

**Senegal Case Study:
Promising Beginnings,
Uneven Progress**

**A Repositioning Family
Planning Case Study**

December 2006



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

ACQUIRE Report

Senegal Case Study: Promising Beginnings, Uneven Progress

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By Jane Wickstrom, Abdoulaye Diagne, and Alyson Smith



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FROM THE AMERICAN PEOPLE

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This publication was made possible by the generous support of the American people through the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID or of the United States government.

The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a collaborative project funded by USAID and managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA). The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based and clinical care.

Printed in the United States of America. Printed on recycled paper.

Suggested citation: Wickstrom, J., Diagne, A., and Smith, A. 2006. *Repositioning family planning—Senegal case study: Promising beginnings, uneven progress*. New York: EngenderHealth/The ACQUIRE Project.

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Acknowledgments

This report was developed for Repositioning Family Planning, an initiative undertaken and funded by the U.S. Agency for International Development (USAID), and it was researched, written, and published by the ACQUIRE Project. Jane Wickstrom, Abdoulaye Diagne, and Alyson Smith are the principal authors of this report. Contributors included John M. Pile and Laura McPherson (consultant).

The authors are grateful to Joan Robertson, Shawn Malarcher, Alexandra Todd-Lippock, Elizabeth Warnick, Ishrat Husain, and Tanvi Pandit of the Repositioning Family Planning Task Force at USAID for their overall guidance in this case study. Elizabeth Warnick provided particularly valuable analysis of the 2005 Senegal Demographic and Health Survey (DHS) that informed the team's work. Former USAID/Senegal Health, Population, and Nutrition Officer Linda Lankenau provided important insights for the analysis.

The authors thank the current USAID/Senegal Health, Population, and Nutrition team of Jennifer Adams, Mary Cobb, Brad Barker, Elizabeth Benga De, and Matilde Ndow, who provided important background documentation and information. Mary Cobb's participation in and contributions to the team's field work are particularly valued. Dr. Salif Ndiaye (Centre de Recherche pour le Développement Humain) provided important reanalysis of the 1986, 1992, 1997, and 2005 DHS data.

Secretary General of the Ministry of Health (MOH) Moussa Mbaye provided keen insight into the structural relationships of family planning within the National Plan for Health and Social Development. Abdou Issa Dieng, the MOH technical advisor responsible for population, provided an interesting perspective on the relationship of family planning within the poverty-reduction strategy. El Hadji Oussenynou Faye offered essential information on current MOH policies. Regional and/or district medical officers visited by the study team in Kaolack, Fatick, Thies, and Saint Louis offered an important decentralized perspective.

Finally, the authors thank the many individuals in Senegal with various governmental, nongovernmental, and private organizations whose knowledge and expertise contributed to this report.

This report was edited by Michael Klitsch and was produced by Elkin Konuk.

Executive Summary

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (PRB, 2005). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. To guide future investments, USAID supported five country-specific case studies to identify strategies and lessons learned that have contributed to or detracted from family planning in the region. Together, the case studies are being used by USAID to guide the strategy development for Repositioning Family Planning and to inform efforts to identify key investments in the region.

Senegal has a reputation of leadership in Francophone West Africa, based on its successful democratic transition, the low level of economic corruption, and the success of its economic reforms. In health care, Senegal is a strong proponent of international treaties and approaches and has a long history of community participation in health.

Yet despite some promising beginnings with the family planning program, progress has been slower in Senegal over the last decade. It is important to note the history of family planning in Senegal to see the strides that have been made. Contraception was illegal until 1980. In 1988, Senegal became one of the first countries in Francophone Africa to adopt an official population policy. Two years later, the National Family Planning Program (PNFP) was launched as a vertical program. In the mid-1990s, Senegal's program was moderately strong, with an annual increase in modern method use of 0.7% (1992–1997). In 1998, the program shifted with the initiation of a plan to integrate family planning into the Division of Reproductive Health within the Department of Primary Health Care. Key respondents from the Senegal program noted that with integration, the focus on family planning was reduced. As one respondent stated, “The ICPD [International Conference on Population and Development] brought a wide agenda to Senegal, where more focus on FP was needed.” Another respondent noted, “You can't expand and integrate when family planning wasn't well-established to begin with.”

With 25 years of program investment by the government and donors, certainly gains have been made. From 1978 to 2005, the total fertility rate (TFR) decreased by almost two lifetime births per woman (from 7.2 to 5.3); overall contraceptive prevalence nearly tripled (from 3.9% to 11.8%); and use of modern methods increased 17-fold (from 0.6% to 10.3%). However, since the time of those baselines, subsequent contraceptive prevalence rates (CPRs) have remained relatively low, and fertility is still high. The annual increase in modern contraceptive prevalence was greater from 1992 to 1997 (0.7% per year) than for the period 1997 to 2005 (0.3% per year). An annual increase of 1–2 percentage points in the CPR indicates a strong family planning program.

Key Findings

Principal factors accounting for Senegal's limited progress in family planning include cultural barriers, access barriers, donor support, the impact of decentralization, lack of strong leadership,

training, supervision, and quality management, and contraceptive security. The impact of each of these is described below.

Cultural Barriers

Senegal has a long pronatalist tradition. Desired family size and actual family size are the same, thus discouraging the use of family planning. In addition, the majority of the population is Muslim (94%), and senior Islamic leaders have been slow to advocate for family planning, despite some early programming intended to mobilize their support. Instead, many people misinterpret Islam as discouraging the use of family planning. Further, the practice of polygamy, which has not decreased significantly in 20 years, encourages more births because of inheritance traditions, as well as competition among wives. The absence of sustained behavior change communications is often cited by key informants as the primary reason for the slow uptake of contraception, especially of modern methods, in Senegal.

Policy, Practice and Regulatory Barriers

Family planning in Senegal was long considered “the midwives’ business,” thus limiting access, especially at the clinic level. Moreover, family planning was “overmedicalized,” and provider bias influenced both method choice and overall access. Many providers refused to provide contraception without the husband’s consent. While policies and practices are changing, and nurses are being trained to provide selected services, the pace of change is slow. Senegal’s policies do not always support open access to contraception. For example, the availability of contraceptives in the private sector is restricted by laws that prohibit counseling for, prescribing, and dispensing contraceptives in the same private facility. Importing and distributing hormonal methods requires a lengthy and difficult regulatory process, which is compounded by high taxes and markups that increase the consumer price of products and limit affordability.

Donor Support

Donors have made important contributions to Senegal’s family planning program, but aspects of this support have contributed to the slow pace of progress. Early on, donors split the country into focus regions/districts for funding and technical assistance purposes. Weak coordination, parallel efforts, and perhaps a lack of cross-learning led to different approaches to program implementation in the various regions and districts. It also challenged institutionalization of the program within government agencies. For example, UNFPA and USAID each had their own contraceptive logistics programs, and the method mixes were different.

While USAID continued to work in its focus districts, programming emphasis shifted more toward supporting decentralization through developing health management and financing systems. UNFPA’s focus also shifted, from family planning to a more integrated reproductive health and rights approach. Both transitions reduced attention to family planning, and government systems had no capacity to take up the slack. By 1997, the Senegal Association for Family Welfare (ASBEF), the local International Planned Parenthood Federation affiliate, supplied 17% of the nation’s contraceptive needs through its clinics, community-based work, and information, education, and communication (IEC) efforts. However, after 2001, when the Mexico City policy was reinstated, ASBEF could no longer be a USAID grantee, and the population it served subsequently decreased by half.

Decentralization and Integration of Health Services

The focus on family planning was weakened by the devolution of authority to district and local levels and by the integration of family planning within reproductive health services. Decision makers allocated resources to perceived priorities. One report found that in one year, health lost 30% of its budget to other sectors. Moreover, family planning programs were left to untrained local authorities and political institutions that knew little about them and did little to expand the program.

Senegalese Leadership

Family planning had never been a priority among the elites, the health profession, or the national leadership. Frequent changes in the family planning program's organizational location (11 times in 19 years) made it difficult for the program to take root at the highest levels. One Senegalese informant noted that without significant champions at the top, it has been difficult to influence cultural norms.

Training, Supervision, and Quality Management

The provision of in-service training and supervision, while technically sound, remains dependent on donor financing for trainers and per diems for supervisory staff. The lack of a national commitment to bringing training, supervision, and quality assurance to scale beyond the USAID districts has hampered the expansion of this program.

Contraceptive Security

Senegal has long been dependent on donors for contraceptives and for contraceptive management tasks, such as forecasting. The government has committed to assuming the management and financing of contraceptives, beginning with procuring IUDs for 2006. However, concerns remain about the sustainability of the system and about contraceptive security over time.

Introduction

Family planning saves lives and has long been considered a key aspect of socioeconomic development. Although this is widely acknowledged and well-documented, decreased attention and resources in recent years have been directed toward improving family planning programs in developing countries, even though need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

In 2003 the U.S. Agency for International Development (USAID) and other stakeholders identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, many African countries found it extremely difficult to strengthen their family planning programs and raise contraceptive prevalence. To guide future investments, USAID supported five country-specific case studies to identify strategies and lessons learned that have contributed to or detracted from successful family planning programs in the region.

The first case studies were conducted in three countries that made significant progress over the past 10–20 years: Ghana, Malawi, and Zambia. Each of these countries had experienced considerable growth in contraceptive prevalence and notable fertility decline, despite a challenging environment and limited resources. While these countries' programs were not perfect, components of their programs can provide guidance for other Sub-Saharan African countries. Subsequently, USAID undertook case studies in two countries that had shown relatively stable contraceptive prevalence and/or fertility rates or a significant decline in growth: Tanzania and Senegal. These latter case studies document both the positive and negative aspects of family planning programming and highlight some of the pitfalls to be avoided. Together, the case studies are being used to guide the strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region.



Methodology

The Tanzania and Senegal case studies are intended to tell the story of family planning in those countries and identify major obstacles to improvements in family planning programs in low-resource settings in Sub-Saharan Africa. The two countries were selected based on composite criteria balanced with USAID's intention to have representation from both West Africa and East Africa. The analysis covers the particularly dynamic socioeconomic, political, and epidemiological contexts of the past 10–20 years in the region.

The methodology for the Senegal study consisted of a combination of group discussions and individual interviews with key informants (Appendix 1) and a review of secondary documents (Appendix 2). This study followed the research protocol established during the Ghana, Malawi, and Zambia case studies and addressed the following key questions in both interviews and secondary research:

1. What have been the main achievements and successes of the family planning program in Senegal in the past 10 years?
2. What were the main reasons for these achievements and successes (including program factors, policies, and societal/cultural factors)?
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Have any regions of the country or segments of the population been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in Senegal?
7. What are the main lessons learned from the work on family planning in Senegal?
8. What are the challenges currently confronting the program, threatening past achievements to date? What should be done about them?

The information presented in this report gives a picture of the family planning program in Senegal and identifies general lessons learned. The report benefits from data and documentation on family planning in Senegal, including project and program progress reports; technical analyses; operations research; statistical surveys; and the preliminary report of the 2004–2005 Senegal Demographic and Health Survey. Appendix 2 provides a listing both of these documents and of the Internet web sites where documents are available for additional information.

Findings

Timeline

Year	Key Policy and Program activities	FP Impact	Context
1964	♦ Blue Cross Clinic initiates family planning services with Pathfinder Fund assistance.	Begin to introduce FP	Contraception still illegal
1973	♦ Family Code increases age of marriage to 16.		
1974	♦ Senegal Association for Family Welfare (ASBEF), International Planned Parenthood affiliate, is established and begins lobbying to change 1920s law prohibiting contraception.		
1976	♦ Leadership recognizes importance of family planning to development goals.		President Senghor links 2.9% population growth with development goals.
1978	♦ Senegal Fertility Survey establishes baseline TFR and CPR data. ♦ USAID authorizes first Senegal Family Planning Project in urban areas in Dakar, Thies, and Casamance, and in rural areas in Kaolack as part of Sine Saloum Health Project.	CPR: 0.6% modern TFR: 7.2	
1979	♦ Secretariat of State for Women's Affairs is assigned responsibility for family planning, in concert with Ministry of Health (MOH). ♦ National Population Commission (CONAPOPOP) is established. ♦ First UNFPA Country Program is launched (1979–1985) for US \$5.5 million.		
1980	♦ Anticontraception provisions of 1920s law are repealed. ♦ ASBEF opens first model family planning clinic. ♦ Directorate of Family Welfare is established within Ministry of Social Affairs and is given responsibility for coordinating family planning.	Family planning is now legal in Senegal.	Longtime President Senghor steps down; President Abdou Diouf is elected (same party).
1981	♦ MOH creates Division of Family Planning within National Maternal/Child Health Service (SNSI).		
1982	♦ USAID's Family Health and Population project starts in six regions: Dakar, Thies, Kaoloack, Fatick, Kolda, and Ziguinchor (parallel to Rural Health Project). ♦ First national seminar on Islam and population is hosted by CONAPOPOP and ASBEF.		
1983	♦ UNFPA's Family Welfare Project starts in four regions: Diourbel, Louga, Saint-Louis, and Tambacounda.		President Diouf is reelected.
1985	♦ First national seminar on youth and family planning is held (by ASBEF). ♦ USAID starts Phase II of Family Health and Population, and Rural Health projects, with significantly increased budget estimated at US \$20 million each over seven years.		Senegal's Seventh Development Plan (1985–1992) includes provision for family planning.
1986	♦ Senegal DHS-I is completed.	CPR: 2.4 % modern TFR: 6.6	

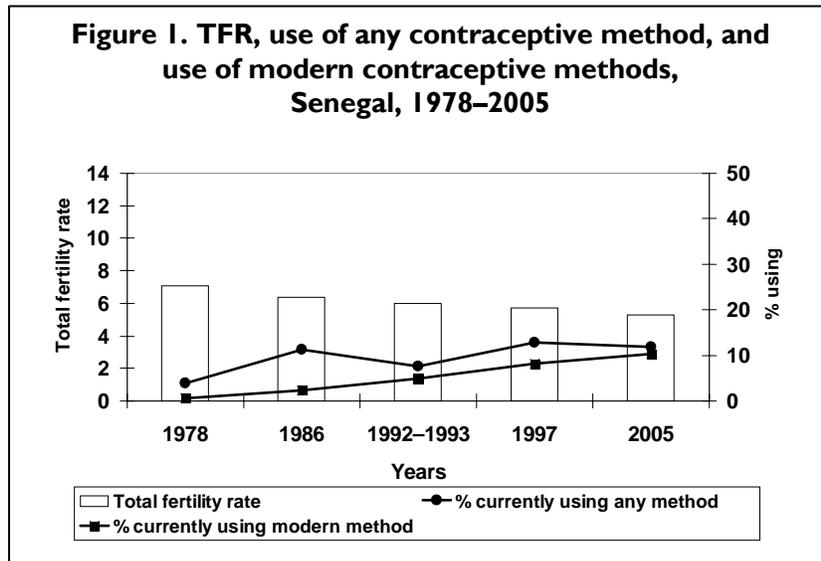
Timeline (cont.)

Year	Key Policy and Program activities	FP Impact	Context
1988	<ul style="list-style-type: none"> ◆ National Population Policy is issued. ◆ UNFPA launches 1987–1991 program for US \$4 million. 		President Diouf is reelected.
1989	<ul style="list-style-type: none"> ◆ Roundtable on Islam and population is held (by ASBEF). ◆ Health Sector Reform design begins; it devolves health planning and budgeting to 48 District Health offices under leadership of District Medical Officers. (It became fully effective in 1991.) 		
1990	<ul style="list-style-type: none"> ◆ National Family Planning Program (PNPF) is launched. 		
1991	<ul style="list-style-type: none"> ◆ Ministry of Health and Social Development issues Order (Arrete) eliminating requirement for laboratory tests prior to prescribing pills or IUD. 		
1992	<ul style="list-style-type: none"> ◆ Senegal DHS-2 is completed. ◆ UNFPA's Family Welfare Project ends. ◆ New USAID project Child Survival/Family Planning is launched. 	CPR: 4.8% modern TFR: 6.0	New USAID/Senegal Five-Year Country Strategic Plan 1992–1997 is developed.
Early 1990s	<ul style="list-style-type: none"> ◆ USAID supports training and equipment for surgical contraceptive methods, including Norplant® implant and minilaparotomy. 		In 1993, President Diouf is reelected.
1994	<ul style="list-style-type: none"> ◆ Senegal attends International Conference on Population and Development (ICPD) in Cairo and signs Programme of Action. 		January devaluation of West African currency (FCFA) triggers shock throughout economy; economic turnaround is slow.
1995	<ul style="list-style-type: none"> ◆ Social marketing of Protec condoms starts. 		
1996	<ul style="list-style-type: none"> ◆ First national norms and standards for family planning are established. 		1996 Decentralization Code transfers authority to manage health, population, and social affairs to local government units.
1997	<ul style="list-style-type: none"> ◆ Senegal DHS-3 is completed. 	CPR: 8.1% modern TFR: 5.7	14,000 local officials are elected to local government units.
1998	<ul style="list-style-type: none"> ◆ MOH issues National Plan for Health and Social Development, (PNDSS) for 1998–2007. ◆ MOH issues Integrated Health Development Program (PDIS) for 1998–2002, which operationalizes PNDSS. 		New USAID/Senegal Country Strategy Plan 1998–2006 shifts to decentralized approach in all sectors. (Some health efforts continue through 2000 as “bridge” activities.)
1999	<ul style="list-style-type: none"> ◆ MOH issues Action Plan for Maternal and Child Health for 2000–2010, which provides more detail on reproductive health; family planning is integrated within plan. 		
2000	<ul style="list-style-type: none"> ◆ New USAID instruments are issued to implement decentralized strategy operational. 		President Abdoulaye Wade is elected (new party).
2002	<ul style="list-style-type: none"> ◆ ADEMAs launch of Securil pills for social marketing creates media backlash, resulting in requirement for generic advertising. Mentions of brand names in mass media are prohibited. 		High rate of turnover in new local government elections results in disruption of rural and communal council functions.
2004–2005	<ul style="list-style-type: none"> ◆ Senegal DHS-4 is completed. ◆ New Reproductive Health Law is drafted and is under review by Parliament. 	CPR: 10.3% modern TFR: 5.3	

What Was Achieved?

Trends in TFR and CPR

Senegal's family planning and fertility indicators have improved significantly in the past 27 years. The total fertility rate (TFR) decreased by almost two lifetime births per woman, from 7.2 in 1978 to 5.3 in 2005. The overall contraceptive prevalence rate (CPR) also rose from 1978 (3.9%) to 2005



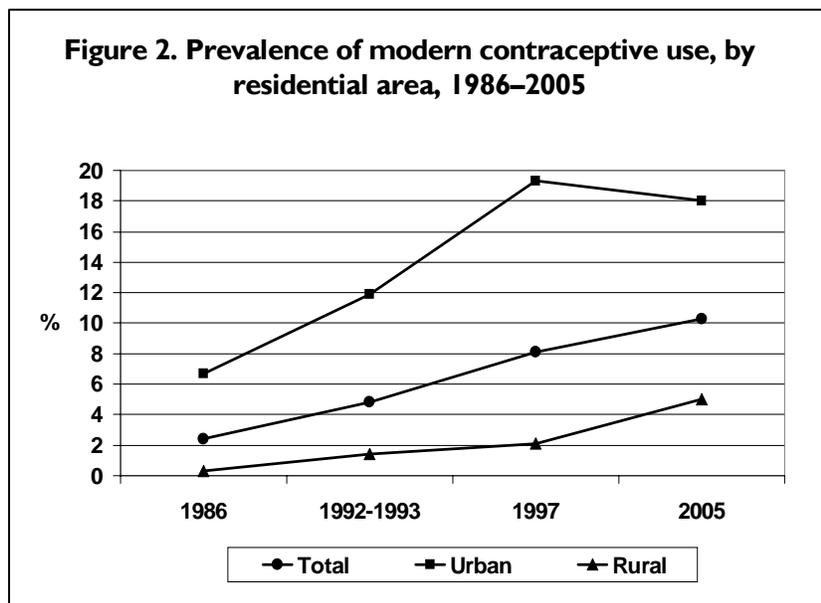
(11.8%), and the use of modern methods increased from 0.6% in 1978 to 10.3% in 2005 (Figure 1). There has also been a significant shift toward use of modern methods over traditional ones: In 1986, of the total CPR of 11.3% among married women, modern contraception accounted for only 21% of the method mix, whereas by 2005, of the total CPR of 11.8%, 87% of women were using modern methods (Figure 1) (ORC Macro, forthcoming).

The greatest gains in reproductive health indicators occurred from 1992 to 1997,

when modern method use rose by 0.7% annually; in other periods, more modest annual gains were seen—0.4% from 1986 to 1992, and 0.3% from 1997 to 2005. (An annual increase of 1–2 percentage points in the CPR indicates a strong family planning program).

Urban-Rural Trends in TFR and CPR

TFR and CPR vary with level of education and rural-urban residence in Senegal. In urban areas, total fertility decreased from 6.3 lifetime births per woman in 1982 to 4.1 births per woman in 2005,

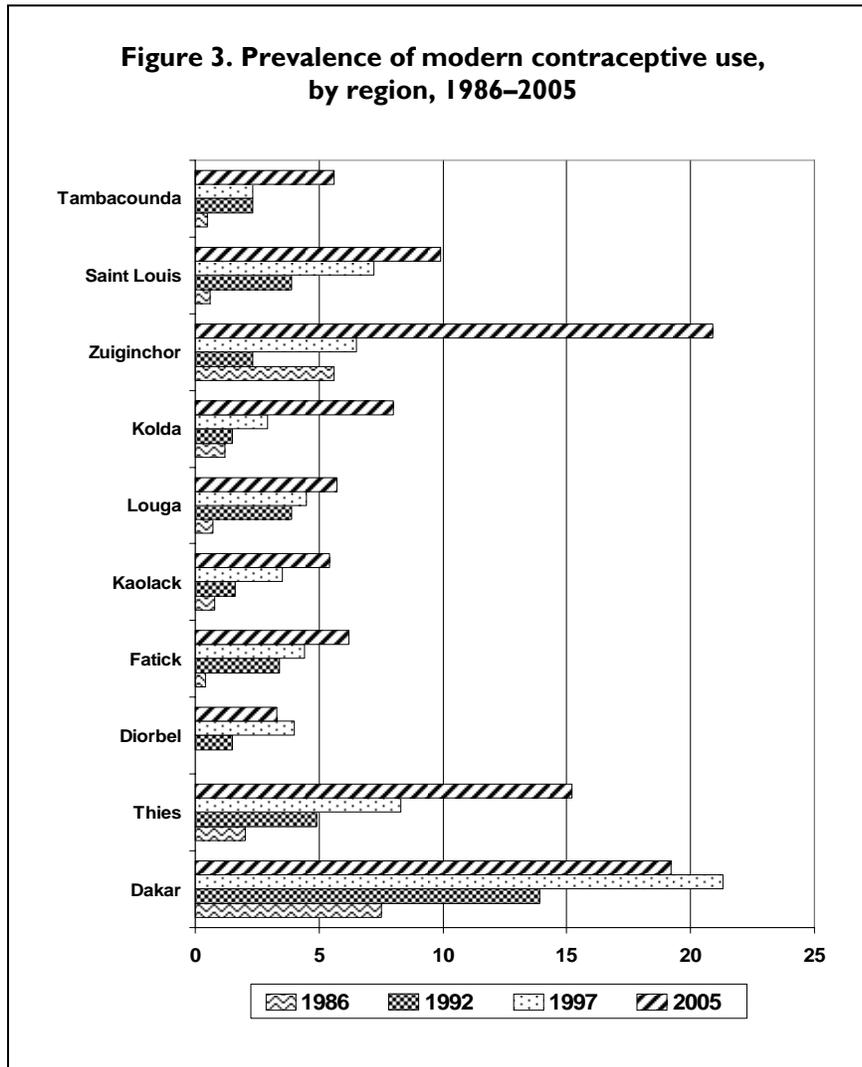


while in rural areas, fertility decreased by 1.5 births per woman, from 7.9 in 1982 to 6.4 in 2005 lifetime births.

Use of modern contraceptive methods in urban areas rose sharply, from 6.7% in 1986 to 19.3% in 1997, but then declined slightly from 1997 to 2005. On the other hand, rural use of modern contraceptives continued to rise and more than doubled from 1997 to 2005, although overall use is still quite low, at 5% (Figure 2). Overall, modern method prevalence in urban areas is almost four times the prevalence in rural areas.

Regional Trends in CPR

Contraceptive prevalence trends vary by region. Figure 3 shows that with the exception of Dakar, modern CPR increased at roughly constant rates in most regions through 1997. From 1997 to 2005, however, there was a striking increase in modern method use in the largely rural regions of Ziguinchor and Kolda, where modern CPR increased by 176% and 221%, respectively, compared with an average rise of 65% for other regions except Dakar. This increased prevalence in Ziguinchor and Kolda likely accounts for the rise in rural use of contraceptives after 1997.



Ministry of Education data show that in all three regions (Dakar, Kolda, and Ziguinchor), levels of literacy are higher. French is widely spoken in those rural areas, and access to health services is greater. One should note that USAID supported the Ziguinchor and Thies regions over the years, which may account for the existence of more service-delivery points there. We do not have additional information on Kolda.

Only Dakar, Thies, and Ziguinchor surpassed a 15% prevalence of modern contraceptive use in 2005, although the CPR for modern methods actually decreased from 1997 to 2005 in Dakar.

Trends in Unmet Need

Senegal's level of unmet need for family planning, especially for spacing, is one of the highest in the world and has actually increased slightly, from 29.3% in 1986

to 31.6% in 2005. Twenty-four percent of noncontracepting married women reported wanting to space their next birth for at least two years, while 7% wanted to limit future births altogether (nonusers only); there was a minimal difference between rural and urban women in this regard. The proportions of noncontracepting married women wanting to either space or limit childbearing have remained relatively unchanged since 1992–1993 (ORC Macro, forthcoming).

Trends in Desired Family Size

Though ideal family size has decreased, it remains high, particularly in rural areas. In 1998, on average, married women wanted 5.7 children, a number identical to the TFR. Rural women wanted more children than did women living in urban areas (6.0 vs. 4.5), while women with no education wanted more children (5.8) than did women with a primary schooling (4.6) or a secondary or higher education (4.0). On average, married men considered 9.5 children ideal (in 1998). As among women, the ideal number of children dropped as educational attainment rose, and men in rural areas wanted several more children than did men in urban areas (Ayad & Ndiaye, 1998).

By 2005, women and men wanted slightly fewer children generally, and the urban-rural and educational divides persisted. On average, women wanted 5.4 children; this number was slightly higher among married women (5.7). Rural women wanted more children than did women living in urban areas (6.2 vs. 4.7), while women with no education wanted more children (6.1) than did women with a primary schooling (4.9) or with a secondary or higher education (4.1). On average, by 2005, men in Senegal wanted 7.2 children; however, married men considered 8.3 children ideal. As was the case among women, men's ideal number of children dropped as their educational attainment rose, and men in rural areas wanted several more children than did those in urban areas (9.0 vs. 5.9).

Accordingly, contraceptive prevalence increased with education level. In 2005, 29.7% of married women with at least a secondary education were using a modern method, compared with 12.6% among those with a primary education and 5.5% among those with no education at all.

Context

While there have been impressive gains, as noted above, a number of factors may account for Senegal's slower progress in expanding the use of contraceptive services.

Religious, Sociocultural, and Gender Issues

Religion

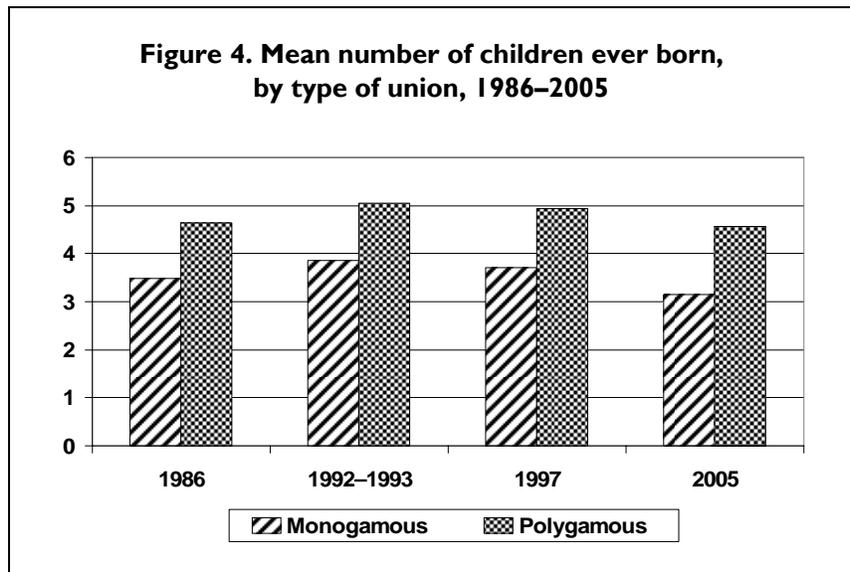
Islam is the predominant religion in Senegal, practiced by approximately 94% of the population. The Christian community (approximately 4% of the population) consists of Roman Catholics and diverse Protestant denominations. The remaining 2% of the population practice exclusively traditional indigenous religions or no religion. The Christian minority is concentrated in the western and southern regions, while groups that practice traditional religions are concentrated in the eastern and southern regions.

Despite numerous conferences, study tours to other Islamic nations, associational support, and focused behavior change communications (BCC), there is still a lack of vocal senior Muslim leadership and guidance on family planning in Senegal. The leadership gap has unfortunately been filled with misinterpretation of the Koran from lower-level imams, resulting in numerous perceived religious barriers to use. However, successive DHS surveys have shown that progressively fewer respondents cite "religion" as a reason not to use contraception.

The practice of polygamy, which is permitted by Islam, has not decreased significantly in 20 years and contributes to a high TFR. This is the result of competition for attention among wives, as well as traditional inheritance patterns. Wives with more children, and especially with more male children, inherit more than women with no children and/or only female children. The 1978 Family

Health Survey showed that 48.5% of women were in polygamous unions; the comparable figure in the 2005 DHS was 40%.

As one observer noted, educated Senegalese men have 2–4 wives as a status symbol. Even within poor rural families, it is culturally acceptable for men to have 2–3 wives. As noted, competition between wives in polygamous relationships frequently centers on women having more children; cultural norms such as this serve as a barrier to increased family planning uptake. This is also evident in data showing that women in polygamous relationships have a slightly lower rate of family planning use, though the difference is not statistically significant.



DHS data do illustrate, however, that women living in polygamous unions have more children than those living in monogamous unions. Figure 4 demonstrates that the difference between the mean number of children ever born to women in polygamous unions and the mean among monogamous women ranged from 1.16 more children in 1986 to 1.43 more children in 2005.

Sociocultural and gender issues

As is the case in many other West African countries, pronatalist sentiment is strong in Senegal. Culturally, the small-family norm has not taken hold. A colonial-era law banning contraception was not repealed until 1980. The status of women is low. More than 66% of Senegalese women are illiterate. Approximately 43% of primary school graduates are girls; the proportion is lower at the secondary level. Of secondary school graduates, 30% use a modern method, as opposed to 5% of unschooled women (Diop et al., 2004).

Single women are expected to remain virgins until marriage, but many do not. The 1997 DHS showed the average age of sexual debut among women aged 20–49 to be 17.5. However, in urban areas younger women are postponing sexual initiation until age 20.6 years, while rural women began having sex at age 16.4 years. Fewer than one-third of young men and women report using contraception at their sexual debut, and access to family planning services for unmarried adolescents is problematic.

The concept of individual reproductive rights essentially contradicts customary norms and practices in Senegal. Senegalese women do not generally have control over their contraceptive choices. The husband's approval is particularly important, because customary law considers women minors and unable to make their own decisions in many matters. In spite of norms and protocols to the contrary, many providers insist on receiving the husband's approval before providing a family planning method to a woman, to protect themselves from the husband's reaction. When women are able to access family planning, injectables are a favorite method for both providers and women, since their use can be hidden. In fact, one informant stated that providers help women choose this method when spousal approval is unclear. MOH norms still require spousal approval for tubal ligation. In

addition, some women also must consult their mother-in-law and often their co-wives prior to accepting a method or else use contraceptives clandestinely. Official policies and unofficial practices continue to be barriers to family planning services and affect the contraceptive prevalence rate.

Continuation rates are not high, even when women can access services. Almost half (49%) of women surveyed in the Service Provision Assessment of 2003 only used a method steadily for less than 12 months; 23% used their present method for 12–36 months; and 27% used their present method for more than three years. Of women who discontinued a method, 14% did so because their husband or partner opposed it (Groupe Serdha, 2003).

Opposition to contraceptive use is still strong in Senegal. Reasons for nonuse cited in the preliminary findings of the 2005 DHS include opposition to use by the woman or her partner or religious reasons (42%), fertility-related concerns (such as wanting more children, being infertile, or not being very sexually active) (29%), lack of awareness (6%, compared with 9% in 1997), and method-related problems (19%). The “opposition to use” category is significant and pervasive throughout Senegal, and includes sociocultural, religious, and modern and customary legal factors that are barriers to effective demand. A 2003 survey in 15 USAID districts revealed that 29% of men cited religion (Islam) as a reason for not supporting family planning (Groupe Serdha, 2003). A 2004 study reported that 12% of women who do not use family planning said it was because their husband opposes it (Diop et al., 2004).

Among community leaders, religious leaders, and leaders of women’s groups and associations, family planning and HIV/AIDS are not perceived as high-priority problems (Ouedraogo, 2004). This was confirmed by many current informants.

Low HIV/AIDS Rate

Senegal has held overall HIV prevalence to 0.7%. Prevalence among pregnant women is still relatively low (1.5%). However, the prevalence rate among commercial sex workers is 20.9% and could result in a dramatic increase in infection rates if it is not controlled. Senegal responded rapidly to the emergence of HIV/AIDS in the mid-1980s and quickly undertook significant measures to prevent HIV/AIDS transmission, including condom promotion, sentinel surveillance, confidential counseling and testing, education of sex workers, and integration of HIV into sex education. Donor support has been strong throughout the years; the support, resources, training, and BCC related to HIV/AIDS have all been resource- and labor-intensive, and have taken attention away from other health initiatives, including family planning.

Political and Economic Issues

Senegal has been relatively stable politically, with democratic presidential transitions. A conflict of more than two decades between the government of Senegal and a separatist group in the Casamance region has been under a ceasefire since December 2004. Half (50%) of young men have no jobs, 70% of the countryside has no electricity, and real growth in GDP averaged over 5% annually during 1995–2004. In 2001, 57% of the population lived in poverty. Sixty percent of the rural population and 45% of the urban population live on less than \$1 per day.

In 2001, Senegal qualified for approximately \$31 million in debt relief under the Heavily Indebted Poor Countries (HIPC) initiative (USAID, 2005), and in 2004 reached the HIPC initiative completion point, resulting in the cancellation of \$850 million in sovereign debt payments over the

next 10 years. Senegal was declared eligible for the U.S. government's Millennium Challenge Corporation assistance in 2004 and is still in the process of establishing the grant mechanism.

Politics within the health sector have affected both policy and services. The head of the MOH changed seven times in seven years. The resulting lack of consistent leadership led to a weak organization overall. The lack of stewardship in the various directorates impeded the implementation of a sector-wide approach, as well as effective project management. While capacity-building efforts were undertaken and evident, especially through the Administrative Directorate (DAGE) and to regional health offices, managerial capacity remains inadequate (World Bank, 2005).

Decentralization and Sector-Wide Approaches

The following quote sums up the current status of the decentralization effort in Senegal:

The decentralization model most frequently adopted in francophone West Africa seems oriented towards substituting new local institutions for existing local institutions. This approach faces a clear difficulty: existing frameworks are based on economic, social and cultural needs, and replacing or undermining these frameworks is likely to create confrontation. The attitude of the population in Senegal to decentralization tends to be one of passive resistance to a new authority whose legitimacy is not recognized.

(Source: Ouedraogo, Public Administration Development 2003, from Smoke, P., 2003)

The Senegalese health system has been slowly decentralizing since the early 1980s. The pace accelerated in the early 1990s, when the MOH “deconcentrated” planning and management authority to its regions and districts, which were still accountable to the central MOH. A health district model of service delivery with a cost-recovery component was put into place, financed by a World Bank loan and the UNICEF-sponsored Bamako Initiative. Planning and management responsibilities were transferred to regional and district health teams, and community-managed cost-recovery programs for primary health care were put in place. (Family planning clients pay for services and commodities out of pocket.) To date, one result of decentralization is that there are more than 800 elected health committees nationwide, not all of which have family planning high on their priority list.

In January 1997, the Government of Senegal implemented the 1996 Decentralization Code. More than 14,000 local officials were elected to local government units. These units coexist with parallel, but slightly different, MOH structures. This initiative instituted a fully “devolved” model of decentralization in which a portion of nine ministries’ budgets would pass directly from the Ministry of Finance to various local government units. Local government units were given the authority to manage local affairs in nine areas, one of which was health, population, and social affairs. Line-item suggestions from central ministries were supposed to guide the local authorities in their decisions on allocations across sectors. A relatively large portion of the MOH budget was put at the disposal of local government officials, who, while provided with some guidance and encouragement to spend that money in the health sector, could choose to spend it elsewhere. Health personnel are paid and supervised by the MOH, but many of the subnational facilities in which they work are under the financial control of locally elected officials.

While the earlier MOH “deconcentration” was closely monitored and accounted for, the new “devolved” model ended up costing the MOH far more resources than any other ministry. Almost 30% of the health budget was spent on nonhealth sectors, while no other ministry lost more than 5%

of its budget to local governments' reallocations. In no case were monies found to have been transferred from outside the health sector to the health sector (Atim, 1998).

The Sector-Wide Approach (SWAp) was instituted during the World Bank's last program cycle, which ended in 2005. All of the elements of a SWAp were begun: a national strategy drawn up by the government for which the government of Senegal was fully responsible; donors' agreement to support the strategy; and coordination mechanisms organized through an annual meeting—Réunion Annuelle Conjointe (RAC). A budgeting process, including all donor contributions, was implemented through annual work plans (*Plans d'Opération*). While the plans were consistent with a SWAp, the World Bank's end-of-project evaluation noted that the implementation did not meet expectations and that only a few partners used the national systems and procedures to channel resources.

The World Bank gave the program (1997–2005) an unsatisfactory rating pretty much across the board, for institutional capacity-building, resource flow (especially to the districts), training and technical inputs, and actual results in terms of health indicators. "Given the resources mobilized in the health sector (2% of gross domestic product and \$50 million from the World Bank), the gross national income per capita (US \$670 in 2004) and the size of the urban population (50%), the results should have been better than those achieved" and will not enable Senegal to meet the Millennium Development Goals, as hoped (World Bank, 2005).

With regard to family planning, the moves to decentralization and health sector reform shifted attention away from specific health issues or diseases (funded via projects) to focus on macro-level health infrastructure, management, and financing issues. In addition to already diminishing donor funding for contraceptive commodities and supplies, the donor focus on specific issues such as family planning was almost completely left to USAID and UNFPA.

What Was Done at the Policy Level?

Reproductive Health and Family Planning Policies

Historically, Senegal's family planning program has had stops and starts. The program changed departments 11 times in 19 years. In the 1980s, Senegal's leadership for family planning was fragmented. The Ministry of Social Development (MSD) had lead responsibility, working through its regional and departmental offices. Clinical family planning services were provided by regional and health district offices, under MOH supervision. Responsibility for information, education, and communications (IEC) efforts was vested in the National Population Commission (CONAPO), within the Ministry of Planning.

The National Health Policy of 1989 reorganized the Ministries of Public Health and Social Development into a Ministry of Public Health and Social Action (MOPHSA), expanded the role of user fees for health services with funds managed at the local level, and decentralized health sector planning and implementation to the regions and districts. (User fees are set in national health regulations and policies. Payments are required for family planning services and commodities, and clients often pay more than the established policy, usually for supplies and/or registration fees.)

MOPHSA launched Senegal's National Family Planning Program (PNFP) in 1990, managed out of the Cabinet of the Minister of Health. A vertical program, PNFP became operational in 1992.

In the mid-1990s, Senegal's leadership recognized the importance of expanding access to reproductive health and family planning services. By 1996, Senegal's first family planning service-

delivery guidelines were approved by the MOH. The guidelines were drafted by a comprehensive working group of representatives from the MOH, from training institutions and schools, and from private-sector service provision organizations. As the first family planning guidelines ever written in Senegal, their development represented a milestone for standardizing care. For example, the guidelines specified that three packets of pills can be provided to oral contraceptive clients at the first visit. In the past, instructions regarding pill resupply, as well as the timing of return visits for all contraceptive methods, were inconsistent. Senegal granted official approval for nurses and midwives to provide Norplant® implant and IUD services even before the guidelines were written.

In 1998, the MOH issued the Plan National de Developpement Socio-Sanitaire (PNDSS) (1998–2007), which included “a decreased fertility rate” as one of three overall objectives. This policy dissolved the PNFP and moved its responsibilities out of the Cabinet of the Minister into what has become the Division of Reproductive Health within the Department of Primary Health Care. While consistent with the principles of the International Conference on Population and Development (ICPD), this integration reduced the status of and advocacy for family planning within the MOH, decreasing its national visibility overall.

Family planning was part of a larger integrated health initiative. The Integrated Health Development Program (PDIS) specified and budgeted the first five years of the PNDSS. The PDIS consolidated the development plans of regions and districts, as well as those of central services. It described in detail the modalities for implementing the plan, the activities to be implemented, estimates of central government, local government, and donor funding, and monitoring and evaluation. However, as noted in the SWAp section, decision making on funding and priorities rests at lower levels of the sociopolitical system, where a focus on family planning can be lost.

Donor Support

Donor support in the health sector is extensive, and includes significant support from the World Bank, the World Health Organization, UNICEF, UNFPA, and the French, U.S., Belgian, German, and Japanese bilateral cooperation agencies. USAID is a predominant donor in Senegal’s health sector, with about 20 other bilateral and multilateral donors also contributing. Over the 1998–2002 period, the government of Senegal covered an estimated 60% of the planned health budget by providing human and material resources, while donors funded about 30% of the budget, mostly for preventive health, HIV/AIDS, maternal and child health, and family planning. Cost-recovery systems were expected to contribute the remaining 10% (USAID, 2002).

As noted above, the SWAp does not focus on particular health care issues and projects, but aims to strengthen the health infrastructure, management, and financing so that local institutions have ownership and authority and function better. While USAID and UNFPA continued their work on family planning outside the “basket funding” of the other donors, their inputs were often seen as smaller, parallel efforts in the health care system.

History of USAID Projects

USAID has been a strong supporter of Senegal’s family planning program since the mid-1980s. Geographically, USAID’s focus areas are Dakar and 21 districts in four regions (Kaolack, Louga, Thies, and Ziguinchor). USAID also provides support to policy, training, and social marketing nationally. The USAID districts have more than 4,000 community health workers trained in a variety of health topics.

USAID's efforts have included expanding service delivery (including through nongovernmental organizations), improving demographic data, training providers, equipping service-delivery points, improving logistics, improving system management and quality assurance, engaging in IEC/BCC, and encouraging operations research and demographic analyses. In recent years, USAID has begun to support decentralization by helping to improve management at all levels within the system and to develop innovative ways to empower local communities to plan and finance health services through initiatives in maternal and child health.

Examples of the range of assistance include the following:

- ◆ Working with the MOH to establish a computerized information system with health indicators
- ◆ Conducting operations research for a community-based approach in Kebemer (a district located on the Dakar–St. Louis national highway)
- ◆ Engaging municipalities to leverage non-USAID funds and expand reproductive health services
- ◆ Conducting BCC interventions and family planning advocacy with Islamic religious leaders to obtain their participation in promoting family planning use
- ◆ Performing studies on community-based distribution
- ◆ Introducing clinical family planning to the country, improving quality assurance, implementing informed choice and consent, and setting up in-service training for long-acting and permanent methods on a limited scale in the larger hospitals
- ◆ Training providers and community health workers in family planning
- ◆ Improving the management of maternal health and family planning services at the community, district, and national levels
- ◆ Engaging in advocacy and social mobilization to promote high-quality reproductive health services
- ◆ Testing health financing mechanisms in the new decentralized environment
- ◆ Promoting social marketing

UNFPA Direct Support to the MOH

UNFPA has been a strong supporter of reproductive health since 1979. UNFPA worked at the national level and in four regions: Diourbel, Louga, Saint-Louis, and Tambacounda. In addition to helping develop services in its focus districts, the agency provided significant assistance under PNFP to the development and rollout of Senegal's in-school family life education curriculum (Naré, C., Katz, K., & Tolley, E., 1996, p. ii). Over the years since the ICPD in 1994, the expansion of UNFPA's mandate moved family planning from being front and center to being part of a more integrated reproductive health and rights approach. Also, in line with other multilateral donors and the Millennium Development Goals, UNFPA asserted that maternal mortality must be cut, and although family planning helps reduce maternal mortality, it was not the central focus of programs and support for UNFPA. Emergency and essential obstetric care, youth issues, HIV prevention, female genital cutting, and other reproductive health initiatives were added to UNFPA's agenda. In Senegal, UNFPA provides solid support to the MOH. Direct funding for developing guidelines, training, and buying commodities (through the UNFPA procurement system) was much appreciated.

What Was Done Programmatically?

Method Choice and Access to Methods

Over time, there has been a shift in Senegal from traditional methods of family planning to oral contraceptives and, over the last 10 years, to injectables. The ease of use and confidential nature of the injectable makes it a favorite with providers and clients. However, overall access to modern

methods was not easy in the early years, with medical providers often requiring exams, blood and other tests, and often, spousal approval. In 1991, the MOPHSA issued an order (*arrete*) eliminating requirements for laboratory tests prior to prescribing the pill or the IUD.

Also, in the early days of the program, midwives were the sole providers of modern clinical methods. This changed with a training program for nurses conducted from 1993 through 1998, in the provision of the pill, injectables, condoms, and spermicides. As of 2005, midwives are still the main providers of hormonal implants and the IUD, while only gynecologists provide female sterilization.

In most cases (57%), women acquired their present method at their community service-delivery location (health center or health post). In only 17% of cases did they go to another village or neighborhood center or post for the service they needed. Community-based family planning programs reached only 5% of the users surveyed with condoms and resupply of oral contraceptives. (A prescription is needed for initiating oral contraceptives.) Pharmacies, shops, or markets supplied 7% of customers with contraceptives. The remaining 14% of respondents stated that they obtained their supply from “other” sources (Groupe Serdha, 2003).

The private sector in Senegal is challenged by a highly regulated environment. The availability of contraceptives in the private sector is restricted by laws that prohibit counseling for, prescribing, and dispensing contraceptives in the same private facility. In particular, hormonal contraceptives are highly regulated by the government. Obtaining the authorization to import and distribute hormonal methods requires a lengthy and difficult process through the Direction de la Pharmacie et du Medicament, the nation’s pharmaceutical regulatory agency. In addition, high taxes and markups increase the consumer price of products and limit the number of users who can afford them. There also are laws against brand-specific advertising for prescription items, including hormonal products. Currently, Senegalese women who desire injectables must first visit their doctor to get a prescription, then go to the pharmacy to obtain the product, and then return to their doctor for the injection. This burdensome procedure hinders access (CMS, 2004).

The medical establishment in Senegal tends either to overly “medicalize” family planning or to forget it altogether. As one informant stated, “elites of the Senegalese health system don’t care about family planning and this filters down throughout the health system and throughout society. They care about curative services, medical procedures, and emergencies.” This lack of interest, coupled with a reduced focus on family planning activities over time, has resulted in slow growth in contraceptive use.

Training of Providers

The family planning program benefited from early training of midwives and doctors. The focus was on technical medical training and updates. In the mid-1990s, USAID supported training and the equipping of sites for such methods as Norplant[®] implants and minilaparotomy. While this was done successfully in one of the main hospitals in Dakar (Le Dantec), female sterilization services were not widespread, and to this day are found only in a few regional hospitals. One former trainer noted that “sterilization services received the least support of all” from the government and donors, and that sterilization “is only done during training situations, often training country teams from other African countries. It is not a routine service.”

Nurses now all receive classroom instruction in family planning, but no practicum. USAID and UNFPA have made positive inroads in the past few years in training nurses, but much remains to be

done to make family planning methods and services truly accessible to the majority of Senegal's population.

As was the case in several of the USAID projects in the 1990s, training opportunities focused on health management, financing, and other systems-related work, with some technical updates in health services. During the USAID Health Decentralization Project, for example, more than 40 workshops and seminars were held on financial management, health services planning, and community-based health financing. For sustainability, in-country training and curricula on decentralized health planning and management were developed and implemented, with a focus on maternal and child and reproductive health (Baade-Joret, 2006).

Services

Senegal's health system is decentralized and has three levels: The lowest level consists of health centers, health posts, health huts, and community health workers; the middle layer consists of 10 regional hospitals and two departmental hospitals; and the top level consists of seven national hospitals. The rate of population increase makes it difficult to ensure national coverage by health facilities, and inequities exist, especially in poor rural areas. The private sector in Senegal, consisting of private clinics, dispensaries, and pharmacies, plays a large role in providing health services. An established informal and illicit market for pharmaceutical drugs also exists.

Family planning services exist at each level of the system, with the lowest level dispensing the pill, injectables, and condoms. In theory, the lowest levels refer clients to the next level for more clinical methods. It is not known how effective the referral system is.

The *cases de santé* (health hut) is a peripheral structure (not operational in all districts) run by a volunteer community health worker and attached to a *poste de santé* (health post). If there is no *poste de santé*, then by regulation a village cannot have a *cases de santé*. These health huts are found in remote villages and are set up to serve the local population with basic health information and services. Sometimes, health huts go beyond their mandate and dispense antibiotics and other medicines without properly trained personnel and/or a license, or they are set up without supervision from a health post. Health huts that are attached to health posts and are legally run may be good points for reaching rural couples with additional family planning information and services.

There were attempts to organize community participation in Senegal's health program. When the primary health care acceleration program was implemented by the Bamako Initiative (and earlier by the Alma Alta Initiative), management committees were created for health centers and health posts to provide community representation for co-management of the health posts and huts by the government and the communities. Reportedly, the liaison system does not work well, due to a lack of motivation on the part of the community health agents (CHAs), as well as a severe shortage of IEC materials. The CHAs received IEC training and from time to time include family planning in their talks. However, they are frustrated by the lack of resources for activities, both in the health huts and at the community level. They also cite lack of transportation as a serious handicap in providing information to rural communities. Supervisory visits by the nurse from the health outpost are rare, and overall the CHAs feel that they have been abandoned to their own resources in spite of their desire to do better (Advance Africa, 2002).

The IPPF affiliate, ASBEF, was a major player in family planning efforts over the years. Like many IPPF affiliates at the time, ASBEF was established in Senegal in 1974 as a voluntary organization to meet the growing needs for family planning. ASBEF opened its first clinic in 1980; by 1997, it

was meeting 17% of the nation's contraceptive needs through its clinics, community-based work, and IEC efforts (ASBEF, 2004). When the Mexico City policy was reenacted in 2001, however, ASBEF began to dismantle its USAID-funded family planning activities. By 2004, ASBEF had closed its clinics in Fatick and Ziguinchor and served only about 34,000 clients nationwide, or half of what it had prior to the restoration of the Mexico City policy. In addition, the IPPF/Africa Region shifted its privately funded work to a focus on adolescent reproductive health and HIV prevention, thus redirecting most of its resources away from family planning service delivery. (Only a few ASBEF-funded clinics remain today.)

SANFAM, another Senegalese nongovernmental organization, also played a role in developing employer-based services, at one point serving approximately 40 workplaces.

There have been pilot programs to develop local health financing schemes, such as *mutuelles*, that are essentially community self-insurance programs. However, these schemes cover primarily curative services, and family planning clients must pay for their commodities and services on their own.

Procurement, Logistics, and Contraceptive Security

USAID and UNFPA have been the primary providers of contraceptives to Senegal for the past 20 years. In the 1980s, the two donors operated separate contraceptive logistics procurement and distribution systems in their respective regions (which meant that different regions had different brands and formulations). Injectables were not available in the USAID regions. The USAID and UNFPA systems were integrated in 1993.

Beginning in 2005, the government of Senegal was to take responsibility for integrating contraceptive distribution into the distribution of essential drugs, with a warehouse person specifically devoted to contraceptives. However, the donors continued to provide technical assistance to prepare the annual contraceptive procurement tables, receive and process contraceptives procured directly by donors, and provide assistance for nationwide distribution.

At the February 2005 regional Repositioning Family Planning conference held in Accra, the government of Senegal committed itself to an action plan that would transfer management and financing of contraceptives to the government within the medium term. The government further committed to procuring IUDs for 2006. However, given significant involvement by donors in procurement and distribution for the last 25 years, there are some concerns about the sustainability of the system and about contraceptive security over time.

Information and Demand Creation

A communications seminar in 1991 highlighted the need for IEC activities that promote birth spacing based on maternal and child health issues rather than on economic arguments. Participants also agreed that the husband's role in decision making is crucial, and that programs to integrate IEC and clinical activities need to be implemented. The transition of IEC from CONAPO to PNFP brought clinical and communications functions together. The national family planning logo was launched during the PNFP period, which also saw the production and distribution of posters and other IEC materials.

PNFP and its partners developed the National Five-Year Family Planning/HIV/Sexually Transmitted Diseases IEC Strategy during the Child Survival/Family Planning (CS/FP) Project (1995–1998). This focused on building community participation by partnering with district health

committees to train and support community health agents to conduct outreach activities in family planning and maternal health (antenatal visits). The community health agents were trained in interpersonal communication, in planning IEC interventions, and in using a new integrated kit of family planning and maternal health IEC materials for clients and providers. Advocacy efforts involved religious leaders in the promotion of family planning and addressing family planning policy issues with parliamentarians.

A 1996 survey found increased knowledge of family planning in the project's target area, which was later confirmed by the 1997 DHS. The survey also showed much greater knowledge of the pill, IUD, and condom than of other methods. From 1997 to 2000, the program used BCC strategies to reach special populations such as Islamic leaders. Another component was aimed at increasing men's participation in family planning, with some special posters and other IEC materials developed. In a 2003 study in 15 USAID districts, more than 90% of men and women of reproductive age could cite a modern method.

However, IEC has received scant attention since the end of PNFP, and most of the IEC materials that remain date back to that period (1996). However, the Gold Bridge (*Pont d'Or*) strategy to recognize and promote quality services with major community involvement has been piloted in Senegal and shows some promise in terms of demand creation. The concept is that the "bridges" of information and needs built between communities and health services will improve clinic-community relations and ultimately improve the quality and increase the use of services.

Social Marketing

Established 17 years ago, ADEMAs is the local nongovernmental organization devoted to social marketing. *Protec* condoms serve family planning clients and are also marketed to groups at high risk for HIV and sexually transmitted infections. *Protec* was introduced into the national network of pharmacies in April 1995. In June 1997, the distribution system was extended to nonpharmaceutical sales points in the private commercial sector in urban and peri-urban areas throughout Senegal. These sales points include coffee shops, bars, restaurants, bus stops, hotels, night clubs, supermarkets, hair salons, cosmetics shops, telephone kiosks, and gas station-based minimarkets.

Between 1998 and 2000, the number of private sales points increased by 17.5%. Traditional sales points (pharmacies) continued to sell the majority of condoms, but the nontraditional sales points showed significant growth in their market share. The number of these nontraditional sales points increased by 13%, but their sales rose by 47%. In fact, the use of condoms for family planning has probably been lost due to greater marketing of condoms for HIV protection. While improved distribution, BCC, and educational campaigns increased sales of *Protec* by 66% between 1999 and 2003, some key respondents noted that most users would not equate condoms with family planning. There is no evidence of "dual protection" or "dual usage" messages over the years.

In 2002, ADEMAs launched a social marketing campaign for an oral contraceptive, Securil. At the time of Securil's launch, only 3.3% of Senegalese women used the pill, and there were no low-cost oral contraceptives available through the private sector. Securil targeted low-income to middle-income married urban women. In the private sector, however, only doctors and midwives can prescribe oral contraceptives, as there is no government-approved training for other medical staff. USAID supported ADEMAs to develop a training curriculum for private providers that focuses on quality of care, interpersonal communication, and side effects management, in hopes that the government will expand the range of private providers allowed to prescribe oral contraceptives (CMS Project, 2004). Private-sector sources now account for 20% of pill distribution and 55% of condom provision.

ADEMAs also sells oral rehydration salts and bed nets, and while ADEMAs is a well-functioning social marketing program (USAID, 2005), the lack of focus on family planning, coupled with medical barriers to increasing pill use, is a handicap for ADEMAs in truly helping the national family planning program to increase contraceptive use.

Data for Decision Making

The World Bank noted that Senegal's health sector lacked appropriate systems for monitoring indicators. They attributed this to the MOH's lack of leadership and accountability, resulting in a lack of quality data and a poor information system: "A lack of accountability in the public sector, due to the lack of a solid monitoring and evaluation system on which both the government and donors can rely, is a major stumbling block for the Sector-wide Approach Program." In the realm of family planning and reproductive health, it is clear that in many instances, USAID and other donors' research and evaluation systems supported a weak government information system. For example, from 1997 until 2000, one of the civil service unions engaged in a "data strike," ceasing to collect, maintain, and disseminate basic health information. In the family planning program, this compromised contraceptive logistics management and led to frequent stockouts. Even in 2006, USAID notes, the MOH lacks a well-functioning health information system that would allow it to demonstrate that progress is being made toward achieving health improvement goals (USAID/Senegal, 2006).

This situation persists despite extensive data collection, much of which was supported by USAID:

- ◆ DHS and other population-based surveys
- ◆ Situation analyses of health facilities (in 1995, 1997, 1998, and 2003)
- ◆ Behavioral surveillance surveys and evaluation of sexually transmitted infections care management surveys

In addition to periodic surveys, USAID/Senegal also collects routine monitoring data on such things as the number and type of contraceptives used and the number of vaccines administered (Groupe Serdha, 2003). However, the weakness of the government information system makes it hard to track progress.

Conclusions and Lessons Learned

Despite some promising beginnings and a moderately strong program in the mid-1990s, the progress of Senegal's family planning program has slowed over the last decade. Reasons for the uneven progress are noted below:

- ◆ Desired family size equals actual family size.
- ◆ Social, cultural, and medical barriers remain, despite attempts to address them.
- ◆ Leadership for and commitment to family planning have been uneven.
- ◆ Organizational and policy changes such as decentralization and SWAps have not supported consistent program growth.
- ◆ Donors refocused their interests in the late 1990s, with USAID moving toward health financing and management issues and UNFPA moving toward integrated reproductive health services, adolescents, and HIV/AIDS. Because government leadership was continually changing, there were few internal champions to take over from the donors.
- ◆ The intensity of family planning activities weakened over time in terms of services, training, IEC/BCC, and private-sector participation.
- ◆ Though excellent data were available, they were not used for program decision making.
- ◆ Effective pilot projects, such as the community-based health operations research project, were not taken to scale.

The principal lessons learned from the Senegal experience are as follows:

- ◆ The Senegal program did not focus enough attention on reducing biases and barriers on both the supply side and the demand side of programming. Policy and practice barriers prevented lower level providers from distributing a wide range of family planning methods. The cultural and social norms served as a barrier in creating a strong environment for a national family planning program. Considerable investments that would have been required to shift cultural norms were not made in behavior change communications and in the development of and support for local champions.
- ◆ The decentralization process weakened the focus on family planning. Family planning programs were left to untrained local authorities and political institutions that knew little about them and did little to expand the program. As part of this process, family planning was integrated within reproductive health services, thus weakening family planning programming.
- ◆ Leadership and advocacy for family planning at all levels is an important component of program success. Family planning was not a top priority for the Senegalese health care system, thus making even the scarce donor resources and inputs less effective and sustainable. Frequent changes in leadership also limited the ability to identify and nurture family planning champions.
- ◆ Few community-based organizations chose to focus on family planning activities, thus limiting the possible positive influence of community involvement via village health committees. Additionally, opportunities for using community health structures like the health providers at the health posts and health huts were not fully supported.

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Appendix I: List of Persons Contacted

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Ministry of Health, Dakar

Moussa Mbaye, Secretary General
Abdou Issa Dieng, Technical Advisor #3, Research, Training, Population, Poverty Reduction
El Hadji Ousseynou Faye, Technical Officer, Division of Reproductive Health
Aboubakry Yero Sy, Program Manager—Youth, Division of Reproductive Health
Dr. Daouda Diop, Pharmacist, Chief of Commercial Services/Marketing/Information/
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Mme. Ndecky, responsible for midwife training, ENDS

NGOs/Private Sector, Dakar

Dr. Ousmane Faye, former Chief of Party, PREMAMA/MSH Project, and former Senior
Technical Advisor, EngenderHealth/Senegal
Philippe Moreira, Chief of Party, PREMAMA/MSH
El Hadji Dioum, Policy Advisor, PREMAMA/MSH
Pape Babalyssa Ndao, Chief of Contraceptive Logistics, PREMAMA/MSH
Ismail Ndiaye, Program Assistant, PREMAMA/MSH
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Alle Diop, AWARE-HIV/AIDS
Nafy Diop, Population Council, Dakar
Jim Dean, Africare
Mady Cisse, DISC
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Youmane Diop, Midwife, former Head of Clinic, ASBEF
Seynabou Mbenge Sow, Director, ADEMAS

Aida Diop, Communications, ADEMÁS
Seydou Nourou Koita, Chief of Marketing, ADEMÁS
Mr. Mbaye, Chief of Operations, ADEMÁS
Amadou Assane Sylla, Statistician-Demographer, Executive Coordinator, CEFOREP
Mr. Alpha Dieng, Director General, SANFAM
Mme. Aminata Diallo Niang, former Reproductive Health Coordinator, SANFAM (current Regional Coordinator-Dakar, PREMOMA/MSH)
Mr. Salif NDiaye, Demographer and Director, Centre de Recherche pour le Développement Humain (CRDH) (lead author, DHS I, II, III, IV)
Dr Cheikh Tidiane Athie, President, ACDEV

Other Cooperating Agencies

Tim Rosche, former Regional Director, FPLM and Director ISTI/Senegal
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Dr. Isaiah N'dong, Chief of Party, AWARE/EngenderHealth
Dr. Placide Tapsoba, Population Council
Nafy Diop, Population Council, Dakar
Ian Askew, Regional Director, Frontiers Project, Population Council
Amelie Sow, Program Officer, JHU/CCP

Dakar Region—Health Facilities

Mme. MBengue, Midwife, Khourounar Health Post
Marieme DRAME, Midwife, Khourounar Health Post
Mme. Djimera Fatou Ndiaye, Chief Midwife, Head of Family Planning, Nabil Choucair Health Center
Dr. Alioune Gaye, Chief Medical Officer, Guediawaye District (Roi Baudouin Health Center)
Mme. Aminata Camara Diop, Midwife-Family Planning, Roi Baudouin Health Center
Mme. Faye, Chief NMidwife, Roi Baudouin Health Center

Thies Region

Dr. Marie Sarr, Chief Medical Officer, Mbour District
Mme. Tapa Ndiaye, Midwife and Reproductive Health Coordinator, Mbour District
Mme. Diakhate, Midwife, Mbour
Mme. Aminata Sidibe, Midwife, Mbour
Mme. Mairam Khaire, President of l'Association de la Lutte contre le SIDA (ARLS, CEDPA Subgrantee)

Kaolack Region

Dr. Issa MBaye, Chief Medical Officer, Kaolack Region
Dr. Mame Coumba Codou Faye Diouff, Chief Medical Officer, Kaolack District
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Moussa Ndour, ARPV Keur Baka

Diourbel Region

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Dr. Mame Touty Ndiaye, Deputy Chief Medical Officer, Fatick Region
Mme. Seynabou Diaite, Regional Coordinator, Reproductive Health
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Mme. Dieynaba Diallo, Reproductive Health Coordinator, Guinguineo

Louga Region

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Mme. Marieme Aidara Gueye, Health of District Pharmacy, Richard Toll District

Mr. Amsatou Fall, Head of Voluntary Counseling and Testing Center, Richard Toll District

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