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FAMILY PLANNING IN SENEGAL:

ASSESSMENT AND RECOMMENDATIONS

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EXECUTIVE SUMMARY

Birth control devices, services and information are still officially illegal in Senegal although a tradition of child spacing exists, with taboos on pregnancy during lactation. Traditional abortifacients and contraceptive fetishes are widely available. Modern contraceptives can be purchased, by those who can afford them, in pharmacies and a few private urban clinics. Poor people have no access to these services except through a government pilot facility in the capital city and, more recently, through informal USAID distribution in preparation for a government-approved family planning project that will provide counseling and services in urban and a few rural areas through the existing health network.

This pilot activity marks the beginning of a growing government awareness and interest in family planning to combat child and maternal mortality and to improve the condition of women in society. More intensive family planning activities are anticipated in the near future as a result of the creation of La Condition Feminine (a Women's Welfare Ministry) and a clarification of the objectives and the role of this Ministry to make family planning products and services available throughout Senegal.

Resources available to meet these new objectives include: a) a few obstetricians and gynecologists with some training in contraceptive techniques; b) a cadre of midwives trained in family planning procedures through the Santa Cruz program; c) an overworked health infrastructure operating under an economy of extreme scarcity; d) a national drug distribution system that controls all prescription items; e) a traditional and widespread system of women's organizations or clubs which provide natural communication and distribution outlets; and f) a number of assistance agencies interested in a variety of family planning/population programs.

Potential impediments to the introduction of family planning programs in Senegal are: a) a common perception of the need to maximize fertility in the face of high child mortality, reinforced by cultural traditions and by local interpretation of the tenets of Islam; b) resistance among physicians to involvement of non-medical personnel in the distribution of family planning products and services; c) difficulties of distribution and delivery in widely dispersed rural populations; and d) the support by some government officials and educated people for a population increase in Senegal.

Following are factors which will influence the acceptability of specific contraceptive methods in Senegal: 1) In general, women are familiar with their bodies and are not reluctant to handle their genitalia. Therefore, inserting intravaginal contraceptives or locating IUD strings should present no problems. 2) Long lactation with frequent suckling is an important natural force working for child nutrition and family spacing in Senegal. Considering this fact, restraint should be exercised in the use, by nursing mothers, of oral contraceptives, the estrogen content of which might disrupt lactation. 3) Injections are well accepted by Senegalese people; hence injectable steroids would be culturally relevant to this society. 4) Condoms have acquired an association with extramarital sex, but are still in demand in cities, where such activities are prevalent.

Discussions with health personnel, government officials, social scientists and representatives from the target population of potential acceptors of modern contraceptive methods clearly indicated that there is: a) widespread interest in family planning/child spacing; b) a need for services among a large segment of the population—both for health and social reasons; and c) an almost total lack of information and education as to what products are available, where to get them, and how to use them properly. Not only the general public, but also government and medical personnel—with the exception of those trained in family planning—have large gaps in their knowledge base.

The following recommendations are offered: 1) Contraceptive products should be adapted for use in Senegal to make them as culturally appropriate as possible. In order to determine the preferences, attitudes and perceptions of the Senegalese towards various contraceptive products, several short-term applied research studies are suggested. 2) Suitable instructional materials for various target groups (service providers as well as users) should be developed to explain proper use of all contraceptive products, what to expect in the way of side effects, and how to handle any problems. 3) A long term research project should be undertaken in Senegal to examine relative risks and benefits of various contraceptive methods versus uncontrolled reproduction. 4) Additional suggestions for the future expansion of family planning programs in Senegal include a social marketing program, community-based distribution and outreach activities, and extensive communication and education programs for both motivation and reinforcement.

TABLE OF CONTENTS

		Page
I.	Introduction	1
II.	Observations	3
	II-1 Availability of Contraceptive Products: Types of products used, by whom, and where available	3
	A. Pharmacies	3
	B. Markets	4
	C. Government Health Facilities	5
	D. Private Clinics/Private Doctors	9
	II-2 Assessment of the Interest and Awareness of Family Planning and Modern Contraceptive Methods Among Government Officials, Health Professionals and the Academic Community	11
	A. Government Officials	12
	B. Physicians	14
	C. Midwives	16
	D. The Academic Community	17
	II-3 The Target Population: Need for—and Receptivity to—Modern Contraceptive Practices	18
	II-4 Potential for Acceptability of Specific Contraceptive Methods in the Senegalese Setting	25
	A. Oral Contraceptives	25
	B. Intrauterine Devices	28
	C. Injectables	29
	D. Condoms	30
	E. Spermicides	30
	F. Diaphragms	31
	G. Abortion	32
	H. Sterilization	32

iv

II-5 Local Manufacturing and Packaging Capabilities 33

III Recommendations 35

III-1 Proposed Activities to Further Program Acceptance and Expansion 35

A. Instructional Materials 35

B. Applied Research 36
1. Motivational Research Study 36
2. Condom Preference Study 37
3. Oral Contraceptive Dosage Study 38
4. Oral Contraceptive—Vitamin Study 39
5. OC Dosage Schedule Preference Study 40
6. IUD Acceptability Studies 40

C. Longer Term Research Project 42

III-2 Additional Suggestions 43

A. Assessment of Reproductive Risk 43

B. Community-based Distribution and Outreach Activities 43

C. Contraceptive Social Marketing 45

D. Special Programs Underscoring Sensitivity to the Needs of the Senegalese People 46

E. Contraceptive Supplies and Logistics 47

F. Communication and Education Activities 48

G. Quality Control 50

H. New Clinic Site 50

APPENDIX A—

Family Planning and Population Activities of the Donor Community

APPENDIX B—

Meetings in Senegal

APPENDIX C—

Site Visits

APPENDIX D—

Contacts in Senegal

APPENDIX E—

Bibliography

I. INTRODUCTION

This report presents an overview of the current status of family planning in Senegal, including the attitudes of the various groups—government officials, doctors, midwives and paraprofessionals, researchers, users and potential users—toward family planning, and an inventory of existing infrastructures. On the basis of our findings, we suggest possibilities for program expansion and a strategy for implementing some applied research studies which could help Senegalese officials make decisions upon which contraceptive product introduction and adaptation might be based.

Our observations and recommendations are based upon meetings with over 50 government, health, social science and donor agency personnel. In addition to reading selectively on Senegal and its cultural, socio-economic and religious traditions (see Bibliography), we gained first hand impressions by numerous site visits to medical facilities, factories, local markets and shops, distribution facilities, and pharmacies. These visits were limited to the Cap Vert, Sine Saloum and Thiès areas, both because of time limitations and the fact that most of the services of the first phase of the USAID/GOS family planning project will be offered in these regions. Fifty-three percent of Senegal's population, estimated[1] in mid-1979 at 5.5 million, live in these three regions.[2]

The need for family planning programs in Senegal is not universally accepted and, were it not for health reasons, would not be of concern to

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[1] Population Reference Bureau, 1979 World Population Data Sheet.

[2] Republic of Senegal, Ministry of Planning and Cooperation, "Ve Plan quadriennal de developpement economique et social, 1977-1981" (June 1977) Tome 1, p. 100.

many Senegalese government officials. Although the annual rate of population growth (2.7%) portends serious problems, the present population is not large enough in the minds of some government leaders who believe that a larger population will mean greater importance in international politics and/or the potential for more rapid industrialization. Furthermore, the population density of $28/Km^2$ is not, in itself, a sufficiently convincing argument for drastic action in the short term to curtail population growth. However, the age structure of the population has primed the system to grow at rapid rates for the next 30 years, even if family planning is enthusiastically endorsed. Furthermore, only 12% of the land area is cultivated; most is subject to a very short growing season and to periodic droughts which can have major economic consequences. At the present time, life expectancy is short (42 years), and infant and maternal mortality are very high. The individual family is locked into a cultural, biological and economic spiral of maximum fertility to ensure survival and mounting misery in the face of scarcity. Breaking this cycle to improve family health and lower fertility will not be easy, but may be initiated by increasing the effectiveness of present cultural practices related to spacing of pregnancies, through the substitution of modern contraceptive methods for traditional practices.

The current USAID/GOS Family Planning project is primarily a program to train paramedic personnel and to integrate some family planning service delivery into existing MCH programs. This effort can be made much more effective by the development and introduction of culturally relevant materials for communication and education; by adapting contraceptive products to make them more relevant to the Senegalese culture; and by utilizing alternative methods of distribution wherever these are found to be acceptable.

II. OBSERVATIONS

II-1 Availability of Contraceptive Products: Types of products used, by whom, and where available.[3]

The French law of 1920 forbidding abortion, the importation or manufacture of contraceptive products, and any propaganda for birth control, remains Senegal's only statute on family planning. However, in recent years the government has chosen not to enforce this law; hence we found products available in the following distribution sites:

A. Pharmacies

Privately owned pharmacies are prevalent in Senegal's urban areas. They sell costly, imported products and seem to cater to a European and middle- and upper-class Senegalese clientele. All those we visited stocked condoms, and more than one brand of regular or low-dose oral contraceptive, either manufactured in France or distributed by a French subsidiary. Some pharmacies had a supply of IUDs (Gravigard/Copper 7s) but, according to the director of the Pasteur Clinic, a private ob/gyn facility, supplies are often erratic and completely undependable. These devices are also expensive--5000 CFA's ($25.00). The injectable Noristerat (Schering) was available in a few pharmacies in Dakar, and the drug company's detail man was beginning to contact area physicians at maternity hospitals and private clinics. Except when purchasing condoms, customers are supposed to present a prescription signed by a doctor or midwife. One popular condom brand cost 500 CFAs ($2.50) for a package of six (not individually wrapped and not lubricated); pills averaged about 440 CFAs ($2.20) per cycle.

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[3] In this analysis we have limited ourselves to the regions of Senegal to be included in the first phase (3 years) of the USAID/GOS family planning project.

A midwife at the Institute of Social Hygiene, who recommends condom use for clients with V.D., reported that most clients are too embarrassed to request this product from a pharmacist. One Dakar pharmacist reported that he has about 10 condom customers a day.

A midwife in Thiès said that young, unmarried women in that city were purchasing pills "as though they were bread", implying that they were available without prescription. Other midwives also claimed that pills could be obtained without a prescription. For those urban dwellers who are sufficiently informed and/or self-motivated to request a specific contraceptive method, and who can afford the "luxury" of purchasing a medical product when they are not ill, the pharmacies of Senegal can usually meet their needs.

B. Markets

Both urban and rural areas of Senegal have markets—a series of booths, stalls and/or open stands—where men and women come regularly to purchase all household supplies: grains, fruit, clothing, fuel, soap, and medicines. Except for some European and American medicines that are probably smuggled into Senegal via the Gambia, these are traditional medicines, made in Africa, from local herbs and other plants. Among a large array of indigenous products, there are many plants and roots sold as both contraceptives and abortifacients. Dr. A. Kone-Diabi, in an introduction to her M.D. Thesis,[4] lists six of these traditional products available in Tilène market in Dakar. On one market visit we discovered a seventh, "San", allegedly a tree root from Nigeria, whose properties (according to the vendor) made it suitable either as a contraceptive, or as an abortifacient (if taken during the first two months of pregnancy).

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[4]Kone-Diabi, A., "Evaluation Medico-Sociale d'une Action de Planification Familiale à Dakar," thesis, University of Dakar, 1976, p.17.

Vendors interviewed in the market, and midwives we spoke to at the clinics, told us that traditional contraceptive products—especially abortifacients—were purchased by unmarried women, especially schoolgirls. Among the target group of possible contraceptive acceptors interviewed in three cities (Dakar, Rufisque and Thiès), many of the women knew of these traditional products, but few had knowledge of modern contraceptive methods.

Since, of necessity, all men and women of every economic strata are familiar with the marketplace, and since many urban women have some sort of market-related, part-time income-generating activity,[5] this is a culturally relevant place to offer any product whose acceptability one is trying to enhance. Adding nonmedicated modern contraceptive products should be seen as a natural extension of the existing commercial system that has, for years, been selling traditional contraceptive products. Although any subsidized commercial venture would be operated by the private sector, the full cooperation of the GOS is a must, for at the present time it is against the law to sell modern contraceptive products (even those—e.g. condoms—not requiring a prescription) any place but in a pharmacy.

C. Government Health Facilities

1. The PMI (maternal and child health) Clinic in Medina, in the heart of Dakar, is the first pilot project to offer free family planning (or child spacing) services under government sanction. Originally established in 1977, the family planning unit was not allowed to operate until May, 1978, when the current Minister of Health encouraged it to begin providing services. "Call it anything you want, but get family planning started", was the way the midwife in charge of the unit

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[5] Falade, S., "The Women of Dakar and the Surrounding Urban Area", in Women of Tropical Africa, D. Paulme, University of California Press, Berkeley, 1963, pp. 217-229.

paraphrased the Minister's edict. Over their entrance door is a sign "Planning Familial". Although we had heard that "planning" had a pejorative, Western connotation, PMI clinic personnel seemed to feel it is also the term with the highest recognition level. Run by two Santa Cruz-trained midwives, this comfortable clinic, stocked with Pathfinder-supplied contraceptive products, offers IUD insertions (Lippes loops), and oral contraceptives (Blue Lady three-month packets, with either 80 or 50 mcg of estrogen). All packets are dated 2/74, but they appeared to be in good condition. Pathfinder had also given the clinic condoms (Sultan, by Akwell) and diaphragms (size 70 and claimed to be too small for most of their clients).

This PMI family planning unit is used by a small cross-section of the working and lower-class urban population. Thus far, the clinic has relied on word-of-mouth publicity, which seems to spread slowly. Some clients are referred by doctors for health reasons; prostitutes are referred by the Institute of Social Hygiene; others hear about the clinic from their friends. As an example of its case load, August's records show that 448 women received services; of these, 74 were new clients. Although no formal studies of follow-up have been undertaken, the judgment of the staff was that most women return; estimated continuation rates were 70 percent.

2. Although the USAID/MOH family planning project is still not officially underway, USAID's Regional Health and Population Officer has informally distributed Pathfinder-supplied pills and condoms to some of the PMI clinics, VD centers, and rural health facilities that are targeted as service and distribution centers during the first phase of

this joint family-planning venture. We found contraceptive supplies in use (although in very small numbers) at the PMIs in Rufisque and Kaolack, at VD clinics in Dakar and Kaolack, and at a Thiès maternity hospital. Supplies at a gynecology clinic in Thiès and a CM (Central Medical Facility) in Niaro, Sine Saloum, had been exhausted, but no one had considered requesting more. Since this is really pre-project distribution, no supply, logistics or recordkeeping system has yet been established. We noticed that contraceptives were kept locked up and were often not distributed, even in response to a request. When we discussed this instinct to hoard with Ms. Siga Sene, MOH Technical Advisor and the Ministry official responsible for coordinating the AID/MOH family planning project, she pointed out that the staff of government-operated medical facilities were accustomed to "an economy of scarcity." Some re-education might be in order. Our other observation relating to product availability was the obvious lack of communication between medical service providers. At one facility, a midwife at the prenatal clinic did not know that the midwife in the gynecology unit was providing family planning counseling and had had (until recently) pills and condoms. At the PMI in Rufisque, the head of the baby clinic did not know that her counterpart in maternal care had set aside 1 day each week to offer family planning/child spacing services. Simply improving communications will definitely improve product availability.

3. The government operates several maternity hospitals. We visited two of the largest, Le Dantec and Abass N'Dao, plus some smaller facilities outside of Dakar. Apparently, most urban women go to a medical facility to deliver their babies; and even in some towns and villages

of Sine Saloum we saw small (fewer than 8 beds) maternity hospitals. While only a tiny percentage of these women come for prenatal care, delivery time could still afford doctors, nurses and midwives an excellent opportunity to inform women about the advantages of child spacing and the options available to them. But the doctors with whom we spoke usually prescribe contraceptive methods only at the request of a patient. Many seemed reluctant to advocate child spacing in the absence of a written government mandate, unless they were counseling a "high-risk" patient, for whom another rapid pregnancy would probably be detrimental, or even fatal. Doctors at Abass N'Dao hospital received some IUDs from Pathfinder, but the supply is exhausted. They still have some OCs (Blue Lady, 80 and 50 mcg), but the instructions are written in English, and one doctor admitted they are often too busy to assure that the woman has fully understood the instructions for proper use. Most of the doctors write pharmacy prescriptions for a particular brand of OC (often a woman requesting the pill will refer to it by a specific brand name), or a copper IUD. In the case of an IUD, the woman brings the device to the hospital for insertion. Understandably, most requests for contraceptive products come at the beginning of the month, when families have more money.

Dr. Ba of Abass N'Dao hospital had received some mini-lap kits from Pathfinder, and had performed a few such sterilization procedures at the request of patients. At Le Dantec hospital, two doctors had been trained by JHPIEGO (Johns Hopkins Program for International Education in Gynecology and Obstetrics) in laparoscopy. No laparoscopies had been done lately, but some new KLI equipment had recently arrived in

Senegal. A JHPIEGO doctor from Tunis visited Dakar in mid-November to demonstrate its use and to supervise as the doctors from Le Dantec performed this operation. (Dr. F. Farah, the director of a private maternity hospital, Clinique Pasteur, told us he has performed several laparoscopies, but requests are not frequent.)

D. Private Clinics/Private Doctors

There are now a few private clinics, run by midwives, that specialize in family planning services, although they offer other gynecological and maternity services as well. The best known of these is La Croix Bleue, located in Castor, a working-class section of Dakar. Pathfinder had supplied it with condoms, Lippes loops, Dalkan Shields (some years ago) and Blue Lady pills (50 and 80 mcg). At this juncture, the clinic has only about 100 Lippes loops, sizes D and C, (and bags full of Size B, which seem to be too small for almost all Senegalese women), plus some TCu 200s that the director, Ms. Phoebe Whest-Allègre, obtained from Pathfinder on her last visit to the U.S. Although condoms and pills are available, IUDs are the principal method of contraception offered at this clinic; complications and event rates are low. This clinic sees about 100-150 family-planning acceptors per month, all from lower-middle and lower-class families. Ms. Whest-Allègre reports that her patient load has dropped significantly since her Pathfinder grant lapsed and she can no longer afford to employ fulltime outreach workers.

In Rufisque we visited a new private clinic, Clinique Nabou, run by Ms. Aicha N'Doye, formerly head of the PMI's family planning unit in Medina. She, too, is using pills and IUDs informally supplied by AID's Health and Population Officer. Her clientele appears to be a mix of middle to upper

and working class women. The latter can afford to come because this is a big industrial area, and the factories have maternity-related insurance programs, to which all female employees contribute.

Single people, if they can afford the family planning counseling of a private physician or a small clinic, prefer the anonymity such a service affords them. Because the range of contraceptive products available in Senegal is meager compared to what is available in Europe, private doctors often carry products back with them when returning from abroad, or have a network of friends who do this for them.

This summarizes product availability, as we found it in late 1979. Implementation of the USAID bilateral agreement, signed in May 1979, has been delayed due to a reluctance on the part of the Senegalese government to begin spending project funds until inter-ministerial responsibilities have been determined. Under this agreement, family planning services and products will be made available in 10 primary PMIs, 19 secondary PMIs, 5 VD control centers (that also provide ob/gyn services) and 33 maternity hospitals. In addition to OCs, condoms, and IUDs, US Government-procured products will include diaphragms and foams. The Regional Health and Population officer recently requested that Neosampoon be added to this commodities list.

II-2 Assessment of the Interest and Awareness of Family Planning and Modern Contraceptive Methods Among Government Officials, Health Professionals and the Academic Community

Before we could consider recommending program expansion possibilities, or a strategy for introducing and adapting contraceptive products for use in Senegal, it was necessary to assess the level of interest and awareness in family planning/contraceptive technology. We interviewed: a) government officials from all ministries currently involved in family-planning/child-spacing programs, or those slated to become involved in the near future; b) doctors, midwives, social workers and other health personnel; c) social scientists, demographers, and researchers whose assistance could be important when conducting attitudinal and/or preference studies; d) donor agency officials working in family planning in Senegal; and e) representatives from the target population of acceptors and potential acceptors of modern contraceptive methods. Full details of these meetings can be found in Appendix B. While we never found unanimity within any one group, there were clear indications that there is: a) widespread interest in family planning/child spacing; b) a need for services among a large segment of the population—both for health and social reasons; c) an understanding of the benefits of child spacing; and d) an almost total lack of information and education as to what products and methods are available, where to get them, and how to use them properly. Not only the general public, but also government and medical personnel—with the exception of those trained in family planning—have large gaps in their knowledge base. The target population is dealt with in more detail in section II-3. The following are some general findings for each of the other groups referred to above:

A. Government Officials

1. Everyone agrees that President Senghor supports the concept of family planning. However, for political reasons, he wants one of his ministers to take the lead in issuing specific policy statements. The general feeling is that he will support the recommendations and programs proposed by any one of several ministries. To date, there has been no written government pronouncement about family planning, but we have indications that there may be one soon.

2. Although the Ministry of Health (MOH), in 1976, took a first small step toward implementing a family-planning program by requesting the Pathfinder Fund to assist in providing services at some government clinics, there was much internal debate within the MOH as to whether—and how—it should proceed, and there was a long delay before the first MOH-sanctioned services were provided in mid-1978.

3. Some of the MOH officials with whom we spoke—for instance, Chief of the Cabinet, Rama Gueye—cautioned patience, and emphasized the need for Senegal to proceed slowly in its implementation of child-spacing activities. They see family planning (which they consistently refer to as "child spacing") solely in the context of maternal and child health, and they are opposed to any kind of commercial or community-based distribution. Many of them agree with those doctors who see family planning as a strictly medical matter, for which services should be provided only by doctors or midwives. Others, like the Technical Advisor, Siga Sene, who is also MOH Coordinator for the USAID/GOS Family Planning Project, commented on the plight of sexually active unmarried girls, and the need to prevent illegitimate births. Although the MOH's position

has been to rely on word-of-mouth to spread family-planning messages, Ms. Sene feels a more organized system for disseminating information must be developed. She also favors sex education in secondary schools, and mentioned the need for materials aimed at informing and instructing illiterates about child-spacing methods.

4. For the past several months, there has been an interministerial dispute as to which ministry should take the lead in setting policy, implementing, and coordinating all government and private family-planning efforts. A National Population Commission was approved in 1978, and the Minister of Planning and Cooperation was designated as its president. It is an interministerial commission created to set policy, but to date it has not met nor have the names of the other people who are to serve on the Commission been announced. This fall, a small three-person Population Unit was created within the Planning Ministry to advise the Commission as to what kind of population policy it should adopt. The Minister, Louis Alexandrenne, has given only general clues as to his position. He has told a member of his Population Unit that Senegal's rate of population growth is too high and must be reduced; therefore child spacing is needed. He also favors mobilizing all forces—political as well as religious—to create an awareness of the population situation.

5. Recently, the Prime Minister issued a letter (an internal communication not yet released to the public) defining the roles of La Condition Feminine (CF, or Ministry of Women's Welfare) and the Ministry of Health (MOH). According to Mr. Mamadou Talla, Director of the Cabinet of CF, who gave us CF's interpretation of this letter, the National

Population Commission, which was established before CF was created a year ago, will now become obsolete, as CF will be responsible for planning and conceptualizing "family protection" policy. Other ministries must communicate all proposals and program needs to CF which will then set priorities for action. CF will serve as contact between the GOS and cooperating agencies and friendly nations "wishing to assist" Senegal's family protection program. CF will also be responsible for sensitizing and informing both the public and the civil servants about options available to them. In contrast to the situation prior to publication of the Prime Minister's letter, Mr. Talla said that the government, through CF, is now committed to launching action designed to reach ALL groups of women who could benefit from family planning methods. He spoke in terms of promoting outreach programs, communication and education programs, and the marketing of nonprescription contraceptive products, and indicated CF would need the technical assistance of private organizations such as PIACT. Mr. Talla said CF would also make decisions as to which contraceptive methods would be offered by the national program, while the MOH will implement all technical matters having medical implications. He requested all the method and product-related information USAID could send him, preferably written in French.

B. Physicians

We were told there are less than 300 doctors in Senegal, and only about 10 are trained as ob/gyns. Most of them are so busy delivering babies, and tending to the needs of the sick and dying, that they have little time to focus on family-planning methods—and even less time to properly explain such methods to their patients. One doctor lectured us on the fact that

infertility was Senegal's main population concern, but even he agreed with the other doctors that child spacing was definitely necessary to improve the health of both mothers and children. According to a study done by Dr. Adanlette, maternal mortality in the Cap Vert region (Dakar and environs) is 188 per 100,000 women. We can assume that in rural areas, where only 5% of the country's doctors reside and where health conditions and facilities are less sophisticated, mortality figures are considerably higher. The infant mortality rate is also enormously high. According to Dr. Correa, professor of Obstetrics and Gynecology, the Faculty of Medicine, Dakar University, 50% of all Senegalese children die before their fifth birthday. Dr. Serigne Ba, Chief of Medicine at Abass N'Dao Maternity Hospital Center, said that, although he personally believes Senegal is underpopulated, contraception is "necessary to space pregnancies so there will be fewer of them, but also fewer deaths."

As discussed in Section II-1, most doctors recommend contraception to women whom they consider "high risk". But they have no opportunity to follow up on these women to ascertain whether their advice is followed. As one doctor reported, "The next time I saw the woman (referring to someone for whom he had prescribed an oral contraceptive), she had a ruptured uterus."

Most doctors insert IUDs and prescribe pills—and some even perform sterilizations—when a woman requests help and is prepared to purchase a particular product. But we did not meet any doctors who, as a routine matter, told their patients about the advantages of child spacing and how they could control their fertility. One doctor explained that he only followed orders and, since the government still has not given official clearance to family planning, he felt he was not in a position to promote family

planning/child spacing. It became apparent to us that, once the government issues a written policy statement supporting family planning, many doctors will feel free to take a more assertive position.

C. Midwives

Between 1976 and 1979 15 government midwives and one social worker were sent to Santa Cruz, California for training in family planning and improved maternal and child care. Currently the first Santa Cruz, in-country, training program for 7 midwives (from various regions of Senegal) is being conducted in Dakar, with some of the US-trained graduates serving as preceptors.

We met with the trainees, and also had occasion to speak to many of the graduates. All returned to Senegal most enthusiastic about their role in promoting family planning, counseling women, inserting IUDs, etc. But most also re-entered a clinic, hospital, or dispensary situation that was not conducive to providing family-planning services. First of all, until last year, they had no products to dispense. Secondly, like the doctors referred to above, most were reluctant to encourage women to use a contraceptive product in the absence of a government pronouncement. And finally, even when a woman requested counseling and a prescription, she often could not afford to continue using the product. A few midwives became discouraged, left government service, and are now operating their own private clinics. (Perhaps they also saw a financial opportunity, but the fact remains that they are providing needed services.)

Almost all the Santa Cruz-trained midwives wished they were doing more family planning. Some voiced the opinion that they and their staff could undertake outreach activities in the surrounding community (once they had official government sanction), and that such a program would do much to

enhance awareness of service availability and interest in taking action to space one's children. Many of the midwives we met have not had the advantage of this special program; they, too, believed in child spacing and would welcome the opportunity to learn more themselves, so they could better advise their clients. Almost all remarked on the unmet need for information, education and services among large segments of the target population.

D. The Academic Community

We found that most of the academicians we met were aware of the unmet need for information on: a) human sexuality, b) contraceptive products and how to use them, and c) where services can be found. Some persons expressed reservations as to the sincerity of the government's position. While the government claims it is sensitive to the rights and needs of women, some of the younger, pro-activist women say its actions belie these claims. These women also urged that proper attention be paid to the religious community which, if antagonized, has the power to cause a considerable backlash that would undermine any family planning effort.

Whether or not the social scientists we interviewed were well versed in modern contraceptive methods was not as important to us as their interest in conducting applied research or undertaking some acceptability, preference and attitudinal studies that could provide information useful to policymakers and program planners making decisions about contraceptive products and how to promote them. Although we were only able to locate a limited number of social scientists and researchers, we learned that the academic community is in general receptive to the idea of collecting data pertinent to its own country and insuring that products which are introduced be culturally acceptable.

II-3 The Target Population: Need for—and Receptivity to—Modern Contraceptive Practices

On the basis of 18 days in the field, we can hardly claim special insight into the hopes, fears and felt needs of the Senegalese people. However, we were able to gather perspectives from the following persons: 30 or so health professionals from most regions of the country; 10 high-ranking members of government ministries with responsibilities related to health, population and the role of women in the country; & social scientists, communicators and activists with an interest in family planning; and more than 20 officers and consultants of 6 bilateral or multilateral assistance agencies involved in some way with population, family planning, or health issues in Senegal. With the obvious biases of these sources taken into account, these borrowed insights (together with token surveys of selected user groups in three different cities, and the numerous documents listed in Appendix E) created impressions for us of people's attitudes which may affect acceptability of specific contraceptive products or services.

Women of child-bearing age (15-44) represent 43.9% of the approximately 2.6 million women of Senegal. There are clearly ethnic and regional differences in their attitudes toward fertility, but these appear small when compared with urban-rural differences. Many urban women of the highest socio-economic classes seem to have the information they need upon which to base decisions about the use of modern contraceptive methods. Judging from pharmacy sales,[6] their needs are being largely met; but they represent only

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[6] UNFPA, "Senegal: Report of Mission on Needs Assessment for Population Assistance," UNFPA Report No. 4, United Nations Fund for Population Activities, New York, New York, 1978, p. 33.

a tiny fraction of the population at risk. For the vast majority of Senegalese women, urban or rural, there are certain basic factors that might affect their responses to the availability of contraceptive products and services.

First and foremost is the concept, common to all developing countries, of the family as a support system, insuring for the parents some possibility of comfort in their old age. With regard to achieving this objective, the reality for most Senegalese is best summed up by L. G. Colvin et al. in the "Senegambia Migration Study": "At the present rate of mortality in the Senegambia, model life tables indicate that in order to have a 90% chance of having one son survive to age 25 to provide support during his parents' old age a woman must average six live births (and . . . an equal number of miscarriages and stillbirths.").[7]

Out of this reality have grown pro-natal traditions and cultural practices, some of which have been reinforced by Islam. Nevertheless, these practices have not ignored the desire to provide the best possible nutrition for the infant; thus, child spacing is a strong tradition, supported by prolonged lactation (18 to 24 months) with frequent suckling; by taboos on postpartum sexual intercourse; and, more particularly, by taboos on pregnancy during the suckling period. These taboos are strong enough to have brought about a demand for contraceptive aids, including the practice of coitus interruptus, and the creation of a market for antifertility fetishes and traditional medicines, many of which are reported to be abortifacients.

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[7]Colvin, L. G. et al, "Senegambia Migration Study," Chapter XIII, Migration and Public Policy in the Senegambia, (Mimeo).

The men of Senegal may accept no reason, other than the need for suckling, for delaying subsequent pregnancy. But the women are tired, and would like some rest from the endless cycle of pregnancy and lactation. Of 23 women in 3 cities interviewed (by a collaborating Senegalese midwife), twelve—with an average of three children apiece—expressed a strong desire to delay their next pregnancy. An additional five women, who had an average of seven children each, had reached or exceeded the number of children they desired. These women emphatically wanted no more children.

Several health practitioners echoed these sentiments, basing their affirmation of the need for contraception on the poor health of the women and high infant mortality rates. An estimate of 10 maternal deaths per 1,000 live births,[8] 50% fetal death rate, and 50% child mortality rate up to age five (statistics from the Abass N'Dao Maternity Hospital and Le Dantec Hospital) give tragic testimony to this state of affairs. Nevertheless, the Senegalese woman has several reasons to fear the consequences of losing her fertility. Childbearing is often the only way she can affirm her right to be a spouse—the threat of her husband leaving her or taking another wife is always present. Competition between co-wives for a larger share of the inheritance (which under Islamic law is based on the number of children) is a strong incentive for fertility in polygynous families. Relatives on both sides of the family are quick to apply social pressure if the interval between pregnancies seems unusually long. The barren or prematurely infertile woman is often a social outcast.

The influence of urban life has, to varying degrees, changed attitudes about fertility in the cities, in the surrounding countryside, and along

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[8] UNFPA Report No. 4, Op.Cit., p. 14.

major highways. Women are becoming more independent: 35% of married women attending the Medina PMI Clinic in Dakar during 1 month did so without permission of their husbands, a violation of tradition said to be unthinkable in the villages. When compiling the results of our interviews, we noted that many women expressed an interest in child spacing for their own health and also for the health of the child. While almost every respondent noted advantages to child spacing, not one mentioned a single disadvantage. Economic factors have caused many men in urban settings to change their traditional views that supported maximum fertility: the soaring costs of urban living and of schooling for children (which is desirable from the social and old-age-security point of view, but costly because of books and clothes, as well as the disadvantage of eliminating children as major contributors to the family income). Exposure to the possibilities of modern contraception is much more likely in the cities, where access is possible for the wealthy, courageous, independent or desperate, than in rural areas where no products or services exist.

Traditional sex education and sexual initiation has disappeared in the urban setting. Consequently, a paradox has arisen: city teenagers know less about the consequences of sexual activity than their rural counterparts. This situation, combined with later age at marriage, and statutes which remove girls from school and prohibit reentry once they have been pregnant, has led to an epidemic of teenage abortions, a thriving traditional abortifacient market, infanticide, and even suicides. These problems were cited, by both high-ranking government officials and health-care professionals, as the basis for a high-priority need for contraceptive services. Unmarried women—young and old—are interested in contraceptive

methods, mainly because of the stigma of illegitimate births, but many do not know where to turn for services.

The effect of the Muslim faith on acceptance of modern contraceptive practices in Senegal is unclear. The conclusion of the 1971 Conference on Islam and Family Planning[9] was that Islamic law does not stand in the way of family planning if the objective is improvements in the quality (education, health and well-being) of the children's lives. Of the modern contraceptive practices, only sterilization and second-trimester abortions are definitely outlawed, except when the woman's life is threatened. These findings have recently been supported by the consensus of participants at a conference on Islam and family planning in Africa,[10] held in Banjul, Gambia, 1 week prior to this PIACT mission to Senegal. The extent to which these pronouncements will influence the highly individualistic practices of the local marabouts (religious leader) and, through them, the people of the small communities, cannot be judged at present. However, several government officials have recognized the need to seek the cooperation of these influential men in the development of child-spacing activities.

Should a contraceptive social marketing program ever be introduced, the amount of cash available to Senegalese, and the extent to which they perceive family planning as a basic necessity, will obviously affect acceptability of contraceptive products and services. For the vast majority of people, many of whom are employed in agricultural practices associated with the short (3 month)

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[9]"Islam and Family Planning," Proceedings of the International Conference held in Rabat (Morocco), I.P.P.F., Middle East and North Africa Region, Beirut, Lebanon, 1971.

[10]Milas, S., Nalwiso, F., et al, "A Preliminary Report on the Conference on Islam and Family Planning," Banjul, the Gambia, October 22-26, 1979.

growing season, availability of cash is highly seasonal. A peanut farmer may have no problem in purchasing modestly priced products in the spring, when the crop is sold to the state-run cooperative, but he may have a different view in the fall, when money has dwindled to subsistence level.

Women in Senegal, however, may have their own cash, which is truly discretionary, resulting from small-scale gardening and trading activities. Under Islamic law, this cash is not considered part of the housekeeping money, since it is the duty of the husband to supply the family's basic needs. These small sums are often accumulated into a larger fund through a unique tradition of women's associations or clubs, which extends even into the remote regions of Senegal. In one small community, we attended a women's group meeting where local mothers were contributing money toward the group purchase of a baby-weighing scale. (In this case, however, they had the added incentive of allocations of powdered feed grains and milk products supplied by Catholic Relief.) The government ministry concerned with women's welfare has recognized the potential of women's groups for child spacing programs, and is in the process of making contact with all such groups throughout the country. Since, in this culture, women are more likely to be the primary acceptors of family-planning products and services, this widespread traditional aspect of the economy may make social marketing of contraceptives a viable option for family-planning programs in Senegal. Nevertheless, the women are unlikely to take such action without permission of their husbands, particularly in the rural areas.

It appears from all these observations, that the response of women in rural or regional urban settings to available contraceptive products and services is likely to be mixed. Vigorous informational activity by a

regional urban midwife trained in-and-enthusiastic about-child spacing activities, with free supplies on hand, did not always result in an impressive record of contraceptive acceptors. Traditional demands for maximum fertility are often likely to win out over the desire for rest from the burden of childbearing unless the people, in particular the men, can be convinced that spacing children will enhance the likelihood that more children survive. However, there appears to be no reason why modern contraception could not replace the chancy and even dangerous traditional practices for extending the interval between pregnancies. It is likely that out of this more efficient way of implementing an existing cultural practice, a new tradition of modern contraceptive practice use will develop, reinforced by the consequent improvement in maternal and child health. The process has already begun. We found that many women had already heard of at least one modern contraceptive method, but most of them knew nothing about how to use the method or where it was available.

The speed with which modern family-planning practices will be adopted in rural regions of Senegal will depend greatly on the sensitivity of the program directors, trainers and practitioners to the conflicts outlined in this section. These conflicts are less apparent in urban areas, and thus acceptance of modern contraceptive practices in Dakar is likely to grow much faster, if products and services are readily available.

II-4 Potential for Acceptability of Specific Contraceptive Methods in the Senegalese Setting

In this section we examine available techniques of family planning and the factors that may impact upon their acceptance and effective use in Senegal.

A. Oral Contraceptives

The effectiveness, compactness and durability for transport and storage, and relative simplicity of delivery and application make oral contraceptives attractive for program operators and users in most cultural settings. On the other hand, rupture of the supply system (difficult to avoid in a developing-country setting) can have a disruptive impact on a community. In addition, there are several potential misapplications of this technology that can affect both acceptability and effectiveness in Senegal. Instructions to take a pill, every day and in a specific sequence, cannot be casually conveyed to illiterate women. They may have a reasonably accurate notion of how conception is related to coitus, and will not understand why a pill is necessary on days when intercourse does not take place. Other beliefs on how babies are made may also confuse the issue, especially when, as is usually the case, no materials are provided to refresh the memory. Many midwives spoke of patients who took oral contraceptives only during menstruation or before intercourse. A doctor in one large maternity hospital in Dakar actually removed the iron tablets from the oral packs because patients would frequently take the various pills in random order.

These problems can be overcome with proper development of culturally relevant training materials and package inserts. However, another more

fundamental misapplication of oral contraceptive technology concerns its impact on lactation[11]— a vital factor for child health, as well as an important natural factor working for child spacing in Senegal. In addition to the possibility of deteriorating infant nutrition, short periods of dosing with combination oral steroid contraceptives during lactation may also, by shortening the period of lactation, bring about a decrease in the interval between pregnancies. It is unrealistic to suppose that oral contraceptives can be supplied or will be used with sufficient consistency over a prolonged period to avoid this outcome in many instances.

Although it is true that most contraindications for oral contraceptives are also contraindications for pregnancy, pregnancy does not produce adverse political reaction, whereas contraceptive use may do so. Therefore, the issue of side effects cannot be ignored, even though the effect on health of continual pregnancies may be the same or worse than that of side effects in high-risk women. Although there are no formal statistics, health-care professionals indicate that hypertension is by no means uncommon among Senegalese women. This issue, in itself, may be important enough to justify some simple system of checks to divert high-risk women to other methods of contraception, as well as some scheme of recourse to medical care in the event of problems and, most important of all, some in-country trials to determine the optimum estrogen dosage levels for Senegalese women.

Oral contraceptives should be used in Senegal only in conjunction with carefully developed and tested training and instructional material. With proper attention to these culturally appropriate communications and to

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[11] For a full review of this subject see Buchanan, R., "Breat Feeding--Aid to Infant Health and Fertility Control," in Population Reports, Series J, No. 4, July 1975.

education, and with information on optimum dose levels, dispensing oral contraceptives need not be limited to the few health-care professionals. Not only are these doctors and midwives overworked, they are by necessity involved primarily with curative rather than preventative measures. Therefore, the very sick (rather than the relatively healthy people in need of contraception) are those who should receive the attention of the country's relatively few doctors and midwives. Over time, paraprofessionals can be properly trained to dispense oral contraceptives, where indicated, through outlets such as women's associations, village pharmacies and health huts.

Utilization of oral contraceptives in a countrywide program will involve a communication, training and supply infrastructure directed ultimately at training women to take pills every day, in a certain sequence. This infrastructure can also be utilized to supply other nutritional and health needs to Senegalese women acceptors. For example, iron and vitamin supplements are obvious possibilities for this scheme, and could be incorporated into each pill, rather than only in the interval placebos. (Potentially, even medication for prophylaxis against parasitic diseases could be incorporated into such a system, although these schemes would require more detailed study; they might be considered for long-term projects.)

Unmarried girls attending high school or college in the cities represent a special category of contraceptive need, for which oral contraceptives may provide one answer. However, these girls will not go to prenatal or maternity clinics for fear of being thought pregnant. Access to hospitals is also difficult because they are often guarded by gatekeepers, who perform a sort of triage function (as well as providing a source of rumor). Going

to any such health facility amounts to a public proclamation, regarding sexual activity, that is unthinkable for many Senegalese girls. Pharmacies are also intimidating, and beyond the private means of most girls. Both the Health and the Women's Welfare Ministry of the government of Senegal give high priority to this group because of the epidemic of abortions, abortion-related injury and death, and school drop-out rates. These officials are therefore giving thought to supplying oral contraceptives in facilities at schools and colleges.

B. Intrauterine Devices

IUDs have been prominent in the rudimentary family planning programs that have developed in Senegal over the past few years (see Section II-1). Widely varying incidences of infection suggest problems associated with inadequate sterilization or acceptors' personal hygiene practices. Inadequate sterilization procedures could easily be overcome by sterile packaging in-country. (A private company with the equipment and capability to do this has been identified.) Cleaning the vagina with the left hand, which is a cultural practice in Senegal, can cause infection unless women are educated as to the importance of carefully washing their hands before doing this. On the positive side, Senegalese women are at ease with their sexual organs and have no problems with checking for strings. If properly instructed in what to expect following insertion, the IUD appears to be well accepted. Since female stoicism is considered a great virtue in this culture, pain tolerance is high and women seldom complain of pain or discomfort arising from IUD use. Nevertheless, some fear of the IUD was expressed by a few of the women interviewed.

The need for professional or paraprofessional IUD insertion, as well as for rapid recourse in the event of problems or elective removal, restricts

the usefulness of this method to predominantly urban settings. It appears that the IUD is sufficiently well regarded amongst urban women to remain an important option. However, more attention needs to be given to the sizes and types of IUDs used in the Senegalese program. In some clinics the Lippes loop C proved too small for first insertions in multiparous women. This suggests a need for greater numbers of Lippes loop size Ds, or some alternative—and perhaps larger—devices. In any event, educational materials for illiterate women are essential to the success of an IUD-based program, since it is clear that continuation rates were higher in those clinics where women were carefully taught what to expect in the initial postinsertion period.

C. Injectable (Sustained Release) Forms of Steroidal Contraceptives

Injectable forms of contraceptives may be culturally appropriate, especially since they appear to have no significant effect on, and may even augment, lactation.[12] Injections have strong positive associations for healthy people in Senegal because of disease prevention programs. The resupply system can be much less elaborate than for oral contraceptives, and the injectable method lends itself well to outreach programs which could utilize (after additional training) existing extension agents employed by the government of Senegal.

Appropriate in-country trials would be required to test acceptability, side effects and delivery systems. Since injectables, unlike pills, require a commitment to an extended period of infertility, carefully developed information and educational materials would be required to permit illiterate women and their husbands to make informed decisions.

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[12] Pinehart, W. and J. Winter, "Injectable Progesterons--Officials Debate but Use Increases," in Population Reports, Series K, No. 1, March, 1975.

D. Condoms

Condoms are already being used in Senegal, but in a way that has rendered them culturally unacceptable for contraceptive purposes in a family situation. They are associated with disease, prostitutes, or extramarital sex; or they may be used by married couples during menstruation. It is doubtful whether this image can easily be expunged, although it is possible that with a good deal of re-education, condoms may become preferable to coitus interruptus for married men mindful of the taboo on pregnancy during early lactation. However, objections were often voiced by men and women to detectable barriers of any type. Also, it is not clear to what extent young men are motivated to contracept, since only the girls suffer the consequences of unprotected coitus.

Condoms are utilized in the informal USAID distribution system (see pp. 5-6), and the speed and enthusiasm with which orderlies and drivers made off with them, when given the opportunity, suggested a ready market among people who did not choose to come to the clinic for a free supply. The young urban unmarrieds, often students, provide a potential population of acceptors for low-cost condoms. In order to reach this group, however, free or low-cost contraceptives would have to be available in places other than maternity and VD clinics. Social marketing programs utilizing small "nar" shops and market places could provide access to condoms for this segment of the population.

E. Spermicides

Intravaginal spermicides have not been used in Senegal. Convenient forms, such as foaming tablets, e.g., Neosampoon, may fill an important need for added protection during early lactation, and for unmarried girls, because

they lend themselves readily to wide-scale social marketing and community-based distribution programs. For such an approach to be successful, it would be necessary for the government of Senegal to rule that spermicides are not medicines; otherwise they will be restricted to pharmacies.

Vaginal insertion presents no problem for Senegalese women who commonly use their fingers to clean their vaginas. The mild tingling or burning sensation often associated with use of foaming compounds may resemble the effect of the ground-up plant material that some women put into their vaginas to erotically stimulate the male. Senegalese health professionals feel that the required interval between insertion of foaming tablets and achievement of maximum protection presents a potential problem that would require special educational efforts and instructional materials. Appropriate packaging would have to be developed for hot and humid conditions, and to avoid breakage of the tablets during transport and handling. (These problems have been encountered in one Asian program.)

F. Diaphragms

Because of strong male objections to objects in the vagina that can be felt during coitus; of problems in storage, hygiene, and the sophistication required for proper use; and the dependence of the device on the conformation of the vagina (which can change after childbirth), conventional diaphragms may have limited application in Senegal. There was a demand for diaphragms at the government family-planning clinic in Medina so that the option could be offered to urban women. If they are to be used, diaphragms should be supplied in sizes of 80-100 mm; the 70 mm size, now available, is too small for most Senegalese women. However, the nonspermicidal, fit-free vault cap approach[13] may be a feasible alternative. By disassociating the

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[13] Stim, E.M., Paper delivered at 17th Annual Meeting, Association of Planned Parenthood Physicians, Philadelphia, Pennsylvania, 1979.

device from coitus, allowing for storage in the vagina, providing a barrier that cannot be detected by the male and permitting paraprofessionals to distribute the device and instruct users, this may be a culturally appropriate, highly acceptable method, both for lactating women and young, unmarried girls. Senegal would be a suitable setting for a trial of this method.

G. Abortion

Since abortion during the first trimester is permitted by Islamic law (under certain circumstances) and since the Ministry of Health and the Women's Welfare Ministry have both expressed grave concern over the incidence of death and injury associated with traditional abortion methods, it is possible that uterine aspiration procedures may find a place in urban health services in Senegal. Folk methods of abortion are widely available, and surgical abortion can easily be obtained in the Gambia by those who can afford it.

H. Sterilization

Although Islam outlaws sterilization except in extreme cases of maternal risk, the Women's Welfare Ministry personnel are beginning to discuss the possibility of making laparoscopic sterilization available in the major health centers. A possible need is anticipated for equipment and training programs beyond those recently given by the JHPIEGO program to Le Dantec Hospital in Dakar.

II-5 Local Manufacturing and Packaging Capabilities

SIPOA, Société Industrielle Pharmaceutique de l'Ouest Africain, is Senegal's only pharmaceutical company. We visited the factory and spoke with its President and Director General, Jean-Pierre Rousselet, to investigate whether SIPOA has the capacity a) to package condoms, pills, vaginal tablets, etc. donated by USAID, and b) should there ever be sufficient demand, to fabricate oral contraceptives from raw materials supplied by AID or another donor agency. The company gets aluminum foil locally and its boxes are made for it (to specifications) by Société Africaine d'Impression Industrielle, an affiliate of one of the local tobacco companies. The company will imprint any logo, design, etc. that is requested. SIPOA's instructional package inserts are made for it by a Dakar paper manufacturing company, also to its specifications. It has the capability to package pills and other items in foils and plastic laminates and to package in cartons for professional and retail use. Carton filling procedures are labor intensive to maximize employment. The unit price of a box holding six condoms is about 4 CFA (2¢) and each package insert costs about 1.45 CFA. Were USAID to experiment with any kind of market distribution program, these costs could possibly be recouped in the sale price.

SIPOA also has an established distribution network: it has three large wholesale distribution centers in various regions of Senegal; it distributes directly to some pharmacies; and, for the government market, it distributes to PHARMAPPRO, the government organization that supplies the village pharmacies. Hence its pipeline extends across the entire country.

If family planning programs in West Africa increased enough to ever warrant local production, this small, clean plant has a product capacity of

one million pills per day. Currently it is producing at only 62 percent of capacity and could perhaps one day produce oral contraceptives for export to nearby countries such as Mali and the Gambia. SIPOA currently produces about 10-12 products which are sold through Senegal's pharmacies, plus 135 additional products produced solely for government hospitals and clinics. Among these products is progesterone, indicating that SIPOA is already handling steroids.

III. Recommendations

III-1 Proposed Activities to Further Program Acceptance and Expansion

As USAID contemplates new program directions, and also takes steps to assure that the current project is as effective as possible, we recommend the following activities:

A. Instructional Materials

It is apparent to us—and to almost all government, health, donor agency and research personnel with whom we spoke—that support materials explaining proper use of any product used in family-planning delivery programs is essential. These materials must be appropriate to the Senegalese situation, and should be developed and pre-tested locally. Since 90 percent of the Senegalese are illiterate, these instructional materials must be mainly pictorial, augmented (where feasible) by simple messages written in Wolof.[14] We also learned that certain products—especially pills and, to a lesser extent, condoms—are not being used properly. Providing people with materials they can comprehend should enhance both continuation rates and use-effectiveness. PIACT is prepared to provide the technical assistance necessary to train Senegalese in preparing materials: booklets to use in clinics, hospitals, at women's clubs, etc.; or package inserts to accompany a product when it is sold or distributed. Products for which appropriate materials are needed NOW include oral contraceptives, condoms, and IUDs (to explain side effects and how to manage them). If AID is to supply diaphragms, foam, and Neosampoon, additional materials will be needed. It is absolutely essential that the women fully understand what they must do; otherwise, the device or product

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[14] While Wolof is a nonliterate language, we found that people are today writing Wolof by using roman script.

will not work, and service providers (and, by implication, the family-planning program itself) will lose their credibility.

Some attractive posters should also be designed—primarily for motivation and reinforcement. The same methodology used to develop instructional materials should also be used to determine the most appropriate messages and the graphics to portray those messages. We have identified two Senegalese advertising agencies (Africa Publicité and Art et Decoration) that employ graphic artists. Their skills would be useful once conversations with acceptors, potential acceptors, and health professionals have helped us determine the necessary messages.

B. Applied Research

In conjunction with host counterparts, there are a number of applied-research studies that should be conducted to gather information pertinent to Senegalese perceptions, attitudes and preferences. The results of these studies (most of which can be completed in 6 to 12 months) will provide GOS decision-makers with information that can be used to enhance the acceptability of products offered in the child-spacing programs they support.

1. Motivational Research Study

In designing appropriate support materials to be used in conjunction with any pill distribution scheme, as well as in planning an effective information and motivation program, there are definite advantages to undertaking a motivational research study. It is a quick way to gather a wide range of information on attitudes, perceptions and preferences among Senegalese women regarding oral contraceptives. Qualitative research techniques, using informal and nonthreatening group discussions, can provide an in-depth analysis and insightful perceptions of OC use. A sociologist at IFAN (Institut Fondamental d'Afrique Noire), Ms. Fatou

Sow, indicated an interest in participating in such a study. After conducting approximately 10 group sessions with 7-9 persons per group, in different areas (socioeconomic and ethnic) of Senegal, she would be responsible for analyzing and interpreting the results and preparing a report. The entire study can be completed in 3 to 4 months.

2. Condom Preference Study

At the present time, both men and women in Senegal associate condom use with extramarital sex. Since that is not an uncommon occurrence, and since a large percentage of sexually active women are either unmarried, divorced or widowed, the potential target population for whom condoms would be an appropriate contraceptive method (given proper promotion) is greater than we had anticipated. We recommend a condom preference study, so that the GOS or a donor organization can procure a product that has the greatest likelihood of being well accepted. A social science researcher at IFAN, Mr. Mamadou Niang, would be willing to develop this study and oversee the interviewers that work on it. Different brands, in a variety of packages, could be distributed (free) to factory employees willing to participate in the study. (We have identified four large factories as potential study sites: Bata, Sotiba Simpafric, Senelec and Sonees. These businesses each employ more than 300 workers, so it should be easy to recruit a sizable study sample.) After a designated period of time each participant would be interviewed to gather information on:

a) how the product was used;
b) attitudes toward condom use;
c) order in which the brands were used—and why;
d) preferred characteristics of the product itself (e.g. shape, type of lubrication, size, color, reservoir, tip, etc.)
e) package preference, both inner and outer;

f) messages needed for package insert;
g) price preferences (Is paying a small fee preferable to receiving the condom free? Does that give it more value? If so, what optimum price would give it "worth" and still not discourage purchases?)
h) preferred distribution channels;
i) preference for an imported or local product and reasons for this preference. (Even in the local markets, many of the products sold are imported. Does that make them more desirable? Is it possible—or appropriate—to try to develop a chauvinistic pride in local products?)

Such a study could be completed in 4-6 months. If any kind of commercial program is contemplated, the next step would be to prepare prototypes of a variety of package designs to pre-test in several different regions. If not, USAID (or any provider or purchaser of condoms for the national program) will at least know those condom characteristics most likely to appeal to the Senegalese, and can buy accordingly.

3. Oral Contraceptive Dosage Study

Oral contraceptives are thought to be the mainstay of a country's family planning program. In Senegal, however, there are at present no studies or data compiled upon which to base selection of the optimal formulation for Senegalese women. A low-dose vs. regular-dose oral contraceptive acceptability study should be undertaken. The PMI clinic in Medina would be a good site for such a study, and the two midwives there, Mame Bayo and Adelaide Diop, are enthusiastic about comparing the effects of different doses of estrogen in a Senegalese setting. Dr. Malek Niang, Chief of the Kasnack Medical Circle in Kaolack, Sine Saloum, would also be interested in conducting such a study, provided he is supplied with the low-dose pills. This would not be a sophisticated, high-cost clinical study. Women attending the clinic and requesting OCs would be randomly assigned to one of the two formulations; then a

field trial would be conducted to find out what happens in an actual program situation. Women will be followed up after 3, 6, 9 and perhaps 12 months and their reasons for discontinuing, mention of side effects that may occur, and continuation rates will be assessed. Results of such a study (or perhaps two separate studies, if one also wanted to look for regional differences) would provide useful data for decision makers to use when selecting a well-tolerated product to use in the government's family-planning program.

4. Oral Contraceptive--Vitamin Study

Since many of the health professionals remarked on the high incidence of anemia and malnutrition in Senegal, another appropriate study might compare the general health of women randomly assigned to a standard, 50 mcg OC vs. those taking OCs fortified with the daily requirements of vitamins and iron. While we realize it may be difficult to convince a pharmaceutical company to make special pills for this test situation, a pill packet could be designed that would release two pills (one OC, one vitamin) each time the plastic dispenser was pressed. By following both these women and the control group for a year, and checking hemoglobin and hemalocrit (mean corpuscular hemoglobin concentration), red cell count (mean corpuscular hemoglobin), serum iron, total iron binding capacity and (if the resources of the university can be utilized) serum ferretin, one could collect enough comparative data to indicate whether or not such a daily regimen positively affected a woman's general health and, if so, whether it would be appropriate to promote oral contraceptives as a general disease prophylaxis. All of the suggested tests, with the exception of serum ferretin, can be done

with a simple spectrophotometer, a microscope and a small centrifuge. Serum ferretin is included in the suggested parameters because, at the present time, it is considered to be the best indicator of early anemia.

Once the government formalizes its position on family planning, and once medical facilities like Le Dantec Maternity Hospital are informing patients about child spacing and offering contraceptive products, Dr. Paul Correa (or one of his young associates, such as Dr. Aly N'Gom) could serve as PI on such a study.

5. OC Dosage Schedule Preference Study

To find out what kind of an OC dosage schedule is most convenient (and hence most acceptable) to Senegalese women, one could do a cross-over study of three dosage schedules (a 21-day schedule, a 28-day continuous schedule with seven iron tablets, a 63-day schedule—or Ramadan pill) of the same pill formulation. The women would be followed up quarterly to learn their preferences and reactions. Such a study could also be conducted at the PMI in Medina, but since doing two studies simultaneously might not be feasible, priorities will have to be set by the Senegalese. Once the USAID/GOS program gets underway and services are being provided on a regular basis at several PMIs, it should be easier to identify additional suitable sites for such studies.

6. IUD Acceptability Studies

We had mixed reports on IUD acceptability in Senegal. Midwives at private clinics reported excellent continuation rates, while those at the government clinic have found increased infection among IUD users. We were also told that, for many Senegalese women with large, stretched uteri, even the Lippes loop D is too small when inserted postpartum.

Since IUDs have, in theory, many of the characteristics of the ideal contraceptive (safe and effective, minimal side effects on health, independent of coitus, requires no attention on the part of the couple, provides long-lasting protection, etc.) it would be well to collect data, in the Senegalese setting, on event rates, comparing the USAID-provided Lippes loop to a copper device similar to those available in the urban pharmacies. We would suggest a comparative study of the Lippes loop D (the most popular size in Dakar, by all accounts) to the TCu 220C (or the Multiload Cu 250, which is being used at one doctor's private clinic). Studies in European countries show good results with the TCu 220C on nulliparous women; if similar results were found in Senegal, it might become a method of choice for young unmarrieds. An ideal site for an IUD acceptability study would be La Croix Bleue Clinic in the Castor section of Dakar. Its director, midwife Phoebe Whest-Allègre, is receptive to the idea of collecting data that might be appropriate for promoting IUD use in Senegal.

With the cooperation of IFRP, if they are interested, Dr. Serigne Ba, Chief of Medicine at Abass N'Dao Maternity Hospital, and Ms. Ndiaye Mame Coumba, a Santa-Cruz-trained midwife at the Thiès Maternity Hospital, would be interested in studying the acceptability and effectiveness of the postpartum IUDs that PIACT de Mexico has fabricated to IFRP's specifications. Both of them remarked that although many postpartum patients (who seem motivated at the time to accept a contraceptive method) say they will return in 6-8 weeks for an IUD insertion, most never do.

C. Longer Term Research Project

As developing countries begin to promote large-scale family-planning programs, the need to collect data on the effects of modern contraceptive products on their own populations becomes very important. Although no final results will be available for several years, we believe a team of Senegalese health scientists should begin a research project to compare the relative risks and impact on maternal and child health of various contraceptive products used or proposed for use in Senegal (and we would hope Depo-Provera could be included as one of the products studied) to the risks of uncontrolled reproduction. This would provide a much-needed perspective on the risks and the benefits of contraceptives used in Senegal (and might well have implications for other West African countries as well). It would also provide data--currently lacking--on which important country-specific health decisions can be made.

Although there is no epidemiologist in Senegal, a Professor of Internal Medicine at Dakar University, Dr. Sow, could possibly be the PI on such a study. Technical assistance from CDC would definitely be helpful. USAID's Regional Health and Population Officer, a trained public health physician, is also willing to assist in the development of this study.

III-2 Additional Suggestions

Although we have already reported on the specific items requested by USAID, some of the information we gathered while assessing the situation in Senegal prompts us to make some additional recommendations which we believe could improve both existing and future family planning program activities:

A. Assessment of Reproductive Risk

1. Senegalese medical practitioners at government hospitals should consider developing and instituting a comprehensive high risk identification system for non-pregnant women, complete with proper record keeping and follow-up care. By developing a high risk chart and using a simple scoring system to assess reproductive risk and establish priorities for contraceptive care, hospital and clinic staff could identify those postpartum women most likely to contribute to subsequent maternal and infant morbidity. Non-medical personnel could be trained to interview all women following their deliveries and to identify those women in the high-risk group.[15] Once identified, such women would receive individual counseling and be encouraged to adopt a reliable contraceptive method.

B. Community-based Distribution and Outreach Activities

1. Schemes for community-based distribution could be developed in conjunction with La Condition Feminine (C.F.). Since any CBD program would be a significant departure from the traditional medical network and since (heretofore) Senegalese officials have been saying family planning should only be offered in conjunction with MCH services, we would recommend starting with a

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[15] For an example of one suitable chart and scoring system, see Perkin, G.W., "Assessment of Reproductive Risk in Nonpregnant Women," American Journal of Obstetrics and Gynecology, Vol. 101, No. 5, July 1, 1968, pp. 709-717.

small pilot project. Using existing women's organizations should be a "natural," as Senegal has all types of women's groups—ethnic, religious, school or compound, tontines (women's credit associations)—at various economic and social levels. Women's clubs appear to be a cultural tradition in Senegal, and La Condition Feminine has already established contact with close to 300 of them. By training one delegate from each club or organization, C.F. could reach all strata of women with information as to how to space one's family, where to go for services, etc. We suggest that these women, once properly trained, could also serve as distributors of certain contraceptive products. They could provide information on proper use and management of side effects, should any occur. Such a distribution system should be quite easy to organize, since the infrastructure already exists.

2. La Condition Feminine also trains all the "monitrices," female extention workers, in Senegal. These women, trained to be "responsive to villagers' needs", play an important role in the lives of village women. The monitrices receive training in agriculture, home economics and health care. Their training could easily be expanded to include information about family planning that they could then pass along to village women, along with appropriate supplies.

3. A prototype infrastructure for outreach already exists through another government secretariat (Promotion Humaine), which sends extension agents around the villages to promote new ideas in sanitation, in women's and youth's skills, and in other activities that may improve the local economy. Some extension agents are women, and all are highly motivated, although hampered by lack of equipment, vehicles, and fuel. Training and augmentation of this cadre to provide family planning information and supplies should be

included in an extended program. Injectables, Neosampoon and nonspermicidal, fit-free diaphragms could be investigated with regard to their feasibility for incorporation into this system.

C. Contraceptive Social Marketing

1. Some midwives, government officials and social scientists favor selling non-prescription modern contraceptive products in the traditional market setting. Almost every Senegalese adult performs some kind of market-related activity, either as a vendor or as a consumer; markets are frequented by all social classes and ethnic groups. Potential outlets for non-medicated contraceptive products would be the main community markets, "nar" shops in the cities, and regional government stores (Sonadis).

Several kinds of traditional contraceptives and abortifacients are already available in the local markets (see p. 5). The idea of contraception is definitely not new in Senegal; the challenge would be to substitute modern methods for the traditional herbs and beads. Government cooperation would be vital, as the Ministry of Health would have to agree not to designate spermicides and condoms as drugs.

Should AID/Washington be interested in actively pursuing the possibilities of establishing a private sector, commercial marketing (CRS) network in Senegal, we have located a company that could handle packaging, printing of inserts, and distribution. We have also identified advertising agencies that could assist with market research and testing designs, logos, etc.(see p. 3.). Large billboard advertising campaigns would not be appropriate at this juncture in Senegal, but discreet messages could probably be broadcast on the radio without precipitating an adverse reaction. Package inserts would have to be carefully designed and tested, since most of the consumers are illiterate, yet they must be able to "read" the package instructions.

D. Special Programs Underscoring Sensitivity to the Needs of the Senegalese People

Always lurking in the background of discussions of family planning, especially with government officials or intellectual groups, was the fear of ulterior motives in foreign-assistance programs aimed at reducing population growth, especially since the view is widely held, among educated Senegalese, that Senegal is underpopulated. Senegalese intellectuals are wary of the possibilities of new and insidious forms of exploitation from abroad, and proceed selectively, with measured caution and on their own terms, toward social change in the direction of the white world. It is easy to see, from the realities of Senegalese rural life outlined in previous sections, why fertility should be a prime virtue for women; and, conversely, why infertility should be a social catastrophe. This is also the reason why some government officials reject such western terms as "family planning" and "birth control" in favor of "child spacing", "spacing of births" or "family protection." These expressions of self-determination should be carefully respected; they emphasize the need for increased attention to the cultural relevance of products and services offered under international assistance programs.

Apart from the general need to develop and apply programs in a way sensitive to the needs and desires for improved national maternal and child health, two areas of activity—infertility and malnutrition—have been identified through which USAID may reassure concerned Senegalese of its willingness to respond to the stated needs of the country. A small program for diagnosis and treatment of infertility should focus on Le Dantec Hospital in Dakar, and might involve a review of documents, literature and cases dealing with causes of infertility in Senegal. A supply of microsurgical equipment,

and training for repair of occluded oviducts should be included. The impact of the latter on fertility may be minimal in view of the probable disease and obstetrical injury-related forms of infertility. Nevertheless, it has been requested by the senior gynecologist in Senegal and, with appropriate publicity, may assist in reassuring officials and the general public of USAID's sensitivity to the concerns of the Senegalese people.

E. Contraceptive Supplies and Logistics

1. To combat the tendency to hoard contraceptive supplies, service providers should be trained in simple logistics and proper reordering procedures and helped to understand that they can prevent shortages. Also, these clinic and hospital personnel should be given a handy laminated chart (or something similar that is also durable) listing all other nearby locations where family planning services are available. If a midwife at one clinic has not been trained to insert IUDs, she should be aware of her nearest colleague who can provide that service. If there is a government doctor in the vicinity performing laparoscopies or mini-laps, it should be listed on the chart. Such a list could also be useful if one clinic happened to have a "run" on a certain product and needed to borrow supplies temporarily.

2. Another option for encouraging optimum distribution of products is to allow (if the government permits) family planning personnel to collect a token fee (e.g. 25 CFAs or 12¢) from each acceptor. These monies could be pooled and used to purchase something for the clinic, or divided among the providers to do with as they please. Either way, it would provide a small incentive for reaching as many women and men as possible.

3. As USAID (or anyone else for that matter) distributes any medicated products, such as oral contraceptives, we feel that the midwives, nurses,

etc. who will be in contact with the clients must be taught basic facts about these products and the various effects they can have on the women. All women should be counseled in proper use and told, in advance, about the side effects they may experience. (This should reduce the acceptor's anxiety level if she experiences any temporary discomforts, spotting, etc.) We also support the development of a short list of questions—appropriate to the Senegalese health picture—that could be asked of any potential O.C. acceptor. Should a woman respond affirmatively to a question, then the service provider knows that pills are not appropriate and she suggests another contraceptive method. Although we appreciate the argument that contraindications to O.C. use are also contraindications to pregnancy, until some risk-benefit analyses in a Senegalese setting (see p. 42) have been attempted, we feel some precaution is necessary to undermine any backlash that could develop against the donor, mainly western, community.

4. Neosampoon might be an appropriate product to add to those commodities being supplied through USAID. As a spermicide with no serious side effects, it would be a good choice to offer through any non-clinical distribution system that the GOS might decide to sanction. It is culturally appropriate, as we learned that Senegalese women are accustomed to digitally cleaning their vaginas daily. Hence there would be no taboo (as in, for example, Indonesia) against inserting a tablet well into the vagina.

F. Communication and Education Activities

1. Spreading family planning information by word-of-mouth is a very slow procedure. Culturally appropriate radio messages might be considered. They could simply talk about the health benefits to be derived from spacing one's children and then give the name, address, and working hours of those clinics providing counseling and services.

2. Relevant posters—primarily pictorial in this country where 90% of the people are illiterate—displayed in places where people naturally congregate (the village community center, "Nar" shops—small provision stores—, mother-child clinics, bus stops) might help to promote the concept of planned families.

3. When visiting maternity, VD, and baby clinics, we noticed a preponderance of waiting rooms crowded with unoccupied women. For a small investment, this time could be used to provide motivation/information and education. We recall that AID/W purchased OMNI viewers. Why not send some to Senegal and place a few in each waiting room? With an African film strip (just pictures) plus one good tape recorder providing an accompanying "story" in Wolof, these women might find their waiting time more pleasant and be provided with a message or two to carry home to others in their compound. Another alternative is to use field workers (these need not be well-educated women, just properly trained ones) to promote discussions on child welfare/maternal health, etc. while the women are awaiting their turn to see the midwife. Also, in every clinic we saw posters proclaiming the advantages of Nestle's formula. Why not something similar on child spacing—or even method-specific posters—to attract the mother's eye and prompt her to ask for more information?

4. As part of the AID-sponsored rural health project, project staff have developed an "Aide-Mémoire" training manual for "matrones" (village midwives—usually women with little, or no, formal education) written in French with frequent pictures and simple Wolof. It contains some pictorial reminders of IUDs, condoms, and diaphragms, but nothing on OCs. We suggest the manual be augmented to include some pictorial instructions on the proper

use and managing side effects of those contraceptive products that the "matrones" can recommend to other women in the village.

This program could also incorporate plans for periodic, short, refresher courses for health paraprofessionals, extension agents, and other outreach workers to maintain a high level of knowledge and awareness of contraceptive techniques, and also to promote interaction among health-care people in a given geographical area. This can lead to a better system of distribution of products and a referral system for family planning services. Updated re-supply instructions and referral lists can be developed and distributed through these meetings. Additionally, problems can be reviewed, basic statistics collected, and procedural adjustments made.

G. Quality Control

1. In one instance we heard complaints on the quality of condoms, the nature of which suggested heat deterioration. We also saw many questionable storage conditions for condoms, particularly where clear plastic packages were exposed to the light. Much concern was also expressed over the shelf life of oral contraceptives. We recommend that condoms be supplied in foil packets and that Senegal be considered as a site for any planned USAID field product quality monitoring system.

H. New Clinic Location

1. A family planning clinic on the grounds of the Institute of Social Hygiene in Dakar would be appropriate due to the diverse array of services already offered and the large patient load that appears to pass through this facility daily. At the present time, on the second floor of the Institute there is some empty space that, with renovation, would make a good family planning clinic. (For more details, see report on our meeting with Aichatou Diop, Appendix B, page B29.)

APPENDIX A

Family Planning and Population Activities of the Donor Community

Apart from the USAID sponsored Family Planning Project in Senegal and the University of Santa Cruz Midwife Training Program, a number of other assistance agencies and donor countries are showing interest, directly or indirectly, in population and family planning activities in Senegal:

UNFPA

UNFPA is currently sponsoring a Law & Population project to study in detail the attitudes and religious teachings on population matters and family planning. This study is being done under the direction of Mr. Mamadou Niang of IFAN (Institut Fondamental d'Afrique Noire), the main social science research group at the University of Dakar. The data has already been analyzed and Mr. Niang is now writing the final report. The results of this study will be presented at a larger meeting of Senegalese leaders. It is expected that this study may provide the needed "ammunition" to allow the National Population Commission (NPC) to try to change the current very restrictive legislation that officially forbids the sale of contraceptive products.

A UNFPA project specialist, Rick Knoop, has $15,000 to create a bibliographic inventory and clearinghouse for all books and documents on demographic studies, population-development issues, socio-economic determinants of fertility, etc. relating to Senegal. This population and development clearinghouse will be located within the Planning Ministry and should be operational some time next year. UNFPA also supports a manpower and immigration study being conducted by ILO, and some demographic projects within the Census Bureau (including the World Fertility Survey).

UNFPA plans to develop a large multi-lateral assistance program with the Government of Senegal. While we were in Dakar we met two UNFPA consultants—Dr. A. Kone-Diabi of Mali and Dr. Jean Lecomte of Belgium—who were planning revisions of an earlier UNFPA proposal. This time they will probably develop their project with La Candition Feminine rather than with the Ministry of Health. Dr. Lecomte believes that UNFPA should mesh its efforts with other family planning projects, such as the USAID project, and establish a closer working relationship with other agencies interested in health and population. He told us that he recommended that UNFPA send a team of four consultants to Dakar in February for 3-4 weeks to prepare a broad integrated family planning project proposal.

IDRC

International Development Research Center (IDRC) was established 9 years ago by the Canadian government as a public corporation. Its health sciences division in West Africa used to be a health and population division, but at present almost all of its population activities have been transferred to the social science section as they deal mainly with demography, computer information sciences, and population policy. It is interested in providing training for demographers.

IDRC was the original sponsor of the West African publication "Famille et Developpement", which it supported for four years. IDRC's goal was to transfer the magazine to African management. Recently a new private non-profit organization was formed to manage and operate this publication. It is called ASAFED, the African Association for Education and Development. UNFPA is contributing $125,000 a year to ASAFED for the promotion of family planning and other health issues in "Famille et Developpement."

Additional assistance is being provided by Ford Foundation, the governments of Senegal, Sweden and Switzerland, and a private Catholic organization headquartered in Switzerland. ASAFED is interested in publishing an English language version of the journal which presently circulates to 50,000 subscribers. An English version would widen the African audience but would require sponsorship. They asked if USAID might be interested in publishing this journal in English.

UNESCO

There is a regional UNESCO office for Population Communication in Dakar, but at present it has no projects in Senegal. UNESCO also has a Population Dynamics and Education Planning office in Dakar which has responsibility for population education programs (both in and out of school) for all sub-Saharan Africa. In Senegal it is establishing, in conjunction with UNFPA, a clearinghouse for population and education materials. It also expects to establish one important population education project in Senegal. The 1.2 million dollar first phase of this project would: a) analyze the current demographic situation; b) introduce population education into the secondary school curriculum; and c) include population education in adult literacy classes. This proposed project was approved by the Ministry of Education, then turned down by the Planning Ministry, and is now back at the Ministry of Education where it is being revised.

World Bank

In October 1979 two representations from World Bank/Washington plus one consultant explored the situation in Senegal in order to identify project possibilities in health and population. When we visited the regional office, the deputy representative said they had not yet received this team's report. He said he thought the Bank would be working with both the

Health Ministry and La Condition Feminine, but that no project would begin for at least a year.

WHO

The full scope of WHO activities in Senegal was not ascertained. However, Dr. Correa, head of Ob/Gyn at Le Dantec Hospital in Dakar, indicated that he was working with WHO on a study of the prevalence and causes of infertility in West Africa. Dr. Correa told us that a paper would be published in French and English during 1980.

Others

The Swedish Government is supporting development of the Association of African Women for Research and Development (AFARD). The president of this group is Marie Angélique Savané, formerly associated with the IDRC sponsored journal "Famille et Developpement." AFARD is interested in undertaking research pertinent to the african woman's condition. While research directed to fertility values and attitudes ranks as a high priority, up until now it has been too political a topic for them to focus upon.

Meetings in Senegal

Government Officials

1. Mr. Mamadou Lo, Conseiller Technique, Ministry of Health

This brief meeting involved only a presentation of PIACT credentials. In introducing and adapting contraceptive products, he said, we are breaking new ground and, therefore, will have to work very closely with USAID. Mr. Lo did indicate that he thought locating institutions to carry out the research related to PIACT objectives might be difficult. There was no time to emphasize the brief and simple nature of the research in question since Mr. Lo had to leave for Tunisia. These finer points will be saved for later discussions with Ms. Siga Sene, MOH official who will coordinate the AID sponsored Family Planning Project.

2. Ms. Rama Gueye, Chef de Cabinet, MOH

Ms. Rama Gueye, assistant to the Minister of Health, is a former Santa Cruz trained midwife who is now helping to train the midwives Santa Cruz is training in Dakar. She discussed government policy as it related to family planning.

Major points were:

- Contraception is just beginning to be accepted in Senegal.
- The main obstacle is the Islamic leaders who must be sensitized and convinced.
- Family planning was introduced with bad propaganda which was interpreted to mean "family limitation". We now must speak of "family spacing".
- Medical professionals have been against broad family planning programs because they feel that family planning is a medical matter and should be provided only by doctors. Many doctors are awaiting an official document before becoming proactive in family planning. In any case, they are overworked and do not have time to volunteer information about family spacing to patients.
- There are strong arguments-that are hard to counteract - that Senegal, with less than 6 million people occupying 76,124 square miles of land, should not be concerned with population control.
- The government has now decided to come out in favour of family planning, although no documents have been provided yet. The MOH is now at the stage of informing and motivating people (staff note: we have found no evidence of any such activities) and is just beginning to provide services.

- They wish to integrate family spacing services into maternity and other health services. The Medina PMI is a pilot center. Rama Gueye does not believe that market distribution of contraceptives is appropriate at this time. This is specially true of pills because information on contraindications and side effects is not widespread enough. If sold without a prescription, pills will be used ineffectively and even dangerously.

- We must have patience and proceed slowly in Senegal. It is a less developed country with fewer trained people. We cannot push these things.

- Rama Gueye says that before thinking of adapting products and making packages more acceptable, you have to convince people that family spacing is a good idea.

3. Mrs. Siga Sene, Conseiller Technique, Ministry of Health

In this meeting with Mrs. Sene (a trained midwife), we learned of a letter from the Prime Minister to the MOH spelling out the role of "La Condition Feminine" as distinct from the MOH. The MOH, it implied, was to be responsible for implementation of all technical matters with medical implications. Dr. Vincent had not seen the letter and we did not learn from Mrs. Sene if it specifically mentioned family planning matters. Mrs. Sene told us that the MOH was to meet tomorrow (Tues. 13 Nov.) with the Minister of Planning, perhaps on matters relating to the population and family spacing.

In response to a question on when the MOH would proceed further with the USAID project, Mrs. Sene indicated that while formal action was confined to the Medina clinic, informal action was taking place at other sites. Both the MOH and "La Condition Feminine" recognized the need for urgent action. Formalization will begin soon and family spacing activities should be well underway 2 years from now when the Sixth 4-year plan is implemented. The Minister of Condition Feminine, an ex-judge, will facilitate translation of family spacing policies into law.

Although fertility is often the only way a woman can affirm her right to be a spouse, child spacing is a well accepted concept among married women. However some men raise objections because they don't want women to control their own fertility. Another important problem is young people and the need to prevent illigitimate births. She pointed to the need for sex education in schools and that, since contraceptives are often found in dormitories and other places where students congregate, it would be better to organize and make them available in a controlled way and to work with the parent-teacher associations to overcome reluctance. Organized systems for disseminating information could be developed through the MOH office of Health Education and through "La Condition Feminine" said Mrs. Sene. Everything will fall into place when the MOH meets with La Condition Feminine. Finally, Mrs. Sene affirmed the need for materials aimed at informing and instructing illiterates in family spacing methods.

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On a return visit several days later we learned that there had been no meeting between MOH and CF so that from the MOH's point of view, nothing seemd resolved.

Ms. Sene went on to discuss the ambivalence of women's attitudes toward pregnancies and the size of their family. She also suggested that even traditional methods were changing from long post-partum abstinence to reliance on fetishes. Replying to a question on the tendency of health care personnel to hoard contraceptives rather than use them, she pointed out that this trait sprang from an economy of scarcity and would yield to education and experience. Mrs. Sene also states that the information and propaganda section of the 1920 anticontraception law had been revoked. (But - to the best of our knowledge - the law has not yet been changed.) Dr. Vincent pointed out the imperative of promulgating this change throughout the entire country so that the AID/MOH program could get underway. He pointed also to the necessity of a) appointing a person to direct each regional and center health program, b) writing detailed job descriptions for them and c) assembling a manual of logistical and administrative procedures.

4. Mr. Mamadou Talla, Director of the Cabinet, Mr. I. Diop, Information and Studies Officer, (Mr. Diop was the Senegalese representative at the recent conference on Family Planning and Islam held late October '79 in The Gambia,) and Ms. Maga Suba, Social Worker, La Condition Feminine.

Mr. Talla in his statements and in response to questions, carefully explained the new role of Condition Feminine (CF) as defined by a recent letter (an internal communication) from the Prime Minister. Selected excerpts of the letter will be made available to the public within 10 days.

CF responsibilities were defined as follows:

1. CF would be responsible for planning and thinking through the concepts of policy in the field of '<u>family protection</u>'.

2. To do these things CF will assume the role of <u>contact</u> between GOS and co-operative agencies and friendly nations wishing to assist in this action.

3. CF must actively seek resources (money or technical assistance).

4. CF is in charge of sensitizing and informing both the population at large and the civil servants.

5. CF will follow up and evaluate all projects that are implemented in <u>family protection</u> even if they originate in other ministries.

6. Other ministries must communicate all proposals and program needs for CF evaluation and recommendations. CF will compile an action plan based on these proposals and set priorities for action.

7. Chances of fulfillment of family protection projects will be maximised by integrating them into the general program of the government and ensuring their financial and material support.

8. All existing structures of the GOS will be used for these programs, not just the MOH.

9. Maternal/Child Health (MCH) Centers will be utilized for these programs as will women's groups and clubs (civil or government) who are willing to develop activities in this field. Already 237 urban and rural women's groups have been contacted and this will reach 300 in 1 year. None of these has been influenced by this sensitization program to date.

10. In contrast to the situation prior to the Prime Minister's letter, the government through CF is now committed to launching action to reach ALL groups of women who could benefit from family protection methods.

11. CF is committed to reaching rural women's groups who are not within reach of a MCH center.

12. The Population Commission, created before CF came into being, has now become, to a large degree, obsolete.

13. This new structure has confirmed a FUNDAMENTAL change in the attitude of the GOS with regard to family planning.

14. The nature of this change is the decision not merely to reach a few of the people but rather the TOTALITY of people in Senegal.

15. In persuit of this new policy, all of the existing structures, government and non-government, will be utilized and all relevant policy-making is entrusted to CF.

16. A structure has already been set up in CF to take charge of these family protection programs. They will be responsible for, among other things, the choice of contraceptive methods offered by the program.

17. These changes are to be implemented and all personnel put in place immediately. CF will start to co-ordinate action by interacting with all organizations that want to play a role in these activities.

18. Existing programs, such as the USAID projects, will not be abandoned.

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It was our opinion that the Director of the Cabinet was announcing a formalization of the shift in government policy in favor of family planning that has been taking place informally over the past few years. We believe that all of the plans, proposals, and individual and group aspirations with respect to the family planning in Senegal, that have been held in abeyance

awaiting official pronouncements of government policy, will shortly be released from their restraints. The time is therefore ripe for rapid and major extension of existing proposals in the field of family spacing including outreach programs, communication and education, and marketing of non-prescription contraceptives.

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Other discussion centered around the role that PIACT might play in this scheme of things. Mr. Talla agreed that people should be able to buy non-prescription contraceptives "where they buy their matches" and was aware that professional medical attitudes can often get in the way of distribution of contraceptive information and products. He indicated that CF will "solve this problem quickly". He said that since MCH centers are for mothers they don't meet the needs of single or childless women or teenage girls and so, other ways have to be found to reach these groups - "every existing structure where women can use services will be utilised". (Here he emphasized again how CF attitude and policy would be radically different from the current MOH attitude).

Since Mr. Talla is a specialist in communication he was particularly interested in PIACT graphic communication materials for illiterate contraceptive users. He specifically requested information (if possible, in French) on the Mexico, Bangladesh, and other Asian experiences. He also wanted information on other methods of contraception suggested by PIACT - Neosampoon and injectables, in particular.

He explained that 8 regional centers were to be set up to facilitate communication of family protection information to the poor people. He hoped for assistance and support for these centers from willing assistance organizations: special rooms were to be built in the centers to house technical experts working in - and collaborating with - the program.

Finally he emphasized the need for expeditious and practical advice rather than bureaucratic obfuscation.

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At a meeting one week later with Mr. Talla and Oumy Fall, technical advisor to CF, Mr. Talla indicated that the Minister of Planning would be sending a letter to AID giving new instructions for proceeding with the projects. Ms. Fall, who had just returned from Dr. Bogue's course on communications at the University of Chicago, expressed an interest in using the mass media for family planning information and sensitization. She also spoke of the necessity of approaching the religious leaders and eliciting their help and cooperation in this effort.

5. Mr. Sougoufara, Conseiller Technique to Mr. Jacques Diouf, Minister of Scientific and Technical Research.

The task of this Ministry is to coordinate and implement scientific research in agronomy, forestry, energy, health and social sciences. Two institutes are totally funded by this ministry - the research centers for agronomy and "elementary technology". Other institutions such as IFAN depend on other ministries for funding but are approved and coordinated by the Ministry of Scientific and Technical Research (MSTR). They are presently preparing the 6th 4-year plan for the period starting 1981. No program in family spacing or contraceptive research has been devised yet. All proposals appear to originate from other ministries through meetings with individual ministry staff. Research proposals are then prioritized through joint meetings of all the ministries. University and other research institute scientists are then contacted to develop detailed technical proposals and carry out the research. The MSTR has not yet met with La Condition Feminine but will do so shortly. Presently, defined priorities in health are:

1) Infectious diseases (Parasitic, Bacterial and Viral with the emphasis on prevention; 2) Traditional pharmacopea 3) Traditional psychiatry.

These have to be further discussed and refined before the plan is complete. They may, presumably, be changed when input from other ministries is taken into account.

The MSTR is able to utilise outside research funds to meet its priorities. All projects carried out in public facilities must be approved by the National Committee on Research. The permanent secretary of this committee is housed in the MSTR building. Program proposals should be sent to Mr. Diouf who will call a meeting of the Committee to review and make recommendations. The MSTR has final decision making power.

Battelle PDP programs and PIACT programs were discussed and Mr. Sougoufara indicated that he would alert the Minister and also make contact with La Condition Feminine Ministry to see if these programs would fit in with their needs.

6. Mr. Abdul Karim Diop, Conseiller Technique, Ministry of Planning & Cooperation

Mr. Diop, one of Senegal's few demographers and ex-head of the Census Bureau, is now the technical advisor to Louis Alexandrene, the Minister of Planning and Cooperation. He has also been designated by the Minister to be in charge of the National Population Commission. From a letter Alexandrenne wrote to him outlining his role, it sounds as though he will be responsible for liaison and coordination between the NPC and the Ministry.

The Minister says the NPC will meet in January, 1980. However, there is still no list of names indicating who will serve on the NPC; hence Mr. Diop would not even guess as to when it will actually meet.

According to Rick Knoop (UNFPA project specialist working closely with A.K. Diop), the Minister wants his newly created Population Unit to advise the NPC as to what kind of a population policy they should take. The Minister gave only very general clues as to his position: the rate of population growth, 2.8% per year, is too high and must be reduced, therefore we need child spacing . He also favors mobilizing all forces—political as well as spiritual—to create an awareness of the population situation.

USAID

1. Dr. Marc Vincent Regional Health and Population Officer, USAID

Marc Vincent met us at our hotel on our first day and took us to the Building Administratif where most of the government ministries are located. We tried to call on Ministry of Health and Ministry of Women's Welfare Officials; none was available, so we made appointments for later this week and next. Vincent went through our list of people to see while in Senegal. Unfortunately, many of them have been transferred or gone abroad. So we are developing a new list. Vincent began briefing us on AID's Family Planning Project in Senegal. Dr. Ismaila Kane who was the MOH official assigned to coordinate this project has been transferred and is now regional chief of medicine for Sine Saloum. Madame Siga Sene, a midwife with good political connections, is now in charge of external cooperation for the MOH and will also coordinate AID's Family Planning Project.

Vincent feels that the situation in Senegal today is more favorably disposed toward family planning than it was when the AID project was designed. One important reason is the creation, last year, of a separate women's welfare ministry, La Condition Feminine, that could be an ideal vehicle for the distribution of contraceptive products at meetings and places where women gather and might also advocate a more forceful educational campaign.

Vincent had met with the Minister of Health last week. They agreed that the Health Ministry would continue to have overall responsibility for the AID-supported family planning program, but that there would be more interaction - and less competition - with La Condition Feminine than there had been heretofore.

The UNFPA is in the throes of developing a project in Senegal, and Vincent feels that several PIACT - like activities (marketing strategies, product specific educational instructional materials) might be incorporated into their proposal. Unfortunately, the UNFPA coordinator, Hans Gaenger, with whom we had corresponded previously, left this post the day we arrived. The new coordinator will not be here until March, 1980, so we will meet with the deputy, Wilma Goppel.

We are probably here at a good time, in terms of making a possible impact and/or suggesting some appropriate additions to the project, since Vincent explained to us that the first PIO/C was signed by the Senegalese government only last week. While the Pro Ag had been signed back in May, the Senegalese had been reluctant to obligate expenditure of the money until the Ministry of Health and La Condition Feminine worked out their relative positions. Now project activities should begin in earnest.

Vincent would like to see AID/W supply Senegal with Neosampoon on condition that the GOS would agree to rule that it would not be considered a medicine; that way it could be sold in stores other than pharmacies. (Pharmacies, we learned elsewhere, are expensive, fairly elitist and not frequented by the masses). Based on our conversations with a broad spectrum of midwives from various sections of Senegal, it might be most appropriate for AID/W to encourage this arrangement.

2. David Shear, Mission Director, USAID

We explained a bit about PIACT and shared with him our AID purchase order outlining the report we are to prepare. He was very interested, and remarked that it was a "large order". He wanted to make sure that we had an AID counterpart with whom to work who was fully tuned to local sensitivities. He stressed the importance of doing our work carefully. He also asked that we brief him towards the end of our stay so that he can share our findings with the Futures Group. A representative from their RAPID program is due to visit Dakar in December. We explained we worked closely with Bob Smith and Malcom Donald, and would contact them when we returned to Washington.

We discussed the PDP program, and Shear mentioned a sociologist, Fatou Sow, at the University of Dakar who had done a good study on migration. She is also interested in the role of women in agriculture. We will contact her.

3. Meeting at AID called by Marc Vincent. In attendance were: Mary Diop, Asst. USAID Regional Health Officer, Wilma Goppel, UNFPA Assistant Coordinator, and Dr. Jean Lecomte and A. Kone Diabi, UNFPA Consultants. (Free and Zimmerman were observers).

Problems of communication, coordination and avoidance of redundancy in family planning assistance programs were reflected in a meeting between the AID Health Director and UNFPA consultants. The meeting concerned a recent UNFPA proposal which, according to Dr. Vincent, paralleled the AID efforts, but was submitted (to the GOS) without conference with AID. It was turned down by the Government or at least returned for revision. Dr. Vincent expressed concern at the lack of communication. He indicated that since the climate of official opinion had become more favorable to family planning since the AID proposal was written, UNFPA could take a more vigorous approach, utilizing more outreach activities with pills, condoms and other non-prescription items.

Other Donor Agencies

1. Ms. Wilma Goppel, UNFPA deputy coordinator, Aguiola Zinsou, staff associate and Rick Knoop, a UNFPA project specialist assigned to the Population Unit of the Ministry of Planning.

UNFPA is currently sponsoring a Law & Population project to study in detail the attitudes and religious teachings on population matters and family planning. This study is being done under the direction of Mr. Mamadou Niang of IFAN (Institut Fondamental d'Afrique Noire), the main social science research group at the University of Dakar. The data has already been collected and Mr. Niang is now writing the final report. Ms. Goppel explained that the results of this study will be presented at a larger meeting of Senegalese leaders. They expect that this study may provide the needed "ammunition" to allow the National Population Commission to try to change the current very restrictive legislation that officially forbids the sale of contraceptive products.

Interesting story: The National Population Commission was approved in 1978 and the Minister of Planning was designated as its president. It is a political body, created to set strategy, but to date it has not met. Moreover, the names of those people from various ministries who will serve on this Commission have not been released. In September 1979, a Population Unit was created within the Ministry of Planning to serve as the technical secretariat of the Commission. The unit is currently staffed by Knoop & two Senegalese. They are supposed to provide technical advice on strategy matters, but this is difficult to do without any political statements having been issued. On November 7, after being here for two months, Knoop was to have his first meeting with the Minister of Planning and hoped to find out when the Commission will meet and what additional things the Population Unit can be doing.

UNFPA also supports a manpower and immigration study being conducted by ILO, and some demographic projects within the Census Bureau (including the World Fertility Survey). They want to develop a large multi-lateral assistance program with the Government of Senegal. As reported in an earlier meeting, a UNFPA consultant, Dr. A. Kone-Diabi, had developed a proposal which emphasized improvement of the existing maternal and child health program and integrating family planning into this strengthened structure. Ms. Goppel said the Ministry of Health was pleased with this proposal but, due to political considerations which were not fully explained to us, they were told that they should develop their project with "La Condition Feminine", the year-old Women's Welfare Ministry. A Belgian consultant to UNFPA, Dr. Jean Lecomte and Dr. A. Kone-Diabi of Mali had just (today) started working with La Condition Feminine. We will try to meet with Dr. Lecomte later this week to learn more about how they have decided to proceed. Although "La Condition Feminine" appears to be interested in educational activities to promote child spacing, Ms. Goppel sounded more cautions to us than anticipated following an earlier conversation with Vincent. She said there was support for family health and child spacing (this terminology is supposedly preferred over "Family Planning" which smacks of a Western-imposed approach to population control) at the higher government levels, but that this support had not yet filtered down through the government systems. She seemed reluctant to express support for any project more innovative than family health integrated into MCH. We tried to point out the advantages of offering contraceptive products at places where men and women naturally congregate and/or work. She expressed personal skepticism about the value of improved packaging and promotion in the Senegalese setting since 1) the products were not sold but were given free of charge and 2) these activities did not address themselves to the individual's internal acceptance of contraception and may seduce them into accepting something they do not really want. We addressed these issues and, in response to her stated interest in injectables for the Senegal Program, we were able to supply her with some information.

All the UNFPA staff indicated having no problem with the USAID proposal as such but stated that the actions of USAID personnel did nothing to allay fears of the old AID "family planning only" approach which emphasizes family planning as a separate entity from women's health. In their opinion, the Budapest philosophy still prevails in Senegal and population problems are seen in the context of development.

2. Ms. Emily Lewis, nurse practitioner and trainer in charge of the Santa Cruz in-country midwives training program.

Ms. Lewis is in Senegal for three months organizing and coordinating Santa Cruz's first Senegalese in-country training program for seven midwives from various regions of Senegal. Prior to this, in 1976, 1978, and 1979, fifteen

Senegalese midwives (sage-femmes) and one social worker (assistante sociale) had been trained at Santa Cruz. Some of the U.S.-trained women are now serving as preceptors in this program. In addition, one ex-Santa Cruz trainee from Benin is on the faculty. Vincent had suggested we get in touch with Lewis as soon as possible since she could provide us access to this large and useful resource, women who work closely with both acceptors and non-acceptors and probably have a good understanding of their perceptions, needs, fears, attitudes, etc. We have arranged to meet with group later this week.

This Santa Cruz sponsored program is designed to train trainers. They are taught how to plan, how adults learn and how to prepare presentations. Besides practical information on contraceptive technology and how to counsel women, they are given pediatric training, taught how to diagnose and treat simple children's diseases, and how to give a complete female physical exam. In the morning the midwives get practical experience in various clinics and hospitals; we will accompany Lewis to the PMI (Maternal and Child Health) Clinic at Medina where she will introduce us to two of her former trainees at Santa Cruz who now run this large clinic.

Lewis told us that one of the biggest problems in providing family planning services in Senegal is the difficulty in getting products. The government clinics have only Lippes Loops and pills (supplied by AID), but if a midwife wants to insert a copper device, she has to write a prescription and then the woman must purchase the device from a pharmacist. This is a luxury that few women attending government clinics can afford.

3. Mr. Georges S. Zouain, UNESCO Regional Advisor in Population Dynamics and Education Planning.

Mr. Zouain's office is in charge of population education programs (both in and out of school) for all sub-Saharan Africa. In Senegal they are establishing a clearinghouse for population and education materials. UNFPA will finance it. I gave him some PIACT materials and the PDP annual report; he asked that both organizations add the clearinghouse to their mailing list. The address is: Clearinghouse, UNESCO, B.P. 3311, Dakar.

They expect to have one important project in Senegal. The 1.2 million dollar first phase of this project would: a) analyze the current demographic situation; b) introduce pop. ed. into the secondary school curriculum; c) include pop. ed. in adult literacy classes. This project was approved by the Ministry of Education and informally approved by UNFPA who was prepared to fund it. However, the proposal then went to the Planning Ministry who said this project did not fall within one of the country's priority fields and would consume too much external aid. So the proposal is now back at the MOE where it is being revised.

Zouain pointed out that the Ministry of Planning still has not defined the priority issues in the field of population. To date no policy statement has said that fertility decline is a Senegalese objective.

4. Mr. France Lewis, UNESCO Regional Advisor on Population Communication.

Lewis stated that introducing contraceptive products into Africa is "a headache" and advised that the use of any family planning programs be accompanied by a communication effort. He feels that family planning would have a better chance in Africa if everyone used UNESCO's definition - family planning means having only as many children as you can feed and educate and also includes concern for the women's health.

At present these are no population communication projects in Senegal. He did discuss a couple of interesting ideas: encourage griots, a caste of musicians who sing at family and religious occasions and are also strolling minstrels, to promote child spacing, improved health, a better quality of life, etc. through song. In some areas, according to Lewis, these men have much influence, as they are often used by the marabouts, respected Islamic holy men whose advice is usually sought by the community on matters ranging from health to predicting the future. He would also suggest a sociological study on traditional contraceptive products such as boiled leaves whose liquid is then drunk by Senegalese prostitutes who claim they have never had an unplanned pregnancy nor an abortion. He also recommended that we visit a clinic in the Pikine area of Dakar. It is a very traditional part of Dakar, but if a program to dispense contraceptive products to encourage child spacing and improved women's health got community cooperation there, the spill-over to other areas of Dakar and the suburbs could be very positive.

5. Dr. Jean Lecomte, Health and Family Planning consultant, living in Brussels, on temporary assignment to UNFPA.

Dr. Lecomte was in Dakar to review and make recommendations on the UNFPA proposals which had been previously submitted to the Ministry of Health or other government agencies. Since most of these proposals were related at least in part to women's health, they were now to be redirected toward "La Condition Feminine" (Women's Welfare Ministry). He indicated that he had recommended the meshing of these efforts with other projects such as the USAID project and close intervention with other agencies interested in health and population. He felt that much more cooperation should have taken place between UNFPA and USAID during the development of both agencies' proposals. He has already recommended that a team of consultants be sent to Dakar in February to prepare a broad integrated proposal encompassing all previous UNFPA proposals concerning women's health. He was enthusiastic about incorporating aspects of PIACT contraceptive acceptability activities into the UNFPA approach and indicated that he would pass the information along to those involved in preparing the proposals. Dr. Lecomte also discussed the need for quality control of contraceptive products in hot climates and cited the case of large numbers of deteriorated Japanese condoms in Morocco during his tenure as Population Council representative in that country.

6. Mr. Claude Paul Boivin, Assistant Director and Dr. Karl Smith, Regional Health Science Advisor, IDRC (International Development Research Center).

We spent a morning at IDRC telling them about PDP and PIACT and our mission on behalf of USAID, learning about their activities in West Africa, and collecting some of their materials. Established 9 years ago by the Canadian government as a public corporation, IDRC spends 72 million dollars (Canadian) around the world supporting research and projects in four divisions: a) agriculture; b) food and nutrition, c) the social sciences, and d) health sciences.

Seventy-five percent of their West African budget goes into agriculture and food/nutrition projects. IDRC's health sciences division used to be a health and population division, but at present almost all their population activities have been transferred to the social science section as they deal mainly with demography, computer information sciences, and population policy.

In West Africa, IDRC is interested in providing training for demographers. Also, they began the West African publication "Famille et Développement" and supported it for 4 years. Their goal was to see it transferred to African management. Recently a new private non-profit organization was formed to manage and operate this publication. It is called ASAFED, the African Association for Education and Development. UNFPA is contributing $125,000 a year to it for the promotion of family planning and other health issues. Additional assistance is being provided by Ford Foundation, the governments of Senegal, Sweden and Switzerland, and a private Catholic organization headquartered in Switzerland. IDRC had hoped this new association would have a diversified support base, but now they are beginning to feel that this will make them more cautious and conservative. Pierre Pradervand, the Swiss editor of "Famille et Développement" since its inception, has departed, as has the Senegalese editor-in-chief, Marie Angélique Savané. The latter is now president of an African women's association; we have arranged to see her.

Boivin could not have been more cordial. He asked one of his assistants to help us set up some appointments with social scientists and offered to accompany us to the university later this week to provide introductions and translate for us. We gave him some PDP literature plus the proposal format and told him PDP might be interested in co-support of a policy-level conference of government leaders concerned with the correlation between population questions and socio-economic planning.

As a place to make contraceptive products available, Boivin suggested someone investigate those private sector shops that sell inexpensive local brands (not the internationally franchised names) of cigarettes to the country's working-class clientele.

7. Mr. Sangone Amar, the World Bank.

We called on Jonathan Brown, World Bank regional rep. in Dakar, but he was back in the US, so we left some PIACT literature with his assistant, Mr. S. Amar. We asked him about the World Bank's activities in health and population in Senegal. Last month two representations from World Bank/ Washington (Mr. Pearce and Ms. Osinski, plus a consultant, had come out to identify project possibilities in health and population. They are still writing their report. This is only the very first step, so it will be at least one year before a Bank project begins. Mr. Amar spoke of their working with both the MOH and La Condition Feminine. Also, AID's rural health project in Sine Saloum has been investigated by the visiting Bank team. The World Bank tries to build on the work of other donor agencies, such as USAID and WHO.

8. Rick Knoop, UNFPA Project Specialist.

There is about $ 15,000 in Knoop's project funds to create a bibliographic inventory and clearinghouse for all books and documents on demographic studies, population-development issues, socio-economic determinants of fertility, etc. relating to Senegal. He has been collecting bibliographic citations for over a year, and is now trying to procure copies of each of the documents, manuscripts, books, and articles. This population and development clearinghouse will be located within the Planning Ministry and should be operational sometime next year. Once all this material is assembled, he and his colleagues in the Population Unit will be able to identify gaps in their knowledge base and will be in a position to recommend pertinent reaserch and/or studies. The Senegalese have not published much in this field. A census was completed in 1976, but very few articles have been published.

The Population Unit will also undertake, for the National Population Commission and the Minister of Planning, an inventory of all policy instruments available to the government as it goes about implementing its family planning program. Also, they were instructed to prepare a report on all the fiscal resources at the government's disposal.

Physicians

1. Dr. Aly N'Gom, Le Dantec Hospital

Dr. N'Gom is a young Ob/Gyn who assists Dr. Correa at the hospital and who also makes clinical presentations to the medical students at Dakar University. Le Dantec is a 1500 bed government hospital run on a $5.00 per day per patient budget. Although this sounds quite modest, in fact this hospital absorbs an enormous percentage of Senegal's health budget.

Dr. N'Gom attended one of the JHPIEGO laparoscopic training programs in Tunis but has not done any laparoscopies lately. He had an old instrument, without fibre optics, that was not useable. New KLI equipment has recently arrived in Senegal, and someone from JHPIEGO came to Dakar in mid-November to demonstrate its use. We asked him about mini-laps and he said he had done three and, in each case, ended by doing a regular laparotomy under general anesthesia. Both he and Vincent said that it is very difficult to do a mini-lap on African women because they have firmer tissues that are less elastic and more resistant to displacement. Vincent mentioned that Dr. T. King at Johns Hopkins was well aware of these differences. Maybe PIACT should approach King to write a monograph for our Papers series on the geography of anatomy and how it impacts on family planning surgical procedures.

The Ob/Gyn unit at Le Dantec has 160 beds; more than 13,000 babies are delivered each year. No woman currently receives information about family planning unless: a) the woman specifically requests a method or b) the doctor feels it is necessary for health reasons. We asked Dr. N'Gom if he favored providing women with some general information so they would begin to realize they had a choice. He felt our question a bit threatening and told us he only followed orders and since the government still has not given official clearance to family planning, he is not in a position to say whether or not he favors such a policy. In response to our questions about how many women (approximately) asked for a contraceptive method, he said that many women - illiterate as well as literate - asked for an IUD or orals, but he could not provide any monthly estimates. Some women even request a specific brand of pills. Most get their information from talking to other women. The doctors can only write a prescription which the woman fills at the pharmacy. If she purchases an IUD, she returns to the Ob/Gyn Unit for the insertion. (Free OCs and IUDs, supplied by AID, are only available - officially - at this time at the Medina PMI and in some Sine Saloum medical facilities.)

Dr. N'Gom does not favor inserting post-partum IUDs, as he is afraid of expulsion and infection. He does, however, sometimes insert an IUD after spontaneous abortion. He also feels post-partum methods are not important due to the protection provided by lactation. He says they see occasional cases of abortion complications at the Ob/Gyn unit, but not very many.

Although Dr. N'Gom would not be interested in doing an O.C. comparative dosage study at the hospital at this time, once the government sanctions such activities, there would probably be no additional obstacles.

We briefly met Dr. F. Adanlette of Togo who has done a study on maternal mortality in Dakar and found that maternal mortality in the Cap Vert region is 188 per 100,000 women. (At some later point in our visit M. Vincent saw Dr. Adanlette at the hospital and the latter reported being approached by La Condition Feminine and asked to develop a sterilization program for them.)

Le Dantec hospital also has a school for midwives; about 25 "sage-femmes"are graduated each year. For the past 3 or 4 years, a course on contraception has supposedly been a component of their curriculum.

2. Dr. Sergine Ba, Chief of Medicine, Abass N'Dao Maternity Hospital Center

After Le Dantec, Abass N'Dao is Senegal's largest maternity hospital. Every 24 hours, Dr. Ba estimates that 50 to 55 deliveries take place. But the infant mortality is enormous - 50% of the children born in this hospital die before they are two, according to Dr. Ba. He feels contraception is necessary — although he personally believes that Senegal is underpopulated — to space pregnancies so there will be fewer of them, but also fewer deaths.

We described Gordon Perkin's high risk chart to assess reproductive risk and establish priorities for contraceptive care. Something similar might be developed for Senegal. Paraprofessionals or social workers could be trained to identify those women at highest risk who would then be counseled by the doctor or midwife. Adoption of a reliable contraceptive method by these highest risk women could significantly improve their health and lead to a reduction in infant and maternal mortality and morbidity. Although Dr. Ba already has a system by which his hospital informally identifies high risk patients, he thinks that instituting a comprehensive high risk identification system with proper record keeping and follow-up would be a welcome addition.

Dr. Ba has identified what he considers the three highest risk groups and counsels those who come for pre-natal care. (However, most women do not come until the time of delivery). The three groups are:

1) Women between 30-32 who already have many children. They have another 10 reproductive years ahead of them, and could well have 6-8 additional pregnancies.

2) Young unmarried women because they are most likely to practice infanticide or risk an induced illegal abortion.

3) Couples whose health is OK, but who already have more children than they can afford to educate or feed. Contracepting could help improve the quality of life for such couples.

Pathfinder proposed to assist Abass N'Dao with a program some time ago and gave them some pills (Blue Lady with 50 and 80 mcg of estrogen), minilap kits and Lippes Loops. He feels the demand for contraception exists, but he has no time to keep proper records and has never reported back to Pathfinder. Dr. Ba's comments on specific methods follow:

Oral contraceptives

a) He opened one Blue Lady package and asked us if they were still OK to use. As in the PMI clinic, they were dated 2/74, but they looked fine.

b) He admitted he often had too little time to explain how to use the pills properly. It is difficult for illiterates to understand and he feels they could benefit from having specially prepared instructional materials to take home with them - along with the pills.

c) Because women don't take the pills in the correct order, he often finds it expedient to cut off the iron pills and tells the women to finish one card of pills and then begin the 2nd card on the 5th day of menses.

d) The hospital has an adequate supply of pills for the next few months.

IUDs:

a) Their Lippes Loop stock is exhausted, so if a woman wants an IUD Dr. Ba must write a prescription; the woman then buys the IUD at the pharmacy and returns to him for insertion.

b) Some of the IUDs Pathfinder gave them were destroyed when someone tried to sterilize them by boiling.

c) He has inserted less than 100 IUDs this past year. He said he would like to do insertions immediately postpartum but does not because even the size D Lippes Loop is too small for most of these women with very large, stretched uteri.

d) We described to him the postpartum IUDs PIACT de Mexico is making for IFRP's studies. He would be very interested in studying their event rates among high risk Senegalese women. For as he said, although he recommends they return for an IUD insertion 6 weeks postpartum, the women deliver and then disappear. When they return they are again pregnant, and this time the result is often a ruptured uterus.

Sterilization

a) He does a few mini-laps on request.

Injectable:

a) Noristerat is available in some pharmacies and Schering's detail men had contacted him. He can write a prescription but the purchase price is very high.

3. Dr. J. Lauray, Chief, Ob/Gyn, Abass N'Dato Maternity Hospital Center

Dr. Lauray, either from France or a French Canadian, also assists at Le Dantec Maternity Hospital (there are only about 10 trained Ob/Gyns in Senegal today). Unless a woman is a high risk patient, he does not suggest oral contraceptives. Even then, he first explains the method and leaves the decision to her. He also has Pathfinder pills, but uses them only as samples, preferring to write a prescription to be filled at the pharmacy. He believes that if the product is given free, it is not valued as much by the patient. Only 1 out of every one or two thousand patients bring up the subject of family planning and request a product.

Dr. Lauray seems to favor large families and is not sure whether infant mortality and diseases are the result of having too many children or simply of having "a different philosophy of life". As he explained, he has many siblings and all were healthy, well educated and are now professionals like himself.

4. Dr. Paul Correa, Chief of Ob/Gyn, Le Dantec Hospital and Faculty of Medicine, Dakar University.

We met for one hour with Prof. Paul Correa, head of Ob/Gyn at the Dantec Public hospital for the past 25 years. Although he had previously been an opponent of family planning he appeared to be adopting a new position of restrained support. He is currently finishing up a paper on Fertility and Infertility in West Africa for WHO. It is being prepared jointly with a British physician in French and English. He discussed child mortality (50% die by 5 years; 42% in Dakar) and the resulting fear as incentive for pregnancy in Senegal. He tries to persuade patients with several successive childbearing years to contracept in order to rest, sometimes going as far as calling the husband. However if the woman delays too long her husband's relatives will pressure him to take another wife. (This translates into more fear for the wife who is not likely to favor such action). Whereas Anglophone African countries generally accept family planning, the Franco-phone countries

do not since French attitudes toward contraception have been different. He stressed that infertility is a major problem in Senegal and a source of misery and disruption, suggesting that the best approach to family planning in Senegal could be summed up in the words "I come to take care of your infertility and also to offer you the means to space your children". So far, assistance programs have done little or nothing for infertility, which Prof. Correa estimates at 20% in Senegal and up to 50% in some other African populations. However, the culture makes this a far greater problem than statistics can describe. He believes that contraception will be generally accepted in Senegal in 10 years but that it will take 20-25 years after a change in political policy before a pronounced effect on birth rate can be seen. Poverty and child mortality must be reduced because these are major factors in the pregnancy rate.

He suggested that prevention of infertility due to venereal and other diseases is very difficult in Senegal. An effective way in which assistance agencies could demonstrate their responsiveness to the needs of the Senegalese world would be to enhance and emphasize preventive programs and, in addition, apply efforts relevant to infertilty diagnosis and treatment, such as 1) equipment and training for microsurgical repair of occluded fallopian tubes; and 2) lasaroscopes for exploratory surgery.

5. Dr. Ismalia Kane, Regional Chief for the Sine Saloum Region, Hospital de Kaolack.

Dr. Kane had only taken over his new position 3 weeks previously. He stated that family planning is needed by everybody but the problem is how to achieve it. Since these are rural populations, the first task is to inform them and to remind them that many of their ailments are linked with malnutrition, which is linked in turn to too many pregnancies. Although family planning has been adopted by Senegal, there are still many judicial problems since the 1920 French law banning all aspects of contraception is still on the books. Once this law is changed, implementation of family planning programs in the rural area will be easy. The GOS has entrusted La Condition Feminine with the task of bringing about a change in this law, because the minister of this secretariat is a judge concerned with women's health and because it has a mandate to reach the masses with family spacing information. Effective communication can be achieved through women's organizations which exist even in the remote villages. One of the problems concerns what communication methods to use to inform this illiterate population so that they can really express their felt needs. As to actual contraception methods, there is a question of whether an illiterate population can be trained to use the pill effectively.

Dr. Kane expressed interest in testing PIACT communication materials under field conditions and we informed him that they must also be developed under field conditions. He indicated that such a program would be really helpful because it addresses their main problem.

6. Dr. Malek Niang, Chief of the Kasnack Medical Circle, Kaolack, Sine Saloum.

Dr. Niang described the traditional barriers to adopting family planning in this region: a) if a woman is contracepting, her husband may take another wife; b) the more children a woman bears, the greater is her share of the husband's inheritance; and c) children provide capital by working for the father. But he believes that attitudes are changing, mainly due to economic pressures. Also, many women are now more concerned about their own health. Also, some believe that limiting the number of children they bear will keep them looking younger.

So far, there are no organized family planning sessions at his clinics - but services are provided if - and when - clients seek advice. Two groups in need of service are: a) young marrieds and b) those women who are divorced, widowed or unmarried. (Many of this latter group attended his VD clinic. Prostitution is legalized and regulated by the government; all women must have medical check-ups at regular intervals).

Many of their clients are given OC prescriptions as they request a specific brand. If they tolerate it well, the midwife has them continue purchasing from the pharmacy. If there are problems or if the woman has no preference, they give the Blue Lady. He would very much like to do an OC acceptability study - but would need a supply of pills with 30 mcg of estrogen.

He believes much education is needed before condom use will become widespread, as condoms are too closely associated with prostitution. Also, he feels men want their wives to take responsibility for contraception. We then brought up the importance of trying to at least involve the husband in the decision-making process, and described the preliminary results of the study in the Danfa area of Ghana.

7. Dr. Frederick Farah, Director, Pasteur Clinic

This small private clinic appeared to serve the European community primarily, although Dr. Farah indicated that his Senegalese patient load is increasing. They are, for the most part, educated women who already know what method of contraception they want. If this is not contra-indicated, he complies, even doing some laparoscopic sterilization. He uses copper 7 (Gravigard) and Multiload (ML Cu 250), both of which he obtains through private connections in France. The supply of copper Ts through the pharmacies is too erratic, he said, and the other copper IUDs require less dilatation.

He expressed some interest in doing studies if participants could be selected by others and sent to his clinic, which will relocate to larger quarters in a few months.

Midwives

1. Mame Boyo, Chief Midwife, and Adelaide Diop, Midwife, and Aby M'Boup, Social Worker, Family Planning Clinic, Medina PMI (Maternal and Child Health Center).

The Medina PMI houses the MOH's pilot family planning clinic. These 2 charming and enthusiastic midwives spent almost 2 hours answering our questions and giving their perceptions of urban clients, the future of family planning in Senegal, and their clinic's needs. This clinic began in February 1977 when the first group of US trained "sage-femmes"(midwives) returned from Santa Cruz. However it was not until May 1978 that the clinic actually began to offer family planning services. Money to renovate and adapt the building came from Pathfinder and AID, as do contraceptive supplies and equipment. The MOH pays salaries and gives its official support. Some equipment also came from UNICEF, via the MOH. Staff includes 2 midwives, a social worker, a nurse's aid, a driver and a cleaning woman. As an example of their case load, August's records show that of 448 women seen, 74 were new clients. No formal studies on follow-up have been done, but they estimate continuation rates at 70-80%. Even when women request an IUD removal to conceive, they return after the delivery. They keep individual records, and would like to do follow-up studies if they had proper personnel. Also without an official government family planning policy, they don't feel they have permission to make home visits.

President Senghor has endorsed family planning and the MOH has said it is OK to talk about it, but they would like to see a written official document. They also feel it is important to make this official policy known to the religious leaders (which seems to us to be just what the politicians are trying to avoid). There is supposedly a new government policy that motivation and publicity should be done by La Condition Feminine, but as yet they have taken no steps to promote family planning. So far, all motivation is by word of mouth.

These women feel that family planning should be very popular in Senegal - especially in the urban areas where they no longer follow the traditional methods of child spacing. These traditional practices involve abstinence while nursing for 18-24 months or coitus interruptus because it is considered shameful to conceive while nursing. They feel too many are ignorant as to what - and where - products are available. They feel there should be messages on the radio telling people where they can find help and providing an address and the clinic's hours. They believe even men are now interested in family planning, because with many children, life becomes prohibitively expensive.

We asked about the sign over their clinic entrance - planning familial - as we had heard "planning" had a pejorative Western connotation. They don't think it matters what term is used, as long as people understand that planning means spacing. They said the current Minister of Health told them to call it anything they wanted, but to get family planning started. Those who are more cautions may prefer to use the terms "family welfare" or "pregnancy spacing".

They discussed with us their colleagues who had also trained at Santa Cruz. All returned to Senegal very enthusiastic about the prospect of integrating all family planning services into maternal and child health programs and the V.D. Clinics. But to date (3 years for some of them) many have had no opportunity to promote and practice family planning. We said this should change now that the AID-sponsored GOS program was beginning.

The average woman who comes to their clinic already has six living children. Some are referred by the doctors for health reasons; others have heard about the clinic from their friends. Some come without telling their husbands; in some cases the husband hears about the service and sends his wife. Many say their husbands tell them "this is your problem". One month the social worker did an informal study. Of 98 women queried, 8 were unmarried, 90 were married, and 60 of them had their husbands' approval. While in the villages the men still make all decisions, the midwives said that city women are becoming increasingly independent. Many young people, often unmarried, use contraceptives, but they usually prefer to go to a private clinic to ensure privacy.

The clinic appeared to have several private rooms and comfortable examining tables. They currently stocked orals(Blue Lady 3 month packets-with either 80 or 50 mcg estrogen; the ones we saw were dated 2/74 but looked fine), Lippes Loops, condoms and diaphragms, all supplied by AID (actually old Pathfinder stock). Some interesting comments on various contraceptive products follow:

Oral Contraceptives:

a) Some women get worried and return to the clinic when they menstruate and they know they haven't skipped a day on a pill. Since this happens with both the 80 and 50 mcg dosage, the midwives prescribe a 30 mcg tablet - which usually works well, but the women have to go to the pharmacy and pay about 400 CFAs per cycle (about $2).

b) They would really like to be able to offer their clinic clients a 30 mcg product. Also, with money to hire appropriate staff, they would be eager to do some comparative studies - of different dosages or different schedules (21 day packet vs 28 days with iron vs 63 day Ramadan pill)or both— to find out which produces the fewest side effects, is most acceptable, and has the highest continuation rate.

c) It would be very helpful to have some Senegalese pictorial instructional material to give out when proper oral contraception use and side effects are being explained. Too many women are using the product incorrectly.

Diaphragms:

a) Cartons of them have been supplied by AID - unfortunately, all are size 70 and too small for most of their clients. They get many requests for diaphragms which they cannot, at present, fill. They should be supplied with 80 and 90 mm diaphragms.

IUD's:

a) They have a lot of problems with the Lippes Loop, but they don't believe substituting other devices would rectify the situation.

b) Their main problem is infection. It is the custom for women to clean their vaginas with their fingers. Although the midwives counsel them on the importance of cleaning their hands well first, the midwives feel they don't listen. Hence the IUD strings get dirty and infection is spread to the uterus. Also, sexually transmitted diseases are almost endemic in Senegal due to multiple social contacts.

c) As part of the cultural tradition, some women also insert powders (ground plant products, usually) into their vaginas to erotically stimulate the male. Either the act of inserting or the product itself - or both - also enhances infection. It should also be noted that IUDs are imported in bulk and sterilized locally. No data are available on the efficacy of these cold sterilization procedures in the Senegalese setting.

Polyurethane Sponge:

a) Although women would not hesitate to insert it, the midwives felt that any method that could be noticed (felt) by the male would not be acceptable. They said that the diaphragm and condom are sometimes rejected for the same reason.

Other Barrier Methods

a) They have no foams, jellies, creams or vaginal tablets at the clinic.

Injectables:

b) They would VERY MUCH like to be able to offer Depo-Provera. Injections are culturally relevant in this society. Someone from IPPF was here some months ago and supposedly is sending them some (details unclear), but they have not heard anything as yet.

c) They would also be willing to do an acceptability study of women using DMPA. This would require governmental permission, but they see no problem if external funds are provided.

Condoms:

a) Their non-colored lubricated condoms are the method of choice for single women and a few young married couples who are going to school or want to continue working, etc.

b) Most men will only use condoms with a prostitute or their mistresses.

c) Many women would be afraid to ask their husbands to use a condom. Husbands and wives seldom discuss such matters.

d) They feel it might be possible to improve the condom's image and promote condom use. Such an educational campaign would have to counteract the prevailing attitude that the condom interferes with pleasure.

While all services - and products - are currently free at the PMI family planning clinic, M. Boyo feels there should be some small charge so that the women feel they are making a contribution. She proposed to the MOH that a service fee be collected from each client, but her idea was rejected. Their problem now is that they have to request everything from the MOH and often have to wait too long. If they collect a small fee, they could build up a small reserve for purchasing needed supplies and equipment. We suggested that perhaps someone at the university could do a small study to find out the optimal price to charge for family services - high enough so that women feel it's a quality service, yet low enough so that no one in need would be excluded. M. Boyo feels there is no need for a study - she thinks 100 CFAs per visit would be appropriate.

We asked the midwives about traditional medicines used for contraception and abortion and shared with them the ground roots (San), touted as both a contraceptive and an abortifacient during the first 2 months of pregnancy, that we purchased in the open market. They knew about one product - M'Bante Mane- that is used as both an abortifacient and as a pospartum cleansing agent, but they had no information as to its effectiveness. They also know there are some old women who perform abortions - but said their information is all hearsay.

2. Group meetings with 10 Senegalese Midwives: (see list of participants under Contacts in Senegal, page 53)

With the cooperation and great assistance of Ms. Emily Lewis and with permission of the students and staff,we met in group session with the 7 participants plus 3 staff members of the first in-country course of the Santa Cruz Midwife Training Program. Since the Ministry of Health had selected a sage-femme from each region of the country to participate in this course, the meeting offered the possibility of obtaining a broad cross section of regional professional opinion.

1. Dakar - Abass N'Dao Maternity Hospital Center. According to the midwife trainee, no contraceptive materials were on hand but in response to requests only, the doctors would write prescriptions which could be filled at a pharmacy. Mainly middle class women were seen but, even so, most requests for contraception occurred at the beginning of the month when money was available. No statistics were available.

2. Thiès-Maternity Hospital.

This maternity clinic has a sage-femme trained at Santa Cruz but does not have a formal family planning program. Some contraceptives are prescribed by the sage-femme and all the materials are on hand. Those who can afford it are sent to the pharmacies to fill their prescription.

3. Kaolack - Dispensary

Family planning had begun in Kaolack. In the Maternity, high risk patients were identified and given contraceptive information. Contraceptive products were available in some rural dispensaries. There was no family spacing center but IUD insertion and other contraceptive products were dispensed at the WHO funded VD clinic. Some people come and ask for IUDs when they are pregnant in the hope that an abortion will be induced. When refused they often return 2 weeks later having aborted by traditional (folk) methods. Some seek abortions in Gambia where they are readily available, at least up to 3 months of pregnancy. Many drugs and contraceptives are brought from Gambia and sold in the market place or even at the main bus stop at one fifth of the cost of identical drugs in the pharmacies. However, their expiry dates, conditions of storage and conditions of use are not available, so the products may be ineffective and inappropriately or dangerously utilized.

4. Diourbel - C.M. (Medical Center)

No pills or IUDs are available in this area. People are sent 150 km to Dakar to fill prescriptions. Follow-up is very difficult under these circumstances. The family planning trainee hopes to have supplies to take back at the end of the course. Even so, there was a question of disapproval of the other sage-femmes of the clinic and the possibility that no space would be made available to provide family planning services.

General discussion centered around the following questions:

a) What do people in the outer region do if they want to space their families?

- o They go to the marabout (religious leaders) and get things ranging from talismans to tie around their waist to herbal powders and other things. Some seem to work but others don't. Some of the powders are abortifacients and it was generally agreed that these work, but effective dose levels are unknown. Some research on these may be going on the University. The Minister of Health wishes to discourage use of these traditional medicines because they may do harm.

- o They delay weaning their latest child.

- o Wife and husband separate.
- o They come to Dakar for modern contraceptives.
- o Husbands take new wives (or lovers).

b) Should non-prescription contraceptives be sold in the market place? Though the Chef de Cabinet of the Ministry of Health had spoken against this, most of the midwives were enthusiastic; some said it should be done discreetly and others openly. One midwife (from a Dakar VD clinic) stated that many of their clients have said that they would like to buy their condoms "where they buy their matches" (presumably in the numerous "Nar" shops distributed around the city) - they do not like to go to the pharmacy. In some regions, the pharmacy did not appear to be such a problem for people as long as they had money. Money was a problem for many people who accumulate sufficient funds to start on oral contraceptives but then run short the month. They have to break their regimen and are then at risk of pregnancy. If they are fortunate enough to live close to the Medina clinic in Dakar they can get free supplies. (But most women do not know this.)

3. Ms. Aicha N'Doye, Midwife-in-charge, Clinique Nabou, Rufisque

Mrs. N'Doye, a Santa Cruz trained midwife, left the government's PMI clinic in Medina earlier this year and, 3 months ago, opened her own private clinic in Rufisque, a fishing & industrial town of around 60,000 persons, 16 miles southeast of Dakar. Besides offering family planning services (her sign uses the word "planning familial"), she also handles deliveries, pre and post natal care, & gynecological problems. Her clinic was clean, well equipped and cosy; the post-partum women seemed well cared for. Daytime staff includes 3 nurses plus Mrs. N'Doye; at night 3 midwives & a nurse's aid sleep at the clinic. Mrs. N'Doye had gone to the bank for a loan to equip & refurbish her clinic; they turned her down (thought it was a bad risk), so she bought all the equipment & supplies herself. She also has AID-supplied pills & IUDs. She has had particularly good success with IUD insertions, mainly because she practices what she learned in Santa Cruz & spends lots of time with the women, counsels them ahead of time, tells them what they can expect by way of side effects, etc. In the 3 months her clinic has been operating, she has inserted about 30 IUDS. The charge is 3,000 CFA

(about $ 15.00). Women return in 8 days & again after 3 months for a check-up. Thus far she has had no problems, although in one case the Lippes Loop C was expelled, and a size D device was reinserted. By the time we (or someone else) are ready to support some Senegalese studies, this clinic should have sufficient clients to undertake a comparative IUD study & or a uterine metrology study. Mrs. N'Doye was enthsiastic about helping to generate some Senegalese data.

Mrs. N'Doye would like to receive size 80 & 90 diaphragms.

Not all of her patients are middle & upper class, as the surrounding factories have insurance programs to which all female employees contribute. This program concerns maternal care & deliveries, but thus far family planning services are not included. Mrs. N'Doye plans to go speak to the factory executives about changing this policy.

Mrs. N'Doye said she doesn't see many cases of sterility, but reported seeing many cases of vaginal infection and lesions; also, many of the women are anemic. (One of the bedridden patients we saw today had malaria & had aborted at 5 months).

4. Ms.Phoebe Whest-Allegre, Director, La Croix Bleue Clinic, Dakar

The Croix Bleue Clinic was started by Ms.Whest-Allégre in 1964 as a maternity clinic. In 1965, moved by the plight of women, exhausted and dispairing over their endless cycle of pregnancy and lactation, she went to the USA (Downstate Medical Center) to learn family planning techniques. When she returned she started an "underground" motivation program and with the help of Pathfinder Fund, was able to develop an outreach and follow-up program. Despite threats of legal action from the MOH she kept going, eventually gaining an audience with the President who indicated that he would watch the clinic activities to test how people would react to the family planning idea. In 1971 Ms.Whest-Allegre began courses in family planning for midwives, at first only enrolling foreigners (14 African countries). Later, with the blessing of a sympathetic Minister of Health, Senegalese midwives were included. Twelve such courses have been given to date, training a total of 125 midwives in family planning techniques.

The present clinic is a modern facility with 5 midwives and 2 part time physicians. Facilities included a surgical suite with general anesthesia and suction apparatus, a three bed intensive care room, labour room, and private and semi-private lying-in rooms. Since Pathfinder funds ran out 2 years ago and she can no longer afford outreach workers, her patient load for family planning has dropped from around 400 new patients per month (July 1978-413 new patients) to 100-150 per month at present.

Although condoms and pills are offered, it was clear that the principle method of contraception offered by this clinic was the IUD. Initially Pathfinder Lippes Loops B, C, and D were available although Dalkon Shields and Copper Ts have been used. Early practice was to put a LL-B in nulliparous women (mainly students and unmarried working women) and LL-C in multiparous women. If the LL-C was expelled, then LL-Ds were inserted. Expulsion of LL-Cs from the gross multipara became too frequent, so the practice was changed to routine installation of LL-Ds in multipara. The experience with Lippes Loops has been very satisfactory (with the exception of one batch, later destroyed at the request of Pathfinder, where several breakages had occurred). IUDs are inserted on the last day of menstruation and expulsion rates were said to be very low. Ms.Whest-Allegre suggested three factors contributing to her high success rate with the IUD:

1) Even though 75% of clients were illiterate she was able to make them understand what to expect by describing the IUD as being like an early pregnancy. The uterus tries to expel the foreign body so cramping and other discomforts may occur, but eventually the uterus "becomes friends with the IUD."

2) Tolerance of pain is considered to be a commendable virtue in African women during childbirth; therefore the discomforts of early IUD experience are not considered worthy of complaint.

3) The lower class women seemed much more motivated to contracept than middle and upperclass women, perhaps because they have experienced traditional contraception and abortion methods which have failed or given rise to much pain.

At present she has only 100 LL-Ds left in stock and no legal way to import new stock, except through assistance programs. No fee is charged for these IUDs or their insertion but patients are charged 1500 CFA ($7.00) for the associated medical exam (blood pressure, urine analysis and general exam). Copper IUDs are available from the pharmacies but cost 5000 CFAs ($25.00). A small lot of Dalkon Shields supplied by Pathfinder had been used in cases where LL-Ds have been expelled. Dr. A. Kone-Diabi conducted a study at the Blue Cross Clinic comparing 200 Dalkon shields with 240 Lippes Loops. (This study was published in French as an M.D. thesis. We obtained a copy from UNFPA for translation at a later date).

The present relationship of the clinic with the GOS appears to be one of quiet cooperation and collaboration. For example, they have a contract for civil servants to use the clinic (at a reduced cost) and Ms.Whest-Allegre has been used as a resource for official speech writing on the subject of family spacing and for practical training in contraceptive procedures for government-sponsored midwife training programs.

Ms.Whest-Allegre indicated that with appropriate support she would be happy to conduct PIACT type studies, especially IUD acceptability and uterine metrology studies, in her clinic.

5. Ms. Aichatou (Aida) Diop, midwife in charge of Urino-Genital Clinic of the Institute of Social Hygiene, Medina, Dakar

The Institute of Social Hygiene is a large complex of clinics - 3 for general medicine, plus gynecology, dermatology, E.N.T., T.B., preventive medicine, dentistry, etc. At the urino-genital clinic, Mrs. Diop (who was trained at Santa Cruz and is currently on the staff of the in-country training program) and her staff see two categories of patients:

a) Prostitutes who are licensed by the Government and are required to come to the clinic for VD tests about every 25 days. If a test is positive, clinic staff takes away the prostitute's license and gives her another card which prohibits her from working until her treatment is completed. When this clinic opened in 1969 most prostitutes had positive tests; now they only see about one positive case per week among their prostitute clientele. Since 1976, the clinic and lab have been funded by WHO. Patients pay 200 CFAs (about $1 US) and then all treatment is free.

b) Persons (men and women) often referred from other clinics, plus their contacts. They see about 30 such persons per day - and at least that many prostitutes.

Discussion revolved around the potential acceptability of family planning. Ms. Diop thinks that with more time for motivation & outreach, many of her patients would become acceptors. As is, she refers many women to the Medina PMI; their small clinic is much too crowded to also offer family planning services. Dr. Vincent had brought boxes of Pathfinder condoms to the Institute, but they were locked in a storeroom and Mrs. Diop did not know they were there. Now that she knows they are available, she will request supplies from the storeroom today and will receive them tomorrow. She plans to offer about 20 condoms to each receptive client, as she feels most of her patients are too embarrassed to go to the pharmacies.

On the second floor of the Institute of Social Hygiene there is some empty space that, with renovation, would make a good family planning clinic. Mrs. Diop thinks it would cost about $10,000 to refurnish this space and add sinks and a W.C. Since this busy compound contains so many different clinics, we feel it would be an appropriate site for a government family planning clinic - even though the Medina PMI (which also offers free services) is nearby. This Institute is frequented by a more diverse population; hence, if proper posters and motivational materials were used to popularize the presence of a family planning clinic on the grounds of the Institute, such a facility has the potential for likely success.

Social Scientists/Academicians

1. Dr. Landing Savané, consultant to CODESRIA, Council for the Development of Economic and Social Research in Africa.

At Lennie Robinson's suggestion, we called on Dr. Landing Savané, formerly coordinator of social and demographic research at the Sahel Demographic Institute in Bamako, Mali, who has recently returned to Senegal. He is consulting for CODESRIA, a small non-governmental organization located within IDEP, Institute for Economic Development and Planning, which is a UN-sponsored training and research institute.

As a demographer, he said he was not familiar with the Senegalese family planning service program, and suggested we should talk to his wife, Marie-Angélique Savané. CODESRIA is conducting research on the causes and consequences of migration in West Africa. We discussed with him PDP's objectives, explained that Battelle would be interested in working in West Africa, and gave him some literature. We also suggested he might want to read the final report of the Senegambian migration study, carried out under an AID contract. He had heard of it, but had not seen a copy.

Dr. Savané suggested we also contact the chief of the Census Bureau, responsible for all surveys done in Senegal, and the acting director of the Statistical Office. The Bureau is currently involved in processing the census and the WFS data and is conducting a survey of employment manpower. Next year they will begin a migration survey. (We never found the time to track down these people.)

2. Marie Angelique Savané, President, Association of African Women for Research & Development.

This small pan — African women's research group is interested in undertaking research pertinent to the African woman's condition. While research directed to fertility values & attitudes ranks as a high priority, up until now it has been too political a topic for them to focus upon. This association has been supported by the Swedish government. Since they as yet have no permanent secretariat, they are worried about overextending themselves by taking on too many projects. Between now and December 1980 they will be working on a rural development project supported by I.L.O. By next year they also hope to develop an inventory of what research projects in Africa have been undertaken by African women. We told them about the PDP program and suggested some study topics for which they might seek support. She replied that when groups (such as UNESCO) were interested in AFARD doing a particular research project, they usually submitted a formal request for a proposal.

When Ms. Savané was editor-in-chef of "Famille et Développement", she often spoke in high schools & to women's groups. She found that the knowledge gap is great and that young, sexually active girls really didn't know where to go for contraceptive advice & supplies. Due to this lack of information, there is a high percentage of induced abortion (although no figures are known). She also feels it is important to control the distribution & use of contraceptive products. Currently black-market products that enter Senegal via Gambia are sold by people - & to women - who have no notion as to their proper use & cannot read the directions (that are often written in English or German). Although she doesn't believe Senegal has problems of over population, there is a definite problem at the level of individual choice.

The government has never been sensitive to the rights of women, nor are doctors. Since 1974, the government has had a semi-official position on family planning, but they never do anything. They say they are concerned about sexually active school girls, but if the Government were really interested it would change the current law that demands the expulsion of such girls from school.

Ms. Savané doesn't think that the secretary of La Condition Feminine, Ms. M. Kane, will take a pro-activist position vis-a-vis family planning because she has only been in office 2 years & is still concerned about her own position. But if she did, everyone knows Senghor would support her. Politicians are still very cautious, due in part to a recent revival of religious influences. As she put it, "we have our own Khomeinis."

Monitrices, female extension agents, come under "La Condition Feminine." They are trained in agriculture, home ec, health, etc. "to respond to villagers needs," but their training courses do not include any information on family planning per se - even though many have expressed an interest in being able to provide relevant information to village women.

Within the ruling Socialist Party there is a Woman's Movement (headed by the Minister of Social Affairs, Madame Caroline Diop, Senegal's first female Minister) but it is very political & very cautious& conservative. Mostly older women, they are not particularly concerned about younger women's interest in spacing children & controlling their own bodies. But in Senegal there are all types of women's groups - ethnic,religious, school or compound, tontines (women's credit associations) - at various economic & social levels. According to Ms. Savané, at this time there is no indication that La Condition Feminine is promoting family planning through these existing networks.

3. Mr. Robert Hall, Researcher from Cornell University Working under a Collaborative grant from AID (Title 12 funds).

Discussions were held with a development sociologist studying community organization as it effects delivery of health in the Sine Saloum region. His three month projects involved an overview of the regional health delivery system and in-depth interviews at the village level. Although he was not directly involved with family planning he was able to offer insights into the village culture, suggest potential outlets for family spacing information and materials, and give information on organizations and government agencies which impact upon village life. He spoke of Promotion Humaine, a government agency set up as a Secretariat, separate from the Agricultural Ministry and concerned with rural communication services, promoting new ideas in such areas as sanitation, women's and youth groups and skills that may enhance the local economy. However, the agency is understaffed. According to Mr. Hall, their agents were highly motivated but were hampered by lack of equipment, serviceable vehicles, and fuel.

In a discussion of possible supply systems and outlets, the SONADIS or government store, was brought up. At least one of these stores exists in every department (county) and, although not offering a convenient outlet to all or even most of the villages, it does present a potential supply pipeline out of Dakar into the regions and departments. The rural communities (clusters of approximately ten villages), market places, and traditional health practitioners (herbal medicines, physical and spiritual healers) offer relatively fixed points of contact with the people although no judgement was made as to their potential for non-clinical distribution of family spacing information and supplies. UNICEF village pharmacies and USAID health huts appear to be natural outlets for child spacing information and products within the frame work of family health care. However, these are pilot projects and limited in scope at present. Each health hut is supposed to have one first aid person, one midwife and one sanitation advisor. These staff, residents of the village, receive a few months training and work from manuals (Aide memoires) written in French and Wolof with explanatory pictures.

Mr. Hall indicated that villagers had little or no money to spend on consumable items. However, since the Administrative Reform of 1972, rural communities do have their own tax base, generating funds that have to be spent on new projects, capital equipment or physical plants.

4. Mr. Modibo Kane Diallo, Director General, African Association for Education and Development (ASAFED), Mr. Segla Yawovi, Financial Manager and Ms. Diana Senghor, Editor of "Famille et Developpement".

This organization has just taken over the publication of the quarterly journal "Famille et Développement", originally sponsored by IDRC. They are hoping to broaden their interests to include other projects promoting self-help for development based on fundamental needs. They are interested in publishing an English language version of the journal which presently circulates to 50,000 subscribers. An English version would widen the African audience but would require sponsorship. They asked if USAID might be interested in this project. They also suggested a joint venture (with PIACT) in the preparation of educational materials, since they are currently planning a book on sex education for use in secondary schools and have an interest in preparing tapes for public education radio broadcasts.

5. Ms. Fatou Sow, researcher in Sociology, IFAN

IFAN (Institut Fondamental D'Afrique Noire) is a social science research organization and part of the University of Dakar. As such, it receives support from the governments of Senegal and France. Located on the grounds of the university, many of its staff members also teach university courses. The institute has separate departments for research in African linguistics, sociology and anthropology, history, geography, and African oral traditions.

Ms. Sow was one of the researchers on the Senegambia Migration Study, completed in November 1978. (Contract AID/AFR-C 1363). She has also done research on education and urban studies. For the last year she has been working on a study, for La Condition Feminine, on the education, beliefs, health care, family planning practices, and employment of the different ethnic women (Fulani, Soninke) of Northern Senegal.

We discussed with Ms. Sow both the PIACT and PDP programs, especially possible studies on various determinants of fertility in the Senegalese setting. Since IFAN personnel often do research under contracts from other organizations, we gave her a PDP proposal application form. She also indicated her interest in - and willingness to do-a qualitative (motivational) research study, to gather information on attitudes, use, perceptions, and preferences (such as pill color, package design) among homogeneous groups of Senegalese women regarding oral contraceptives. She said she has no difficulties finding research assistants to help her from among the sociology department's M.A. students.

While discussing the unmet needs (for information and contraceptive products) among urban unmarried teens, Ms. Sow said that in traditional societies girls between the ages of 13-16 were given "social initiation" and taught about sex, conjugal responsibilities, etc. by other people of the community. Now that more women are in school and these traditions have broken down, there is no substitute body of information-such as in school sex education - to take their place.

6. Mr. Mamadou Moustapha Niang, Chargé de Recherches on Social Sciences, IFAN, University of Dakar.

Mr. Niang has just completed collection and computer entry of data for a UNFPA sponsored study on regional attitudes on fertility and contraception. He was not able to identify any major findings at this time since data analysis was not complete. He anticipates that a report of the study will be completed by February or March, 1980, at which time a national seminar will be held on the subject. Mr. Niang specializes in the sociological impact of laws and expects that his study will help formulate new legislation on family planning in Senegal. He teaches courses at the University in sociology, African law, and problems of rural development. He has lectured on African law - especially as it affects women - at UCLA and Cornell. Mr. Niang was willing to organize and supervise PIACT-type applied research projects and should be a good resource for PIACT objectives.

APPENDIX C

Site Visits

1. Tilène Market - Dakar

We visited a typical Dakar market to look at folk medicines and gain some impressions of the demand and supply of traditional medicines sold for the purpose of contraception or abortion. With the help of Wolof speaking Mary Diop of USAID we had no trouble finding vendors selling herbal products for avoiding and terminating pregnancy.

One powder(SAN, allegedly a tree root from Nigeria) was purchased for 500 CFAs, from a man who referred to himself as a marabout (spiritual leader). The vendor explained carefully that the procedure for use was to mix a pinch of the powder with water and drink it. Menstruation would occur the same day and the potion was effective for the first 2 months of pregnancy. (This powder was later identified by a group of midwives as smelling similar to a Senegalese medicine GNGUIDEK, which is used against diarrhea in nursing babies.) When questioned, the vendor indicated that many women, "especially students," come to buy the product. These and other sex related products such as powders to ensure that a woman would attract the man of her choice and potions for menstrual cramps suggested that sex and fertility control were at least unfettered enough at this level to create a market demand for products.

A list of Senegalese traditional contraceptive/abortificient materials available at the Tilène market is given by Dr. A.A. Kone-Diabi in her thesis "Evaluation médico-sociale d'une action de Planification Familiale à Dakar" (see pp. 17).

2. Peace Corps Regional Training Resource Center

We had been told that the Peace Corps had prepared interesting educational materials for illiterates for some of their African projects, so we checked into their Resource Center to see what had been done and perhaps identify persons who could serve as resource people to provide technical assistance should Senegal decide to promote non-verbal instructional materials to enhance contraceptive use. We were assisted in our search for materials by Gary Engleberg who runs the Center, but failed to locate any materials specifically prepared for low-literates. We did find some interesting Senegalese newspaper articles, written in 1972, extolling the importance of family planning and pointing out that this should be interpreted to mean family spacing and not population control. We also found a flier, of uncertain date but several years old, that advertised "a Pilot Clinic for Family Welfare." On the reverse side it showed the Indian Family Planning triangle with an African family of four in the center of the triangle. Could it be that Family Planning was better promoted in Senegal in the early 70's than it is today?

3. Rufisque PMI Clinic

This clinic was situated in a small industrial town about 16 miles Southeast of Dakar. We secured the services of an unemployed midwife from Dakar, Mrs. Sokhna Deme and, with the permission of sage-femme Jassine Kunta, she was able to interview patients waiting for baby care consultations, using a questionnaire format we supplied. Meanwhile, accompanied by Mary Diop from USAID, we interviewed the midwife in charge of prenatal care and family planning activities, Mrs. Tall née Marien Diop. Although I) pills (30 and 80 mg estrogen) and condoms (Akwell's Sultan) were available in the clinic, 2) sage-feme Kunta has spoken enthusiastically of family planning, 3) the prenatal staff told of radio broadcasts on family planning and 4) seven out of eight patients questioned in the baby care clinic expressed an immediate need for family planning activities; nevertheless, only 24 women had been given contraceptive services since April and neither the midwife in charge of baby care nor her clients were aware of the supply of free contraceptive in the adjacent building. Dr. Vincent of USAID had given instruction on pill and condom use, but IUD insertionswere not available there. None of the midwives at their clinic had been trained in family planning.

The patient interviews suggested that the majority of women (7 out of 8) had vaguely heard about methods of contraception and all could cite advantages for spacing their children (child and maternal health). In contrast, no disadvantages were cited and five of the women set a limit (4-7) on the number of children they desired.

4. SIPOA, Société Industrielle Pharmaceutique de l'Ouest Africain

We were greeted by the President and Director General, Jean-Pierre Rousselet, a doctor of pharmacology. Created in 1973, SIPOA is a quasi-governmental pharmaceutical company in that 20% of the stock is owned by the Senegalese government. Ten percent of the stock is held by private pharmacists & 70% of the stock is held by SOFFIN, a French affiliate of a German pharmaceutical company, Ingelheim.

We went there to investigate whether this local factory had the capacity to a) package condoms, pills, vaginal tablets, etc. donated by USAID and b) should there ever be sufficient demand, fabricate oral contraceptives from raw materials supplied by AID or another donor agency. They get aluminum foil locally and their boxes are made for them (to specifications) by Société Africaine d'Impression Industrielle, an affiliate of one of the local tobacco companies. The company will imprint any logo,design, etc. that is requested. SIPOA's instructional package inserts are made for them by a Dakar paper manufacturing company, also to their specifications. They have the capability to package pills and other items in foils and plastic laminates and to package in cartons for professional and retail use. Carton filling procedures are labor intensive to maximise employment. The unit price of a box that would

hold about 6 condoms is about 4 CFA (2¢) and each package insert costs about I.45 CFA. Were AID to experiment with any kind of market distribution program, these costs could possibly be recouped in the sale price.

SIPOA also has an established distribution network. They have 3 large wholesale distribution centers in various regions of Senegal, they distribute directly to some pharmacies &, for the government market, they distribute to PHARMAPPRO (see below), the government organization that supplies the village pharmacies; their pipeline reaches the entire country.

If family planning programs in West Africa increased enough to ever warrant local production, this small, clean plant has a product capacity of one million pills per day. Currently they are only working at 62% of capacity and could perhaps one day produce oral contraceptives for export to nearby countries such as Mali & the Gambia. SIPOA currently produces about 10-12 products for pharmaceutical sales, but then Mr. Rousselet showed us a list of 135 additional products they produce solely for government hospitals & clinics. Among these products we noticed progesterone, so they already handle steroids.

Mr. Rousselet seemed most cooperative and said that, while they obviously could not manufacture condoms, they would be pleased to package & distribute them. He was careful to explain to us that, for the importation of products like pills & Neosampoon, a special authorization is required from the government. He also bemoaned the fact that agencies like USAID and Catholic Relief often asked them for studies, price quotes, etc, but then continue to import their own US manufactured products.

5. PHARMAPPRO (Pharmacie Nationale d'Approvisionnement)

This is the only organization in Senegal that is allowed to order medicines (and some equipment) for all the government's hospitals, clinics and health training facilities. Private pharmacies do not need to order through PHARMAPPRO. We were taken through the warehouse. They had a cold storage room for vaccines, and upstairs, products were aranged alphabetically on shelves. Most of their medicines come from Europe and re-ordering (using air freight) takes from 1-3 months. Government facilities in the northern part of Senegal can pick up their medicines from a warehouse in St. Louis; Soon a 3rd warehouse will open in Kaolack to serve the Sine Saloum area. However, all ordering and re-ordering must be done through Dakar. They have a laboratory but it does not do any Q.C. testing. The gentlemen showing us around said they used the lab to make up iodine and mercurochrome solutions.

They have not ordered any family planning products directly from manufacturers. Products supplied by donor organization (like USAID, Pathfinder, IPPF) go to a separate warehouse. Our guide could not locate the key and so we could not investigate supplies on hand. But he said he thought the room only contained Sultan condoms. He referred to contraceptive products as "bourgeois medicine" because they are "not necessities".

6. Sine Saloum Region

We spent one full day in the region. In addition to meeting with the regional Chief of Medicine, Dr. Kane, and the Chief of Medicine for Kasnack Medical Circle, Dr. Niang, (see under Meetings, pp 31-32), we visited the following clinics, dispensaries, and rural health posts:

A. P.M.I. Clinic, Kaolack

1. The midwife here believes that family planning services should be integrated into the prenatal and well-baby clinic hours, rather than having a special day set aside for family planning acceptors (as they did in Rufisque). Under this system she thinks the women feel their privacy is respected as no one knows those who are coming expressly for family planning.

2. If women ask for pills or condoms, the midwife said they are given free of charge. The midwives do not promote family spacing, unless there is a medical indication and they feel another pregnancy will jeopardize the patient's health.

3. If a woman requests an IUD, they send her to the Kasnack Dispensary, as one of the midwives there, A. Diallo (whom we met at the Santa Cruz training program), was previously trained to do IUD insertions.

4. The two large waiting rooms, one for mothers with babies, the other for pregnant women, were crowded, with most of the women sitting around doing nothing. Where are some of those OMNI hand viewers AID/W purchased? An African slide show on child spacing (pictures only) plus one good tape recorder providing a narrative in Wolof could entertain - and educate - these women while they wait to see the midwife. A few good, colorful posters might also attract these women's attention.

5. The clinic was dirty, with an ancient examing table and a lamp that had long ago lost its bulb, but this PMI obviously gets a lot of business and could be a good vehicle for dispensing family planning information and supplies.

B. Kasnack Dispensary (also a VD Clinic)

1) About 25 women, sometimes more, almost all unmarried, attend this VD clinic daily; about 3 request contraceptive products each day.

2) There were no pills or condoms in evidence. They said their supplies had run out. But when we got someone to unlock the supply cupboard, we found a few boxes of OCs - but no condoms (which they said had been even more popular than the pills). What can program personnel do to unlock this hoarding mentality? It's definitely a major stumbling block to providing easy access to supplies.

3) Although staff midwife and nurses knew they were out of condoms they never considered re-ordering, or even telling their medical chief they needed a resupply.

4) We returned to the USAID office in Kaolack, gathered up a trunkful of OCs and condoms and delivered them to the Kasnack Dispensary. We made a bulletin board display of condoms and pills and tried to show the staff how they might go about promoting these products.

5) We explained proper condom use and told them that it was important for them to keep the condom strips out of direct sunlight or florescent light— and tell their customers to do likewise.

C. CM (Medical Circle) in Nioro

1. There is a maternity clinic, as part of this central compound, where about 30 babies are delivered each month. We spoke to the 2 midwives who believe many women need contraceptive products (and they sometimes go and tell the husbands, because the women are afraid to do so). They have not kept any records on how many people got free OCs and condoms. Their supplies are now exhausted and they write about 2 to 3 prescriptions per month.

2. They told how some of their condoms had struck together - i.e. they would not enroll without breaking. We tried to find some from that batch, but they were gone.

3. We told Dr. Si (who heads this CM; actually, he's a nurse, but he's an older, respected member of this town and serves as the "doctor" for Nioro District) where to go in Kaolack to replenish his supply of OCs and condoms.

4. One of the Nioro midwives completed a family planning course in Kaolack and is qualified to explain proper use of products to the population.

5. Because of their previous condom problem in Nioro we selected one box of condoms from the USAID Kaolack storeroom which we will take back to the US to test on the PIACT Q.A. equipment.

6. The midwives explained they do not insert IUDs, as they don't feel there is adequate hygiene. Also, the women do not like to have foreign objects inserted into their bodies.

7. This Nioro CM had consumed 2 large cartons of OCs (Blue Lady) over a 15 month period. Dr. Si had also distributed products to his Health Post Chiefs.

8. There are 12 health posts or dispensaries in Nioro district. Each health post is responsible for a number of village health huts (of which there are 110 in Nioro district).

D. Villager Health Post in Paoskoto

1. We visited the dispensary, built with USAID health project funds and the small 4 or 5 bed maternity clinic, built by the villagers themselves.

2. In the village community center building across the road, the male nurse who heads the Village Health Post was giving a monthly P.P.N.S. (protection, nutrition and sanitation) course at the women's well baby clinic. It operates as a women's club. About 18 mothers (all with infants and/or small children) were present. They collect 50 CFA from each woman per child and are saving the money to purchase a baby weighing scale. The nurse gave a talk on proper diet, and grain and milk powder was distributed, courtesy of Catholic Relief.

3. All the dispensaries in this district have similar women's clubs. The nurse agreed it would be an ideal place to discuss family planning and child spacing. He said he had given a talk on this topic at a women's organization in Kaolack and would do so here as soon as supplies were available.

E. Village Health Hut in Gapakh

1. It was almost dark when we visited this village and saw a newly constructed village health hut (part of USAID's rural health project). We met the 3 local part-time employees - a first aid worker, a matron and a sanitation advisor - who have all been trained with the aid of materials specially prepared as part of the project. We were told that just yesterday the matron had shared her "Aide Memoire" with all the women of the village. We asked her if it contained simple Wolof plus pictorial instructions for proper use of pills and condoms. She wasn't sure (as the health huts were not originally designed to stock contraceptive products - but simply 8 or so basic drugs). The Aide Memoire does, in fact, contain pictorial reminders of IUDs, condoms and diaphragms, but not OCs. However, these are much less detailed than other midwives' procedures described in the book and clearly did not serve this matron to maintain a clear understanding of contraceptive delivery - procedures.

7. Thiès

Thiès, one of Senegal's largest cities with a population in excess of 100,000, is also one of the country's eight regional capitals. As this area will participates in Phase I of the GOS/USAID family planning project, we wanted to check existing facilities, talk to medical and paramedical personnel, and collect some information on knowledge and attitudes of the target population.

Since Mr. Bathily, the region's medical chief, had not yet returned from Mecca, we called on the doctor who was substituting for him, N'Doye Assane. He began by telling us that family planning is a very delicate subject here in the Third World. In Thiès there has been almost no information about family planning and where to find services, so many women, rather than contracept, have induced abortion. As though to reinforce this communication gap to which he had alluded, Dr. N'Doye told us there was no

section of this particular health facility, Dixième, offering family planning services. Once outside his office, we made inquiries around the compound and learned that the gynecology section was promoting family planning.

Gynecology Section: Ms. Ba, midwife in charge

1) This clinic sees about 20 new and 20 repeat patients per day. Most come for sterility-related problems; the main problems are syphilis or miscarriages and still-births.

2) At least 15 women a month request family planning services. Most already have many children or are working women. Also, years ago Vincent supplied them with condoms and pills; these were finished about 2 months back.

3) This clinic had a Santa-Cruz trained midwife, but she left the country in June and has not returned.

4) Ms. Ba used to work at the PMI in Thiès where they sometiems gave special talks for the women on child spacing. She would like to go for training and learn how tc insert IUDs.

5) One of her nurses announced that she had 10 children and wanted an IUD but didn't know where to go. At the Thiès Maternity hospital, we learned that the midwife-in-charge inserts IUDs. (If information does not travel through the paraprofessional community, how can we expect campaigns that rely upon word of mouth among satisfied users to get very far?).

Prenatal clinic

1) This clinic is also on the grounds of the Dixième, an old military complex. They used to offer post-natal (infant) services as well, but the facility was overcrowded and so services for mothers and infants are now provided at another PMI near the center of the city. It should provide an excellent location for education and training.

2) When clients request a contraceptive method the midwife writes a prescription. No one there was aware that the gynecology section had been distributing pills and condoms.

3) No one on this staff has yet received any special training in family planning.

Maternity Hospital: Ms. Ndiaye Mame Coumba, chief midwife.

1) This newly renovated and expanded 90 bed hospital (at the other end of town from the Dixième) does at least 20 deliveries a day.

2) Ms. Ndiaye, a Santa-Cruz trained midwife, says she tries to motivate them all to accept a family planning method. Many say "yes" and she tells

them to return in two months; most never do. Since June '78 she has only inserted 17 IUDs, fitted one diaphragm, and has four pill patients.

3) She would definitely like to do an acceptability study using IFRP's postpartum IUD. She prefers IUDs to OCs, as no daily intervention is required.

4) She thinks contraceptive products should also be offered outside a maternity hospital setting -especially one with a gate-keeper (as we have seen in many Senegalese hospitals) who makes you announce your mission before granting permission to enter. Such an atmosphere is not conducive to attracting young unmarrieds.

5) Ms. Ndiaye believes there is definitely a need for family planning counseling and services. "Pills are being sold like bread" to young women in the pharmacies of Thiès.

Interviews with target audience:

While we were talking to service providers, a midwife from Dakar was interviewing women at the prenatal clinic as to their knowledge and attitudes re contraceptive methods and child spacing. As with those interviews done at other sites (Rufisque and Medina), a majority actually expressed an ideal family size (4-6). Only 2 had ever used modern contraceptives (OCs). All respondents were positive or even enthusiastic about family spacing, although one woman (with 8 live children) rejected the idea of spacing - she wanted to <u>stop</u> having babies!

APPENDIX D

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12/12/79

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