49	N/A	N/A	N/A	Baseline+5%				2-3 years	
					Urban: 13,3%	Urban											
					Rural: 17,3%	Rural											
					Rural: 88,2%	Rural											
FPI.2	TRaC FP 2014 – 2015	Percentage of WRA who perceive that their partner support them to use modern contraceptives (urban, rural, and by age)	Number of WRA 15 to 49 years old and 15 to 24 years old who perceive that their partner support them to use modern contraceptives as a proportion of all WRA 15 to 49 years old and 15 to 24 years old in urban and rural areas	2012	National: 67.8%	National	Female	15-49	N/A	N/A	N/A	Baseline+5%				2-3 years	
					Urban: 58,0%	Urban											
					Rural: 71,9%	Rural											
					Rural: 58,2%	Rural											
DPI.1	TRaC IMCI 2014-2016	Percentage of target audience who know two ways to prevent diarrhea (urban and rural, and by sex)	Number of male and female target audience who know at least two ways to prevent diarrhea as a proportion of all male and female target audience in urban and rural areas	2011	58.6%	National	Male		N/A	N/A	N/A	63%		70%		2-3 years	
						Urban											Female
						Rural											
DPI.2	TRaC IMCI 2014-2016	Percentage of target group who know the three key messages of Diorano WASH (urban and rural)	Number of target group who know the three key messages of Diorano WASH (emphasizes potable water, latrine use and hand washing) as a proportion of all target group in urban and rural areas	2011	0.3%	National			N/A	N/A	N/A	5%		9%		2-3 years	
						Urban											
						Rural											
DTI.3	TRaC IMCI 2014-2016	Percentage of target group who cite that diarrhea treatment with ORS and Zinc is effective (urban and rural, and by sex)	Number of target group who perceived that ORS and Zinc is effective to treat diarrhea as a proportion of all target group in urban and rural areas	2011	0,03	National	Male		N/A	N/A	N/A	7%		12%		2-3 years	
						Urban											Female
						Rural											
PI.1	TRaC IMCI 2014-2016	Percentage of target group who cite cough and rapid breathing as the main symptoms of ARI/pneumonia (urban and rural, and by sex)	Number of male and female target group who cite cough and rapid breathing as the main symptoms of ARI/pneumonia as a proportion of all male and female target group in urban and rural areas	2011	6.3%	National	Male		N/A	N/A	N/A	12%		16%		2-3 years	
						Urban											Female
						Rural											
PI.2	TRaC IMCI 2014-2016	Percentage of caregivers with knowledge on ways to prevent pneumonia in children under five – including exclusive breastfeeding for the first six months (urban and rural, and by sex)	Number of male and female caregivers who know at least one way to prevent pneumonia in child under five including exclusive breastfeeding for the first six months as a proportion of all male and female caregivers in urban and rural areas	2011	0	National			N/A	N/A	N/A	6%		12%		2-3 years	
						Urban											
						Rural											
MPI.1	MIS survey 2013-2015	Percentage of target group who cite that sleeping under an LLITN every night prevents them from getting malaria (urban and rural, and by sex)	Number of male and female target group who know that sleeping under an LLITN every night prevents from getting malaria as a proportion of all male and female target group in urban and rural areas	2011	N/A	National	Male	Female	National: 21.3%	72%	29,6%	80%				2 years	
						Urban			Urban: 29.3%								
						Rural			Rural: 20.6%								

Output	Data source	Indicator	Indicator's definition	Baseline		Area	Sex	Age	FY13			Target				Frequency of data collection
				Year	Value				Achievement FY13	Target FY13	Achievement % FY13	FY14	FY15	FY16	FY17	
MPI.5	MIS survey 2013-2015	Percentage of pregnant women who know to go to a basic health center to receive two doses of IPTp during pregnancy	Number of pregnant women who know to go to a basic health center to receive two doses of IPTp as a proportion of all pregnant women in urban and rural area	2011	70.5%	National Urban Rural	Female		National: 72.6% Urban: 68.2% Rural: 73%	73%	99.5%		77%		2 years	
MT1.7	MIS survey 2013-2015	Percentage of target group who perceive ACTs including ASAQ and/or ALU as an effective treatment for malaria for CU5 (urban and rural, and by sex)	Number of male and female target group who perceived that ACTs including ASAQ and/or ALU is effective to treat malaria for CU5 as a proportion of all male and female target group in urban and rural areas	2011	19% (ASAQ only)	National Urban Rural	Male Female		National: 32% Urban: 43% Rural: 29.6%	n/a	n/a		55% (per USAID request)		2 years	
SC3.1	For rural areas: MIS For urban areas: MAP	Coverage of social marketed products (by product, urban and rural)	Number of distribution areas that have outlets with social marketed products (according to minimum standards for each product)												Mid way during life of project	
			<i>Piplan OC Community</i>	2011	N/A	Rural			N/A	N/A	N/A	80%				90%
			<i>Piplan OC Pharmaceutical</i>	2011	58.4%	Urban			N/A	N/A	N/A	65%				75%
			<i>Confiance Inj Community</i>	N/A	N/A	Rural			N/A	N/A	N/A	80%				90%
			<i>Confiance Inj Pharmaceutical</i>	2011	45.5%	Urban			N/A	N/A	N/A	60%				70%
			<i>Safe Water Solution (Sir'Eau)</i>	N/A	N/A	Rural			N/A	N/A	N/A	80%				90%
				2005	65.6%	Urban			N/A	N/A	N/A	70.8%				80%
			<i>Hydrazinc DTK (Pharmaceutical)</i>	N/A	N/A	Urban			N/A	N/A	N/A	55%				65%
<i>Viasur DTK (Community)</i>	N/A	N/A	Rural			N/A	N/A	N/A	80%			90%				
<i>Pneumostop</i>	N/A	N/A	Rural			N/A	N/A	N/A	80%			90%				
SC3.2	Program MIS	Percentage of trained community supply points in USAID HPN supported project zones who report no stock out of social marketed products in the last month (by distribution zone and by product)	Number of trained community supply points that didn't have a stock out of social marketed products in the last month as a proportion of all trained community supply points in each distribution zone for each product	2012	80%				N/A	N/A	N/A	85%		90%	Semester	
CB2.3	Client Satisfaction Surveys, 2013, 2016	Percentage of clients indicating satisfaction for services received at a Top Réseau clinic (urban and rural, by age, by type of service, and by client sex)	Number of male and female clients indicating satisfaction for services received at a Top Réseau clinic as a proportion of all male and female Top Réseau clients in urban and rural areas by age for each type of service	2013	N/A		Female Youth	100%	N/A	N/A				Maintain at 95% or more		
							Male Youth	95%								
							Women > 24	98%								
							Caregivers of CU5	100%								
CB2.4	Mystery Client Surveys 2014-2016	Percentage of Top Réseau providers reaching minimum service quality standards for FP and IMCI services (urban and rural, by provider sex and by type of service)	Number of male and female Top Réseau providers reaching minimum service quality standards for FP and IMCI services as a proportion of all male and female Top Réseau providers in urban and rural areas by type of service	2009	35%				N/A	N/A	N/A	45%	80%	Once during the project life		
SM3.8	Total Market Analysis	Total Market Value for FP (oral and injectable contraceptives) ⁽¹⁹⁾	Price times volume for each product on the market (public sector, social marketing and private sector)	2014	OCs : TBD				N/A			OCs Baseline			OCs Baseline+10%	2-3 years (NB. Frequency will depending on chosen methodology and related budget)
					Inj. Contra-ceptives : TBD							Inj. Contra-ceptives Baseline			Inj. Contra-ceptives Baseline+10%	

⁽¹⁹⁾ Calculated as price times volume for each product on the market. Total Market Value = (Price * Volume Public Sector) + (Price*Volume Social Marketing) + (Price*Volume Private Sector).

NB: PSI/M does not have a fixed budget to measure TMA in FY17

Quarterly Reports Results Framework
ISM Program

PSI/Madagascar (2013-2017)

4-Activity Level Indicator

Output	Data source	Indicator	Indicator's definition	Baseline		Area	Sexe	Age	FY13			Target				Frequency of data collection	
				Year	Value				Achievement FY13	Target FY13	Achievement % FY13	FY14	FY15	FY16	FY17		
FP1.3	Program MIS	Number of target population reached through mid-media (mobile video units) communication on FP (urban and rural, by age, and by sex)	Number of male and female target population reached through mid-media (mobile video units) (including projections, special events, flash sales) communication on FP in urban and rural areas	2012	22 563	Urban	M		60 868	24 000	254%	48 000	72 000	96 000	120 000	Semester	
							F										
						Rural	M										
							F										
TOTAL																	
FP1.4	Program MIS	Number of target population reached through IPC activities on FP (urban and rural, by age, and by sex) (1)	Number of male target population reached through IPC activities on FP in urban and rural areas by age	2011	237 750	Urban	M	15-24	5 811	144 132	257%	336 309	690 873	1 045 437	1 400 000	Semester	
								25-49									
						Other											
						TOTAL (Male)											
			Rural			F	15-24	363 891									
							25-49										
			Other														
			TOTAL (Female)														
DP/DT 1.4	Program MIS	Number of target population reached through mid-media communications (mobile video unit) on diarrhea prevention and treatment (urban and rural, and by sex)	Number of male and female target population reached through mid-media communications (mobile video unit) on diarrhea prevention and treatment in urban and rural areas	2011	21 419	Urban	M		58 330	24 000	243%	48 000	72 000	96 000	120 000	Semester	
							F										
						Rural	M										
							F										
TOTAL																	
SI.1	Program MIS	Number of new <i>Top Réseau</i> health clinics integrated into the franchised network (urban and rural, and by provider sex)	Number of <i>Top Réseau</i> health clinics recruited into the franchised network in urban and rural areas	2012	0	Urban		13	15	87%	20	20	20	20	Semester		
					0	Rural		16	15	107%	20	40	40	40			
SI.2	Program MIS	Number of <i>Top Réseau</i> health clinics offering integrated services in at least three health areas (FP/RH; IMCI/nutrition; malaria) (urban and rural)	Number of <i>Top Réseau</i> health clinics offering at least three health areas (FP/RH; IMCI/nutrition; malaria) in urban and rural areas	2012	213	Urban		226	228	99%	233	233	233	233	Semester		
					0	Rural		16	15	107%	20	40	40	40			
CB2.1	Program MIS	Number of <i>Top Réseau</i> providers trained in business training & financial management (urban and rural, and by provider sex)	Number of male and female <i>Top Réseau</i> providers trained in business training & financial management in urban and rural areas	2012	0	Urban	M	109	255	42,7%	270	270	270	270	Semester		
							F										
						Rural	M									0	
							F										0
TOTAL			109	255	42,7%												
CB 2.2	Program MIS	Number of new <i>Top Réseau</i> providers who received quality training (urban and rural, and by provider sex)	Number of male and female new <i>Top Réseau</i> providers who received quality training in urban and rural areas	2012	0	Urban	M	46	25	184%	20	10	5	60	Semester		
							F										
						Rural	M										
							F										
TOTAL																	

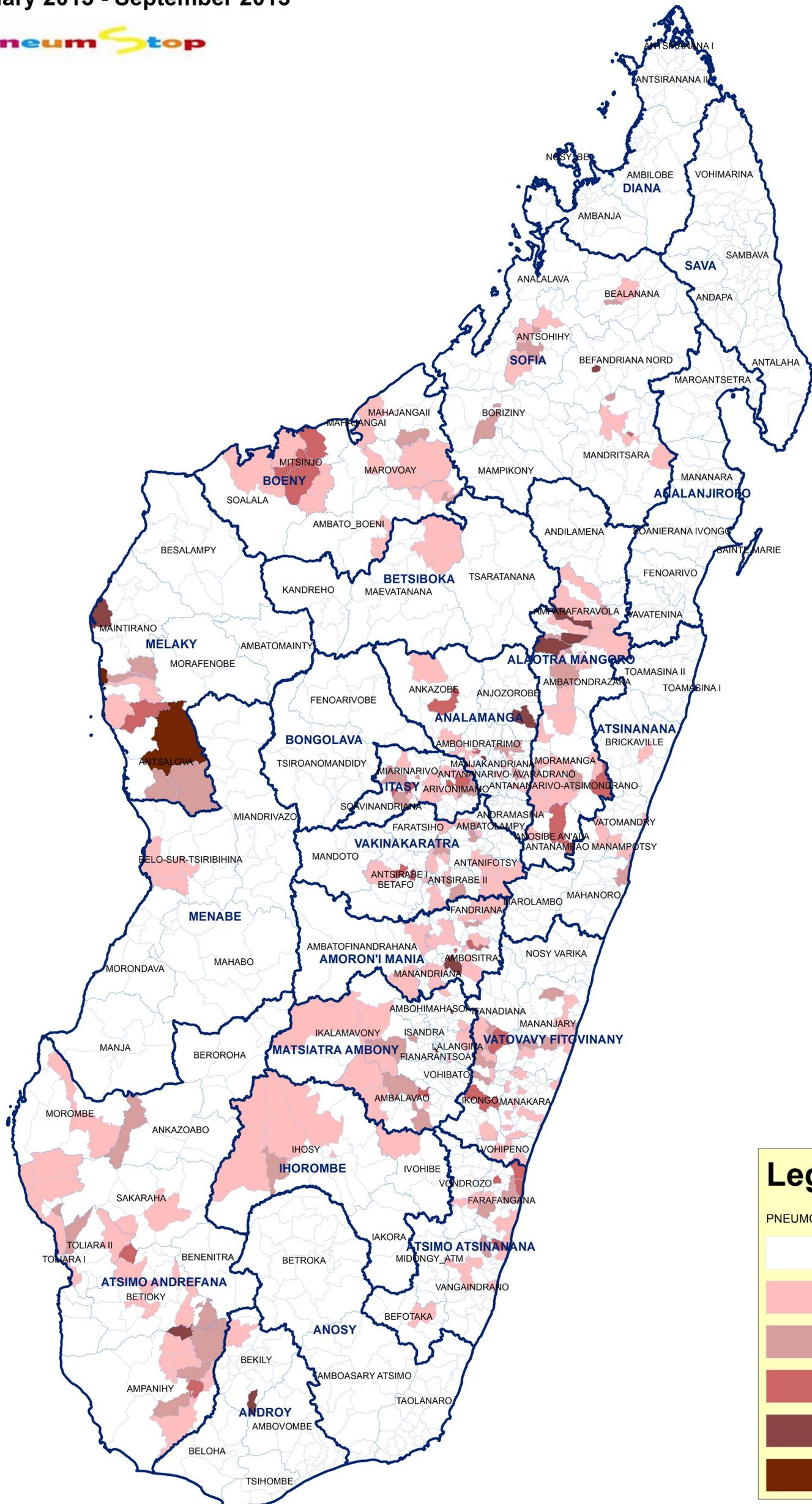
Output	Data source	Indicator	Indicator's definition	Baseline		Area	Sexe	Age	FY13			Target				Frequency of data collection
				Year	Value				Achieve ment FY13	Target FY13	Achieve ment % FY13	FY14	FY15	FY16	FY17	
SM 3.4	Program MIS	Number of insecticide treated nets (ITNs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year through the private/commercial sector	Number of ITN/LLIN distributed	2012	0				0	200 000	0%	TBD	TBD	TBD	TBD	Semester
SM 3.5	Program MIS	Number of insecticide treated nets (ITNs) purchased with USG funds	Number of ITN/LLIN purchased	2012	2 111 750				0	0	0%	2 700 000	0	0	TBD	Semester
SM 3.6	Program MIS	Number of artemisinin-based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	Number of artemisinin-based combination therapy (ACT) distributed in this reported fiscal year	2012	0				0	N/A	0%	TBD	TBD	TBD	TBD	Semester
SM 3.6a	Program MIS	Number of artemisinin-based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed by community health workers in this reported fiscal year (NB. With concurrence from USAID/IM PSI/IM would report distribution to supply points and not community health workers)	Number of artemisinin-based combination therapy (ACT) distributed by CHWs in this reported fiscal year	2012	0				0	N/A	0%	TBD	TBD	TBD	TBD	Semester
SM3.6b	Program MIS	Number of health workers (Top Reseau providers) trained, with USG funds, in case management with artemisinin-based combination therapy (ACTs) (by provider)	Number of male and female TR providers trained in case management with ACTs	2012	0		M F		0	N/A	0%	TBD	TBD	TBD	TBD	Semester
SC3.3	Program MIS	Number of distributors of social marketing products (by product, and by type and by distributor sex)	Number of male and female distributors distributing social marketing products by product and by type	2012	Commercial : 286				317	N/A	N/A	Commercial : 5-10				Commercial : 5-10
					Pharmaceutical : 13				13	100%	Pharmaceutical : 14				Pharmaceutical : 14	
					Community : 870				1 088	100%	Community : 1 155				Community : 1 200	

(1) Results include results from WHP financed IPC agents

Annex C
DISTRIBUTION MAPS

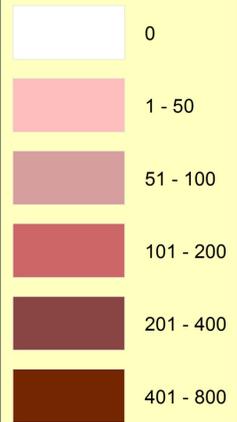
Annexe C1a - MATERNAL CHILD AND HEALTH (FY13) (Pneumonia Treatment Kits)

COMMUNITY BASED DISTRIBUTION PNEUMOSTOP
Period : January 2013 - September 2013



Legend

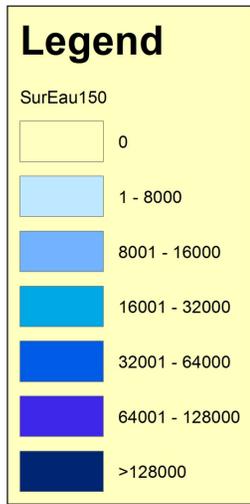
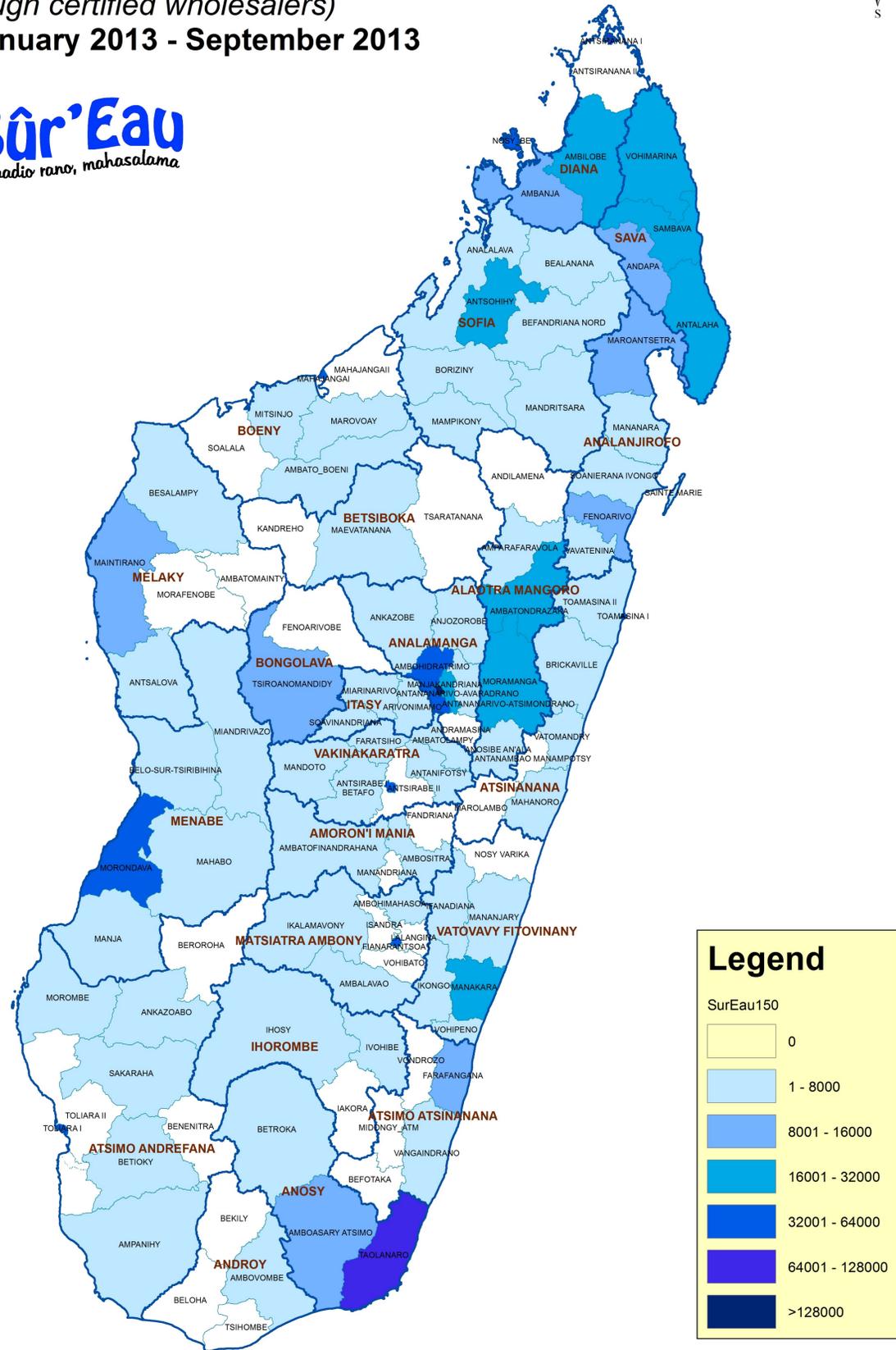
PNEUMOSTOP FY13



Annexe C1b - MATERNAL CHILD AND HEALTH (Result 2)

(Diarrheal diseases prevention and treatment)

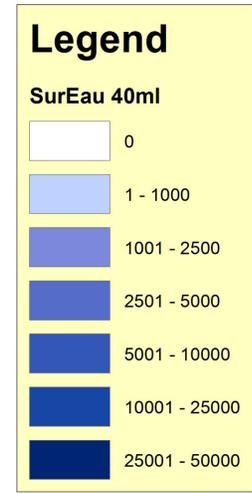
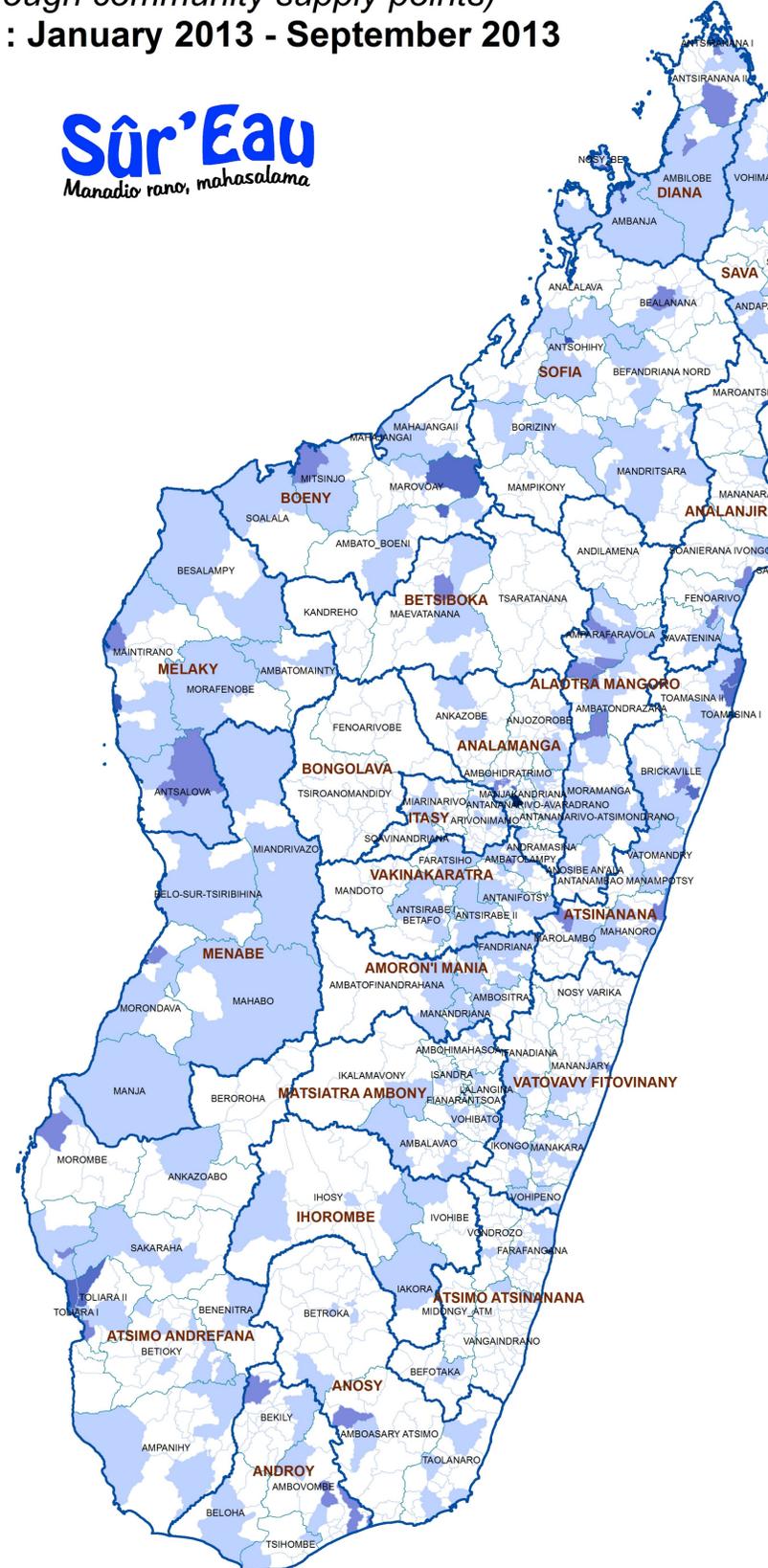
COMMERCIAL DISTRIBUTION SUR'Eau
(through certified wholesalers)
 Period : January 2013 - September 2013



0 75 150 300 Km
 Datasource : CTL Reports Jan13 to Sept 13



COMMUNITY BASED DISTRIBUTION SUR'Eau
(through community supply points)
 Period : January 2013 - September 2013

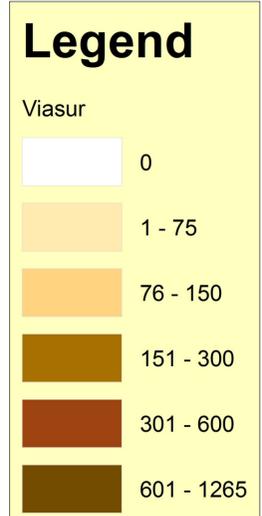
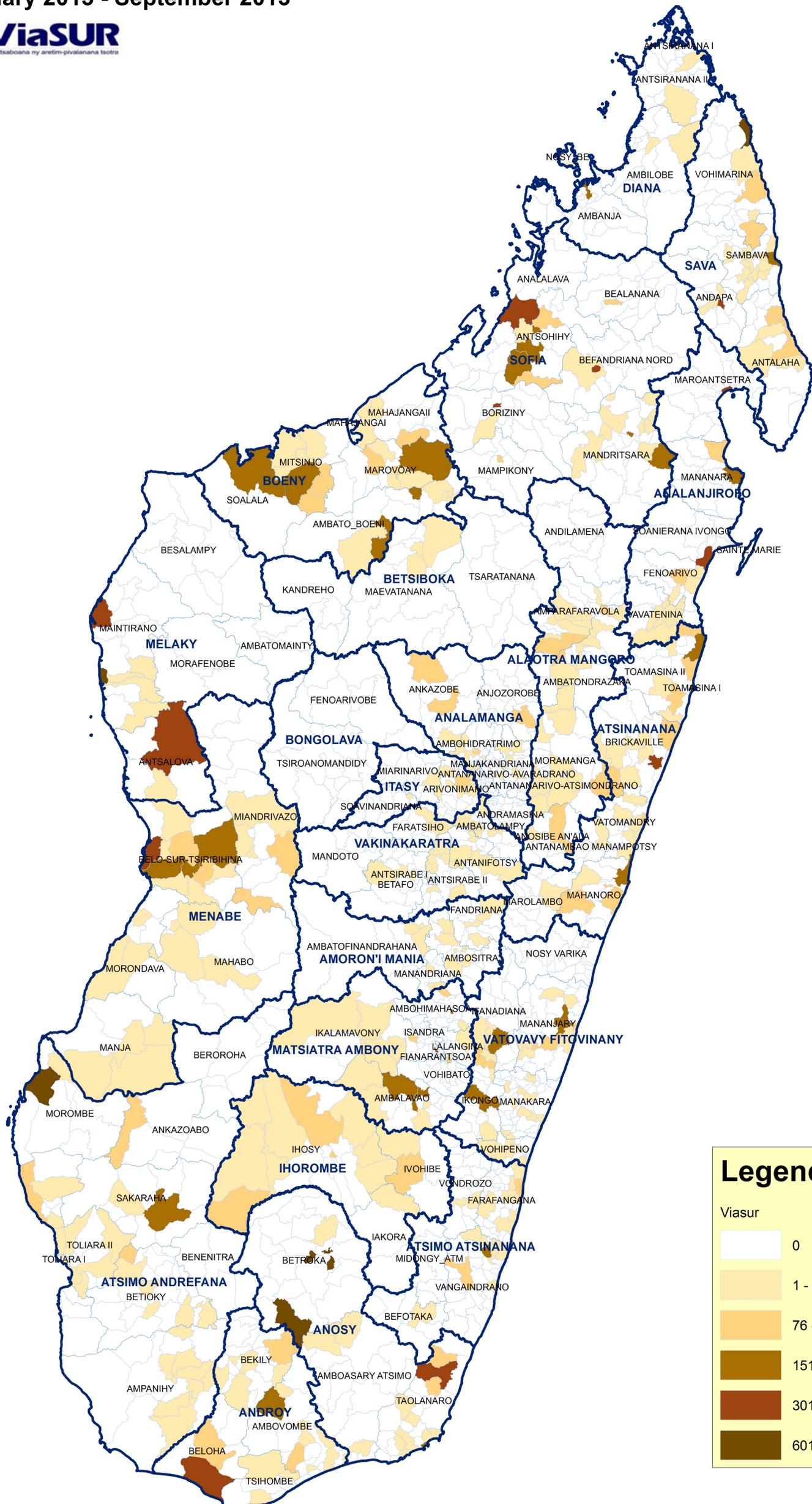


0 75 150 300 Km
 Datasource : CTL Reports Jan 13 to Sept 13



Annexe C1c - MATERNAL CHILD AND HEALTH (Diarrheal diseases prevention and treatment)

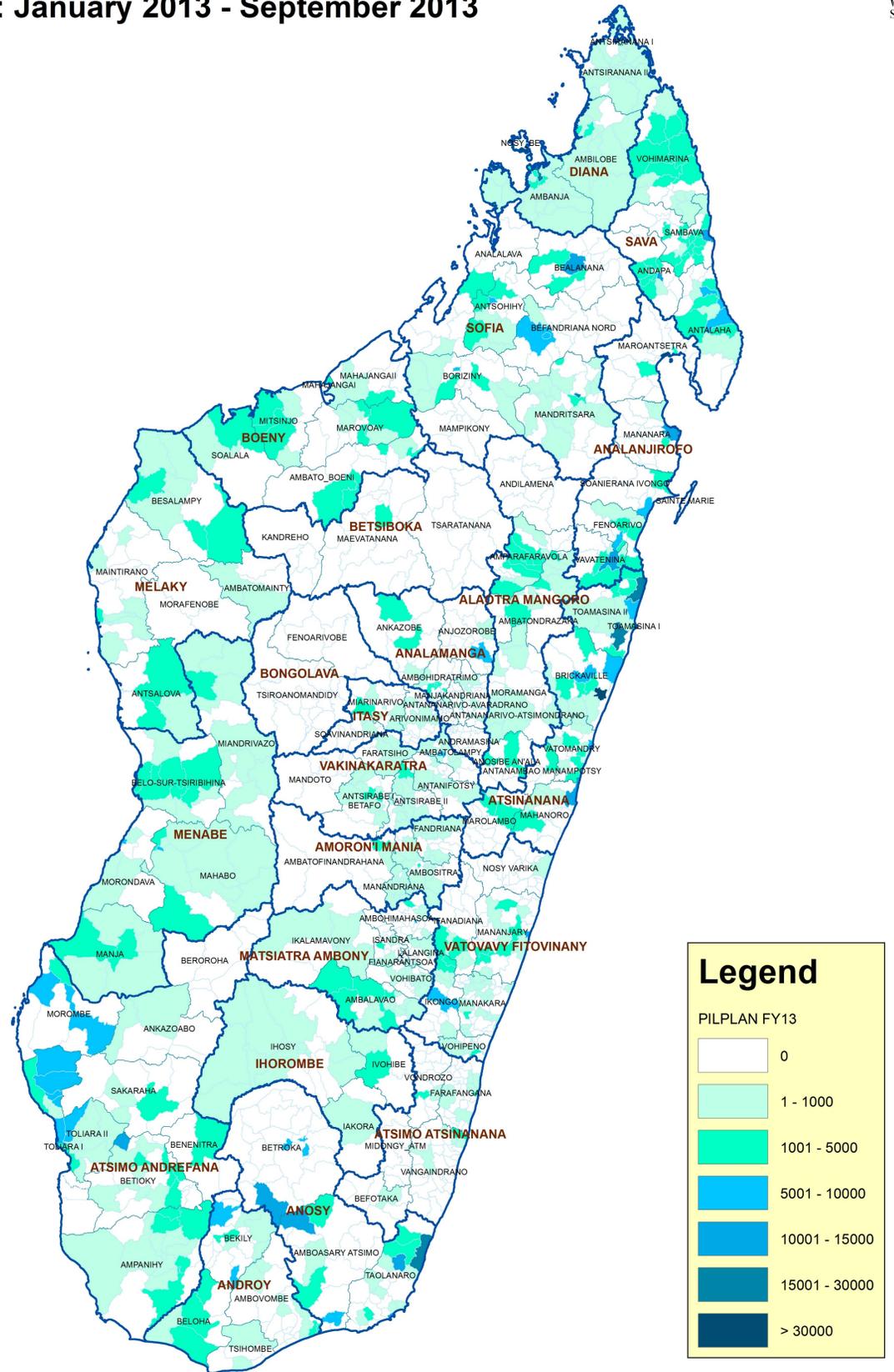
COMMUNITY BASED DISTRIBUTION VIASUR
Period : January 2013 - September 2013



Datasource : CTL Reports Jan to Sept.13
Harivola (Novembre 2013)

Annexe C2 - COMMUNITY BASED DISTRIBUTION FAMILY PLANNING (FY13) (Contraceptives)

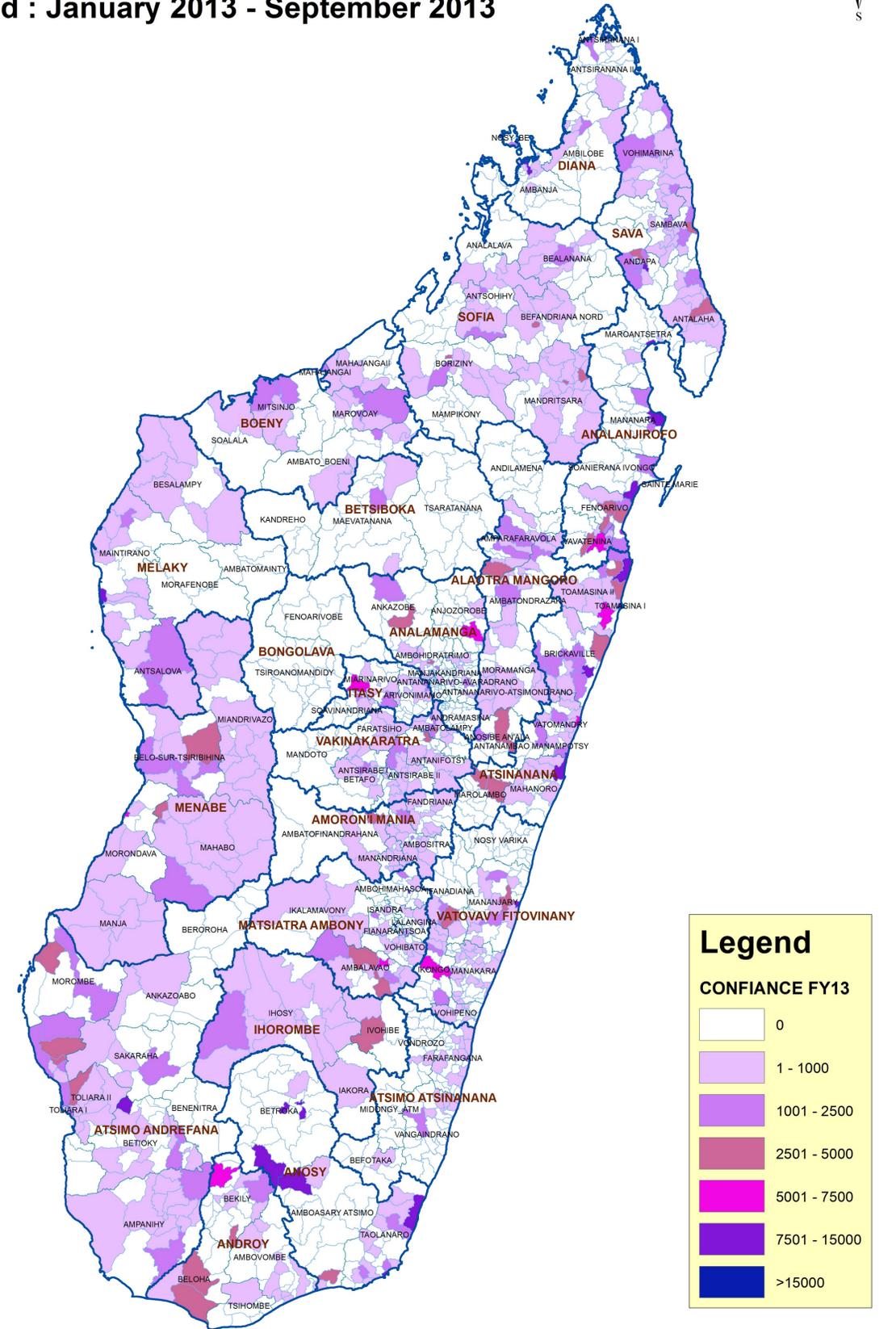
COMMUNITY BASED DISTRIBUTION PILPLAN Period : January 2013 - September 2013



0 75 150 300 Km
Datasource : CTL Reports Jan13 to Sept 13



COMMUNITY BASED DISTRIBUTION CONFIANCE Period : January 2013 - September 2013

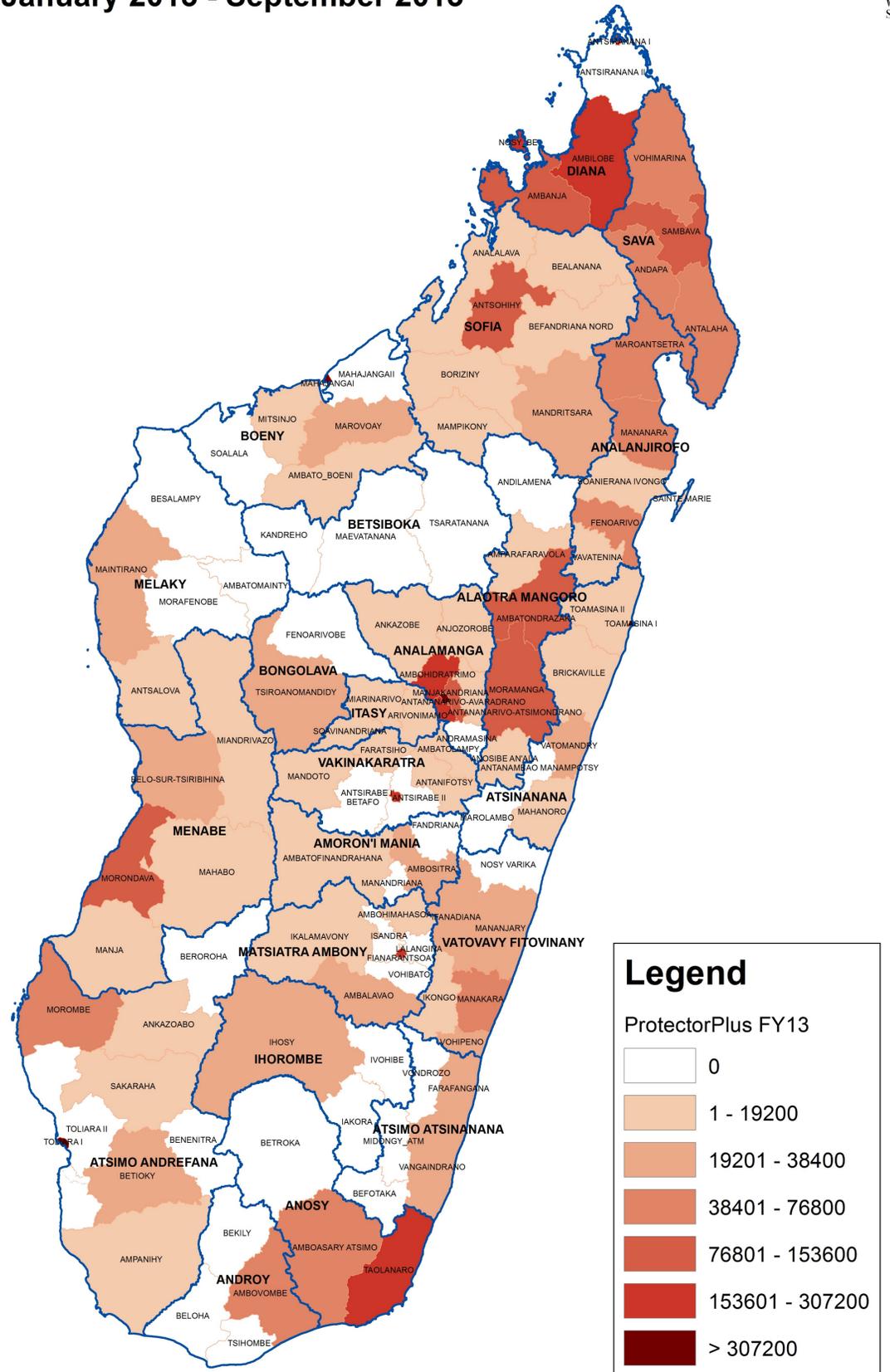


0 75 150 300 Km
Datasource : CTL Reports Jan 13 to Sept 13



Annexe C4 - HIV PREVENTION (FY13) (Condoms)

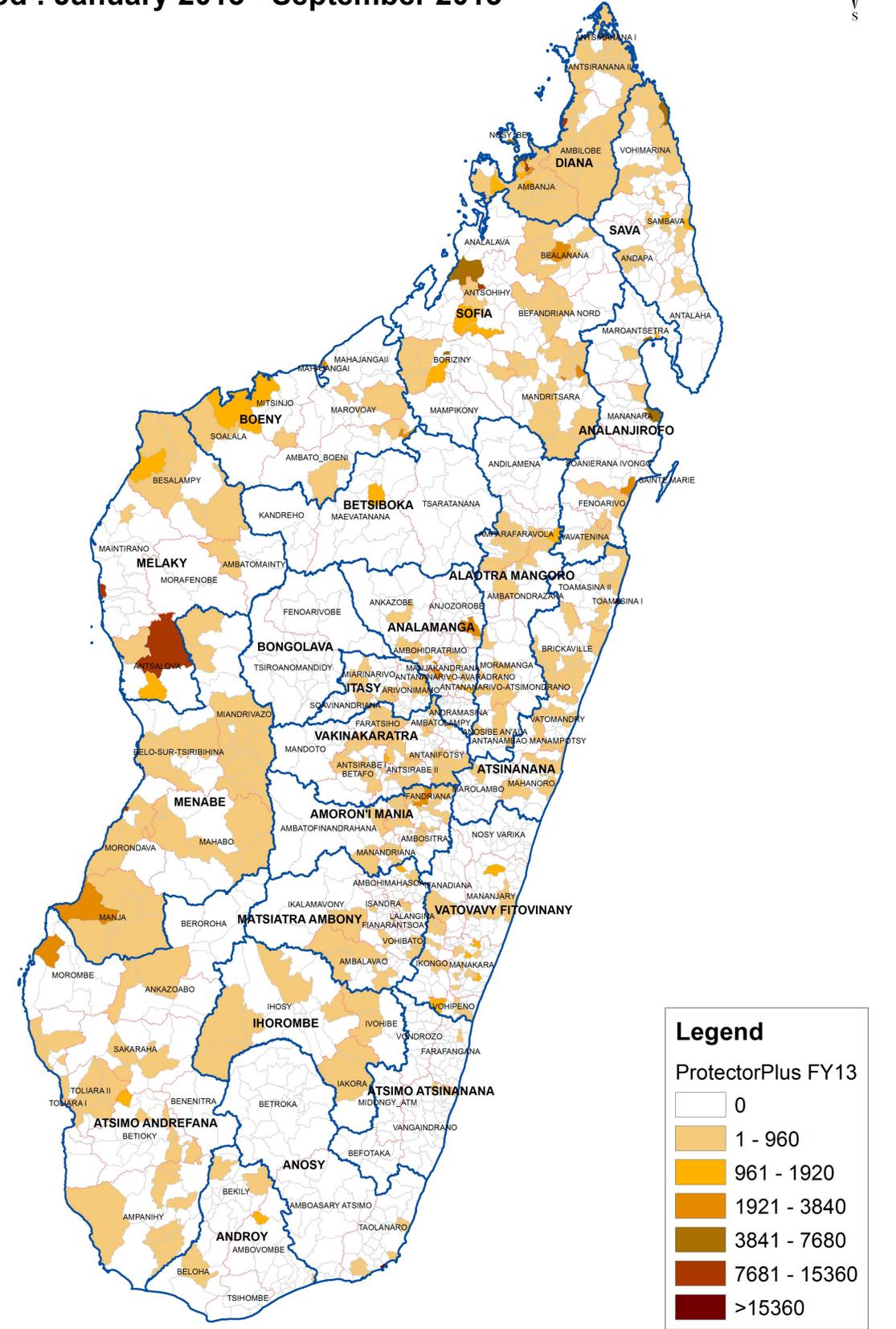
COMMERCIAL CONDOM DISTRIBUTION Period : January 2013 - September 2013



0 75 150 300 Km
Datasource : CTL Reports Jan. 13 to Sept. 13



COMMUNITY BASED CONDOM DISTRIBUTION Period : January 2013 - September 2013



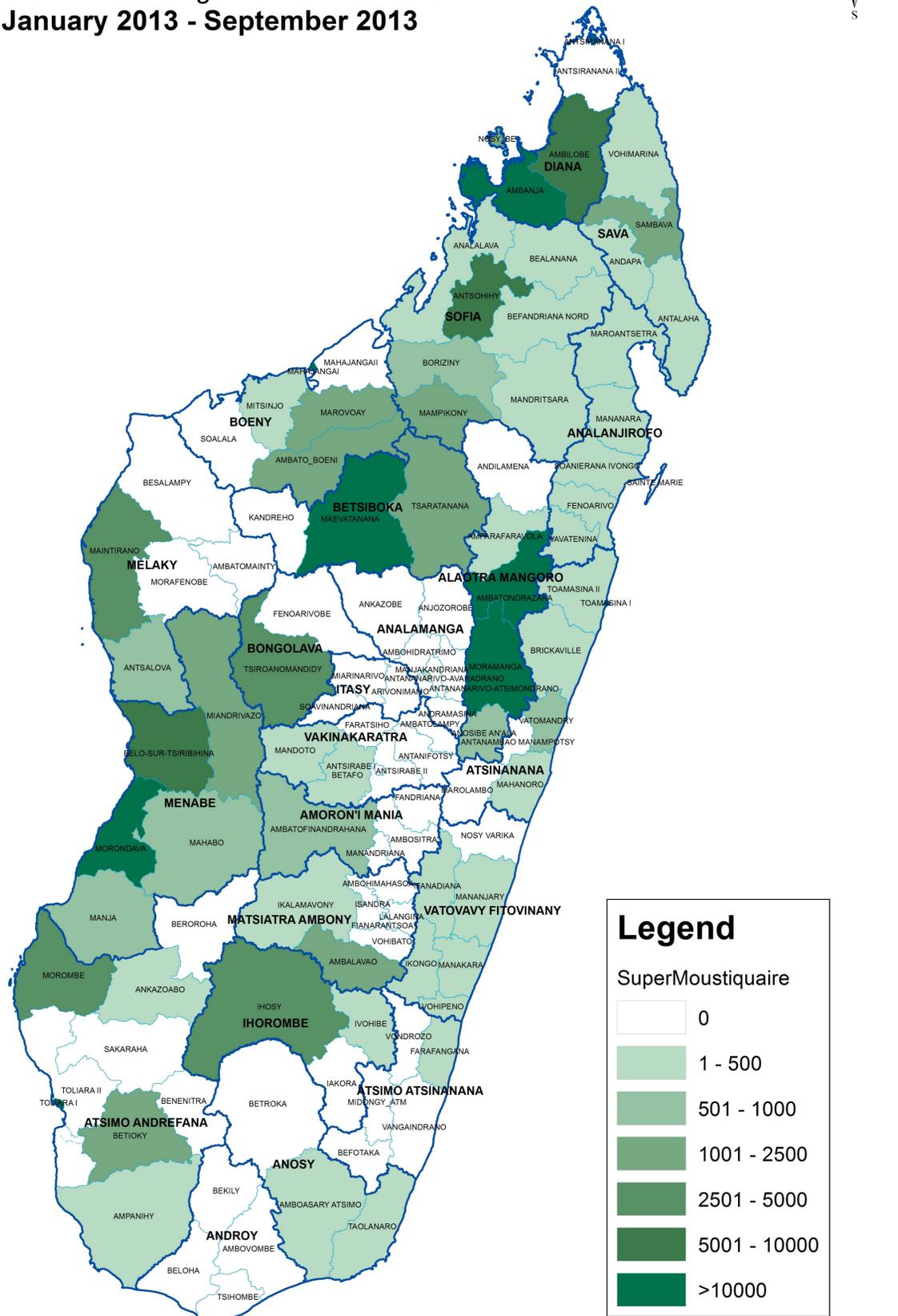
0 75 150 300 Km
Datasource : CTL Reports Jan. 13 to Sept. 13



Annexe C5 - MALARIA (FY13)

Super Moustiquaire

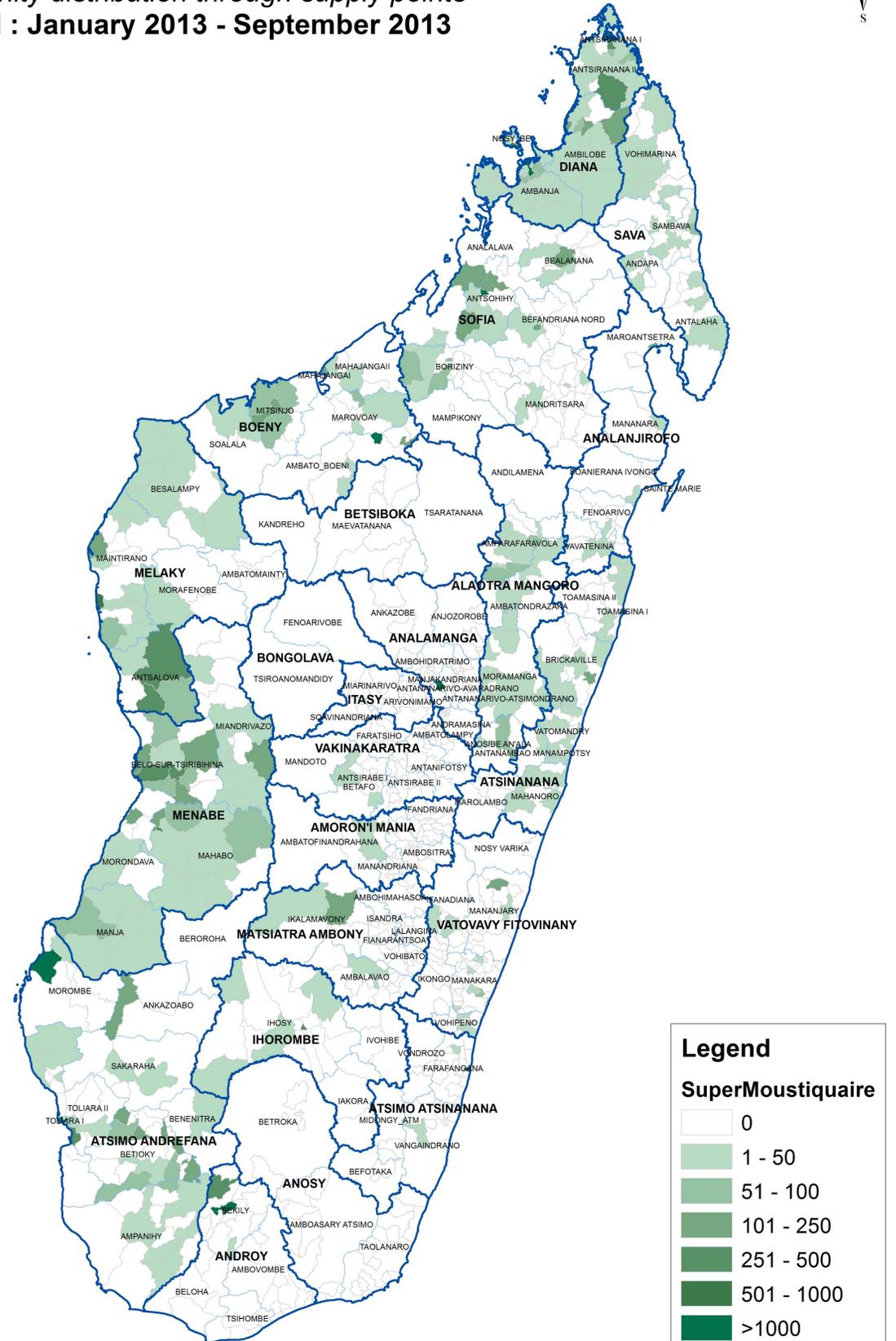
SOCIAL MARKETING DISTRIBUTION LLINs
Commercial distribution through certified wholesaler
 Period : January 2013 - September 2013



Datasource : CTL Reports Jan. 13 to Sept. 13



SOCIAL MARKETING DISTRIBUTION LLINs
Community distribution through supply points
 Period : January 2013 - September 2013



Datasource : CTL Reports Jan. 13 to Sept. 13



Annex D

**FAMILY PLANNING COMPLIANCE
PLAN**



Healthy lives. Measurable results.



PSI Family Planning Regulations Compliance Plan Integrated Social Marketing Program in Madagascar

Submitted November 2013

Primary Contact:

Chuck Szymanski

Country Director

Population Services International / Madagascar

Immeuble-FIARO, Rue Jules RANAIVO

ESCALIER-D, 2eme Etage

BP 7748; Antananarivo 101

Madagascar

Table of Contents

Acronyms

1. Background / Introduction
2. Applicability of the Family Planning Requirements
3. Actions to ensure compliance
 - 3.1 Preventive Actions
 - 3.2 Monitoring Actions
4. Abortion

ANNEX

ANNEX – Quality Assurance Plan

ACRONYMS

CA	Community Agent
CHW	Community Health Worker
DMPA	Depot-Medroxyprogesterone Acetate
FP	Family Planning
CPF	<i>Conseiller en planification Familiale</i>
GATHER	Greet, Ask, Tell, Help, Explain and Return
GoM	Government of Madagascar
IEC	Information, Education and Communication
IPC	Inter Personal Communication
MoH	Ministry of Health
NGO	Non Governmental Organization
PSI/M	PSI Madagascar
RH	Reproductive Health
USG	United States Government

1. BACKGROUND / INTRODUCTION

PSI/Madagascar (PSI/M) promotes healthier behaviors and increased access to use of effective health products and services in the areas of reproductive health and family planning, cervical cancer screening and referral, sexually transmitted infections syndromic management, HIV prevention, malaria prevention and treatment, diarrheal disease prevention and treatment, prevention of anemia and other micro-nutrient deficiencies, and the treatment of acute respiratory infections in children under five.

The FP and RH program seeks to expand access to RH care and services including high quality voluntary FP services, voluntary participation in FP projects and complete information about the FP methods chosen, thus reducing unintended pregnancies and promoting healthy reproductive behaviours of men and women.

In Madagascar, abortion is illegal and family planning programs are guided by the principles of voluntarism and informed choice. Since 2007, to further prioritize FP in the country and increase access to contraceptive commodities, the Government of Madagascar declared that all contraceptives would be provided free of charge to clients in the public sector.

The FP compliance plan describes PSI/M's activities to ensure compliance with United States Government (USG) FP statutory and policy requirements.

To ensure the conformity of all FP implemented activities on USG FP statutory and policy requirements, the PSI/M FP compliance plan will be updated annually.

2. APPLICABILITY OF THE FAMILY PLANNING REQUIREMENTS

To ensure the availability of a range of contraceptive methods for those in need, the USAID/M mission provides contraceptive commodities through social marketing activities, and as an implementing partner, PSI/M distributes FP products through two distribution channels:

1/ Community-based channel through "Supply Points" (*'points d'approvisionnement'* or PA) that act as relay distribution points for community agents who are directly serving the community; and

2/ Pharmaceutical channel through existing pharmaceutical distributors such pharmaceutical wholesalers, pharmacies and medical warehouses.

Additionally, the USAID mission supports FP service delivery through the social franchise network *Top Réseau* for short term and long term contraceptives methods (IUDs and implants). To ensure complete information about the availability of FP services in the *Top Réseau* clinics and to give an informed choice to potential/new FP users, Inter Personal Communication (IPC) activities are conducted at the community level.

The Tiahrt amendment is applicable for FP distribution, service delivery and demand creation activities. A US-based private foundation is co-funding PSI/M's FP activities especially for long term methods service delivery in *Top Réseau* clinics.

3. ACTIONS TO ENSURE COMPLIANCE

3.1.Preventive Actions

Preventive actions are channeled through information, training and dissemination.

3.1.1. Training and information for PSI/M staff

PSI/M staff involved in FP activities are required to take an online training session on USAID's FP requirement policy including: Tiahrt amendment, Helms (1973), Leahy (1994), Biden (1981), Siljander (1981), Kemp-Kasten (1985), De Concini (1985), Livingston-Obey (1986), Additional Provisions (1977) (1986), USAID Policy on Voluntarism and Informed Choice, and PD-3 (1977). This training session teaches PSI/M staff about the existence of these laws and helps them understand the importance of these laws.

A Quality Assurance (QA) plan for FP has been developed to describe how PSI/M service providers follow the minimal norms and standards of quality, aligning with PSI globally and with international standards of practice. PSI/M ensures that services delivered by affiliated providers are consistent with the five following standards that are widely regarded in the medical community as being essential to quality of care:

1. Technical Competence
2. Client Safety
3. Informed Choice
4. Privacy and Confidentiality
5. Continuity of Care

These five standards are consistent with USAID FP requirement policy.

3.1.2. Training of implementing partners

a) Sub-contractors

PSI/M uses training and BCC tools to inform its sub-contractors and other implementing partners of the existence of the USAID FP requirement policy and to this end, has included information about informed and free choice in FP training curricula CHWs.

b) Training

Private sector providers, PSI/M peer educator and outreach workers, CHWs and pharmaceutical detailers who sell social marketed FP products and/or provide FP services are trained by PSI/M staff on client rights to free and informed choice. PSI/M

has developed and provided tools to service providers and outreach teams, to be used with clients for informed decision making.

c) *Providers*

PSI/M provides basic training and refresher training on FP to private sector franchised and non-franchised providers. The curriculum that is used for the training complies with the Tiahrt amendment, and PSI/M requires that providers give their clients fair and balanced information on all contraceptives methods. Figure 1 shows the document that informs the customer of his/her rights. This document is included in the FP provider training curriculum.

Figure 1. Document on Service Quality that Highlights Informed Choice

1) LA QUALITE DE PRESTATION DE SERVICE

◆ Définition de la qualité de prestation de service de santé
La qualité de prestation de service est définie par le niveau de conformité d'une action de santé à des références proposées par les professions de santé, en tenant compte des attentes des clients (droits des clients).

◆ *Définition opératoire d'un service de qualité en Planification Familiale*
Un service de qualité en PF est offert dans un site où :

- les 7 droits du client sont respectés
- le prestataire jouit de ses 3 droits fondamentaux
- les prestations de service et les procédures respectent les normes et standards
- les ressources humaines et matérielles sont suffisantes et utilisées de façon rationnelle
- l'esprit d'équipe règne
- et le site respecte les normes exigées

Les 7 droits du client :

1. Droit à l'information
2. Droit à l'accès
3. Droit au choix
4. Droit à la sécurité
5. Droit à l'intimité et à la confidentialité
6. Droit à la dignité, l'opinion et le confort
7. Droit à la continuité

Les 3 besoins du prestataire:

1. Besoin en matériel et infrastructure de site de bonne qualité
2. Besoin en bonne gestion et en supervision
3. Besoin en information, formation et développement

Prestation de qualité :

- sourire
- faire preuve de respect
- mettre le client à l'aise
- utilise la liste de contrôle
- expliquer les contraceptifs
- parler des effets secondaires et signes d'alarme
- prescrire le contraceptif
- favoriser une communication à double sens
- fidéliser la cliente
- la disponibilité du produit pour assure la continuité

d) *Youth Peer Educators*

Under the USAID Integrated Social Marketing (ISM) program, PSI/M has recruited teams of youth peer educators in nine large towns to sensitize young women about FP and in particular the availability of youth-friendly FP services at the franchised *Top Reseau* clinic network. The training curriculum has been updated to be an integrated curriculum for the new “Tanora 100%” Youth Program as a guide in conducting training for youth peer educators to become stewards for sexual and reproductive health behavior and enhancing their peer education work in the community. This curriculum also provides the Youth Peer Educators with an overview on all contraceptive methods available and provided by *Top Reseau* clinics.

Figure 2 below provides an example of an end-of-session training check list used during youth peer educator training on FP.

Figure 2. End-of-Session Training Checklist for Youth Peer Educators

Objectifs spécifiques

A la fin de la session, le participant devrait être capable de

1. Définir ce qu'est la planification familiale
2. Citer au moins 3 avantages de la planification familiale.
3. Donner les informations essentielles sur les méthodes contraceptives
4. Connaître les méthodes contraceptives proposées par PSI
5. Connaître les messages clés sur l'utilisation de méthodes contraceptives
6. Savoir argumenter contre les principales rumeurs sur les méthodes contraceptives



e) *FP Counselors*

Under PSI/M's Women's Health Project, PSI/M has recruited teams of outreach workers, called FP counselors or '*animateurs de PF*' to discuss FP with women in their communities and to refer interested women for more information, products and services to the franchised *Top Reseau* clinics. The FP counselors are trained, equipped and required to discuss all contraceptives methods and are expected to refer clients to an appropriate provider. All trained FP counselors have a reference document that describes the desired behavior of a FP counselor. In this document, which is part of the training manual, the standard of informed and free choice is clearly mentioned (see Figure 3).

Figure 3. Outline of Desired Behavior of a Trained FP Counselor Including Information Provision on all Contraceptive Methods and Informed Choice



CHARTRE REGISSANT LES ANIMATEURS DE PLANIFICATION FAMILIALE

Les animateurs en Planning Familial consentent à :

1. Respecter les autres par : la confidentialité – la transparence et l’ouverture – l’approche impartiale – l’approche non discriminatoire – l’anonymat – l’acceptation et la non exclusion
2. Donner à la cliente toutes les informations concernant toutes les méthodes de Planning Familial existantes
3. Respecter le principe de « Libre Choix » de la cliente quelle que soit la méthode de Planning Familial qu’elle choisit
4. Etre toujours ponctuels, rigoureux et organisés dans son travail
5. Etre dignes de confiance et être des modèles de conduite dans la société
6. Ne jamais critiquer ni juger les autres pour leurs choix personnels, ni profiter de leur manque de connaissances
7. Avoir un esprit d’ouverture et respecter les idées des autres, même si elles sont différentes de celles de l’animateur
8. Respecter et aider les membres de son équipe
9. Participer activement à chaque activité du Projet
10. Ne pas exercer des activités pouvant concurrencer ou nuire à celles du Projet

f) Community Health Workers (CHWs)

PSI/M team conducts a training of trainers for CHW Supervisors for sub-contractors SAF and SALFA and partner MAHEFA. Training of trainers was focused on Inter-Personal Communication through Education through listening (ETL) techniques and respect of informed and free choice in FP, and the NGO trainers subsequently conduct CHW training in their respective project areas.

g) Pharmaceutical Outlets

Commercial and community distributors are trained on FP products. The curriculum is aligned with the Tiahrt amendment and features all contraceptives products. Furthermore, PSI/M imposes no sales target for FP products on any of its pharmaceutical wholesalers or retailers.

Figure 4. Master of product management as well as supply system and storage

OBJECTIFS INTERMEDIAIRES

A la fin de la formation, chaque participant devrait être capable de:

- 1- Expliquer les procédures du système d'approvisionnement en produits de santé et les rôles des acteurs du système d'approvisionnement ;
- 2- Renforcer l'engagement communautaire en matière d'approvisionnement des produits de Marketing Social ;
- 3- Maitriser les formules de base et leur application dans le système d'approvisionnement ;
- 4- Assurer la gestion des produits de santé en utilisant les outils de gestion ;
- 5- Résoudre les problèmes identifiés et relatifs à l'approvisionnement en établissant d'un plan d'action immédiat et à long terme.

page 4

h) Healthy family campaign

Under the USAID Integrated Social Marketing (ISM) program, PSI/M is developing an integrated communications campaign for different target groups that will address behaviors across different health areas. Family planning communications is integrated into this campaign and in essence will promote three behaviors: i) use of modern contraceptive method; ii) social support of partners to use modern contraceptive methods; iii) delay of first pregnancy (for youth 15-19 of age).

3.2. Monitoring Actions

The PSI/M FP program is based on national and international FP service delivery standards. The correct application of these standards calls for the implementation of a technical supervision plan to ensure compliance with quality standards in providers' daily practice. PSI/M has developed and distributed a series of IEC materials for providers, outreach workers and CHWs to help them clarify the different contraceptives methods to their clients. As shown below, the tools include a counseling card, a clinic poster, a client health booklet, and a consumer flyer.

Figure 5: FP Counseling Cards for FP Counselors and Service Providers

Ireo Fomba Fandrindrana ny Fiainam-Pianakaviana Profemina

<p>MAMA (Rindrat' Andro na Mampiasa kaoka)</p> 	<p>Kapsoty ho an' ny lohilahy</p> 	<p>Pilina atelina</p> 	<p>DIU (Dispositif intra-uterin)</p> 
<p>TANAN' NY FANOMBIAZANA TFP</p>			
<p>Vakana</p> 	<p>Kapsoty ho an' ny vehivavy</p> 	<p>Tsoliroana</p> 	<p>Implant</p> 

Eto ho an' andro ny vehivavy 2 kaoka ny vehivavy 500 kaoka kaoka
 Latsaky ny vehivavy 1 kaoka ny vehivavy 100 kaoka kaoka




Figure 7: Client Health Booklet at Top Réseau Franchised Clinics

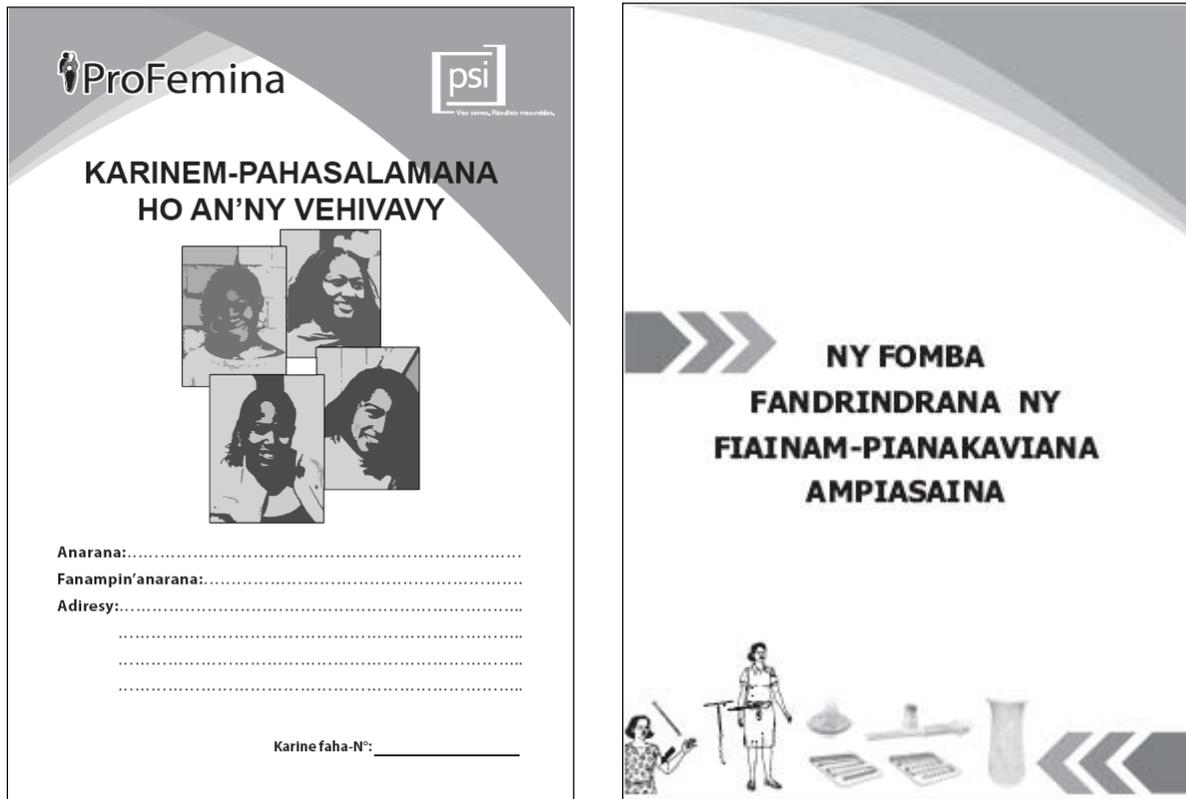


Figure 8: Consumer Flyer Showing and Explaining the Different Contraceptive Methods for FP Counselors and Service Providers

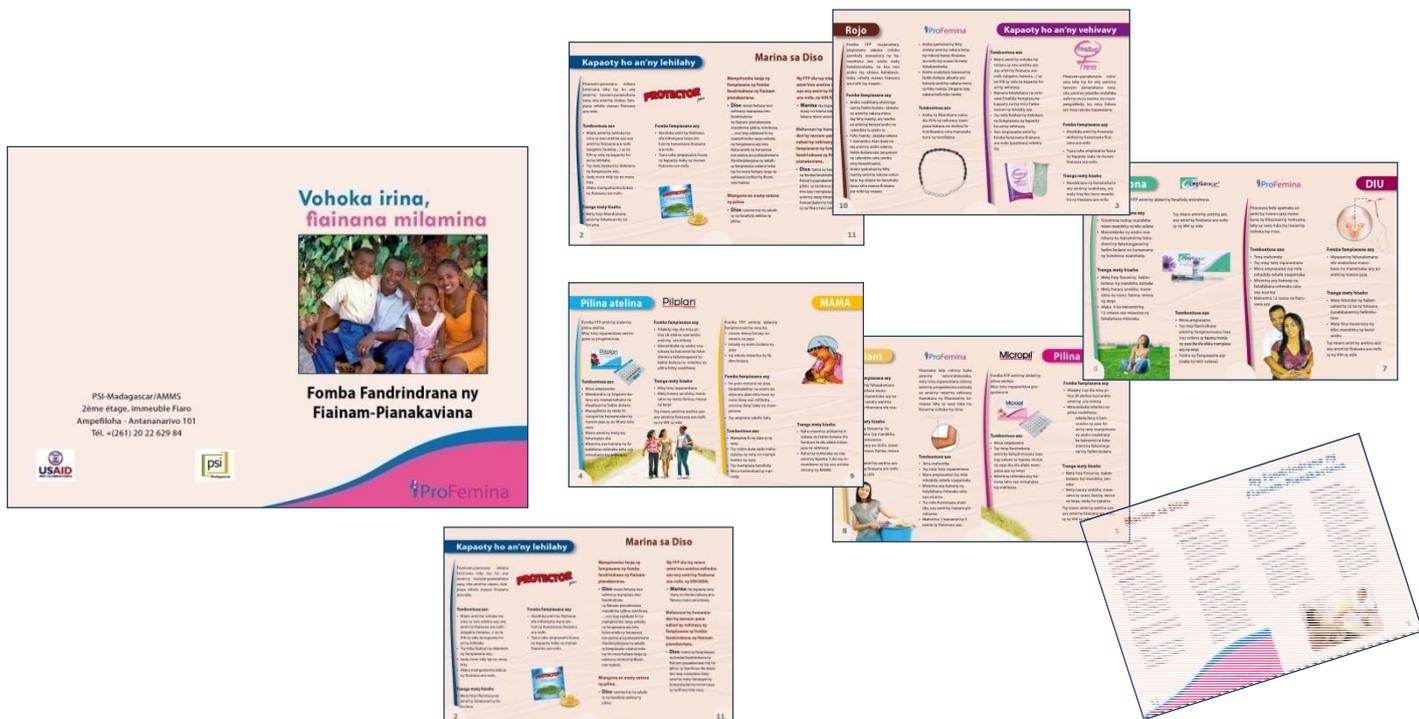


Figure 9: Categories of Family planning users showing the step of behavior change and frequency follow-up

Sokajy misy ireo vehivavy mampiasa	
Vao mampiasa	<ul style="list-style-type: none"> •Pilina /Kapaoty/DIU/Implants < 3 volana (na fampiasana mahalana) •Tsindrona < 2 tsindrona mifanaraka •Dingana misy azy: Manandrana Dingana irina: Mampiasa •Sokajy irina: Mampiasa ka afa-po •Impiry: indray isam-bolana mandritra ny 3 volana
Reny tera-bao	<ul style="list-style-type: none"> •Vehivavy manan-janaka latsaky ny 6 herinandro •Dingana misy azy: Mahafantatra Dingana irina: Liana •Sokajy irina: tsy mampiasa nefa liana •Impiry: indray isa-kerinandro mandritra ny iray volana
Tsy mampiasa nefa liana	<ul style="list-style-type: none"> •Vehivavy efa afaka miteraka tsy mampiasa FFP nefa liana •Dingana misy azy: Liana Dingana irina: Manandrana •Sokajy irina: Vao mampiasa •Impiry: indray isaky 2 herinandro mandritra ny 2 volana
Mampiasa FFP afa-po	<ul style="list-style-type: none"> •Vehivavy efa nampiasa FFP mihoatran'ny 3 volana •Dingana misy azy: Mampiasa Dingana irina: Mandresy lahatra •Sokajy irina: Mampiasa FFP ka afa-po •Impiry: indray isaky ny 3 volana
Mampiasa FFP tsy afa-po	<ul style="list-style-type: none"> •Vehivavy efa mampiasa FFP nefa tsy afa-po •Dingana misy azy: Mampiasa Dingana irina: Mampiasa/Manandrana •Sokajy irina: Mampiasa ka afa-po •Impiry: isaky 2 herinandro mandritra ny 2 volana
Tanora loatra	<ul style="list-style-type: none"> •Tanora lahy/vavy efa afaka miteraka anelanelan'ny 15-18 taona •Dingana misy azy: Mahafantatra Dingana irina: Liana •Sokajy irina: Tsy mampiasa/Mampiasa ka liana •Impiry: indray isaky ny tapa-bolana/mandritra ny 15mn eo ho eo ao anatin'ny 2 volana

3.2.1 Franchised Providers

PSI/M supervisors are trained to assess the quality of provider FP counseling, to make sure that clients receive information on all contraceptive methods including advantages, side-effects and risks. In the observation sheet that is used for supervision of new FP clients, two main indicators are included on this namely: “gives comprehensive information on all contraceptive methods”, and “allows client the choice of contraceptive method” (see highlighted section in Figure 10 below).

Figure 9: Observation Sheet for Quality Assurance in FP for Franchised Providers

Clinique / Centre: _____

Nom et prénoms du prestataire: _____

Date de l'évaluation/supervision _____

Nom et prénoms de l'évaluateur/superviseur _____

Domaine : Nouvelle Cliente

1. Le prestataire aide la cliente à choisir une méthode	<ul style="list-style-type: none"> • Utilise le van de méthodes contraceptives • Présente les différentes méthodes contraceptives (mode d'utilisation, efficacité, avantages, inconvénients) • Demande à la cliente si elle a fait son choix
---	---

3.2.2 FP counselors (CPFs)

Quarterly evaluations are conducted by PSI/M communication supervisors to ensure that FP counselors provide key messages on all FP methods using the communication technique 'Education Through Listening', and to allow customers to choose their method. Figure 11 shows the evaluation sheet that is used for this purpose (including compliance with the FP counselor charter and compliance with the Tiahrt amendment).

Figure 10: Evaluation Sheet for FP Counselors

RENSEIGNEMENTS SUR LA CPF	# Personnes sensibilisés (VAD & Réceptions) et accompagnés	TOTAL FAR référées	# utilisatrices suivies	(**) Technique d'animations ÉTÉ	(**) Respect de la CHARTE des CPF Conformité à l'amendement Tiahrt	(**) Comportement avec l'équipe de CPF, les partenaires et le staff de PSI
---------------------------	--	--------------------	-------------------------	---------------------------------	--	--

3.2.3 IPC Workers and CHWs

Regular supervision is done by partner NGO supervisors and to the extent possible, by PSI/M trainer and promoters to ensure that CHWs provide key messages on all family planning methods and allow customers to choose their method. Figure 12 shows the supervision sheet that is used for this purpose (including observation of the GATHER or 'MANOME' component).

Figure 11: Supervision Sheet for CHW FP Activities

OUTILS DE SUPERVISION DES INTERVENTIONS COMMUNAUTAIRES						
Outils N°2 : Observations du travail des Agents Communautaires						
<p>Note: Cet outil sert à supporter l'observation effectuée durant une séance de sensibilisation d'un Agent Communautaire. Le superviseur devrait assister aux séances et effectuer les feedbacks. Cet outil peut être utilisé pendant les séances de suivi individuel ou groupé afin d'évaluer les capacités des ACs</p>						
Nom du superviseur		Fonction				
Type de séance		Lieu				
Date		ONG partenaires				

1. MANOME		Notation					Commentaires
		1	2	3	4	5	
1.1	Miarahaba (Acceuil)						
1.2	Anton-dia (motif de visite ou entretien)						
1.3	Mampahafantara FFP+ safidy (Renseignement et Choix)						
1.4	Manambara tranga mety hiseho (Explications effets Ilaire eventuels)						
1.5	Mampiasa masontsivana (vérification éligibilité)						
1.6	Entanina hiverina (retour)						

4. ABORTION

In Madagascar, the practice of abortion is illegal and a stiff penalty awaits offenders as stipulated in the country's abortion law by the provisions of the Penal Code art 317 in 1920. PSI/M promotes women's sexual and reproductive health and helps women to have access to quality, affordable FP and reproductive health services. PSI/M does not use any USAID funds in support of abortion services or involuntary sterilizations.

Annex E

**Environmental Mitigation and
Monitoring Plan**

Environmental Mitigation and Monitoring Plan (EMMP)

Project Title: Integrated Social Marketing Program

Implementing Partner: PSI Madagascar

Country or Region: Madagascar, Southern Africa

Award Number: CA#687-A-13-00001

Program Area: Health

Date of last revision: September 30th 2013

Negative Determination with Conditions:

Malaria prevention				
Num	Activity	Mitigation measure(s)	Actions implemented	Remarks
1	Use pre-approved WHO Pesticide Evaluation Scheme (WHOPES) brand of LLINS to ensure quality and efficacy of the LLINs purchased	All bed nets procured are WHOPES recommended LLINS	The LLINS purchased by DELIVER for the mass campaign in FY 2013 were WHOPES certified. This will be assured also for all future LLINs.	
2	Make all effort to ensure that the packaging, storage, transport, and disposal of LLINs, comply with the WHOPES guidelines, and with the USAID Programmatic Environmental Assessment For Insecticides Treated Materials (ITM PEA) in Sub-Saharan Africa	<p>All LLINs procured are WHOPES recommended LLINs, which reduce the need for re-treatment avoiding environmental or health risks</p> <p>Whenever possible (depending on the supplier that wins the international tender) the packaging of LLINs will be made of 100% biodegradable plastic bags</p> <p>LLINs warehouse temperatures are monitored to ensure temperatures are within standard</p>	<p>WHOPES certification for all procured LLINs (mass campaign in FY 2013, future campaigns and routine SM in future)</p> <p>Temperature at all of the warehouses is monitored daily. Temperature datasheet is</p>	

			available. This will continue in FY 2014 and beyond.	
3	LLIN distribution during mass campaign and social marketing of LLIN	<p>Logistics team at central and regional levels are trained on correct packaging, storage, transport, distribution and disposal of LLINs in compliance with WHO and USAID environmental guidelines and standards</p> <p>All LLIN distribution campaign agents especially the mobilization agents and community agents and community leaders are trained on how to use the LLIN , not to throw away the packaging nor to reuse it but dig a hole at distribution sites and put the used packaging inside</p> <p>The campaign training curriculum and the BCC materials include mentioning of how to manage LLIN used packaging</p>	Proper handling in all stages of the LLINs was part of the training curriculum of the CHWs during the mass campaign in late FY 2013, and will be part of all future campaigns and/or routine SM of LLINs.	
4	Continue in-field research to evaluate efficacy of LLIN products	<p>Incorporate environmental questions into LLIN household survey</p> <p>Support operations research by partners around recycling and reuse of old used LLINs</p>	This research activity is planned during FY14	
5	Monitor ongoing activities for compliance with approved IEE recommendations	Information sharing, supervision/monitoring	Monitoring is part of community supervision activities, specifically the compliance of the CHWs with the instructions provided during the training. This will continue into	

			FY 2014 and beyond.	
All health products				
Num	Activity	Mitigation measure(s)	Actions implemented	Remarks
1	<p>Procurement and distribution of health commodities: handling, storage and disposal</p> <p>Health commodities under the ISM program include: <i>Sur'Eau</i>, injectable contraceptives (at <i>Top Reseau</i> centers); and LLINs (see current section)</p>	<p>Conduct systematic monitoring by distribution agents (while delivering products) on handling, storage and expired medicine</p> <p>Information sharing, supervision/monitoring</p> <p>Packaging (instructions on handling, storage, disposal)</p> <p>PSI/M logistics team receives training on correct packaging, storage, transport and disposal of health commodities</p> <p>Warehouse temperatures are monitored to ensure temps are within standard for each health product,</p> <p>Reinforce appropriate medical waste management</p>	<p>Monitoring of the storage and handling conditions of the products is part of the supervision conducted by the distribution team. Each supply point is visited approx. every 2 months by someone from the distribution team. Close follow up is provided by the distribution team and expired products are gathered and sent back to the main warehouse. This will continue into FY 2014 and beyond.</p> <p>Logistic and distribution teams master the principles of handling the products. Periodic refresher will be organized in FY 2014 as needed.</p> <p>Daily monitoring of temperature datasheet is available.</p> <p>Ongoing process into FY 2014. PSI/M is in the process of identifying different options for the disposal of expired products</p>	
Ensure	1-Collaborate with Mahefa and PHC to	Training curricula include waste	The CHW training curriculum	

sound waste management at community level	provide training to community agents on waste management 2-Handle packaging and expired commodities	management measures Return expired <i>Sûr'Eau</i> bottles to the manufacturer for recycling NB. For LLIN (See malaria section)	includes instructions on waste management. 6,000 CHWs were trained by MAHEFA. Training will continue in FY 2014 also for PHC. At the end of FY 2013, 5397 <i>Sûr'Eau</i> bottles were returned to the manufacturer. This process will be continued in FY 2014 and beyond .	
	3-Collaborate with Mahefa and PHC on handling sharps and contaminated waste		In FY 2013, safety boxes are provided to the Supply Points where the CHWs of MAHEFA (and in future, PHC) can obtain them. This will be continued into FY 2014 and beyond.	

Top Réseau Social Franchise (Integrated Franchised Service delivery)				
Num	Activity	Mitigation measure(s)	Actions implemented	Remarks
1	Promote environmental protection and product safety through: Management, distribution and use of health products by franchised <i>Top Reseau</i> providers	Provide training to counselors and laboratory technicians in universal precautions Provide health centers with garbage cans for ordinary wastes (paper...) to facilitate separation from wastes that require specific processing Provide health centers with sharp	In FY 2013, 74 <i>Top Reseau</i> providers were trained. This will be continued in FY 2014 and beyond. In FY 2013, 213 existing <i>Top Reseau</i> clinics and 13 new ones were provided with garbage cans, sharp containers and gloves, etc.	

		<p>containers</p> <p>Provide health centers with gloves for handling of wastes and for screening</p> <p>Provide supervision to the centers by using the rapid monitoring tool</p> <p>Wash hands, gloves and containers after handling or throwing away infectious wastes</p> <p>Decontaminate contaminated tools/equipment before throwing them away (gloves...)</p>	<p>This will be continued into FY 2014 and beyond.</p> <p>In FY 2013, all <i>Top Reseau</i> clinics were provided with posters on infection prevention, accidental exposure to blood and waste management. This will be continued into FY 2014 and beyond.</p>	
--	--	--	--	--

Annex F

**PARTICIPANT TRAINING
INFORMATION**

Annex F : Participant Training Activities

ISM Program

PSI Madagascar : FY13

Start Date	End Date	Subject area of training	Male	Female	Total	Direct Cost (KAr)	Direct Cost (USD)
Stock Management							
Community supply points trained on stock management for Social Marketing products							
25/02/2013	26/02/2013	Supply points trained on stock management of all SM products (PA Ambilobe)	7	8	15	-	\$ -
11/03/2013	12/03/2013	Supply points trained on stock management of all SM products (PA Ambanja)	10	14	24	-	\$ -
14/03/2013	15/03/2013	Supply points trained on stock management of all SM products (PA Diego I)	8	10	18	-	\$ -
19/03/2013	20/03/2013	Supply points trained on stock management of all SM products (PA Antsohihy)	6	11	17	-	\$ -
11/04/2013	12/04/2013	Supply points trained on stock management of all SM products (PA Maintirano)	3	7	10	-	\$ -
29/04/2013	30/04/2013	Supply points trained on stock management of all SM products (PA Mandritsara)	10	15	25	-	\$ -
		Subtotal	44	65	109	-	\$ -

IMCI/Child Survival							
Top Reseau rural providers trained on IMCI/Child Survival							
02/09/2013	05/09/2013	Top Reseau rural providers trained on IMCI/Child Survival - Vague 1 (SAF/SALFA)	7	4	11	-	\$ -
17/09/2013	20/09/2013	Top Reseau rural providers trained on IMCI/Child Survival - Vague 2 (SAF/SALFA)	7	10	17	-	\$ -
		Subtotal	14	14	28	-	\$ -

Family Planning							
Top Reseau providers trained in Long Term FP methods IUD							
28/05/2013	31/05/2013	Top Reseau urban & rural providers trained in Long Term FP methods IUD (Tana Vague 1)	1	11	12	3 870	\$ 1 761,68
04/06/2013	07/06/2013	Top Reseau urban & rural providers trained in Long Term FP methods IUD (Tana Vague 2)	1	8	9	5 005	\$ 2 312,92
11/06/2013	14/06/2013	Top Reseau urban & rural providers trained in Long Term FP methods IUD (Tana Vague 3)	4	8	12	4 629	\$ 2 138,96
		Subtotal	6	27	33	13 504	\$ 6 213,55

Top Reseau rural providers trained in Short Term FP methods							
06/09/2013	07/09/2013	Top Reseau rural providers trained in Short Term FP methods - Vague 1 (SAF/SALFA)	7	4	11	-	\$ -
24/09/2013	25/09/2013	Top Reseau rural providers trained in Short Term FP methods - Vague 2 (SAF/SALFA)	7	10	17	-	\$ -
		Subtotal	14	14	28	-	\$ -

Youth Peer Educators linked to Top Reseau providers							
11/06/2013	15/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Fort-Dauphin)	5	5	10	3 219	\$ 1 487,52
15/06/2013	19/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Tulear)	4	4	8	2 952	\$ 1 364,14
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Diego)	5	5	10	2 650	\$ 1 224,54
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Toamasina)	5	5	10	3 282	\$ 1 516,64
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Majunga)	6	5	11	3 045	\$ 1 407,04
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Antsirabe)	9	9	18	1 276	\$ 589,76
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Tana Centre)	7	6	13	-	\$ -
17/06/2013	21/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Tana Peripherique)	7	6	13	-	\$ -
18/06/2013	22/06/2013	Youth Peer Educators linked to Top Reseau providers (ISM Fianarantsoa)	9	9	18	2 044	\$ 944,49
30/07/2013	02/08/2013	Youth Peer Educators linked to Top Reseau providers (ISM Fort-Dauphin)	-	1	1	-	\$ -
		Subtotal	57	55	112	18 468	\$ 8 534,14

Refresher training for Top Reseau providers in Long Term FP methods IUD							
20/08/2013	20/08/2013	Top Reseau providers trained/refreshed in IUD (Majunga)	3	3	6	657	\$ 301,24
26/08/2013	26/08/2013	Top Reseau providers trained/refreshed in IUD (Antsirabe)	3	9	12	687	\$ 314,94
26/08/2013	26/08/2013	Top Reseau providers trained/refreshed in IUD (Morondava)	-	1	1	172	\$ 78,60
05/09/2013	05/09/2013	Top Reseau providers trained/refreshed in IUD (Fort-Dauphin)	2	4	6	125	\$ 57,29
12/09/2013	13/09/2013	Top Reseau providers trained/refreshed in IUD (Toamasina)	2	8	10	494	\$ 226,26
		Subtotal	10	25	35	2 135	\$ 978,32

Business Training & financial management							
Top Reseau providers trained in business training & financial management (urban and rural)							
09/07/2013	09/07/2013	Top Reseau providers trained in business training & financial management (Tana urban)	6	9	15	1 226	\$ 566,54
16/07/2013	16/07/2013	Top Reseau providers trained in business training & financial management (Tana urban)	7	10	17	1 242	\$ 573,94
23/07/2013	23/07/2013	Top Reseau providers trained in business training & financial management (Tana urban)	2	7	9	1 179	\$ 544,82
13/09/2013	13/09/2013	Top Reseau providers trained in business training & financial management (Antsirabe)	7	10	17	-	\$ -
23/09/2013	23/09/2013	Top Reseau providers trained in business training & financial management (Tana urban)	7	10	17	1 520	\$ 696,53
24/09/2013	24/09/2013	Top Reseau providers trained in business training & financial management (Tana urban)	1	17	18	1 520	\$ 696,53
26/09/2013	26/09/2013	Top Reseau providers trained in business training & financial management (Tana urban)	6	10	16	1 520	\$ 696,53
		Subtotal	36	73	109	8 207	\$ 3 774,90

Annex G
SUCCESS STORY



Success Story: Veronique - IUD

On market days, Veronique, 26 years old, operates a market stall. She is the mother of two daughters and has been married for 7 years. Veronique lives in South Lazaretto, near Diego-Suarez, a province located in the north of Madagascar. Her husband is a farmer and to support her family she sells vegetables, eggs, yogurt and cake in the market.

Veronique is an IUD (Intra-Uterine Device) user, a modern long-term contraceptive method. She says: "Since I've begun to use the IUD, I feel comfortable working and moving".

During the first two years of use, her life began to improve. She set up a few small businesses to increase her household income and improve the living conditions of her family. "I sold crops, poultry and eggs. I also set up a tavern and I even sold cakes and cookies from my bike", she says. She adds that her husband really supports her effort of contributing to the family income. "He is proud of my decision to use the IUD and he supports me" she adds.

In 2009, Veronique's life as a wife and a mother changed after a discussion with Rivo, a Family Planning Consultant (FPC). As a result of Rivo's advice,

Veronique chose the IUD as a modern family planning method. "If I could space the births by a few years, I will improve the quality of life for my children," she explains. One day, she went alone with strong support from her husband to a Top Réseau clinic operated by the NGO SAF FJKM Diego. She says: "My husband is a very confident person and he accepts all the positive ideas that I propose. Regarding the IUD, I informed him of my decision and he immediately agreed ". Since then, she still seeks advice from FPCs. When her agenda permits her, she now works every week on sensitizing her peers during Family Planning Counselor sessions.

Veronique is a new IUD user and the IUD is the first form of family planning she has used. Veronique is one of the 261,380 women sensitized by PSI Madagascar's Family Planning counselors on the benefits of modern contraceptive methods, including the IUD. PSI Madagascar's sensitization program promotes and offers short and long term modern family planning methods to both women and couples.

In 2011, Veronique decided to remove the IUD to conceive her second child. Eight months after this birth, she returned to the clinic have another IUD inserted. Her ambition is still to increase her financial security to improve her life for her and her family and the IUD helps Veronique achieve this goal.

Annex H
GENDER ASSESSMENT REPORT



GENDER ASSESSMENT REPORT

Prepared by:
Maryce Ramsey
Malalatiana Razafinimanana

Madagascar Gender Assessment

September, 2013

Maryce Ramsey, IntraHealth International

Malalaticiana Razafinimanana, IntraHealth International

"Since our ancestors it has been this way. Cooking and children is women. Hard work and money is men. We know things can change and they should work together but this is how it is." – Rural Community Health Worker

TABLE OF CONTENTS

List of Acronyms	v
Executive Summary	ii
Findings	ii
Project Background	1
Gender Concepts and United States Government (USG) Gender Imperatives	1
Objective of the Gender Assessment	2
Methodology and Limitations	3
Methodology	3
Findings: Family planning	5
Counting Days, Withdrawal, Abstaining	5
Family Planning: Modern methods	7
Barriers to use: perceived acceptability and side effects	8
Motivations for Use	14
Roles in family planning	19
Family planning decision-making	20
Hidden Use	23
Consequences of hidden use	24
Family Planning Use, Negotiation and Relationship Quality	26
Making services more male and female friendly	37
Findings: children under five services	41
Opportunity: Men	47
Recommendations	49
Annex A: Scope of Work for Gender Assessment	57
Annex B: gender assessment schedule	60
Annex C: individuals Interviewed	66
Annex D: Documents Reviewed/references	67
Annex E: Focus Group Discussions by Sites	70
Annex F: Focus Group Discussion Guides	71
Annex G: initial draft workplan	78

LIST OF ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communications
CU5	Children under 5
CHW	Community Health Worker
DHS	Demographic Health Survey
DTK	Pre-packaged Diarrhea Treatment Kit
ETL	Education Through Listening
FBO	Faith-Based Organization
FoQus	Framework for Qualitative Research in Social Marketing
FP	Family Planning
GBV	Gender-based violence
GFTAM	Global Fund for Tuberculosis, AIDs and Malaria
GOM	Government of Madagascar
HWT	Household Water Treatment
ICM	Integrated Case Management
ICT	Information and Communication Technology
IEC	Information, Education, Communication
ICCM	Integrated Community Case Management
IGWG	Interagency Gender Working Group
IPC	Interpersonal Communications
IPTp	Intermittent Preventive Treatment in Pregnancy
IUD	Intrauterine Device
ISM	Integrated Social Marketing
LAPM	Long-acting and Permanent Contraceptive Method
LLIN	Long-Lasting Insecticide Nets
MNP	Micro Nutrient Powder
MIS	Monitoring and Information System
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
OC	Oral Contraceptive
ORS	Oral Rehydration Salts
PERForM	A Performance Framework for Social Marketing and Communications
PNC	Postnatal Care
PSI	Population Services International
QA	Quality Assurance
RDT	Rapid Diagnostic Test for Malaria
RH	Reproductive Health
SAF/FJKM	Sampan' Asa Fampandrosoana/Fiangonan' I Jesosy Kristy eto Madagaskara
SALFA	Sampan' Asa Loterana Momban'ny F Ahasalamana
TRaC	Tracking Results Continuously

UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	US Agency for International Development
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

Gender analysis is the process of identifying gender inequalities and determining their programmatic and developmental implications. Gender Analysis identifies and examines the social constructions that influence the different identities, roles, and social, economic, and political relations between women and men. It helps us to understand the differential distribution of power and resources based on gender in different societies including differences in men and women's access to health services and to the information necessary for making decisions about healthcare. Gender Analysis also reveals different constraints and opportunities that affect men's and women's health risks and capacity to seek appropriate quality care.

The Integrated Social Marketing (ISM) Program gender assessment team consisted of five members from ISM implementing partners: Maryce Ramsey, Senior Gender Equality Advisor, IntraHealth International, Washington, D.C. and Gender Assessment Team Leader; Tiana Razafinimanana, Gender Coordinator ISM project, IntraHealth International; Ando Rambelason, Women's Health Coordinator, PSI; Anja Rakotomalala, Qualitative Research Coordinator, PSI; and, Bakoly Nirina Rahaivondrafaritra, Qualitative Research Supervisor, PSI. (For Ms. Ramsey's Scope of Work, see Annex A.)

This gender assessment was carried out from May 22 through June 7, 2013, following standard gender assessment procedures: interviews with staff, partners, cooperating agencies, and donors agencies; a review of project and other relevant documents; meetings with project implementers (facility-based providers, Community Health Workers, Supply Points) and project target populations (unmarried men/women ages 15-25; married women/men, ages 26-35, with a child under the age of five). Given the service specific focus of the assessment, it was heavily weighted to the service users groups, which took the form of focus group discussions. These focus groups took place in five different locations – both urban and rural - in two regions.

Findings

Among the Malagasy young people in this assessment, contraceptive use is negotiated through a lens of marriageability to determine what use or potential use says about the partners involved and the quality of the relationship. Global research has demonstrated the connection between aspects of relationship quality such as intimacy, commitment and duration and contraceptive use. Those studies show a transition from condoms to hormonal methods as relationship quality increases. This transition was not readily apparent from these FGDs where young people talked primarily about "counting days" and condom usage. One possible explanation is the strong perception that hormonal methods are not appropriate for unmarried people or those women who have not already given birth.

Among married couples contraceptive use is negotiated through a lens of mistrust where partners interpret use or non-use in terms of marital infidelity. Given the levels of mistrust and the potentially devastating impact on the couple, all of the FGDs discussed hidden contraception as a viable option for women who are not able to convince their partners to use family planning or for whom such a conversation would be problematic. While unmarried young people talked primarily about the calendar method and condoms, married couples discussed hormonal methods the most. Studies have shown

that injectables are the most popular method for those hiding contraceptive use. As with young people, fear of side effects remains a barrier to modern contraceptive use.

While all of the FGDs revealed men and women fulfilling traditional gender roles, those same FGDs all provided glimpses into a Malagasy culture in transition particularly in those places where women have access to employment and income. Yet even in the rural areas men are more involved in the health and daily lives of their wives and children and in more non-traditional ways than might have been expected. This makes it a very opportune time to launch BCC on Model Father/Mothers and Healthy Families that offer positive images of masculinity and encourage these men who are stepping out of traditional roles or who would like to be more involved in their families but do not know how.

PROJECT BACKGROUND

In December 2012, PSI/Madagascar was awarded the Cooperative Agreement (COAG) No. AID-687-A-13-00001 for the Integrated Social Marketing (ISM) Program in Madagascar, along with partners IntraHealth International, Banyan Global, Human Network International (HNI), Sampan' Asa Loterana Momban'ny F Ahasalamana (SALFA) and Sampan' Asa Fampandrosoana/Fiangonan' I Jesosy Kristy eto Madagaskara (SAF/FJKM). The ISM Program runs from January 1, 2013 through December 31, 2017.

The goal of the program is to improve the health of the Malagasy people – particularly women of reproductive age (WRA), children under five (CU5), youth 15-24 years old and those living in rural and underserved areas -- through an increasingly sustainable social marketing program that delivers essential health products and services with a focus on reaching rural and underserved areas. By the end of this program, the Malagasy people should see improvements in their health status with regard to family planning (FAMILY PLANNING), reproductive health (RH), maternal and child health (MCH), and malaria.

The project proposed to integrate gender throughout programming by building on a gender analysis during the start-up phase. This report details the findings of that gender analysis and concludes with recommendations and actions for integration.

Gender Concepts and United States Government (USG) Gender Imperatives

When we talk about gender we are referring to a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements and obligations associated with being female and male, as well as the relationships between and among females and males. The definition and expectations of what it means to be a male or female varies across cultures and over time.¹ The variability across and within cultures necessitates a gender assessment be carried out within a given culture while changes in gender over time give hope that targeted programmatic interventions can effect change in harmful gender norms. Roles of interest for this assessment are husband/wife, father/mother and unmarried sexual partners. In addition to examining these roles and the relationships that exist between them, we will look as well at the power associated with each role and within these relationships. Power is a key gender concept particularly within health because gender norms and relations influence people's ability to freely decide about:

- *one's body* such as whether to use family planning, to have children or when or how many;
- *affairs of the household* such as how decisions are negotiated between partners;
- *children* such as whether to seek treatment or purchase health products or carry out health behaviors such as sleeping under a bednet;
- *use of household or individual resources and income* including whether a woman can pay for health services or products using the family's or her own money; and,
- *moving about and associating with others* such as going for family planning services, taking a child for treatment, or seeking the services of a community health worker.

¹ Interagency Gender Working Group (IGWG). <http://www.igwg.org/training/DevelopingSharedVocabulary/DefiningGenderRelatedTerms.aspx>

A gender assessment of services offered through the ISM Project is in keeping with several applicable USG mandates and policies including the Quadrennial Diplomacy and Development Review (QDDR) which places women at the center of U.S. diplomacy and development — not simply as beneficiaries, but also as agents of peace, reconciliation, development, growth, and stability and further recognizes gender equality as one of the six core aid effectiveness principles that the U.S. must adhere to in order to achieve the best results.² The United States' Strategy for Meeting the Millennium Development Goals highlights an "acceleration of efforts to mainstream gender into core development efforts."³ The first operational principle in the USAID Policy Framework 2011-2015 is to "Promote Gender Equality and Female Empowerment."⁴

The policy notes that female empowerment is achieved when women and girls acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. The outcome of any gender work, and of empowerment in particular, is gender equality defined as a state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources such as health services and socially marketed health products. Ultimately, gender equality means expanded freedoms and improved overall quality of life for all people.

The new USAID Gender Equality and Female Empowerment Policy stresses the importance of a gender analysis at both the strategy and project levels in identifying women and men's "differing needs, constraints and opportunities, and the impact of these differences on their lives."⁵

By identifying and addressing gender barriers/enablers to men's and women's service use with a particular emphasis on men's involvement in family planning; the ISM Project stands ready to contribute to two of the three outcomes identified in the Gender Policy, namely:

- Reduce gender disparities in access to, control over, and benefit from resources, wealth, opportunities, and services—economic, social, political, and cultural
- Increase capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making in households, communities, and societies.⁶

Objective of the Gender Assessment

The objectives of the assessment were to:

- Understand existing (and planned) services and programming under ISM and men's and women's involvement;
- Identify barriers/enablers to men's and women's service use with a particular emphasis on men's involvement in family planning;
- Identify opportunities to integrate gender into existing and planned materials with an emphasis on social marketing and BCC strategies and materials, including but not limited to:

² *Leading Through Civilian Power* The First Quadrennial Diplomacy and Development Review, U.S. Department of State, U.S. Agency for International Development, 2010. Page 23 http://pdf.usaid.gov/pdf_docs/PDACQ604.pdf

³ Celebrate, Innovate & Sustain Toward 2015 and Beyond The United States' Strategy for Meeting the Millennium Development Goals, September, 2012, Page 29, <http://www.usaid.gov/sites/default/files/documents/1870/USMDGStrategy.pdf>

⁴ USAID Policy Framework 2011-2015, Page 11. http://transition.usaid.gov/policy/USAID_PolicyFramework.PDF

⁵ USAID Gender Equality and Female Empowerment Policy, March 2012, Page 12.

http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/GenderEqualityPolicy.pdf

⁶ USAID Gender Equality and Female Empowerment Policy, March 2012. Page 10

- DELTA marketing planning for the integrated communications campaign for healthy families and development of model rural mothers and fathers;
- Interpersonal Communication (IPC) tools for Community Health Workers (CHW)s;
- Innovative BCC activities with SAF and SALFA IPC agents;
- Identify opportunities to integrate gender into planned research such as the Focus on Qualitative Research (FoCus) study on rural youth, client satisfaction surveys with youth and older clients as well as a provider motivational study;
- Develop recommendations for integrating gender into the QA process, training, and audits;
- Identify where improvements in strategy, access, quality, service delivery, messaging, policy and/or measurements/indicators are needed;
- Identify opportunities to collaborate with other partners as appropriate;
- Develop recommendations for improving service uptake and integrating gender throughout the project;
- Develop a work plan, based on the recommendations, for mainstreaming gender.

METHODOLOGY AND LIMITATIONS

This is a qualitative programmatic assessment, and the findings are not meant to be generalizable to other programs. Given the qualitative assessment methodology used, standard limitations do exist regarding the scope, representativeness, and extent to which generalizations can be made based on the data collected. The contextual depth of analysis that interviews, literature review, focus group discussions (FGDs), and field site visits allow compensates for these limitations. The assessment presents the views and perspectives of an array of stakeholders (approximately 100) allowing for some degree of validation and triangulation.

Methodology

The gender assessment used a qualitative methodology following standard gender assessment practices. Three methods were used to collect information:

1. Key informant interviews

This aspect was quite focused, targeting individuals with specific gender and/or programmatic expertise from USAID, other donors, ISM partners, and cooperating agencies. For a list of individuals and organizations, see Annex B.

2. Literature review of pertinent documents

For a list of documents reviewed, see Annex C. Types of materials reviewed include:

- Literature on male involvement in FAMILY PLANNING and CU5
- Published studies, assessments and surveys on gender in Madagascar, and basic gender data
- ISM Project documents including research, curricula and reports.
- Relevant provider training materials

- Materials on gender programs carried out by other donors, nongovernmental organizations, and cooperating agencies.
- Literature on relationship quality

3. Focus group discussions

FGDs were conducted with 93 people most affected/potentially affected by the services of interest, namely, family planning and services for children under five. FGD questions looked at: the role that men and women play regarding family planning decision-making and use; the roles that mothers and fathers play when CU5 are sick regarding decision-making and treatment seeking; and what constitutes male and female friendly family planning services.

In all, 12 FGDs were held in two regions and five locations both urban and rural:

- Married men, aged 26-35 with a child under the age of five (two FGDs)
- Married women, aged 26-35 with a child under the age of five (two FGDs)
- Unmarried women, aged 15-25 without children (two FGDs)
- Unmarried men, aged 15-25 without children (two FGDs)
- Community Health Workers and supply points (two FGDs)
- Top Reseau providers (two FGDs)

For a complete list of FGDs and sites, see Annex D. For FGD guides, see Annex E.

Site selection criteria

The selection of informants and project sites was based on purposive sampling in order to maximize the collection of relevant data within the limited time frame. Five sites were selected using the following criteria:

- Presence of a Top Reseau Clinic
- Active Supply Points and Community Health Workers
- Different culture and realities (urban/rural, coastal/interior)
- Convenience was taken into account in terms of location to maximize time and data collection.

Based on a combination of the above criteria, the following sites were selected:

- Antananarivo, Analamanga Region
- Soamiandalana, Analamanga Region
- Ambohitrimanjaka, Analamanga Region
- Diego I, Diana Region
- Anivorano, Diego II, Diana Region

Gender Assessment Team preparation

Key ISM staff, including all of the gender assessment team, received gender training covering: basic gender concepts; values clarification regarding gender; USAID gender commitments and requirements;

the domains of gender analysis: identification of causes and consequences of reproductive health problems such as low male involvement in family planning; application of the gender domains to those causes and consequences; and the gender continuum framework. In a practical application of gender concepts and gender analysis, the Gender Assessment team pared down thematic interview lists to final FGD guides, which were also vetted for cultural appropriateness and subsequently translated into Malagasy. All FGDs were facilitated by experienced qualitative researchers. Two sets of notes were taken – one in English and one in French – and conversations were taped with the permission of the participants.

Data collection

Data was collected in the form of notes—a primary set taken by the Senior Gender Advisor and a backup set by a member of the Gender Assessment team. FGDs were also audio recorded. FGDs were conducted in Malagasy with simultaneous translation into English for the Senior Gender Advisor. Translation and note taking were conducted outside of the FGD circle of discussion to minimize disruption. At the end of the gender assessment, the team met to identify preliminary findings from the FGDs for the staff and USAID debrief. Subsequently, the Gender Advisor carried out the full analysis by employing a thematic manual analysis of the data and by color coding persistent words, phrases, or concepts within the data according to broad themes. Data categories were grouped, summarized, and integrated with other data from resource materials in order to draw conclusions for the project.

Informed consent

There were two levels of consent for participants: one verbal consent at the time of invitation to participate and the second a verbal consent confirmation at the time of participation. Both were obtained in Malagasy. No names or individual identifiers were recorded. Group discussions were closed to participants only and held where others could not overhear.

FINDINGS: FAMILY PLANNING

Counting Days, Withdrawal, Abstaining

Unmarried

The unmarried young focus group participants came from rural and urban, coastal and interior places with those in the urban areas - both male and female - more apt to be university students. Among young people, male and female, urban and rural, the method most often mentioned and talked about was “counting days.” This is the method that most young people learned about in school and which they use in conjunction with abstention, withdrawal and condom usage. Unmarried urban boys, in particular, discussed this method and their role in it at length.

“We learned lots of ways to prevent pregnancy in school. We learned about condoms but I don’t like. If you learn how to count days correctly you can avoid pregnancy.” – Unmarried Urban Man

“I don’t like condoms because it is like eating candy with a wrapper on. Doesn’t your girlfriend know how to count her days? Some still get pregnant. If she is fertile you should abstain. I won’t use condoms.” – Unmarried Urban Man

“If a university girl then she counts [her days]. If a high school girl, you count. If you ask her and she hesitates you should abstain. I prefer to count for her.” – Unmarried Urban Man

“You have to wait until it is safe for you.” – Unmarried Urban Man

“When you’re ready for sex you don’t count days. That’s ridiculous. You withdraw. You don’t cause her to run away if she’s

ready.” – Unmarried Urban Man

“If she is your regular partner you both should know her cycle. You should do something else on her days of conception. Avoid being naked. We guys are always the one to ask for sex.” – Unmarried Urban Man

“I tell him that this is my time of conception and we aren’t ready to be parents so we use [a condom].” – Unmarried Urban Woman

“We can withdraw.” – Unmarried Urban Man

“I don’t like a condom. I always withdraw. Withdrawal is safe.” – Unmarried Urban Man

“If they ever went to school they learned to count days.” - Unmarried Rural Man

“We count days.” - Unmarried Urban Woman

[We use a condom] “Just around unsafe days. Not always, just on unsafe days.” - Unmarried Urban Woman

“We don’t use one [condom] if we know the time of the month and know she won’t get pregnant.” - Unmarried Rural Man

There were also, especially among the urban boys, those who questioned the effectiveness of abstinence, withdrawal; and counting days.

“That is inefficient.” – Unmarried Urban Man

“This is why many girls are pregnant because they think withdrawal works.” – Unmarried Urban Man

“My friend if you count, so count. What if you want to have sex during her fertile days? What will you do?” – Unmarried Urban Man

“The problem is the closer you are to her the more you want to have sex with her. During her fertile days she should stay away from you and not excite you. He should stay away from her.” – Unmarried Urban Man

“I learned in high school that counting days isn’t accurate because different girls have different cycles. Girls can get pregnant counting days.” – Unmarried Urban Man

“If you are having sex and ready to climax you can’t stop when it wants to come out.” – Unmarried Urban Man

“Girls have regular and irregular cycles. We count for 28 days but some have 30 day cycle so what can you do? You can get trapped. She can have a different cycle and she gets pregnant anyway.” – Unmarried Urban Man

A literature review focused on adolescent contraceptive decision making in sub-Saharan Africa, noted similar findings regarding misperceptions of pregnancy risk based on incorrect knowledge of the fertile period.⁷

In addition to wrong ideas regarding fertile periods and counting days, a few young people mentioned other myths of ways to prevent pregnancy:

“You can take a bath to prevent pregnancy.” - Unmarried Urban Man

This finding again echoes other studies: “...some decisions about sex appear to derive from insufficient knowledge and misconceptions rather than from a rational consideration of the alternatives and consequences of sexual behavior. These researchers found that many adolescents believed they could avoid pregnancy by such measures as washing their genitals after intercourse, jumping up and down after sex, and having sex standing up.”⁸

⁷ Gage AJ. Sexual activity and contraceptive use: The components of the decision-making process. *Studies in Family Planning*. 1998;29(2):154-66. Page 160.

⁸ *Ibid.*

Married

While “counting days” was the method most often mentioned by unmarried young people, it was never mentioned in the focus groups with married couples. Neither was abstaining or withdrawal.

Family Planning: Modern methods

Unmarried

Among the modern methods mentioned by unmarried young people, condoms were mentioned most often in terms of actual use, and certainly generated the most conversation. Urban young men and women, in particular, talked openly about their use of condoms. Condoms were recognized as both a method for preventing STIs /HIV as well as pregnancy. Actual use of any other method was mentioned only once by someone who reported using pills. In general, the relative popularity of condoms, pills, injectables and the calendar method over other methods found in this gender assessment is in keeping with the findings of the 2010 PSI TRaC study among urban young women; however that study looked at both married and unmarried young women.⁹ This is also in keeping with the 2008-9 DHS which found similar use of injectables and pills among married and unmarried women but higher use of periodic abstinence and condoms among unmarried, sexually active women.¹⁰

In the focus groups with young people, and with rural young people in particular, the discussion about family planning, especially discussions about modern methods, seemed more hypothetical. When discussing, they often referred to what “husbands” or “wives” would do rather than what an unmarried young woman or man or they themselves do or would do and their examples referenced couples who already had children such as these comments by rural young people:

“He has five boys and he is looking for a girl so he won’t let his wife use family planning.”

“Maybe she already had two children and doesn’t want more.”

“Maybe her children are old enough and she doesn’t want more.”

However discussion about counting days (see above) and condoms were often in regards to their own experiences:

“I am tired of school. I don’t want to count days. I use condoms. It prevents stress. I don’t have to count.” – Unmarried Urban Man

“We have sex everyday so we use a condom so there is no limitation on sex.” – Unmarried Rural Man

“Many like getting younger girls – 15 or 16 – who don’t know how to count days. You have your girlfriend but when you have a younger girl she doesn’t know her cycle so you use a condom.” - Unmarried Urban Man

“We have a stock of condoms we keep. We don’t buy before each time.” – Unmarried Urban Woman

“We buy a box [of condoms] and store at home.” – Unmarried Urban Woman

“We all use condoms.” – Unmarried Urban Woman

“I’ll go and find a condom if she’s ready to have sex.” – Unmarried Urban Man

⁹ PSI Research Division, “Madagascar (2010): Family Planning TRaC Study Evaluating the Pill and Condom Use as Contraceptive Methods among Young Females (15-24 years)” *PSI Social Marketing Research Series*, (2011), page 7.

www.psi.org/research/cat_socialresearch_smr.asp

¹⁰ Institut National de la Statistique (INSTAT) et ICF Macro. 2010. *Enquête Démographique et de Santé de Madagascar 2008-2009*. Antananarivo, Madagascar : INSTAT et ICF Macro.p. 81

"When I was in high school I used [condoms] because I wanted my baccalaureate and I told my partner. I also told my friends. It seemed they all used condoms. They also used pills." - Unmarried Urban Woman

Young girls are negotiating condoms. During break time in high school YPE come and educate. But some get pregnant because they didn't convince their partner. – Unmarried Urban Woman

"I use condoms so I like that [if partner asks you to use a condom]." Unmarried Urban Man

"I use pills, not condoms." – Unmarried Urban Woman

Married

Married men and women only mentioned pills, injectables and, once, IUDs. Most of the discussion on methods with the women was about specific side effects and the men talked mainly in generic terms about "family planning." Condoms were never mentioned by either married women or men.

Providers

Focus groups with providers were comprised of urban facility based providers and rural community health workers (CHW)s. In discussing methods, they did not generally distinguish between method use by married or unmarried clients. Injections was the method most often mentioned in these groups as being popular while pills and implants were also mentioned but less often.

"Many used implants but then didn't like and had them removed. Like injections better. Don't wait three years to remove implants." – Rural CHW

"First liked pills then injections. Now MSI is here and they like implants because they last 3 years." – Rural CHW

"Some women don't like injections so they use pills." – Rural CHW

"[They] prefer injections." – Urban Provider

"Some say that their periods are longer – they went to the hospital because they are always bleeding so stopped implants and uses injections." – Rural CHW

"People prefer injections here." – Rural CHW

"They forget to take pills but the injection lasts 3 months." – Rural CHW

"People here like injections whether at hospital or CHWs." – Rural CHW

Barriers to use: perceived acceptability and side effects

Unmarried

The acceptability of counting days, condoms, pills and, to a much lesser degree, injectables was reflected in the main barriers to use of these and other methods: misconceptions about what methods are appropriate for young people as well as rumors of side effects. Counting days, abstaining and withdrawal were most talked about in terms of acceptability while, among actual methods, condoms and pills were seen as being more appropriate for unmarried young people.

Hormonal methods, especially long term ones, were seen as not being appropriate for unmarried women or women who have not already had children with many fearing infertility as a side effect. Likewise, a 2010 PSI TRaC study found that 40.9% of young women thought that pills are not made for

youth and 27.1% thought pills were only for women who already have many children.¹¹ Other studies in Africa have found a similar preference for “counting days” along with a belief that modern contraceptives cause infertility.¹²

“If a woman hasn’t had a baby yet, we can use a condom. – Unmarried Rural Man

“If you use family planning, you’ll become sterile.” - Unmarried Rural Woman

“If you haven’t had a baby, you shouldn’t use family planning.” – Unmarried Urban Woman

“Married women [can use family planning], a woman who has children, who has already given birth.” – Unmarried Rural Woman

“[A woman uses a] long term method because she doesn’t want kids anymore.” – Unmarried Rural Woman

“[Short terms methods] are for those that want to have kids again.” – Unmarried Rural Woman

“If you haven’t given birth yet you shouldn’t use because you won’t be able to give birth later when you stop using.” – Unmarried Urban Woman

“There are different categories of family planning – those for those without children.” – Unmarried Urban Woman

“For those with no children, then use pills. Injections are for those who are older. If you use injections the man might leave you. You will have a hard time having a child once you stop using.” – Unmarried Urban Woman

“The girls think that you want to have a baby when you marry and if you can’t he will leave you.” - Unmarried Urban Woman

“I use a condom. Some say the lubricant on the condom makes them sick. Is that true? I’ve never been sick so far.” – Unmarried Urban Woman

“From pills and injections, I heard that it causes a big tummy even though there is no baby inside. You might still get pregnant.” – Unmarried Urban Woman

“If you use, your vagina will always be wet. And you will have things on your underwear.” – Unmarried Urban Woman

“I am afraid to use because it seems inefficient.” – Unmarried Urban Woman

“Maybe the woman is afraid of side effects.” – Unmarried Rural Man

“Pills make you either very slim or very fat.” – Unmarried Urban Woman

“Some men think that there might be effects like diseases as a consequence of using family planning. Side effects.” – Unmarried Rural Man

IUDs were mentioned when asked specifically about long term methods but never in terms of use.

As noted above, counting days and condoms were mentioned in terms of actual use while other methods were discussed in more theoretical terms. These discrepancies may be explained by the belief that hormonal family planning methods are only appropriate for those who are married and have already had children and these FGDs were with unmarried, childless young people.

Additionally, condoms face potential barriers that other methods do not. They may have benefitted from being promoted through HIV prevention programs but at the same time may have been “tainted”

¹¹ PSI Research Division, “Madagascar (2010): Family Planning TRaC Study Evaluating the Pill and Condom Use as Contraceptive Methods among Young Females (15-24 years)” PSI Social Marketing Research Series, (2011) www.psi.org/research/cat_socialresearch_smr.asp.

¹² Gorgen, Regina, Birga Maier, and Hans Jochen Diesfeld. 1993. “Problems related to schoolgirl pregnancies in Burkina Faso.” *Studies in Family Planning* 24,5:283-294.

in terms of family planning. Urban users spoke more positively about condoms as did women in general. Rural men spoke about using condoms and had positive things to say but also negative things and were particularly negative about whom they use a condom with:

“When you have sex with a girl you suspect might have STIs.”

“With sluts.”

“With women of bad behavior.”

“With women we don’t like.”

“In my mind, I have two ideas: she is a prostitute or she is afraid to get pregnant.”

“They use condoms because he is afraid the girl has an STI and he doesn’t want to catch.”

A PSI 2013 study also found that a condom can be a source of contention between the couple because it is perceived to signal both a lack of trust as well as potential infidelity. Young people in that study reported that they use condoms with casual partners only or with girls they meet by chance.¹³

This echoes other studies findings that use of a condom “indicates a general lack of respect for the female partner (Agyei et al., 1992). The nonmonetary costs of condom use appear to be even higher among girls than among boys. Some girls feel that a partner’s wish to use a condom suggests that they, the girls, are not clean, that they are commercial sex workers, or that they are involved in extra-relationship sexual activity (Feldman et al., 1997; Havanon et al., 1993).”¹⁴ For more on condom use, decision-making and relationship quality, see page 26

That negative perception of condoms may also explain why some young women and men took pains to explain that they only use condoms occasionally:

“We don’t use one if we know the time of the month and know she won’t get pregnant.” – Unmarried Rural Man

“[We use a condom] just around unsafe days. Not always, just on unsafe days.” – Unmarried Urban Woman

Service Providers Perspectives on Abortion

None of the focus groups was asked specifically about abortion and it did not come up in the discussions with young people. However, it was a topic of discussion among the service providers who reported demand for abortion among young people. In one place in particular the service providers noted with alarm that because some young people don’t think that family planning is appropriate for them, believing that it will inhibit future fertility, they elect instead to have abortions, sometimes repeatedly. They also noted the presence of unscrupulous providers who take advantage of the situation.

“They prefer abortion over family planning – they abort over and over rather than use family planning.” – Service Provider

“But there are many young people who come to my clinic to ask for abortion. I had four this week. There are many young people.” – Service Provider

¹³ PSI, Flash Focus Condom Youth - Antananarivo - Toamasina July 2013.

¹⁴ Gage, *op. cit.*, p. 160.

"There is a region in the north where abortion is high and the doctors say that family planning doesn't work. They tell young people in school can't use family planning. They go to the Chief and convince that family planning isn't good." – Service Provider

"The doctors who do abortions are well known for abortions and all know so they go there. We wonder if abortion is legal now. There is a center that does abortion and people aren't afraid to go there." – Service Provider

"There is information on family planning but the number of abortions always increases." – Service Provider

Married Barriers to use: myths and side effects

There were a variety of barriers to family planning mentioned including that some people just want to have many babies, religious beliefs, lack of information on family planning, cost of family planning; with the most mentioned being myths and fear of side effects. A 2012 PSI TRaC had similar findings, with 72.9% of the respondents reporting incorrect beliefs with regard to side effects of pills.¹⁵ A 2002 PSI study on family planning decision-making found men's fears of side effects as a barrier to contraceptive use particularly with regards to perceived irreversibility of the method.¹⁶ This latter fear - that those who use family planning won't be able to have children when they stop using it - was expressed in both the FGDs with the unmarried and married groups.

"They are afraid they won't get children later on." – Married Rural Woman

"Some men don't know; the woman should explain that she can stop and they can have children later." – Married Rural Man

Another side effect mentioned among married women and echoed in the provider discussions is men's fear that family planning use will negatively affect a woman's libido. (see provider discussion on barriers below). It is interesting to contrast this fear of reduced libido with the more often expressed fear of women using family planning to remain sexy for others. See discussion on married relationship quality and decision-making on page 20.

Barriers to Family Planning Use - Myths, Fear of Side Effects

"She won't use because people will say you'll get cancer." - Married Rural Woman

"Pills will gather in your intestines." – Married Rural Woman

"They heard you'll have an ectopic pregnancy." – Married Rural Woman

"Here in [this town] many people gossip in the main street. They say people who use [family planning] have died." – Married Urban Man

"Pills and injections make you fat." – Married Rural Woman

"She will gain weight." – Married Rural Woman

"More men are convinced but the problem is the woman's body changes so the man doesn't like." – Married Urban Man

"We don't want to gain weight." – Married Rural Woman

"Many misconceptions about family planning hinder women to use." – Married Rural Woman

"Many people are afraid of things you put inside." – Married Rural Woman

"When you have an IUD you are afraid when you bathe that the string will come out." – Married Rural Woman

¹⁵ PSI Madagascar 2012: Family Planning Trac Study Evaluating the use of Modern Contraceptive Methods among Women of Reproductive Age, 15-49 years.

¹⁶ PSI, Genre et mecanisme de prise de decision en matiere de PF a Antsirabe et Antsohihy (Mai 2002).

"I have a stomach ache if I eat the pills so I don't use." – Married Rural Woman

Barriers to Family Planning Use – Lack of Information

"Some want to know how to use it." – Married Rural Woman

"Some don't know about it so won't use." – Married Rural Woman

"The first problem is there isn't enough information on methods or how to choose. If you had the information you wouldn't be afraid to use." – Married Urban Man

Provider Perspectives on Barriers:

Providers are in a unique position to discuss perceived barriers as clients often discuss with them their reasoning for selection or rejection of a particular method as well as reasons for removal or discontinuation of a method. Side effects, both real and rumored, were the most talked about barriers in the groups of providers and was raised as a barrier to family planning use in every group. Some barriers were generic – such as religious prohibition against all forms of family planning - and some barriers were method specific such as dislike of condoms or the IUD string or a belief that pills and implants cause prolonged menstrual bleeding. The providers also discussed that men feared family planning use's negative effect on women's sexual desire and enjoyment of sex.

Just as providers noted that some unscrupulous providers use young people's fear of family planning causing fertility loss to promote abortion, they also noted that it was likely that men were using the fear of side effects to justify their opposition to family planning use by their wives:

"The community all tells her that IUD causes cancer so she comes back to ask us to take it out."

"Men are also afraid their wives will get cancer."

"The men also use the information to justify not letting the wife use family planning."

In terms of discussion, the concept of "men as barriers" to family planning was second only to side effects, was raised in every group and echoes earlier PSI findings.¹⁷ This barrier was also one of two most discussed barriers among the married and unmarried groups but is discussed in the sections on roles, decision-making and relationship quality.

Providers also discussed the negative impact that other providers can have on family planning whether through their performance, beliefs or practices.

Barriers – General Side Effects

"Misconceptions, IUD, implants used for tracking you. Injections create headaches, you'll die, many rumors, think pills aren't reliable, prefer to count days." – Urban Facility Based Provider

"When they come for other illnesses, they always think it is related to family planning use." – Urban Facility Based Provider

"They are hearing a lot of things on family planning from their friends and think it makes them sick. Some say I bleed all day and that spreads thru the village." – Rural Community Health Worker

"Their husbands are afraid of consequences of family planning. They hate that they will get fat when they use family planning."
-Urban Facility Based Provider

"Some say that pills and medicines are expired from abroad. They dump here." – Rural Community Health Worker

Method Specific Barriers

¹⁷ PSI, Genre et mecanisme de prise de decision en matiere de PF a Antsirabe et Antsohiy (Mai 2002).

"Before men like to use condoms but then someone said the lubricant causes HIV. Others don't believe that HIV/AIDS exists. They say 'show us someone with HIV and we will use a condom. Otherwise don't bother us.'" – Rural Community Health Worker

"People are ready to use. They don't feel obliged to use and they know they need it but because of side effects they don't. Many go directly to the pharmacy to get pills without a prescription so doctors can't address side effects. 'My sister uses pills so I use.' They go to clinic once then go to the pharmacy for the pills. Sometimes I go to pharmacy to tell them to ask for a prescription for pills. They don't take pills correctly because they didn't get counseled by a doctor." - Urban Facility Based Provider

"There is no taste. Eating a candy with the wrap is like eating no candy at all." – Rural Community Health Worker

"The man will say the IUD is embarrassing – it affects his pleasure." - Urban Facility Based Provider

"Not many use IUD – they don't like having something put inside – they are afraid it will move and the string hang out. Don't know what it is made from." – Rural Community Health Worker

Effect on Women's Libido

"The men think it will affect women's ability to enjoy sex if she uses family planning." - Urban Facility Based Provider

"The man says he doesn't like her to use because she won't have desire for sex anymore." - Urban Facility Based Provider

"Investigate why people don't use family planning – when she uses and is aroused she is a bit dry and the men don't like. And women's desire is low so men interpret that she is having an affair." - Urban Facility Based Provider

Religious Barriers

"There are Catholic doctors who tell them "no" so the clients are confused." - Urban Facility Based Provider

"They think it is against God's will. That it is killing babies. You are preventing God from doing His work." – Rural Community Health Worker

Men as Barriers

"Hard to convince men about family planning." - Urban Facility Based Provider

"When you do counseling just the woman is there and when she goes home she can't convince the man." - Urban Facility Based Provider

"Men just like to have babies and take no responsibility." – Rural Community Health Worker

"Here only women came for sensitization – men aren't interested." - Urban Facility Based Provider

"Before women hid that they used family planning but then government encouraged women in 2005 – they know the benefits of family planning. Hard to convince before but women are convinced. Men are the main barrier." – Rural Community Health Worker

Provider Barriers

"Different training for different doctors. We all have different information. When client comes and says it's [IUD] here 1 year with no period and the doctor says you need to get your womb cleaned. They say this a lot." - Urban Facility Based Provider

"Many doctors haven't been trained. May give injections although not trained. Discourages many to stop because not well trained." - Urban Facility Based Provider

"Even me, before I didn't like family planning but the more information I got the more convinced I became." - Urban Facility Based Provider

"The previous doctor said that the woman had to bring her husband's medical card to prove he supports family planning. Sometimes we have to testify that you don't need your husband's ID card." – Rural Community Health Worker

Motivations for Use

Unmarried

Despite the perceived barriers, both unmarried women and men, whether urban or rural, expressed clear motivations for using family planning. Overall, the most important motivator for all groups was that a pregnancy would hinder the achievement of one's goals. A recent study in Kenya found that single young people there were motivated to use contraception in order to "secure their future."¹⁸ This idea was particularly true in this assessment for urban young women and men who focused on having a dream or goal and pregnancy as a barrier to achieving their goal.

The latter may be because the urban youth, both male and female were primarily university students. It is not surprising that university girls would be more apt to speak about family planning use or about having a goal. Research from around the world consistently shows a strong correlation between women's higher educational attainment and increased contraceptive use and reduced childbearing. In many sub-Saharan African countries, women with no schooling have two to three more children than women with secondary or higher education, in keeping with a global pattern of the higher the level of education, the lower the fertility.¹⁹ But the positive effect of girls' education isn't just on the future. Girls currently in school are more likely to exhibit protective behaviors. A systematic review of research on transitions to adulthood in developing countries found that "girls' attendance in formal school is positively correlated with delayed sexual initiation, later marriage and childbearing, lower rates of HIV/AIDS and other reproductive morbidities, fewer hours of domestic and/or labor market work, and greater gender equality."²⁰

Additionally, rural young women spoke of the shame of getting pregnant before marriage or before being of age (18); young men talked of fear of impregnating an under-age girl, having to pay a pregnant girl's family, having to marry and/or move in with their parents. For urban youth there was a discussion about problems related to getting a younger girl pregnant but no discussion by the girls of shame related to getting pregnant. All groups discussed financial hardship ("life is hard") as a motivator for family planning use and that using family planning would free them from the stress of worrying about an unintended pregnancy. They also talked about using a condom or supporting a partner's use of family planning as a measure of a man's love, respect and caring for his partner.

Motivations for Family Planning Use

Goal/Dream/Future Planned

"I will tell him I will leave [if he disagrees with family planning use] because I have a goal." – Unmarried Urban Woman

"I like the girls who dare to ask [me to use a condom]. She is thinking about her future so I like. She cares about herself so I like. I will help protect her." – Unmarried Urban Man

¹⁸ Alaii, J., and Nanda, G. 2012. *Fears, Misconceptions, and Side Effects of Modern Contraception in Kenya: Opportunities for Social and Behavior Change Communication*. Research Report. Washington, DC: C-Change/FHI 360, p. 23.

¹⁹ Mboup, G. and Saha, T., 1998, Fertility Levels, Trends and Differentials, DHS Comparative Studies No. 28, Calverton, Maryland, Macro International, Inc.

²⁰ Cynthia B. Lloyd with Juliet Young, *New Lessons: The Power of Educating Adolescent Girls*, 2009, The Population Council.

"A man who thinks about the future supports his partner." – Unmarried Rural Man

"If she is my friend, I will ask her what is her dream? [She should] ask her partner if he has a goal in life. If she wants to continue to study what will she do if she gets pregnant? [She should say:] If I get pregnant, I will have to live with my mother-in-law. Do you want me to live with your mother? Then they will use a condom." – Unmarried Urban Woman

"When I was in high school I used [family planning] because I wanted my baccalaureate and I told my partner." – Unmarried Urban Woman

"Tell her to think about her future. Convince her partner her future is at stake." – Unmarried Urban Woman

"If you care about your partner's future life. You may want children later but preserve the future now." – Unmarried Urban Man

"[She uses family planning] To protect her future." – Unmarried Rural Man

"A serious man uses because he thinks he will have to stop studying so he protects you and him." – Unmarried Urban Woman

"They [the ones who support family planning] are all still studying. A working man would not support." – Unmarried Urban Woman

""[She uses family planning because] She is still studying and dating someone." – Unmarried Rural Man

"We have a dream now and he knows we can't fulfill it if we get pregnant. Life is hard. We know if we get pregnant he knows he won't be able to feed." – Unmarried Urban Woman

"When you are both students it is easier to convince. If not studying it will be harder to convince him [to use family planning]." – Unmarried Urban Woman

Must pay her family/marry/Move in with parents:

"If she ends up pregnant [the man] is responsible. You and your family will get in trouble if she gets pregnant. I will tell her if you don't want the condom I will leave you because my family has no money." – Unmarried Urban Man

"We are all students here: do we want our parents to be paying for our children, too? Who will pay for children while we are in school? Do we want our children to have a bad life? If we finish school and get a good job we can give our children a good life. So it is not our parents' responsibility." – Unmarried Urban Man

"If we don't like her and she gets pregnant we will be trapped." – Unmarried Rural Man

"He is afraid her parents will bother him if she gets pregnant so he uses a condom." – Unmarried Rural Woman

"He will be obliged to marry the girl if she gets pregnant." – Unmarried Rural Woman

"If she is under 18, he can go to jail." – Unmarried Rural Woman

"If they get a younger girl pregnant her family will ask for a lot of money so they use condoms." – Unmarried Urban Woman

Shame/Underage

"She will have a good family because she won't be pregnant before marriage." – Unmarried Rural Woman

"[A girl uses family planning] Because she is under 18 and a minor." – Unmarried Rural Woman

"[If we get pregnant at this age] we will get in trouble with our parents. And it is a shame to be pregnant under 18." – Unmarried Rural Woman

"If you get pregnant your parents will kick you out." – Unmarried Rural Woman

Life is Hard

"Life is hard. When you have many mouths to feed but limited resources there is trouble. Too many children and limited resources you are creating trouble for yourself. You should space even if you are married." – Unmarried Urban Man

If [she is] my friend, I will tell her you have to convince your partner – life is so hard so you have to convince him [to use family planning]. Being pregnant will keep you from your goals." – Unmarried Urban Woman

"[Family planning is] Good for economics – because you don't want babies - if you don't know about it [family planning] you'll

get a baby.” – Unmarried Rural Man

“She thinks the man can’t support her. She’ll suffer if she marries this man. So she asks him to use a condom.” – Unmarried Urban Woman

“[A man supports family planning use if he] Doesn’t want to have children because not working yet and can’t feed.” – Unmarried Urban Woman

“Negotiation and discussion are important. I will explain why condoms are important for me. Discussion is important. I think she will think about her future. I think she can think for herself. If you explain well that you don’t have money for children if you get pregnant or I don’t want to live with your mother – so need to discuss.” – Unmarried Urban Man

Prevents stress

“Maybe she doesn’t want stress and worry about getting her period.” – Unmarried Rural Man

“Maybe she wants to enjoy sex and can if she doesn’t have to worry.” – Unmarried Rural Man

“She wants to be confident, not be thinking about pregnancy.” – Unmarried Rural Man

“Less stress – she can work.” – Unmarried Rural Woman

“Stressing to think if she is pregnant or not.” – Unmarried Rural Woman

“I use condoms. It prevents stress” – Unmarried Urban Man

In every group, among males and females, there were those who mentioned a man’s relationship with his wife/partner and family as motivators for either using family planning or supporting a partner’s use of family planning. The groups talked about this in terms of the man’s love, respect and care for his partner and family. The 2010 TRaC found that social support from one’s partner significantly influenced the use of modern contraceptive methods among young women 15-24 years old.²¹

“A man [supports his partner to use family planning] who cares about his family and doesn’t want trouble, wants to live in harmony and wants all children to get care.” – Unmarried Rural Man

“He loves his partner/wife and doesn’t want her to suffer from delivery a lot.” – Unmarried Rural Man

“He respects his wife.” – Unmarried Rural Man

“Once she asked [me to use a condom] and to please her I did.” – Unmarried Urban Man

“[A man supports his partner to use family planning because he] Respects his partner.” – Unmarried Rural Woman

“[A man supports his partner to use family planning because he] Is kind.” – Unmarried Rural Woman

“If he likes her he will say ‘yes.’ Many couples break up because he won’t use a condom. If he loves her he will accept.” – Unmarried Urban Woman

“He [the Youth Peer Educator] can tell the man that if he really likes the woman he should use family planning. He can explain that unwanted pregnancy causes your partner to suffer so if you really like her you should use.” – Unmarried Urban Woman

Motivations for Use of Family Planning Among Married

The motivations for use by married couples were similar to those identified by the unmarried young people but the emphasis was different. Married couples also cited having a plan or dream, financial motivations, less stress and shame as reasons for using family planning. However, the reason that was

²¹ PSI Research Division, “Madagascar (2010): Family Planning TRaC Study Evaluating the Pill and Condom Use as Contraceptive Methods among Young Females (15-24 years)” PSI Social Marketing Research Series, (2011).

discussed most often as a motivator for family planning use was that “life is hard” and the financial cost of children. This motivation was raised by each type of married focus group: male/female and urban/rural.

One motivation that was discussed by married participants but not the unmarried ones was the idea of spacing babies to be better able to care for the babies and for the mother. This likely reflects these groups’ direct experience with raising children (having at least one child under the age of five was a criteria for inclusion in the married groups) whereas the unmarried groups did not have experience as parents. Spacing babies to better care for the babies was only raised as a motivator by the women’s groups, reflecting their roles, albeit changing ones, as primary care givers for children. Although shame was also a motivator for the unmarried participants, the shame they referred to was in regards to having a child before marriage or while underage. For the married group, shame as a motivator for family planning use was in regards to getting pregnant while still breastfeeding the last baby. One final motivator for use of family planning was if a woman suspected her husband was unfaithful. (For more on the role that infidelity plays in family planning decision making and relationship quality, see below.)

Motivations for Family Planning Use

Life is Hard

“Because life is getting hard that is why you use family planning. You earn less than 1 million a month you have 5 children. The children don’t understand. The mother has to feed. If you don’t pay attention the children think you don’t love them. So you use family planning because you want to show you love each and you want to feed each.” – Married Urban Woman

“Life is hard so the woman wants to manage the number of kids.” – Married Rural Woman

“It depends on the income of the family. If you have too many children there won’t be resources. The couple should discuss to decide if family planning fits them. If you make little and have many kids you won’t have a good life.” – Married Rural Man

“If the woman uses family planning it helps the children because there won’t be enough food at home.” Married Rural Man

“My wife had an unplanned pregnancy so life is hard. After the child I told my wife to have no more children.” - Married Urban Man

“Sometimes the hard life convinces us to use.” – Married Rural Man

“Life is hard so I decided to have fewer children. I didn’t go to school but I want my children to finish.” – Married Rural Man

Space in Order to Better Care for Baby and Mother

“It is also good to space births. It is hard to care for them if you have too many.” – Married Urban Woman

“If you space, even if you breastfeed you can’t manage all of those children.” – Married Urban Woman

“To space babies.” – Married Rural Woman

“Manage the number of babies.” – Married Rural Woman

“If she uses family planning she can raise children in a better way because she will have more money to send them to school.” – Married Rural Woman

“He will tell his wife if she spaces she will have time to take care of herself.” – Married Rural Man

Goal/Dream/Future Planned

“My wife and I use. I was convinced. If there was an unwanted pregnancy it would change our plans.” - Married Urban Man

“In life there are things that define your life: mission, vision and experience. We have a plan. Stick to the plan and you won’t have problems. You can fulfill your dreams.” - Urban Man

Provider Perspectives on Motivations

The most discussed motivation among groups of providers was the same as among the groups of married participants; namely “life is hard,” the financial burden posed by too many children and the desire to care for their needs. There were some motivations that were method specific primarily in regards to condom use and protection from STIs and HIV. And reflective of the earlier finding that men can be barriers to family planning use, husbands, as well as others, can be influential in getting women to use family planning. It is important to note that the men’s motivations for supporting their partner’s family planning use should not necessarily be assumed to be positive but can range from love and care for her to threats and coercive behavior to bring about compliance with his decision.

Motivations for Family Planning Use

Life is Hard

“I am a man so we should talk to the men. I tell my wife we need to save money – if we have many children we cannot save money.” – Rural Community Health Worker

“Those men who experience the benefits of using family planning. They have more money so keep using.” – Rural Community Health Worker

“At first men didn’t support but life is hard and we encourage our wives to use.” – Rural Community Health Worker

“Sensitization from CHWs – we explain the benefits of family planning. Do mathematical calculations – using family planning is less expensive than having a lot of babies.” – Rural Community Health Worker

“Use family planning for economic reasons.” - Urban Facility Based Provider

[They use family planning because] “there isn’t enough money.” - Urban Facility Based Provider

“Life is really hard and people are getting poorer – they can’t properly raise their children. They want to limit the number of children so they can send them to school.” - Rural Community Health Worker

If a woman has a limited # of children she can do more work planting and house work. - Rural Community Health Worker

Motivated by Partner or Others

“The trend now is that they men encourage the partners to use the IUD because no side effects on woman’s body.” - Urban Facility Based Provider

[The man says] “If you get pregnant again I will leave you,’ so the woman uses family planning.” - Urban Facility Based Provider

“Sometimes the men are more strict. The women are afraid of the equipment. Men push the women to use the IUD. They coerce them and the women feel pressured by the husband to use the IUD.” - Urban Facility Based Provider

“If sisters and mothers use a particular method, she will too.” - Urban Facility Based Provider

“There are also men who love and care for their wives. They don’t want to see them tired and suffering.” - Rural Community Health Worker

“Even among men, we are tired of seeing our women breastfeeding so we encourage our wives to use.” - Rural Community Health Worker

“She sees her friend uses family planning and she has only 2 kids and she is well dressed so she wants to be like her.” Rural Community Health Worker

Motivation to Use Condoms

“Men use [condoms] for family planning but also to prevent HIV and STIs – they don’t want their wives to use injections and pills.” - Rural Community Health Worker

Roles in family planning

Unmarried

The roles that the men and women play in family planning depend on the type of method used. If using the calendar "counting days" method both young men and young women said that their role and/or the role of their partner was to keep track of her cycle and know her fertile days. Among the urban young men their discussion noted a difference in their role counting depending on the girl's age and whether she was their regular partner or not:

"Many like getting younger girls – 15 or 16 – who don't know how to count days. You have your girlfriend but when you have a younger girl she doesn't know her cycle so you use a condom." – Unmarried Urban Man

"If a university girl then she counts [her days]. If a high school girl, you count. If you ask her and she hesitates you should abstain. I prefer to count for her." - Unmarried Urban Man

"If she is your regular partner you both should know her cycle." – Unmarried Urban Man

As noted in the discussion on methods on page 6, young men also use condoms and practice withdrawal and abstain. They provide money for condoms as well as purchase the condoms. They support their partner's use of family planning by encouraging or convincing her to use, helping to seek advice, going with their partner to the health facility or reminding their partner to take pills.

A young woman's role in family planning is to know her body so that she can select an appropriate method, count days/ know her cycle, seek information and services, purchase condoms, initiate a discussion with her partner and to convince her partner to use a method or accept her decision to use a method. Preliminary findings from PSI's 2013 Focus on Rural Youth Dashboard identified similar roles for rural young men and women.

Married Roles

Unlike the unmarried FGD participants, the married participants were not asked specific questions about family planning roles and decision making. This was due to the broader nature of the FGDs with married couples. While the FGDs with unmarried participants only focused on family planning, the FGDs with married participants also covered the "child under five" health topics of malaria, diarrhea and pneumonia. However, in asking the married FGD participants about use of family planning, partner support and female and male friendly health services, the issues of roles, decision-making and hidden contraceptive use did come up.

When asked specifically about how a husband could support his partner to use family planning, women described men's roles thusly:

Men's Roles in Supporting Partner's Family Planning Use

"The man reminds the woman to take pills or get injection." - Married Rural Woman

"My husband encourages me to take on time and take water." – Married Rural Woman

"Sometimes when I can't get the pill he can buy." – Married Rural Woman

"If he isn't ashamed to buy at the grocery he can buy. [Most say the man will be ashamed to buy.]" – Married Rural Woman

"He can ask about the consultation." – Married Rural Woman

While some responses were clearly based on actual experience most of the responses appeared to be purely conjecture as reflected in this exchange:

Focus Group Leader: "How can a man support his partner to use family planning? Please describe."

Married Rural Woman: "The man agrees with her decision to use [family planning]."

Focus Group Leader? "How does he show he agrees?"

Married Rural Woman: "Hard to answer because that never happens."

Provider Perspectives on Roles and Family Planning Decision-Making

Provider perspectives on roles and decision-making in regards to family planning use are based on cultural assumptions or what they see or hear during consultations. As one provider put it when the question on who within a couple makes the decision to use family planning came up:

"When they don't come together they decided at home and you don't know who decided." – Urban Facility Based Provider

And as noted by one provider, facilities do not keep statistics on couples but on the individual. In one community the providers noted that the number of men who seek their services for family planning either alone or with their partner is, from their perspective, quite low. Some men come alone to discuss family planning but the providers noted that these are primarily unmarried young boys. For the most part if men do come it is to seek information regarding side effects, seek information for his wife or to check the place out before he will allow his wife to come. The latter was seen as a lack of trust between the partners. In the FGD with providers, they said that the women always come by themselves because they know that they are sick or want family planning.

Family planning decision-making

Unmarried

Decision making regarding family planning ranged from "the man decides" on one end to "the woman decides" on the other end with joint decision-making in the middle and fairly complicated negotiations happening in between. The sex of the group only mattered for "the man decides" which was only suggested in the men's groups; whereas "the woman decides" was offered as an option by both men and women. Some decision-making was method specific depending on who would be using it - such as with the condom [he wears so he decides]. Interestingly, only the young men said that the man alone decides or has the final say whereas both men and women thought the woman should decide.

The Man Decides

"The boy has the last word. Because they wear the condom." [laughter] – Unmarried Rural Man

"Maybe because it [the condom] affects the feeling so it is up to him." – Unmarried Rural Man

"The man is the one who doesn't want to withdraw or to use the condom. The problem with family planning is always from the man so he should decide." – Unmarried Urban Man

"The final word goes to the man. It's not just regarding sex: the man has the final word in everything in the couple. If she gets pregnant we are responsible. If there are any problems we are responsible. So we decide." – Unmarried Urban Man

"The man takes the decision because if you talk about withdrawal, you withdraw. The final word is up to you." – Unmarried Urban Man

"...so it is up to the man to decide..." - Unmarried Urban Man

"I take the decision. The first responsible is the man." – Unmarried Urban Man

In the groups that identified women as the decision-makers, men acknowledged that the primary consequence of pregnancy falls to the woman whereas women highlighted knowledge of one's own body. There were also those women who said that it was a woman and her doctor who should decide. Those were grouped with the women decide.

The Woman Decides

"The woman decides." – Unmarried Rural Man

"It should be the woman because she will suffer the consequences of getting pregnant." – Unmarried Rural Man

"The woman should have the last word because she fears getting pregnant." – Unmarried Rural Man

"The girl will decide what fits her body." – Unmarried Rural Woman

"The girl decides." – Unmarried Rural Woman

"The doctor proposes and she follows." – Unmarried Rural Woman

"The girl knows her body so she decides." – Unmarried Rural Woman

"The woman decides." [All agree] – Unmarried Rural Woman

"The woman will decide." – Unmarried Rural Woman

"She should decide which one she uses – pills, injections, etc. She is the one who knows her body and what is better." – Unmarried Rural Man

"It is her body; she should know the consequences of her behavior. The decision should be hers. She should know her body and take the decision." – Unmarried Urban Man

In the middle were those that felt that the decision to use family planning should be made by both the man and the woman –because it is a better to discuss and they share the potential consequences as well as responsibility.

Joint Decision-Making

"They make the decision together." – Unmarried Rural Man

"The two decide." – Unmarried Rural Woman

"The woman should know her cycle to know when she can't have sex. The man should monitor calendar if during her fertile days and they still want sex, the couple should decide to use condoms. The couple should set rules which they define." – Unmarried Urban Man

"They should both decide." – Unmarried Rural Man

"If he really loves the girl they will both decide." – Unmarried Rural Man

"The couple should have discussion in their daily lives. Discuss the impact of pregnancy in their lives. Each should be aware and take responsibility. They need to think of the consequences and both take responsibility." – Unmarried Urban Man

"Women shouldn't decide alone but should discuss with her partners." – Unmarried Rural Man

"Negotiation and discussion are important. I will explain why condoms are important for me. Discussion is important. I think she will think about her future. I think she can think for herself. If you explain well that you don't have money for children if you get pregnant or I don't want to live with your mother – so need to discuss." – Unmarried Urban Man

Any movement between the ends of the decision-making spectrum - "he decides" or "she decides" - and the middle of the spectrum - "they decide" - is the result of discussion, negotiation and as the assessment group often heard "convincing." Sometimes it is as simple as the person who has made the choice asking the other person to go along with their choice ("when you ask, they accept"). For the women, it was an acknowledgement that although she can choose, her partner "may say 'no'" and she will then have four possible choices:

- 1) Acquiesce to his decision;
- 2) Negotiate a different method ("The girl chooses first then asks her partner. If he says 'no' then she asks her partner which he prefers.");
- 3) Try to convince him to change his mind ("She will convince him."); or
- 4) Follow-through with her decision to use a method without his approval or knowledge, i.e., hidden contraception ("Tell him you respect his decision and then protect yourself").

Men also mentioned that they sometimes need to convince their partners, especially in regards to condom use:

"I know they do sensitization but if they reach me but not my partner they don't explain how to convince my partner. They just say 'you should use.' We know how to use but they don't give us arguments to convince our partners."

"They don't need to bring a fake penis and show us how to use. We know how. We need arguments to convince."

Women and men offered a variety of arguments for convincing reluctant partners: the benefits of the particular method; the financial burden of children; an unwanted pregnancy being an impediment to reaching a goal; not wanting to live with their mother/mother-in-law – basically the same arguments presented as motivations for use. From the women's perspective, if they are the ones that need to be convinced, "It is important that he be romantic."

Absent their partner's agreement, many had fall back means for seeking to enforce their decision on their partner which was less persuasion and convincing and more toward coercion and threatening:

"I will tell her if you don't want the condom I will leave you..." – Unmarried Urban Man

"In the beginning he didn't like but I told him if he says 'no' I will keep my virginity. So he said 'yes.'" – Unmarried Urban Woman

"Some say they won't have sex with you if you use." – Unmarried Urban Woman

"She should not have sex if they don't use." – Unmarried Rural Man

"Maybe the man will say 'I will go away if you don't use.'" – Unmarried Rural Woman

"She can tell her partner that if he doesn't want to use a condom she will not have sex." – Unmarried Rural Woman

"I will tell him I will leave because I have a goal." – Unmarried Urban Woman

Young women in relationships where partners maintain rigid gender roles - "the man has the final word in everything in the couple" – may face real difficulties in negotiating protection, having no choice but

to acquiesce to the partner's decision or face the loss of the relationship. While a pregnancy is a potential problem, the loss of one's partner is a very real and immediate one. "Culturally based gender roles that reinforce male rights over sexual and reproductive decision making can, therefore, contribute in important ways to female adolescents' powerlessness to make reproductive decisions and to their vulnerability to the negative consequences of unprotected sex."²²

Married Decision-making

There were no real discussions about family planning decision making per se in the FGDs with married participants. These FGDs were focused on how to make family planning services more male and female friendly and how to better engage men in family planning. Just as with the unmarried women, married women were cast in the role of "convincers" as in the following:

"It's always the wife who convinces the man. If it were up to men, they wouldn't use [family planning]." – Married Urban Man

And if women were unable to convince the men and they still said "no" to family planning the rural women pronounced "those are selfish men" and predicted the results would be that "They will fight and not sleep together" and there would be a "Big fight."

Hidden Use

Neither unmarried nor married FGD participants were asked directly about hidden contraceptive use and yet it came up in every group. Service providers were asked specifically about hidden use. For that discussion, please see page 24, below.

Unmarried

For unmarried young people negotiations regarding family planning use were primarily about negotiating for condom use. When asked about what happens should negotiations fail, then hidden contraception was mentioned. Hidden contraception was not presented as an optimal choice (see consequences below) but as more of a realistic response to an obstinate partner. The first choice is to come to agreement with one's partner regarding contraceptive use but hidden use is the natural fall-back in order to secure protection of one's future.

"Maybe they already had a discussion and he said "no" so she hides because she tried to convince him and he said ""no."" – Unmarried Rural Woman

"We will tell her to go back and convince her partner and if he says 'no' then hide it." – Unmarried Rural Man

"She will hide it from her partner." - Unmarried Rural Woman

"Tell him you respect his decision and then protect yourself." - Unmarried Rural Woman

Hidden Use Among Married

While the married rural women talked about fights as a result of men not agreeing to family planning use, the urban women talked more about hidden contraceptive use among married women. And one rural man suggested that those who hide contraceptive use should be encouraged to do so.

"Many women hide the use and men don't find out." – Married Urban Woman

"If poor, I will hide the use if he has no money. I know he won't be able to feed my children, I will hide. If he says "no" I don't

²² Gage, *op. cit.*, p. 161.

care." - Married Urban Woman

"Even if he has money, it is your life. Your life is important. You have to think about yourself. If you are pregnant you will be tired and he will leave. [He will say] 'This isn't who I married.' He will leave and your children will be there. So you use and you hide it." – Married Urban Woman

"Sometimes they will go there on their own and hide it. She decides on her own. You can encourage her to continue doing it." – Married Rural Man

Other programs in Madagascar have similarly found reports of hidden contraceptive use among married women.²³

Service providers perspectives on hidden use

While all of the groups discussed hidden contraceptive use, the discussion was particularly robust among the groups of providers – urban facility based providers as well as the rural Community Health Workers. Both urban and rural felt that hidden use was common. What is interesting about the providers is that they can find themselves in a position of playing an active role in hiding contraception either by choice or by being put into the middle of a situation.

Providers' Roles in Hidden Contraception

"Sometimes the men want children and the woman doesn't have any so he asks the doctor why." – Urban Facility Based Provider

"The husband asked the wife 'where are you going?' She said [to the doctor] 'if my husband checks tell him I'm not using.'" – Urban Facility Based Provider

"She leaves her medical records at the doctor so he won't find out." – Urban Facility Based Provider

"They also hide from their mothers and sisters and ask doctor to write on their record that it was removed." – Urban Facility Based Provider

"We encourage them to hide." – Rural Community Health Worker

"We tell them to give us their medical reports and we keep for them." – Rural Community Health Worker

"We tell them you better hide from your husband because you suffer the consequences so you better hide." – Rural Community Health Worker

"Sometimes they leave their medical record at the doctor and he knows her next appointment." – Urban Facility Based Provider

"The man doesn't like them to use. Even when we do sensitization we hide from the men. I keep the medical records of some of the clients because they have to hide from their husbands." - Rural Community Health Worker

"There are many men who don't ever find out. He feels IUD during sex and asks wife to remove. Doctor says tell him you already did." – Urban Facility Based Provider

Consequences of hidden use

Unmarried

Young people reported a variety of consequences as a result of hidden contraceptive use being discovered by the partner. Those consequences ranged from a positive response by the partner to a

²³ Hanitra Njatonirina, Mahefa Project, Rapport d'Analyse de Genre Avec Lesgroupes Ethniques Dans La Region De Sofia, John Snow International, 2013.

neutral one to a negative one. Surprisingly it was young men who mentioned potential positive benefits to hidden use. On balance, there were many more potential negative consequences mentioned than positive or neutral.

Potential Responses to Partner Discovering Hidden Contraceptive Use	
Positive	<p>"The man will be happy because he will see that his wife is independent." – Rural Man</p> <p>"He will see the benefits of family planning." – Rural Man</p>
Neutral	<p>"My partner said he heard bad things about pills but I said 'let's try'. I went by myself. He wasn't happy and said I wanted to have an affair outside. I went to the pharmacy directly. He said don't use pills, let's try another way. But I went on my own to the pharmacy. When he found out he said nothing." – Urban Woman</p>
Negative	<p>"The couple could breakup because there is no consensus. One goes left and one goes right." – Urban Man</p> <p>"They will separate." – Rural Man</p> <p>"They can argue." – Rural Woman</p> <p>"In general, we think that the consequences of her decision will be bad. This is an important decision and she should always ask permission." – Rural Man</p> <p>"The couple will be in trouble." – Rural Woman</p> <p>"Now life is hard and she is using money for such purpose without permission?" – Rural Man</p> <p>"Before there was respect among the couple." – Rural Man</p> <p>"He will cheat on her." – Rural Woman</p> <p>"Even if there is no direct consequence in the family there will be a problem because her husband will know in his mind that she did this without his consent." – Rural Man</p> <p>"He won't be happy if he told her 'no.'" – Rural Man</p> <p>"If he finds out she used after he said 'no' he will be angry." – Rural Woman</p>

Consequences of Hidden Use Among Married

Not all of the groups of married participants discussed the consequences of hidden use. Only the women – both urban and rural - did. Primarily they noted the negative responses of quarreling and divorce as well as the husband cheating with another woman. They also mentioned that fighting was a natural consequence of not making a joint decision. One participant said that men don't understand family planning and that the woman needed to explain to her husband that she could stop at anytime and have children.

Provider Perspectives on Consequences of Hidden Use

The providers discussed consequences in general terms, such as "Most men just threaten to leave the women" but others told very specific stories: "The husband took out the IUD himself. She came back and asked for another. Until today she hides."

What is interesting about the providers' discussions on the consequences of hidden contraceptive use is that there can be consequences for them as well as the couple. For example:

"That's one of the reasons I decided to keep records at the office. The woman's husband saw her records and she brought them back and said 'I will always use family planning, so keep [the records] here.'" – Urban Facility Based Provider

“A woman who used injections never had her period so the woman told her doctor please make my period come. My husband wants a baby so I have to show blood.” – Urban Facility Based Provider
 They also noted that the consequences depended on the interpretation of the outcomes of using family planning, particularly on the part of the husband. “If the man sees the benefits of family planning then he’s okay with her hiding but if he doesn’t like he will blame her.” – Urban Facility Based Provider

Family Planning Use, Negotiation and Relationship Quality

Unmarried

Young people have a myriad of inputs to sort through in making a decision regarding family planning use: perceived acceptability of methods; side effects and myths; differing motivations both their own and their partners; and something even less tangible related to the quality of the relationship. As the table on the following pages shows, for every family planning behavior there are a variety and often contradictory impressions about what the behavior is perceived to say about the woman and man involved.

Action	What it says about her	What it says about him
He Uses a condom w/her	She is a “slut” She is a woman of bad behavior. He doesn’t like her. Marriage to her would be a trap. He wouldn’t want to marry her. He likes her and wants to protect her. He doesn’t want to marry her. He thinks the girl has an STI.	He is an adulterer who sleeps with a lot of women. He doesn’t want to be a father. He doesn’t want to get his partner pregnant.
He doesn’t use a condom w/her	He trusts her. She is a virgin. She is of age and he would marry her He thinks she is pretty and would marry her. He’s thinking about marrying her He doesn’t like her.	He wants to marry her and be a father.
She asks to use a condom	She just likes sex. She is adventurous. She is a prostitute She’s a slut. She wants to see what it feels like. She is afraid of getting pregnant. She is a flirt. She doesn’t want to be stressed. She wants to protect herself. She wants to enjoy sex without worry. She is thinking about her future. She has an STI/HIV.	She doesn’t trust him. She thinks he will run away if she gets pregnant. She doesn’t think the man can afford to marry her She no longer trusts the man. She doesn’t like him. She wants to protect him.

	<p>She's not ready to be pregnant.</p> <p>He thinks she has an STI.</p> <p>She has a goal.</p>	
He doesn't support family planning use	<p>He doesn't trust her</p> <p>He doesn't want to marry her.</p> <p>He thinks she is cheating.</p> <p>He doesn't care for her.</p> <p>He doesn't care at all about her or if she gets pregnant.</p>	<p>He is jealous and thinks he won't be able to tell if she cheats</p> <p>He travels a lot and is afraid his partner will cheat</p> <p>He just wants sex.</p> <p>He is good-for-nothing</p> <p>He likes to see women suffer</p> <p>He is proud to have children everywhere.</p> <p>He is a bad boy.</p> <p>He wants to have a baby with her.</p> <p>He plans to cheat.</p>
He supports family planning use	<p>He respects her.</p> <p>He doesn't want her to suffer delivery.</p> <p>He cares about her future.</p> <p>He wants to preserve her body.</p>	<p>He is poor and can't afford children.</p> <p>He cares about his family.</p> <p>He thinks about the future.</p> <p>He likes sex a lot.</p> <p>He doesn't want his parents to support him.</p> <p>He isn't working and can't afford to feed children.</p> <p>He is a serious man.</p> <p>He is kind.</p>
She uses family planning	<p>She is weak or in ill health.</p> <p>She is still studying.</p> <p>She is not married.</p> <p>She's a slut.</p> <p>She is a student.</p> <p>She is afraid of getting pregnant.</p> <p>She is a minor.</p> <p>She has a goal for her life.</p>	<p>He likes sex a lot.</p> <p>He is a student.</p> <p>He has a goal for his life.</p> <p>He wants to marry her.</p>
She hides contraceptive use	<p>She is cheating or planning to cheat</p> <p>She has as many children as she wants</p> <p>She couldn't convince her partner</p> <p>She isn't trustworthy</p> <p>She thinks about her future</p> <p>She couldn't convince her partner.</p>	<p>He doesn't support her family planning use</p> <p>[see also he doesn't support family planning use above.]</p>

Male comments are paraphrased in green.

Female comments are paraphrased in orange.

The seeming randomness as well as the contradictions can make explanation difficult. A 2006 systematic review of 268 qualitative research studies identified 7 key themes in how social and cultural forces shape young people's sexual behavior to which we can compare our findings:²⁴

- Theme 1: *Young people use various subjective means to determine whether their sex partner is "clean" or "unclean."* In this assessment's FGDs with young people we heard that young men would use condoms with "sluts" or "women of bad behavior" or "with a girl you suspect might have STIs."
- Theme 2: *The sexual partner and one's own behavior are seen in the light of how it might influence the partnership and not just sexual behavior. For instance might a pregnancy drive the partner away or seal the relationship? What role does violence or the potential for violence play in determining behavior?* "[I don't use condoms] with a girl I think about marrying." "It is common here to beat the women. It is the alcohol. They come home drunk and see something they don't like and they hit her."
- Theme 3: *Use of a condom can be stigmatizing for both partners and signal a lack of trust.* For example when asked why a woman would ask to use a condom young people responded because "She is afraid if she gets pregnant the man will run away." "She doesn't trust the man anymore." "She just likes sex." "She is a prostitute." "She loves you but she doesn't trust you."
- Theme 4: *Gender norms prevail in determining behavior. Men are expected to be highly sexually active while women are supposed to be chaste or at least pretend to be. Women link sex to romance.* "Some get a lot of girls pregnant. They like to see women suffer." "They have children in every neighborhood. I don't know why they do that. It makes them proud to have children everywhere." "We [men] had many partners before." "I am young. I always have girlfriends." Women would be willing to use contraception: "If the man wants to marry her." "If the man is romantic...It is important that he be romantic."
- Theme 5: *There can be penalties and rewards from society for having sex. Men can gain status from having many partners while women may be rewarded for chastity or for securing an exclusive relationship or a marriage.* "[I don't use condoms] with a girl I think about marrying." "He will be obliged to marry the girl if she gets pregnant." "I told him if he says 'no' I will keep my virginity." "It makes them [young men] proud to have children everywhere."
- Theme 6: *Reputations play a key role in social control of sexual behavior. There can be severe consequences for men of not being seen to engage in heterosexual sex [being labeled a "queer" or "fag"] and for women if perceived to have too many partners [being labeled a "slut" or "whore"] which can result in social isolation or worse. Families and communities can play important roles in protecting reputations.* "You and your family will get in trouble if she gets pregnant." "She will have a good family because she won't be pregnant before marriage." "He is afraid her parents will bother him if she gets pregnant so he uses a condom." "They have children in every neighborhood. I don't know why they do that. It makes them proud to have children everywhere." [We use condoms] "With sluts...with girls you don't want to marry."
- Theme 7: *Social expectations [such as women shouldn't want sex or men should always want sex] make communication about sex difficult. If a good woman should not be seen as wanting sex then*

²⁴ Cicely Marston & Eleanor King, Factors that shape young people's sexual behaviour: a systematic review .*The Lancet*; Nov 4-Nov 10, 2006; 368, 9547.

asking for a condom or discussing contraception in advance of sex is risky for a young woman. "In my neighborhood, many young girls around us are pregnant because they didn't convince. It is hard for the very young to negotiate." "[If a woman asks me to use a condom] I think the woman doesn't like me. She is flirting." "Usually the woman is afraid of the man so it is up to the man to decide [whether to use family planning]. She is afraid to express her opinion."

While the FGDs with Malagasy young people are consistent with these broad categories found in many other qualitative studies, these categories do not offer complete explanations as to what is happening and why. Additional insight can be gained from viewing these behaviors through the lens of relationship quality. Work on relationship quality traces back to work on marital quality, defined as "The subjective evaluation of a married couple's relationship on a number of dimensions and evaluations."²⁵ High marital quality thus defined was "associated with good adjustment, adequate communication, a high level of marital happiness, integration, and a high degree of satisfaction with the relationship." Over time "marital" quality has extended to "dyadic" or relationship quality in recognition that not all intimate relationships are marital. There is not agreement on the definitions of the various elements of relationship quality or, as a result, the scales for measuring. There is, however, significant overlap. Studies in Germany and Canada identified four dimensions of relationship quality and concluded that intimacy was "more central to relationship quality than [the] others:"²⁶

- *Intimacy* is comprised of twenty variables including taking time for each other, listening to each other, openness, honesty, trust, etc.
- *Agreement* includes similarities, shared goals, few quarrels, common activities, harmony, and security.
- *Independence* looks at autonomy, maintaining individuality, and having and allowing for freedom.
- *Sexuality* includes sexual harmony, sexual satisfaction, and physical contact.

Still others have used similar and overlapping scales to measure relationship quality across the dimensions of commitment, trust, communication and satisfaction.²⁷ More recently and primarily in developed countries, work has begun to focus on relationship quality and reproductive behaviors such as condom use as well as other contraceptive methods (Kusunoki and Upchurch 2010; Manning et al. 2012; and Manlove et al. 2011). For example,

"Distinct domains of adult romantic relationships, as identified by 'healthy marriage' research, include relationship duration, intimacy and commitment, and lack of violence or conflict. An expanding literature focusing on teenage populations suggests that many of these same dimensions—as well as asymmetries between partners with respect to age, race or ethnicity, and education—may be associated with contraceptive use."²⁸

The same study by Manlove goes on to identify three overlapping conceptual frameworks used in research on relationship quality and contraceptive use among young people:

²⁵ Spanier G.B. & Lewis R.A. 1980. Marital Quality: A Review of the Seventies. *Journal of Marriage and Family*, 42:4, 825-839.

²⁶ Hassebrauch, M and Fehr, B., Dimensions of relationship quality, *Personal Relationships*, 9 (2002), 253–270.

²⁷ Muntifering, C, Hindin, M & Otupiri, E. Marital Relationship Quality and Contraceptive Use in Kumasi, Ghana.

²⁸ Manlove, J., Welti, K., Barry, M., Peterson, K., Schelar, E. & Wildsmith, E. (2011). Relationship Characteristics and Contraceptive Use Among Young Adults. *Perspectives on Sexual and Reproductive Health*, 43: 119–128.

1. The *saw tooth model* is named thusly because the line for condom use over time is shaped like the teeth of a saw with condom use fairly high in casual relationships but dropping off the longer the relationship and the greater the perceived commitment and intimacy. Condom use rises again at the start of each new casual relationship. As relationships transition from casual to steady or main ones, the couple moves from condoms to longer acting hormonal methods.
2. The *communication model* says that overall contraceptive use rises as partners' knowledge of each other, time together and level of intimacy increase and, further, that relationship duration, intimacy and commitment are associated with increased hormonal method use and reduced condom use. The same model finds that conflict within a relationship and partner asymmetries, namely having an older partner or a large age or education gap, is associated with reduced contraceptive use among young people likely due to barriers in communications.
3. The *power dynamics model* overlaps with the communication model in identification of relationship conflict, including coerced and forced sex, as well as measure of frequency of disagreements with reduced contraceptive use as well as reduced consistency of use.

Based on these three conceptual frameworks, the Manlove study focused on four relationship domains: relationship duration, intimacy and commitment, partner violence or conflict, and partner asymmetries and found:

- Overall contraceptive use did not decline in longer relationships, but reliance on hormonal methods increased, suggesting a greater focus on pregnancy than on STD prevention.
- An elevated contraceptive use in relationships in which sex occurred before dating began suggested that young adults engage in more protective behaviors against STDs and pregnancy in more casual relationships.
- Greater relationship intimacy was associated with increased odds of using any method at last sex, particularly hormonal methods or dual methods.
- Young adults in more committed relationships (i.e., those who had discussed marriage or cohabitation) had reduced odds of using any method, especially condoms and dual methods.
- Both measures of intimacy and commitment were associated with greater use of hormonal methods rather than condoms, confirming an expectation of greater reliance on such methods in more serious relationships.
- Increases in the number of relationship asymmetries were associated with reductions in contraceptive use, particularly use of hormonal and dual methods.²⁹

Other studies have sought to further distinguish types of relationships beyond just the dichotomous "love" or "like" categories. One such study broke relationships into five categories: (1) stranger hook-ups, (2) friend/acquaintance hook-ups, (3) dating with less sex, (4) dating with more sex, and (5) serious dating/cohabiting. That study found:

- In the least committed relationships, familiarity (characterized as length of time partner was known before first sex) increases condom use among women but decreases it among men and

²⁹ *Ibid.*

concluded that “familiarity seems especially beneficial for women, who may be better able to negotiate condom use when casual partners are well known.”

- In the most committed relationships, condom and dual method use is lower for women but not for men and concluded that “negotiating condom use in a committed relationship may be more difficult for women than for men. Those in serious relationships may be hesitant to use condoms because they associate their use with infidelity, distrust, or casual sex (Gilmore et al. 1996; Hynie et al. 1998; Wingood and DiClemente 1998; Woodsong and Koo 1999); these issues may be more salient for women because condom use requires partner cooperation.”³⁰

Participants in this assessment’s FGDs were not asked about the type or length of their current relationship. The only criterion was that they be sexually active. A key finding for the study by Kunoki, described above, which looked at relationship-specific contraceptive practices, was “that individuals may behave differently in different relationships.”³¹ Or as one young urban man in this assessment put it: “When it comes to love, whether you are just dating or married it is not the same.” The discussions in this assessment hinted at a variety of types of relationships - multiple, concurrent, “regular partner,” cohabitating - of varying duration.

In all of the focus groups with the young people, the relationship between pregnancy/childbearing and marriage was clear: children are supposed to happen within marriage. Or as one young urban man put it: “Once you marry, you become parents” or as a young woman said: “The girls think that you want to have a baby when you marry...” Should a pregnancy happen before marriage, the expectation is that the young couple will marry or that the young woman and her family will pressure the young man into marriage. A pregnancy before marriage is a source of shame for a young woman and a potential financial liability for a young man. Should a young woman get pregnant, even if the young man does not want to marry her, he will “be trapped” into doing so.

Pregnancy and Marriage

“You can get trapped. She can have a different cycle and she gets pregnant anyway.” - Unmarried Urban Man

“If he doesn’t like her and she gets pregnant he will be trapped.” - Unmarried Rural Man

“He will be obliged to marry the girl if she gets pregnant.” - Unmarried Rural Woman

[She should say:] “If I get pregnant, I will have to live with my mother-in-law. Do you want me to live with your mother?” - Unmarried Urban Woman

“The first responsible is the man. If she ends up pregnant he is responsible. You and your family will get in trouble if she gets pregnant. I will tell her if you don’t want the condom I will leave you because my family has no money.” – Unmarried Urban Man

She will have a good family because she won’t be pregnant before marriage. - Unmarried Rural Woman

In the recent Focus on Rural Youth study, when young women were asked what measure an unmarried couple would take if they got pregnant, the number one answer was “abortion” followed by “prepare

³⁰ Kusunoki Y and Upchurch DM, Contraceptive method choice among youth in the United States: the importance of relationship context, *Demography*, 2011 November; 48(4): 1451–1472.

³¹ *Ibid.*

for birth/marriage." For young men the first answer was "prepare for marriage" followed by "prepare for birth/find money."³² These responses reflect the cultural norm of childbearing within marriage.

What is interesting about the FGDs with unmarried young people is the extent to which they view their relationships and contraceptive use in terms of marriageability - whether theirs or their partner's - each trying to assess the level of commitment or potential for commitment within the relationship. As noted in the section on contraceptive methods on page 6 above, for unmarried young people in these discussions, family planning use primarily referred to condom use.

Who Do You Use a Condom With?

[You] "use condoms with girls you don't want to marry." – Unmarried Rural Man

"She thinks the man can't support her. She'll suffer if she marries this man. So she asks him to use a condom." – Unmarried Urban Woman

[A woman asks a man to use a condom if] "She is afraid if she gets pregnant the man will run away." – Unmarried Rural Man

Who would a man not use a condom with?

"With a girl I think about marrying." – Unmarried Rural Man

"If you have sex with a girl who is old enough and you want to marry." - Unmarried Rural Man

"If she is pretty and you would marry her." - Unmarried Rural Man

[A man would not use a condoms with a girl] "Because they want to marry the girl and want to be a father." – Unmarried Rural Woman

How Can a Man Convince a Woman to Use a Condom/Family Planning?

"If the man wants to marry her." – Unmarried Rural Woman

"You and your family will get in trouble if she gets pregnant. I will tell her if you don't want the condom I will leave you because my family has no money." – Unmarried Urban Man

From these discussions we see that young men and young women use condoms with partners that they would not be willing to risk a pregnancy with, primarily because an unintended pregnancy would lead to marriage and these are not partners that they would want to marry. In regards to condom usage, unmarried young men, particularly unmarried rural men, were especially harsh about the kinds of women that one uses a condom with: sluts and prostitutes (see pages 10-11 above). Other studies have found that young women are well aware of some men's negative perception of young women who allow condom use: "Some girls feel that a partner's wish to use a condom suggests that they, the girls, are not clean, that they are commercial sex workers, or that they are involved in extra-relationship sexual activity (Feldman et al., 1997; Havanon et al., 1993)" and that "girls who carry condoms around may be perceived as being ready for sex or sexually available, a situation that would reduce their eligibility as potential wives."³³

Such negative perceptions regarding young women who allow condom use would explain some young women's negative views regarding condoms:

"I don't like the condom nor does my partner."

³² PSI, Flash Foqus – Condom Youth, Antananarivo & Toamasina urbains, July 2013, PowerPoint

³³ Gage, *op cit.*, p. 160.

"I asked him to take it off because I don't like it and he took it off."

Conversely, for young women in particular, a young man's willingness to marry may be enough to convince her to forgo condom or other contraceptive use and to risk pregnancy. As noted above, from a young woman's perspective, a young man could convince a young woman not to use a condom "If the man wants to marry her." Rural young men were aware of this and described a young woman's ideal partner as one "Who is committed to marry her." As the earlier FGD exchange among urban young men regarding their differing roles in counting days depending on whether it is their "regular girlfriend", a university girl or a high school girl (see page 19) demonstrates, young men in this assessment have access to multiple partners. Young women, aware their partners have other partners, may be willing to forgo contraceptive use and risk pregnancy to achieve the status of "main girlfriend" and potential wife.

Other studies have found young men making similar distinctions between "main girlfriends" whom young men would marry versus their other girlfriends that they would not.³⁴ Research carried out in Sierra Leone found that young men had categories of girlfriends with those girls who are seriously pursuing an education as more marriageable while other girls were datable but not marriageable.³⁵

The findings here of not using a condom with those that you would be willing to marry is in keeping with other research that has found that "discussions about marriage and cohabitation are often accompanied by discussions about childbearing, which may reduce contraceptive use."³⁶ The study by Manlove, mentioned above on page 29 had similar findings, namely that relationship commitment was inversely associated with contraceptive use. The respondents "in relationships in which marriage or cohabitation had been discussed were less likely than others to have used any method, particularly condoms, yet such respondents were more likely than others to have used a hormonal method only." The author surmised the reduced use of condoms in more committed relationships was due to a lower perceived risk of STIs in these relationships.³⁷

However, in all of the FGDs with young people, they talked about using condoms and not only with women whom they considered "sluts" or "prostitutes." Even the rural young men said that young women "should not have sex if they don't use [a condom]" and that if the man "really loves the girl they will both decide [to use a condom]." Among the urban young men and women they talked of using condoms with their regular partners, with long time girlfriends and in cohabitating relationships.

What is not clear from these FGDs is whether there is a transitioning from condom usage to hormonal methods as relationships increase in duration, commitment and intimacy in-line with other studies' findings. We do know there was very little talk of hormonal methods. Perhaps owing to the belief that hormonal methods are inappropriate for the unmarried, those using pills and injectables were unwilling to speak openly about their use for fear of censure. The seeming lack of transition from condoms to hormonal methods could also be explained if all of the young people present were in relationships of low relationship quality – of shorter duration, less commitment and less intimacy. That is possible but not likely. Or that in the face of cultural norms for childbearing within marriage and pervasive beliefs that hormonal contraceptives lead to infertility and are not appropriate for the unmarried and those who have not given birth, unmarried young people are relying on non-hormonal methods such as the

³⁴ Meekers, Dominique and Anne-Emmanuele Calves. 1997. "'Main' girlfriends, marriage, and money: The social context of HIV risk behaviour in sub-Saharan Africa." *Health Transition Review Supplement to Volume 7*: 316-375, p, 362.

³⁵ Harrell-Bond, Barbara E. 1975. *Modern Marriage in Sierra Leone: A Study of the Professional Group*. The Hague: Mouton.

³⁶ Musick K, Cohabitation, Nonmarital childbearing, and the marriage process, *Demographic Research*, 2007, 16(9):249–286.

³⁷ Manlove, *op cit.*, p. 126.

calendar method and condoms, despite condoms being “tainted.” Other studies have certainly found this: “Perceptions that an early start on hormonal contraception may compromise future life goals (e.g., getting married) and fertility desires influenced newly married couples to tend to rely on the male partner using a condom.”³⁸ However, the DHS findings do not support this. Although unmarried women did use condoms more than married women and they (unmarried women) used the calendar method more than they (unmarried women) used condoms or pills, they also used injectables the most and used pills more than they used condoms.

The field of “relationship quality” offers the potential for understanding some of the seemingly contradictory findings seen in the table on page 26, particularly in regards to condoms and commitment, i.e., marriageability, as well as whether Malagasy youth experience a transition from condoms to hormonal methods as relationships progress to more committed and intimate ones. However, the data available from the four focus groups with unmarried youth in this gender assessment as well as the limitations of the questions asked do not afford the depth to be able to explore this further.

Family Planning Use, Negotiation and Relationship Quality Among the Married

Much like marriageability and commitment was the lens through which unmarried people viewed family planning negotiation and use, trust and mistrust shaped perceptions of family planning among the married. And just as a behavior could be interpreted in contradictory ways among the young – for example, *he uses a condom with her* was interpreted as both “she’s a slut” and “he likes her and wants to protect her” - family planning use when viewed by the married through the lens of trust/mistrust can be interpreted to mean contradictory things about marital fidelity.

FP Use/Non-Use	What it Says About Infidelity	Quotes from FGDs With Married Men and Women, Providers and Community Health Workers
She is using FP or wants to use FP	She is cheating or plans to cheat	<p>“The women want to have affairs. Want to keep their bodies attractive for other men. They stay trendy.”</p> <p>“If they do family planning, they stay sexy.”</p> <p>“If a woman uses family planning, she will have an affair.”</p> <p>[A man says no to FP] “Because he will think you will have an affair.”</p> <p>“The jealous man. He is afraid she will have affairs. This man lacks confidence.”</p> <p>“I am really afraid of family planning. I don’t want my wife to use. Maybe she won’t have dark kids.”</p> <p>“Maybe he doesn’t trust her because he thinks she will have an affair because she won’t get pregnant if she cheats.”</p> <p>“Because the women will be unfaithful if she uses.”</p> <p>“Before men think they [women] use so they can have affair...”</p> <p>“Lack of information among men when we talk about family planning we talk about rumors. Fear of affairs and effects on the body.”</p>

³⁸ Alaii, *op cit.*, p. 45.

		<p>"The men fear that women will be unfaithful." [ALL AGREE]</p> <p>"There are jealous men – they think their wives will have an affair."</p> <p>"If she uses family planning, she can do anything she wants."</p> <p>"Maybe she wants to use family planning because she wants to cheat so she doesn't tell the husband."</p> <p>"The woman wants to use family planning and the man won't let the wife use because he is afraid she will have an affair."</p>
She won't use FP	Because he is cheating	"Women are more afraid of the IUD – there are many misconceptions. Won't prevent STIs and will get worse if husband cheats on you. IUD won't work if your husband cheats."
She uses FP	To keep him from cheating	"She thinks if she is always ready to have sex the man won't cheat on her."
She uses FP	Because he cheats	<p>"There are women whose husband is cheating and if he is cheating you don't want to have children with him."</p> <p>"Sometimes the men are cheating and she doesn't want to get pregnant by him so she hides the family planning."</p>
She is using FP	So he cheats	<p>"The man who wants many children and his wife doesn't he may have affairs to have more."</p> <p>"If they see the neighbor's wife is pretty and uses family planning he will let you go" [for fp]. [If he says 'no, you can't use, you use and he finds out, will he still say 'no?'] "He'll go to the neighbor's wife."</p> <p>[What happens if she hides family planning use] "He will cheat on her."</p>
He won't let her use FP	Because he is cheating	<p>"He will cheat on you. He will tell you he doesn't like you to use it."</p> <p>"He wants you to be overwhelmed with kids so you don't notice [his] affairs."</p> <p>"If he wants to cheat he will anyway. He will tell you not to use family planning – you'll have kids and he'll cheat anyway. You have children on you – who will want you?"</p>
If she doesn't use FP	no one will want to cheat with her	"The man says the more you are pregnant then no man will want you. You'll stay home. The men are very jealous."
If she sees a male doctor for FP	then she will cheat with the Doctor	"If you talk about family planning then you think sex. If a man doctor gives her an injection she won't get pregnant so she has an affair – the husband will be jealous. He will say 'You like that male doctor.' "

While aspects of relationship quality – particularly commitment, trust, communication and satisfaction – may help to explain the contradiction, little research on marital relationship quality and family planning use within developing countries exist. One study on relationship quality and contraceptive use among married couples in Ghana did find that dimensions of relationship quality, particularly communication

and empathy for one's partner and family are important aspects of contraceptive decision-making.³⁹ Others studies have found that women's desire to use contraception, particularly hormonal methods, can be viewed by their husbands as a sign of infidelity and a challenge to his authority.⁴⁰ PSI's recent study on gender and family planning decision-making likewise found that men feared modern family planning because they believe that I promotes infidelity and adultery among women.⁴² Spousal communication in the face of the oft reported perceived link between family planning use and infidelity could be difficult and offers a possible explanation of covert contraceptive use (see discussion on hidden use above on pages 25). A study in Zambia found that "...difficult spousal communication about contraception is the strongest determinant of covert use. Husbands' disapproval of contraception works through spousal communication rather than as a direct influence on covert use."⁴³ Other studies have found that hidden use is highest in countries where contraceptive prevalence is low and is more common in rural than urban areas. One study found a relationship between covert use and birth intervals with covert contraception increasing once children are weaned. This is in keeping with women's desire to space their children found in many other studies and expressed here on pages 18⁴⁴

The desire to covertly contracept affects method choice as well with one study estimating that 6–20% of women in Sub-Saharan Africa using the injectable covertly.⁴⁵ Injectables are the most popular method for both married and unmarried women in Madagascar.⁴⁶

While many studies have highlighted the important role that men play in reproductive health decision-making and contraceptive use, leading to calls to increase male involvement in family planning programs such as the ISM Program, covert contraception reminds us that men do not always make reproductive health decisions that are in the best interests of their female partner or that accurately reflect their partner's reproductive intentions and "serves as a strong reminder that spouses should not be assumed to act together as a decision-making unit."⁴⁷ The same study offers important advice for programs such as the ISM: "If providers do not continue to ensure women's privacy and confidentiality in the delivery of family planning services, the strategies to involve men may have the unintended effect of leading a number of women to decide *not* to use contraceptives despite their desire to delay or avoid pregnancy."⁴⁸

³⁹ Mutifering, et al., A Mixed Method Approach to Understanding Marital Relationship Quality and Contraceptive Use in Kumasi, Ghana, presentation at the International Conference on Family Planning, November 30, 2011.

⁴⁰ Williams CM, Larsen U and McCloskey LA, Intimate partner violence and women's contraceptive use, *Violence Against Women*, 2008, 14(12):1382–1396.

⁴¹ Mosha et al. BMC Public Health 2013, 13:523 Page 12 of 13 <http://www.biomedcentral.com/1471-2458/13/523>

⁴² PSI, Gender and decision-making mechanism for Family Planning in Antsirabe and Antsohiy, May 2012, p. 19.

⁴³ A. E. Biddlecom and B. M. Fapohunda, 'Covert contraceptive use: prevalence, motivations, and consequences', *Stud Fam Plann*, Vol. 29, no. 4, Dec 1998, pp. 360-72.

⁴⁴ Bledsoe, Caroline and William F. Hanks. 1998. "Legitimate recuperation or illicit stalling? Time, contraceptive use, and the divided man in rural Gambia." Paper presented at the annual meeting of the Population Association of America, Chicago, 2–4 April., cited in Biddlecom, *op cit*, p 364.

⁴⁵ Biddlecom, *op cit*.

⁴⁶ Mboup. *op cit*, p. 80.

⁴⁷ Biddlecom, *op cit*, p. 360.

⁴⁸ *Ibid*.

Making services more male and female friendly

Provider Sex

In all of the focus groups with men and women whether married or not, urban or rural, there were men and women who felt very strongly about having a provider of the same sex – for them and for their spouse. Others in the groups were more open or wanted a choice. In only one group of potential clients – of married rural women did anyone say that a provider of the opposite sex was preferred, although a few providers felt that clients might prefer a provider of the opposite sex. The group of married rural women was happy with a particular male doctor with whom they were familiar.

Doesn't Matter - Depends

"Depends on who is gentle." - Married Rural Woman

"Depends on the person." - Married Rural Woman

"I think it doesn't matter the sex because if you are sick you want treatment." - Unmarried Rural Man

"I don't care as long as the doctor remains professional." - Married Urban Woman

"Young people don't care." - Urban Service Provider

"If you're welcoming and smiling then they won't hesitate to get naked in front of you and allow you to insert the IUD. The IPC workers do good work getting them ready." - Urban Service Provider

Women who Prefer a Particular Doctor

"Everybody likes the public doctor. [male] That doctor moved and we all followed him." - Married Rural Woman

Men for Men and Women for Women

"For women it should be a woman and for man a man doctor." - Married Rural Man

"Men should have a male doctor and woman should have a woman." - Unmarried Rural Man

"So everyone will be comfortable." - Unmarried Rural Man

"There should be a male for males and female for females. If there is a woman, I won't go." - Unmarried Urban Man

"Man for men and woman for women." - Unmarried Urban Man

"Men need a male provider." - Unmarried Rural Woman

[For men] "The doctor should be a man." - Unmarried Rural Woman

"For women it is important to see a woman." - Unmarried Urban Man

Women Who Prefer Women

"I am ashamed when it is a male doctor. I prefer a female doctor." - Rural Married Woman

"I like to have a woman. A woman like me so I can tell her anything. How can I tell a man? I can tell her anything. But I would not tell him anything. She has the same body as me." - Married Rural Woman

"We want a woman doctor." - Unmarried Rural Woman

"We think if it [the doctor] is a man, we will be ashamed." - [ALL] Unmarried Rural Woman

"A female doctor gives more explanations/information." - Unmarried Rural Woman

"Women are more convinced." - Unmarried Rural Woman

"We like a female doctor more." - [ALL agree.] Unmarried Rural Woman

"Yes, this is common. Girls go to females." - Urban Service Provider

"If a young person/unmarried girl she won't get undressed even with a female." - Urban Service Provider

"Girls prefer my wife." [also a doctor] - Urban Service Provider

"The women clients run away from me because I am a man." - Urban Service Provider

Men Who Prefer Men

"If a woman doctor greets a man he won't be happy." - Rural Married Man

"Should be male doctor we will be shy with a female doctor." - Unmarried Rural Man

"Should be a male so we can discuss freely." - Unmarried Rural Man

"At the end we think it is better to have a male doctor." - Unmarried Rural Man

"Should be male doctor we will be shy with a female doctor. Should be a male so we can discuss freely." Unmarried Rural Man

"For me it is better to have a man. If you have wrong idea about sex and you are older you won't tell that to a woman. Even if you feel pain, you won't share that with a woman. Unmarried Urban Man

"There needs to be a male doctor for boys. You go there for male disease and you see a female? I will hide everything. But if there is a male I will tell everything." - Unmarried Urban Man

Men Who Prefer Women for Their Wife/Partner

"If it is a man who touches my wife for family planning, I won't be happy and will say no." - Rural Married Man

"I will say no to a young man doctor touching my wife." - Rural Married Man

"If you talk about fp then you think sex. If a man doctor gives her an injection she won't get pregnant so has an affair – the husband will be jealous. Will say 'You like that male doctor.'" - Rural Married Man

"So male doctor won't be tempted by a female patient." - Unmarried Rural Man

"If he touches her he will be aroused and tempted." – Unmarried Rural Man

Prefer Opposite Sex

"Women prefer a male doctor to deliver babies rather than women." – Urban Service Provider

"The women prefer the male doctor because they think the female doctor talks more." – Urban Service Provider

"My husband and I work together within the clinic. If a client wants a man then they go to my husband. The women all ask for my husband but he is an ophthalmologist and I am a gynecologist." – Urban Service Provider

For some of the unmarried rural young men the conversation was an opportunity to joke around:

"It would be cool to have a pretty female doctor. I would go every day."

"It would be cool to have pretty smart female doctor who smiles – she will attract many."

"I don't want a pretty doctor because I will fall in love and she won't like me."

While for others the implications of not having a provider of the same sex were very serious:

"you won't tell" "Even if you feel pain, you won't share" "I will hide everything." "I won't go" "I would not tell him anything"

"The women clients run away" "We will be ashamed"

Characteristics of Male and Female friendly services

In all of the focus groups when asked about ways to make services more male or female friendly, most responded with suggestions that would make the services better for everyone such as friendly and

welcoming doctors who smile, provide clear information without being rude, are well-trained and have the full complement of safe, clean equipment at their disposal.

A doctor who respects confidentiality was also mentioned. In two instances, married urban women raised the importance of simply shutting the door to ensure privacy and confidentiality:

“The door needs to be closed so you can freely discuss. If you have an STI you don’t want a lot of people around. You need a safe place to talk.”

“I had a female doctor, my legs were open and a male doctor came in. The next day I saw him outside. We want the door closed when our legs are open.”

The issue of confidentiality has come up before, most recently in the evaluation of Top Reseau clinics which found that “Lack of confidentiality and discretion in relation to logistics (consultation room is not closed, comes and goes in the house)... less than half of the respondent doctors verbally provide confidentiality assurance to the patient.”⁴⁹

Participants wanted a clean facility, easily accessible, offering affordable services at all times, while some stated a preference for Saturday afternoon.

Youth Friendly Health Services

WHO defines youth friendly services as those that are:

- **EQUITABLE:** All adolescents, not just certain groups, are able to obtain the health services they need.
- **ACCESSIBLE:** Adolescents are able to obtain the services that are provided.
- **ACCEPTABLE:** Health services are provided in ways that meet the expectations of adolescent clients.
- **APPROPRIATE:** The health services that adolescents need are provided.
- **EFFECTIVE:** The right health services are provided in the right way and make a positive contribution to the health of adolescents.”⁵⁰

The FGDs with young people touched on all of these and as is often the case, emphasized their desire to be treated with respect and to have their confidentiality maintained. Accordingly, they wanted to access services in a private place where others would not be able to see them. They wanted doctors who were friendly and non-judgmental, who would encourage them and not treat them “harshly.” They suggested separate times and/or rooms for young men and young women and they wanted services to be offered in places and ways that were entertaining such as with free WiFi or at sporting venues or be a “place that is cool and has music” but mainly it should “be a place where we can talk.” Wednesday and Saturday afternoons were the times most often mentioned as being convenient.

Friendly services for married men

The assessment had a particular emphasis on male involvement in family planning. Married men in particular were quite outspoken about what they would like to see and what they would not like to see. Interestingly, the men felt that there was currently no information or programs on family planning for them:

“No one gives us information.” – Married Rural Man

⁴⁹ PSI, Evaluation de la qualite de prestation de service au sein des centres Top Reseau et TR plus, Novembre 2011.

⁵⁰ World Health Organization (2009) *Quality Assessment Guidebook: A guide to assessing health services for adolescent clients.*

"In the North the sensitization is for young people but none for adults or fathers. They have YPE but us fathers have nothing. There is no opportunity for fathers to meet up and talk. The PEs are too young to talk to us. But among fathers like us we could talk." – Married Urban Man

In particular, married men and fathers felt they had their own needs and that programs should be tailored to those needs and their realities. They expressed dissatisfaction with the current outreach:

What Married Men Don't Like

"I would like to have more practical things where we talk openly like this about practical. Most information is theoretical."

"Some use songs but people just dance to it and forget the song."

"Those who walk with a microphone: no one pays attention."

"Those [radio] dramas only talk about bad things in the community and never show good images of men. Just focus on bad things that happen. They just target men so we aren't interested. Shows men drinking and beating women. Women cheat but they only show bad men. Both cheat."

"I think it depends on who you are. I'm not against YPE. I support that idea but I think there are realities we don't share. They don't talk about fp. They talk about HIV and STIs. I am a father and I talk to other fathers. We share a reality. He will respect me because we are both fathers. But if a YPE came to me with no experience I won't listen to him. We will say 'you are too young to talk to me. I should be teaching you about fp.'"

"A father should sensitize other fathers. The same age, the same realities. We will continue this discussion after we leave but not talk to the young."

"FP should target fathers and mothers but not young people. I have a wife and children. I am too old to talk to these kids who are just doing the job to buy cigarettes."

"I like the idea of the story but when you listen to the drama they show the man as the one who needs to be convinced. Maybe that is the politics of you women. You show a good image of a supportive man."

Men also had suggestions as to what they would like to see. In terms of what time services should be offered in order to be most convenient, as one father put it: "What might fit you might not fit everyone." However, for most fathers weekends were the most convenient. This was especially true in the rural area where all of the participants agree that Saturday afternoon would be the best time for them.

What Married Men Would Like

"There should be interesting things in the health center."

"Show cartoons for the children."

"There should be advertisement. If there are cards and dominoes they can play with, they will go. If you just tell them to come to sensitization they won't go so if they can have fun they will go."

"Make the information accessible to men. Access to information."

"Group discussion and personal discussions."

"Separate flyers for men and women – different messages. Only the woman will be interested [if just one flyer] but if men think it is for them also they will read."

"Theater and movie theatre and afterwards have discussion."

"People here don't like radio. They like TV or DVD. The old people might like [radio] but the young people don't."

"You can use TV or radio. You can do a mass campaign on TV, before the news. Because I want to watch the news, I will listen

to you – short and prime time.”

“Before we go to bed we watch TV. We won’t go out for sensitization. We are tired. Make the channel attractive to fathers.”

“Maybe when international football match all men watch. We will watch. Now we hear about telephone providers and that isn’t interesting.”

“Go to the soccer pitch – go where fathers are likely to go.”

“If you use the main street everyone will see.”

“I listen to the national radio to drama and news and some documentary.”

“There is a national channel that targets fathers. It targets men and you can call in. Many people in Diego like the program. There are those that are experienced in these types of issues and you can call in and others hear you.”

“Organize at the workplace.”

Provider Perspectives

Providers felt that many in the community are ready to use family planning but because of the fears of side effects, they are holding back. They did suggest that information on family planning focus more on the benefits of family planning and less on the products as in this exchange:

“They can provide comprehensive information about family planning. There are rumors and misinformation. If they understand the benefits and know how to use and the effects they will understand. Maybe we can do a program on TV. Don’t encourage them, just explain. We spend too much time advertising the product rather than the benefits of family planning.”

“When we look at IUD we just say the IUD is good. We don’t explain why it is good or how to use it. We just sell the product. They say that those people are paid to say that. We should focus on the benefits.”

“If people experience good things they will advocate for the product. There aren’t those that advocate. We need to create these people. People can give testimonial rather than just promoting the product.”

“I have a client who has used IUD for 10 years. She could give testimonial and convince others. If we don’t focus on sharing the benefits of the IUD others will just spread the rumors.”

FINDINGS: CHILDREN UNDER FIVE SERVICES

Roles of mothers and fathers in C<5 health in general

When mothers described their roles as mothers of children under the age of five they talked about being “closer” to the child. It was not clear whether by closer they meant physically closer because they are home with the child, or breastfeeding or whether they were talking about being emotionally closer as reflected in this comment:

“If asked how old the child is, some [fathers] don’t even know. Some don’t think it is their responsibility. Mothers are closer, so the responsibility is theirs.” Married Rural Woman

However, not everyone agreed that the mother is closer to the children as reflected in this quote from an Urban Married Man:

“When you talk about the father, I will take responsibility for everything but breastfeeding. I do everything. I cannot be coercive with my wife. I cannot push her. Some mothers say they are closer to the children. I disagree. We really love our children. We may not know how to show it.”

In general terms in FGDs with mothers, fathers and providers, similar ideas were shared about the roles that mothers and fathers play in the health of children under five. Mothers take the children for their health appointments and see to it that the children are vaccinated. They breastfeed their babies,

prepare nutritious food, provide clean water and keep the children clean. In general, they can seek the support and treatment of the community health worker when their child is sick but may need the involvement and permission of the father to seek treatment at the hospital. Many spoke of the father's role as being one of monitoring and giving advice to the mother and providing money for health services and treatment. Monitoring the mother, offering her advice and teaching her what to do may reflect relationships with age or education disparities.

As might be expected there were very conservative and traditional roles presented, perhaps best summed by this quote:

"I think I am strict when it comes to the health of the family. I tell my wife what to do. I don't do it, but I tell her." – Urban Married Man

"We men just order the women to do things. We monitor and tell them to "wash" etc. We order and they do everything." – Rural Male CHW

"The men just give the money and go." – Rural CHW

"In general if the mother is there the father takes full responsibility for giving advice to the mother. To make the decision to go to the doctor. If no one monitors her she will just do what she knows. It is his responsibility to monitor, especially in the health." – Urban Married Man

"The woman never takes decisions – she asks. In terms of health she can go on her own but the man is the man and she must ask permission. She must value the man." – Urban Married Man

"Since our ancestors it has been this way. Cooking and children is women. Hard work and money is men. We know things can change and they should work together but this is how it is." – Rural Male CHW

"In our community if you see a man holding a baby you think the baby is dead. That's the only reason he would hold. The baby is dying or very sick. Otherwise the man will never carry a C<5 outside the house." – Rural CHW

"Before the baby is 4 months old, the father never holds the baby." – Rural CHW

"Sometimes he forgets about the child's health." – Rural Married Woman

"In Diego the men are like kings – when they go out and it is hot the man brings an umbrella and the woman brings the baby and everything else." – Urban Provider

"The man pays for the treatment. He owns the money. He orders the woman to buy." – Urban Provider

"The mother needs the man's permission even if she wants to bring the child, without money, there is nothing she can do." – Urban Provider

"He brings the money." – Rural Married Woman

"He loves and he teaches her what to do." – Rural Married Woman

"He provides advice." – Rural Married Woman

"He reminds the mother to take the child to the facility when the child is sick." – Rural Married Woman

"For me, the father has no responsibility – we just give advice to the mother on what she should do. I am always in the office." – Urban Married Man

One might expect that the rural areas were more conservative than the urban or the coastal more than the interior but in each community there were those expressing both traditional as well as more gender equitable views of the roles of men and women. One rural community did stand out in terms of the

views expressed by the Community Health Workers who participated in that FGD. For more on that community, see recommendation on page 53.

For every traditional or stereotyped view presented there were mothers, fathers and providers presenting a different view: "We should not separate the responsibility of the mother and the father. We are the same and have the responsibility." – Urban Married Man

"It's not just the responsibility of the mother. Also the Dad." - Urban Married Woman

"They work together. If the mother isn't there, the father will seek treatment. Fathers check on the baby's weight." Rural CHW

"You can't just rely on the mother. We have to help each other. She can't do everything. When she is in the kitchen, I can keep the child out of the mud. The father can monitor the vaccines and know when the next appointment is." - Urban Married Man

"The father shouldn't wait for the mother to do these things. The father can take the responsibility. They decided to live together so he should take responsibility like for nutrition." - Rural Married Man

"My daughter loves more her Dad. Her dad was sleeping. Before she goes to school she asks her dad to bathe her. This morning I gave her 200 for snacks at school but today she wanted 300. She was happy her dad gave it to her. The parents should work together in the family. The father can wake up at night. My husband learned with our younger child." – Urban Married Woman

"I also have the responsibility to be close to my kids so they aren't afraid to talk to me if something is wrong. They shouldn't be afraid of the father." - Urban Married Man

"My husband is the one who goes to the pharmacy to fill the prescription especially if it is late. We should both participate in the lives of our children. My husband bathes our daughter every day. I am busy in the kitchen." – Urban Married Woman

"When they come to the health facility, it is the father but when seek CHWs it is the mother." – Rural CHW

"Many men bring their children because the women are working in the factory." – Urban Provider

"He should participate in bringing the child to the health provider..." - Rural Married Man

"I see that men are more involved now." – Urban Provider

"The woman gives the treatment but the man comes more often to the doctor because he is concerned when the child is sick." – Urban Provider

"I agree that is our role. When we are home we do everything. But we aren't always home. When we are gone we encourage our wives. When I am there I am responsible. That way the child has continuous care. But I can't oblige my wife to do everything." - Urban Married Man

"We can clean the surrounding. He seeks money and buys food so he needs to make sure he buys good food and not spoiled."- Rural Married Man

"You shouldn't wait for your wife to look after children but should get involved in dressing child. She can't do everything. Maybe she is in the kitchen and the children are outside so you should get involved." - Rural Married Man

"I have a different idea. We don't have water at home. We use the public tap. Most of the time the man takes the water from the tap. I think if the man cares for his children he will treat the water for his children." – Urban Married Man

Part of the difference in these two views of the roles of mothers and fathers is attitude and part is the reality of the demands of life. For many communities, the fathers are away working and do not take a more active role in the health of their children because they are not physically present as reflected in these quotes:

"The mother is closer to the child. The mother doesn't wait for the father. She is the one at home so she knows everything. If the father is there they come together." - Rural CHW

"The father is always out working, so the mother is closer." - Urban Married Woman

"What is different here from Diego is that our men work in the forest not in an office so the men aren't there. It's not that the men are lazy, it's just that they aren't home. If they are home and not too tired, they can help." - Rural CHW

"The father isn't always home - he is overwhelmed with work - he should support the mother. If the child is sick, the mother is stressing and he should be there to support the child also." - Rural Married Man

However, as more women have access to paid employment, the roles within the family are shifting as health workers in both the urban and rural areas have seen:

"If the woman is not working, she is doing everything else at home. If she is working the man has more respect for her." - Urban Provider

When discussing the changing gender roles in their community, the CHWs of Ambohitrimanjaka insisted that: "Women should have access to income generation and access to her own income. She has to have her own sustainable income." In that community women have begun working in the "free zone" and are now often bringing home more money than their husbands can from agricultural work. It was interesting to hear the CHWs discuss how this change affected the family:

He [the husband] also needs support from the wife. It doesn't need to be a lot of money. They need to work in common for the household. She can sew. He pays for the rent and school fees and she pays for food. He has control if he pays for everything. And he will borrow money which hurts the family." Rural CHW

For more on the CHWs of Ambohitrimanjaka and their work, see page 53

Roles of mothers and fathers in regards to C<5 fever and diarrhea

In discussing the roles that men and women play in child care, children's health, and decision-making in regards to fever and diarrhea, it was clear that existing roles are fairly gender-determined with mothers home and providing primary care to children and the home and father working outside and primarily responsible for bringing home money. However, it would be a disservice to the families interviewed to suggest that picture presented in stark black and white accurately reflects the nuances that these FGDs revealed. Even in groups where women said "the mother always decides" or groups of men that said "men have the last word" there were those who said "they both have responsibility" or "they discuss and decide."

Mom's Role in Fever	Dad's Role
Take to doctor	Go with mother to the doctor
Take to CHW	Give advice to mother
Monitor and complete the treatment	Remind mother of treatment
Inform father	Monitor baby's progress
	Calm baby when it cries
	Get up at night with the baby
	Give water to the baby
	Hold baby while mother cooks
	Help mother with the treatment
	Convince mother to seek treatment

Reasons to Seek Care	Barriers to Seeking Care
<p>She is afraid the fever will get worse.</p> <p>Afraid the child will die. So goes straight away.</p> <p>Can't care for at home with paracetamol</p> <p>If the temperature goes high.</p> <p>Avoid complication.</p>	<p>No money.</p> <p>The father will say "Why go there?"</p> <p>Some Christians just pray</p> <p>Some will say this is just a fever, why go to the doctor?</p> <p>Some are busy with their work.</p> <p>Some wait for the baby to be tired before they will go to the Doctor.</p> <p>They think Malagasy diseases shouldn't be cured with foreign medicine, so they use traditional medicine.</p> <p>Afraid of the doctor. Of getting an injection. We think injections cause polio – disability.</p> <p>If your child goes to the hospital he can catch more illnesses there and be sicker.</p> <p>Think the problem is caused by a curse so they seek traditional medicine.</p> <p>First parents seek a traditional massage.</p> <p>Traditional medicine is cheaper.</p>
Who Decides to Seek Care?	
<p>Always the mother.</p> <p>Mother or grandmother – mother of the mother</p> <p>The husband encourages.</p> <p>Father isn't there and you can't wait.</p> <p>For my experience, I decide. If she hesitates, I decide.</p> <p>They will discuss and ask each other. The wife says the child didn't eat all day. They discuss what to do.</p>	
Barriers to Bednet Use	
<p>The nets are expensive.</p> <p>Don't like the smell of the medicines.</p> <p>My kids have an allergy to the smell.</p> <p>Don't want to use because no one else does.</p> <p>The chemical in the bednet has some consequences on your face.</p>	<p>Too lazy. Just want to sleep.</p> <p>Claustrophobia</p> <p>Too hot under the bednet.</p> <p>The father will feel jailed.</p> <p>Can just close the windows instead.</p>

Mom's Role in Diarrhea	Dad's Role in Diarrhea
<p>Wash your hands</p> <p>Give boiled water to the kids.</p> <p>Don't allow child to eat street food.</p> <p>Take the child to the doctor immediately</p> <p>Give water to the child.</p> <p>Make sure the food is clean</p> <p>Boil the water.</p> <p>Prepare the Surreau.</p> <p>Mother pays for treatment</p> <p>Fulfill treatment</p> <p>Inform the husband when the child is sick</p> <p>Ask the advice of the husband</p> <p>Continue breastfeeding</p> <p>Make sure she can see what child is doing while it plays.</p>	<p>Reminds her to prepare Surreau</p> <p>Blame mother when child gets sick</p> <p>Give mother advice on children's food.</p> <p>Each time kids have diarrhea the father should ask the mother what she gave the child.</p> <p>We don't see a role for the father in preventing diarrhea.</p> <p>The father should care about the nutrition – is the food well cooked and clean.</p> <p>The father should monitor what the mother is doing to make sure what she is cooking is healthy.</p> <p>He father can monitor the child - especially when child is still crawling.</p> <p>The father can in an ideal world remind the mother to take the baby for a check-up.</p> <p>He pays.</p> <p>Support Mother and child.</p> <p>Take child to the health care provider</p> <p>He buys quality food.</p> <p>Don't give money for snacks outside</p> <p>Give child boiled water</p> <p>Keep baby from putting everything in its mouth.</p> <p>Cleans the surrounding.</p> <p>He treats the water.</p>
Reasons to Seek Care	Barriers to Seeking Care
<p>We can always tell her the child is tired and sick so she should bring it to the doctor.</p> <p>We will tell him the dangers of waiting for a complication. If you wait for a complication you will pay more.</p> <p>In the community, they didn't take the girl to the doctor but waited. She died. We tell them don't wait because you will pay more.</p> <p>If the parents disagree, the child might die. You leave to seek treatment as soon as possible.</p> <p>If she waits the child might die so she will take the child.</p>	<p>In general it is the man who disagrees,</p> <p>It's a money issue</p> <p>Maybe when he leaves in the morning the child wasn't sick so why take it to the doctor.</p> <p>Some fathers think this is nothing. Just leave it alone.</p> <p>Some fathers are hard to convince.</p> <p>Men don't like you to tell them what to do.</p> <p>Use traditional medicines.</p> <p>Lack of education.</p> <p>Afraid of doctor</p> <p>Afraid of injections – think they cause polio</p> <p>This hospital just gives paracetamol so why not buy it yourself?</p>

Who Decides to Seek Care?	
<p>Sometimes the woman will follow the man's decision because she is worried he will get angry.</p> <p>[If the father says "no" to seeking care] We will take the child anyway.</p> <p>Always the women who decides if children should go to the doctor.</p> <p>If they disagree he has the final word.</p> <p>"Usually the mother brings the child with diarrhea. Even if it is late and dark, it is the mother."</p> <p>"The mother is closer to the child. The mother doesn't wait for the father. She is the one at home so she knows everything. If the father is there they come together."</p> <p>"When they come to the health facility, it is the father but when seek CHWs, it is the mother."</p>	
Barriers to Using Surreau	Who Decides to Use Surreau?
<p>The water is clean in the country.</p> <p>We store the water in a clean place.</p> <p>We just boil the water.</p> <p>We drink the rice water.</p> <p>Nobody uses Surreau here.</p> <p>We don't like chlorine.</p> <p>It changes the taste.</p> <p>It smells.</p> <p>Women use it to bleach clothes.</p>	<p>The mother.</p> <p>The father doesn't care about the family life.</p> <p>Sometimes they decide together.</p> <p>It's always the mother.</p> <p>"At home everything that goes into the mouth is your job not the husband. He will say 'that is your responsibility' if you ask him."</p> <p>"When it comes to health no single person takes the decision [to buy Surreau.] It is the couple who decides. The father or the mother can decide. There is no one responsible. The mother and the father are both responsible."</p> <p>"It depends. The woman may feel she should decide and buy Surreau but he says let's just boil [the water.] She can convince him. The one who feels the needs should take the decision."</p> <p>"We use the public tap. Most of the time the man takes the water from the tap. I think if the man cares for his children he will treat the water for his children."</p>

What was pretty remarkable from the discussions were the varying roles that men in particular played as reported by them and their wives. From calming the crying baby, getting up with the baby at night, watching the child, buying the food and treating the water – men are much more involved in caring for their children and families in spheres that have traditionally been the purview of wives and mothers.

Opportunity: Men

As the quotes on page 44 above demonstrate, there are men who are willing and able to move beyond expected norms for them. Significantly—and in contrast to the traditional gender norms detailed on the previous pages and on page 43 that equate health in general, and family planning and child care in particular, as female spheres, there were many *men* who expressed either frustration at being excluded or a desire to be included in these important aspects of family life.

While all of these quotes reflect a desire on men's part to get involved in reproductive and child health, a good thing, it presents a challenge. The oft-repeated challenge of male involvement programming is how to engage men in reproductive health and child health services in ways that, at a minimum, do not exploit power imbalances that exist in relationships, such as reflected in the quote about the man telling his wife what to do, but offer very real opportunities to transform gender roles in ways that meet the needs and aspirations of women *and* men.

The conceptual framework used most often by USAID programming is the *Gender Integration Continuum*, developed by the USAID Interagency Gender Working Group (IGWG).⁵¹ It is useful both as an analysis tool but also as a guide for planning a gender approach. This framework has five categories for gender:

Gender Blind refers to little or no recognition of local gender differences, norms, and relations in program/policy design, implementation, and evaluation.

Gender Aware refers to explicit recognition of local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation and evaluation. This recognition derives from analysis or assessment of gender differences, norms, and relations in order to address gender equity in health outcomes.

Gender Exploitative refers to approaches to program/policy design, implementation, and evaluation that take advantage of existing gender inequalities, behaviors, and stereotypes in pursuit of health and demographic outcomes. The approach reinforces unequal power in the relations between women and men, and potentially deepens existing inequalities.

Gender Accommodating refers to approaches to project design, implementation, and evaluation that adjust to or compensate for gender differences, norms, and inequities. These approaches respond to the different roles and identities of women and men. They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.

Gender Transformative refers to approaches that explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, and as a result achieve both health and gender equality objectives.⁵²

With this gender analysis/assessment, the ISM Project moves from gender blind to gender aware. Implementation of the various recommendations contained herein, for both family planning and healthy families, offers the possibility of moving along the continuum with some of the activities offering gender accommodation and yet others a more transformational approach.

Some men have already begun the process:

"When you talk about the father, I will take responsibility for everything but breastfeeding. I do everything. I cannot be coercive with my wife. I cannot push her. Some mothers say they are closer to the children. I disagree. We really love our children. We may not know how to show it." – Urban Married Man

⁵¹ <http://www.igwg.org/about.aspx>

⁵² This framework draws from a range of efforts that have used a continuum of approaches to understanding gender, especially as they relate to HIV/AIDS. See Geeta Rao Gupta, "Gender, Sexuality and HIV/AIDS: The What, The Why and The How" (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; G.R. Gupta, D. Whelan, and K. Allendorf., "Integrating Gender into HIV/AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002," Geneva: World Health Organization 2002; and WHO/ICRW, "Guidelines for Integrating Gender into HIV/AIDS Programmes, 2003.

Recommendations

Recommendation 1: Better Involve Married Men in Family Planning

Married fathers in this assessment were clear about their desire to access information regarding family health and family planning. That said, they wanted it to be tailored to them in their roles as married men. They wanted messages and materials that reflected their reality and they wanted those messages and materials to be delivered by married men and fathers like them. They expressed gratitude at being able to participate in the FGDs and for some the discussion was a window into their wives lives: "...you reflect our wives. Maybe you are asking questions our wives are thinking." And for others, it was the beginning of a conversation that they would continue: "We will continue this discussion after we leave..." The challenge is to create the opportunities for them to continue the discussion.

- *Implement the HIM program for married fathers.* Under Extending Service Delivery (ESD), USAID's global family planning flagship program and the precursor to the current E2A, IntraHealth developed and delivered the Healthy Images of Manhood (HIM) program. HIM is a health education intervention that changes gender attitudes, improves men's intimate relationships and helps them to adopt healthier and more gender sensitive behaviors.

HIM is implemented through male Peer Educators. The PEs serve not only as change agents, facilitating group discussions with other men, but also as positive deviants in their communities. They are models of healthier and more gender-equitable behaviors including seeking health care services; being supportive, caring and involved husbands and fathers; and adopting healthy and non-violent means to respond to conflict. HIM encompasses a training workshop and the development of action plans; a supportive supervision system to create an enabling environment for the implementation and monitoring of outreach educational activities; on-going monthly continuing education/training sessions; and a communication and monitoring and evaluation system.

Originally implemented as a workplace program in Tanzania in conjunction with the Unilever Tea Company and subsequently at the community level in Burundi, the HIM led to key changes in the affected communities for both the male participants and the PEs, including:

- ✓ Increased family planning use
- ✓ Increased service use by men of HIV/services
- ✓ Transformed gender relations in the workplace
- ✓ Increased involvement of fathers in family health services.
- ✓ Transformed gender relations in the home
- ✓ Attitude changes among the male Peer Educators

ISM could implement the HIM in a few pilot communities perhaps using the men identified as Model Fathers. They would meet on an on-going basis with fathers in the community using the HIM curriculum to guide their discussions. It would be important to review the existing HIM manual to incorporate some of the language and results from this assessment in order to ensure that the HIM is credible and resonates with the male participants.

For more information on the HIM project:

http://www.esdproj.org/site/DocServer/ESD-legacy-HIM_Jan_2011.pdf?docID=4041

For the HIM curriculum:

<http://www.esdproj.org/site/DocServer/Healthy Images of Manhood Training Manual For Workplace.pdf?docID=4081>

- *Take advantage of every interaction with the family – whether on family planning or child health – to engage the fathers.* A few of the CHWs in one of the FGDs reported that fathers “ran away” when they came to talk to the wives about family planning or health. But other CHWs, particularly those from Ambohitrimanlaka, reported success in their outreach to men: “When we visit we look at all things in the family. You also talk about other things than health – people have other interests so you use that. It is the role of the CHWs to engage men. In the WB project we have to weigh the baby 2 times a week. We sensitize the men, too.” For more on their overall approach, see recommendation 2, below. To help facilitate discussions with men, it would be good to increase the number of male CHWs and IPC agents (see recommendation 53 below). Additionally, it would be useful per some of the suggestions of the fathers to develop materials geared to them. Some of the sessions of the HIM could be adapted and provided to the CHWs and SAF/SALFA IPC agents as well as targeted materials.

- *Use the Healthy Families campaign and the selection of the Model Father and Mothers to present new, healthier and more positive images of men.* Malagasy culture is changing as are the roles that men and women are playing in their communities and families as reflected in the FGDs. Rather than reflecting and reinforcing traditional and sometimes harmful norms for masculinity, the healthy families can offer support to those men who are already taking steps to be more involved in their families. Many men are engaging in their families in new ways and many others would like to but just do not know how as reflected in the quote on page 48. The Healthy Families campaign can offer a roadmap to those men. Throughout the FGDs people used the words “responsible” and “respect” in regards to both men and women and about “having a vision for the family.” as reflected in these quotes about what constitutes a model mother/father:

- ✓ “That’s my goal in life. I didn’t have a father. My dad left and I only found out who he was a year ago. I want to be a model father. I will take my responsibility for my children. I want to be closer to my children. The father should be the first responsible. Many fathers don’t understand what is expected. If you have a child you have to take responsibility in front of your child and your wife.”

- ✓ “The father should have a vision for his family. He takes responsibility and he has a vision.”

- ✓ “He ensures the security, health and life of the family. He protects and feeds and provides care.”

- ✓ “The father...has the vision and project for the family.”

- ✓ “He should care for his children and his wife. He should do his homework and others will see and he will be a role model.”

- ✓ “I want to emphasize the role of the father. If you misbehave as a father at home the children won’t respect you so you should be a model so they respect you.”

- ✓ “Loves and respects his family.”

- ✓ [A model mother or father] “Takes full responsibility.”

- ✓ To be a model they take responsibility whether at home or outside.

The focus on the Model Father/Mother should be on shared responsibility - "we discuss and we decide" and away from hands-off fathers who "monitor" "give advice" or "tell her what to do" and more on hands-on fathers who carry out any of the activities found on page 44 or in the boxes on pages 46-48 such as "Go with mother to the doctor" "Monitor baby's progress" "Calm baby when it cries" "Get up at night with the baby" "Hold baby while mother cooks" etc.

A model father is responsible – to himself, his partner, his family and his community.

- Oneself: taking care of self, having time for oneself, protecting yourself
- One's partner: being faithful, protecting your partner, discussing family planning together, discussing family decisions together, supporting one another as parents, discussing and making a plan for the family with your partner, does not use violence with his partner.
- One's family: getting children vaccinated, seeking appropriate medical care, sleeping under a net; treating water, having only the children that you can feed and send to school and love and spend time with. Does not use violence with his family Helps care for children, discusses family planning and child health with CHW or IPC, takes child to health facility, pays for health care services and treatment, provides financial support to his family, supports his partner to earn income.

Having a vision for one's family could include limiting the number of children to only those that you can afford to educate. Having a vision for the family could include each member contributing to the vision including encouraging one's wife to earn income and supporting the children to get educated, saving for the future.

The project should consider use of the Gender Equitable Men (GEM) Scale, adapted as necessary for Madagascar, to measure progress. The GEM scale consists of 24 items broken into two subscales: equitable and inequitable. It has been used with men and women to measure attitudes toward gender norms in intimate relationships or differing social expectations for men and women. Findings suggest that the GEM scale is sensitive and cross-culturally relevant having been used in multiple countries and regions. It is predictive of condom use, contraceptive use, multiple sexual partners and partner violence. It can also be used to measure before and after an intervention such as the HIM or a gendered Model Father/Mother, Healthy Families campaign. For more on the GEM, see:

http://www.c-changeprogram.org/content/gender-scales-compendium/pdfs/C-Change_Gender_Scales_Compndium.pdf

In designing any BCC materials it is important to remember the comments of the father who complained about the negative images of men used in BCC:

"Those [radio] dramas only talk about bad things in the community and never show good images of men. Just focus on bad things that happen. They just target men so we aren't interested. Shows men drinking and beating women."

Recommendation 2: Learn gender mainstreaming from the CHWs of Ambohitrimanjaka

In all of the areas of discussions with the CHWs of Ambohitrimanjaka, it was clear that they were outliers, or positive deviants. The four CHWs in this rural community (one of whom is featured on the

cover of this report) started the conversation talking about gender which they defined thusly: "We think this means men and women taking responsibility."

They started their gender work with training under Santenet with a five-day training by an NGO from South Africa which focused not only on gender but women's leadership. This is how they described gender mainstreaming since their original introduction to gender:

"We own the concept. You have to own the process as CHWs. We have to live it at home. [They] started with the CHWs and convinced us. Once we understood and lived it, we convinced the community. We use every channel to talk about gender - at the well, grocery, funeral, church - we find ways to introduce gender."

"When Santenet introduced gender, they did advocacy to the chief so when he does registration of the new couple, he does sensitization on gender. During the Mayor's speech he talked about gender - 'The importance of men taking responsibility.'"

"We start new behaviors with ourselves."

They acknowledged that in the beginning it was very hard but report that they began to see more results in 2012. Among those results:

"There is more communication in the home now."

"Men allow women to work outside the house. They don't think women are the weaker sex."

"In nutrition it was just women who brought children but now more men are bringing children."

"The women do not hide contraceptives here - sometimes the men ask us when their wife's next check up is. Here the men encourage injections because they [the women] forget to take the pills. This is why injections are common here - because men encourage."

"They [the mother and father] work together. If the mother isn't there, the father will seek treatment."

"The father checks on [the baby's] weight."

"Usually the father pays but if the mother has money, she pays. This is why it is important for women to have access to income."

"In the beginning family planning was hard but now they knock on our door."

The CHWs of Ambohitrimanjaka had general recommendations for gender based on their experiences:

- *Women should have access to income generation* and their own income. This may have been easier in their community where women have begun to work in the free zone and to make handicrafts but the results have been immediate. In particular the CHWs highlighted that by having her own income the balance of power within the household shifts and it takes pressure off of the husband. "He has control if he pays for everything. And he will borrow money which hurts the family."
- *Target men with gender* and not just the women - "don't hide gender mainstreaming from men."
- *Change image of roles of men and women in the house.* "Men can wash clothes and care for children." "I would add on barriers there is some pride among the men who learned that child's health is the mother's problem so they are too proud 'this is not my role'. We need to sensitize men that babies are in common."
- *Teach men to respect women.*

Recommendation 3: Strive for gender appropriate staffing

Currently, the staffing of the project is such that the Community Health Workers are predominantly female and the facility based providers are primarily male. What we heard in this assessment is that women, who are the main users of family planning, want female providers and that, for some, the presence of a male provider would be an insurmountable barrier. This will be a critical issue to address when scaling up the program in the rural areas with partners SALFA and SAF. Even if female providers can be found, they may face additional hurdles trying to access needed financing to become a Top Reseau franchise. The project along with SALFA, SAF and Banyan will need to seriously consider affirmative action in recruiting along with targeted efforts to remove barriers to financing in order to increase the numbers of female health providers in the rural areas. If female providers cannot be recruited or until they can be, increased emphasis should be placed on provider training in regards to respect for women's privacy- whether privacy of their person (covering with a drape, keeping the door closed during exams and while a woman is undressed, minimizing the number of staff present during exams, avoiding interruptions), privacy of conversations or privacy of one's personal records (see recommendation 4 below for more on this).

Likewise, we heard from married men that what they most want is to be able to talk with men such as themselves about family health issues including family planning. They want their own venue, their own materials and messages and they want it delivered by men like them – married with children. Small groups with materials specifically developed for men such as the HIM, mentioned above, provides a lot of what the men asked for. However, whether it would be possible or feasible to be able to hire enough male CHWs or IPC is the question. There were very few male CHWs and the project would not want to sacrifice female CHWs or IPCs for male ones as the providers noted that it was the IPC workers that were most effective in sending them their female clients. Many of the female FGD participants noted that they would not like to have male IPC or CHWs anymore than they wanted male providers. If the project cannot increase the number of male CHWs or IPCs without sacrificing female ones then it should increase the mass media that targets married men. For those areas where there are female IPC/CHWs and unmarried PE, they can still do better outreach to married men if they are able to tailor their messages and materials to this specific audience. See recommendation 1 above.

Recommendation 4: Involve men in family planning but respect women's right to privacy

While we would hope that increased communication between couples would lead to increased agreement on reproductive intentions and contraceptive use (and studies support this), the reality is that is not the case for every individual. There will continue to be women whose only choice is to hide their contraceptive use from their husbands and those women may face real risk if that use is revealed – from accusations of infidelity, to contraceptive sabotage to interpersonal violence. So the ISM should take measures to balance male involvement in family planning with women's right to privacy. Providers and CHWs discussed ways in which they currently assist women in hiding their contraceptive use from their husbands and others but these methods should be incorporated into provider and CHW training and emphasized in training components on confidentiality and privacy. This will require further investigation to better understand the ways in which providers and CHWs can act to protect women's hidden use.

It also means that the project needs to better understand the ways in which hidden use may be disclosed. We heard from women about the need to hide their records or to not tell husbands about their contraceptive use. Additionally, the study by Biddlecom found that covert use can affect method

choice as well as discontinuation as women try to find a method which does not have side effects which could reveal her contraceptive use to her husband and recommended that “programs should take into consideration the provision of a range of methods that allow all women to realize their contraceptive-use goals, including covert use, at minimal costs.”⁵³ So while the ISM may develop a healthy families campaign which emphasizes couple communication and *joint decision-making* in regards to contraception as ways in which one shows responsibility and respect for one’s partner, the project should also emphasize and protect the individual’s right to contraception. As part of this effort the project will need to:

- Identify ways in which providers and CHWs currently assist women to hide their contraception and incorporate those into provider and CHW training as well as into the QA process and tools. Provider and CHW training should emphasize privacy (body, conversations and records), confidentiality and right to choice. While the QA tools may currently cover privacy and storage of health records, it was not clear what was being done when women who covertly use family planning are leaving their health cards with the provider to hide their use.

Recommendation 5: address relationship quality in programs and materials for unmarried young people

Looking back on the FGDs with the unmarried young people, they reported that one of the roles for a man and a woman in regards to family planning use is to “convince” their partner to use family planning (see roles on page 19). Depending on the couple, he may make the decision to use or not to use family planning or she may decide. But if they are in disagreement in regards to the decision and want to come to agreement, serious negotiation must take place. Not surprisingly, young people said that what they needed from health programs was support in being able to convince their partners to use family planning as reflected in these comments by unmarried young men:

“I know they do sensitization but if they reach me but not my partner they don’t explain how to convince my partner. They just say “you should use.” We know how to use but they don’t give us arguments to convince our partners.”

“They don’t need to bring a fake penis and show us how to use. We know how. We need arguments to convince.”

As research in relationship quality suggests, what may be useful in convincing one type of partner to use family planning might not be effective in convincing another. The FGDs revealed all types of relationships: multiple and concurrent, “main girlfriends,” cohabitation, those with large age/education gaps (university boys and secondary school – or younger – girls), and relationships of long duration.

Two of the recommendations from the study by Manlove seem especially relevant here:

- Young people need support in understanding what constitutes a healthy relationship and they need opportunities to develop the skills needed to have healthy relationships and to negotiate within different types of relationships. “Our findings also suggest that it may be helpful for programs to have teenagers and young adults role-play the negotiating of contraceptive use with multiple types of partners, such as one whom a teenager does not know well, an older partner, a partner of a different race or ethnicity, or a partner in a high-conflict relationship. An extension of this approach would combine relationship education approaches with sex education curricula to help teenagers and young adults improve their relationship level communication skills and recognize how the relationship context may influence decisions about having sex and using

⁵³ Biddlecom, *op cit.*, p. 370.

contraceptives.”⁵⁴ PEs and IPC agents can be equipped to provide this support in terms of materials and opportunities to role play negotiation. It will be important to think of young people not only in secondary school but also university students. Given the discussion by the university men about seeking out much younger girls (in addition to their regular partners) it will be important to target those younger girls with skills and the information to be able to protect themselves in that type of situation so that they can become like the university women who protect themselves because they have a goal. For while communication can lead to contraceptive use, many young people are not having those discussions, as Manlove surmised perhaps due to power differences within the relationship. Therefore, in order to be effective “...programs must also address whether power differences in a relationship—due, for example, to not knowing the partner well, to experiencing physical violence in the relationship or even to desires for intimacy—may compromise decision-making or negotiating skills.”⁵⁵

- For whatever reason, it is unclear whether young people are transitioning from condoms to hormonal methods as their relationships increase in intimacy commitment and duration as one would expect from the literature. From the FGDs it appears that myths regarding the appropriateness of these methods may play a significant role. Materials and programs for IPC and PEs to target to these longer duration relationships regarding these myths may help these couples to better protect themselves. And as noted in the following quote and in response to the young men’s quotes that started this recommendation, these materials and programs need to be crafted with young men in mind as well as young women. “...our findings indicate that few couples maintain condom use as relationships become more committed, and other research suggests that many fail to transition to more effective, hormonal methods. Because it is important to engage both men and women in the transition to hormonal methods, program and clinic efforts should help dispel couple-level misperceptions about the prevalence and severity of side effects associated with these methods and the potential underestimation of methods’ effectiveness. However, men are much less likely than women to access reproductive health services, highlighting the challenges of couple-level reproductive health education.

- Additionally, completed, on-going and planned research - such as the Focus on Qualitative Research (FoCUS) study on rural youth – offer the opportunity to delve further into the how relationship quality affects contraceptive use among Malagasy youth and to better understand and define the types of relationships that those youth engage in.

⁵⁴ Manlove, et al., *op cit.*, p. 126.

⁵⁵ Manlove J, Ryan S and Franzetta K, Contraceptive use and consistency in teens’ most recent sexual relationships, *Perspectives on Sexual and Reproductive Health*, 2004, 36(6):265–275.p. 273.

"If you like your work, it goes easy. This is like our hobby." - Rural Community Health Worker in Ambohitrimanjaka

ANNEX A: SCOPE OF WORK FOR GENDER ASSESSMENT

I. Identification of Task:

Maryce Ramsey, IntraHealth Senior Gender Equality Advisor, in collaboration with the Integrated Social Marketing (ISM) Program Gender Officer, Tiana Razafinimanana, over the course of the two week TDY will conduct a gender assessment and analysis of the Madagascar (ISM) Program. The assessment will result in a work plan for integrating gender into key activities and products.

II. Background:

In December 2012, PSI/Madagascar was awarded the Cooperative Agreement (COAG) No. AID-687-A-13-00001 for the Integrated Social Marketing (ISM) Program in Madagascar. The ISM Program runs from January 1, 2013 through December 31, 2017.

The goal of this program is to improve the health of the Malagasy people -- especially women of reproductive age (WRA), children under five (CU5), youth 15-24 years old and those living in rural and underserved areas -- through an increasingly sustainable social marketing program that delivers essential health products and services with a focus on reaching rural and underserved areas. PSI/Madagascar and its partners Intrahealth, Banyan Global, Human Network International (HNI), SAF and SALFA – all together referred to as the ISM Team --will apply its expertise in social marketing, social franchising and behavior change to bring more users into the Malagasy health market. By the end of this program, the Malagasy people will see improvements in their health status with regard to Family Planning (FAMILY PLANNING), Reproductive Health (RH), Maternal and Child Health (MCH), and Malaria.

The ISM Program is organized along three Intermediate Result (IR) areas, as summarized below. During FY 2013, PSI/Madagascar will continue promoting healthier behaviors and increasing access to and use of effective health products and services in each of these areas. This work plan narrative described key activities for each IR area.

- IR 1: Increased adoption and maintenance of health behaviors
- IR 2: Improved quality of selected health services in the private sector
- IR 3: Increased availability of life saving health products and services

III. Purpose of the Gender Assessment

The goal of this assessment is to identify barriers and constraints to services as well as opportunities to increase gender equality. Information will be collected through open-ended interviews with key informants, group discussions with service providers and male and female potential clients and a review of pertinent supplementary information on sociocultural and economic factors with regard to gender norms, practices and power relations between men and women. Results and recommendations of the assessment will inform the development of the project's gender strategy and work plan.

The process of identifying gender inequalities and determining their programmatic and developmental implications is called Gender Analysis. Gender Analysis identifies and examines the social constructions

that influence the different identities, roles, and social, economic, and political relations between women and men. It helps us to understand the differential distribution of power and resources based on gender in different societies. Gender Analysis reveals differences in men and women's access to health service, information necessary for making decisions about healthcare. Gender Analysis also helps us to understand the different constraints and opportunities that affect men's and women's health risks and capacity to seek appropriate quality care.

The objectives of the assessment are to:

- Understand existing (and planned) services and programming under ISM and men's and women's involvement;
- Identify barriers/enablers to men's and women's service use with a particular emphasis on men's involvement in family planning;
- Identify opportunities to integrate gender into existing and planned materials with an emphasis on social marketing and BCC strategies and materials, including but not limited to:
 - DELTA marketing planning for the integrated communications campaign for healthy families and development of model rural mothers and fathers;
 - Interpersonal Communication (IPC) tools for Community Health Workers (CHW)s;
 - Innovative BCC activities with SAF and SALFA IPC agents;
- Identify opportunities to integrate gender into planned research such as the Focus on Qualitative Research (FoCus) study on rural youth, client satisfaction surveys with youth and older clients as well as a provider motivational study;
- Identify opportunities to integrate gender, specifically the ethical treatment of birthing women, into maternal health service packages;
- Develop recommendations for integrating gender into the QA process, training, and audits;
- Identify where improvements in strategy, access, quality, service delivery, messaging, policy and/or measurements/indicators are needed;
- Identify opportunities to collaborate with other partners as appropriate;
- Develop recommendations for improving service uptake and integrating gender throughout the project;
- Develop a work plan, based on the recommendations, for mainstreaming gender.

IV. Proposed Period of TDY: May 17 - May 31.

V. TDYer: Maryce Ramsey, Senior Gender Equality Advisor, IntraHealth International

VI. Deliverables:

- Staff orientation design and presentation.
- Gender assessment report and strategy for mainstreaming gender throughout the ISM project.

VII. Contacts:

- Andry Nirina Rahajarison
- Ando Rambeloson Rampararany
- Tiana Razafinimanana

VIII. Overview of Schedule (illustrative)

1. Day 1 (Friday, May 17)- Orientation and planning with project Gender Officer
2. Day 2 (Saturday, May 18) – Review project materials
3. Day 3 (Sunday, May 19) – finalize arrangements and materials for staff training
4. Day 4 (Monday, May 20) - Gender Orientation for key project staff.
5. Day 5, half day, (Tuesday, May 21) - Finalize gender assessment guides and orient staff to roles.
6. Day 5 (Tuesday, May 21), half day, - meet with key project staff
7. Days 6-7 (Wednesday, Thursday, May 22-23) – Meet with project partners, INGOs, NGOs key informants
8. Days 8, 9, (Friday, Saturday, May 24-25) – travel to and carry out facility and community site visits and discussions.
9. Day 10 (Sunday, May 26) - travel
10. Days 11, 12 (Monday, Tuesday, May 27-28) Facility and community site visits and discussions continued.
11. Day 13, (Wednesday, May 29) Review of project documents
12. Day 14, 15 half-day (Thursday, Friday, May 30-31) Preliminary data analysis and action planning with Gender Officer and selected ISM staff
13. Day 15 (Friday, May 31) - Debrief with USAID

ANNEX B: GENDER ASSESSMENT SCHEDULE

Date	Time	Activity	Outcomes	Contact person
22/05/2013	8:30 AM	Meeting with Dr Andry	<ul style="list-style-type: none"> - Welcome Maryce - Introduction to PSI Senior Management Team 	Andrinirina RAHAJARISON Directeur DPSS andrinirinar@psi.mg
	10:00 AM	Orientation and planning with Gender Assessment Team	<ul style="list-style-type: none"> - Review the planning of the TDY - Organise every meeting 	Anja Rakotomalala Coordinator of Qualitative Research anjar@psi.mg Bakolinirina Rahaivondrafaritra Supervisor of Qualitative Research bakolyr@psi.mg Ando Rambiloson Coordinator of Women's Health Andor@psi.mg
	12:00 PM	Lunch break		
	3:00 PM	Meeting Delta and Healthy Family Campaign	Have been discussed the possibility of: <ul style="list-style-type: none"> - Integrating Gender into the Healthy Family Campaign - Participate in the Caractere development - Integrate gender in the script development - Give inputs for the IEC tools - Participate in the Delta Youth Process 	Marie-Alix Valensi TA Communication and Marketing Andry Rasoarahona Coordinator Communication and Public Relation
	4:30 PM	Wrap up		
	23/05/2013	8:00 AM	Set up	<ul style="list-style-type: none"> - Make sure all the materials are ready

	9:00 AM	Training / orientation on Gender	Topic covered : * Definition of gender * Clarifications * Donor requirements * Reproductive Health issues * Gender assessment * Relevance of Gender mainstreaming for the ISM project	
	4:30 PM	Wrap up		
24/05/2013	8:00 AM			
	12:30 PM	Brown Bag	General orientation to gender	Patricia Razanakolona
	2:00 PM	Wrap up		
	After	Document Review		Maryce
25 - 26/05/2013		Document Review		Maryce
	9:30 AM	Meeting with Intrahealth	- Incorporate gender into the planned training - Identify areas to integrate gender in the QI process	Baholy Rakotomalala Technical Advisor on Malaria and Child Survival Mamy Tiana Ranaivozanany Family Planning Technical Advisor
	10:30 AM	Meeting with Social Franchising, FP Team and Training Team	- Participate in the client satisfactory survey	Mbolatiana Razafimahefa National Coordinator of Social Franchising Mbolatianar@psi.mg Ando Rambelason Coordinator of Women's Health Andor@psi.mg Velonirina Andrianifahanana Coordinator LMT velonirinar@psi.mg
	2:00 PM	Meeting with Diarrhea	- Participate in the Delta Youth process	Nicole Andriamampianina Coordinator Diarrhea Prevention nicoler@psi.mg

	3:00 PM	Meeting with ISM Team Leader	<ul style="list-style-type: none"> - Replicate the Gender training - Identify gender sensitive indicator to capture gender activities - Contribute in the study design for the Client survey 	<p>Monique Weiss Deputy Program Country Rep moniquew@psi.mg</p> <p>Ietje Reerink TA Senior Research and Program ietjer@psi.mg</p>
	4:30 PM	Wrap up		
28/05/2013	8:00 AM	Meeting with Banyan	Incorporate gender in the training manual	<p>Kajy Harizo Financial Advisor Banyan Global</p>
	8:30 AM	Meeting with SALFA		<p>Dr Saholinirina Jeanne</p>
	9:00 AM	Meeting with SAF/FJKM		<p>Liva Harintsoa Violette Assistante Communication iec_saf@yahoo.fr</p>
	11:00 AM	UNFPA		<p>Tolotra Aina Andriamanana Chargee de Programme en Genre andriamanana@unfpa.org</p>
	12:00 PM	Lunch break		
	2:00 PM	Meeting with the Ministry of health	Identify opportunities to collaborate as appropriate	Dr Bako Rakotoelina
	4:00 PM		Finalisation of FGD discussion guide and questionnaires	Maryce- Andry - Ando - Tina
29/05/2013	10:00 AM	Meeting with IPPF/ Country office	<ul style="list-style-type: none"> Identify opportunities to collaborate as appropriate - Understand the national context 	<p>Dr Dominique Rakotomanga Executive Director rakotomangad@yahoo.fr</p>
	11:30 AM	Meeting with Child Survival Director	<ul style="list-style-type: none"> - Identify opportunities to collaborate as appropriate - Identify potential genders barriers in seeking treatment behaviors 	<p>Dr Davy Robson Child Survival and Malaria Director davyr@psi.mg</p>

	1:30 AM	Meeting with HNI	- Identify opportunities to collaborate as appropriate - Understand the national context	Kellen Eilerts Country Director keilerts@hni.org Randrianarisoa Barilolona Director of Operations lolonar@hni.org	
	2:30PM	Meeting with Gender links	- Identify opportunities to collaborate as appropriate - Understand the national context	Claudia Rakotonirina	
30/05/2013	7:30 AM	Travel to Soamiandalana		Maryce - Ando - Tina - Anja - Bakoly	
	9:00 AM	1st FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Women aged 15-25 not married and without child	
	11:00 AM	2nd FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Men aged 15-25 not married and without child	
	12:00 PM	Lunch break			
	2:00 PM	3rd FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Women aged 26-35 married and with at least one CU5	
	3:00 PM	4th FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Men aged 26- married with at least one CU5	
	4:00 PM	Travel to Tana			
	31/05/ 2013	9:00 AM	Meeting with research team	Identify opportunities to integrate gender into planned and ongoing research : the rural youth and the youth female condom	Maryce - Ando - Anja - Bakoly
		11:00			

	AM			
	12:00 PM	Lunch with Top Reseau Health care providers	Understand existing services withing Top Reseau Clinics	Maryce - Tina - Ando - Selected TR service providers
	2:00 PM	travel to Ambohitrimanjaka		
	3:00 PM	FGDs with Community Health workers	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Maryce- Ando- Tina- Anja- Bakoly
		Interview of Sypply point responsible	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Maryce - Ando- Tina - Anja - Bakoly
	4:00 PM	Travel back to Tana		
1st/06/2013	all day	Review of FGDs data and other		Maryce
2nd/06/2013	4:00 AM	airport pick up	Travel to Diego	Maryce - Ando - Tina - Anja
	7:20 AM	Departure Tana		
	8:35 AM	Arrival in Diego		
	All day	- Organise FGDs - Review Tana FGDs data and other		Maryce - Ando - Tina - Anja - Bakoly
3rd/06/2013	9:00AM	1st FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Women aged 15-25 not married and without child
	11:00 AM	2nd FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Men aged 15-25 not married and wuthout child
	12:00 PM	Lunch break		
	3:00 PM	3rd FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize	Women aged 26-35 married and with at least one CU5

			on men's involvement	
	4:00 PM	4th FGD	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Men aged 26- married with at least one CU5
4th/06/2013	6:00 AM	Travel to Anivorano		
		FGDs with Community Health workers	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Maryce- Ando- Tina- Anja- Bakoly
		Interview of Sypply point responsible	Identify barriers/ enablers to men and women's service use with a particular emphasize on men's involvement	Maryce - Ando- Tina - Anja - Bakoly
	3:00 PM	Travel back to Diego		
	7:00 PM	Lunch with Top Reseau Health care providers	Understand existing services withing Top Reseau Clinics	Maryce - Tina - Ando - Selected TR service providers
		Review of FGDs data and other		Maryce - Tina - Ando - Anja - Bakoly
5/6/2013	all day	Review of FGDs data and other		
	4:00 PM	Departure to Tana		
	5:15 PM	Arrival in Tana		
6/6/2013	all day	Work planning		
7/6/2013	9:00	Presentation of findings and debrief		Maryce - Tina - Ando - Monique (Deputy Country Representatives / Programs) - Ietje (Senior Technical Advisor) - Andry (Health Service Delivery Director)
	10:00:00	debrief with USAID		Ietje- Andry - Maryce
	22:00:00	Airport pick up		

ANNEX C: INDIVIDUALS INTERVIEWED

Organizations and individuals contacted:

Organization	Individual	Title
PSI	Dr Andrinirina Rahajarison	Health Services Delivery Director
PSI	Monique Weiss	Deputy Country Representative, Programs
PSI	Ietje Reerink	STA Research and Programs
PSI	Ando Rambelason	Women's Health Coordinator
PSI	Anja Rakotomalala	Qualitative Research Coordinator
PSI	Bakoly Rahaivondrafaritra	Supervisor Qualitative Research
PSI	Marie-Alix Valensi	TA Communication and Marketing
PSI	Andry Rasoarahona	Communication and Public Relations Coordinator
PSI	Dr Mbolatiana Razafimahefa	Social Franchising National Coordinator
PSI	Dr Velo Andrianifahanana	LMT Coordinator
PSI	Dr Davy Robson	Child Survival and Malaria Director
PSI	Nicole Andriamampianina	Diarrhea Prevention Coordinator
PSI	Muriel Ralambo	Supervisor Qualitative Research
PSI	Zo Andrianoelina	Supervisor Qualitative Research
Intrahealth International	Dr Baholinirina Rakotomalala	Maternal and Child Health - Malaria Training Advisor
Intrahealth International	Dr Mamy Tiana Ranaivozanany	Reproductive Health Advisor
Banyan Global	Kajimalala Harizo	Financial and Business Advisor
SALFA	Dr Saholinirina Jeanne	Project officer
SAF/FJKM	Mme Violette Harisoa	Communication Manager
UNFPA	Mrs Tolotra Andriamanana	Gender Program Officer
Ministry of Public Health	Dr Bako Rakotoelina	Director of Mother and Child Health
FISA (linking organization of IPPF)	Dr Dominique Rakotomanga	Executive Director
HNI	Mrs Barilolona Randrianarisoa	Directeur des opérations
Gender Links	Mrs Claudia Rakotonirina	Program Officer
USAID	Mr Roberts Kolesar	Senior Health Advisor
USAID	Mr Sixte Zigirumugabe	PMI Malaria Advisor

ANNEX D: DOCUMENTS REVIEWED/REFERENCES

- Alaii, J., and Nanda, G. 2012. *Fears, Misconceptions, and Side Effects of Modern Contraception in Kenya: Opportunities for Social and Behavior Change Communication*. Research Report. Washington, DC: C-Change/FHI 360.
- Barker, G., Contreras, J.M., Heilman, B., Singh, A.K., Verma, R.K., and Nascimento, M. *Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES)*. Washington, D.C.: International Center for Research on Women (ICRW) and Rio de Janeiro: Instituto Promundo. January 2011.
- Biddlecom AE and Fapohunda BM, Covert contraceptive use: prevalence, motivations, and consequences, *Studies in Family Planning*, 1998, 29(4):360–372.
- Gage AJ. Sexual activity and contraceptive use: The components of the decision-making process. *Studies in Family Planning*. 1998;29(2):154-66.
- Gorgen, Regina, Birga Maier, and Hans Jochen Diesfeld. 1993. "Problems related to schoolgirl pregnancies in Burkina Faso." *Studies in Family Planning* 24,5:283-294.
- Hanitra Njatonirina, Mahefa Project, Rapport d'Analyse de Genre Avec Lesgroupes Ethniques Dans La Region De Sofia, John Snow International, 2013.
- Harrell-Bond, Barbara E. 1975. *Modern Marriage in Sierra Leone: A Study of the Professional Group*. The Hague: Mouton.
- Hassebrauch, M and Fehr, B., Dimensions of relationship quality, *Personal Relationships*, 9 (2002), 253–270.
- Institut National de la Statistique (INSTAT) et ICF Macro. 2010. *Enquête Démographique et de Santé de Madagascar 2008-2009*. Antananarivo, Madagascar : INSTAT et ICF Macro.
- Interagency Gender Working Group (IGWG), gender definitions, 2000. http://www.prb.org/igwg_media/GuideIncorpGendrConsid.pdf
- Kusunoki, Y., & Upchurch, D. M. (2011). Contraceptive method choice among youth in the United States: The importance of relationship context. *Demography*, 48(4), 1451-1472.
- Lloyd, Cynthia B. with Juliet Young, *New Lessons: The Power of Educating Adolescent Girls*, 2009, The Population Council.
- Manlove J, Ryan S and Franzetta K, Contraceptive use and consistency in teens' most recent sexual relationships, *Perspectives on Sexual and Reproductive Health*, 2004, 36(6):265–275.

Manlove, J., Welte, K., Barry, M., Peterson, K., Schelar, E. & Wildsmith, E. (2011). Relationship Characteristics and Contraceptive Use Among Young Adults. *Perspectives on Sexual and Reproductive Health*, 43: 119–128.

Manning, W. D., Giordano, P. C., Longmore, M. A., & Flanigan, C. M. (2012). Young Adult Dating Relationships and the Management of Sexual Risks. *Population Research and Policy Review*, 31(2), 165-185.

Marston, Cicely & Eleanor King, Factors that shape young people's sexual behaviour: a systematic review. *The Lancet*; Nov 4-Nov 10, 2006; 368, 9547.

Mboup, G. and Saha, T., 1998, Fertility Levels, Trends and Differentials, DHS Comparative Studies No. 28, Calverton, Maryland, Macro International, Inc.

Meekers, Dominique and Anne-Emmanuele Calves. 1997. "'Main' girlfriends, marriage, and money: The social context of HIV risk behaviour in sub-Saharan Africa." *Health Transition Review Supplement to Volume 7*: 316-375.

Mosha et al. BMC Public Health 2013, 13:523 Page 12 of 13
<http://www.biomedcentral.com/1471-2458/13/523>

Mutifering, et al., A Mixed Method Approach to Understanding Marital Relationship Quality and Contraceptive Use in Kumasi, Ghana, presentation at the International Conference on Family Planning, November 30, 2011.

Musick K, Cohabitation, Nonmarital childbearing, and the marriage process, *Demographic Research*, 2007, 16(9):249–286.

Nanda, Geeta. 2011. *Compendium of Gender Scales*. Washington, DC: FHI 360/C-Change.

Ott, M., Alder, M., Millstrein, N., Tschann, S., & Ellen, J. (2002). The Trade-Off Between Hormonal Contraceptives and Condoms Among Adolescents. *Perspectives on Sexual and Reproductive Health* 34(1): 6-14.

PSI, Flash Focus Condom Youth - Antananarivo - Toamasina July 2013.

PSI, Genre et mecanisme de prise de decision en matiere de PF a Antsirabe et Antsohiy (Mai 2002).

PSI Madagascar 2012: Family Planning Trac Study Evaluating the use of Modern Contraceptive Methods among Women of Reproductive Age, 15-49 years.

PSI Research Division, "Madagascar (2010): Family Planning TRaC Study Evaluating the Pill and Condom Use as Contraceptive Methods among Young Females (15-24 years)" *PSI Social Marketing Research Series*, (2011), page 7. www.psi.org/research/cat_socialresearch_smr.asp

Spanier G.B. & Lewis R.A. 1980. Marital Quality: A Review of the Seventies. *Journal of Marriage and Family*, 42:4, 825-839.

U.S. Department of State, U.S. Agency for International Development, *Leading Through Civilian Power The First Quadrennial Diplomacy and Development Review*, 2010.
http://pdf.usaid.gov/pdf_docs/PDACQ604.pdf

U.S. Agency for International Development , USAID Policy Framework 2011-2015, Page 11.
http://transition.usaid.gov/policy/USAID_PolicyFramework.PDF

U.S. Agency for International Development , Gender Equality and Female Empowerment Policy, March 2012.
http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/GenderEqualityPolicy.pdf

U.S. Agency for International Development, Celebrate, Innovate & Sustain Toward 2015 and Beyond, The United States' Strategy for Meeting the Millennium Development Goals, September, 2012.
<http://www.usaid.gov/sites/default/files/documents/1870/USMDGStrategy.pdf>

Williams CM, Larsen U and McCloskey LA, Intimate partner violence and women's contraceptive use, *Violence Against Women*, 2008, 14(12):1382–1396.

World Health Organization (2009) *Quality Assessment Guidebook: A guide to assessing health services for adolescent clients*.

ANNEX E: FOCUS GROUP DISCUSSIONS BY SITES

Sites	Married Women w/CU5 Ages 26-35	Married Men w/CU5 Ages 26-35	Unmarried Women Ages 15-25	Unmarried Men Ages 15-25	Top Reseau Providers	CHWs and Supply Points	Total FGDs
Antanarivo					1 (8)		1 (8)
Soamiandlalana	1 (8)	1 (8)	1 (8)	1 (8)			4 (32)
Diego	1 (8)	1 (8)	1 (8)	1 (8)	1 (8)		5 (40)
Anivarano						1 (9)	1 (9)
Ambohitrimanjaka						1 (4)	1 (4)
Total FGDs	2 (16)	2 (16)	2 (16)	2 (16)	2 (16)	2 (13)	12 FGDs (93 people)

= Urban

= Rural

= Coastal

= Interior

(number) = number of people in the discussion

ANNEX F: FOCUS GROUP DISCUSSION GUIDES

Interview Guide for NGO, INGO, and Donors

Instructions for the Interviewer:

1. *Introductions, including an overview of the ISM project in Madagascar.*
 2. *Provide information on the gender assessment purpose and process.*
 3. *Provide information on the interview process, including duration, content and outcomes. Remind participants of their verbal consent and rights as a participant.*
 4. *Ask for an overview of the organization's programs and depending on the programmatic focus of the interviewee organization, information on any of their work related to gender, family planning including male involvement, malaria or child survival, and women's status.*
-

Interview questions:

1. What are the main gender issues in Madagascar?
2. What are the gender issues within your own work?
3. What do you think are the main gender issues for men/women in relation to
 - a. Family planning?
 - i. What do you think are the main barriers to women's family planning use?
 - ii. What would increase women's family planning use?
 - iii. What programs work well to empower women?
 - iv. What do you think the main barriers to positive male involvement in family planning?
 - v. What do you think would help increase male involvement and support for family planning?
 - b. Malaria?
 - i. What do you think are the main barriers to bed net use?
 - ii. What do you think would help increase use of bed nets by the whole family?
 - iii. Why don't parents bring young children to the health facility when they experience fever?
 - c. Treatment seeking for young children?
 - i. What roles can a mother play in seeking treatment (malaria, pneumonia, and diarrhea) for her young children? What roles can a father play in seeking

treatment for his young children? How can we better involve fathers in seeking treatment in a timely manner?

4. What recommendations do you have for us in our gender work?
5. What materials or reports can you share or suggest for us to obtain that might be helpful to our gender assessment and work?
6. What other organizations or individuals do you suggest that we speak with?
7. Do you have any questions for us?

Thank you!

Women and Men, Aged 15-25, Not Married and w/o Children

Begin with introductions and informed consent.

1. In general, what have you heard about family planning (family planning)?
2. Long term methods? (Be prepared to briefly describe LTM)
3. Short terms methods? (Be prepared to briefly describe STM)
4. Why would a man use condoms for family planning? Why not?
5. Why would a woman use family planning? Why would she use a short term method? Why would she use a long term method?
6. What would keep a woman from using family planning?
7. What role does/can her partner play?
 - a. Who makes the decision to use family planning?
 - b. Who pays?
8. What kind of man supports his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.
 - a. What kind of man doesn't support his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.
9. If a women's partner does not want her to use family planning but she wants to, what can she do? What advice would you give her? What will happen if she uses it without telling her partner?
10. What can the community do to get men involved in supporting their partners if they want to use family planning?
11. What can Community Health Workers do to get men involved in supporting their partners if they want to use family planning?
12. What can the health provider do to get men involved in supporting their partners if they want to use family planning ?
13. What can be done to make family planning services more attractive to women? (Probe for issues related to time, place, etc.).
 - a. To men?
14. Is there any final thing that you would like to share?
15. Do you have any questions for us?

Thank you!

Women and Men, Aged 26-35, Married w/Child<5

Begin with introductions and informed consent.

1. In general what roles do mothers play in helping children under 5 (or young children) to stay healthy?
2. What roles do fathers play?
3. If a child develops a fever, what should a mother do? What should a father do?
4. What might keep a mother from taking her child with fever to the health facility for treatment? Who makes the decision to take the child for treatment? What if the parents disagree about seeking treatment?
5. What might prevent a family from sleeping under a bed net? Prevent the father? Mother? A child? What can be done about this?
6. What can a mother do to prevent diarrhea in her child? What can a father do?
7. There is a product which can be used to treat the water to make it safe. Who in the family will decide to buy this product? Who has responsibility to use it?
8. When a child is sick with fever, diarrhea or a cough, who makes the decision to seek treatment at the health facility? Who pays for it? What if the parents disagree?
9. What can be done to help mothers seek treatment for their sick child in a more timely way? What can be done to help fathers seek treatment for their sick child in a more timely way?
10. Why would a woman use family planning? Why would she use a short term method? Why would she use a long term method?
11. What kind of man supports his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.
 - a. What kind of man doesn't support his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.
12. What can be done to make family planning services more attractive to women? (Probe for issues related to time, place, etc.).
 - a. What can be done to make family planning services more attractive to men? (Probe for issues related to time, place, etc.).
13. Is there any final thing that you would like to share?
14. Do you have any questions for us?

Thank you!

Community Health Workers

Begin with introductions and informed consent.

1. Can you please tell us about your role in promoting health in the community?

FAMILY PLANNING: From your experience in promoting family planning in the community, can you tell us:

2. Why would a man use condoms for family planning? Why not?

3. Why would a woman use family planning? Why would she use a short term method? Why would she use a long term method? What helps a woman to decide?

4. Why would keep a woman from using family planning?

5. What role does/can her partner play?

a. Who makes the decision to use family planning?

b. Who pays?

6. What kind of man supports his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.

a. What kind of man doesn't support his partner to use family planning? To use a long-term method? To use a short-term method? Please describe.

7. If a women's partner does not want her to use family planning but she wants to, what can she do? What advice would you give her? What will happen if she uses it without telling her partner?

8. What can the community do to get men involved in supporting their partners if they want to use family planning?

9. What can Community Health Workers do to get men involved in supporting their partners if they want to use family planning?

10. **Child Health:** In general what roles do mothers play in helping children under 5 (or young children) to stay healthy?

11. What roles do fathers play?

12. You sell products to keep children and families healthy such as:

- Sureau (water treatment)
- Viasur (diarrhea treatment)
- Super Mosustiquaire (bed net)
- Actipal (Malaria treatment)
- Pneumostop (Pneumonia treatment)

Who in the family makes the decision to buy these products? Who pays for these products? What can be done to influence the mother? To influence the father?

13. When a child is sick with fever, diarrhea or a cough, who makes the decision to seek treatment at the health facility? Who pays for it? What if the parents disagree?
14. What can be done to help mothers seek treatment for their sick child in a more timely way? What can be done to help fathers seek treatment for their sick child in a more timely way?
15. Is there any final thing that you would like to share?
16. Do you have any questions for us?

Thank you!

Facility Based Providers

Begin with introductions and informed consent.

1. What kinds of services do you provide?
2. From the women who come to you for family planning, what concerns do they have about using family planning?
3. Do they share with you the role that their partners played in making the decision? What, if anything, do they tell you?
4. What concerns do women say that their partners have about them using family planning?
5. Do you see women who use family planning but hide it from their partners? Why do they do this?
6. What can you as a health provider do to get men involved in supporting their partners if they want to use family planning ?
7. What can the community do to get men involved in supporting their partners if they want to use family planning?
8. What can Community Health Workers do to get men involved in supporting their partners if they want to use family planning?
9. What can be done to make family planning services more attractive to women?
 - a. To men?
10. What role does a mother play in bringing her child in for timely treatment of fever, cough or diarrhea? What role does the father play?
11. If parents (mother or father) delay in bringing the child for treatment, what reasons does the mother give? Does the father give?
12. What can be done to convince mothers to bring their sick child earlier?
13. What can be done to convince fathers to bring their sick child earlier?
14. Is there any final thing that you would like to share?
15. Do you have any questions for us?

Thank you!

ANNEX G: INITIAL DRAFT WORKPLAN

Activities	Time line
IR 1: Increase adoption and maintenance of Healthy behaviors	
Identify gender equitable behaviors for role model	June
Insert the gender equitable behaviors in the Healthy Family Campaign	June 2013 – Sept 2017
Contribute in the concept design of the father and mother role model	June – August 2013
Review rural youth report for gender analysis	June
Review study design for the youth condom research	June
Review the TOR for the selection of the script writer	July
Review Youth Peer Education training Curriculum	June
Contribute in the Delta Youth Process	10-11 June

Activities	Time line
IR 2: Improve quality of selected health services in the private sector	
Review QA process (training and supportive supervision) for gender emphasis on: <ul style="list-style-type: none"> - Confidentiality - Choice - Privacy 	June – July
Review IPC workers training Curriculum	
Integrate gender in the client/ provider satisfactory survey	
IR 3: Increase the availability of life saving health products and services	

Activities	Time line
Provide input to Banyan on provider training on Business and financial management	
Capacity building	
Develop a standard gender training curriculum	June – July
Organize training for PSI Staff and partners	

Annex I
RESEARCH REPORTS



PROVIDER SUMMARY REPORT PSI DASHBOARD

MADAGASCAR (2013): General Motivation among Top Reseau providers and Knowledge and Attitudes towards IUD among FP providers in Madagascar

Sponsored by:



Women's Health Project

PSI's Four Pillars

Bottom Line Health Impact * Private Sector Speed and Efficiency * Decentralization, Innovation,
and Entrepreneurship * Long-term Commitment to the People We Serve

Research Division
Population Services International
1120 Nineteenth Street NW, Suite 600
Washington, D.C.20036

**MADAGASCAR (2013): General Motivation among Top Reseau providers and
Knowledge and Attitudes towards IUD among FP providers in Madagascar**

PSI Research Division
2013

© Population Services International, 2013

Contact information

Justin RAHARINIAINA, Quantitative Research Supervisor

Population Services International

Antananarivo, Madagascar

Tel : +261 20 22 629 84

Fax : + 261 20 22 361 89

justinr@psi.mg

Suggested citation of this work:

PSI Research Division, "MADAGASCAR (2013): General Motivation among Top Reseau providers and Knowledge and Attitudes towards IUD among FP providers in Madagascar".

TABLE OF CONTENTS

TABLE OF CONTENTS	3
SUMMARY	4
BACKGROUND	4
RESEARCH OBJECTIVES.....	5
DESCRIPTION OF INTERVENTION	5
METHODOLOGY.....	6
MAIN FINDINGS.....	6
PROGRAMMATIC RECOMMENDATION.....	8
KEY RESULTS TABLES AND GRAPHS	9
PROVIDER MOTIVATION ANALYSIS	9
PROVIDER KNOWLEDGE AND ATTITUDE ABOUT IUD ANALYSIS	13
ANNEX	20

SUMMARY

BACKGROUND

Work motivation is defined as the individual's degree of willingness to exert and maintain an effort towards organizational goals¹. Particularly, motivation contributes to the health worker's performance and improves consequently the quality of the service that they provide.

PSI/M has been supporting a network of franchised private clinics, named Top Reseau ® (TR) since 2000. Currently, the TR network works with liberal, private and NGO providers in 19 of Madagascar's 22 regions. Clinics are supervised by medical staff based out of 9 regional PSI offices.

The number of TR providers that are active members of the network fluctuates regularly as a result of many factors including external reasons unrelated to TR (ie, moving to another site; closing the clinic joining the public sector) as well as TR related reasons such as the lack of provider motivation to belong to the TR network or non compliance/consistent low performance with agreed quality norms and standards.

Basic services are provided in all TR centers and include Reproductive Health (RH) services, Family Planning (FP) and Maternal and Child Health (MCH) services. Optional services (LTM provision or VCT for HIV) are provided in centers selected according to their interests, their infrastructure and PSI capacity to support and supervise them, as well as PSI's budget for equipment and other support.

Some of TR providers currently provide Long Acting Reversible Contraception (LARC) such as IUD through PSI/M supported program activities.² Despite the advantages of the IUD, many service providers are resistant to recommending, inserting, or counseling potential clients about this form of contraception. This study seeks to determine barriers that deter providers from recommending IUDs to their clients, given the many advantages of this method.

¹Kanfer R. 1999. *Measuring Health Worker Motivation*. MAR5, Working Paper No. 1, Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

²MADAGASCAR (2012) Study: *LTM services provision productivity among PSI supported providers in Top Reseau Site in Madagascar. PSI Madagascar*

RESEARCH OBJECTIVES

The study was designed to examine Top Reseau providers' motivation, as well as knowledge and attitudes with regards to IUD insertion among FP providers (TR or non TR).

Findings from the study will feed into improved support and supervision systems to ensure optimal provider performance. Effectively, the study seeks to provide information on how to motivate providers to deliver quality services to target clients, how to increase their collaboration and commitment to adhere to required quality standards and norms, while delivering essential health services to as high a client number as possible.

In addition the data gathered from this study is intended to help the PSI/M franchising team understand and subsequently address: i) the knowledge gaps that exist among their providers; ii) providers' intention to recommend IUDs to a variety of client types; and iii) providers' perceived risks and barriers to IUD provision, including structural constraints, attitudinal constraints, profitability related concerns, and perceived client willingness.

DESCRIPTION OF INTERVENTION

As part of its activities to support and strengthen the social franchise's overall performance (in terms of access, quality, product/service portfolio, equity etc), PSI/M is continuously looking for ways to improve its provider motivation strategy. The motivational strategy – in general -- aims to recruit potential providers into the network, to maintain well performing providers in the TR network and to make them high performers. PSI/M is concerned about investing resources (time, money, HR) into supporting low or mediocre performance, which can lead to a negative image of the overall network. At the same time, PSI globally has adopted providers as an important secondary target to reach vulnerable populations with essential quality health services. As such, under the new Integrated Social Marketing Program (2013-2017) PSI/M will explore ways to maintain and improve provider motivation and quality of service delivery.

In essence, PSI/M encourages TR providers to adopt a series of 'desired behaviors', which are:

- Efficiency (provision of services according to quality standards)
- Performance in terms of productivity (number of customers)
- Good collaboration with PSI (assiduity on reporting, meetings and training, availability for supervision, availability to receive clients referred by agents, improving the clinic according to PSI/M recommendations).

The Woman's Health Project (WHP) aims to increase the use of IUDs in Madagascar through private and public sector redynamisation. Program objectives include increasing both the supply of and demand for IUDs through improved provider knowledge and motivation to recommend and provide IUDs, and improved consumer knowledge, beliefs, and willingness to accept this relatively unpopular form of contraception. Prevalence of IUD use among Malagasy women aged 15 to 49 years old is only about 0.8%.³

METHODOLOGY

A sample of network Top Reseau providers and non-Top Reseau FP providers was selected and interviewed between 18th and 23rd June 2013. The same Top Reseau providers of IUD service and same providers in the control group will be surveyed in the follow-up study in 2 years' time. In this sampling frame, study respondents were selected from two groups of providers. The first group comprises providers in the Top Reseau network. All providers from the Top Reseau network were selected. The second group comprises family planning providers who are not a part of the network but have the potential to be part of Top Reseau. This control group was recruited from the private sector facilities around PSI providers offering IUD services, and was matched with the Top Reseau providers by status (medical doctor or midwife).

Performance of Top Reseau providers was defined according to the number of clients registered in the PSI Management Information System database from January to June 2013. Performance is categorized into low (less than 25 clients per month), medium (between 25 and 70 clients per month) and high (71 clients and more per month).

MAIN FINDINGS

The provider motivation analysis highlighted that:

- ❖ Top Reseau providers are motivated by three main reasons to work as health providers. As many as 92% of the providers mention that they work as health providers because they want to do something good for their community (humanitarian values). 83% mention that being independent to have own business is the reason, while about 69% reported that earning money in order to have a good living was the main motivator. These reasons do not vary by performance of the provider.

³Madagascar (2012): Family Planning TRaC Study Evaluating the Use of Modern Contraceptive Methods Among Women of Reproductive Age. Family Planning among women 15-49 years old - FIFTH ROUND. Family Planning among 15-24 years old in rural area - SECOND ROUND.

- ❖ On a scale of 1 to 4 with 4 being most important factors that providers value in a network are training/meetings support (3.15); humanitarian/community values (2.49); belonging to a quality network/visibility of the network (2.47); and increase in client flow and profits (1.89) ranked in order of importance. All the factors -- except humanitarian values – were no different according to provider performance level. Fewer providers among high performing providers mentioned humanitarian values as an important factor compared to providers in lower performance categories ($p < 0.05$).
- ❖ Most providers agreed that all motivational factors are key reasons why they belong to a Top Reseau network. The means of these motivational factors were training/support (4.17), opportunity to provide humanitarian/community support (4.62), belonging to a quality network of providers (4.52), expected increase in client flow (3.74) and prestige of belonging to a network (3.87). These reasons/factors did not vary by performance of providers.
- ❖ Top Reseau providers ranked barriers to belonging to the network as follows in order of severity: pricing problems due to the fact that most clients are low income (3.81), being asked to work in technical one is not familiar with (3.22), reporting challenges (2.91), supervision that takes too much time (2.79), and training/meetings being time consuming (2.27). These barriers also did not vary by performance of the provider.
- ❖ The proportion of Top Reseau providers complying with PSI reporting requirements is high. About 74% of Top Reseau providers report always attending PSI organized meetings while 85% always reported to PSI on time in the last 6 months. Meeting and reporting compliance did not vary by performance of providers.

The provider knowledge about and attitude towards IUDs analysis showed that:

- ❖ Overall, the percentage of providers scoring at least 75% on all knowledge items is very low. Only 4.6% of all providers met this standard. There was no difference between Top Reseau providers and non Top Reseau.
- ❖ Top Reseau providers have higher positive attitudes and beliefs towards IUDs compared to their non-Top Reseau counterparts.
- ❖

- ❖ Overall, both Top Reseau and non Top Reseau providers face the same barriers to recommending IUDs. However, as expected more non Top Reseau providers (10.4%) do not have adequate supply of IUDs compared to Top Reseau providers (2.2%) ($p < 0.01$). Similarly about 30.4% of non Top Reseau providers do not have the required equipment for IUD insertion compared to only 2.9% of Top Reseau providers who report the same ($p < 0.001$). In addition about 35.2% of non Top Reseau providers mentioned need for training on IUD insertion as a barrier to recommending IUD compared to only 4.4% among the Top Reseau providers ($p < 0.001$). Lastly, about 18.4% of non Top Reseau providers reported that they are not comfortable inserting IUDs compared to 1.5% among Top Reseau providers ($p < 0.001$).
- ❖ As expected Top Reseau providers exhibited superior beliefs that they can insert IUDs compared to non-Top Reseau providers. Overall, almost all Top Reseau providers (97%) either agreed or strongly agreed that providing IUD insertion services is a good use of their skills and experience compared to about 80% among non Top Reseau providers who reported the same ($p < 0.001$).

PROGRAMMATIC RECOMMENDATION

- ❖ To improve provider's motivation, PSI staff plan to provide at least 2 training session per year to Top Reseau providers. Quality insurance held by supervisor will be also reinforced as it was shown that high quality network and training are part of the most important motivation factors for Top Reseau provider with high performance.
- ❖ Real differences were seen between Top Reseau and non Top Reseau providers. Top Reseau providers exhibit more positive attitudes and beliefs inter alia knowledge about IUDs. This suggests that the network has a positive influence on these providers. The program will retain and expand the network.
- ❖ The results indicated that three factors need to be addressed (not having the equipment required for IUD insertion and the adequate supply of IUD, and also the need for training in inserting IUD) to change the knowledge and attitude of Non-TR providers
- ❖ Communication activities will be strengthened to address KAP toward IUD appropriateness and risk.
- ❖ The results show that the two main barriers on provider attitude are the IUD recommendation to youth and nulliparous. The program will address these through medical detailing visit among providers by medical supervisors.

KEY RESULTS TABLES AND GRAPHS

PROVIDER MOTIVATION ANALYSIS

Table 1: Reasons that motivate Top Reseau providers by Performance, Madagascar 2013

Reasons (%)	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Humanitarian values/ to do something good for his/her community	92.0	87.0a	94.0a	96.0a	ns
Status/prestige in the community/in his/her family	32.0	31.0a	38.0a	27.0a	ns
To earn money and make a good living	69.0	66.0a	72.0a	68.0a	ns
To have authority/influence/respect	39.0	43.0ab	45.0a	27.0b	*
To be independent/have his/her own business	83.0	87.0a	80.0a	80.0a	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Performance results are segmentation of the providers in three population groups according to the number of their clients per week. Performance is categorized by low (less than 25 clients), medium (between 25 to and 70 clients) and high (71 clients and more). 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.
3. Percentages across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.
4. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

Table 2: Ranking of Factors that motivate providers to be part of Top Reseau network by Performance, Madagascar 2013

Rank of Top Reseau provider Motivation	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Mean					
Trainings/support/meetings	3.15	3.07a	3.07a	3.30a	ns
Humanitarian/community	2.49	2.68a	2.60a	2.20b	*
Belonging to a quality network/Visibility of the network	2.47	2.32a	2.51a	2.57a	ns
Increase in client flow and profits	1.89	1.92a	1.82a	1.93a	ns

Note:

1. *ns: not significant, *: p <.05; **: p <.01; *** p<.001*
2. *Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.*
3. *Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.*
4. *Means result from the ranking the four items from 1 to 4 (1=least important, and 4=most important) .*
5. *Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.*

Table 3: Means of Motivation of Top Reseau providers by Performance Madagascar 2013

MOTIVATIONAL FACTORS (means)	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Trainings/Support	4.17	4.13ab	4.08a	4.30b	ns
Humanitarian/Community	4.62	4.62a	4.62a	4.62a	ns
Belonging To A Quality Network	4.52	4.39a	4.56ab	4.59b	ns
Increase In Client Flow And Profits	3.74	3.68a	3.61a	3.92a	ns
Prestige	3.87	3.69a	3.89a	4.02a	ns

Note:

1. *ns: not significant, *: p <.05; **: p <.01; *** p<.001*
2. *n/a: not applicable*
3. *Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.*
4. *Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.*
5. *Means factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)a*
6. *Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.*

Table 4: Ranking of Barriers that make Top Reseau providers unsatisfied with the network by Performance, Madagascar 2013

	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Barriers (mean)					
Training/Meetings/ Time consuming	2.27	2.31a	2.43a	2.07a	ns
Supervision	2.79	2.94a	2.81a	2.62a	ns
Reporting	2.91	3.03a	2.79a	2.93a	ns
Technical/areas of intervention	3.22	3.07a	3.27a	3.31a	ns
Price/serving low income clients	3.81	3.65a	3.70a	4.07a	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.
3. Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.
4. Means result from the ranking of the five items from 1 to 5 (1=least important and 5=most important)
5. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

Table 5: Means of Barriers that make Top Reseau providers unsatisfied with the network by Performance, Madagascar 2013

BARRIERS FACTORS	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Trainings/ Meetings	1.53	1.52a	1.57a	1.49a	ns
Supervision/Reporting	1.70	1.63a	1.82a	1.67a	ns
Technical/ Areas of intervention	1.81	1.80a	1.76a	1.85a	ns
Income/Client issues	2.14	2.10a	2.24a	2.09a	ns
PSI Support	1.68	1.76a	1.81a	1.46b	*

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25

clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.

3. Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.
4. Means factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)
5. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

Table 6: Provider Attendance in PSI Meetings and Compliance with Reporting by performance

Provider Attendance in PSI Meetings/Compliance with Reporting	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Percentage					
Providers always attended meeting organized by PSI (when they were invited) within the last 6 months	74.0	81.1a	65.6a	76.0a	ns
Providers always sent PSI their report on time within the last 6 months	85.2	85.6a	84.0a	88.0a	ns

PROVIDER KNOWLEDGE AND ATTITUDE ABOUT IUD ANALYSIS

Table 7: Comparison of provider knowledge on IUD between Top Reseau and Non Top Reseau providers, Madagascar 2013

INDICATORS	Total of providers (N=261)	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Percentage of providers scoring at least 75% on questions in section 3 and section 4 (1-14) of the provider IUD study questionnaire	4.6	6.6	2.4	ns
Mean score of provider knowledge on section 3 and section 4 (1-14) (out of 22 items)	11.7	12.7	10.6	***

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

Table 8: Comparison of provider attitudes and beliefs towards IUDs between Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

INDICATORS (%)	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
ATTITUDE TOWARD DEMOGRAPHIC APPROPRIATENESS OF IUDs			
Would recommend IUD to woman who is not married	75.7	60.0	**
Would recommend IUD to woman who has no children (nulliparous)	78.7	39.2	***
Would recommend IUD to woman who is 17 years old	53.7	19.2	***
Would not recommend IUD to woman who has more than one sexual partner	69.9	56.0	**
Would recommend IUD to woman who has one child	97.8	84.0	***
Would recommend IUD to woman who is of very small stature (short, tiny, etc.)	83.1	93.0	ns

Would recommend IUD to woman who wants to delay her next pregnancy	100	90.4	***
Would recommend IUD to woman who is illiterate	99.3	89.6	**
Would recommend IUD to woman who has 4 children	100	94.4	**
Would recommend IUD to woman who does not want to have any more children	97.1	78.4	***
Would not recommend IUD to woman whose sexual partner is not monogamous	73.5	59.2	*
Would recommend IUD to woman who does heavy physical labor every day	97.1	82.4	***
Would recommend IUD to woman who is very poor	98.5	91.2	**
BELIEF TOWARD SIDE EFFECTS			
False belief about side effects or adverse outcomes associated with using a copper IUD (at least one side effect)	24.3	32.8	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

Graph 1: Provider attitudes towards IUDs between Top Reseau providers and Non Top Reseau providers, Madagascar 2013

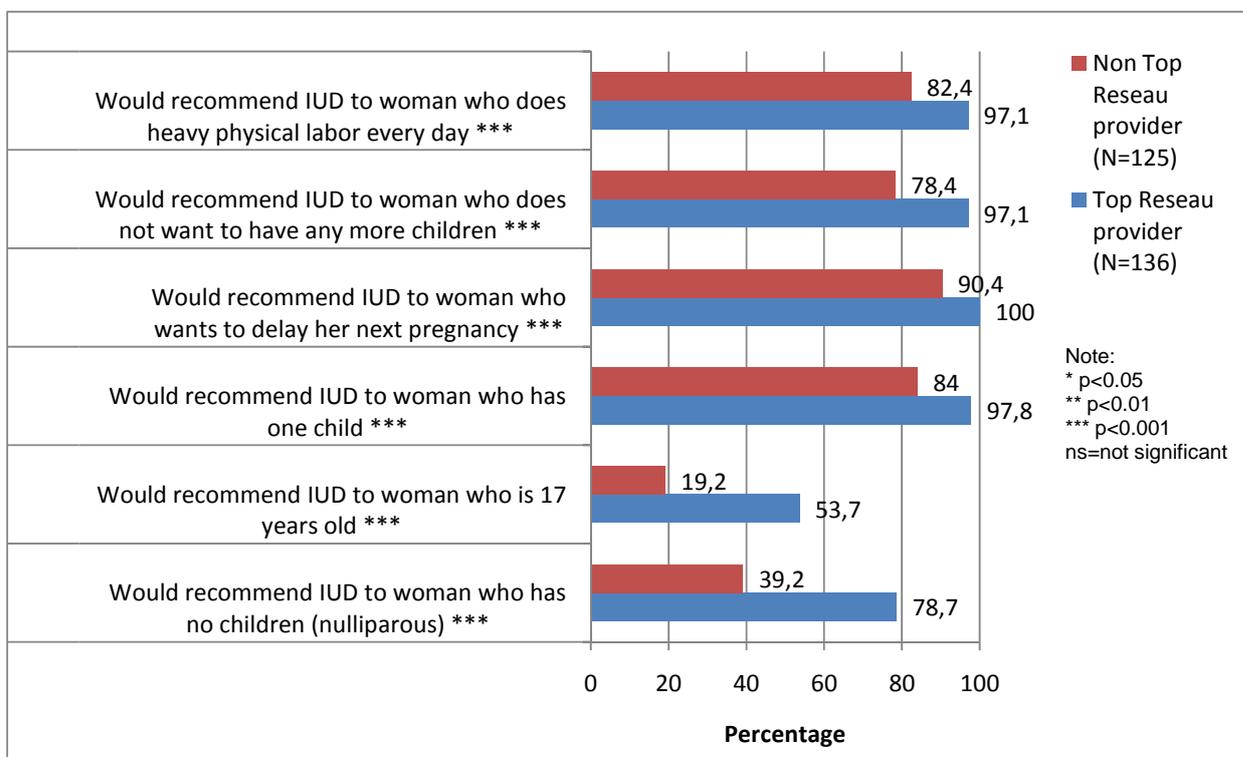


Table 9: Factors that prevent providers to recommend IUDs or to provide IUDs between Top Reseau provider and Non Top Reseau providers, Madagascar 2013

INDICATORS (%)	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
BARRIERS FACTORS TOWARDS TO IUD RECOMMENDATION			
Insertion procedure is complicated	1.5	5.6	ns
Do not have adequate supply of IUD	2.2	10.4	**
Do not have the equipment required for IUD insertion	2.9	30.4	***
Requires disinfection of clinic/instruments	5.2	8.0	ns
Requires helper (another staff person) for insertion	4.4	3.2	ns
Takes too much time for counseling of women	10.3	9.6	ns
Takes too much time for insertion	2.9	2.4	ns
Clients do not ask for it	13.24	16.8	ns

It is too expensive for his/her clients	4.4	0.8	ns
It is not a profitable method for him/her	2.9	0.8	ns
Felt not comfortable inserting IUD	1.5	18.4	***
needs training in inserting IUD	4.4	35.2	***
There is the possibility of uterus perforation	3.7	2.4	ns
The side effects are too much for the client	7.4	3.2	ns
It is not a suitable method for most of his/her clients	4.4	4.8	ns
It can be expelled	3.7	3.2	ns
Clients can get pregnant when using IUD	4.4	4.8	ns
Clients have difficulty getting pregnant after using the IUD	0.7	0.0	ns
Insertion is too painful for client	1.5	0.0	ns
It can shift / be displaced in uterus	2.9	5.6	ns
I am concerned I will acquire HIV during the insertion	1.5	1.6	ns
Clients are afraid of IUD	22.1	19.2	ns
Requires follow-up visit by client	15.4	15.2	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

Graph 2: Factors that prevent providers to recommend IUDs or to provide IUDs between Top Reseau provider and Non Top Reseau providers, Madagascar 2013

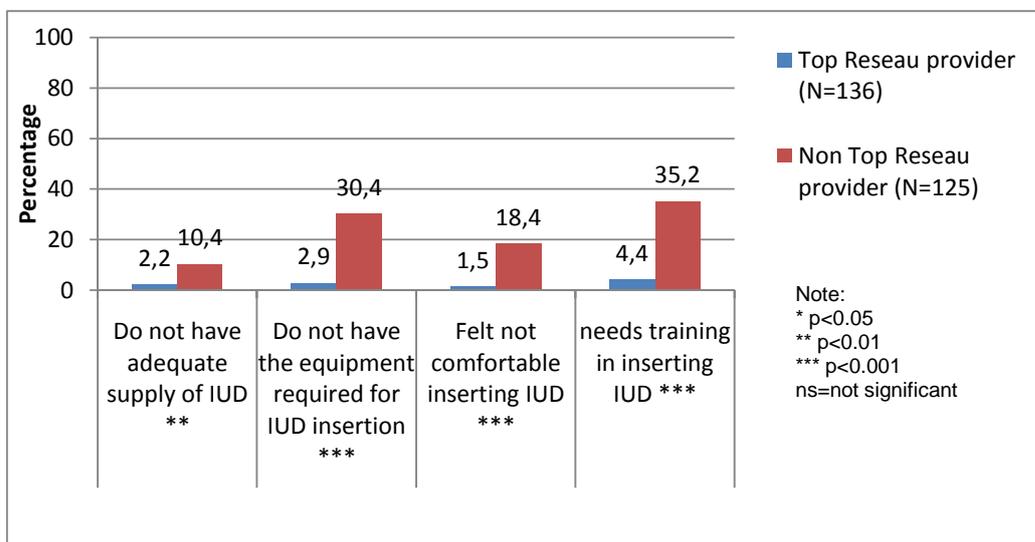


Table 10: Self efficacy towards IUDs between Top Reseau provider and non Top Reseau providers, Madagascar 2013

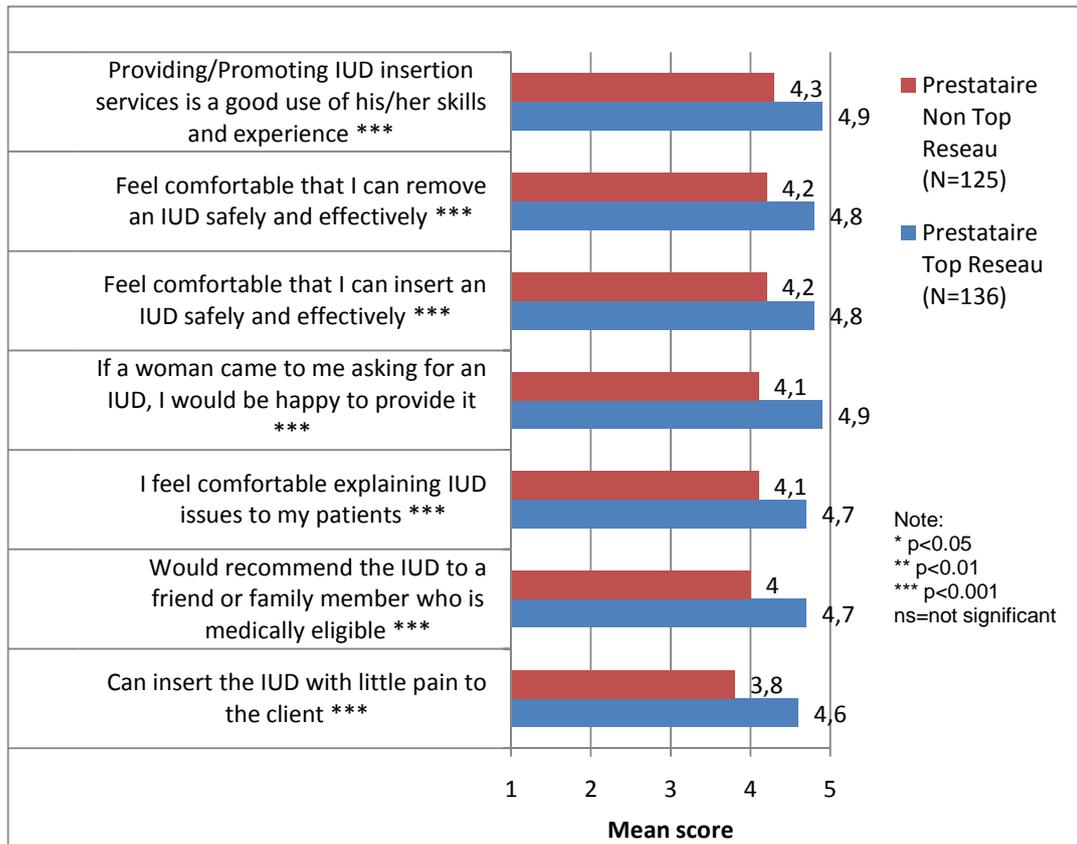
Mean scales for self efficacy	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Can insert the IUD with little pain to the client.	4.6	3.8	***
IUDs are too difficult to insert.	1.5	1.9	**
IUDs are too time consuming to insert.	1.7	2.0	*
The risk of complication when inserting an IUD is too great.	1.6	2.0	**
Would recommend the IUD to a friend or family member who is medically eligible.	4.7	4.0	***
When inserting the IUD, he/she is worry about infecting himself/herself with a sexually transmitted disease or HIV.	1.4	1.7	*
There are too many issues to consider when deciding if a woman can use an IUD.	2.7	3.0	*
I feel comfortable explaining IUD issues to my patients.	4.7	4.1	***
There are many days when I am too busy to discuss about/provide IUDs.	2.2	2.5	*

It is very difficult to convince clients that many rumors about the IUDs are actually false	3.6	3.5	ns
If a woman came to me asking for an IUD, I would be happy to provide it	4.9	4.1	***
Feel comfortable that I can insert an IUD safely and effectively.	4.8	4.2	***
Feel comfortable that I can remove an IUD safely and effectively	4.8	4.2	***
Provision of IUDs is not profitable for him/her.	2.2	2.6	*
Providing/Promoting IUD insertion services is a good use of his/her skills and experience.	4.9	4.3	***
Worry that complications arising from an IUD will damage the reputation of my clinic.	2.0	2.1	ns
Providers reporting a score of 4 or 5 on a 5-point Likert scale for the statement "Providing IUD insertion services is a good use of my skills and experience" (%)	97.1	80.8	***

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.
3. Means factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)

Graph 3: Self efficacy towards IUDs between Top Reseau provider and Non Top Reseau providers, Madagascar 2013



ANNEX

Table 11: Top Reseau provider characteristic by Performance, Madagascar 2013

PROVIDER CHARACTERISTIC	Entire (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Mean					
Average of clients in a month (from MIS)	67.1	12.7a	42.7b	144.8c	***
Age	48.5	48.3a	48.7a	48.5a	ns
Duration of working as a health provider (years)	17.6	18.3a	17.6a	17.0a	ns
Duration of working at the health facility (years)	10.6	9.9a	10.9a	11.0a	ns
Duration as Top Reseau provider (years)	5.0	3.9a	5.5b	5.4b	**
Average of other facilities in the same fokontany	2.7	2.5a	3.1a	2.6a	ns
Average of the population of the fokontany	6577.8	5780.2a	5533.6	8443.6b	*
PROVIDER CHARACTERISTIC	Entire (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Percentage					
Female	56.5	44.0a	59.0ab	66.0b	*
Medical Doctor	87.9	83.1a	92.3a	87.8a	ns
Workplace serve as primary source of income	87.0	76.0a	91.0b	93.0b	*
Owner of the facility	48.0	35.0a	46.0ab	62.0b	**
Provide Family planning	98.2	98.0a	100.0b	100.0b	*
Provide Antenatal Care	64.6	54.0a	60.0a	80.0b	**
Provide Labor and Delivery Care	37.2	30.0a	36.0ab	46.0b	*
Provide Postnatal Care	63.2	46.0a	68.0b	74.0b	**
Provide CTV (HIV/AIDS diagnosis)	30.9	20.0a	35.0b	38.0b	*
Provide Child Nutrition	57.8	51.0a	59.0a	64.0a	ns
Provide Other Child health	61.0	52.0a	62.0ab	69.0b	*

Note:

5. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
6. Performance results from a segmentation of the providers in three population groups according to the number of their clients per month. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.
7. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

Table 12: Provider professional profile (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

PROVIDER CHARACTERISTIC	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Mean			
Age	48.57	48.62	ns
Duration of working as a health provider (years)	17.66	18.74	ns
Duration of working at the health facility (years)	11.01	10.23	ns
Average of clients in a week	74.14	45.18	***
Average of clients for family planning in a week	19.27	10.59	**
PROVIDER CHARACTERISTIC	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Percentage			
Female	66.0	50.0	*
Medical Doctor	84.6	82.4	ns
Workplace serve as primary source of income	88.0	65.0	***
Owner of the facility	49.0	74.0	***
Provide oral contraceptive as family planning	96.0	90.0	ns
Provide injectable contraceptive as family planning	97.0	93.0	ns
Provide condom as family planning	93.0	75.0	***
Provide IUD as family planning	100.0	18.0	***
Provide Implant as family planning	67.0	18.0	***
Provide fertility awareness/natural method as family planning	86.0	79.0	ns
Provide emergency contraception	65.0	38.0	***

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

Table 13: Provider personal profile (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

PROVIDER CHARACTERISTIC	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Percentage			
Currently use a modern family planning (Her partner or herself)	26.3	23.8	ns
Ever used an IUD as a family planning (Her partner or herself)	12.5	4.8	*
Currently use an IUD (Her partner or herself)	4.5	2.1	ns
Currently use of a method among those who use modern family planning (Partner or herself)	Top Reseau provider (N=48)	Non Top Reseau provider (N=32)	Sig.
Currently use an oral contraceptive	17.0	3.0	*
Currently use an injectable contraceptive	8.0	9.0	ns
Currently use condom as family planning	23.0	31.0	ns
Currently use an IUD	17.0	9.0	ns
Currently use an Implant	8.0	0.0	*
Currently use a female sterilization	6.0	6.0	ns
Currently use lactational amenorrhea as family planning	0.0	0.3	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

MOTIVATIONS AND BARRIERS ITEMS FACTORS AMONG TOP RESEAU PROVIDERS

Table 3A: Motivational item factors of Top Reseau providers by Performance Madagascar 2013

MOTIVATIONAL FACTORS (means)	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Trainings/Support	4.17	4.13ab	4.08a	4.30b	ns
Support offered by PSI allows him/her to have access to technical trainings	4.72	4.53a	4.71ab	4.87b	*
Support offered by PSI allows him/her to have access to trainings on managing a clinic, procurement, finance/accounting that help him/her run his/her clinic	4.19	4.13a	4.12a	4.33a	ns
Support offered by PSI allows him/her to receive equipment	3.97	3.9a	3.78a	4.25b	*
Support offered by PSI allows him/her to benefit from promotional items and IEC materials	4.33	4.26a	4.38a	4.34a	ns
Support offered by PSI allows him/her to benefit from word of mouth and IPC promotion of his/herclinic	4.46	4.36a	4.36a	4.66a	ns
Support offered by PSI allows him/her to benefit from personalized support from people who care about him/her and his/her work	3.33	3.59a	3.09b	3.33ab	ns
Humanitarian/Community	4.62	4.62a	4.62a	4.62a	ns
Motivated on working for vulnerable groups (humanitarian work) as member of Top Reseau	4.42	4.46a	4.36a	4.43a	ns
motivated on doing something good for his/her community, as member of Top Reseau	4.83	4.79a	4.88a	4.80a	ns
Belonging To A Quality Network	4.52	4.39a	4.56ab	4.59b	ns
Felt to belong to a like -minded community of health providers as member of Top Reseau	4.76	4.72a	4.79a	4.76a	ns
Felt known and recognized in the community as a quality health provider member of Top Reseau	3.81	3.67a	3.84a	3.91a	ns
Adhere to norms and standards that improve his/her service quality as member of Top Reseau	4.69	4.54a	4.73ab	4.79b	ns
Sharedhis/her experiences with other doctors in the networkas member of Top Reseau	4.54	4.53a	4.54a	4.54a	ns

Received certificates to hang on the wall to show his/her commitment to quality as member of Top Reseau	4.43	4.13a	4.53ab	4.60b	*
Received visitors who are interested in his/her work as member of Top Reseau	4.61	4.52a	4.60a	4.71a	ns
Improved his/her technical skills (LTM FP, HIV testing, IMCI, nutrition, etc) as member of Top Reseau	4.78	4.63a	4.87b	4.83ab	ns
Increase In Client Flow And Profits	3.74	3.68a	3.61a	3.92a	ns
By becoming a member of Top Reseau, He/she can increase his/her client volume	4.09	4.02a	3.97a	4.27a	ns
By becoming a member of Top Reseau, He/she can increase his/her earnings	3.38	3.33a	3.26a	3.57a	ns
Prestige	3.87	3.69a	3.89a	4.02a	ns
Being a member of Top Reseau allows him/her to have authority and prestige as a result of his/her relationship with an international NGO/well known organization	2.72	2.61a	2.63a	2.92a	ns
Being a member of Top Reseau allows him/her to incorporate new health areas into his/her practice	4.41	4.16a	4.46ab	4.61b	ns
Being a member of Top Reseau allows him/her to attend lectures and meetings on health topics that interest him/her	4.48	4.30a	4.58a	4.55a	ns

Note:

6. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
7. Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.
8. Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.
9. Means factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)
10. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

Table 5A: Barriers item factors of Top Reseau providers by Performance Madagascar 2013

BARRIERS	total	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Trainings/ Meetings	1.53	1.52a	1.57a	1.49a	ns
The required Top Reseau training/meeting activities take up too much time/are too many/are too long	2.24	2.05a	2.41a	2.23a	ns
The required Top Reseau training/meeting topics do not correspond to his/her interests as a doctor	1.80	1.42a	1.38	1.29a	ns
The required Top Reseau training are too frequent	1.29	1.30a	1.27a	1.30a	ns
The required Top Reseau training/meeting don't meet his/hery objectives	1.22	1.31a	1.22a	1.14a	ns
Supervision/Reporting	1.70	1.63a	1.82a	1.67a	ns
The required Top Reseau supervision visits take up too much time/are too many	1.73	1.62a	1.75a	1.82a	ns
The required Top Reseau supervision visits don't meet his/her objectives	1.30	1.31a	1.36a	1.24a	ns
The required Top Reseau reporting procedures take up too much time/are too many/are too long	1.90	1.89a	2.01a	1.79a	ns
Felt required to adhere to too many norms and follow too many procedures	1.90	1.69a	2.15b	1.84ab	ns
Technical/ Areas of intervention	1.81	1.80a	1.76a	1.85a	ns
Felt more confident technically than he/shel did before joining the network	1.46	1.41ab	1.30a	1.69b	ns
The required public health areas (FP; STI management, counseling....)he/she need to work in take too much time	3.29	3.38a	3.18a	3.30a	ns
The required public health areas he/she need to work in don't correspond to his/her objectives	1.34	1.25a	1.43a	1.32a	ns
The health areas do not interest him/her technically	1.13	1.17a	1.14a	1.10a	ns
Income/Client issues	2.14	2.10a	2.24a	2.09a	ns
Felt required to work in health areas that generate little client fees	2.99	2.82a	3.12a	3.02a	ns
Felt required to work with vulnerable groups that generate very little client fees	3.11	2.92a	3.14a	3.26a	ns
Felt that his/her clinic is becoming stigmatized as serving at risk groups for STI/ HIV/poor people	1.24	1.20ab	1.40a	1.12b	ns

Felt that his/her work is becoming too monotonous with too many similar clients	1.17	1.21a	1.11a	1.20a	ns
His/her client volume hasn't increased as expected	2.22	2.33ab	2.45a	1.86b	*
PSI Support	1.68	1.76a	1.81a	1.46b	*
Felt that loose part of his/her independence working with PSI	1.27	1.24a	1.39a	1.18a	ns
Felt that his/her clinic doesn't benefit from PSI supported demand creation	1.51	1.57ab	1.68a	1.28b	ns
Felt that his/her clinics doesn't benefit from direct support to improve its infrastructure	2.26	2.46a	2.36ab	1.95b	ns

Note:

11. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
12. Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more). 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.
13. Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.
14. Means factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)
15. Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.

TOP RESEAU BRAND PERSONALITY AMONG TOP RESEAU PROVIDERS

Table 14: Opinion and expectation on what a member of Top Reseau should be like, Madagascar

2013

	Idea on what the current profile of a Top Reseau member is like (spontaneous) (N=223)	Agreement with what a Top Reseau member should be like (directed) (N=223)
Smart	16.1	13.5
Public health minded	12.6	19.7
Interested in quality	23.3	27.4
Interested in self improvement	3.1	4.5
Care about their work	13.0	17.9
Care about their communities	12.1	15.7
None of above	19.7	1.3
Total	100.0	100.0

Table 15: Opinion and expectation on what Top Reseau should offer them, Madagascar 2013

	Idea on what being a Top Reseau means to them (spontaneous) (N=223)	Agreement on what Top Reseau may mean to them (directed) (N=223)
Quality	15.7	39.0
Affordability	2.2	3.1
Doing good/charitable work	17.0	13.9
Reliability	2.2	8.5
Modernity	4.0	6.7
HIV/STI	3.1	1.3
FP	11.7	7.6
Youth	13.0	7.6
Maternal and childhealth	7.6	3.6
Health for at risk groups (MSM, FSW, etc)	4.9	3.6
None of above	18.4	4.9
Total	100.0	100.0

Table 16: Top Reseau Brand personality, Madagascar 2013

Brand Personality factors	Total (N=223)	Low (N=71)	Medium (N=78)	High (N=74)	Sig.
Mean score					
Felt that he/she understood whom TR services are for	4.85	4.85a	4.82a	4.87a	ns
TR services are important for his/her practice	4.80	4.77a	4.79a	4.85a	ns
TR services are important for his/her community	4.79	4.72a	4.76a	4.89a	ns
Proud to be a member of the TR network	4.35	4.20a	4.37a	4.48a	ns
Felt more confident as a provider since joining the TR network	4.60	4.51a	4.61a	4.68a	ns
Felt that there are good reasons to being a member of TR network	4.88	4.87a	4.89a	4.88a	ns
Would recommend becoming a TR member to his/her peers	4.59	4.55a	4.55a	4.68a	ns
Would wear a TR t-shirt outside his/her practice	3.85	3.73a	4.08a	3.73a	ns
TR is for doctors like him/her	4.83	4.84a	4.86a	4.79a	ns

Note:

1. *ns: not significant, *: p <.05; **: p <.01; *** p<.001*
2. *Performance results from a segmentation of the providers in three population groups according to the average number of their clients per month as provided by the MIS. Performance is categorized by low (less than 25 clients), medium (between 25 and 70 clients) and high (71 clients and more).. 9 Top Reseau providers were excluded from the sample as they are not yet recorded in the MIS.*
3. *Percentage and Means across performance are adjusted for key demographic characteristics, including age, gender, professional status (Medical doctor or Midwife/laboratory technician), workplace serve as your primary source of income, owning the facility, number of facilities in the fokontany and the population size of the fokontany.*
4. *Mean factors results from a likert scale 1 to 5 (1=strongly disagree and 5=strongly agree)*
5. *Superscripts denote pair-wise comparisons. Significance testing results for pair-wise comparisons can be presented using letters. For example, means/percentages with the same letter in their superscripts do not differ significantly from one another according to a Least Significant Distance (LSD) test with a .05 limit on family wise error rate.*

PROVIDER KNOWLEDGE ABOUT IUD

Table 17: Provider knowledge toward IUD device and appropriateness and risk on IUD (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

INDICATORS	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
KNOWLEDGE TOWARD IUD DEVICE			
Knows about the rate of the effectiveness of the copper TCu 380A IUD at preventing pregnancy annually	58.1	35.2	***
Knows about the maximum length of time a woman can use the TCu 380A IUD after it is inserted	92.7	60.0	***
Knows about the main mechanism of action of copper-bearing IUDs at preventing pregnancy	58.1	39.2	**
Knows that IUD can be safely inserted when woman is menstruating	75.1	59.8	**
Knows that IUD can be safely inserted anytime during the menstrual cycle if the woman is not pregnant and has no signs of infection	86.7	81.6	ns
Knows that IUD can be safely inserted within 48 hours post-partum if there is no infection or hemorrhage	52.9	34.4	**
Knows that IUD cannot be safely inserted up to 7 days post-partum if there is no infection or hemorrhage	0.0	0.0	ns
Knows that IUD can be safely inserted four weeks after delivery	72.8	59.2	**
Knows that IUD can be safely inserted six months after delivery	84.6	85.6	ns
KNOWLEDGE TOWARD APPROPRIATENESS AND RISK			
Knows that woman currently breastfeeding is medically eligible for IUD insertion	72.1	75.2	ns
Knows that HIV positive woman is medically eligible with screening for IUD insertion	40.4	32.8	ns
Knows that woman with history of ectopic pregnancy is medically eligible for IUD insertion	41.2	24.0	**
Knows that woman smoking less than 15 cigarettes per day is medically eligible for IUD insertion	81.6	75.2	ns

Knows that overweight/obese woman is medically eligible for IUD insertion	91.9	80.0	**
Knows that Hypertension patient is medically eligible for IUD insertion	90.4	70.4	***
Knows that patient under anti-Retroviral Therapy but clinically well is medically eligible with screening for IUD insertion	17.7	24.8	ns
Knows that woman with vaginal discharge is medically eligible with screening for IUD insertion	53.7	48.0	ns
Knows that woman who had pelvic inflammatory disease 3 years ago is medically eligible for IUD insertion	38.2	28.0	ns
Knows that current STI patient is medically eligible with screening for IUD insertion	41.9	32.0	ns
Knows that woman with Iron-deficiency anemia is medically eligible for IUD insertion	22.8	32.0	ns
Knows that woman with Irregular menstrual pattern is medically eligible for IUD insertion	69.9	74.4	ns
Knows that woman less than 48 hours post-partum is medically eligible for IUD insertion	31.6	13.6	ns

PROMOTIVES AND BARRIERS FACTORS TO IUD RECOMMENDATION

Table 18: Promotional factors towards IUD Recommendation (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

INDICATORS	Top Reseau provider (N=125)	Non Top Reseau provider (N=34)	Sig.
PROMOTIVE FACTORS TOWARDS TO IUD RECOMMENDATION			
It is a safe contraceptive	65.0	68.0	ns
It is affordable for his/her clients	20.0	15.0	ns
It is a long term method	75.0	65.0	ns
It does not have many side effects	48.0	41.0	ns
It is very effective at preventing pregnancy	21.0	21.0	ns
It is easily reversible / return to fertility is rapid	26.0	24.0	ns
Client requests the IUD	5.0	15.0	ns

It is being promoted by PSI	6.0	9.0	ns
It is being promoted by Ministry of Health	3.0	6.0	ns
It is a profitable method for him/her	5.0	3.0	ns
It is easy for women to use	38.0	47.0	ns
It is hormone free	54.0	68.0	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

PROVIDERS FAMILY PLANNING EXPERIENCE

Table 19: Providers training with IUD (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

TRAINING INDICATORS	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Percentage			
Ever been trained to insert an IUD	95.0	34.0	***
TRAINING INDICATORS	Top Reseau provider (N=129)	Non Top Reseau provider (N=42)	Sig.
Trained on IUD when Medical/nursing Student	5.0	21.0	*
Trained on IUD when Resident	1.0	2.0	ns
Trained on IUD at another facility as part of previous job	20.0	38.0	
Trained on IUD while at this facility as part of current job	96.0	60.0	***
TRAINING INDICATORS	Top Reseau provider (N=129)	Non Top Reseau provider (N=42)	Sig.
Mean			
Most recent training related to IUDs (months ago)	31.0	110.0	***
First training related to IUDs (months ago)	70.0	145.9	***

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$

2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

Table 20: Providers experience with IUD (Top Reseau provider vs Non Top Reseau provider), Madagascar 2013

EXPERIENCE INDICATORS	Top Reseau provider (N=136)	Non Top Reseau provider (N=125)	Sig.
Percentage			
Ever inserted an IUD	92.0	28.0	***
EXPERIENCE INDICATORS	Top Reseau provider (N=125)	Non Top Reseau provider (N=35)	Sig.
Last insertion of IUD within the last 6 months	94.4	40.0	***
Last remove of IUD within the last 6 months	77.6	45.7	**
Mean	Top Reseau provider (N=125)	Non Top Reseau provider (N=35)	Sig.
Number of IUD inserted in the last 6 months	100.0	20.2	***
Mean	Top Reseau provider (N=97)	Non Top Reseau provider (N=16)	Sig.
Number of IUD removed in the last 6 months	7.4	6.4	ns

Note:

1. ns: not significant, *: $p < .05$; **: $p < .01$; *** $p < .001$
2. Top Reseau providers are paired with Non Top Reseau provider by area (in the same commune) and by status (doctor or midwife). All Top Reseau providers offer IUD service and all Non Top Reseau providers provide family planning method. The total of Non Top Reseau providers (N=125) is less than the total of Top Reseau providers (N=136) because in some communes there is no other private provider.

FLASH FOQUS - CONDOM YOUTH

Antananarivo & Toamasina urbains



Juillet 2013



Objectifs de l'étude

Identifier et connaître :

- Les **connaissances** en matière de marques de préservatif disponibles sur le marché
- Les **marques** de préservatif qu'ils utilisent/ont utilisé régulièrement : quelle marque ? à quel prix ? lieu d'achat habituel du produit ?
- La **perception** des cibles par rapport aux marques existantes sur le marché (positionnement de la nouvelle marque par rapport au marché existant)
- Le **rôle du partenaire** dans l'achat/utilisation du préservatif : qui a initié la discussion ? qui a pris la décision ? qui a acheté le service/le produit ?
- Les **barrières et les motivations** pour l'achat/acquisition/utilisation de préservatif
- Les **attentes des jeunes pour un préservatif destiné spécifiquement pour eux**
- Les **préférences** des cibles en termes d'attributs d'un préservatif
- La **volonté de payer** des cibles pour un nouveau condom pour les jeunes.
- Les **points de vente** proposés par les jeunes pour le nouveau condom
- Les **moyens de promotions** suggérés par les jeunes.

Méthodologie

Atelier des consommateurs

Total de 88 participant(e)s

Segments : 26 Utilisateurs réguliers ;
35 Utilisateurs non réguliers
(intermittents) ; 27 anciens utilisateurs



Plan de présentation

1. Les attitudes des jeunes par rapport au condom
2. La connaissance et la perception par rapport au condom existant sur le marché
3. Les barrières et les motivations des jeunes par rapport au condom
4. Le condom idéal selon les jeunes : attributs, volonté de payer , promotion
5. Rôles et responsabilité du jeune homme et de la jeune fille par rapport au condom

Attitudes des jeunes face au condom

POSITIVES

- Efficacité de la double protection du condom (axé à la GND)
- Praticité lors de RS pendant les règles (Sp TNR)
- RS sans souci/prévention de l'avenir
- Praticité par rapport aux autres méthodes PF
- Abordable par rapport aux autres méthodes et aux conséquences du GND (Sp IR TNR)
- Rallongement de la durée du RS (Sp IR TNR)

NEGATIVES

- Sensation d'étroitesse, gêne
- Réduction de plaisir
- Déchirure du condom
- Rallongement de la durée du RS
- Source de manque de confiance pour le couple (Sp IR TNR)
- Achat intimidant (Sp IR TNR)

AUTRES REMARQUES

- S'utilise avec partenaires occasionnelles (fille de passage et TDS)/infidélité
- S'utilise uniquement avec la partenaire fixe pendant la période d'ovulation (sp R)



Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
PROTECTOR PLUS	<input type="checkbox"/> Lubrifiant constant/facilitant la pénétration <input type="checkbox"/> Épais/Résistant <input type="checkbox"/> Texture : lisse <input type="checkbox"/> Abordable <input type="checkbox"/> Haute qualité <input type="checkbox"/> Fait durer le RS <input type="checkbox"/> Garant de la protection <input type="checkbox"/> Accessibilité <input type="checkbox"/> Durée de péremption longue <input type="checkbox"/> Nombre suffisant /boîte <input type="checkbox"/> Liberté d'utilisation (Sp A TVE)	<input type="checkbox"/> Lubrifiant : abondant/moindre/inconstant <input type="checkbox"/> Forte odeur (plastique, oignon) <input type="checkbox"/> Épais/fin /non résistant <input type="checkbox"/> Sensation d'étroitesse <input type="checkbox"/> taille : standard <input type="checkbox"/> Inodore (Sp A TNR) <input type="checkbox"/> Perturbateur de feeling <input type="checkbox"/> Se détache facilement <input type="checkbox"/> Marque vulgaire/basse qualité/non fiable (Sp A TNR) <input type="checkbox"/> Fait durer le RS (Sp A TVE) <input type="checkbox"/> Fait pousser les poils	<input type="checkbox"/> Épicerie <input type="checkbox"/> Grossiste <input type="checkbox"/> Hôtel <input type="checkbox"/> Hôpital <input type="checkbox"/> Bar <input type="checkbox"/> Pharmacie <input type="checkbox"/> CSB <input type="checkbox"/> Marchand ambulant <input type="checkbox"/> PE <input type="checkbox"/> Top Réseau	<input type="checkbox"/> Gratuit <input type="checkbox"/> 100 Ar/3U (Sp A) <input type="checkbox"/> 200 Ar/3U

Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
FIMAILO	<input type="checkbox"/> Lubrifiant : suffisant <input type="checkbox"/> Odeur : neutre <input type="checkbox"/> Fin/résistant <input type="checkbox"/> Taille adaptée pour les malagasy <input type="checkbox"/> Accessible <input type="checkbox"/> Gratuit <input type="checkbox"/> Empochable <input type="checkbox"/> Emballage bien décoré	<input type="checkbox"/> Bas de gamme <input type="checkbox"/> Fin <input type="checkbox"/> Déchirure facile <input type="checkbox"/> Lubrifiant : Trop/insuffisant/inconstant <input type="checkbox"/> Taille : petite (selon la taille du calibre) <input type="checkbox"/> Absence de parfum <input type="checkbox"/> Odeur : forte avec le plastique <input type="checkbox"/> Durée de péremption courte <input type="checkbox"/> Emballage : infantilisant (papillon) (Sp JHA TNR)	<input type="checkbox"/> Hôpital /CSB II <input type="checkbox"/> PE <input type="checkbox"/> Infirmierie Fokontany <input type="checkbox"/> Médecine préventive <input type="checkbox"/> Lycée <input type="checkbox"/> Hôtel	Gratuit

Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
GENERIQUE	<input type="checkbox"/> Taille adéquate <input type="checkbox"/> Fin/résistant/souple <input type="checkbox"/> Gratuit <input type="checkbox"/> Bonne odeur <input type="checkbox"/> Lubrifiant : suffisant	<input type="checkbox"/> Taille : trop petite <input type="checkbox"/> Lubrifiant : inconstant <input type="checkbox"/> Odeur : forte (plastique brûlé) <input type="checkbox"/> Peu connu par le public <input type="checkbox"/> Difficile à retenir <input type="checkbox"/> Accessible uniquement dans Génicure	<input type="checkbox"/> CSB II <input type="checkbox"/> Rue <input type="checkbox"/> Génicure	Gratuit

Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
KAMASUTRA	<input type="checkbox"/> Lubrifiant : suffisant <input type="checkbox"/> Parfum : différents types <input type="checkbox"/> Texture : striée <input type="checkbox"/> Anneau : bien résistant <input type="checkbox"/> Épais (Sp TNR) /fin,/souple <input type="checkbox"/> Importé <input type="checkbox"/> Connotation de sensualité	<input type="checkbox"/> Nécessité de consultation de l'avis de la partenaire <input type="checkbox"/> Cher <input type="checkbox"/> Incitation à l'expérimentation	<input type="checkbox"/> Pharmacie <input type="checkbox"/> Grande surface	2000 AR 2500 AR 3000 AR

Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
TAC TAC	<input type="checkbox"/> Sensation de fraîcheur /chaleur <input type="checkbox"/> Parfumé/inodore <input type="checkbox"/> Fin/Souple <input type="checkbox"/> Taille : diversifiée <input type="checkbox"/> Coloré <input type="checkbox"/> Lubrifiant suffisant <input type="checkbox"/> Packaging attrayant	<input type="checkbox"/> Cher <input type="checkbox"/> Inaccessible <input type="checkbox"/> Sensation de chaleur	<input type="checkbox"/> Pharmacie <input type="checkbox"/> Grande surface <input type="checkbox"/> Station de service	<input type="checkbox"/> 2000 AR/3U <input type="checkbox"/> 6000 AR <input type="checkbox"/> Don
DUREX (TVE)	<input type="checkbox"/> Epaisseur : Fin/souple/résistant <input type="checkbox"/> Sensation de fraîcheur <input type="checkbox"/> Parfumé <input type="checkbox"/> Lubrifiant :suffisant <input type="checkbox"/> Coloré		<input type="checkbox"/> Partenaire	<input type="checkbox"/> Gratuit

Connaissances et perceptions des condoms existants sur le marché.

	POSITIF	NEGATIF	LIEU	PRIX
Magnum (TNR)	<input type="checkbox"/> Grande taille <input type="checkbox"/> Épais <input type="checkbox"/> Résistant	<input type="checkbox"/> Trop grande taille	<input type="checkbox"/> Ami	<input type="checkbox"/> Don
Carex (TVE)	<input type="checkbox"/> Fin <input type="checkbox"/> Souple <input type="checkbox"/> Résistant	<input type="checkbox"/> Cher <input type="checkbox"/> Inaccessible	<input type="checkbox"/> Pharmacie <input type="checkbox"/> Grande surface	

Barrières à l'utilisation

Régulier	Irrégulier	Abandon
<ul style="list-style-type: none"><input type="checkbox"/> Contact indirect<input type="checkbox"/> Refus du partenaire<input type="checkbox"/> Confiance au partenaire<input type="checkbox"/> Utilisation méthode calendaire<input type="checkbox"/> Éjaculation hors du vagin<input type="checkbox"/> Rumeur sur effets secondaires pour les testicules (Sp TNR)		
<ul style="list-style-type: none"><input type="checkbox"/> Sensation d'ouverture/largesse<input type="checkbox"/> Perception de graisse solidifiée après RS (Sp TVE)<input type="checkbox"/> Présence d'odeur<input type="checkbox"/> Rejet par la religion catholique (Sp TNR)	<ul style="list-style-type: none"><input type="checkbox"/> Sensation de douleur (Sp TNR)<input type="checkbox"/> Enfilement accaparant (Sp TNR)<input type="checkbox"/> Rallongement de RS (Sp TNR)<input type="checkbox"/> Souci de déchirure<input type="checkbox"/> Gêné à l'achat (Sp TNR)	

Barrières à l'utilisation (suite)

Régulier	Irrégulier	Abandon
	<ul style="list-style-type: none"><input type="checkbox"/> Inefficacité par rapport aux IST (Sp TVE)<input type="checkbox"/> Sensation d'étroitesse (Sp TVE)<input type="checkbox"/> Dégoûtant (Sp TVE)<input type="checkbox"/> Exigence de savoir faire (Sp TVE)	<ul style="list-style-type: none"><input type="checkbox"/> IST maladies curables (Sp TVE)<input type="checkbox"/> Gêne/manque de plaisir<input type="checkbox"/> Source de dispute<input type="checkbox"/> Épais/odeur/lubrifiant inconstant/abondant<input type="checkbox"/> Futilité/manque de conviction<input type="checkbox"/> RS cogité (Sp TNR)<input type="checkbox"/> Fidélité à la partenaire<input type="checkbox"/> Souci de poils

Motivations à l'utilisation

Régulier	Irrégulier	Abandon
<input type="checkbox"/> Infidélité <input type="checkbox"/> Prévention de GND <input type="checkbox"/> RS sans souci		
<input type="checkbox"/> Non maîtrise du cycle par la partenaire (Sp TNR) <input type="checkbox"/> Prévention de la vie d'étudiant (Sp TNR)		
<input type="checkbox"/> Camouflage d'odeur (SP TVE) <input type="checkbox"/> Suite à la présence de perte vaginale (SP TVE) <input type="checkbox"/> Protection en cas d'ivresse (Sp TNR) <input type="checkbox"/> RS pendant les règles (Sp TNR)		<input type="checkbox"/> Multi partenariat <input type="checkbox"/> Peur de contraction de SIDA <input type="checkbox"/> Atteinte d'IST <input type="checkbox"/> Risque du retrait <input type="checkbox"/> Premier RS <input type="checkbox"/> Évitement de piège (Sp TNR)

Condition à l'utilisation future

Utilisation régulière

- Fidélité
- Changement des attributs du produit
- Présence de témoignage

Revenir à l'utilisation

- Condom de meilleure qualité
- Conscientisation sur l'irrégularité du cycle (Sp TNR)
- Contraction d'IST
- Levée de la honte à l'achat (Sp TNR)
- Infidélité (Sp TVE)
- Envie du partenaire pendant la période d'ovulation (Sp TVE)

Condom idéal pour les jeunes

Rmq : Moyenne générale des attributs prioritaires (quorum: 88 participants)

Attributs	Moyenne générale
Finesse et résistance	5,38
Parfum/odeur	3,97
Dimension	3,59
Lubrifiant	3,42
Texture	3,17
Couleur	2,33



Packaging

Forme :

- Rectangulaire (Manix, Tac Tac)
- Aplatie

Couleur :

- Sombre (noire, bleu) pour les garçons
- Claire (rouge, rose) pour les filles

Images :

- Couple (silhouette, face)
- Neutre (fleur, style jeans...)

Moyens de promotion suggérés par les jeunes

Régulier	Irrégulier	Abandon
Sensibilisation (établissement scolaire, night club, masse)		
Publicité TV/Radio/cinéma (témoignage, émission, Drama)		
Affiche		
Evénement pour les jeunes (sportifs, animations, bal des jeunes, spectacles)		
CIP par des jeunes dans les lieux d'affluence des jeunes		
	Facebook (Sp TVE)	
Production d'une chanson (Régulier et Abondan)	Panneau publicitaire (Sp TNR) SMS (Sp TVE) VAD Distribution gratuite	Coller le condom dans des magazines (Sp TNR) PLV (Sp TNR)



Lieux de vente suggérés

Épicerie

Pharmacie

Grande surface (coin adulte)

Station service

Hôtel (chambre)

Bar

Night club

Hôpital

Gargote (spec TVE)

Kiosque



Jeunes Hommes, Jeunes Filles et condom

Jeune homme	Jeune fille
<ul style="list-style-type: none"><input type="checkbox"/> Demander l'avis du partenaire sur le condom adéquat<input type="checkbox"/> Initier à la discussion<input type="checkbox"/> Inciter la partenaire à l'utilisation<input type="checkbox"/> Prendre la décision finale à l'utilisation<input type="checkbox"/> Trouver les astuces pour ne pas gêner le partenaire<input type="checkbox"/> Acheter<input type="checkbox"/> Ouvrir le condom<input type="checkbox"/> Poser<input type="checkbox"/> Changer<input type="checkbox"/> Enlever<input type="checkbox"/> Nouer après usage<input type="checkbox"/> Jeter<input type="checkbox"/> Maîtriser le mode d'utilisation<input type="checkbox"/> Stocker	<ul style="list-style-type: none"><input type="checkbox"/> Choisir le condom qui lui convient<input type="checkbox"/> Initier à la discussion<input type="checkbox"/> Inciter le partenaire à l'utilisation<input type="checkbox"/> Prendre la décision finale à l'utilisation*<input type="checkbox"/> Trouver les astuces pour ne pas gêner le partenaire<input type="checkbox"/> Rappeler le partenaire à l'achat/utilisation*<input type="checkbox"/> Acheter* (moindre)<input type="checkbox"/> Ouvrir le condom/paquet*<input type="checkbox"/> Poser*<input type="checkbox"/> Enlever *<input type="checkbox"/> Nouer après usage*<input type="checkbox"/> Jeter*<input type="checkbox"/> Maîtriser le mode d'utilisation<input type="checkbox"/> Stocker* (cause de dispute)<input type="checkbox"/> Vérifier la date de péremption*

Remarques:

- * = Infime minorité
- Stockage une boîte de 3 en moyenne à Tamatave



Conclusions et recommandations

Conclusions	Recommandations
<input type="checkbox"/> Différence de pratique pour les trois segments	<input type="checkbox"/> S'appuyer beaucoup plus sur les résultats des utilisateurs réguliers (expériences/perceptions/volonté de payer)
<input type="checkbox"/> Énoncée récurrente de la gêne et de la sensation d'étroitesse pendant le rapport sexuel avec condom	<input type="checkbox"/> Inclure dans les messages éducatifs/promotionnels du rôles de l'anneau
<input type="checkbox"/> Plusieurs remarques sur la quantité et inconstance de lubrifiant	???
<input type="checkbox"/> Plainte fréquente de la déchirure du condom	<input type="checkbox"/> Reparler du mode d'utilisation et des précautions à prendre lors de la promotion du nouveau condom jeune.

Conclusions et recommandations (suite)

Conclusions	Recommandations
<input type="checkbox"/> Persistance de la honte à l'achat	<input type="checkbox"/> Produire un packaging discret <input type="checkbox"/> Mettre le moins d'inscription possible
	<input type="checkbox"/> Reconsidérer les lieux de vente proposés par les jeunes
<input type="checkbox"/> Moindre importance accordée pour le parfum mais plainte axée sur l'odeur de plastique ressentie sur le condom	<input type="checkbox"/> Neutraliser l'odeur de plastique
<input type="checkbox"/> Le parfum du condom peut être un sujet de discordance dans le couple. <input type="checkbox"/> Ce sont les jeunes filles qui ont la décision finale concernant le parfum de condom à utiliser.	<input type="checkbox"/> Plus impliquer les jeunes filles dans les tests de parfum .

Conclusions et recommandations (suite)

Conclusions	Recommandations
<input type="checkbox"/> Plainte par rapport à l'étroitesse et par rapport au détachement du condom	<input type="checkbox"/> Voir la possibilité d'avoir 2 différentes dimensions du condom.
<input type="checkbox"/> Les jeunes sont conscients qu'il est très important de préserver leur avenir en évitant les GND	<input type="checkbox"/> Considérer cet aspect émotionnel dans le positionnement du nouveau produit.
<input type="checkbox"/> Il a été noté que beaucoup de jeunes filles ne sont pas encore capable de négocier l'utilisation du condom et de refuser un rapport sexuel non protégé	<input type="checkbox"/> Intégrer dans les communications : <ul style="list-style-type: none">• Qu'une fille soucieuse de l'utilisation du condom pour la prévention du GND et des IST est une marque d'indépendance et d'autonomie.• Rappeler dans les communications pour les jeunes, la gravité de la conséquence des IST récidivantes et les séquelles dans le futur/avenir.



MERCI DE VOTRE ATTENTION !





MAI 2013

FOQUS ON RURAL YOUTH DASHBOARD

Prévention des grossesses précoces et des grossesses non désirées auprès des jeunes ruraux : *Connaissances, attitudes, pratiques et comportements.*

à Miarinarivo, Antsohihy et Ihosy



Objectifs généraux de l'étude

	GP	GND
Collecter les informations relatives à :	La première activité sexuelle	
	Leurs connaissances en matière de PF	
	Leurs pratiques de PF	
	Les rôles respectifs de chaque partenaire	
	Les barrières et motivations à l'utilisation /acquisition de services ou méthodes PF	
	Les personnes influentes pour les jeunes	
	Attitudes, comportements et pratiques en cas de GND	
Comprendre :		La vision/les perspectives d'un jeune couple non en union en zone rurale

Les groupes cibles de l'étude

145 jeunes ruraux dont 72 jeunes filles et 73 jeunes hommes, majorité de niveau secondaire, sexuellement actifs. Habitant à Miarinarivo, Ihosy et Antsohihy.

Constat général :

❑ Il n'y a pas de différences significatives entre les informations reçues des jeunes de 15 à 19 ans et de 20 à 24 ans.



La première activité sexuelle des jeunes

	15 – 19 ans		20 - 24 ans	
	Jeunes Femmes	Jeunes Hommes	Jeunes Femmes	Jeunes Hommes
Age de 1 ^{ère} fréquentation	13 ans	15 ans	14 ans	15 ans
Age des 1 ^{er} RS	13 ans	16 ans	-	-
Age Idéal de la 1 ^{ère} grossesse	23 ans	24 ans	25 ans	25 ans



Jeunes, Genre & PF



Perception du couple en cas de GND

Jeune femme	Jeune homme
<ul style="list-style-type: none"><input type="checkbox"/> Déception , Peur, inquiétude, crainte, problème , échec<input type="checkbox"/> Impressionné<input type="checkbox"/> Joie<input type="checkbox"/> Colère<input type="checkbox"/> Souffrance<input type="checkbox"/> Insouciance<input type="checkbox"/> Piège du partenaire	<ul style="list-style-type: none"><input type="checkbox"/> Déception , angoisse, culpabilité, panique<input type="checkbox"/> Acceptation de la situation<input type="checkbox"/> Joie<input type="checkbox"/> Appréhension du jugement de la société<input type="checkbox"/> Perspective de mariage

Mesures prises par le couple en cas de GND

Jeune femme	Jeune homme
<ul style="list-style-type: none"><input type="checkbox"/> Avortement<input type="checkbox"/> Se préparer à la grossesse/accouchementPréparation au mariage<input type="checkbox"/> Parler au parent<input type="checkbox"/> Confirmation de la grossesse<input type="checkbox"/> Discuter avec le partenaire<input type="checkbox"/> Réfléchir à la situation<input type="checkbox"/> Consulter le médecin<input type="checkbox"/> Se séparer du partenaire<input type="checkbox"/> Poursuite en justice	<ul style="list-style-type: none"><input type="checkbox"/> Se Préparer au mariage<input type="checkbox"/> Se préparer à la naissance : <i>recherche de moyen financier, achat matériels..</i><input type="checkbox"/> Refus de paternité / Test de paternité<input type="checkbox"/> Avortement<input type="checkbox"/> Se suicider<input type="checkbox"/> Se séparer



Personnes influentes en cas de GND

	Jeune femme	Jeune homme
Personne informée par le jeune homme	<input type="checkbox"/> Membre de la famille <i>(parent, mère, père, frère)</i> <input type="checkbox"/> Ami	<input type="checkbox"/> Membre de la famille <i>(mère, parent, père, sœur)</i> <input type="checkbox"/> Ami
Personne informée par la jeune fille	<input type="checkbox"/> Membre de la famille <i>(mère, sœur, parent, tante)</i> <input type="checkbox"/> Amie <input type="checkbox"/> Partenaire <input type="checkbox"/> Médecin	<input type="checkbox"/> Membre de la famille <i>(mère, parent, aîné)</i> <input type="checkbox"/> Amie
Personnes consultées par le couple	<input type="checkbox"/> Membre de la famille <i>(parent, mère, tante, frère, cousine)</i> <input type="checkbox"/> Amie <input type="checkbox"/> Médecin <input type="checkbox"/> Sage femme	<input type="checkbox"/> Membre de la famille <i>(parents, mère, aîné)</i> <input type="checkbox"/> Ami(e)s <input type="checkbox"/> Médecin <input type="checkbox"/> Sage femme <input type="checkbox"/> Aîné du village



Déroulement de la décision en PF

	Jeune femme	Jeune homme
Déroulement de la décision en général	Décision : Consensuelle De la jeune fille Du jeune homme	Décision : consensuelle Imposition de la jeune fille Aucune discussion Imposition du jeune homme Considération des conseils des parents
Qui initie la discussion	Jeune fille Jeune homme	Jeune homme Jeune fille Absence de conversation
Qui décide	Jeune fille Jeune homme Couple	Jeune homme Jeune femme Couple
Qui paie le produit/service	Jeune homme Jeune fille Gratuit	Jeune homme (condom) Gratuit Jeune fille

Rôles spécifiques en PF

Jeune femme	Jeune homme
<ul style="list-style-type: none"><input type="checkbox"/> Suivi des cycles<input type="checkbox"/> Utilisation régulière et continue<input type="checkbox"/> Suivi et contrôle de PF<input type="checkbox"/> Aucun rôle<input type="checkbox"/> Acceptation de la décision du jeune homme sur méthode à utiliser<input type="checkbox"/> Abstinence<input type="checkbox"/> Utilisation en cachette<input type="checkbox"/> Rappel du retrait pendant l'ovulation	<ul style="list-style-type: none"><input type="checkbox"/> Suivi ou apprentissage du calendrier d'ovulation / utilisation de méthode<input type="checkbox"/> Appui financier<input type="checkbox"/> Décider la méthode à utiliser<input type="checkbox"/> Acceptation de la décision du partenaire<input type="checkbox"/> Suivi état de santé / Consultation trimestrielle<input type="checkbox"/> Suivi conseil médecin<u>Par rapport au préservatif :</u><input type="checkbox"/> Achat du préservatif et utilisation<input type="checkbox"/> Rappel de l'utilisation de condom<input type="checkbox"/> S'assurer que le condom ne manque pas<input type="checkbox"/> Enfiler le préservatif<input type="checkbox"/> Jeter le préservatif après utilisation

Les acquis chez les jeunes filles

Par ordre décroissant :

- Conscience de prévention des GND
- Le sentiment d'être soutenues par les pairs
- Conscience de prévention des IST
- Connaissance de la PF à travers les sensibilisations
- Conviction à l'efficacité de la PF
- Mauvaise expérience de la méthode calendaire
- Praticité des méthodes de PF modernes
- Gratuité de quelques méthodes de PF modernes



Les acquis chez les jeunes hommes

Par ordre décroissant :

- Conscience de prévention des GND
- Conscience de prévention d'IST
- Sentiment d'être soutenu par l'entourage (amis, fratrie, enseignants,...)
- Perception que les effets secondaires des méthodes modernes sont moindres
- Abordabilité / gratuité / Accessibilité du condom

Les perceptions et croyances chez les jeunes filles

Par ordre décroissant :

- Craintes des effets secondaires
- Perception que la PF moderne non appropriée pour les nullipares
- Crainte de risque de stérilité
- Peur d'être su par les parents
- Déconseillé par l'entourage
- Confiance en la méthode de calendrier
- Stigmatisation des utilisatrices de PF moderne
- Méconnaissance des méthodes PF moderne et de leurs avantages.



Les perceptions et croyances chez les jeunes hommes

Par ordre décroissant :

- Craintes des effets secondaires
- Perception d'un manque de plaisir avec le condom
- Confiance aux méthodes alternatives (calendrier, retrait)
- Manque de connaissance pour les méthodes modernes de PF
- Problème financier.

Que faire en cas de refus de PF par le partenaire ?

Jeunes Femmes

Négocier :

Evoquer les avantages de la PF

Evoquer les conséquences du GND sur l'avenir du couple

Invoquer l'utilité de la prudence

Insister la pratique de PF

Accepter sa décision / si mariage en vue

Utiliser en cachette

Se séparer du partenaire

Si GND :

Menacer de garder le bébé

Demander les dispositions et conséquences

Jeunes Hommes

Se séparer avec la partenaire

Négocier, discuter, convaincre, moraliser :

=) Vanter les avantages du PF moderne

=) Evoquer les inconvénients du condom pour utiliser d'autres méthodes

Refus de RS/abstinence

Utilisation du calendrier

Si GND :

Ne pas reconnaître l'enfant



Les historiques d'acquisition

	Jeune Femme	Jeune Homme
Méthodes traditionnelles (Calendaire, retrait)	Programme SVT à l'école	
	Partenaire	
Méthodes modernes (Pilule, injectable, DIU...)	CSB Centre libre (MSI, SAF, TR...) Agents communautaires Partenaires	
	Partenaire (condom)	Sensibilisation de masse (Cinémobile)

Pour passer des messages aux jeunes (1/2)

Canaux	Supports	Jeune fille	Jeune homme
Mass média	Audio visuel	Radio local (Théâtre radiophonique, documentaires, variétés, dédicace, évangélique...)	
	Support imprimé	Affichage Livre	Affichage
MID Média	Evénements	Pratique du sport (foot, basket, hand, pétanque, karaté...)	
CIP			Sensibilisation de masse (MVU...)
Autres		Ballade (ami, amoureux) Vidéo Discussion entre ami, voisin, entourage...	
			Combat de coq

Pour passer des messages aux jeunes (2/2)

	Jeune fille	Jeune homme
Personnes influentes	<ul style="list-style-type: none">•Personnel de santé (médecin, sage femme, AC)•Professeur de SVT•Ami(e)s•Membres de famille (sœurs, frères, mères, cousines)	
	<ul style="list-style-type: none">•Partenaires	

NB: Importance de la décision personnelle pour les non utilisateurs

Les expériences (CatEx)

	Jeune fille	Jeune homme
Méthode traditionnelle	<ul style="list-style-type: none"> <input type="checkbox"/> Confiance aux expériences du partenaire <input type="checkbox"/> Utilisation suite au témoignage des proches, anciennes utilisatrices de PF moderne 	<ul style="list-style-type: none"> <input type="checkbox"/> Perception de RS comme étant une émission de sperme dans le partenaire <input type="checkbox"/> Importance de l'intervention de professeur de SVT sur le choix de la méthode <input type="checkbox"/> Assurance et maîtrise de la méthode
Méthode moderne	<ul style="list-style-type: none"> <input type="checkbox"/> Tranquillité d'esprit et liberté de RS <input type="checkbox"/> Pratique à l'insu du partenaire <input type="checkbox"/> Prise de décision suite au conseil du partenaire <input type="checkbox"/> Pratique suite aux témoignages des utilisatrices <input type="checkbox"/> Recherche de la méthode adéquate pour son état de santé 	<ul style="list-style-type: none"> <input type="checkbox"/> Recherche de la PF adéquate pour le partenaire

Perceptions positives des méthodes modernes 1/2

	CONDOM	INJECTABLE	PILLULE
	Evitement des GND		
ASPECTS POSITIFS	<input type="checkbox"/> Seule prévention des IST <input type="checkbox"/> Espacement des naissances <input type="checkbox"/> Accessible	<input type="checkbox"/> Non contraignant (tous les 3 mois) <input type="checkbox"/> Procure une tranquillité d'esprit <input type="checkbox"/> Espacement /limitation des naissances <input type="checkbox"/> Permet des RS illimités <input type="checkbox"/> Fortifie	<input type="checkbox"/> Procure une tranquillité d'esprit <input type="checkbox"/> <i>Espacement de naissance</i> <input type="checkbox"/> <i>Permet des RS illimités</i>
	<u>Spécifique JF</u> <input type="checkbox"/> Abordable <input type="checkbox"/> Gain de satisfaction avec le lubrifiant <input type="checkbox"/> Peut être trouvé à tout moment	<input type="checkbox"/> Adéquat pour les étourdiées Confort : absence de règles	<input type="checkbox"/> <i>Efficace : forte dose</i> <input type="checkbox"/> Fortifie <input type="checkbox"/> Gain de poids Régularité des règles <input type="checkbox"/> <i>Menstruation normale</i> <input type="checkbox"/> Protection contre les maladies <input type="checkbox"/> <i>Provoque les règles</i> <input type="checkbox"/> <i>Pratique (pas besoin de prestataire)</i> <input type="checkbox"/> Réversible
	<u>Spécifique JH</u> <input type="checkbox"/> Double protection	<input type="checkbox"/> Gain de poids <input type="checkbox"/> Se dissout dans l'organisme	

Perceptions négatives des méthodes modernes 2/2

	CONDOM	INJECTABLE	PILLULE
ASPECTS NEGATIFS	<input type="checkbox"/> Stérilité <input type="checkbox"/> Insatisfaction partenaire <input type="checkbox"/> Incitation à l'infidélité	<input type="checkbox"/> Gain / perte de poids <input type="checkbox"/> Problèmes utérins (crampe- diminution libido- trouble hormonal) <input type="checkbox"/> Irréversible <input type="checkbox"/> fausse couche <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Abondance/arrêt des règles <input type="checkbox"/> Stérilité <input type="checkbox"/> Stigmatisation	<input type="checkbox"/> Maux d'estomac <input type="checkbox"/> Stérilité <input type="checkbox"/> Perte/prise de poids <input type="checkbox"/> fausse couche / mort- né / malformation <input type="checkbox"/> Problème utérin/kyste/destruction <input type="checkbox"/> Omission <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Vertige <input type="checkbox"/> Trouble hormonale <input type="checkbox"/> Maux de tête <input type="checkbox"/> Difficulté de fécondation après utilisation <input type="checkbox"/> Chute de cheveux <input type="checkbox"/> Nausée <input type="checkbox"/> Manque d'appétit <input type="checkbox"/> Règle irrégulière
	<u>Spécifique JF</u> <input type="checkbox"/> Gène <input type="checkbox"/> Risque de mycose <input type="checkbox"/> Augmentation pénis <input type="checkbox"/> Destruction du col	<input type="checkbox"/> Malformation	
	<u>Spécifique JH</u> <input type="checkbox"/> Risque de déchirure Compression pénis Odeur	<input type="checkbox"/> Provoquant une grossesse extra utérine	

Perceptions des méthodes modernes de longue durée

	DIU	IMPLANT
ASPECTS POSITIFS	<ul style="list-style-type: none"> <input type="checkbox"/> Évite la GND <input type="checkbox"/> Longue durée <u>Spécifique JF</u> <input type="checkbox"/> Limite les naissances / Possibilité d'épargne <input type="checkbox"/> Donne de l'appétit <input type="checkbox"/> Régularise les cycles <u>Spécifique JH</u> <input type="checkbox"/> Procure un esprit tranquille <input type="checkbox"/> Retirable si besoin 	<ul style="list-style-type: none"> <input type="checkbox"/> Evite la grossesse <input type="checkbox"/> Repousse/espace les naissances <input type="checkbox"/> Procure un esprit tranquille <input type="checkbox"/> Gain de temps (triennal) <u>Spécifique JF</u> <input type="checkbox"/> Régularise le cycle <input type="checkbox"/> Fait maigrir / grossir/ bonne forme <u>Spécifique JH</u> <input type="checkbox"/> Longue durée <input type="checkbox"/> Gain de poids <input type="checkbox"/> Retrait en temps voulu <input type="checkbox"/> Dans les normes
ASPECTS NEGATIFS	<ul style="list-style-type: none"> <input type="checkbox"/> Risque de cancer / perte/blessure <input type="checkbox"/> Risque de stérilité <input type="checkbox"/> Perte de poids <input type="checkbox"/> Risque d'IST par présence de corps étranger <input type="checkbox"/> Durée trop longue 	<ul style="list-style-type: none"> <input type="checkbox"/> Risque de stérilité /Hypertension <input type="checkbox"/> Perte/gain de poids <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Favorise les IST <input type="checkbox"/> Risque de déplacement du bâtonnet <input type="checkbox"/> Activité limitée <input type="checkbox"/> (JH) Difficulté de fécondation/malformation après utilisation /Substance forte provoquant maladie
	<ul style="list-style-type: none"> <u>Spécifique JF</u> <input type="checkbox"/> Pose douloureuse <input type="checkbox"/> Gène pendant RS 	<ul style="list-style-type: none"> <u>Spécifique JF</u> <input type="checkbox"/> Vertige / Chute de cheveux <input type="checkbox"/> Abondance de règles

Perceptions des méthodes alternatives

	CALENDRIER	RETRAIT	COLLIER
	<input type="checkbox"/> Evite les GND		
ASPECTS POSITIFS	<input type="checkbox"/> Aucune dépense <input type="checkbox"/> Aucun effet secondaire <input type="checkbox"/> Méthode naturelle		<input type="checkbox"/> Aucun effet secondaire <input type="checkbox"/> Méthode naturelle <input type="checkbox"/> Facile à trouver
ASPECTS NEGATIFS	<input type="checkbox"/> Risque d'erreur de comptage de jour <input type="checkbox"/> Méthode non maîtrisée	<p><u>Spécifique JF</u></p> <input type="checkbox"/> Insatisfaction du partenaire <input type="checkbox"/> Possibilité de fuite	<p><u>Spécifique JF</u></p> <input type="checkbox"/> Oubli de déplacement de l'anneau <input type="checkbox"/> Incertain
		<p><u>Spécifique JH</u></p> <input type="checkbox"/> Grossesse en cas de retard de retrait	<p><u>Spécifique JH</u></p> <input type="checkbox"/> Nécessité de formation

Constats et recommandations

Constats	Recommandations
La famille « nucléaire » tient en même temps une grande place, mais aussi est influente pour les jeunes ruraux	Intégrer la famille et l'amour et le soutien familial dans les communications pour les jeunes ruraux.
Les réponses de tous les participants convergent vers la prévention des grossesses non désirées , la perception de risque des grossesses précoces , n'a pas été explicitement évoquée.	Expliquer dans les CIP la nuance et l'imbrication de la GP/ GND
Les jeunes ruraux sont prêts à négoier l'utilisation de PF avec leurs partenaires en évoquant les avantages des méthodes.	Renforcer la connaissance des méthodes contraceptives modernes chez les jeunes ruraux .

Constats et recommandations

Constats	Recommandations
Les rumeurs et les fausses croyances autour les méthodes de PF modernes, sont présentes mêmes auprès des jeunes.	Adresser les rumeurs et les fausses croyances pendant les communications auprès des jeunes ruraux, en utilisant tous les canaux disponibles.
Le personnel de santé figure parmi les personnes les plus influentes pour les jeunes ruraux.	Le service de conseil jeunes s'avèrerait pertinent en milieu rural

Ciblage : Audience profile

Audience
Insight



TONY l'aventurier prévenant en quête de réussite

Issu d'une famille de 6 enfants, Tony est âgé de 19 ans, est de niveau d'étude secondaire, il était contraint de quitter l'école car ses parents ne pouvaient plus subvenir à ses frais de scolarité.

Tony exerce des petits boulots et des travaux de champs lorsqu'il est à la campagne. En effet, Tony affirme qu'il a vraiment besoin d'argent pour être bien vu par sa copine et ses autres partenaires. Tony a commencé à fréquenter les filles depuis l'âge de 15 ans, lorsqu'il reste à la campagne, Tony a des rapports sexuels avec les jeunes filles, tandis que lorsqu'il monte en ville, Tony se rend également auprès des travailleuses de sexe pour acquérir des expériences. Tony affirme qu'il aime les filles et qu'il profite de chaque occasion pour avoir un rapport sexuel.

Bien que sexuellement actif, Tony craint les IST . En effet il en a déjà contracté et surtout lorsqu'il est en ville, il dit qu'il fait même des récidives. Tony connaît comment il faut faire en cas d'IST, aussi, il ne consulte pas un médecin mais se fait guider par ses amis qui lui procurent même des médicaments pour l'auto-médication.

Tony a très peur que sa copine qui est sa partenaire fixe ou que ses partenaires occasionnelles tombent enceintes et qu'il soit forcé à abandonner ses études pour se marier d'un mariage forcé . La possibilité d'être traîné en justice et d'être emprisonné en cas de grossesse chez une fille mineure est également une grande menace pour lui.

Ciblage : Audience profile



TONY l'aventurier prévenant en quête de réussite (suite)

Lorsque Tony est en ville, il dit qu'il n'utilise pas systématiquement de condom. Voici ce qu'il dit « *pour moi le condom ne donne pas du vrai plaisir ; pour ce qui est de la prévention des IST : je sais avec quelle fille je devrais ou non utiliser le condom car je reconnais si la fille est porteuse de maladie ou non, rien qu'en la voyant par son apparence* ». Par contre lorsque Tony est à la campagne, il commence à prendre des mesures pour se protéger par la méthode de calendrier, ou la pratique de coït interrompu ou l'abstinence pendant les jours féconds. Tony pratique le football et le rugby pendant ces temps libres. Il aime écouter la radio, se promener avec ses copains, regarder des VCD et faire des jeux de société comme le domino.

Tony voudrait obtenir un travail stable et bien rémunéré, fonder une famille et avoir une vie heureuse. Tony voudrait gagner le respect de ses beaux parents et de la société plus tard lorsqu'il aurait beaucoup d'argent, des possessions de bien matériels ou encore un cheptel de Zébu.

Ciblage : Audience profile



NATHALIE : La responsable en quête d'affection

Agé de 18 ans, Nathalie est issue d'une famille de 5 enfants. Elle est de niveau d'étude secondaire.

Nathalie a commencé à fréquenter les garçons à 13 ans et a eu son premier rapport sexuel à 14 ans.

Depuis l'adolescence, réussir les études est classé parmi les choses les plus importantes, elle pense que c'est grâce aux diplômes qu'elle peut assurer son avenir et trouver un travail stable et rémunérateur, comme travailler comme fonctionnaire. Cependant, Nathalie a été contrainte de quitter l'école en classe de 3^{ème}, faute de moyens financiers de ses parents. Aussi, Nathalie considère que l'argent est essentiel pour subvenir aux besoins quotidiens et pour être indépendante des parents. Les valeurs morales telles que le fihavanana, les bonnes conduites, le respect d'autrui et la foi sont autant de vertus qui sont chères à Nathalie.



Les aspirations de Nathalie seraient de se marier légitimement fonder une famille, et de posséder des biens matériels à commencer par de beaux vêtements, mais également une richesse qui peut assurer l'avenir.

Comme tous les jeunes, dit-elle « *j'ai besoin de l'amour de mon partenaire, être heureuse dans le couple, et avoir le support de ma famille ,surtout de mes parents* ».

Nathalie a très peur de tomber enceinte et surtout de devoir avorter en cas de grossesse. En effet , elle reconnaît qu'une grossesse non désirée gâcherait son avenir. Elle craint également de contracter une IST, d'ailleurs elle n'ose pas dire si elle l'a déjà contracté auparavant ou non. Nathalie utilisait la méthode de calendrier , ou pratiquait le coït interrompu, mais actuellement suite à des sensibilisations, Nathalie a adopté la contraception par l'injectable.

Nathalie aime beaucoup faire du sport comme le foot, le basket pendant ses temps libres, elle aime passer du temps avec son copain, faire des ballades en amoureux et aussi se promener avec ses amis.

Comme Nathalie n'a pas de télévision chez elle, elle préfère écouter la radio ou aller dans les salles de vidéos pour regarder des films.

Ciblage : Audience profile

PRISCA : L'insouciant en quête d'identité

Issue d'une famille de 3 enfants, Prisca a 17 ans. Elle étudie au lycée, en classe de première.

Lorsque Prisca avait quinze ans, elle était fidèle à son copain. Elle se disait : « *je ne fais pas de rapport sexuel que si la liaison est sérieuse* » mais en fin de compte elle a eu beaucoup d'expériences sexuelles. « *De nos jours, les garçons sont infidèles et mieux vaut faire autant parce que c'est la mode* » dit-elle. Dès fois, Prisca sort avec des hommes plus âgés qu'elle qui ont de l'argent pour la sponsoriser ou lui offrir des cadeaux dit-elle.

En faisant l'amour avec son copain, Prisca n'utilise pas de condom parce qu'elle ne trouve pas de plaisir et elle pense que le lubrifiant de la capote rend malade. Pourtant, les IST et le VIH commencent à se répandre actuellement dit-elle, et elle avoue qu'elle a peur d'en contracter. Ce qui lui fait le plus peur surtout c'est de tomber enceinte.

Ciblage : Audience profile

Audience
Insight

Prisca dit qu'il lui arrive d'avorter très fréquemment, en prenant le conseil de ses amies qui lui disent de prendre du Cytotec ou de faire des efforts physiques intenses (course, broser le parquet ...) pour provoquer l'avortement. Prisca n'utilise pas de méthode PF parce qu'elle croit aux rumeurs que les méthodes de PF rendent stérile, provoque une prise de poids ou simplement parce que son copain ne veut pas qu'elle fasse de PF.

Prisca ne fait de consultation chez le docteur que très rarement parce qu'elle a honte, surtout en cas d'IST. C'est pour cela qu'elle n'a jamais fait de dépistage de VIH. Si elle a des soucis concernant la reproduction, c'est avec ses amies que Prisca en parle le plus.

Pendant ses temps libres, Fréquente les boîtes de nuits ou les karaokés.

Sinon, à part la sortie avec ses amies, Prisca reste à la maison pour regarder la télé ou lire des bouquins ou encore écouter de la musique comme Princio, Ambondrona ou Justin Beiber.

Dans la vie, Prisca souhaite réussir, avoir sa propre entreprise pour gagner beaucoup d'argent. Mais pour le réaliser, elle aimerait d'abord partir à l'étranger pour étudier si elle aurait les moyens.



Healthy lives. Measurable results.



MADAGASCAR (2013) – FoQus study : Prévention des grossesses précoces et des grossesses non désirées auprès des *jeunes ruraux* :
Connaissances, attitudes, pratiques et comportements.

À Miarinarivo, Antsohihy et Ihosy



SOMMAIRE

SOMMAIRE	2
REMERCIEMENTS	3
LISTE DES ACRONYMES	4
<i>BACKGROUND ET JUSTIFICATION DE L'ETUDE</i>	5
<i>STUDY DESIGN & ECHANTILLONAGE</i>	10
<i>RESULTATS SAILLANTS DE L'ETUDE</i>	18
<i>DE LA RECHERCHE A L'ACTION</i>	20
<i>LES RESULTATS DETAILLES DE L'ETUDE</i>	22
ARCHETYPE DES JEUNES RURAUX	22
LES MOTIVATIONS À L'ADOPTION DE LA MÉTHODE CONTRACEPTIVE MODERNE PAR LES JEUNES FEMMES	25
LES MOTIVATIONS A L'ADOPTION DE LA METHODE CONTRACEPTIVE MODERNE PAR LES JEUNES HOMMES	26
BARRIÈRES À L'UTILISATION DES MÉTHODES CONTRACEPTIVES PAR LES JEUNES FEMMES	27
BARRIERES A L'UTILISATION DES METHODES CONTRACEPTIVES PAR LES JEUNES HOMMES	28
LES RÉACTIONS DES JEUNES FACE AU REFUS DU PARTENAIRE D'UTILISER UNE MÉTHODE CONTRACEPTIVE MODERNE	29
LA CONNAISSANCE DE LA METHODE DE CONTRACEPTION MODERNE PAR LES JEUNES RURAUX	31
LES SOURCES D'INFORMATION DES JEUNES RURAUX	34
ANNEXES: Dashboards	35

REMERCIEMENTS

Cette présente étude a été rendue possible grâce aux supports et à l'assistance provenant de United States Agency for International Development. Les résultats consignés dans ce présent rapport ne reflètent pas nécessairement les points de vue de l'USAID, mais engagent uniquement les auteurs de ce rapport.

Nous voudrions adresser nos remerciements à toutes les autorités locales qui nous ont accueillies et qui nous ont ouverts la porte de leur communauté, afin que nous puissions approcher les cibles et leur parler de leurs réalités.

Nous exprimons également notre gratitude à toutes les personnes qui nous ont épaulées pour le recrutement des participants de cette étude.

Et finalement, nous sommes très reconnaissants à toutes les jeunes femmes et les jeunes hommes résidant à Antsohihy, Miarinarivo et Ihosy qui ont volontairement acceptés de participer à cette étude et qui nous ont livré leurs réalités et leurs intimités.

L'équipe de Recherches

Bakoly RAHAIVONDRAFAHITRA , Superviseur des Recherches Qualitatives

Hiaro Zo ANDRIANOLENINA, Superviseur des Recherches Qualitatives

Muriel RALAMBO , Superviseur des Recherches Qualitatives

Anja RAKOTOMALALA, Coordinateur des Recherches Qualitatives

LISTE DES ACRONYMES

CCC :	Communication pour le Changement de Comportement
DIU :	Dispositif Intra-utérin
GND :	Grossesses non désirées
IST :	Infections sexuellement transmissibles
PF :	Planification Familiale
SA :	Sexuellement actif
SVT :	Science de la Vie et de la Terre
VIH :	Virus d'Immunodéficience Humaine

BACKGROUND ET JUSTIFICATION DE L'ETUDE

Dans le cadre du nouveau projet Integrated Social Marketing financé par l'USAID, PSI/Madagascar va principalement orienter ses activités de CCC (communication pour le changement de comportement) prestation de service de santé ciblant les jeunes de 15 à 24 ans autour de l'adoption des comportements de santé suivants :

- Le report de l'âge de la première grossesse par l'utilisation de méthodes contraceptives modernes et
- L'utilisation du préservatif pour la double protection (prévention des IST/VIH et méthode contraceptive).

Les prestataires de services de santé seront quant à eux encouragés à offrir aux jeunes un large choix de méthodes contraceptives.

Cette nouvelle orientation intervient également avec l'expansion des sites Top Réseau vers les zones rurales nécessitant une approche de promotion des services Top Réseau spécifique pour les jeunes ruraux de 15 à 24 ans.

Cependant, il faut mentionner que nous ne disposons pas de suffisamment d'informations qualitatives sur la santé reproductive et sur les dynamiques de « genre » concernant l'utilisation de la planification familiale auprès des jeunes ruraux de 15 à 24 ans sexuellement actifs, sans enfants et non en union.

Par conséquent, la présente étude visera à collecter et à compléter toutes les informations sur respectivement ces jeunes femmes et ces jeunes hommes ruraux concernant leurs pratiques en matière de prévention des grossesses précoces et leurs attitudes face aux grossesses non désirées.

Santé reproductive des jeunes selon l'EDS 2008-2009

Chiffres concernant les jeunes de 15-19 ans, non en union et sexuellement actifs

Pour les femmes

- a) 11,8 % des femmes appartenant à la tranche d'âge 15-19 ans, avait 15 ans à leur première union (ici, en union reprend la définition dans l'EDS qui qualifie toutes personnes qui se sont déclarées mariées ou vivant maritalement avec un(e) partenaire).
- b) 7,5% des filles sexuellement actives de 15-19 ans utilisent une méthode contraceptive moderne
- c) 13,9 % des femmes non en union, sexuellement actives utilisent de la contraception moderne dont la répartition par méthode se fait comme suit : 3,9% pilule, 7,4% injectable, 0,1 % implants, 2,6 % le condom masculin.

- d) Concernant l'exposition aux messages sur la planification familiale auprès de la tranche d'âge 15-19 ans : 22,7% ont entendu des messages à la radio, 10,1% ont vu des messages à la télé, et 2,6% ont lu des messages dans les journaux ou les magazines.
- e) 19,8% des filles rurales ont eu des rapports sexuels avant d'atteindre 15ans
- f) 1,7% des jeunes femmes et 3,7% des jeunes hommes ont utilisé un condom au cours des premiers rapports sexuels

Pour les hommes

- a) 0,2 % des hommes appartenant à la tranche d'âge 15-19 ans, avait 15 ans à leur première union (*ici, en union reprend la définition dans l'EDS qui qualifie toutes personnes qui se sont déclarées mariées ou vivant maritalement avec un(e) partenaire(e)*).
- b) 9,4% des hommes ruraux ont eu des rapports sexuels avant d'atteindre 15ans
- c) Concernant l'exposition aux messages sur la planification familiale auprès de la tranche d'âge 15-19 ans : 13,7 % ont entendu des messages à la radio, 5,3% ont vu des messages à la télé, et 1,0% ont lu des messages dans les journaux ou les magazines.

Chiffres concernant les jeunes de 20 -24 ans, non en union et sexuellement actifs

Pour les femmes

- a) 69,9 % des femmes appartenant à la tranche d'âge 20-24 ans, avait 20 ans à leur première union (*ici, en union reprend la définition dans l'EDS qui qualifie toutes personnes qui se sont déclarées mariées ou vivant maritalement avec un(e) partenaire(e)*).
- b) 35,1 % des femmes non en union, sexuellement actives utilisent de la contraception moderne dont la répartition par méthode se fait comme suit : 10,3 % pilule, 22,1% injectable, 0,3 % implant et 1,7% condom masculin.
- c) Concernant l'exposition aux messages sur la planification familiale auprès de la tranche d'âge 20-24 ans : 28,1 % ont entendu des messages à la radio, 10,8 % ont vu des messages à la télé, et 3,50% ont lu des messages dans les journaux ou les magazines.

Pour les hommes

- a) 32,9 % des femmes appartenant à la tranche d'âge 20-24 ans, avait 20 ans à leur première union (*ici, en union reprend la définition dans l'EDS qui qualifie toutes personnes qui se sont déclarées mariées ou vivant maritalement avec un(e) partenaire*).
- b) Concernant l'exposition aux messages sur la planification familiale auprès de la tranche d'âge 20-24 ans : 22 % ont entendu des messages à la radio, 7,2 % ont vu des messages à la télé, et 2,1% ont lu des messages dans les journaux ou les magazines.

Résultats des études quantitatives TraC auprès des jeunes femmes de 15-24 ans

Les résultats des TraC Jeunes 2008 et 2010 auprès des filles de 15 à 24 ans en zone urbaine ont révélé que les principaux facteurs déterminant l'utilisation de la pilule comme moyen contraceptif sont :

- a) l'efficacité personnelle à se rappeler la prise quotidienne de la pilule, à être à l'aise vis-à-vis des autres d'acheter et d'utiliser la pilule ;
- b) Les croyances liées aux effets secondaires de la pilule notamment sur la fertilité et la réversibilité de la méthode ainsi que sur la qualité des rapports sexuels ; et
- c) Le support social du partenaire et des amis.

Les résultats du TraC Femmes 2010 démontrent que les principaux facteurs déterminant l'utilisation de la pilule chez les jeunes femmes 15-24 ans en zone rurale sont :

- a) l'efficacité personnelle à se rappeler la prise quotidienne de la pilule ;
- b) le support social du partenaire ;
- c) la situation matrimoniale : les femmes mariées/en union sont plus susceptibles d'utiliser la pilule comme méthode contraceptive que les femmes célibataires ;
- d) les normes sociales négatives sur les utilisatrices de pilules (par exemple, les utilisatrices de pilules sont des personnes sur lesquelles on ne peut pas compter)

Les résultats des TraC Femmes 2010 et 2012 ont également démontré une augmentation significative dans l'utilisation de méthodes contraceptives modernes auprès des jeunes de 15 à 24 ans en zone rurale en passant de 20.3% en 2010 à 26.3% en 2012.

Par ailleurs, les mêmes résultats du TraC Femmes auprès des filles de 15 à 24 ans en zone rurale montrent que toutes les filles interrogées confirment que l'utilisation de méthodes contraceptives modernes leur permet de gérer et planifier leurs grossesses (cf. PSI/Madagascar a largement axé ses communications sur le facteur « résultats attendus » qui est le deuxième facteur déterminant l'utilisation de pilules ou d'injectable chez les femmes de 15 à 49 ans au niveau national) ; les résultats sont passés de 67.6% en 2010 à 100% en 2012.

Bien que les résultats de ce TraC Femmes montrent une diminution significative sur les fausses croyances des effets secondaires de la pilule avec 93,4% en 2010 et 76,8% en 2012 et sur les effets secondaires de l'injectable avec 91,9% en 2010 et 61,9% en 2012, les statistiques demeurent néanmoins élevés.

Résultats des études qualitatives FoQus auprès des jeunes femmes de 15-24 ans

L'étude FoQus on Marketing Planning pour les méthodes contraceptives modernes (2011) conduite auprès des jeunes femmes de 15 à 19 ans désirant repousser les premières naissances en milieu rural d'Antsohihy et d'Antsirabe, a renseigné sur les points suivants :

- **Les barrières** des jeunes femmes à la pratique de contraception moderne sont par ordre de priorité : le fait qu'elles n'ont pas encore d'enfants donc ne perçoivent pas la nécessité d'une PF de manière permanente. Ensuite les croyances des rumeurs que les méthodes modernes de PF rendent malade sont très présentes. Une minorité des jeunes femmes pense que l'adoption d'une méthode moderne de PF fatigue les femmes et une autre minorité adopte la méthode de calendrier pour éviter les grossesses¹.

¹ La méthode de calendrier a été enseignée par la mère pour celles qui la pratique.

- **Les motivations** à la pratique de PF moderne : la minorité des jeunes femmes rurales qui utilise une méthode moderne est convaincue de la non efficacité à 100% de la méthode de calendrier, d'où un manque de tranquillité malgré la pratique de comptage des jours.
- Par rapport aux fausses croyances et les rumeurs sur les méthodes de PF moderne, et les dires que la méthode de PF n'est pas faite pour les jeunes femmes qui n'ont pas encore d'enfants, les cibles pensent qu'il serait toujours nécessaire de se renseigner auprès des médecins et du personnel de la santé d'abord avant d'informer leur compagnon.

Résultats des études formatives sur la pratique sexuelle des jeunes de 10 à 24 ans : Antananarivo, Antsiranana et Taolagnaro (2003)

L'étude a surtout fait ressortir les perceptions de la virginité par les jeunes de 10 à 24 ans, ainsi que de recueillir les facteurs qui les ont incités à entrer dans leur premier rapport sexuel. D'une manière générale, les participants à l'étude s'accordent à dire qu'il s'agissait surtout de l'influence de leurs pairs, la pression du partenaire, les influences des films et des livres qui les incitaient à entrer dans leur première expérience sexuelle. Il faudrait noter que cette étude a été portée sur des jeunes sexuellement et non sexuellement actifs en milieu périurbain. L'aspect de relation de couple, ni de la planification familiale n'ont pas été abordé au cours de cette étude.

D'après cette étude : les pairs, les parents, les partenaires, la fratrie ont été comme les principales personnes qui les influencent positivement mais également négativement dans le sens de l'aspect d'encouragement ou de découragement des activités sexuelles.

Selon les participants à l'étude, les vrais caractéristiques d'un vrai homme et des vraies femmes se distinguent et se résument en général pour eux, d'abord par les traits physiques, ensuite les traits de caractères. Il a été cité par exemple pour les hommes : les signes physiques de virilité, un sens de responsabilité, une indépendance voire abondance financière.

Chez les femmes ce seraient plutôt une bonne présentation physique, une morphologie féminine, une ouverture d'esprit, la sympathie et les talents de gestion d'un futur foyer.

Objectifs généraux et spécifiques de l'étude

L'étude comprend 2 volets spécifiques, à savoir la prévention des grossesses précoces d'une part et la prévention des grossesses non désirées d'une autre part.

Grossesses précoces

- a) L'étude a collecté les informations relatives aux jeunes femmes et jeunes hommes ruraux de 15-19 ans, sexuellement actifs, non en union et sans enfants, sur : leur première activité sexuelle : âge, moyen contraceptif utilisé, type de partenaire
- b) Leurs connaissances en matière de planification familiale : différentes méthodes contraceptives, connaissance de la disponibilité du service/des produits, source d'informations, etc.

- c) L'utilisation de méthode contraceptive : méthode utilisée ? avantages/inconvénients de la méthode choisie ? coût de la méthode ? source d'approvisionnement/acquisition du service/produit ?
- d) Le rôle du partenaire dans l'utilisation de la méthode contraceptive : qui a initié la discussion ? qui a pris la décision ? qui a payé le service/le produit ?
- e) Les facteurs (barrières et les motivations) influençant l'acquisition/utilisation de produits/services de planification familiale
- f) Les barrières et les motivations pour l'utilisation d'une méthode contraceptive moderne vs l'utilisation d'une méthode contraceptive de longue durée pour prévenir les grossesses précoces
- g) Les personnes qui influencent l'utilisation d'une méthode contraceptive moderne et le choix de l'âge de la première grossesse et du premier rapport sexuel
- h) Leurs attitudes/comportement et les pratiques en cas de grossesses : âge de la première grossesse ? contexte ? etc.

Grossesses non désirées

Auprès des jeunes femmes et jeunes hommes ruraux de 20-24 ans, sans enfants, sexuellement actifs, non en union mais en relation stable depuis au moins 3 mois, l'étude a visé à :

- a) Identifier leurs connaissances en matière de planification familiale : différentes méthodes contraceptives, connaissance de la disponibilité du service/des produits, source d'informations, etc.
- b) Connaître la méthode contraceptive utilisée : quelle méthode ? coût de la méthode ? source d'approvisionnement/acquisition du service/produit ?
- c) Explorer le rôle du partenaire dans l'utilisation de la méthode contraceptive : qui a initié la discussion ? qui a pris la décision ? qui a payé le service/le produit ?
- d) Déterminer les barrières et les motivations pour l'acquisition de produits/services de planification familiale
- e) Déterminer les barrières et les motivations pour l'utilisation d'une méthode contraceptive moderne vs l'utilisation d'une méthode contraceptive de longue durée
- f) Identifier les personnes qui influencent l'utilisation d'une méthode contraceptive moderne
- g) Comprendre la vision/les perspectives d'un jeune couple non en union en zone rurale
- h) Expliquer leurs attitudes/comportements et les pratiques en cas de grossesses.

Les résultats de l'étude permettent de répondre aux questions et aux besoins programmatiques suivants :

a. Elaborer une approche :

Cette approche sera spécifiquement élaborée pour les jeunes ruraux sur la prévention des grossesses précoces et des grossesses non désirées GND.

Les éléments ci-après serviront à compléter ladite approche :

- Développement du profil type d'une jeune fille rurale utilisatrice et d'une non-utilisatrice de méthode contraceptive moderne en particulier pilule, condom et injectable
- Elaboration du profil type d'un jeune homme rural utilisateur de condom ou partenaire d'utilisatrice de méthode moderne de PF, prévenant et/ou ayant recours au traitement des IST

b. Développer la stratégie de communication :

De manière spécifique, cette étude devra permettre de développer les messages clés relatant les principales orientations du nouveau projet ISM pour les jeunes sur le report de l'âge de la première activité sexuelle, le report de l'âge de la première grossesse et l'utilisation de méthode contraceptive moderne en particulier la pilule, l'injectable et le préservatif pour la double protection. L'étude servira également d'identifier les canaux de communication les plus appropriés (préférés/suggérés) pour véhiculer ces messages clés et pour atteindre ces jeunes en milieu rural.

STUDY DESIGN & ECHANTILLONAGE

Étant donné que cette présente étude s'inscrit dans le cadre interne, elle n'a pas été soumise auprès du comité d'éthique malgache auprès du Ministère de la Santé.

A. Techniques de collecte des données

Du 17 au 25 Avril 2013, les données ont été collectées par le biais de mini groupes de discussions dirigés² d'une part afin de récolter les interactions des groupes. Les participants ont été regroupés d'une manière homogène par tranche d'âge, par genre et par comportement (prévention des grossesses précoces, prévention des grossesses non désirées). Les groupes de discussions dirigés ont traité d'une manière générale les aspects des besoins d'informations qui suscitent des avis des groupes, des pratiques communes qui créent une discussion de groupe.

D'une autre part, les interviews individuelles approfondies ont été également utilisées afin d'aborder les sujets intimes, tels les aspects de la contraception, les relations de genre....

² Mini groupe de discussion : regroupe 4 participants au lieu de 8 à 10 participants. Le mini GDD est utilisé dans le cas d'existence de plusieurs segments de groupes cibles dans plusieurs sites. Les analyses sont portés à l'intérieur des segments similaires et permettant d'assurer la représentativité qualitative des données.

Les éléments rattachés à la collecte des archétypes des cibles ont été intégrés dans les questionnaires des groupes de discussions dirigés et des interviews individuelles, ainsi que dans les questionnaires de criblage des participants.

La stratégie d'échantillonnage

Pour les deux comportements à étudier, un total de 145 participants a été recruté, à savoir 72 jeunes femmes et 73 jeunes hommes au total. D'une manière plus détaillée, voici la répartition par site :

	Ihosal	Miarinarivo	Antsohihy
Jeunes femmes	24	24	24
Jeunes hommes	24	24	25

Les données ont été collectées par 6 consultants interviewers – animateurs et 1 superviseur par site d'étude.

Recrutement des participants

L'équipe de recherche a travaillé en étroite collaboration avec les entités locales à savoir les ONG, les leaders d'association des jeunes, les agents de terrains dans chacun des sites, en fournissant préalablement les listes des participants à recruter avec les critères d'inclusion et d'exclusion des participants à considérer pour le recrutement.

Formation des consultants

Les consultants animateurs-rapporteurs-interviewers sont des consultants individuels, membres du pool de consultants de recherches qualitatives qui ont offerts leurs services pendant au moins 2 ans.

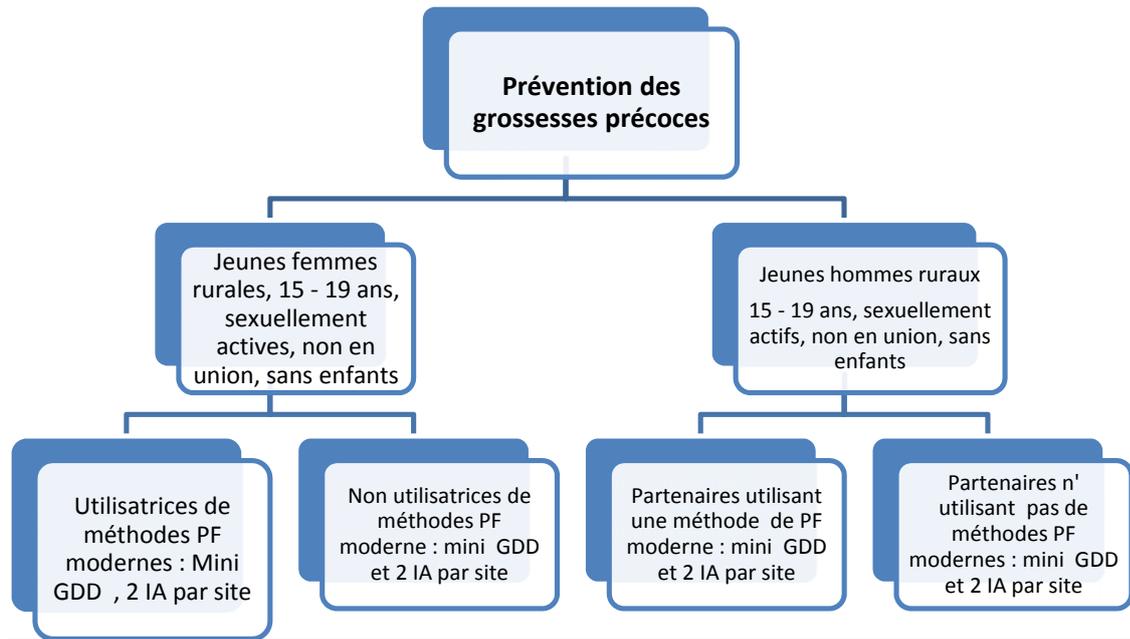
Préalablement à l'étude, les consultants ont été formés pendant 3 jours sur les étapes d'étude : à savoir comment mener les groupes de discussions et les interviews individuelles, comment conduire les exploitations et les analyses de données en conformité avec les objectifs d'études et sur les principes éthiques fondés sur le respect de la personne, la bienfaisance et la justice.

Groupes cibles de l'étude

a) Paramètres de segmentation

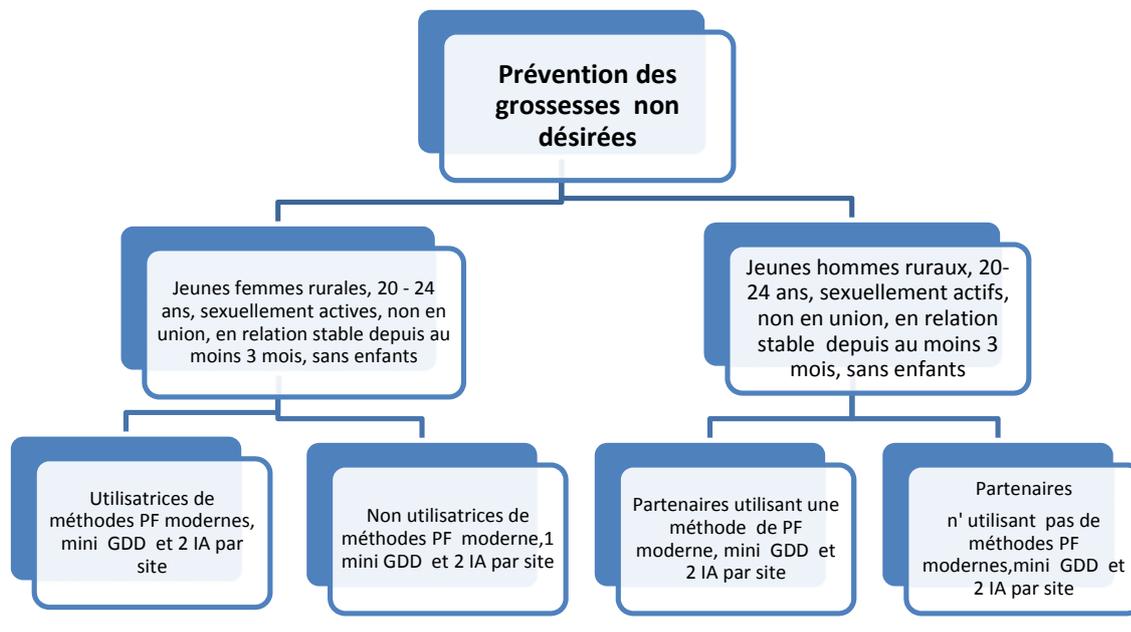
L'étude s'est portée sur 2 comportements dont le premier : La prévention des grossesses précoces et le second la prévention des grossesses non désirées.

Chacun des comportements a fait l'objet de segmentation différente :



Les critères d'inclusion des participants :

Critères d'inclusions	Critères d'exclusions
<ul style="list-style-type: none">• Jeunes femmes et jeunes hommes appartenant à la tranche d'âge 15-19 ans• Habitant dans les zones rurales• Sexuellement actif• Non en union (n'est pas déclaré mariée, ni vivant maritalement avec un(e) partenaire, d'après la définition ne vivant pas maritalement ici, en union reprend la définition dans l'EDS)• N'ayant pas d'enfants• Utilisant / partenaire d'utilisatrice de méthodes modernes de PF depuis au moins 3 mois : pilule, injectable et condom (<i>remarque : le collier du cycle ou Rojo n'est pas admis comme étant une méthode moderne de PF) ou les MLD.</i>• N'utilisant pas des méthodes modernes de PF depuis au moins 12 mois : pilule, injectable et condom (<i>remarque : le collier du cycle ou Rojo n'est pas admis comme étant une méthode moderne de PF) ou les MLD.</i>• Le niveau d'étude reste un critère secondaire.	<ul style="list-style-type: none">• Jeunes femmes et jeunes hommes n'appartenant pas à la tranche d'âge 15-19 ans• qui ont déjà des enfants• N'habitant pas dans les zones rurales• Non sexuellement actif• En union (déclaré marié ou vivant maritalement avec un(e) partenaire)• Utilisant des méthodes naturelles ou traditionnelles de PF (si on recherche des utilisateurs et utilisatrices)• Non autorisé par les parents ou par des tierces personnes à participer à l'étude.



Les critères d'inclusion des participants :

Critères d'inclusions	Critères d'exclusions
<ul style="list-style-type: none"> • Jeunes hommes et jeunes femmes appartenant à la tranche d'âge 20-24 ans • Habitant dans les zones rurales • Sexuellement actif • Non en union (n'est pas déclaré mariée, ni vivant las maritalement avec un(e) partenaire, d'après la définition ne vivant pas maritalement ici, en union reprend la définition dans l'EDS) • N'ayant pas d'enfants • En relation stable avec un (e) partenaire depuis au moins 3 mois • Utilisant / partenaire d'utilisatrice de méthodes modernes de PF : pilule, injectable et condom et MLD. (<i>remarque : le collier du cycle ou Rojo n'est pas admis comme étant une méthode moderne de PF</i>) depuis au moins 3 mois • Non utilisateurs de méthodes modernes de PF depuis au moins 12 mois • Le niveau d'étude reste un critère secondaire. 	<ul style="list-style-type: none"> • Jeunes femmes et jeunes hommes n'appartenant pas à la tranche d'âge 20-24 ans • qui ont déjà des enfants • N'habitant pas dans les zones rurales • Non sexuellement actif • En union (déclaré marier ou vivant maritalement avec un(e) partenaire) • Ne pensant pas repousser l'âge idéal de la première grossesse. • Utilisant des méthodes naturelles ou traditionnelles de PF (si on recherche des utilisateurs et utilisatrices) • Non autorisé par les parents ou par des tierces personnes à participer à l'étude.

Le traitement et analyses des données

Les données ont été recueillies et enregistrées en malgache. Elles ont été codifiées et distillées par les chercheurs mêmes, à travers les 8 codes standards d'une étude FoQus on Segmentation, à savoir : Archetype (ARCH), les croyances à renforcer (B2R), les croyances à changer (B2C), les stratégies à se comporter (S2B), les ouvertures (O), les connaissances (KS), les catégories d'expériences (CaTex), les historiques d'acquisition (AqS).

Les autres thématiques appartenant aux besoins d'informations, ont été également traitées, codés et analysés.

Les résultats principaux ont été présentés auprès de l'assistante technique en « genre » dans un premier temps, avant d'être partagés aux programmeurs dans un second temps. Ce présent rapport d'étude relatera les résultats principaux obtenus à partir du coding thématique.

II.2- Les outils de recherches

Les outils de recherche comprenant en même temps des guides de discussion et des guides d'interview pour chaque comportement étudié ont été préparés par les équipes de Recherches basés sur les besoins d'information programmatique.

Les guides de discussion et les guides d'interview ne sont pas prévus pour diriger ou dicter l'ordre des questions, mais ils servent plutôt à prioriser les narratifs qui permettent aux participants de donner des informations à leur propre rythme, tout en usant des questions de sondage qui permettent de récolter les données additionnelles.

Les guides de discussion sont également des outils qui aideront les équipes des chercheurs à se remémorer des sujets à aborder au fil de la collecte de données

Les guides de discussion ont développés en français et traduits en malgache (langue de conduite de la récolte de données), ils ont été pré-tests avant d'être raffinés et finalisés.

II.3- Les résultats

Les résultats de l'étude sont composés l'archétype, le FoQus dashboard par type de comportement étudié, le category map ainsi que le diagramme de segmentation par type de comportement. Les autres thématiques relatives aux besoins d'informations programmatiques sont également restituées.

II.4 - Sites d'étude

Nous avons opté pour des sites d'étude ayant une représentativité géographique et culturelle à partir desquelles nous pourrions développer une campagne de communication à l'échelle nationale et rurale. Nous avons également privilégié les sites inclus dans les zones d'intervention des projets communautaires financés par USAID.

Par ailleurs, ci-après les éléments recueillis complémentaires qui permettront de décider sur les 3 sites d'études :

1) Région Itasy (district de Miarinarivo, commune rurale de Anosibelfanja)

- 35,1% pourcentage d'utilisatrices de méthodes contraceptives modernes parmi les femmes de 15 - 49 ans
- 0,7% pourcentage d'utilisatrices de condom masculin comme moyen contraceptif
- 5,2% des jeunes femmes et 12,8% des jeunes hommes ont déjà eu des rapports sexuels avant d'atteindre 15ans
- 12 % des jeunes femmes entre 15-19 ans ont eu une naissance vivante

2) Région Ihorombe (district de Ihosy, fokontany de Ambia ou Ankily)

- 19,5% pourcentage d'utilisatrices de méthodes contraceptives modernes parmi les femmes de 15-49 ans
- 0,1% pourcentage d'utilisatrices de condom masculin comme moyen contraceptif
- 52,4% des jeunes femmes et 23,3% des jeunes hommes ont déjà eu des rapports sexuels avant d'atteindre 15ans
- 45,4% des jeunes femmes entre 15-19ans ont eu une naissance vivante

3) Région Sofia (district d'Antsohihy, fokontany de Anahidrano)

- 19,9% pourcentage d'utilisatrices de méthodes contraceptives modernes parmi les femmes de 15-49 ans
- 0,1% pourcentage d'utilisatrices de condom masculin comme moyen contraceptif
- 19,8% des jeunes femmes et 15,7% des jeunes hommes ont déjà eu des rapports sexuels avant d'atteindre 15 ans
- 28,4 % des jeunes femmes entre 15-19ans ont eu une naissance vivante

RESULTATS SAILLANTS DE L'ETUDE

La prévention des grossesses précoces et des grossesses non désirées

1. Les réponses de tous les participants convergent vers la prévention des grossesses non désirées, la perception de risque des grossesses précoces n'a pas été explicitement évoquée. Aussi, les opinions relatées dans ce présent rapport d'étude se rapportent à la prévention des grossesses non désirées.

Les archétypes des jeunes ruraux

2. Des dissemblances et des nuances sont présentes dans l'archétype de la jeune femme rurale et urbaine. Les pratiques et les comportements varient selon le contexte et les lieux de résidence, si les aspirations et les craintes sont à peu près les mêmes. Par contre, l'archétype du jeune homme rural et urbain se rejoint. Cette étude a ainsi fourni les détails d'information qui permettront aux programmeurs de connaître Nathalie : *la responsable en quête d'affection* représentant la jeune femme rurale, et Tony : *l'aventurier prévenant en quête de réussite* représentant le jeune homme en même rural et urbain.

Motivations et barrières à l'adoption des méthodes contraceptives modernes par les jeunes ruraux

3. La conscience de la nuisance d'une grossesse qui survient précocement ou en dehors d'une vie maritale est la motivation première des jeunes femmes et jeunes hommes, à utiliser des moyens de contraceptions. Cependant, le moyen de contraception habituellement adoptés est la méthode de calendrier ; étant donné qu'elle est enseignée à l'école par les professeurs de Sciences de la vie et de la terre³. A cela s'ajoute les conseils entre pairs, les recommandations de la famille proche ainsi que les avis du personnel médical approché par les jeunes lorsqu'ils cherchent des conseils en matière de santé de la reproduction.
4. La crainte des effets secondaires qui pourraient rebondir sur la fertilité à venir, constitue la barrière principale des jeunes ruraux. En effet cette crainte serait reliée au manque d'informations par rapport aux méthodes modernes disponibles et adaptés pour les jeunes. Cette situation expose les jeunes ruraux à croire les rumeurs et les perceptions négatives autour des méthodes modernes, d'autant plus que la pratique de la méthode calendaire est déjà très ancrée chez les jeunes ruraux.

Les techniques adoptées par les jeunes ruraux en cas de refus d'adoption de contraception moderne par le partenaire

³ L'appellation « SVT » a remplacé celle de « [biologie](#) » à la rentrée [1994](#), et s'en différencie par l'incorporation de la [géologie](#). Jusqu'au début des [années 1990](#) le terme utilisé était « sciences naturelles ». (Source Wikipédia)

5. Le principal argument que les jeunes s'échange concerne principalement leur impossibilité d'assumer la charge d'un enfant qui pourrait arriver suite à une défaillance de contraception.

La connaissance des méthodes contraceptives modernes par les jeunes ruraux

6. Seule une infime minorité des jeunes ruraux connaît les méthodes contraceptives de longue durée. Ni la durée de protection contraceptive, ni le mécanisme des méthodes ne sont connus des jeunes. En effet, les jeunes ruraux ne sont pas encore exposés aux sensibilisations concernant la contraception moderne. Ce sont plutôt les rumeurs et les dires de l'entourage qui forment la connaissance des jeunes actuellement.
7. Même pour les méthodes de courte durée, plusieurs fausses croyances restent très présentes chez les jeunes ruraux. Le manque de connaissance qui résulterait d'un manque d'exposition de ces jeunes à des sensibilisations focalisées aux méthodes de contraception moderne.
8. Les méthodes naturelles sont celles qui sont les plus connues des jeunes car celles les plus pratiquées, et celles qui sont les plus abordables pour eux. Cependant ils sont conscients qu'un dérapage de comptage et de fuite pourraient leur être fatal.

Les sources d'informations des jeunes ruraux

9. Les jeunes ruraux s'informent surtout en écoutant la radio, à l'aide d'affiches même s'il y en a peu dans les endroits qu'ils fréquentent, lors des rencontres sportives. Le personnel médical est également une personne qui leur est très influent en termes de conseil.

DE LA RECHERCHE A L'ACTION

Cette étude auprès des jeunes ruraux a fait ressortir les principaux points suivants pour les actions et décisions programmatiques :

Les jeunes femmes rurales et urbaines ont des archétypes différents. Il a été noté durant cette étude que les jeunes femmes urbaines sont plus enclines à fréquenter beaucoup de garçons en même temps, si les jeunes femmes rurales se montrent plus réservées et pudiques sur la question du nombre de leurs partenaires, cependant les jeunes femmes rurales sont plus conscientes de la nécessité de prévenir les grossesses non désirées étant donné qu'une grossesse survenant précocement ou en dehors d'une vie maritale est perçue par les jeunes ruraux comme un grand danger qui pourrait leur faire subir un rejet familial voire un rejet de l'entourage, ou encore la contrainte d'assumer la charge d'un enfant avec l'interruption des études

Dans les communications avec les jeunes ruraux, il serait ainsi pertinent d'utiliser comme arguments cet aspect d'évitement du rejet familial, ainsi que la possibilité de poursuivre les études jusqu'à la fin si les jeunes ruraux se préservent des grossesses précoces et non désirées. La valeur familiale, l'affection et le soutien familial constituent également des accroches émotionnelles propices à utiliser dans les communications interpersonnelles ou de groupe pour les jeunes ruraux.

Désireux de prévenir les grossesses non désirées ; les jeunes ruraux puisent leurs connaissances dans les cours qu'ils reçoivent au collège et lycée ; ou d'après des expériences qu'ils se partagent entre eux concernant la méthode de calendrier. Pourtant les jeunes ruraux sont conscients que cette méthode n'est pas réellement fiable.

Il serait pertinent de considérer la formation des professeurs de SVT (Sciences de la Vie et de la Terre) par le biais d'un partenariat avec l'éducation nationale, afin de leur donner les bases nécessaires pour qu'ils puissent donner des informations correctes, crédibles et fondées.

Les jeunes ont manifestés leur soif de pouvoir être sensibilisés et informés sur les méthodes contraceptives modernes d'une source sûre et fiable. Cette étude a permis de savoir que la connaissance de ces méthodes est encore faible et que les jeunes ruraux redoutent beaucoup les effets secondaires connaissant plus les rumeurs que les informations correctes autour des méthodes contraceptives modernes.

Renforcer la connaissance des méthodes contraceptives modernes chez les jeunes ruraux à travers tous les canaux de communication possible. En deuxième lieu, il serait également important d'informer les parents parallèlement avec les jeunes pour une meilleure compréhension.

Les jeunes prennent des informations en écoutant la radio, en lisant les affiches et en assistant à des évènements sportifs et en parlant et s'échangeant avec leurs pairs.

Le service de counseling pour les jeunes est très recommandé d'ailleurs que le besoin de pouvoir avoir des informations détaillées et claires est ressenti fortement par les jeunes ruraux. La disponibilité de ce service améliorerait fortement la connaissance auprès des jeunes ruraux et corrigerait les rumeurs circulant à propos de la contraception et des méthodes contraceptives, afin d'aboutir à un changement de comportement.

LES RESULTATS DETAILLES DE L'ETUDE

ARCHETYPE DES JEUNES RURAUX



NATHALIE : La responsable en quête d'affection

Âgée de 18 ans, Nathalie est issue d'une famille de 5 enfants. Elle est de niveau d'étude secondaire.

Nathalie a commencé à fréquenter les garçons à 13 ans et a eu son premier rapport sexuel à 14 ans.

Depuis l'adolescence, réussir les études est classé parmi les choses les plus importantes, elle pense que c'est grâce aux diplômes qu'elle peut assurer son avenir et trouver un travail stable et rémunérateur, comme travailler comme fonctionnaire. Cependant, Nathalie a été contrainte de quitter l'école en classe de 3^{ème}, faute de moyens financiers de ses parents. Aussi, Nathalie considère que l'argent est essentiel pour subvenir aux besoins quotidiens et pour être indépendante des parents. Les valeurs morales telles que le fihavanana, les bonnes conduites, le respect d'autrui et la foi sont autant de vertus qui sont chères à Nathalie.

Les aspirations de Nathalie seraient de se marier légitimement fonder une famille, et de posséder des biens matériels à commencer par de beaux vêtements, mais également une richesse qui peut assurer l'avenir.

Comme tous les jeunes, dit-elle « *j'ai besoin de l'amour de mon partenaire, être heureuse dans le couple, et avoir le support de ma famille, surtout de mes parents* ».

Nathalie a très peur de tomber enceinte et surtout de devoir avorter en cas de grossesse. En effet, elle reconnaît qu'une grossesse non désirée gâcherait son avenir. Elle craint également de contracter une IST, d'ailleurs elle n'ose pas dire si elle l'a déjà contracté auparavant ou non. Nathalie utilisait la méthode de calendrier, ou pratiquait le coït interrompu, mais actuellement suite à des sensibilisations, Nathalie a adopté la contraception par l'injectable.

Nathalie aime beaucoup faire du sport comme le foot, le basket pendant ses temps libres, elle aime passer du temps avec son copain, faire des ballades en amoureux et aussi se promener avec ses amis.

Comme Nathalie n'a pas de télévision chez elle, elle préfère écouter la radio ou aller dans les salles de vidéos pour regarder des films.

ARCHETYPE du jeune homme rural



TONY l'aventurier prévenant en quête de réussite⁴

Issu d'une famille de 6 enfants, Tony est âgé de 19 ans, est de niveau d'étude secondaire, il était contraint de quitter l'école car ses parents ne pouvaient plus subvenir à ses frais de scolarité.

Tony exerce des petits boulots et des travaux de champs lorsqu'il est à la campagne. En effet, Tony affirme qu'il a vraiment besoin d'argent pour être bien vu par sa copine et ses autres partenaires. Tony a commencé à fréquenter les filles depuis l'âge de 15 ans, lorsqu'il reste à la campagne, Tony a des rapports sexuels avec les jeunes femmes, tandis que lorsqu'il monte en ville, Tony se rend également auprès des travailleuses de sexe pour acquérir des expériences. Tony affirme qu'il aime les filles et qu'il profite de chaque occasion pour avoir un rapport sexuel.

Bien que sexuellement actif, Tony craint les IST . En effet il en a déjà contracté et surtout lorsqu'il est en ville, il dit qu'il fait même des récidives. Tony connaît comment il faut faire en cas d'IST, aussi, il ne consulte pas un médecin mais se fait guider par ses amis qui lui procurent même des médicaments pour l'automédication.

Tony a très peur que sa copine qui est sa partenaire fixe ou que ses partenaires occasionnelles tombent enceintes et qu'il soit forcé à abandonner ses études pour se marier d'un mariage forcé. La possibilité d'être traîné en justice et d'être emprisonné en cas de grossesse chez une fille mineure est également une grande menace pour lui.

Lorsque Tony est en ville, il dit qu'il n'utilise pas systématiquement de condom. Voici ce qu'il dit « *pour moi le condom ne donne pas du vrai plaisir ; pour ce qui est de la prévention des IST : je sais avec quelle fille je devrais ou non utiliser le condom car je reconnais si la fille est porteuse de maladie ou non, rien qu'en la voyant par son apparence* ».

Par contre lorsque Tony est à la campagne, il commence à prendre des mesures pour se protéger par la méthode de calendrier, ou la pratique de coït interrompu ou l'abstinence pendant les jours féconds.

⁴ Tony représente l'archétype du jeune homme rural et urbain à la fois.

Tony pratique le football et le rugby pendant ces temps libres. Il aime écouter la radio, se promener avec ses copains, regarder des VCD et faire des jeux de société comme le domino.

Tony voudrait obtenir un travail stable et bien rémunéré, fonder une famille et avoir une vie heureuse. Tony voudrait gagner le respect de ses beaux parents et de la société plus tard lorsqu'il aurait beaucoup d'argent, des possessions de bien matériels ou encore un cheptel de Zébu.

LES MOTIVATIONS À L'ADOPTION DE LA MÉTHODE CONTRACEPTIVE MODERNE PAR LES JEUNES FEMMES

Par ordre décroissant, les jeunes femmes ont évoquées les facteurs suivants comme étant des facteurs de motivations à l'utilisation de la méthode de contraception moderne :

La prévention des grossesses non désirées (GND)

Pour la quasi-totalité des jeunes femmes rurales, la motivation principale d'utilisation des méthodes contraceptives modernes demeure la prévention des grossesses précoces et non désirées. En effet, les jeunes femmes ont conscience des méfaits de la venue d'une éventuelle grossesse qui aurait un impact tant sur leurs études que sur leur vie en général. Selon elles, une grossesse non désirée leur empêcherait de continuer leurs études et gâcherait leur perspective d'avenir. Elles auraient par ailleurs peur du rejet de leur partenaire, et de devenir une mère célibataire. Elles sont également conscientes que si un bébé arrive, elle n'aurait ni les moyens financiers, ni les connaissances requises pour élever et prendre l'enfant en charge.

« Tu peux faire autant des rapports sexuels sans peur de tomber enceinte » (Jeune Fille, 19 ans, secondaire, Miarinarivo)

Support social

La seconde motivation évoquée est le support et l'encouragement de la famille, des pairs surtout auprès de celles qui ont déjà eu des expériences antérieures d'utilisation d'une méthode de contraception moderne, et du personnel médical.

Les témoignages concernant l'absence d'effets secondaires et l'efficacité d'une méthode utilisée sont les informations les plus convaincantes.

Conviction à l'efficacité des méthodes modernes

La conscience que les méthodes contraceptives modernes sont plus efficaces pour prévenir les grossesses encouragent les jeunes femmes à les utiliser, contrairement à la méthode de calendrier qui n'est pas toujours fiable selon ces dernières.

Prévention des IST

Les jeunes femmes sont conscientes de se protéger des IST par le condom.

Praticité et gratuité

Les jeunes femmes pensent que les méthodes contraceptives modernes sont pratiques et faciles à utiliser, en l'occurrence l'injectable et les pilules. Les méthodes de contraception moderne sont également faciles à trouver. Une infime minorité des jeunes femmes a également citée la gratuité des méthodes comme étant une source de motivation à leur adoption.

Exposition aux sensibilisations

Les jeunes femmes auraient évoqué être motivées à utiliser les méthodes contraceptives modernes après avoir été exposées aux séances de sensibilisation effectuées par les AC dans les Fokontany ou à proximité des villages. Des sensibilisations menées par MSI ont été également évoquées par les jeunes femmes.

LES MOTIVATIONS A L'ADOPTION DE LA METHODE CONTRACEPTIVE MODERNE PAR LES JEUNES HOMMES

Par ordre décroissant, les jeunes hommes ont évoqué les facteurs suivants comme étant des facteurs de motivations à l'utilisation de la méthode de contraception moderne par eux-mêmes et à l'incitation de leur partenaire :

La prévention des grossesses non désirées (GND)

La crainte des grossesses motive les jeunes hommes à utiliser les méthodes contraceptives modernes et d'inciter leur partenaire. En effet, ils sont conscients qu'ils ne peuvent plus continuer leurs études en cas de grossesse de leur partenaire. Ils craignent par-dessus tout, la réprimande venant de leurs propres parents ; ou encore l'exigence d'un mariage forcé venant de la famille de la fille.

Une grossesse n'est guère souhaitée selon les jeunes hommes car ils n'ont pas encore les moyens de prendre un bébé en charge.

Etre traîné en justice en cas de grossesse d'une mineure représenté également une forte appréhension pour les jeunes hommes.

Ces raisons font en sorte que les jeunes hommes sont enclins à adopter une méthode qui serait fiable

Et efficace, telle la méthode moderne qui est le seul garant d'une protection sûre contre les grossesses non désirées.

Prévention des IST

Les jeunes hommes utilisent essentiellement le condom pour se protéger des IST.

De part leur expérience antérieure d'IST, les jeunes hommes sont conscients que le condom est un moyen de protection efficace.

Moindre effet secondaire

Selon les jeunes hommes, le condom présente un moindre effet secondaire. La pilule a également une faible composition hormonale selon eux. Par conséquent la détérioration de l'utérus n'est pas à craindre.

Le condom pour les jeunes hommes

Les jeunes hommes sont motivés à utiliser le condom par fierté que ce produit leur est spécifiquement destiné.

La facilité d'accès à la méthode contraceptive moderne

Suite aux conseils prodigués par les proches, les parents, les amis, les personnels de santé et voir les professeurs de sciences naturelles ; les jeunes hommes ont été encouragé à l'utilisation de méthode contraceptive moderne, d'autant plus qu'une minorité d'entre eux ont été octroyé gratuitement de condom lors des séances de sensibilisation de masse par le biais du Ciné-mobile, ou par des séances de sensibilisations interpersonnelles. Il faudrait remarquer que cette facilité d'accès est exclusivement attribuée pour le condom d'après les groupes cibles.

BARRIÈRES À L'UTILISATION DES MÉTHODES CONTRACEPTIVES PAR LES JEUNES FEMMES

Par ordre décroissant, les jeunes femmes ont évoquées les facteurs suivants comme étant les barrières à l'utilisation de la méthode de contraception moderne :

Crainte des effets secondaires

La crainte des effets secondaires des méthodes contraceptives modernes restent très présentes chez les jeunes femmes. En effet, les rumeurs les plus cités sont les maux d'estomac, la chute des cheveux, un état maladif, des maux de tête permanents, la détérioration de l'utérus, une hémorragie, l'irrégularité des règles, la mort de l'enfant in-utéro, la prise excessive ou la perte de poids, la malformation du bébé in-utéro.

« Si ton corps ne supporte pas, tu auras des conséquences sur ton corps, quelque chose va s'agglomérer dans ton ventre, et on doit t'opérer » (Jeune Fille, 16 ans, secondaire, Antsohihy)

Non appropriées pour les nullipares

Les jeunes femmes pensent que les méthodes contraceptives modernes sont destinées uniquement pour les femmes qui ont déjà un enfant ou plus. Les jeunes femmes appréhendent en effet la stérilité qu'elles pensent être due à l'utilisation des méthodes modernes de contraception, selon les rumeurs qu'elles ont entendues, et même d'après leurs professeurs de sciences naturelles qui leur conseillent vivement d'adopter une méthode naturelle plutôt qu'une méthode chimique. Les parents surtout les mères interdisent également leurs filles à ce propos.

Non praticité et non accessibilité de la méthode

Selon une infime minorité de jeunes femmes, les pilules ont été citées comme étant une méthode non pratique étant donné la nécessité de toujours se rappeler du moment de prise afin d'éviter l'oubli afin de garantir l'efficacité de protection contre les grossesses précoces et non désirées.

Les déplacements vers les prestataires sont également contraignants pour les jeunes femmes qui souvent à cause des études ne sont pas disponibles pour les rendez-vous ou en oublient la date.

Les non accessibilité de la méthode injectable dans les épiceries et les cas d'indisponibilité de condom ont été également évoqués comme étant des blocages à leur utilisation.

Confiance et appréciation de la méthode de calendrier

La méthode de calendrier étant une méthode naturelle, ne présentant aucun effet secondaire s'avère être plus appréciée par les jeunes femmes, d'autant plus que c'est une méthode apprise au lycée, pendant les cours de sciences naturelles et recommandées pour les jeunes par les professeurs.

Stigmatisation des utilisatrices comme étant une personne infidèle

Spécifiquement pour les jeunes femmes qui craignent les grossesses non désirées, les partenaires pensent que les filles qui utilisent les méthodes contraceptives modernes sont infidèles car elles ont l'assurance d'être protégées des grossesses. Les partenaires craignent que cette liberté n'envenime leur relation.

Méconnaissance des avantages de la PF moderne

Les jeunes femmes de 20 à 25 ans ne connaissent pas les avantages des méthodes contraceptives modernes. Leurs connaissances se limitent juste aux méthodes qu'elles utilisent habituellement telle la méthode de retrait ou la méthode de calendrier.

Manque d'argent

Le manque de moyen financier constitue l'un des blocages cités par les jeunes femmes de 20 à 25 ans à utiliser les méthodes contraceptives modernes.

BARRIERES A L'UTILISATION DES METHODES CONTRACEPTIVES PAR LES JEUNES HOMMES

Par ordre décroissant, les jeunes hommes ont évoqué les facteurs suivants comme étant des facteurs de motivations à l'utilisation de la méthode de contraception moderne par eux-mêmes et à l'incitation de leur partenaire :

Crainte des effets secondaires

Les principales barrières des jeunes hommes à l'utilisation des méthodes contraceptives modernes concernent les craintes des effets secondaires sur la santé et l'organisme. Les effets secondaires les plus cités sont : les mycoses vaginales contractées par l'utilisation de condom, la perte ou la prise de poids pour l'injectable, la stérilité, le cancer, la détérioration de l'utérus, la malformation, l'infection de l'appareil génital, l'absence de règles pour les méthodes autres que le condom. Les jeunes hommes sont ainsi enclins à utiliser les méthodes alternatives comme le calendrier ou le retrait étant donné que ce sont des méthodes naturelles selon eux et qu'ils ont acquis l'habitude de les utiliser.

Manque de plaisir

Spécifiquement pour le condom, les jeunes hommes ont affirmé qu'il entrave le plaisir pendant les rapports sexuels.

Manque de sensibilisation et de crédibilité des messages

Les jeunes hommes sentent qu'ils ne sont pas suffisamment informés par rapport aux méthodes contraceptives modernes, afin de lutter et de résister lorsqu'ils sont faces aux rumeurs et les fausses croyances concernant celles-ci.

Ces jeunes hommes voudraient bien ainsi s'informer auprès d'une personne convaincante et persuasive pour augmenter leurs connaissances sur des détails comme : le mode d'utilisation, les effets secondaires et tous les détails sur chaque méthode.

Risque d'infidélité de la jeune fille

Les méthodes contraceptives modernes ne sont pas appréciées par les jeunes hommes pour l'impact que son utilisation donne sur les jeunes femmes qui l'utilisent. En effet selon eux, leur utilisation procure beaucoup trop de liberté aux jeunes femmes et cela aurait tendance à faire perdre le respect qu'elles ont envers leur partenaire.

Problème d'argent

Pour les jeunes hommes le manque de moyen financier pour l'achat des méthodes contraceptives modernes constitue l'un des facteurs limitant à leur utilisation. Ils n'ont pas encore les ressources financières pour s'en acquérir étant donné qu'ils sont encore étudiants.

LES RÉACTIONS DES JEUNES FACE AU REFUS DU PARTENAIRE D'UTILISER UNE MÉTHODE CONTRACEPTIVE MODERNE

a) Pour les jeunes femmes

Pour les jeunes femmes, spontanément, la réaction d'une minorité est tout de suite le **mécontentement** face au refus de leur partenaire. Elles pensent que leurs partenaires sont trop égoïstes et ne pensent pas à une possibilité de grossesse. Tandis que la majorité d'entre elles réagissent en persuadant leur partenaire à adopter une contraception.

« C'est toi-même la victime si tu ne fais pas attention ! » (Jeune Femme, Utilisatrice, 17 ans, Secondaire, Antsohihy)

Face à l'opposition de leur partenaire, les actions entreprises par les jeunes femmes sont différentes : il y a celles qui préfèrent prendre en cachette le planning familial ou celles qui pensent à la séparation en cas de refus du partenaire.

« Je fais la PF à son insu, quand c'est fait, on ne peut plus l'enlever ! » (Jeune Femme, Utilisatrice, 17 ans, Secondaire, Antsohihy)

Une minorité des jeunes femmes essaye de négocier auprès de leur partenaire l'utilisation du planning familial en évoquant leurs avantages, ainsi que les conséquences de la grossesse non désirée sur l'avenir. Ces filles abordent l'utilité de la prévention des grossesses non désirées afin de persuader leur partenaire.

« Je lui dis : si on allait à l'hôpital chéri pour faire une consultation à propos d'une méthode contraceptive moderne, parce que moi je ne veux pas encore être enceinte, et comme ça on aura une vie bien équilibrée » (Jeune Femme, Non Utilisatrice, 17 ans, Secondaire, Antsohihy)

« Tu m'interdis d'utiliser une méthode contraceptive ? Et si j'aurai un enfant : avec quoi on va le nourrir ? Et moi, je ne veux pas venir cohabiter avec ta mère hein ! » (Jeune femme, 23 ans, non scolarisée, agricultrice, Ihosy)

Une infime minorité des filles adopte la menace comme stratégie. D'une part, l'exigence de la disposition à prendre en cas de grossesse : tel un mariage forcé, la prise en charge financier du bébé par le partenaire. Mais également d'une autre part un refus catégorique de rapport sexuel sans l'utilisation de condom.

« S'il n'y pas a de capote, alors on ne fait pas de rapport sexuel » " (Jeune femme, 20 ans, secondaire, étudiante, Ihosy)

b) Pour les jeunes hommes

Selon, une minorité des jeunes hommes, le non conviction de la partenaire à utiliser une méthode contraceptive moderne peut provoquer une colère au prime abord et entraîner par la suite une idée de séparation. Cependant, selon cette même minorité, la conscience d'entamer une négociation à l'utilisation de méthode contraceptive moderne est le reflexe qui s'en suit.

« D'une manière spontanée, je suis irrité car c'est par soucis de la préserver et de me préserver moi-même des grossesses que je lui propose la PF et elle refuse ! » (Jeune homme, 18 ans, secondaire, Miarinarivo)

Sinon, la mise en exergue des avantages de la contraception moderne dans les négociations est les techniques les plus courantes pour les garçons à adopter pour que leurs partenaires acceptent. Selon toujours les jeunes hommes, la manière de négocier se retrouve également dans le ton de la voix, les cadeaux qu'ils offrent à leurs partenaires pour qu'elles acceptent.

Cependant, la négociation ne réussie pas à toutes les fois déclare une minorité des jeunes hommes et dans ce cas le refus de la partenaire est respecté.

« Je ne la force pas, si elle ne veut pas, je laisse tomber pour ne pas avoir une dispute (Jeune Homme, 19 ans, secondaire, Miarinarivo)

Par contre, les jeunes hommes sont particulièrement vigilant en cas de refus de pratique de contraception. Ils pensent que des dispositions doivent être prises pour éviter les éventuels pièges que les jeunes femmes peuvent leur tendre en tombant enceinte, un cas qui engagerait leur responsabilité. C'est dans ce contexte que les jeunes hommes exigeraient l'abstinence pendant les jours féconds, ou encore l'application de la méthode de calendrier ou encore avertissent qu'ils vont refuser la reconnaissance de l'enfant en cas de grossesse.

LA CONNAISSANCE DE LA METHODE DE CONTRACEPTION MODERNE PAR LES JEUNES RURAUX

PAR RAPPORT AUX METHODES DE LONGUE DUREE

a) Le dispositif intra-utérin (DIU)

Seule une infime minorité des jeunes ruraux connaît cette méthode de longue durée. Ces derniers ont évoqué qu'il s'agit d'un dispositif placé dans l'utérus sans pouvoir dire la durée exacte de protection reçue de cette méthode. Quant aux avantages la possibilité de retrait du dispositif à tout moment a été évoquée, ainsi que l'efficacité de la protection.

Le dispositif intra-utérin cependant est présumé pouvant perforer l'utérus en cas de mouvement brusque, ou encore de favoriser l'entrée des IST dans l'utérus en étant un corps étranger et pouvant ainsi dégénérer jusqu'à la stérilité.

« Le DIU peut être poussé par le pénis et s'enfoncer en profondeur à l'intérieur de l'utérus » (Jeune Femme, 16 ans, Secondaire, Antsohihy)

b) L'implant

La méthode est connue par une minorité des jeunes ruraux. Selon cette minorité, l'implant est matérialisé par des bâtons introduits dans le bras de la femme. La durée de protection de 3 ans a été connue par une infime minorité des jeunes. La praticité de par le non nécessité de consultation périodique a été évoquée comme étant une caractéristique de l'implant, vient ensuite l'efficacité de la méthode pour la prévention des grossesses non désirées.

« Si on n'adopte pas cette méthode, on accouchera tous les ans ». (Jeune homme, 21 ans, non scolarisé, agriculteur, Ihosy)

« On n'est pas obligé de faire le va -et- vient, on ne perd pas son temps ». (Jeune fille, 20 ans, scolarisée, étudiante, Ihosy)

« Comme cela, la prochaine naissance sera retardée, on donne naissance maintenant et la prochaine sera dans 5 ans (Jeune Homme, 17 ans, Secondaire, Antsohihy)

Les inconvénients cités par une infime minorité des groupes sont la perturbation du cycle menstruel, l'enflure du bras, la perte de poids.

« Il se peut qu'il y ait un impact sur le corps, la dose d'hormone est très forte parce que l'effet du bâtonnet part du bras et arrive jusque dans l'utérus" (Jeune homme, 16 ans, secondaire, Miarinarivo)

a) Le condom

Le condom est la méthode moderne la plus connue et la plus utilisée par la majorité des jeunes ruraux. La double protection contre les grossesses non désirées et les infections sexuellement transmissibles est la caractéristique la plus connue du condom. Les jeunes ruraux exposent bien la méthode en étant une barrière préservant le contact direct des deux sexes.

« Il se peut que la fille est malade et il vaut mieux qu'on utilise le condom (Jeune homme, 21 ans, non scolarisé, agriculteur, Ihosy) »

« La maladie ne se transmet pas même si c'est une fille contaminée » (jeune homme, 22 ans, secondaire, Antsohihy) »

Même si, l'absence de contact physique pendant les rapports sexuels ont été évoqués en tant qu'appréciation négative du condom par une infime minorité des jeunes ruraux.

« L'important pour moi, est d'éjaculer dans le vagin de ma partenaire et que tout le sperme lui parvienne » (Jeune Homme, 19 ans, Secondaire, Antsohihy) »

L'accessibilité du condom dans les épiceries et à tout moment sont des caractéristiques évoqués par les jeunes ruraux en tant qu'avantages du condom.

Une supposition que le condom incite à l'infidélité a été faite par une infime minorité des jeunes ruraux. Il y a également une infime minorité des jeunes femmes qui pense qu'au fil de l'utilisation, le condom fait augmenter le pénis de volume. Une infime minorité des hommes a une sensation de compression du pénis et ceci les gênerait lors des rapports sexuels. L'odeur du lubrifiant laissera une forte odeur chez la fille.

« Le lubrifiant du condom laisse une mauvaise odeur » (Jeune Fille, 20 ans, secondaire, Ihosy) »

b) L'injectable

La majorité des jeunes ruraux ne connaissent que la méthode injectable s'administre tous les 3 mois. Cette méthode est jugée de non contraignant et convient aux jeunes femmes qui peuvent avoir des oublis.

« Cela me convient bien car j'oublie tout le temps » (Jeune femme, 20 ans, secondaire, Ihosy) »

Selon la majorité des jeunes ruraux, l'injectable permet de faire des rapports sexuels à tout moment et sans limite, d'autant plus que c'est une méthode réversible et sans effet néfaste sur le poids.

« Si tu as envie d'avoir un enfant, tu arrêtes de faire l'injection et ça viendra » (Jeune Femme, 18 ans, Secondaire, Antsohihy) »

«Tu es tranquille car ça ne rend ni grosse ni maigre» (Jeune Homme, 18 ans, Primaire, Miarinarivo)

Plusieurs autres perceptions ont été citées par une infime minorité des jeunes ruraux, à savoir : les troubles des menstruations comme l'irrégularité des cycles ou voire même l'absence des règles ; la prise ou la perte de poids ; ou la stérilité définitive.

« J'ai peur d'utiliser l'injectable pendant tout l'année, j'ai peur de grossir. En effet les graisses vont s'incruster autour de mon utérus et je ne pourrai plus avoir d'enfant. » (Jeune femme, 21 ans, primaire, Ihosy).

« Je n'aimerai pas que mes règles soient bloquées, sinon les impuretés ne seront pas évacuées » (jeune femme, 20 ans, secondaire, Antsohihy)

c) La pilule

La durée de protection d'un mois , l'efficacité du produit qui leur enlève la crainte d'une grossesse non désirée ont été évoqués par les jeunes ruraux qui sont surtout ravis de pouvoir faire des rapports sexuels autant qu'ils veulent.

«On fait tout le temps de rapport sexuel sereinement parce qu'on prend déjà la pilule donc il n'y aura pas de grossesse" (Jeune Homme, 18 ans, Primaire, Miarinarivo)

« On est encore jeune et on profite de la vie... » (Jeune Homme, 20 ans, Secondaire, Antsohihy)

Spécifiquement la minorité des jeunes femmes savent que la pilule peut les aider à régulariser leur cycle menstruel. La praticité : traduit en termes de non nécessité de consultation médicale et l'accessibilité de la pilule traduit en terme de non nécessité de prescription médicale sont également connues de l'infime minorité des jeunes femmes rurales.

« Il suffit de prendre la pilule sans se déplacer dans les hôpitaux » (Jeune fille, 16 ans, secondaire, Miarinarivo)

Néanmoins plusieurs aspects négatifs ont été énoncés à savoir la stérilité suite à une prise prolongée de la pilule, la possibilité d'effets secondaires sur l'organisme : prise ou perte de poids, kystes, déséquilibre hormonal, nausées, vertiges et maux de tête, chute des cheveux, fausse couche, malformation des bébés à naître.

PAR RAPPORT AUX METHODES ALTERNATIVES

a) La méthode de calendrier

Adoptée par la majorité des jeunes ruraux, la méthode de calendrier est la méthode qu'ils disent connaître le plus, qu'ils trouvent la plus sécurisante du fait que c'est une méthode naturelle et qu'à travers laquelle les jeunes ne craignent pas d'effets secondaires. La gratuité de la méthode est la caractéristique principale que les jeunes retiennent le plus de cette méthode.

« Je ne veux pas faire des dépenses supplémentaires, parce que je sais compter les jours (Jeune femme, 22ans, sec, Antsohihy)

«Tu ne tomberas pas malade en comptant les jours » (Jeune Femme, 19 ans, secondaire, étudiante, Ihosy)

Il faudrait remarquer qu'une minorité des jeunes ruraux connaît l'utilisation du collier comme accessoire au comptage de cycle.

« Il n'y a rien à insérer ni à prendre » (Jeune Femme, 19 ans, secondaire, Ihosy)

Cependant les jeunes ruraux connaissent également qu'une erreur de comptage leur fait courir un grand risque de grossesse.

« Les étourdies ne devraient pas utiliser le collier du cycle, elles tomberont enceinte si elles ratent le déplacement de l'anneau » (Jeune Femme, 19 ans, secondaire, Ihosy)

b) La méthode de retrait

Cette méthode a été citée par les cibles en accompagnement de la méthode calendaire pour éviter les grossesses non désirées. L'absence d'intermédiaire pendant le rapport sexuel est le plus apprécié des jeunes ruraux.

« Pendant les périodes à risque, on fait le retrait quand le sperme commence à arriver pour éviter la grossesse » (Jeune homme, 16 ans, Secondaire, Miarinarivo)

Néanmoins, les jeunes ruraux savent bien que cette méthode est incertaine. Une fuite n'est jamais à écarter selon elles.

« Il se retire et il éjacule sur moi, il y a un risque que ça coule et que je tombe enceinte » (Jeune femme, 18 ans, secondaire, Miarinarivo)

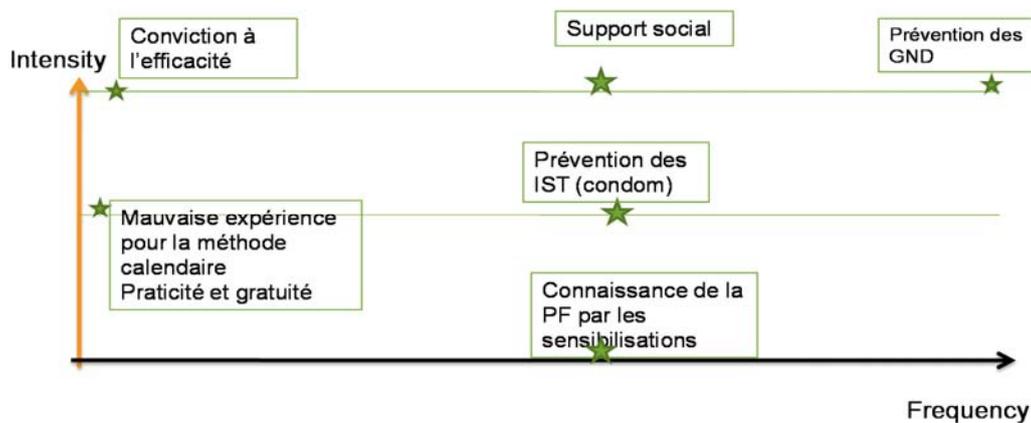
LES SOURCES D'INFORMATION DES JEUNES RURAUX

Les jeunes ruraux écoutent la radio locale disponible dans leurs localités respectives. Ce sont surtout les théâtres radiophoniques, les variétés et les émissions de dédicaces qu'ils suivent le plus. Ensuite, les affiches bien qu'elles sont rares en milieux ruraux sont des sources d'information des jeunes.

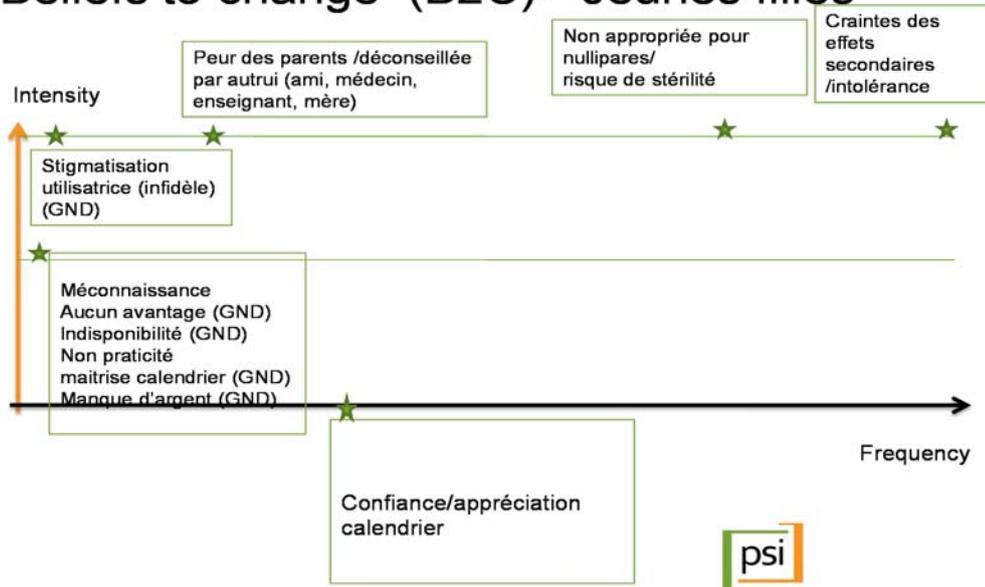
Concernant les évènements : ce sont surtout pendant les rencontres ou les tournois : foot, basket, handball, pétanque ou karaté que les jeunes s'échangent des informations entre eux ou encore prennent des nouvelles informations.

Les personnes avec qui les jeunes ruraux ont le plus d'échange concernant des sujets en général, ou concernant spécifiquement la santé sont en premier lieu le personnel de santé à savoir les médecins, les sages femmes et les agents communautaires. Ensuite, leurs professeurs de SVT, leurs ami(e)s, les membres de leurs fratricies, ainsi que leurs partenaires.

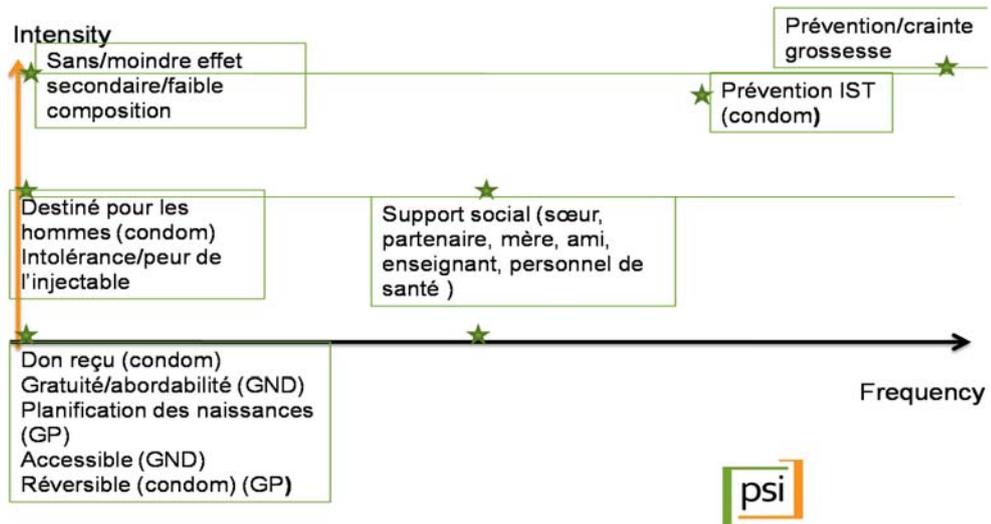
Beliefs to reinforce (B2R) - jeunes filles



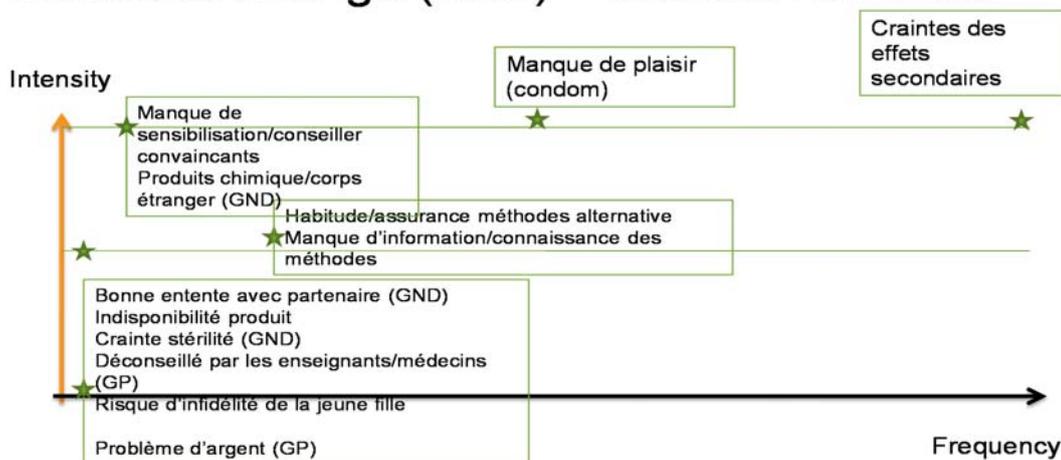
Beliefs to change (B2C) - Jeunes filles



Beliefs to reinforce (B2R) - Jeunes hommes



Beliefs to change (B2C) - Jeunes hommes



Category Map MCD 1/2

	CONDOM	INJECTABLE	PILLULE
	Evitement des GND		
ASPECTS POSITIFS	<input type="checkbox"/> Seule prévention des IST <input type="checkbox"/> Espacement des naissances <input type="checkbox"/> Accessible	<input type="checkbox"/> Non contraignant (tous les 3 mois) <input type="checkbox"/> Procure une tranquillité d'esprit <input type="checkbox"/> Espacement /limitation des naissances <input type="checkbox"/> Permet des RS illimités <input type="checkbox"/> Fortifie	<input type="checkbox"/> Procure une tranquillité d'esprit <input type="checkbox"/> Espacement de naissance <input type="checkbox"/> Permet des RS illimités
	Spécifique JF <input type="checkbox"/> Abordable <input type="checkbox"/> Gain de satisfaction avec le lubrifiant <input type="checkbox"/> Peut être trouvé à tout moment	<input type="checkbox"/> Adéquat pour les étourdiées Confort : absence de règles	<input type="checkbox"/> Efficace : forte dose <input type="checkbox"/> Fortifie <input type="checkbox"/> Gain de poids Régularité des règles <input type="checkbox"/> Menstruation normale <input type="checkbox"/> Protection contre les maladies <input type="checkbox"/> Provoque les règles <input type="checkbox"/> Pratique (pas besoin de prestataire) <input type="checkbox"/> Réversible
	Spécifique JH <input type="checkbox"/> Double protection	<input type="checkbox"/> Gain de poids <input type="checkbox"/> Se dissout dans l'organisme	

Category Map MCD 2/2

	CONDOM	INJECTABLE	PILLULE
ASPECTS NEGATIFS	<input type="checkbox"/> Stérilité <input type="checkbox"/> Insatisfaction partenaire <input type="checkbox"/> Incitation à l'infidélité	<input type="checkbox"/> Gain / perte de poids <input type="checkbox"/> Problèmes utérins (crampe- diminution libido- trouble hormonal) <input type="checkbox"/> Irréversible <input type="checkbox"/> fausse couche <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Abondance/arrêt des règles <input type="checkbox"/> Stérilité <input type="checkbox"/> Stigmatisation	<input type="checkbox"/> Maux d'estomac <input type="checkbox"/> Stérilité <input type="checkbox"/> Perte/prise de poids <input type="checkbox"/> fausse couche / mort- né / malformation <input type="checkbox"/> Problème utérin/kyste/destruction <input type="checkbox"/> Omission <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Vertige <input type="checkbox"/> Trouble hormonale <input type="checkbox"/> Maux de tête <input type="checkbox"/> Difficulté de fécondation après utilisation <input type="checkbox"/> Chute de cheveux <input type="checkbox"/> Nausée <input type="checkbox"/> Manque d'appétit <input type="checkbox"/> Règle irrégulière
	<u>Spécifique JF</u> <input type="checkbox"/> Gène <input type="checkbox"/> Risque de mycose <input type="checkbox"/> Augmentation pénis <input type="checkbox"/> Destruction du col	<input type="checkbox"/> Malformation	
	<u>Spécifique JH</u> <input type="checkbox"/> Risque de déchirure Compression pénis Odeur	<input type="checkbox"/> Provoquant une grossesse extra utérine	

Category Map MLD

	DIU	IMPLANT
ASPECTS POSITIFS	<input type="checkbox"/> Évite la GND <input type="checkbox"/> Longue durée <u>Spécifique JF</u> <input type="checkbox"/> Limite les naissances / Possibilité d'épargne <input type="checkbox"/> Donne de l'appétit <input type="checkbox"/> Régularise les cycles <u>Spécifique JH</u> <input type="checkbox"/> Procure un esprit tranquille <input type="checkbox"/> Retirable si besoin	<input type="checkbox"/> Evite la grossesse <input type="checkbox"/> Repousse/espace les naissances <input type="checkbox"/> Procure un esprit tranquille <input type="checkbox"/> Gain de temps (triennal) <u>Spécifique JF</u> <input type="checkbox"/> Régularise le cycle <input type="checkbox"/> Fait maigrir / grossir/ bonne forme <u>Spécifique JH</u> <input type="checkbox"/> Longue durée <input type="checkbox"/> Gain de poids <input type="checkbox"/> Retrait en temps voulu <input type="checkbox"/> Dans les normes
ASPECTS NEGATIFS	<input type="checkbox"/> Risque de cancer / perte/blessure <input type="checkbox"/> Risque de stérilité <input type="checkbox"/> Perte de poids <input type="checkbox"/> Risque d'IST par présence de corps étranger <input type="checkbox"/> Durée trop longue <u>Spécifique JF</u> <input type="checkbox"/> Pose douloureuse <input type="checkbox"/> Gène pendant RS	<input type="checkbox"/> Risque de stérilité /Hypertension <input type="checkbox"/> Perte/gain de poids <input type="checkbox"/> Aménorrhée <input type="checkbox"/> Favorise les IST <input type="checkbox"/> Risque de déplacement du bâtonnet <input type="checkbox"/> Activité limitée <input type="checkbox"/> (JH)Difficulté de fécondation/malformation après utilisation /Substance forte provoquant maladie <u>Spécifique JF</u> <input type="checkbox"/> Vertige / Chute de cheveux <input type="checkbox"/> Abondance de règle

Category Map méthode alternative

	CALENDRIER	RETRAIT	COLLIER
ASPECTS POSITIFS	<input type="checkbox"/> Evite les GND <input type="checkbox"/> Aucune dépense <input type="checkbox"/> Aucun effet secondaire <input type="checkbox"/> Méthode naturelle		<input type="checkbox"/> Aucun effet secondaire <input type="checkbox"/> Méthode naturelle <input type="checkbox"/> Facile à trouver
	<input type="checkbox"/> Risque d'erreur de comptage de jour <input type="checkbox"/> Méthode non maîtrisée	<p><u>Spécifique JF</u></p> <input type="checkbox"/> Insatisfaction du partenaire <input type="checkbox"/> Possibilité de fuite	<p><u>Spécifique JF</u></p> <input type="checkbox"/> Oubli de déplacement de l'anneau <input type="checkbox"/> Incertain
ASPECTS NEGATIFS		<p><u>Spécifique JH</u></p> <input type="checkbox"/> Grossesse en cas de retard de retrait	<p><u>Spécifique JH</u></p> <input type="checkbox"/> Nécessité de formation

CONTACT INFORMATION

Country Representative: Chuck SZYMANSKI,

czynanski@psi.mg

Technical Assistance: Ietje REERINK

ietjer@psi.mg

Research Manager: Anja RAKOTOMALALA

anjar@psi.mg



RESULTATS DU PRETEST DES AFFICHES DE SENSIBILISATION ET DE LOCALISATION

Tsiroanomandidy

Juillet 2013



Objectifs généraux du Pré-test

Déterminer si les messages clés promus à travers les supports sont retenus et compris d'une part , d'identifier les éléments d'attrait , de persuasion, d'appréciations, de crédibilité d'une autre part et enfin de récolter les suggestions d'amélioration.

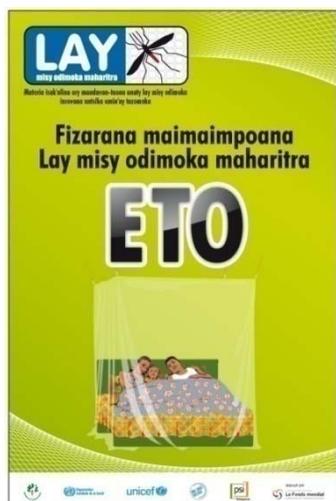
Méthodologie du pré test des affiches

- Technique utilisée :
 - Focus group (4)
 - Mise en contexte de l'affiche (position à 5 à 10 m des pax)
 - Test une à une des affiches avec interversion pour chaque focus group

Zones: Tsiroanomandidy

- Groupes d'étude :
 - 12 chefs de ménage de sexe masculin
 - 12 chefs de ménage de sexe féminin

PLAN DE PRESENTATION



POUR LES AFFICHES

Les acquis pour les affiches

Les non acquis, remarques et les suggestions d'amélioration

Les constats et recommandations des chercheurs

RESULTATS DU PRE TEST DES AFFICHES



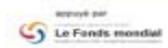
LAY
misy odimoka maharitra

Matria isak'alina ary mandavan-taona anaty lay misy odimoka ierovana antsika amin'ny tazomoka

**Fizarana maimaimpoana
Lay misy odimoka maharitra**

ETO

Illustration of a family (mother, father, and child) sleeping under a mosquito net.

Logos at the bottom:  Organisation mondiale de la Santé,  unicef,   psi,  approuvé par Le Fonds mondial



LAY
misy odimoka maharitra

Matria isak'alina ary mandavan-taona anaty lay misy odimoka ierovana antsika amin'ny tazomoka

**Fizarana maimaimpoana
Lay misy odimoka maharitra**

Illustration of a family (mother, father, and child) sleeping under a mosquito net.

Manatona ny sefo fokontany maka fanampim-panazavana

Logos at the bottom:  Organisation mondiale de la Santé,  unicef,   psi,  approuvé par Le Fonds mondial

LES ACQUIS POUR LES AFFICHES



Éléments compris

- Affiche de localisation par l' Indication « ETO»
(tot.)

-Sensibilisation sur l'utilisation du Lay pour la
prévention du paludisme (tot)

Éléments retenus

-Distribution gratuite (moit.)
-Dormir sous lay tous les soirs et toute l'année pour
la prévention du paludisme (min.)

-Distribution gratuite (maj)
-Dormir sous Lay tous les soirs et toute l'année pour
se protéger contre le palu (min)
-Aller demander de plus amples infos auprès du chef
fokontany (min.)

Éléments les plus attrayants

Inscription ETO : Caractère majuscule
Illustration du moustique : vecteur de transmission
Inscription fizarana maimaimpoana... : importance
de la gratuité, de grande taille

- Inscription fizarana maimaimpoana... : de grande
taille, gras, centré
-logo en entier : identification du produit
- Illustration de la famille: bénéfice de l'utilisation ,
sérénité
- Inscription « manatona ny sefo fokontany... » et de
la bande blanche: indication de la date et du lieu de
distribution

LES ACQUIS POUR LES AFFICHES



Emplacement des éléments

Emplacement logique et illustratif des images et des textes
Complémentarité des images et des textes

Formulation des messages

Phrases simples – compréhensibles – mode impératif et incitatif

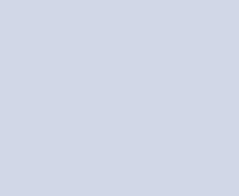
Illustrations

Image de famille pertinente: bénéfique (sérénité), démonstration d'utilisation, sensibilisante
Image incitative de lay

Couleur de fond verte

Attrayante
Associée aux buissons
Idée d'espoir

LES REMARQUES ET SUGGESTIONS DES CIBLES

	REMARQUES	SUGGESTIONS DES CIBLES
	« Matoria isak'alina... » - « manatona ny sefo fokontany... » sont illisibles	A agrandir comme 'Fizarana...'
	Couleur Verte non attrayante - moustiquaire non mise en évidence (confusion couleur de fond et moustiquaire)	Adopter couleur de fond rouge – mettre image de moustiques autour du lay
	Posture non endormie inappropriée de la famille	Mettre famille en position couchée
	'Fizarana maimaimpoana » non incitative car non impérative	A changer en mode impérative “Tongàva fa misy fizarana maimaimpoana Lay misy odimoka maharitra”
	Chef Fokontany non concerné par la santé	Changer en “Manatona ny tobim-pahasalamana”
	Image trop petite de la famille	Adopter l'image de famille pour fond
	Lit ciblant les riches	A changer par tsihy ou matelas par terre
	Incohérence de l'image de famille avec l'idée de gratuité	Changer image de famille en image de bureau de fokontany
	Distribution trop mise en évidence	'Lay misy odimoka maharitra' à agrandir Mettre la phrase “Izao ny olona matory anaty Lay misy odimoka” dans la bande blanche

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
	
<p>Messages sur la nécessité de dormir toutes les nuits et pendant toute l'année retenue seulement par une minorité</p>	<p>Agrandir la taille des écritures – faire la sensibilisation même en dehors de la campagne</p>
<p>Couleur de fond verte appréciée par la majorité Couleur de moustiquaire confondue avec couleur de fond selon les cibles</p>	<p>Adopter la couleur de fond verte mais la rendre encore plus foncée</p>
<p>Image de famille jugée pertinente Posture non endormie inadéquate selon les cibles</p>	<p>Garder image de famille Si possible, adopter une posture endormie de la famille</p>
<p>Message sur demander de plus amples informations identifiée par une minorité des cibles Mode impératif des phrases apprécié par les cibles</p>	<p>Agrandir la taille de sefo fokontany et reformuler par « Tongava haingana any amin'ny sefo fokontany... » Mettre les initiales Sefo et Fokontany en <small>page 9</small> maiuscule</p>



RESULTATS DU PRETEST DU GUIDE MOBILISATEUR

Tsiroanomandidy
Juillet 2013

Objectifs du pré-test

Déterminer si les messages clés promus à travers les supports sont retenus et compris d'une part , d'identifier les éléments d'attrait , de persuasion, d'appréciations, de crédibilité d'une autre part et enfin de récolter les suggestions d'amélioration.

Méthodologie

- Technique utilisée :
 - Focus group (2)
 - Distribution à chaque AC d'un exemplaire du guide et leur laisser le temps de le lire
 - Prise de note du sens de la lecture et ainsi des communications non verbales pendant la lecture
 - Récolte des informations suivant les objectifs du pré test et des suggestions d'amélioration du guide

- Zones: Tsiroanomandidy

- Groupes d'étude :
 - 16 Acs

PLAN DE PRESENTATION

POUR LE GUIDE MOBILISATEUR

Les acquis pour le guide

Les non acquis ,remarques et suggestions
d'amélioration du guide

Les constats et recommandations des chercheurs



RESULTATS PRE TEST DU GUIDE MOBILISATEUR

Ny andraikity ny mpanentana ara-pahasalamana mandritra ny hang up

- Manantontosa ny « Yangivangy Arahana Dinidinika » any amin'ireo tokantrano rehetra : miarahaba izay olona resahana, mampahafantatra ny fena ary ny anton-dia
- Manontany ny tokantrano raha efa nahazo ny lay misy odimoka maharitra mandritra ny fizarana faobe
- Raisina ny mombamomba ny tokantrano raha toa ka tsy mbola nahazo ny anjarany izy ary mamandre ny sefo CSB. Raketina antsoatra anaty « fisy fanisana » ny mombamomba ilay tokantrano.
- Ho an'ireo tokantrano efa nahazo ny lay misy odimoka maharitra: Hamarinina raha nampiasaina araka ny tokony ho izy ny lay misy odimoka maharitra (mihantona) ary raha ilaina dia ampiana ny tokantrano hanantona ny lay misy odimoka maharitra
- Hamafisina ireo hafatra mikasika ny fanentanana (fanasana, fikojakojana, fampiasana ara-dalana, fandraisana andraikitra mikasika ny loto)
- Fenoy ny fisy hang up :
Asaina manao sonia izay olona mandray ao an-trano,
Soratana hoe « HITA » eo amin'ny varavaran'ny tokantrano notsidihana (aza adino ny tsaoka)
- Hamarino tsara raha feno ara-dalàna ny fisy hang up
- Asio daty sy sonia ny fisy
- Asaina asan'ny mpiandraikitra ny toby fizarana daty sy sonia ny fisy
- Aterina eny anivon'ny RSE ny fisy efa feno

Torolalana famenoana ny fisy hang up

1. Anaran'ny toby fizarana lay misy odimoka maharitra
2. Anaran'ny fokontany misy ilay tokantrano tsidihina
3. Anaran'ny kaominina misy ilay fokontany
4. Anarana feno ny mpanentana
5. Anaran'ny SR/ONG mpiara-miombon'antoka amin'ny fizarana lay misy odimoka maharitra
6. Nomeraon'ny fanisana napetraky ny mpanisa tamin'ny fotoana ny fanisana
7. Anarana feno ny loham-pianakaviana. Jereo ny anarana voasoratra anatin'ny boky fanisana (tokony hitovy amin'ny anaran'ny loham-pianakaviana voasoratra tamin'ny fanisana).
8. Sonian'ilay olona monina anatin'ny tokantrano nandray ny mpanentana
9. Isan'ny olona natory tao anaty tokantrano tamin'ny alina
10. Isan'ny zaza latsaky ny 5 taona natory tao anaty tokantrano tamin'ny alina
11. Isan'ny lay misy odimoka maharitra ao an-trano (tsy isaina ny lay tsy misy odimoka maharitra).
Angatahana ireo lay misy odimoka maharitra aza nandritra ny fizarana nefa tsy mihantona.
12. Isan'ny lay misy odimoka maharitra mihantona (raha tsy mihantona fa mipirina ny lay misy odimoka maharitra, dia atao ahoana? Ahoana koa ny lay misy odimoka maritra vao aza anatin'ny 3 volana?)
13. Isan'ny olona natory tao anaty lay misy odimoka
14. Isan'ny zaza latsaky ny 5 taona natory tao anaty lay misy odimoka
15. Fanazavana sy fepetra noraisina mikasika ny lay misy odimoka maharitra ao anatin'ilay tokantrano
16. Totaly isaky ny tsanganana
17. Daty sy sonian'ny mpanentana nitsidika ny tokantrano taorian'ny fizarana lay misy odimoka maharitra
18. Daty sy sonian'ny sefon'ny toby fizarana



Materia isakalina ary mandovan'noho anaty lay misy odimoka izavava antsika amin'ny tazomoka

Anontanio ny sefo fokontany misy anao mikasika ny andro sy ny toerana hanaovana ny fizarana.

TSARA HO FANTATRA

- ◆ Ny kaikity ny moka ihany no mahavoana ny tazomoka.
- ◆ Tokony hampiasa lay misy odimoka maharitra ny isan-tokantrano mba hiarovana ny fianakaviana amin'ny tazomoka.
- ◆ Hisy ny fizarana faobe lay misy odimoka maharitra amin'ireto faritra ireto (iray amin'ireo faritra 4). Raiso ary alaivo ny anjara lainao eny amin'ireo toerana voatondro hizarana izany manomboka ny ka hatramin'ny ...
- ◆ Anontanio ny sefo fokontany misy anao mikasika ny andro sy ny toerana hanaovana ny fizarana
- ◆ Mandehana maka ny anjara lainao eny amin'ireo toerana hizarana izany, izay misy ny soratra "ETO".
- ◆ Tokony halevina 100 metatra miala ny rano fatsakana ary anaty lavaka manana halalina 1,50 m ambanin'ny tany ny fonosana lay misy odimoka

ANDRAIKITRA NY MPANENTANA

1. Mahafantatra ny tanjona ankapobeny sy ny asa takian'ny "Campagne MID 2013";
2. Mahafehy ny ao anatin'ny taridalana ho an'ny mpanentana (Guide des mobilisateurs);
3. Miady amin'ireo tsaho ;
4. Mahalala ny fantson-pifandraisana sy ireo fitaovan-tserasera hanentanana ny olona mandritra ny Campagne MID 2013;
5. Mahay ny teknika fanantonana ny Lay;
6. Mahafantatra ny andraikitra sy ny asan'ny mpizara Lay;
7. Mahafantatra ny andraikitra sy ny asan'ny mpitahiry (magasinier);
8. Mahay manao ny tatitra ny asa vita.



page 2

Les acquis

Compréhension

Outil de sensibilisation sur l'utilité de l'utilisation du Lay, standardisation de la sensibilisation, facilitation du travail des ACS...

Sens de lecture suivant l'ordre des pages du guide

Les éléments les plus faciles à capter

- Rôle des Acs pour lutter contre les rumeurs (*Page.1 - 3.*)
- « Kaikitry ny moka ihany ny mahatonga ny tazomoka » (*Page.1 - 1.*)
- Existence de la campagne (*Page.1 – 3.*)
- Gestion des déchets (*Page.2 encadré jaune*)
- Gratuité du MID (*Page.2- image2*)
- Interdiction pour d'autres usages (*Page.2 – image 5*)
- Nécessité de dormir toutes les nuits et pendant toute l'année sous une moustiquaire (*Page.3*)
- Entretien du Lay: suspendre en haut dans la journée et remettre pendant la nuit (*Page.3 - image2*)
- Compter les MID utilisées et suivi de son utilisation (*Page.4*)

Éléments de call to action identifiés

Sensibilisation et persuasion pour une utilisation correcte du Lay
Education de la population sur la cause du paludisme
Incitation à lutter contre le paludisme

Les acquis (suite)

Volume d'information

Informations complètes – détaillées – faciles à capter (tot)

Simplicité des messages

Phrases simples et compréhensibles (tot)

Illustrations

Complémentarités des images et textes (tot)

Autres appréciations positives

Emplacement des textes bien adéquat (tot)

Écritures bien lisibles (encadré jaune, caractères majuscules, gras, différence des couleurs) (tot)

Les non acquis du guide (1/2)

Remarques	Suggestions des cibles
Volume d'information	
Informations trop chargée - difficile à retenir (<i>Page.4</i>)	⇒Accompagner le guide par une fiche bien détaillée pour faciliter l'exécution des tâches ⇒Agrandir la taille des écritures comme dans ancien guide ⇒Utiliser des mots-clés
Information superflue (<i>Page 4, n° 13</i>) (impossible à réaliser)	⇒Enlever N°13
Information incomplète et non précise (<i>Page1, titre 1</i>)	⇒Ajouter « ny tsy fatoriana ao anaty lay no mahatonga ny tazomoka »
Information non précises sur les rumeurs (<i>Page1, titre2 – 3.</i>)	⇒Énumérer les rumeurs possibles
Autres utilisations prohibées non détaillées (<i>Page 2 – image 5</i>)	⇒Énumérer « tsy azo atao rideau, tsy anihifana, tsy atao amin'ny trano vorona , tsy isamborana valala »

Les non acquis du guide (2/2)

Remarques	Suggestions des cibles
Illustrations	
Bureau fokontany non exprimé (vide) <i>(Page1, image)</i>	⇒ Insérer une image de personne qui accueille
Absence de fil d'attente <i>(Page2 – image 1)</i>	⇒ Insérer file d'attente
Image prêtant confusion <i>(Page2 – image 4)</i>	⇒ Séparer les deux images
Page 3 – image 2 et 3: ordre inadéquat Page 3 – image 4: visage flou et texte non explicite	⇒ Inverser image 2 et 3 ⇒ Bien montrer le visage ⇒ « Rehefa maina dia avereno ahantona amin'ny toerany indray »
Messages - phrases	
« Fantsom-pifandraisana » et « fitaovan-tserasera » incompréhensible <i>(Page1, titre 2, Point.4)</i>	⇒ Mettre entre parenthèses des exemples
Phrase non claire <i>(Page2 – image 1)</i>	⇒ Changer 'voatondro amin'izany' par 'hizaràna ny lay'
Manque d'uniformisation du signe d'interdiction <i>(Page 2 – image 2 – 4 – 5)</i>	⇒ Insérer « TSIA » (image 4 et 5) pour insister le message



CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
Généralités	
Les écritures illisibles empêchent les Acs de bien retenir les messages (surtout Page 1 et Page 4)	Agrandir autant que possible la taille des écritures (idem écritures dans les encadrés jaune ou titre)
Les informations trop nombreuses empêchent les Acs de retenir les messages essentiels	Ne pas mettre que les messages essentiels, utiliser des mots-clés pour alléger les informations Mettre en jaune les messages d'appel à l'action
Les rubriques sont éparpillées dans les pages	Regrouper tout ce qui est rôle des Acs (page 1 et 4) et les connaissances et messages de sensibilisation (Page 1, 2 et 3)
Page 1	
« fantsom-pifandraisana » et « fitaovan-tserasera » incompris par les ACs	Mettre des exemples entre parenthèses
Bureau de fokontany jugé non expressif selon les cibles	Prendre une image réelle de bureau de fokontany et ajouter un personnel à l'accueil Arranger la posture de la main de l'homme (en dessous du menton de la jeune femme) page 10

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
PAGE 2	
Phrase de l'image 1 jugée non claire Attrait des cibles surtout sur les pages d'illustrations	Changer 'takio ny anjara lainao eny amin'ny toerana hizarana ny lay' Reprendre l'image de Page 1 dans cette séquence
Image de Lay dans son sachet non expressif	Rendre le dessin le plus proche possible d'un sachet de Lay
Expression du signe d'interdiction non uniforme	Adopter 'croix' et « TSIA » pour image 2 – 4 – 5
Non concordance de l'image 4 avec le texte, d'après les cibles	Séparer chaque message avec l'image qui lui correspond (dormir toute les nuits et pendant toute l'année ET ne pas ranger le Lay)
Attente des cibles d'énumérer les autres mauvaises utilisation du Lay Image non expressive (Page 2- image 5)	Énumérer les autres utilisations du lay évoquées par les cibles « tsy azo atao rideau, tsy anihifana, tsy atao amin'ny trano vorona , tsy isamborana valala »
Attente des cibles de continuer les sensibilisation même en dehors de la campagne	Continuer les sensibilisations sur l'utilisation du lay même en dehors de la campagne

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
PAGE 3	
Logique des cibles de considérer image 3 avant 2	Inverser image 2 et 3
Non reflexe des cibles selon les Acs de ne pas mettre le Lay suspendu une fois sec.	« Rehefa atoandro dia avereno ahantona amin'ny toerany indray » (image 4, texte point 5)
Image de la femme jugée floue (<i>Page 3. - image 3</i>)	Bien dessiner le trait du visage de la femme
PAGE 4	
Écritures jugées illisibles (informations en blanc)	Agrandir la taille des écritures
Les phrases simples et faciles à comprendre aident les Acs à maîtriser le contenu du guide La lourdeur des informations à la page 4 a été évoquée comme facteur limitant à la bonne utilisation du guide Evocation des Acs de la maîtrise du contenu du guide après beaucoup d'exercices et de lecture	Ne choisir que les messages essentiels et enlever ceux qui peuvent déjà être contenus dans la fiche hang-up Insister sur l'assimilation des instructions sur l'utilisation de la fiche hang-up dans les formations Favoriser les exercices pendant les formations



RESULTATS DU PRETEST DES SPOT RADIOS PER – PRE – POST Campagne

*Tsiroanomandidy
Juillet 2013*

Objectifs généraux du Pré-test

Déterminer si les messages clés promus à travers les supports sont retenus et compris d'une part , d'identifier les éléments d'attrait , de persuasion, d'appréciations, de crédibilité d'une autre part et enfin de récolter les suggestions d'amélioration.

Méthodologie du pré test des spots radios

Technique utilisée :

- Focus group (4)

- 1^{ère} Ecoute du premier spot et récolte des informations sur la rétention des messages. Reprendre pour les 2 autres spots.

- 2^{ème} Ecoute du premier spot et récolte des informations sur les appréciations et les suggestions. Reprendre pour les 2 autres spots.

- Intersion de l'ordre de diffusion des spots pour chaque focus

Zone: Tsiroanomandidy

Groupes d'étude :

- 12 chefs de ménage de sexe masculin

- 12 chefs de ménage de sexe féminin



PLAN DE PRESENTATION

1. Résultats du spot pré campagne

Les acquis

Les remarques et les suggestions d'amélioration

Les constats et recommandations des chercheurs

2. Résultats du spot per campagne

Les acquis

Les remarques et les suggestions d'amélioration

Les constats et recommandations des chercheurs

3. Résultats du spot post campagne

Les acquis

Les remarques et les suggestions d'amélioration

Les constats et recommandations des chercheurs

Rappel du contenu des spots

Pré campagne	Per campagne	Post campagne
Une seule piqûre de moustique peut causer le paludisme	Le MID est maintenant distribué GRATUITEMENT	Quelques indications très simples sur son utilisation : chacun doit donc dormir sous le MID toutes les nuits, pendant toute l'année . Accrochez le MID en couvrant le lit et faire entrer les rebords du MID sous le matelas
Pour protéger la famille contre le paludisme, doit utiliser les Moustiquaires Imprégnées d'Insecticides à effet durable	Récupérer votre part de MID dans les lieux où il y a l'inscription ETO	Laver le MID dans une koveta avec du savon "simple" tous les 3 mois et laisser sécher à l'ombre
Existence de la campagne de distribution gratuite dans la région	Demander vite les détails des lieux de récupération du MID et la date exacte de la distribution à votre chef fokontany	Raccommoder les MID déchirées
Se préparer pour venir récupérer la part de MID dans les lieux où il y a ETO à partir du (date) au (date). Demander les détails des lieux de récupération et la date exacte de distribution au chef fokontany	Dormir sous les MID toutes les nuits et pendant toute l'année pour se protéger contre le paludisme	Dormir sous les MID toutes les nuits et pendant toute l'année pour se protéger contre le paludisme
Dormir sous les MID toutes les nuits et pendant toute l'année pour se protéger contre le paludisme		

SPOT

**Pré
campagne**



ECOUTE DU SPOT PRE CAMPAGNE



LES ACQUIS POUR SPOT PRE CAMPAGNE

Messages retenus	Appel à l'action	Appréciations positives
		<ul style="list-style-type: none"> •Messages sous forme de conseil /mise en garde (m)
<ul style="list-style-type: none"> •Gratuité du Lay (tot.) •Protection contre le paludisme par l'utilisation systématique du lay (tot.) •Demander les détails de la distribution auprès des chefs fokontany (maj.) •Paludisme mortel (maj.) •Distribution lay à partir du 30 septembre (moit.) 	<ul style="list-style-type: none"> •Utiliser /systématiquement le lay (tot.p) •Prise de responsabilité des pères de famille (maj.p) •Se renseigner auprès du chef fokontany sur la distribution (moit.m) 	<ul style="list-style-type: none"> •Sensibilisation appropriée à la zone endémique (m)
		<ul style="list-style-type: none"> •Durée appropriée •Dialogue naturel -courant –facile à retenir •Voix mature – distincte – audible – captivante – ferme •Phrases polies – compréhensibles •« eh » interpellant (p)

LES REMARQUES ET SUGGESTIONS DES CIBLES

REMARQUES	SUGGESTIONS
Message manquant	
Interdiction de vente manquante (p)	Evoquer dans le spot 'AZA AMIDY'
Les éléments non appréciés	
Musique trop présente (p)	Enlever fond de musique
Langage officiel incompris des ruraux (m)	Adopter une variation dialectale
Trop de mise en scène (m)	Changer le spot en sketch comique ou ajouter un artiste comique Dialogue en chemin entre AC et mère
Durée trop courte (m)	Bien préciser la non utilisation de lay comme raison de l'insomnie de la femme et de son enfant
Débit trop rapide (m)	Ralentir le débit de la parole
	<u>Autres suggestions pour faciliter la rétention des messages:</u> <ul style="list-style-type: none">•Ajouter une voix d'enfant interpellant les parents•Préciser l'âge des enfants pouvant dormir sous lay•Insister sur les symptômes du paludisme en début du spot•Faire des diffusions multiples•Ajouter les avantages de l'utilisation du lay

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
SPOT PRE CAMPAGNE	
<p>Seule une minorité a identifié le message d’aller demander les renseignements auprès du Chef Fokontany sur le lieu et la date de distribution</p>	<p>Arranger le scénario: Etape 1. Changer Chef Fokontany en « mpanentana ara-pahasalamana ». Mettre le message en début mais pas vers la fin. Enlever “fa izao eh!” . “Handao isika hanontany ny mpanentana ara-pahasalamana atsy ambadika atsy hoe fa hisy fizarana lay maimaipoana nyhandao hanontaniana tsara azy ny toerana sy ny daty hanaovana ny fizarana”</p> <p>2. Danger du paludisme (...sady tato ho ato izahay tsy natory fa be moka ny tazomoka mahafaty “Tato ho ato dia tsy mahita tory mihitsy izahay mianaka fa kaikerin’ny moka foana ! H: Oay! Tandremo fa kaikitry ny moka indray mandeha fotsiny dia mety hahavao ny tazomoka e! Ary tsarovy fa ny tazomoka dia aretina mahafaty kanefa azo sorohana tsara amin’ny fatoriana anaty lay misy odimoka maharitra. F: tokony hatory ao anaty lay misy odimoka maharitra isak’alina ary mandavan-taona izany ny mpianakavy hisorohana ny tazomoka ?</p> <p>3. Prévention par l’utilisation du MID.</p>
<p>Débit de parole jugée trop rapide</p>	<p>Ralentir le débit des paroles surtout sur les principaux messages.</p>

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
SPOT PRE CAMPAGNE (suite)	
Dormir toute l'année et toutes les nuits sous un lay identifiée par les chefs de ménage Message évoqué deux fois dans le spot	Insister sur le message d'aller se renseigner auprès de l'AC plutôt que ce message (3ème phase de la campagne)
Aucune rétention des cibles sur le message 'une seule pique de moustique peut causer le paludisme' mais plutôt sur le danger mortel du paludisme	Insérer le message 'une seule piqure peut causer le paludisme' dans spot 3 pour renforcer la nécessité de dormir de manière continue sous le moustiquaire maintenant que le MID est dans les ménages
Langage officiel incompris des ruraux selon la moitié des chefs de ménage	Adopter une variation dialectale des spots

SPOT

**Per
campagne**



ECOUTE SPOT PER CAMPAGNE



LES ACQUIS POUR SPOT PER CAMPAGNE

Messages retenus	Appel à l'action	Appréciations positives
<ul style="list-style-type: none"> •Gratuité du Lay (tot.) •Demander les détails de la distribution auprès des chefs fokontany (maj.) •Dormir toutes les nuits et toute l'année sous un lay (tot.) •Distribution sur les lieux où il y a les inscriptions 'ETO' (moit.) <p><u>Spécifiques mères:</u></p> <ul style="list-style-type: none"> •Ponctualité de l'arrivée des lay (inf.m) 	<ul style="list-style-type: none"> •Utiliser en permanence le produit (dormir toute l'année/toute les nuits) (maj.) Sensibiliser les pairs sur l'utilisation du lay (min.) 	<ul style="list-style-type: none"> •Message clair - facile à retenir •Message aux bénéfiques de la santé – utile pour les ruraux •Durée courte – non lourd
<p><u>Spécifiques pères:</u></p> <ul style="list-style-type: none"> •Sensibilisation sur l'arrivée des lay (quasi.p) •Incitation à l'utilisation lay (maj.p) •Récupérer immédiatement le lay (min.p) 	<p><u>Spécifiques pères:</u></p> <ul style="list-style-type: none"> •Acquérir le produit auprès des chefs Fokontany (moit.p) <p><u>Spécifiques mères:</u></p> <ul style="list-style-type: none"> •Se renseigner auprès des chefs fokontany (tot.m) •Récupérer le lay auprès des locaux où il y a les inscriptions ETO (moit.m) •Récupérer rapidement le lay (haingana) (moit.m) •Sensibiliser les ruraux sur la gratuité (inf.m) 	<p><u>Spécifiques pères:</u></p> <ul style="list-style-type: none"> •Dialogue dynamique •Voix forte/pressante (homme) – joyeuse (femme) - impliquant les deux parents •Débit audible •Musique décorative •Phrase malgache intégrale

LES REMARQUES ET SUGGESTIONS DES CIBLES

REMARQUES SUR SPOT PER CAMPAGNE

SUGGESTIONS

Les éléments non appréciés

•Haingàna non malgache

Remplacer 'haingana' par « Faingàna » ou par « Mandehana haingana » ou « haingankaingana »

Langage officiel incompréhensible en milieu rural (p)

Adopter une variation dialectale

Pub non attrayant pour ruraux (m)

Faire un spot avec un artiste connu (Tsiliva, Barinjaka, Jerry Marcos)

Débit trop rapide (m)

Ralentir le débit de la parole

Spot trop court (m)

- Ajouter une voix d'enfant (pleurs)
- Ajouter plus de personnages (deux mères ayant des enfants de tranche d'âge différents - un animateur comique qui explique le MID)
- Diffuser le spot deux fois de suite
- Insister sur la gratuité (répéter tsy andoavam-bola)

Coupure des mots non appropriée (eh tonga) (m)

Mettre un arrêt entre les deux mots

Autres suggestions pour renforcer les messages:

Ajouter réplique « maimaipoana hoe ramatoa? »

Renforcer le quota de mid par famille

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats

Recommandations des chercheurs

SPOT PER CAMPAGNE

Compréhension par la majorité que distribution sur les lieux où il y a les inscriptions ETO au lieu de affiche ETO

Ajouter le mot « afisy » ('...toerana misy ny afisy ETO)

Tsarovy fa ny tazomoka dia aretina mahafaty kanefa azo sorohana tsara amin'ny fatoriana anaty lay misy odimoka maharitra.

... maharitra ela. Pour mieux évoquer l'effet durable et non pas moustiquaire tout court

Débit de parole jugée trop rapide par les cibles

Bien couper et articuler les mots sur les messages

Rétention par la majorité des cibles d'aller demander les détails de la distribution au niveau des Chefs Fokontany

Changer Chef Fokontany par mpanentana arapahasalamana

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats

Recommandations des chercheurs

SPOT PER CAMPAGNE

(suite)

Interprétation par une minorité des cibles d'acquérir le produit auprès des Chefs Fokontany

Haingàna jugé non malgache selon les chefs de ménage

Insister le message et Adopter :

« Lahy : Efa hoe tonga hoy aho ny lay misy odimoka maharitra zaraina maimaimpoana , ... **Handao haingana** isika samy haka ny anjara laintsika avy !

Vavy : Aiza no angalana azy ?

Lahy : Eny amin'ireo toerana ahitana ny afisy misy soratra ETO , sady tsy andoavam-bola mihitsy an!

Vavy : Aiza hoe ?

Lahy : Eny amin'ireo toerana ahitana ny afisy misy soratra ETO no hangalana ny lay

SPOT

**Post
campagne**



ECOUTE SPOT POST CAMPAGNE



LES ACQUIS POUR SPOT POST CAMPAGNE

Messages retenus	Appel à l'action	Appréciations positives
<ul style="list-style-type: none"> •Utilisation du lay (tot.) -faire entrer par le rebord du lit sous le matelas (tot.) -suspendre du coté du lit (tot.m) •Entretien du lay (tot.) -laver avec du savon ordinaire tous les 3 mois (tot.) -Coudre en cas de déchirure (quasi.) -Suspendre à l'ombre après lavage (moit.m) <p><u>Spécifiques pères:</u></p> <ul style="list-style-type: none"> •Dormir toutes les nuits et toute l'année sous un lay (tot.p) <p><u>Spécifiques mères:</u></p> <ul style="list-style-type: none"> •Arrivée à domicile du lay (moit.m) 	<ul style="list-style-type: none"> •Suivre les consignes d'utilisation/entretien (quasi.) •Utiliser systématiquement le lay imprégné (moit.) <p><u>Spécifiques mères:</u></p> <ul style="list-style-type: none"> •Suivre des infos à la radio (moit.m) •Sensibiliser les pairs sur la nécessité de prendre soin du lay (moit.m) 	<ul style="list-style-type: none"> •Message compréhensible / pratique / sensibilisante/ courte •Durée appropriée à un spot publicitaire – courte •Musique captivante •Intonation respectant la ponctuation <p><u>Spécifiques pères:</u></p> <ul style="list-style-type: none"> •Concept flash info original/facile à capter / animé •Voix masculine impliquant les hommes - sérieuse •Mots courants <p><u>Spécifiques mères:</u></p> <ul style="list-style-type: none"> •Débit calme (m)

LES REMARQUES ET SUGGESTIONS DES CIBLES

REMARQUES SUR SPOT POST CAMPAGNE	SUGGESTIONS
Message manquant	
Mauvaise utilisation (m)	Evoquer dans le spot les pratiques prohibées (pêche, ...)
Age des utilisateurs (m)	Ajouter l'âge de l'enfant qui peut dormir sous le lay
Éléments non appréciés	
Slogan trop rapide (m)	Bien marquer la coupure des phrases pour mieux évoquer le slogan
Voix trop nombreuse/confuse (m)	Bien différencier les voix des personnages
Musique gênante (p)	Adoucir le fond musical Réalisation du spot à la campagne
<u>Autres suggestions pour renforcer les messages:</u>	
<ul style="list-style-type: none">• Adopter une variation dialectale• Ajouter « Tandremo ary ny fanadinoana ny fampiasana ny lay » pour rappeler l'utilisation du lay• Diffuser le spot périodiquement après la distribution• Ajouter enfant rappelant les bonnes pratiques à ses parents (utilisation, entretien)• Ajouter « mbola azo amboarina fa tsy hakàna trondro »	

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
SPOT POST CAMPAGNE	
<p>Compréhension par la majorité des cibles que le spot incite à suivre les instructions d'utilisation et d'entretien du lay mais intention par une minorité de dormir systématiquement sous lay</p> <p>Le message « une seule pique peut causer le paludisme » « paludisme mortel » sont évoqués dans le script pré campagne</p>	<p>Reprendre le message de danger du paludisme et Adopter: « Tandremo fa kaitry ny moka indray mandeha monja dia mety mahatonga ny tazomoka, izay aretina mahafaty. » et reprendre le slogan «Matoria isak'alina ary mandavan-taona anaty lay misy odimoka maharitra, hiarovana antsika amin'ny tazomoka”</p>
<p>Attente des cibles d'évoquer l'interdiction à d'autres usages du lay</p>	<p>Évoquer dans le spot TSY AZO AMPIASAINA AMIN'NY ZAVATRA HAFA ny lay misy odimoka maharitra</p>
<p>Slogan trop rapide selon la moitié des cibles</p>	<p>Ralentir le débit de la parole sur le slogan</p>
<p>Voix trop nombreuse selon les cibles</p>	<p>Adopter la voix d'une seule femme sur le slogan et les instructions sur mode d'utilisation et entretien du lay pour éviter de perturber la concentration des cibles</p>

CONSTATS ET RECOMMANDATIONS DES CHERCHEURS

Constats	Recommandations des chercheurs
SPOT POST CAMPAGNE	
<p>Les raisons « techniques » des bonnes pratiques d'utilisation et d'entretien du MID ne sont pas évoqués dans le spot:</p> <p>« Accrochez le MID en couvrant le lit et faire entrer les rebords du MID sous le matelas <u>pour éviter que les moustiques entrent dans votre couche et dérange la sérénité de votre sommeil.</u></p> <p>Laver le MID dans une koveta avec du savon "simple" tous les 3 mois et laisser sécher à l'ombre <u>pour garder l'effet de l'insecticide.</u></p> <p>Raccommoder les MID déchirées »</p>	<p>Vérifier la conformité des scripts selon les messages à véhiculer.</p>

Annex J
BUDGET ANALYSIS

ANNEX K: FY 14 BUDGET ANALYSIS

Name of Project: **Integrated Social Marketing Program**

Cooperative Agreement Number: **AID-687-A-13-00001**

Starting Date: **January 1, 2013** Ending Date: **December 31, 2017**

Reporting period: **January to September 2013**

Organization: **Population Services International (PSI)**

USAID Project Manager: **Sixte ZIGIRUMUGABE**

Date of Last Site Visit:

Number of Review in the last 6 Months:

Description	LOP Budget	Obligated Amount	Actual Expenditures (Jan-Sep-2013)	Remaining Funds as of Sep 2013	Estimated Expenses FY 14	Required funds FY14
Child Survival (CS)	11 761 729	4 749 224	1 189 284	3 559 940	3 329 659	(230 280)
Family Planning (FP)	15 009 572	2 493 662	1 717 752	775 910	4 154 157	3 378 247
Malaria (MAL)	10 051 752	1 581 394	930 660	650 734	2 400 986	1 750 252
TOTAL	\$ 36 823 053	\$ 8 824 280	\$ 3 837 696	\$ 4 986 584	\$ 9 884 803	\$ 4 898 219

Description	LOP Budget	Actual Expenditures (Jan-Sep-2013)	Remaining Budget as of Sep 2013	Estimated Expenses FY 14	Total Remaining Budget
Furniture/Equipment	429 119	49 509	379 610	365 550	14 060
Commodities	3 033 122	174 159	2 858 963	1 671 757	1 187 206
Training/Conf/Mtg	1 793 462	97 872	1 695 589	533 433	1 162 156
Subawards	5 008 837	230 077	4 778 760	1 567 589	3 211 171
Other Direct Costs	23 451 564	2 869 898	20 581 666	4 841 317	15 740 349
Indirect Costs	3 106 950	416 182	2 690 769	905 157	1 785 612
TOTAL	\$ 36 823 053	\$ 3 837 696	\$ 32 985 357	\$ 9 884 803	\$ 23 100 554