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MANAGEMENT DEVELOPMENT PLAN  
FOR  
FAMILY PLANNING MANAGEMENT TRAINING  
IN SENEGAL

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## I. EXECUTIVE SUMMARY

Public family planning services have only recently become available in Senegal as a child spacing measure. Recognition of the adverse health and social consequences of high fertility, high infant and maternal mortality have led to a relaxation of the traditional opposition to contraception often found in Francophone Africa, although strict medical control over distribution remains. The USAID's seven year bilateral Family Health and Population Project has introduced family planning services in six of Senegal's ten regions with plans to extend services to the remaining four regions by the end of the project. The project has provided funds to develop a comprehensive IEC program to promote the use of these services as well as some funds to promote service delivery in the private sector. The FPMT Needs Assessment Team reviewed the operations of the national and regional service delivery structure of the project and identified several key areas in which FPMT training could improve the implementation of program objectives.

Regional teams are responsible for coordinating and delivering family planning services, supplies, and IEC at the regional level and below. FPMT identified the need to strengthen program operations at this key regional level by developing work plans, coordinating the IEC and clinical programs, and generally developing skills in program planning, implementation and control. Supervisory protocols for both the IEC and clinical programs are needed. FPMT has proposed a two phase workshop to address these problems, with the first addressing the problems of regional program implementation and the development of workplans, and the second to develop supervisory protocols, and to follow up on the workplans.

Since public service delivery of family planning is new, utilization of services is still fairly low. Recent trends do indicate a growing demand for services and better IEC programs are needed to direct women to service outlets and educate them about options. The FPMT team identified serious gaps in the current IEC program approach and management. The management issues will be addressed in the above two workshops. Technical assistance in program planning and content has been and should continue to be arranged through Population Communications Services or another appropriate organization.

The Senegalese medical community's conservative approach to contraceptive distribution has inhibited the practical availability of services and supplies to most women. FPMT recommended that a study tour of key physicians and the director of the Pharmacy be arranged to countries with less restrictive policies on contraceptive distribution. It was agreed that this activity would have more impact in later years of the project after service delivery is more widespread and problems are more obvious.

The Centre Africain d'Etudes Supérieures en Gestion (CESAG) was identified as a possible site of a regional training institute for french speaking Africa. Several regional training activities were identified as relevant for several countries in the region. These include a workshop to improve the management of integrated health and family programs. Another workshop will bring together senior managers of African family planning programs to assist FPMT in accurately identifying and developing training course content for the region.

## II. DESCRIPTION OF ASESMENT

In response to a request from the USAID Senegal Office of Health, Population and Nutrition, the Family Planning Management Training Project (FPMT) undertook a needs assessment mission in Senegal from May 19-30, 1986. The purpose of the mission was to work with the Senegal Family Health and Population project to identify problems in program management and to develop a management development plan addressing those problems. A complementary objective of the visit was to assess the potential for collaboration with a Dakar-based regional training organization, the Centre Africain d'Etudes Superieure en Gestion (CESAG).

The assessment team consisted of Mr. Ken Heise, the FPMT Operations Officer for Africa and Asia; Ms. Joan Kaufman, the FPMT family planning advisor; and Dr. James Wolff, a training specialist on the project staff. Mr. Heise and Ms. Kaufman focused on analyzing the Family Health Project's management needs, while Dr. Wolff examined the possibilities for FPMT collaboration with CESAG. Together, and in conjunction with the USAID Population Officer Sara Seims and the Family Health Project Staff, they elaborated a preliminary proposal for management training.

Over the course of the two week visit, the assessment team conducted a series of interviews and group meetings with members of the Family Health Project, the ISTI technical assistance team, representatives of the Ministry of Health and Ministry of Social Development, USAID, CESAG, and other organizations and individuals involved in family planning in Senegal. The discussions served to acquaint the people working in Senegal with the goals of the FPMT, and to identify problem areas in family planning program management which could be addressed through FPMT-sponsored training and technical assistance. A thorough review of evaluation and consultant reports and project documents was helpful in clarifying many of the management problems identified.

Field trips were made by Mr. Heise and Ms. Kaufman to clinics offering family planning services in Dakar and in the region of Thies. Clinic visits permitted the team to examine many aspects of the service delivery program, including patient record and filing systems, IEC materials, patient examination procedures, patient referral systems, patient flow, contraceptive and drug supply management, statistics, and supervision. In Thies, the team also met with the Family Health Project's regional coordinators for clinical and IEC services and discussed with them their responsibilities for coordinating the implementation and expansion of family planning services in the region. The team was accompanied to Thies by the assistant to the director of the Family Health Project's Private Sector Program. The team visited with him the Taiba Phosphate Company Headquarters and participated in discussions with top level administrative and medical personnel concerning the potential health and financial benefits of incorporating family planning services into the health care services currently provided to employees and their families.

Dr. Wolff conducted an assessment of local management training capabilities. Discussions were held with representatives of CESAG, the training facilities were visited, and Dr. Wolff had the opportunity to observe ongoing training activities at the Center. Dr. Wolff was

also able to meet with several CESAG consultant faculty as well as other local management consultants.

The final days of the assessment team visit were spent developing the proposal for management training and discussing it with the staff of the Family Health Project and the USAID Health, Population, and Nutrition Office. During the team debriefing with the USAID HPN Office different mechanisms for funding the proposed training activities were discussed. The mission stated that it would be prepared to cover all in-country costs associated with the proposed training. Subject to approval by USAID Washington, the FPMT project would cover all costs of technical assistance and material's development.

Upon returning to Boston the assessment team and other members of the FPMT project will review and further develop the proposed management training plan and submit a draft proposal of training activities to AID Washington for approval. Copies of the management development plan will be forwarded to USAID Senegal for review by the HPN Office and the Family Health Project.

### III. COUNTRY PROFILE

#### SENEGAL

##### A. ECONOMIC AND SOCIAL INDICATORS OF DEVELOPMENT

###### 1. BACKGROUND

Senegal is located on the Northwest coast of Africa bordering on Mauritania to the north, Mali to the east and Guinea and Guinea-Bissau to the south. The nation of Gambia lies entirely within Senegal's territory. The country is about the size of South Dakota, (200,000 square miles) and is made up of five main regions (Cap-Vert, Sine Saloum, Region du Fleuve, Thies, and Casamance) and ten administrative regions.

In 1985 the population was estimated at about 6.5 million, growing at an annual rate of 3% a year with a population doubling time of 24 years. About 35% of the population is urban based and the population density of the country, averages 33 persons per square kilometer but varies widely, with population density highest at 250 persons per square kilometer in Cap-Vert, but only with six per square kilometer in eastern Senegal.

###### 2. ECONOMICS

The Senegalese economy is dominated by the weight of a large national debt and concomitant questions of balance of payments. The national debt was 27% of the country's total export earnings in 1981. Per capita income is on the order of US \$400 a year. The inflation rate of 10-12% a year will cut this in half by the year 2000. The current urban unemployment rate for adolescents is over 72% for men and 63% for women. The major crop and export of Senegal is peanuts. All cereal grains are grown for domestic consumption, but Senegal still imports a substantial percentage of total food grain needs. Natural resources are few although a growing phosphorus industry is contributing to export earnings. The difficult terrain and the last ten years of Sahelian drought have exacerbated an already difficult agricultural base. Cotton, phosphorus, commercial fishing and tourism are being developed as part of economic expansion plans for the country.

The economy is highly centralized and controlled by the government, although less so than in some of Senegal's neighbors, and with a relatively favorable attitude towards the private sector. Foreign investment in Senegal is large, both public and private. A bilateral investment treaty with the U.S. was signed in 1983 and large amounts of aid for economic development have come from France (major donor), the World Bank, IMF, other European nations, the U.S., Germany, Canada, and OPEC. A multilateral donor group is assisting in the development of the Senegal river basin.

### 3. POLITICS

Senegal achieved independence from France in 1960. The government is a republic with an elected president, currently President Abdou Diouf, head of the Socialist Party. The socialist party advocates a moderate form of socialism based on traditional African concepts which leaves scope for private enterprise and foreign investment.

### 4. CULTURAL AND RELIGIOUS CHARACTERISTICS

Islam is the dominant religion of Senegal (75%). 10% of the population, predominantly among the educated, are Catholics, and the remainder of the population follow traditional African tribal beliefs. French is the official language although only 15% of the population speak it. Another 80% speak Wolof, the major national language of Senegal. The major ethnic groups are Wolof, Serer, Peul and Toucouleur. Traditionally, Senegalese women marry early (average 16 years old) and acquire full social status only after they are married and have children. 83% of married women of reproductive age are married, 48% of these in polygamous unions. As in other countries, numbers of wives and children are symbols of status and wealth, and four wives, each with five or six children is not uncommon. Strict traditional moral codes preclude sex education in the schools.

### 5. SOCIAL CHARACTERISTICS

Adolescent fertility is on the rise in Senegal as in many parts of Asia. Economic factors, especially unemployment, have disrupted traditional patterns in which couples wait until they have acquired enough resources to marry and raise children. The government recently repealed the section of the 1920 French law restricting the sale and advertising of contraceptives, but retained sections of a law prohibiting abortions. Family planning services are now starting to become available in Senegal, but are still inaccessible for most people because of insufficient availability.

Literacy is low in Senegal: 10% for men and only 1% for women, although some persons estimate that over 50% of women can read and write the Wolof language in arabic script. Primary school enrollment is estimated at 48% with secondary school only 12%. Women nevertheless make up a sizable portion of the labor force: 70% of the agricultural work in Senegal is performed by women.

### 6. HEALTH

Health status in Senegal is quite low. Average life expectancy for both sexes is about 43 years, reflecting an extremely high infant mortality rate of 146 deaths per 1000 live births. The death rate of

the general population is twice that of the U.S. at 18/1000; the childhood mortality rate is about 200/1000 or 20% of all children who reach their first birthday do not survive to their fifth birthday. The major causes of death are identifiable as malaria, tuberculosis, measles, and gastrointestinal diseases. All of these are doubtless compounded by inadequate nutrition and poverty. Maternal mortality rates are estimated at 5.3/1000 (U.S. 0.29/1000). Sexually transmitted diseases are a major and growing health problem in Senegal, compounded by the practice of polygamy and promiscuity. It is estimated that 10% of infertility in Senegal is directly attributable to STDs.

## B. DEMOGRAPHIC INFORMATION

### 1. PRESENT DEMOGRAPHIC SITUATION

The total population of Senegal is 6.5 million, with 1.5 million women in the childbearing ages. One half the population is under eighteen. The birth rate in 1983 was 48 per 1000. With the death rate of 18 per 1000 this gives a RNI of 3% a year. The average total fertility rate in 1984 was 7 children per woman. The national contraceptive prevalence rate was estimated in 1984 to be only 4%, although Cap-Vert, with a population of 1.2 million people, has a higher rate of 7-9%.

### 2. POPULATION TRENDS

It is estimated that the population will reach about 9.7 million by the year 2000. Internal migration, especially rural to urban, is high. This is attributable to the worsening agricultural situation due to the drought, and is causing a strain on the already overcrowded cities, especially Dakar.

## C. HISTORY AND CURRENT STATUS OF FAMILY PLANNING

### 1. POLITICS AND ORGANIZATION

Although no explicit family planning policy has been formulated, a family planning program does exist and family planning services are being provided to promote child spacing in the context of maternal and child health services.

A National Commission of Population (CONAPOP) was created, by presidential decree, in 1979 under the direction of the Ministry of Planning and Cooperation. The purpose of CONAPOP is twofold: to assist in the incorporation of demographic and socioeconomic variables into the development planning of the Ministry, and to formulate a national population policy, although adoption of an explicit policy endorsing family planning is unlikely for the moment. CONAPOP has the capability to reach high level decision makers. All relevant ministries are members of the Commission, and in principle should be informed of the results of population research carried out by CONAPOP and other related institutions. However, CONAPOP has not as yet been effective as a catalyst for the development of policies favorable to an expansion of family planning services.

## 2. SERVICE DELIVERY

In 1978-79 family planning services were introduced into some maternal and child health facilities initially in Dakar. ASBEF, the Family Planning Association of Senegal and the IPPF affiliate, opened a clinic in Dakar in 1981. Several public and private clinics in Dakar have also delivered family planning services since the mid 1970's. In 1979, the first phase of the USAID Family Health Project was signed with the Government of Senegal and in 1982 the introduction of public sector family planning services to regional health centers began. Twenty two clinics in six regions were established during phase I of the project. The second phase began in 1986, and there are plans to expand service delivery to 106 more clinics nationwide by the end of the project in 1992. The project which is under the administrative control of the Ministry of Social Development is the institutional arrangement through which FPMT will operate in Senegal and is described more fully in later sections of this report.

In most cases clinical services are provided in both the public and private clinics by trained nurse midwives. Services offered include IUDs, oral and injectable contraceptives, provision of some barrier methods, diagnosis and treatment of STDs, and infertility services. Sterilizations are rare in Senegal. Extensive lab tests are required before OCs are prescribed. Contraceptives are available at pharmacies on a prescription basis. Some brochures are available at the clinics, but in general outreach IEC for family planning is limited. Some activity has begun under the auspices of the Family Health Project to introduce family planning IEC through the MSD mass mobilization infrastructure. A more detailed description of ASBEF, and the Medina Clinic (public) are described below.

The Ministry of Health's Department of Maternal and Child Health includes a Division of Family Planning which reviews and approves all clinical training and administrative aspects of family planning service delivery in Senegal. The regional family planning centers are responsible to the Division through the chief medical officer of the medical region.

## 3. DONOR SUPPORT

UNFPA has been active in Senegal since the late 1970's. A Family Welfare Project begun in 1982 was designed to strengthen MCH/FP services and to promote their integration. In fact most assistance to date has been for ORT and immunization, in keeping with the self-identified needs of communities the project is working in. UNFPA plans to introduce family planning activities during phase two. Some assistance is also being provided for population and development planning activities under the Ministry of Planning.

AVS, FHI, FPIA, IDRC and IPPF have had small cooperative programs. The IPPF affiliate, ASBEF, was described above. Pathfinder assisted the Croix Bleue private family planning clinic in Dakar during the 1970's but is not active in Senegal at the present time. CEDPA has an alumnae association in Dakar and has plans to begin several small

## Association Senegalaise pour le Bien-Etre Familial (ASBEF)

ASBEF is the IPPF affiliate and the major non-governmental organization involved in family planning activities. The Association aims to increase public awareness of the advantages of family planning; to help in the training of governmental personnel; and to collaborate with other agencies interested in family planning, with a view to integrating family planning with other development activities. It runs projects in information, education and communication throughout the country, and has operated a clinic at the Association's headquarters since 1981, with another one recently opened in Lugar and one planned for Kaolac in the south. A small experimental CBD program for OCs and condoms has been initiated in the densely populated Pekine district of Dakar. ASBEF trains personnel at the Dakar model clinic for other family planning clinics in Dakar including personnel for the Family Health Project clinics.

The ASBEF board of directors is composed of leading Senegalese doctors, journalists, women's leaders, and other influential people. The role of the board is to develop policy, gain approval for family planning at top government levels, and to approve the ASBEF work plan. Assistance has been provided to ASBEF in the past by UNFPA and Canadian and French bilateral agreements. An upcoming loan from the World Bank will support technical assistance for the resolution of some management problems. Self identified management training needs include donor reporting, stock management, and financial management. Some ASBEF activities may be supported by the private sector component of the Family Health Project.

## Protection Maternelle et Infantile (PMI) de Medina

The largest of the three clinics, with an estimated caseload of about 2000 family planning clients, PMI is a government MOH clinic supported by the Family Health Project and situated in the densely populated urban center of Dakar. The clinic is a separate section of a larger MCH facility. Established in 1976 and funded through support from USAID and UNFPA, the PMI/FP clinic principally offers IUDs, standard-dose OCs, and condoms, all at no charge. Low-dose pills are available when standard formulations are contraindicated. Female barrier methods are available but infrequently used. The supply seemed adequate by the time of the FPMT Needs Assessment. Services are provided by trained MOH midwives (sage-femmes) under the supervision of a physician who directs the PMI. The clinic is open 6 mornings a week.

There were approximately 4200 patient visits to the clinic in 1983. Average daily case load during the time of the Needs Assessment visit was twenty visits a day, with 3-4 being first visits, and the remainder follow up. IUD acceptors are required to return after one month for the first follow up visit, and every three months thereafter for a regular check up. At the time of the FPMT team visit, the pill had become the most popular method among young acceptors with the IUD favored among older women.

There has been some concern in Senegal about the large number of IUD acceptors with so high a prevalence of STDs in the country. The clinic is also a site for diagnosis and treatment of Sexually Transmitted Diseases. All first time visitors are required to undergo an extensive series of lab tests both for STD's and for OC prescription if desired. Since no lab facilities exist at the clinic, the lab tests are sent out at a charge to several labs in Dakar. Some family spacing information and contraceptive brochures are available to women who come into the clinic, but it was notable that no outreach IEC was being done to the literally dozens of women waiting for MCH services in another section of the same hospital facility.

primary health care/family planning and income generation/family planning projects. Larger family planning projects are anticipated for the future under a large worldwide block grant to CEDPA from USAID's Office of Population. Columbia University recently began an operations research project in family planning with the Ministry of Health, and has a resident advisor in Dakar.

USAID has been the major donor in family planning in Senegal. Phase I of the Family Health Project began in 1982 with training for service delivery and IEC and limited family planning service delivery. The second phase Family Health and Population Project which began in 1985, will last for seven years, and plans to reach 200,000 couples by offering services throughout the country. The Phase II project is the institutional arrangement through which FPMT assistance is to take place.

#### 4. TRAINING FOR FAMILY PLANNING PERSONNEL

A substantial amount of personnel training took place under Phase I of the Family Health and Population Project for personnel of both the Ministry of Social Development, which handles the IEC portion of the program, and for the clinical personnel who deliver services through the Ministry of Health's PMI clinic system. This training is described in greater detail in later sections of this report. A complete list of personnel trained under Phase I of the project is attached as Annex 2.

The nurse midwife is the key provider of family planning services in Senegal and is responsible for gynecological examinations, assisting in the choice of contraceptive methods, insertion, follow-up, and removal of IUDs, detection of sterility, genital and mammary cancers, and sexually transmissible diseases. A training program for the nurse midwives in family planning will soon be introduced in the School of Midwifery. This pre-service training is supplemented by an active in-service training program in family planning under the auspices of the second phase of the Family Health Project, and other donors, like IPPF, through the ASBEF clinic.

#### 5. ATTITUDES TOWARDS FAMILY PLANNING AND OBSTACLES TO USE

Lack of knowledge about contraceptive methods as well as reticence from the medical profession and the Islamologues are the important factors mitigating against wider acceptance of family planning. Nevertheless, the religious leaders are pro health and have generally supported child survival programs, which may include child spacing. The requirement of permission from the husband for a woman to visit a clinic, expensive lab tests, and strict control over contraceptive distribution, doubtless reduce availability and access to services. Service outlets themselves are for the moment limited to Dakar and the regional centers, limiting access for rural women. Competition among the wives for status in the husband's household is related to desire for sons by women and high fertility; in fact, one indication of wealth is the number of wives and children in the household.

A study examining contraceptive use among clients at three FP clinics in Dakar in 1983, reveals that most clients first became interested in family planning following the birth of a child, and that most are interested in spacing future pregnancies, although 1/3 state that they want no more children. Nearly 1/2 of clients interviewed said that a lack of knowledge about contraception is the reason for low contraceptive prevalence rates among Senegalese women; another frequently cited reason was the opposition of the husband. Most clients reported the broadcast media to be the best means of providing family planning information to potential acceptors. However, few women had received clinic-specific information from the media. Depending on the clinic, clients had learned about the clinically-provided services through a friend or relative, or from a doctor or nurse. At each clinic, fewer than 10% stated that the husband was the best source of family planning information. While contraceptive knowledge is low, it did increase four times in four years from 14% in 1978 to 59% in 1982 in Sine Saloum, according to a 1982 Survey. The same survey concluded that an average of 20% of all pregnancies were involuntary or unwanted, that this percentage increased with age, and that of a sample of women interviewed, 26% did want another birth, with 42% of these women wanting to space that birth, and another 8% not desiring any more births at all. These data point strongly to the need for a strong, outreach oriented IEC program, aimed at informing women how to space births and where to obtain services.

## 6. LAWS AND REGULATIONS RELATED TO FAMILY PLANNING

Abortion is permitted only to save the life of the mother and the performing physician must receive written certification from two other doctors. It is a criminal offense to "provoke, by various means (e.g. posters, books, announcements, etc.) the crime of abortion or to distribute abortifacients."

The legal status of sterilization is ambiguous since there are no explicit provisions for it covered in existing laws. Voluntary sterilization for family planning purposes is rare, being employed only rarely by women with large families. Islamic leaders do not approve of sterilization and medical professionals will recommend it with great hesitation and only when the life of the mother would be threatened by another pregnancy.

All contraceptives, including barrier methods are considered pharmaceuticals and subject to the same strict import and licensing procedures as any other pharmaceutical products. The manufacturer must submit a dossier which provides background information on previous analytic, toxic and pharmacologic and clinical studies. All products must be approved for sale in the country of manufacture (this could pose a problem with Depo-provera and Norplant), although some exceptions to this rule are allowed. This information is evaluated by the Pharmaceutical Commission of the Ministry of Health and visa approval granted or denied. Senegalese drug standards are closely tied to the French system. The Director of the Pharmacy claimed that condoms were exempt from the visa acquisition process, although USAID said they did not believe that the case.

Distribution of contraceptives is regulated by the Director of the Pharmacy of the Ministry of Health. His office decides which drugs can be sold over the counter and which require prescriptions (for the moment OCs require a prescription and could not be distributed through a CBD program). All drugs must be marked with expiration date and color coded as to who is authorized to dispense. Drugs for the Public Sector are ordered through the National Pharmacy (PNA), and State hospitals must order 75% of their pharmaceutical requirements this way and clinics 100%. Private sector pharmacies supply themselves through three major distributors. The Ministry of Health is currently working with the World Bank to set up a system of regional pharmacies in an attempt to decentralize and make the distribution system more responsive.

Advertising of contraceptives is now allowed. A law of 24 December 1980 expressly repeals the French law of 1920 which prohibited propaganda for contraception. Sex education in the schools is not prohibited but is virtually nonexistent. The Ministry of Social Welfare has the responsibility for coordinating the sex education program. Expected resistance from religious leaders has stifled initiatives to introduce even limited family life education into the Senegalese school system. Some informal overtures have been made by the Family Health Project with occasional lectures presented in Dakar schools.

A legal age of marriage was introduced in 1979. It is 20 years for men and 16 years for women.

#### IV. THE FAMILY PLANNING ORGANIZATION

##### A. Overview of the Family Planning Organization:

##### 1. Project Description and Organizational Background

The Senegalese Family Health and Population Project (PSF) began in 1983 and is a \$27.4 million, seven-year USAID project with two aims: to improve the health of Senegalese women and their children and to help achieve population growth rates compatible with Senegal's capacity to provide basic health and social services for its people. The project is administered by the Senegalese Ministry of Social Development, with clinical aspects under the direction of the Ministry of Health. Stated objectives are to:

- o Improve the capacity of the governmental and non-governmental sector to provide safe and effective contraception to 15% of married women of reproductive age (approximately 200,000 couples);
- o To provide comprehensive support to Maternal and Child Health (MCH) services, including the detection and treatment of sexually transmitted diseases and infertility as well as the provision of integrated family planning and health services at the community level;
- o To improve the demographic data base so that more effective development planning can take place;
- o To increase the awareness of policy makers, planners and the general community of the impact of rapid population growth on development.

Approximately two-thirds of the USAID contribution goes to the support of the government's family planning effort. This support includes over \$2 million earmarked for clinical, management, and IEC training both in-country and overseas; \$1.4 million for contraceptive commodities; \$1.7 million for IEC materials, clinical equipment and medications; and \$1.5 million for encouraging family planning services in the private sector. A small amount of funds are set aside to support local women and development projects to support family planning. The government of Senegal is covering all domestic costs of the project, an estimated \$7.4 million or 26% of total project costs. Approximately 20% of all rural health posts are to be renovated and equipped for family planners by the end of the project.

The current project was preceded by a three-year Phase I project during which family planning services were made available at 22 health centers in six of Senegal's ten regions. The IEC component of the project in Phase I was mostly directed at publicizing the project and generating support for it at the national and regional levels. Additionally, IEC services were made available in several Ministry of Social Development (MSD) facilities, which were renovated and equipped with project funds. Staff were trained at the national level and in the six regional levels for the provision of clinical and IEC family planning services.

The second phase of the PSF project, which began in 1985, will expand to another 106 centers by the end of seven years. For the first four years the MSD/MOH project will concentrate on the current six regions of activity. During the remaining three years of the project, service delivery will be expanded by the joint program to cover the whole nation. The plan is to expand service delivery in ten health centers/health posts annually for the first four years of the project and in 22 centers/posts annually for the last three years of the project. At the same time, the project will support and assist family planning service delivery by private health care providers and private enterprises which employ over 100 persons and are legally required to provide health services to their employees. Extensive IEC efforts will be developed to support both public and private-sector service delivery.

The Ministry of Social Development has set up a project office under its jurisdiction to execute and administer the project. The project staff consists of a director, financial administrator, logistics officer, two national IEC coordinators, and a national clinical coordinator.

The project office is advised by a resident technical assistance team from ISTI (International Science and Technology Institute) which consists of a chief technical advisor, a clinical advisor from the American College of Nurse Midwives, a national clinical supervisor, a logistics liaison officer, a director of private and para-statal activities and his assistant. All technical posts for the team have been filled, but various start-up problems have been experienced. The USAID mission believes that the Family Planning Management Training Project (FPMTP) can help lay the groundwork for technical collaboration which will be taken over by the ISTI resident team as soon as it becomes feasible.

A chart denoting the relationships of all organizations involved in the project is attached as Annex 1.

Regional teams are responsible for project activities at the regional level and below. The regional director of the Ministry of Social Development and the regional Medical Director are responsible in principle for PSF activities. The regional MCH coordinators personally supervise clinical aspects. Major responsibility for clinical matters at the regional level belongs to the regional clinical coordinator for the project, a nurse-midwife. She directly supervises the regional clinics and personnel delivering family planning services under the project. IEC matters are the responsibility of the IEC Coordinator who works under the Ministry of Social Development's regional director. She supervises community level activities in her region, and she works through the MSD's mass mobilization network in the communities.

As the project continues, it is envisioned that clinical services will be extended down below the regional level to district and arrondissement levels.

## 2. Organizational Structure and Decision-Making

As stated above, the Ministry of Social Development is the government organization in charge of the Family Health Project and it is under this Ministry that the project office operates. Clinical aspects of the project are under the jurisdiction of the Ministry of Health (MOH); technical responsibility for the IEC portion of the project falls to the MSD which has a mass mobilization infrastructure throughout the country. Coordination of these two vertical government ministerial hierarchies has proved a major challenge in the implementation of the project.

Technical assistance to the project was provided by the Research Triangle Institute during the first phase. The phase two technical assistance contract was awarded to ISTI, which, as described above, has assembled a team in Dakar to advise the PSF office. Since the second phase got off the ground only about six months ago, the ISTI team role is not yet clearly defined. While responsible in principle for management and IEC advising to the project, ISTI has thus far concentrated its technical assistance to clinical training matters. The ISTI technical office is housed in a separate facility several miles away from the project office, making project communication difficult. The paucity of general staff meetings among the clinical, IEC, and TA teams has also contributed to coordination and communication problems. In recognition of the need for better internal communication, regular staff meetings for the teams were instituted, but they have been held rarely in the last several months. It was noted by one participant that regular meetings may be unwelcome because large meetings in Senegal tend to last for several hours, taking up more time than busy people can spare.

The project is directed by Mr. Ousmane Samb. He is assisted by a logistics officer and a financial officer. All three received management training either in Santa Cruz or at the Management Sciences for Health 1985 Morocco course during phase one of the project. The project director has also participated in study tours to Mexico and Colombia to observe the management of the family planning programs there. Two national IEC coordinators also work under Mr. Samb. They are responsible for coordinating all project activities in IEC at the national and regional levels, including materials development, and audience analysis and communication planning. They both attended the first IEC training course offered by Santa Cruz in 1985; neither were satisfied with the preparation by the training staff for the course. The national clinical coordinator, Marie-Victoire Albis, is a nurse-midwife. She attended a Santa Cruz training course in the management of family planning and health projects in 1984, during the first phase of the project.

Decision-making is centralized in the project director's office in Dakar. His office sets an overall annual workplan (Annex 2) for project activities and keeps track of the achievement of objectives of the project every six months (Annex 3). These activities are communicated by his staff directly and

often personally to the regional personnel involved in the project: for clinical matters by the clinical coordinators, for IEC matters by the IEC coordinators, and for supply matters by the logistics officer. Occasionally the regional coordinators meet on an ad-hoc basis to coordinate their work. No real regional workplans exist, only a general idea of work responsibilities for the coming period. This ad-hoc approach seems to work better for the clinical coordinators than the IEC ones, perhaps because technical advising has been stronger in this area.

For the moment, because the project involves only 22 clinics in the six regions, the hierarchical flow of information through personal communication has not caused major problems, but as the project expands during the next seven years this approach will clearly not be adequate. In contrast the lateral flow of information in Dakar between the ISTI office and the project office does not work very well. This is a result of individual personalities, of the insufficiently developed role of the ISTI office, and of the physical separation of the two offices.

The French bureaucratic tradition has left a legacy of layers of formality and hierarchy in administration which sometimes impedes the flow of information. A strong tradition of the need for consensus often inhibits debate on issues. Added to this is the problem of lack of coordination and even competition between the two ministries responsible for the project. Regional coordination on an ad hoc basis is not adequate to manage personnel and for good coordination between the two technical areas. The physical separation of the two operations regionally, and the as yet weak role of ISTI which itself is physically separated from the project office, has created a fragmented system of operations with uncoordinated work plans at all levels, but particularly the regional one where most services are delivered.

### 3. Financial Considerations

The Senegal Family Health and Population Project is funded at \$27.4 million, of which USAID will finance \$20 million and the Government of Senegal \$7.4 million, or 26% of project costs. The allocation of these funds by type of activity is presented earlier under "Project Description and Organizational Background." The government contribution will be chiefly in the form of personnel and facilities for project services. Annex 4 below details the percent distribution of the USAID contribution by major line item, and Annex 5 presents an estimate of the distribution of the government contribution by major category. The government will also contribute space for family planning services in regional and national hospitals and labs for use in the Infertility and Sexually Transmitted Disease project component.

USAID financial reporting procedures are followed, with the PSF submitting quarterly budgets to the USAID office. These are prepared by the

project's financial officer. ISTI likewise accounts for its funds according to USAID procedures. Annual budgets are estimated directly from the annual work plan for the project by the project financial officer, according to several major line items. Vouchers for expenses are submitted to ISTI which makes payment accordingly. The project can acquire funds for activities not specified in the workplan by submitting a justification to USAID directly. All contraceptives are provided free from USAID. Mechanisms for financial control below the national level have not been instituted, and there does not appear to be a clear plan to do so. This is presumably because staff time is provided by the various ministries involved in the project as part of their regular regional operations; commodities are provided free from the project, and other recurrent costs are absorbed by the MOH and MSD regional budgets.

Virtually no revenue-generating activities occur under the project. All services and supplies are provided free and covered by the USAID, government, and individual ministry budgets. (One exception is lab tests required for oral contraceptive prescription which are sent out to private labs for analysis. It was not clear whether the client is always responsible for paying for these sometimes costly tests, which could clearly be a disincentive to the use of OC's.) In general, fundraising is not really a consideration at this stage of the project. The program is small and the budget covered by USAID and the GOS for the next seven years.

## B. Planning:

### 1. Strategic and Operational Planning

Clearly stated project goals and operational objectives exist and are stated in the project paper and presented under Project Description and Organizational Background above. A stated concern of the ISTI team is the need for expansion planning: to make the transition from a small project covering only 22 service sites to a more complex project with 106 sites and many new acceptors. Another stated problem is that the overall project goal to reach 200,000 acceptors has not been translated into tangible operational tasks for the various groups of personnel involved, especially the IEC and clinical coordinators at the regional level. Such an operational plans might include targets by regions, workplans to reach these targets, and a plan for assessing progress in reaching them.

### 2. Policy Formulation

All contraceptives, including condoms and barrier methods, are classified as pharmaceuticals. This practice subjects contraceptives to a strict set of controls which preclude non-clinical distribution strategies, putting contraceptive use beyond the reach of all but the most highly motivated women.

Currently no official population policy exists in Senegal. There has been historic resistance to promoting family planning on several fronts, most notably from the medical profession trained under the French colonial pronatal tradition. Some members of the GOS have also been opposed to promoting non medical delivery of contraception, calling such

practice "contraception sauvage" and wish to retain strict control over the policies governing contraceptive use in the country, ostensibly to protect Senegalese women from the health risks of steroids and IUD's. Permission for a woman to use contraception must be obtained from the husband; then a prescription as well as an extensive and expensive series of lab tests are required to obtain the pill and IUD.

During the first phase of the PSF project, education activities directed at both the medical community and the Islamologues were initiated. Several senior doctors were sent abroad under the project for family planning clinical and management training, while national and regional sensitization campaigns were directed at the Islamologues to promote the benefits of child spacing to maternal and child health.

Despite these efforts, along with supportive statements by the president of Senegal in support of a population policy, no such policy seems forthcoming. Family planning remains controversial and sensitive for the reasons stated above.

### 3. Program Planning

The project's operational objectives form the basis of annual workplans (attached) at the national level for the project office. No workplan for ISTI or the regions has been formulated yet. It appears that at the regional level work is handled as the need for it arises or as it is communicated from the national project office. There are as yet no standards to which the nurse-midwives can compare their performance. All these problems point to the need for detailed coordinated regional workplans for the IEC and clinical operations of the project.

In general clinical plans seem to be better implemented than the IEC plans, but for both components, the lack of clear planning oriented towards outputs leads to a crisis management style. Coordination of planning is especially weak, although a few coordinated activities have been planned (combined training; standardized forms for MIS and contraceptive logistics systems in the public and private sectors). As stated earlier, a coordination meeting between the MSD and MOH takes place only every three months. There is little formal coordination among the funding agencies, although some informal information sharing takes place. Since the MSD coordinates all population activities, any more formal mechanism should be through them. JNFPA's large family welfare project for the moment provides no family planning services, but does plan to do so in the future and will require close coordination.

#### C. Program Management:

##### 1. The Approach to the Clients

###### a. Community Participation

The low demand for child spacing services has increased in recent years, but lack of information about outlets for family planning has been at least partly responsible for the low contraceptive prevalence rate in Senegal. To counteract this problem, another strategy of the PSF project has been to organize women's groups at the community level; through the existing mass mobilization apparatus of the MSD, the project is attempting

to provide family planning IEC to these groups of women. This work is the direct responsibility of the regional IEC coordinator and of several instructors who work under her, each of whom covers five villages. Two-week IEC Training courses are being held in each of the regions by the national IEC coordinators to train the instructors in IEC techniques, as well as to educate and involve local leaders. The instructors and local organizers under them receive basic training in clinical and IEC aspects of family planning and then organize groups of about 200 women to discuss child spacing and other health and nutrition matters. In the course of these discussions, women are presumably directed to the nearest PMI offering family planning services. The instructors for an entire region meet irregularly with the family planning coordinators to discuss regional needs. An area of concern voiced by one MSD regional director was that the local instructors must constantly respond to new programs, and need time and training to adjust to each change.

The MSD has also identified over 200 local women's groups of various sorts, including income generation groups, to whom they feel family planning IEC should be provided, adapted appropriately to the audience. Since the project does have some money allocated specifically to Women in Development (WID) activities, this is an area to be developed. Many people commented that individual women talking to their friends are the most important source of new clients at the clinics.

#### b. Client Public Relations

For the moment, the public profile of the program is low. While most women seem favorably inclined towards child spacing once they hear about it, opposition from the Islamic religious leaders remains. Phase I of the project focused on promoting awareness of the Family Health Project to government and religious leaders. Phase II will concentrate on promoting the project to local leaders and to stimulate demand for services at the local levels through radio, T-shirts, keychains, and other consciousness raising techniques.

## 2. The Service Delivery System

### a. Strategies for Service Delivery

As discussed previously, free public family planning services for child spacing are currently provided in the PMI (Protection Maternelle et Infantile) in Dakar and in regional health centers in six of ten regions. Private physicians and clinics also provide services on a fee-for-service basis. Clinical services offered include IUD's, oral contraceptives, injectables, barrier methods, diagnosis and treatment of STD's, infertility services, and infrequently female sterilization by referral to a local hospital. Family planning is integrated into maternal and child health services in terms of rationale as a child spacing strategy but actual service delivery is often separated with family planning services at separate hours, and often in separate facilities. Although the target group for services is essentially all women in the childbearing ages in the region served by the PMI, there is little or no recruiting of women coming to the clinic to receive MCH services.

At this time, no community-based non-clinical service or supply delivery programs exist, other than a small experimental CBD program carried out by ASBEF in a crowded Dakar district. Supplies are provided free at the PMI clinics, and are also available by prescription for a fee at many pharmacies.

Phase II of the project includes plans for an extension of family planning services into the private sector. Factories and other commercial enterprises will be supported in introducing family planning services into the health clinics, legally required of all enterprises with over 100 employees. The rationale will be partly based on the potential cost savings to the employer, who must provide health services to the families of the workers, which can be quite large with several wives each with four or five children. Many enterprise health clinics also provide services to the local populations. Five enterprises will introduce family planning services in 1986, and a total of 20 will be supported by the end of the project. Provision of contraceptives to employees will be taken over by the enterprises after project support ends. A private commodity distribution company in Senegal (SONADIS) has been contacted and has expressed interest in contraceptive distribution to pharmacies and other outlets, pending deregulation by the Office of the Pharmacy of the MOH.

Coordination between the private and public components of the project will take place through the national project office. Standard report forms have already been introduced into the public clinics, and the same forms will be provided to the private clinics. For the moment, there appears to be little or no coordination between the public-sector program run by the PSF and the various private physicians and pharmacies providing services and supplies in Senegal.

#### a.1 Service Mix

Actual data on numbers and percentages of users by method of contraception were not available. The most popular methods are IUD's for older women, and pills and injectables for the younger acceptors.

#### b. Service Providers

Clinical services at the health centers are delivered primarily by trained nurse-midwives. The nurse-midwives are specially trained to be family planning service providers but also provide general MCH care. These nurse midwives are described by many as the dynamic force in the family planning program, and seeing them in action confirmed this. They are highly committed and perform essentially all family planning procedures -- methodconsulting and advising, followup, and distribution -- with minimal medical supervision. These nurse-midwives are salaried personnel of the Ministry of Health who have received special in-service training in family planning under the auspices of the PSF. IEC services are provided by instructors working under the MSD's mass mobilization network, which is described in more detail under "The Approach to Clients".

#### b.1 Personnel Training

Under the first phase of the project, virtually all the national project staff and all the regional IEC and clinical coordinators were trained in

technical and management skills. Some nurse-midwives at the regional and PMI clinic level were trained in clinical family planning. A list of persons trained under phase I of the project and the type of training they received is attached (Annex 1). The project budget contains \$2 million for training in Phase II. The strategy is to train an additional 300 nurse-midwives who will provide services in the health posts supported by this project, and to train the faculty of the School of Midwives, so that they will integrate family planning into the curriculum into the general curriculum. 350 IEC outreach agents will be trained in family planning IEC techniques, and appropriate training will be integrated into the curriculum of the National Training Center for Extension Agents under the Ministry of Social Development. General training on integrated health and family planning services and STD's will be provided to the regional chief doctors and MCH coordinators. Clinical training includes both pre-service and in-service programs. At this time there is no formal system for evaluation of training. For clinical personnel, ad hoc supervisory visits serve as a means of evaluating skills. For the IEC workers, there is an obvious gap between training and the implementation of an effective IEC program.

### b.2 Supervision

Supervision of the nurse-midwives is the responsibility of the regional clinical coordinator of the PSF project. She tries to visit once a month the nurse-midwives under her jurisdiction. These visits serve to promote on-the-job training; answer questions about stocks, forms, and clinical problems; and do examinations herself. The regional coordinator the FPMT team visited also performed clinical services in the regional PSF clinic. She is technically under the supervision of the regional medical director of the Ministry of Health although no formal supervisory visits seemed to occur. Periodic visits by the national clinical coordinator to the regions serve as a more formal means of supervision for the clinical coordinators.

Several problems in the supervision system were identified. A lack of transportation often interferes with the scheduling of visits, although we were told that vehicles specifically designated for supervisory visits will be provided soon. Another, more serious, problem is the confusion by both supervisors and their supervisees as to the purpose of supervision, which is often interpreted as evaluation of performance rather than as a constructive trouble shooting opportunity. No supervisory protocols exist, which certainly contributes to the confusion. A plan to combine the responsibilities of the clinical coordinator with those of the regional MCH coordinator was mentioned; this should be carefully evaluated in terms of task coordination and management of the various responsibilities the MCH coordinator already has.

### 3. The Referral System

Most family planning services are delivered on an out-patient basis in the PMI's and regional project clinics. The PMI visited in Dakar had an attending physician who visited the clinic twice a week to deal with more complicated cases. Complicated cases are presumably referred to the nearest hospital.

#### 4. Public Education and Motivation

Development of an effective IEC program for family planning comprises nearly half the activity of the Family Health Project. The approach is twofold: providing information in the clinics to acceptors of contraception, and mounting community-based education and motivation programs to reach new acceptors. The IEC program organization is described above (C.1 The Approach to Clients.) Media approaches to date have included information spots on local radio messages and posters, and the production and distribution of five types of posters with messages about the economic costs of large families, the health benefits of child spacing, and the infertility consequences of untreated STD's. Current media production is concentrated on the development of flipcharts and brochures for use in the clinics by women who have already accepted a contraceptive method.

The media approach is weak, with virtually no market analysis and strategic planning done for the IEC campaign. Efforts are directed at women who already have accepted, rather than reaching women who do not know of services and outlets. A recent DHS survey will soon yield information on attitudes and practices towards contraception and should be used for IEC strategic planning. Knowledge of family planning services is growing in at least one region as demonstrated by the dramatic increase in those who knew of a method in the Sine-Saloum region between 1978-82 from 14% to 59%. Despite this increase, only 5% knew of an outlet for the method in 1982, suggesting that IEC programs need to concentrate at least partly on directing women to service outlets.

The FPMT team met with a consultant who had developed extensive culturally acceptable and appropriate nonliterate ORT materials for use in village health education campaigns, and who had experience and interest in family planning materials development as well. Utilization of this in country expertise in materials development is advisable, and integrating child spacing motivation into overall child survival health education campaigns is probably a good route to pursue.

A recent IEC evaluation by PIACT and AED pointed up several serious gaps in the IEC program, including a lack of training for the grass roots workers, too little emphasis on extension programs, and a general weakness in overall planning and administration of the program. The evaluation team recommended a stronger role for ISTI in addressing these problems. While an overall national IEC workplan does exist, no regional plans have been formulated.

#### 5. Key Management Support Systems

##### a. Logistics

All contraceptive supplies for the PSF are provided by USAID. They are stored centrally in a warehouse in Dakar and delivered to the PSF clinics by the project logistician during his regular supervisory visits. As the project only covered 22 centers during the first phase, this distribution approach worked adequately; no center visited reported stockouts of contraceptives, although other supplies were often insufficient. This supply system depends on a monthly report of consumption and stock on hand.

A recent visit by a logistics consultant from the CDC made recommendations to accommodate the needs of the expanded numbers of centers in Phase II of the project. These recommendations include establishing a system of regional warehouses with a six week buffer of supplies, under the supervision of the regional clinical coordinators, and providing supplies to centers in the regions using regional vehicles as part of the coordinator's supervisory visits. The coordinators would be responsible for requisitioning their supplies from the central warehouse. The monthly report would be replaced by a quarterly report so as to ease the reporting requirements on the clinical staff. The second recommendation has already been instituted, but the status of the plan for the regional warehouse system is unclear, although the topic is under discussion.

In general, the current logistics system appears to work satisfactorily but will most likely be unable to accommodate an expanded program without some modification. Some problem with expired pill cycles was reported, with a shipment received too close to the expiration date. Since contraceptive acceptors are still fairly few in number in Senegal, there is current oversupply of some contraceptives has added to this problem, with the project reporting current stocks of 40-50 months. Phasing of ordering and importing contraceptives should be undertaken by the ISTI technical assistance team which is in principle responsible for drug procurement. In general there does not appear to be any demand forecasting based on estimates of current or projected use. The soon to be published report of the recent nationwide Demographic and Health Survey for Senegal could be used as a baseline for this purpose.

Private-sector distribution of contraceptives is regulated by the Director of the Pharmacy of the Ministry of Health and follows the system described earlier in the section of this report Distribution Regulations. Most contraceptives available in pharmacies are French products, and can only be obtained by prescription.

#### b. Human Resource Development and Management

Personnel for the project and the training they have received are described in earlier sections of this report Service Providers. The project office and the ISTI technical assistance team were set up specifically for the implementation of the project, with clinical and IEC personnel at the regional and national level seconded from the Ministries of Health and Social Development. All key personnel were trained during Phase I, but little followup or training evaluation has taken place. Turnover of trainees was identified as a serious problem, especially of the clinical staff trained with project funds and then relocated by the Ministry of Health to clinics in places not served by the project.

#### c. Financial Management

Financial management of the project follows standard USAID procedures for the USAID portion of the budget. Since the government portion of the budget mostly covers salaries of staff paid for by the respective Ministries, accurate accounting of costs is difficult. An overall project budget and annual budgets are the basis for expenditures, and vouchers are submitted to ISTI for payment.

#### d. Management Information Systems

A rudimentary management information system has been instituted for the project. Information on commodities used and on hand at each clinic is sent to the national project office every three months. A copy of the reporting form is attached. Monthly Activity Reports (Annex 7) for each clinic convey information on active users. These reports are compiled from three forms (Annexes 8, 9, 10) family planning, STD, and infertility consultation forms which are the basis of the clinic patient record system. The monthly activities report summarizes the number of active users in each clinic by method of contraception, and records all visits for STD's and infertility. The regional reports are summarized by the project office into a monthly country-wide statistical report.

It was not clear how these reports are used at the national office, and it was stated that they are not used at all at the regional levels. Obvious uses would be a comparison of clinic performance, with feedback to the regions; forecasting of commodity needs based on trends in acceptors in each clinic; or identification of personnel training needs by looking at current service demand. Training in the management use of service statistics is a clear need. Some clinics were using an additional form which collected background data on patient socio-economic and demographic characteristics, presumably for studies at a later date. This information could be useful for planning IEC program messages and identifying target audiences.

The clinics use a color code method of filing, with a different color for each method accepted. This system seems to work well for the moment. The information on active users is pulled manually from card files which are organized by month of followup appointment. As the number of clinics and acceptors increases, this system may become unwieldy, and plans for automating and reorganizing the filing system have begun. Data are computerized at the national project office. The project logistics and information officer, who attended an MSH MIS training course in Morocco, appears competent in data entry and processing and seems able to handle the current system. As the project expands, he will clearly need assistance. A suggestion has been made to reduce the paperwork of the clinic nurse-midwives who are burdened with large reporting requirements and a non-automated system in addition to their clinical responsibilities. A more efficient plan for the use of the data currently being collected is probably the place to start.

## V. TRAINING INSTITUTIONS

### A. Institutional Context

During the needs assessment visit the assessment team had discussions with CESAG, the Centre Africain d'Etudes Superieures en Gestion. CESAG had been recommended as a possible regional training center and the assessment team explored the feasibility of using CESAG as a regional training institution.

CESAG was created by the Ministers of the West African Economic Community with the purpose of enlarging the role of the Ecole Superieure de Gestion des Entreprises (ESGE) in Dakar so that it could serve the needs of the entire West African Community. It has a large part-time faculty drawn from private enterprise and a permanent faculty engaged full time in teaching, research, and consultation. It offers degree and non-degree programs of varying lengths primarily to members of the West African Economic Community. In addition to seminars and short training courses, CESAG offers an MBA degree equivalent, "Le Diplome Superieur de Gestion des Entreprises". Courses include MIS, Marketing, Financial Management, Personnel Management, Communications and Public Relations. CESAG's objectives are to train managers of public and private enterprises and regional administrators; to become an in-service management training institution; to train trainers for regional management training institutions; to provide consultancies to public and private enterprises in management and administration and to training institutes in management training; and to become a regional center for research and information on management, with particular emphasis on regional problems. Currently CESAG receives funds from the World Bank, the UNDP, the ILO, as well as member countries.

The Director was very interested in family planning and expressed enthusiasm for collaborating with the FPMT consortium to build management training capabilities in the family planning area. He noted that their experience in family planning training or management training for family planning organisations was limited, although they have recently supplied a consultant for three days to assist the Planificacion de Sante Familiale in running a regional workshop for family planning personnel.

The acting director and the team identified two CESAG staff members that could serve as institutional counterparts to the FPMT team. Dr. Wolff had the opportunity to meet with one of the suggested counterparts, Mr. Ibrahima Lo, and to observe his course on Human Resource Management. Dr. Wolff was impressed with Mr. Lo's personal style and interest in collaborating with the FPMT Project. Mr. Lo is a part-time faculty member at CESAG and the full-time director of human resources for the National Electric Company, SENELEC. Mr. Lo was formerly a nurse and holds a master's degree in nursing as well as an MBA in Management. Before changing careers and joining the Electric Company, Mr. Lo worked for the health ministry and still maintains an interest in the health field.

During the visit the following observations relevant to the proposed collaboration between the FPMT consortium and CESAG were made:

1. CESAG has an extremely attractive building with a library of current management publications, numerous classrooms, and a cafeteria that can be hired to prepare meals.
2. CESAG has a well-developed micro-computer training facility with four micro-computers and a full-time faculty member who runs the micro-computer center. They are familiar with IBM PC's and with main stream micro-computer business software (LOTUS, D-base III etc.).
3. Although they claim to be familiar with participatory teaching methodologies, the French pedagogic tradition still predominates. They will need more exposure to participatory training methodologies before they can do training using these methods on a wide-spread basis.
4. Management of CESAG does not appear to be particularly strong. There is for instance no current training plan for short-term courses to be offered in 1986-87. The last program schedule put out by the department of continuing education was for 1983-84.
5. A 60-70 room dormitory is to be constructed, and when built, CESAG will be able to hold residential training workshops.
6. Part-time faculty have a substantial number of other commitments, so scheduling of training workshops would have to be done far in advance to insure their availability.
7. Course evaluations are done after each course. A sample of the course evaluation form is attached in Annex 7.
8. Although CESAG offers management consultation it has almost no experience in the health and family planning field.
9. Although CESAG has used consultants in the past to provide management training, they have no procedures for following up on consultant performance.

CESAG offers some interesting possibilities for collaboration with the FPMT project. While CESAG is not presently able to provide technical assistance or conduct management training programs for family planning organizations, they are interested in developing a capacity to do so, and could build this capacity by collaborating with us in regional training activities. The FPMT project, however, would initially have to bear the lion's share of both administrative and training tasks. CESAG has a large, well developed training center that could be used by the FPMT project and hopes to have the capability of lodging participants on site in the near future. In addition they have considerable interest and expertise in micro-computers, and their micro-computer training center would be an ideal place to hold a regional course in the use of micro-computers.

## VI. MANAGEMENT DEVELOPMENT PLAN

### A. Proposed Training/Technical Assistance Activities for Senegal

1. Problem: Operational Planning, Implementation, and Control
  - o Lack of workplans at regional level
  - o Lack of planning skills
  - o Insufficient monitoring of operational objectives at regional level
  - o No standard mechanism for coordinating activities between units, ministries, and central and regional staff
  - o Difficulty in evaluating and implementing consultant recommendations

Suggested Training Intervention:

#### Workshop for Regional Planning

Goal: To enable regional teams to develop coordinated plans for implementation of family planning services.

Description: This workshop will help guide regional family planning coordinators and their supervisors in developing detailed, coordinated workplans for the implementation of PSF programs at the regional level. FPMT trainers working with national PSF staff will conduct this workshop. Participants will come from each of the six regions where PSF activities have already begun. The training will be highly participatory in nature and will be structured around a Management by Objectives and Results methodology. A second workshop on to develop supervisory protocols, described below, will be designed to follow up on the work plans developed in this workshop. Similar activities for the four regions to be covered beginning in year four of the project will be organized at a later date. Close collaboration between FPMT trainers and the ISTI team during the training should facilitate ISTI follow up of the training activities.

Audience: Regional Medical Directors, SMI director, Regional Inspector from Ministry of Social Development, and all regional IEC and clinical coordinators.

Duration: One week

Location: To be determined

Trainers: 2 senior FPMT trainers. National PSF staff, and the ISTI Technical Assistance Team will be invited as key consultants.

Date: Not before October 1, 1986

## 2. Problem: Supervision, Monitoring, and Evaluation

- o Lack of supervisory protocols for IEC and Clinical staff
- o Need to coordinate national and regional supervisory strategies

### Proposed Training Intervention:

#### Workshop to Develop Supervisory Protocols

**Goal:** To develop supervisory protocols for regional IEC and Clinical Coordinators

**Description:** This workshop, which will follow the Regional Planning Workshop described above, will examine relationships between national and regional strategies for supervision and develop supervisory protocols for regional IEC and clinical coordinators. It will also serve as an opportunity for a follow up evaluation of the workplans developed in the earlier workshop. Both the development and implementation of this activity will be closely coordinated with the Direction of Research, Planning, and Training of the MOH. Because some of those to be trained have already participated in a supervisory workshop under the SHDS project, the proposed workshop will attempt to build upon the content of the SHDS course. Close collaboration between FPMT and the ISTI Technical Assistance Team during the training should result in the transfer of in-country follow up activities to the ISTI team.

Audience: Regional IEC, Clinical, and SMI Coordinators, National PSF Coordinators, Regional health education Coordinator, and staff from the direction of Research, Planning, and Training Division of the MOH.

Trainers: 3 FPMT staff and ISTI Technical Staff as key consultants.

Location: To be determined

Date: This workshop should take place approximately six months after the Regional Planning Workshop.

### 3. Problem: IEC

- o Need for defining audience characteristics and messages for IEC campaigns (radio, written materials, etc).
- o Need to identify and use other existing resources and networks for IEC programs.
- o Lack of clearly defined implementation strategy for IEC at regional level

#### Proposed Training Intervention:

- o The Workshop for regional planning will address the need to improve implementation of IEC programs at the regional level.
- o Defining audience characteristics and messages for IEC campaigns and identifying and using other existing resources and networks for IEC programs can be done most effectively by using the resources of Population Communication Services or other organizations.

### 4. Problem: Contraceptive Prescription and Use

- o Current policies for contraceptive use are restrictive
- o Key physicians are reticent to relax rules for contraceptive distribution and use.
- o Barrier methods are currently considered as pharmaceutical products and therefore have limited distribution.

**Proposed Training Intervention:**

**Study Tour for key physicians and the director of the MOH Pharmacy**

**Goal:** Expose present and future decision makers to programs which use less restrictive medical criteria for contraceptive use.

**Description:** This study tour will take participants to several countries for discussions with family planning program directors, their staff, and medical professionals, in order to examine different policies regarding the distribution and use of contraceptives. The study tour will include a post-study workshop to draw conclusions from the trip and re-examine strategies for policies regulating the use of contraceptives.

**Audience:** The director of the MOH pharmacy and a group of key medical professionals representing different points of view about policies regulating the use of contraceptives. Optimal group size of six people identified by the AID mission and PSF staff. The group will be accompanied by someone from the FPMT staff and a translator.

**Trainers:** FPMT staff and translator.

**Location:** To be determined. One or more countries in Africa and Asia.

**Date:** This activity will be scheduled at a date when PSF activities have been further extended and when PSF and USAID staff feel that the study tour would have optimal impact. This proposed study tour will be reviewed after the FPMT overall regional plans for study tours have been finalized.

**5. Other Individual Training Needs**

- o Financial planning and cost-benefit analysis (for public and private sector)
- o Managing effective training organizations
- o Microcomputer training
- o Field evaluation of impact and effectiveness of training programs. (This need was stressed by the PSF director and could be addressed through a combined technical assistance/training activity)

### Technical Assistance Missions

A one-person, two week TDY by an FPMT trainer is proposed to take place four months after the workshop for regional planning. The goal of the TDY is to work with the mission and the staff of the PSF to:

- a) review the development of the workplans
- b) develop the materials for the supervisory protocol workshop
- c) finalize the agenda for the supervisory protocol workshop

In order to ensure sufficient FPMT follow-up and technical assistance after the supervisory protocol workshop, it is planned that biannual TDYs, lasting approximately two weeks each, be undertaken for two years. A two-person team is proposed for this training follow-up. After the two year period, it is expected that the pendent ISTI technical assistance team can take over the management follow-up.

## B. PROPOSED TRAINING/TECHNICAL ASSISTANCE ACTIVITIES: REGIONAL

### 1. Seminar for Family Planning Program Leaders

**Goal:** To identify and develop training course content for Francophone Family Planning Programs.

**Description:** This workshop will further develop the management problem areas identified during the basic needs assessment visits. This activity will ensure that future course material will respond to the real needs of Francophone family planning programs and help prepare these leaders to participate in the future training activities in their own countries.

**Participants:** Leaders of family planning projects or organizations from five or six francophone countries including the Magreb as well as FPMT training and curriculum staff. Potential candidates from Senegal are Mr. Ousmane Samb and Dr. Correa.

**Location:** Boston

**Duration:** One week

**Date:** To be determined

### 2. Inter-African Conference on the Management of Integrated Health and Family Planning Programs

**Goal:** To exchange experiences on integrating health and family planning program activities at both the policy and operational level.

**Description:** This conference will bring together managers and decision-makers responsible for maternal and child health and family planning programs from different countries in the region. This exchange of experience will provide a basis for developing an effective strategy for integrating family planning and maternal and child health programs. Case studies from Sudan, Morocco, or other countries could be used during this conference.

**Participants:** Those involved in maternal and child health and family planning at both the policy and operational level.

**Location:** Dakar.

**Trainers:** FPMT staff and technical resource persons from other donor agencies.

**Date:** Not before May 1, 1987.

C. ESTIMATED BUDGET

Workshop 1 or 2\*

Travel:

2 Round trip Boston/Senegal	\$4,000.00
In-country (trainers)	\$200.00
*Participants - 40 x \$25.00 per person	\$1,000.00

Per Diem:

2 FPMT trainers, 16 days @ \$110/day	\$3,520.00
2 In-country trainers, 7 days @ \$110/day	\$1,540.00
*40 participants, 7 days @ \$55/day	\$15,400.00

Fees:

50 FPMT days (preparation and course) @ \$261/day plus overhead	\$23,490.00
2 In-country trainers, 7 days @ \$200/day	\$2,800.00

Equipment and Services:

Communications	\$500.00
Materials production	\$250.00
Shipping	\$400.00
Conference Room rental (7 days, \$100/day)	\$700.00

\$53,800.00

Contingency (10%)	\$5,380.00
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GRAND TOTAL: \$59,180.00

Total if USAID/Senegal covers in-country costs \$42,780.00

\*The cost for workshop 2 will be approximately the same.

Technical Assistance Budget for Two Years

Travel:		\$
9 round trip Boston/Senegal		18,000.00
Per Diem:		
9 person trips, 16 days @ \$110/day		15,640.00
Fees:		
180 FPMT days (preparation and ir-country assistance) @ \$261/day plus overhead		84,560.00
Communication		500.00
		<hr/>
		118,900.00
Contingency (10%)		11,890.00
		<hr/>
		130,790.00
Total		
Two workshops a \$42,780.00*		85,560.00
Technical Assistance Missions		130,790.00
		<hr/>
Grand Total		216,350.00

\*Assumes mission pays in-country workshop costs.

## VII. LIST OF PERSONS CONTACTED

### USAID

Dr. Mary Ann Mica, Head, HPN  
Dr. Sara Seims, Population Officer  
Ms. Fatimata Hann, Deputy Project Manager

### PROJET SANTE FAMILIALE

Mr. Ousman Samb, Director  
Mr. Maseck Seck, Financial Administrator  
Mr. Fallou Gueye, Logistics Officer  
Mme. Marie Caroline Diop, National Coordinator IEC  
Mme. Ndiaye Aissatou Sambe, National Coordinator IEC  
Mme. Marie Victoire Albis, National Clinical Coordinator

### ISTI

Mr. George Stathes, Technical Advisor  
Ms. Laura Evison, Clinical Advisor  
Ms. Pricilla Randall, Logistics Liason Officer  
Mr. Alpha Dieng, Director Private and Para-statal Sector  
Mr. Mamadou Aidara, Asst. Director Private and Para-statal Sector  
Ms. Aminata Niang Diallo, Clinical Supervisor

### MINISTRY OF SOCIAL DEVELOPMENT

Mr. Cheikh Diop, Director of Cabinet  
Ms. Senadu Ndao Diallo, Head of Conditionne Feminine  
Mr. Ousmane Ndiaye, Technical Advisor  
Mme. N'Deye Soukeye Lesse, Chef de Division l'Action Feminine  
Ms. Nafi Diao, Cheif of Women's Work Division  
Mme. Fatimata Tandiang, Head of Family Planning Division  
Mr. Abiboulye Ly, Inspecteur Pedagogique  
Mme. Niang Khadidiatou, Technical Advisor Human Resource Training  
Mr. Ndiaye, Regional Inspector, Thies  
Mme. Mbayang Ndao Ndiaye, Regional Coordinator IEC PSF

### MINISTRY OF HEALTH

Mr. Moumirou Ciss, Director of Pharmacy  
Mme. Dado Ndiaye, Regional Clinical Coordinator, Thies  
Ms. Diakhate Khady NDiour, Nurse, Clinic, Thies  
Mme. Gaye, Sage-Femme, Clinic Medina, Dakar.  
Mme. Kebe, Sage-Femme, Clinic Medina, Dakar.  
Dr. Kane, Clinic Medina, Dakar.

### TAIBA PHOSPHATE COMPANY

Dr. Abou Kone, Company Physician

ASSOCIATION SENAGALAISE POUR LE BIEN ETRE FAMILIALE

Mme. Toure Tamarou, President

UNFPA

Dr. Sabwa Matanda, Deputy Representative

CESAG

Mr. Hongui Gbayoro, Director  
Mr. Hugues Cahuzac, Head of Continuing Education  
Mr. Fara Brangale, Media Relations  
Mr. Souleymane Samake, Professeur permanent  
Mr. Ibrahima Lo, Consultant Faculty, Human Resource Management

AFRICA CONSULTANTS INC.

Mr. Gary Engelberg, Director  
Ms. Lillian Baer, Asst. Director

PRITECH

Dr. Suzanne Pryor-Jones, Regional Representative for the Sahel

COLUMBIA UNIVERSITY

Dr. Don Lauro, Director Operations Research  
Dr. Ann Kimbel, Resident Advisor Operations Research

SINE SALOUM PROJECT EVALUATION TEAM

Dr. Robert Cushman, Team Leader  
Dr. John Lioni, Team member  
Mr. Jim Keyser, Team member  
Mr. Don Rudisuhle, Team member

HIID

Ms. Fay Newfield, Logistics manager, Kaolack.

AFRICARE

Mr. Walter Williams, Country Director

WESTINGHOUSE HEALTH SYSTEMS

Ms. Jean Cushing, Consultant for Demographic Health Survey Senegal

OTHERS

Dr. Souleymane M'Boup, AIDS Researcher  
Dr. Dominique Ricard, AIDS Researcher  
Dr. Pierre Davloose, WHO, Thies.

## VIII. SCHEDULE OF VISITS

Thursday 15 May

1800 Heise/Kaufman depart Boston

Friday 16 May

1200 Heise/Kaufman arrive Dakar

1500 Meeting with USAID Population Officer and CESAG Representative

Saturday 17 May

1030 Meeting with CESAG Director and Technical Staff

Sunday 18 May

1230 Discussion of FPMT workplan with USAID Population Officer

Monday 19 May

1000 Review of documents

1400 Background discussion on Family Health Project with Pop Officer

Tuesday 20 May

0900 Logistical arrangements

1030 Courtesy Visit with UNFPA

1330 Meeting USAID Pop Officer and ISTI Liason Officer

1430 Meeting with Project Director PSF

1630 Review of discussion notes

Wednesday 21 May

0800 Meeting with USAID Pop Officer and Director  
of Private Sector Component PSF

0900 Meeting with Staff of Private Sector Component PSF

1500 Meeting with ISTI Technical Assistance Team and Pop Officer

Thursday 22 May

0830 Visit FP clinic/PMI de Medina, Dakar

1430 Visit to ASBEF

1600 Meeting with Director of the Cabinet, MSD

Friday 23 May

1000 Meeting Director National Pharmacy

1300 Team Work Session

1500 Meeting with USAID Pop Officer

Saturday 24 May

1630 Meeting with UNFPA/DRSAP

2200 Arrival Dr. Wolff

Sunday 25 May

0930 Briefing Breakfast with HPN and Pop Officer

Monday 26 May

0930 Heise/Kaufman Depart for Thies

0900 Wolff Meeting with CESAG

1030 Visit FP Clinic PMI Thies

1130 Meeting with Regional FP Clinical Coordinator

1200 Wolff Meeting with PRITECH Regional Representative

Monday May 26 (Continued)

1300 Heise/Kaufman Meeting with Regional IEC Coordinator FP

1400 Wolff Meeting with Africa Consultants Inc. .

Heise/Kaufman Meeting with Regional Director of MSD

1500 Heise/Kaufman Visit to Taiba Phosphate Factory

1900 Heise/Kaufman return to Dakar

Tuesday May 27

0930 Meeting with Director PSF

1030 Meeting with ISTI Technical Advisor

Meeting with Logistics Chief PSF

Meeting with Administrative Director PSF

1230 Team Meeting

1500 Presentation of initial impressions and discussion with Pop Officer

Wednesday May 28

0900 Meeting with 2 National IEC Coordinators PSF

1000 Meeting with Administrative and Logistic Officers PSF

1200 Wolff Meeting with Pritech Regional Representative

1300 Meeting with Logistics Liason Officer ISTI

1500 Wolff Meeting with CESAG

Heise/Kaufman Meeting with Director, Conditionne Feminine MSD

1630 Wolff observation CESAG Training Session

Thursday May 29

0800 Formulation of MDP

1000 Debriefing with USAID HPN, Pop Officer, Asst. Project Officer

1400 Team Meeting

2000 Report Writing

Friday May 30

0800 Debriefing for PSF Director and Staff

1200 Report Writing

1430 Meeting with CESAG Consultant

1159 Kaufman departs for Boston

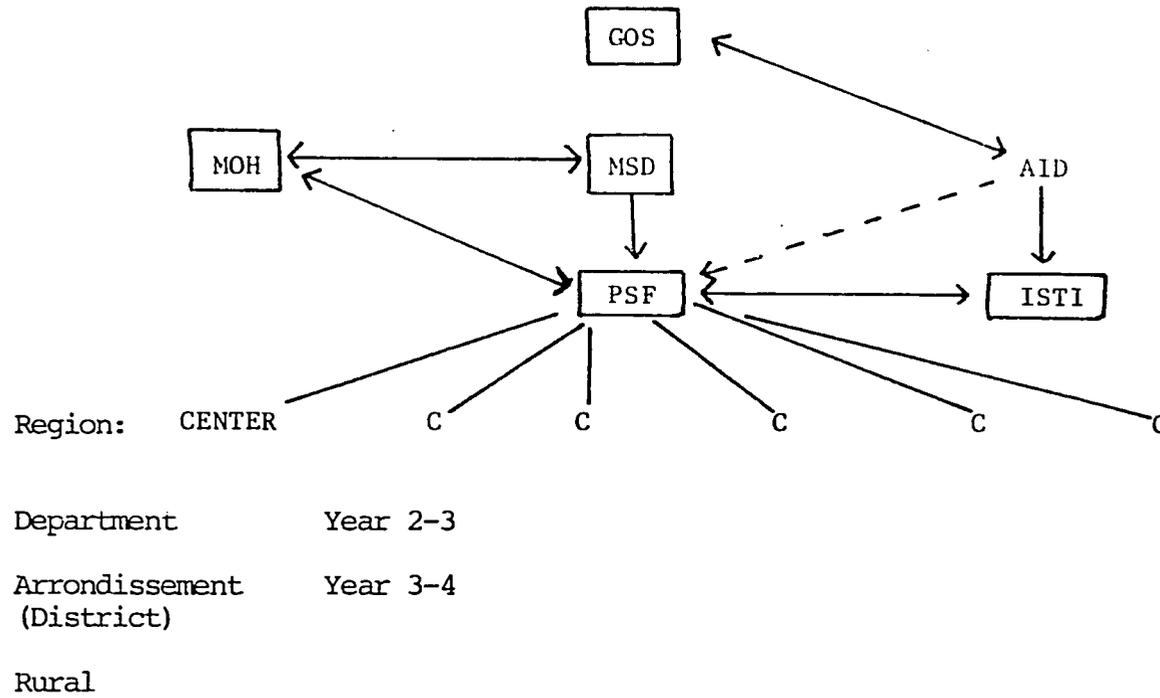
Saturday 31 May

0200 Wolff departs for Boston

2200 Heise departs for Rwanda

ANNEX 1

ORGANIZATIONAL CHART



ANNEX 2

Work Plan for the Family Health and Population  
Project for the Period January - December 1986

ACTIVITES	JANV.	FEV.	MARS	AVRIL	MAI	JUIN	JUIL.	AOUT	SEPT.	OCT.	NOV.	DEC.
Travail Administratif	[Continuous line across all months]											
Journées d'Etudes	[Arrow from Jan to Feb]											
Tournées de supervision	[Continuous line across all months]											
Mise en place Matériel I.E.C.	[Continuous line across all months]											
<u>REUNIONS</u>												
Périodiques de la Cellule Nationale	[Continuous line across all months]											
Mensuelles de coordination AID/PSFP.	[Continuous line across all months]											
Trimestrielles dans les régions	[Continuous line across all months]											
<u>FORMATIONS</u>												
Agées-femmes	[Arrow from Apr to May]											
Audio-visuelles + Recyclage	[Arrow from Apr to May]											
Formations départementales	[Arrow from Apr to May]											
Formation des auxiliaires (Kaolack)	[Arrows: Jun-Jul, Aug-Sept, Oct-Nov, Dec]											
Formation des auxiliaires (Thiès)	[Arrow from May to Jun]											
<u>REALISATION BROCHURES</u>												
Prétest de légendes	[Continuous line across all months]											
Impression brochures	[Arrow from Feb to Mar]											
Distribution des brochures.	[Arrow from Mar to Apr]											



ANNEX 3

Achievement of Objectives

Titre du projet : Santé familiale et Population  
Numéro du projet : 685-0248  
Période couverte par le rapport : 1 octobre 85 - 31 mars 1986

I. <u>INDICATEURS DE L'ETAT DE FIN DE PROJET</u>	<u>REALISATION ACCOMPLIES</u> <u>DURANT LES 6 DERNIERS</u> <u>MOIS</u>	<u>REALISATIONS</u> <u>DEPUIS LE</u> <u>DEBUT DU PROJET</u>	<u>% D'ATTENTE DES</u> <u>OBJECTIFS</u>	<u>REALISATIONS PREVUES DANS LES</u> <u>6 PROCHAINS MOIS</u>
1a) Fourniture de Services contraceptifs à 170,000 couples par les cliniques du secteur public et à 30,000 couples par les cliniques du secteur privé.				
b) Services de planification familiale disponibles dans les centres urbains de 10 000 hts ou plus au niveau de toutes les 10 régions.	Too early to evaluate			
2. Une base de données immédiatement accessibles existe au niveau du BNR; ces données brutes sont fournies de façon appropriée et utile aux planificateurs du développement.	v			
II. <u>INDICATEURS DE RESULTATS</u>				
A. <u>Planification familiale services publics</u>				
1a) Les services aux utilisateurs actifs des 22 centres initiaux passent de 8.500 à 57.000.	4000 utilisateurs dans les 20 centres fonctionnels.	20 centres fonctionnels avec 12.000 utilisateurs.	21%	Toucher 4000 nouveaux utilisateurs dans les 20 centres fonctionnels.
b) Accroissement du nombre de centres fonctionnels dans les 6 premières rég. à raison de 10 par an pour atteindre un total de 90 à la 7ème année.	-0-	22 centres ont été implantés dans les 6 rég. lors de la 1ère phase.	24%	- Démarrage des travaux de construction et rénovation de 10 nouveaux centres.

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATIONS ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	D'ATTENTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
2a) 20 médecins formés en PF, traitement des maladies sexuellement transmises et stérilité.				Formation de 4 médecins : - 2 Santa Cruz - 1 Columbia - 1 Piégo
b) 140 SF (dt 1/3 au USA) 140 infirmières et 140 auxiliaires formées.	-0-	-0-	-0-	- Format* 30 SF au Sénégal - " 30 auxiliaires rég. - " 3 SF (extérieur) (1 Santa Cruz, 1 Columbia, 1 Piégo).
c) 50 agents formés (Sénégal et étranger) en gestion de la planification familiale, gestion des produits contraceptifs et collecte des données.	-0-	-0-	-0-	- Format* 2 agents MDS à Santa Cruz.  - Elaborat* plan formation pour gestion de produits contraceptifs + collecte des données (Friedman) - la format* se fera au Sénégal.  - Planification des sessions de recyclage en gestion des activités et supervision pour le personnel clinique des régions
d) 100 agents de services de logistique et d'approvisionnement formés.	-0-	-0-	-0-	Format* 30 SF (module sur logistique + approvisionnement prévue dans formation des SF en avril).
e) 70 agents d'IEC formés au Sénégal; 5 agents d'IEC formés à l'étranger/an.	-0-	-0-	-0-	- Défini* stratégie + besoins en IEC (Mme Parlato)  - Format* 60 agents dans les régions.  - " 4 agents à l'extérieur.
f) 70 agents de santé communautaire formés en SSP et soins de santé familiale à	-	-	-	-

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATION ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	% D'ATTENTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
3a) Activités de formation et de distribution de matériels d'IEC dans tous les centres de PF existant avant la fin de la 2e année.	-0-	-0-	-0-	<ul style="list-style-type: none"> <li>- Journée de réflexion sur volet IEC à l'intention des personnel de la cellule nationale et responsables des services EPS; MDS, MPS et islamologues.</li> <li>- Elaboration termes référence pour étude impact des activités IEC déjà menées.</li> <li>- Stage audio-visuel pour les coordinatrices régionales.</li> <li>- Distribution du matériel audio-visuel dans centres régionaux.</li> <li>- Distribut* brochures, tshirts, bics, etc. dans tous les centres.</li> </ul>
b) Création d'émissions radiophoniques dans toutes les régions dotées de services de PF et où il existe une antenne de l'ORTS avant la fin de la 2ème année.	Réalizat* +/- 12 émiss* dans la rég. de Zig.	1 région utilise de façon efficiente la radio pour sensibiliser les pop. sur la santé familiale.	+/-16%	<ul style="list-style-type: none"> <li>- 12 émissions à Dakar (2/mois).</li> <li>- 24 émissions à Zig. (1/semaine)</li> <li>- Sensibilisat* régions disposant antenne ORTS à établir 1 programme radio.</li> </ul>
c) Programme de santé familiale conçu avant la fin de la 3e année du projet pour les élèves de l'école des SF, des infirmiers, des agents sanitaires, et d'économie familiale.	Les contacts ont été pris avec école SF + centre d'économie familiale de Zig. et principe accepté.			<ul style="list-style-type: none"> <li>- Formation de 4 monitrices de l'école des SF.</li> <li>- Participation des resp. de l'école des SF et des responsables cliniques du projet à un séminaire traitant de cette question à Abidjan.</li> <li>- Examen du curriculum actuel des écoles de formation.</li> <li>- Journée de réflexion sur ce thème avec la participation de resp. de Le Dantec, MSP et PSF.</li> </ul>
d) 10 chefs religieux et responsables administratifs et politiques participent chaque année à des voyages d'études.	-0-	-0-	-0-	Envoi de 4 personnes (2 p. politiques et 2 administratives).

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATION ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	% D'ATTEINTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
4a) 5 formateurs de la santé par an ont bénéficié de 3 formations spécialisées dans le traitement de la stérilité et des maladies sexuellement transmises.	-0-	-0-	-0-	Formation de 6 formateurs - 4 monitrices école SF - 1 moniteurs école infirmiers - 1 moniteur de l'enseignement Tech. féminin. - 1 agent de la DRPF.
b) Le centre de vénéréologie et de lutte contre l'infertilité de l'hôpital le Dantec rendu fonctionnel (équipé et doté de personnel formé).				Consultat* d'1 spécialiste MST (CDC) pour établir besoins en matériel + équipement + élaborer plan d'action pratique.
c) 2 centres régionaux assurent le traitement des maladies sexuellement transmises.	Suivi du fonctionnement du centre de l'Institut d'Hygiène Sociale (IHS)	3 centres assurent ces services : IHS+ Kasnack + Collette Senghor.	100%	Démarrage travaux rénovation + commande matériel + approvisionnement pour améliorer services offerts.
d) 27 centres de santé assurent le diagnostic des MST.	Tournée identification besoins nécessaires pour améliorer services dans 22 centres existants.	20 centres régionaux et IHS assurent ces services.	78%	- Assurer ces services dans 22 centres. - Améliorer services : formation personnel - aménagement locaux - renforcement du matériel.
e) Traitement de MST pour un minimum de 30 000 patients.	- MST = 900 clients - Infécondité = 650	- MST = 3430 clients - Infécondité = 2640	11,4% (HST)	- MST = 900 nouveaux clients - Infécondité = 650 nouveaux clients
f) Accroissement de 50 % des cas de MST transférés des centres de santé et des postes de santé au centre de référence de traitement de maladies sexuellement transmises.				
5) Des activités d'IEC sont réalisées dans les projets de groupements féminins; recrutement de clients pour des services de planification familiale effectués à partir de ces projets.	- Pour les projets : 0 - Pour les cases foyers: des activités IEC sont menées dans 4 des 5 cases existantes.	- Projets : 0 - Construction de 5 cases foyers.	Impossible à évaluer actuellement.	- Dans les 5 cases foyers recrutement d'au moins 10 acceptatrices/case pour les services de planning. - Elaborer un instrument pour évaluer nombre clientes en planning familial recrutées à partir des cases des projets.

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATION ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	% D'ATTENTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
<b>B. Secteur non gouvernemental</b>				
1) 10 000 utilisateurs actifs avant la 4e année.	- Prises contact avec 8 sociétés. - Elaborat* textes juridiques de base du VSPP. - Recueil de 6 requêtes en cours d'examen et d'approbat* par comité d'étude.	-0-	-0-	- Approuver requête de 5 sociétés. - Fournir matériel - équipement à ces sociétés. - Couvrir 1475 acceptatrices dans ces 5 sociétés.
2) 200.000 personnes sensibilisées avant la 4ème année.	-0-	-0-	-0-	Sensibiliser 10.000 personnes.
3) 21 sages-femmes - 21 infirmières/infirmiers - 21 auxiliaires formés pour être des formateurs en PF.	-0-	-0-	-0-	Former : - 25 SF en clinique PF dont 11 en avril - 3 agents en gestion PF - 5 infirmiers en PF - 10 agents en IEC
<b>C. Bureau National du Recensement</b>				
1a) 35 statisticiens/démographes formés en analyse de données démographiques, après le recensement.	Formation LT d'1 démographe en cours.	Envoi d'1 démographe en formation au USA.		
b) 35 planificateurs formés en modélisation et interprétation des résultats à partir de 1989 (RAPID II).	-	-	-	
1c) Traitement et analyses intégrales des données du recensement de 1987 et publication des résultats trois ans après la collecte des données.	Préparation et mise au point à l'enquête cartographique (méthodologie-documentation-préparation matérielle).	Formation agents en cartographie.	-	Pour la cartographie : - achever l'acquisition du matériel - recruter le personnel - mettre en place équipes dans régions - débiter les travaux.

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	<u>REALISATION ACCOMPLIES</u> <u>DURANT LES 6 DERNIERS</u> <u>MOIS</u>	<u>REALISATIONS</u> <u>DEPUIS LE</u> <u>DEBUT DU PROJET</u>	<u>% D'ATTENTE DES</u> <u>OBJECTIFS</u>	<u>REALISATIONS PREVUES DANS LES</u> <u>6 PROCHAINS MOIS</u>
2) 35 planificateurs formés dans le domaine de la planification économique en relation avec l'accroissement démographique à partir de 1989 après recensement.	-	-	-	
3) Maximum de 3 séminaires sur micro-ordinateurs et/ou les méthodes statistiques entre la 1ère et la 4e année.	- Séminaire CENT 4 pour 25 agents. - Formation USA de 2 informaticiens (1 achevé et 1 en cours).	Réalisation d'un séminaire (CENT 4).		- Tenir en juillet le séminaire CONCOR pour 25 agents.
4a) 10 enquêtes régionales réalisées avant la 7ème année et ceci à partir de 1987.				
b) 2 enquêtes démographiques et santé familiale réalisées (1986-1991)	Préparation de l'enquête: (questionnaire-formation personnel - échantillonnage - pré-test).			- Collecte des données à partir de mai. - Début de l'exploitation.
5) Modèle RAPID mis à jour/présentation avant la fin de la 3e année.	Rédaction rapports sur les modèles sectoriels très avancée.			- Tenir le séminaire de présentation en juin.
6) 3 séminaires organisés sur l'impact de l'accroissement démographique rapide sur le développement du Sénégal à partir de 1987.				

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATION ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	% D'ATTENTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
III. Intrants : Type et qualité				
USAID (pm = personne mois)				
1a) 348 mp d'assistance technique à long terme.	5 personnes pour 17,5 PM	5 - 17,5 PM	5%	5 personnes pour 30 PM
b) 50 pm d'assistance technique à court terme.	11 personnes pour 6,5 PM	11 - 6,5 PM	13%	- VSPP : 1 PM - BNR + PSFP : 16p. pour 8 PM
2a) Formation à long terme de 240 mp.	1 agent du BNR pour 3 PM	1 - 3 PM	1,2%	27 PM prévue encore pour l'agent du BNR payé par : Sahel Manpower Development.
b) Formation à court terme de 500 pm.	2 agents du BNR pour 2,5 PM.	2 - 2,5 PM	0,5%	- PSFP : 5 agents pour 6,25 PM S. Cruz 1 agent pour 1 PM Columbia 2 agents pour 1,5 PM Piego - BNR : 1 agent pour 1 PM 2 agents pour 2 PM
c) 70 séminaires et ateliers organisés sur place.	BNR : 1 séminaire CENT 4 1 " en cours (WESTINGHOUSE). PSF : 1 séminaire national.	Tenue d'1 séminaire sur la cartographie par le BNR (9/1985).	4,2%	- BNR : 1 séminaire CONCOR (juillet) - PSF : 1 atelier national en IEC - 3 ateliers régionaux (plans d'action) et 2 séminaires régionaux en IEC.
3a) Contraceptifs 1 667 000 dollars	-0-	-0-	-0-	- PSFP : 567.000 - VSPP : 18.225
b) Autres équipements : 2.457.000 dollars.	68.000	68.000	2,8%	- PSFP : 172.800 - BNR : 180.250 - VSPP : 78.700

I. INDICATEURS DE L'ETAT DE FIN DE PROJET	REALISATION ACCOMPLIES DURANT LES 6 DERNIERS MOIS	REALISATIONS DEPUIS LE DEBUT DU PROJET	% D'ATTENTE DES OBJECTIFS	REALISATIONS PREVUES DANS LES 6 PROCHAINS MOIS
4. Rénovation de 106 infrastructures sanitaires qui incluent 14 cases foyers.	-0-	-0-	-0-	- PSFP : 128,000 pour démarrer travaux construction/rénovation de 14 centres et cases foyers. - VSPP : 2.900 pour démarrer rénovat* 4 centres (2 CNSS - 2 C.R).
5. IEC : 1 082 000 dollars.	27.000	27.000	2,5%	- PSFP : 35.700 - VSPP : 16.915
6. Frais de fonctionnement : 2.727.000 dol.	73.000	73.000	2,7%	- PSFP : 61.700 - BNR : 33.200 - VSPP : 20.115
7. Comptabilité/gestion financière 500 000 dollars.				
8. Evaluation : 150 000 dollars 2 évaluations à mi-parcours 1 évaluation finale.	-0-	-0-	-0-	-0-
9. Imprévus et inflation : 3.311.000 dols.				
GOS : Avant 1992, l'équivalent de 550 personnes assurent les activités du projet à plein temps.		20 SF - 20 auxiliaires: 15 Infirmiers - 4 manoeuvres travail- lant à temps plein pour le projet.	10,7%	
Avant 1992, les services de planification familiale sont fournis dans 148 infra- structures dont les coûts de fonctionnement sont pris en charge par l'Etat sénégalais.	Too early to evaluate:			

ANNEX 4  
Family Health and Population Project: USAID Contribution

TABLE I: SUMMARY PROJECT COSTS: USAID CONTRIBUTION

Item	Foreign Exchange (\$000)	Local Currency (\$000)	Total AID Contribu- (\$000)	Percent of Total USAID Contribution
Training	634	2,520	3,154	16%
Commodities (exclu- ding contraceptives)	1,407	1,371	2,778	14%
Contraceptives	1,667	0	1,667	8%
Technical Assistance	3,229	1,039	4,268	21%
Renovation	0	750	750	4%
Operations (including salaries)	0	2,855	2,855	14%
Outreach (IEC)	30	716	746	4%
Data Base Improvement	100	500	600	3%
Subtotal	7,067	9,751	16,818	-
Contingency	875	1,118	1,993	10%
Subtotal	7,942	10,869	18,811	-
Inflation 5% compounded	689	500	1,189	6%
Total	8,631	11,369	20,000	-
				---
				100%

## ANNEX 5

## Family Health and Population Project: Government of Senegal Contribution

TABLE IV

Salaries of midwives/nurses at \$2,500 per year increasing 10% annually	\$2,012,000
Salaries of outreach workers at \$1,500 per year increasing 10% annually	1,934,000
Salaries of midwife assistants at \$1,500 per year increasing 10% annually	1,934,000
Salaries of guardians at \$1,50 per year increasing 10% annually	483,000
Gasoline and operating expenses at headquarters	368,000
Salaries of GOS headquarters staff	50,000
Provision of facilities (including operating expenses and some equipment) estimated at \$1,000 annually per center increasing 10% annually	639,000
	<u>\$ 7,420,000</u>

## ANNEX 6

## Trained Under Phase I of the Family Health Project

PROJET SANTE FAMILIALE - 685-0217/0248 - PIO/Ps  
(achèvement 30 juin 1985)

COURS	DATES	PARTICIPANTS	FONCTIONS DES PARTICIPANTS
Family Planning Nutrition and PHC - Univ. of Columbia	June 4-29, 84	Ms. Mame Coumba Ndiaye Dieng	Regional Midwi- fe FHP Thies
Family Planning Management Univ. of Cali- fornia Santa Cruz	March - May 84	Mr. Ousmane Samb Ms. Caroline Mané	Resp FHP Dakar Coord IEC FHP
Voyage d'étude: Haïti - Mexico City - Bogota	March 84	Mr. Ousmane Samn	Resp FHP
Management of FHP Univ. Calif. Santa Cruz	Sept - Nov. 84	Ms. Gomis M. Victoire Ms. Salamon Melia Ms. Diop Maramé	Midwife FHP Coord IEC Zig. Midwife S.Saloum!
IEC training Univ. Californ. Santa Cruz	June - July 85	Ms. Aïssatou Samb Ms. Caroline Mané Ms. Arame D. Sow Ms. Marième D. GBAYA	Coord IEC FHP " " FHP " " C.Vert! " " C.Vert!
Management of FHP CEDPA Wash.	Sept - Oct 83	Ms. Aïssatou Samb	Coord. IEC PSF
Management of FHP Univ. Calif. Santa Cruz	July - Aug. 82	Ms. Mbayang Ndao Ndiaye Ms. Aïssatou Samb Ms. Aminata Guèye Ndoye Ms. Ndèye Faly Ba Ms. Marième GBaya Ms. Tapa Nd. Diame	Coord IEC Thies " FHP " Casam. " S.Sal. " C.Vert! Midwife FHP Cas.!

4 wk x 1 = 4

8 wk x 2 = 16

3 wk x 1 = 3

8 wk x 3 = 24

8 wk x 4 = 32

3 wk x 1 = 3

8 wk x 6 = 48

130 wk/4

18 @ 32.5 PM

COURS	DATES	PARTICIPANTS	FONCTIONS DES PARTICIPANTS
Observation and study tour of family planning programs in Muslim countries (Maroc-Egypt)	Feb. 85	Mr. Ahmed Lyane Thiam Mr. Moustapha Guè, e Mr. Abdoul Aziz Sy Mr. Ousmane Samb Mr. Idrissa Diop Mr. Makhtar Seck Mr. Ibrahima Mahmoud Diop dit Barham	Resp. PSF
Management Sciences for Health in Morocco	Jan - Feb. 85.	Mr. Ousmane Samb Mr. Masseck Seck Mr. Fallou Guèye Mr. Babacar Dramé	PSF PSF PSF Méd-Chef Fatick
Conference on reproductive Health Management in Sub-Saharan Africa Freetown (Sierra Leone)	Nov. 84	Mr. Ousmane Samb Mme Aminata D. Niang	PSF PMI Medina

2 wk x 8 = 14

1 wk x 4 = 4

1 wk x 2 = 2

14 = 5.5 PM  
2.2v

AID Project  
1 MD ?  
5 MW ? 9  
12 but  
3 doubled ? 13  
∴ 9 0

Comb = 5x  
Assessor = 3x  
Caroline = 2x

32 for 38 PM  
-10  
22  
+3  
25 peppe for 38 PM

Monthly Activities Report

REPUBLIQUE DU SENEGAL

M.D.S. - M.S.P.

PROJET SANTE FAMILIALE ET  
POPULATION.

Rapport d'activités pour le mois de ..... 198 .....

Centre de .....

Responsable .....

1. PLANIFICATION FAMILIALE

A. Visites de Consultation

Pilule D.I.U. Diaphragme Condom Autres Visite TOTAL  
METHODES D'URGENCE

	Pilule	D.I.U.	Diaphragme	Condom	Autres	Visite	TOTAL
Nouvelles							
Anciennes							
Total							

B. Nombre de Consultantes actives-

Pilule D.I.U. Diaphragme Condom Autres méthodes TOTAL

Pilule	D.I.U.	Diaphragme	Condom	Autres méthodes	TOTAL

2. MALADIES SEXUELLEMENT TRANSMISES ET STERILITE

A. Visites de Consultation -

M . S . T .

STERILITE

TOTAL

	M . S . T .	STERILITE	TOTAL
Nouveaux			
Anciens			
Total			

Fig. 8

## D. APPROVISIONNEMENT et CONSOMMATION

METHODE	CONDITIONNEMENT	SOLDE au DEBUT du MOIS	RECU PENDANT le MOIS	CONSOMMATION PENDANT le MOIS	SOLDE à FIN du MOIS.
Noriday 1+50	Plaquelette (Cycle)				
Lo-Femnal	Plaquelette (Cycle)				
Boucle de lip- pes.	Unité				
T en Cuivre	Unité				
Tablettes vagi- nales- contra- ceptives.	Tube				
Diaphragme	Unité				
Condoms	Unité				
Crème Koromex	Tube de 25 ap- plications				
Pénicilline					
Butazolidine					
Ampicilline G					
Tablettes vagi- nales.					
Tétracycline					
Chloroquine					
Carno-analgésic					
Fer					
Foldir					
Observations					

REPUBLIQUE DU SENEGAL  
MDS / MSP  
PROJET SANTE FAMILIALE

Région de _____
Dépt de _____
Centre de _____
Numéro _____

N° \_\_\_\_\_ | 1-6  
Date \_\_\_\_\_ | 7-12  
\_\_\_\_\_ | 13-18

**FICHE DE CONSULTATION**

**I - INTERROGATOIRE**

Prénoms \_\_\_\_\_ Adresse \_\_\_\_\_  
Nom \_\_\_\_\_ Age \_\_\_\_\_

19 - 20

<p><b>Ethnic 21</b></p> <p>1 Wolof _____ <input type="checkbox"/></p> <p>2 Serère _____ <input type="checkbox"/></p> <p>3 Toucouleur _____ <input type="checkbox"/></p> <p>4 Mandingue _____ <input type="checkbox"/></p> <p>5 Diola _____ <input type="checkbox"/></p> <p>6 Autres _____ <input type="checkbox"/></p>	<p><b>Religion 22</b></p> <p>1 Musulman _____ <input type="checkbox"/></p> <p>2 Chrétien _____ <input type="checkbox"/></p> <p>3 Autres _____ <input type="checkbox"/></p>	<p><b>Sit. Matrim 23</b></p> <p>1 Mariée _____ <input type="checkbox"/></p> <p>2 Célibataire _____ <input type="checkbox"/></p> <p>3 Veuve _____ <input type="checkbox"/></p> <p>4 Divorcée _____ <input type="checkbox"/></p> <p>5 Séparée _____ <input type="checkbox"/></p>	<p><b>Niveau Inst. 24</b></p> <p>1 Non-scolarisée _____ <input type="checkbox"/></p> <p>2 Primaire _____ <input type="checkbox"/></p> <p>3 Secondaire _____ <input type="checkbox"/></p> <p>4 Supérieure _____ <input type="checkbox"/></p>
<p><b>Genre de vie 25</b></p> <p>1 Café _____ <input type="checkbox"/></p> <p>2 Tabac _____ <input type="checkbox"/></p> <p>3 Alcool _____ <input type="checkbox"/></p> <p>4 Autres _____ <input type="checkbox"/></p>	<p><b>Prof. du mari 26</b></p> <p>1 Néant _____ <input type="checkbox"/></p> <p>2 Cultivateur _____ <input type="checkbox"/></p> <p>3 Salarie _____ <input type="checkbox"/></p> <p>4 Travail à _____ <input type="checkbox"/></p> <p>5 Son compte _____ <input type="checkbox"/></p> <p>6 Autres _____ <input type="checkbox"/></p>	<p><b>Source inf. PF 27</b></p> <p>1 Amic / Parent _____ <input type="checkbox"/></p> <p>2 Mari _____ <input type="checkbox"/></p> <p>3 Agent santé _____ <input type="checkbox"/></p> <p>4 Groupement _____ <input type="checkbox"/></p> <p>5 Radio _____ <input type="checkbox"/></p> <p>6 Télévision _____ <input type="checkbox"/></p> <p>7 Affiche _____ <input type="checkbox"/></p> <p>8 Autres _____ <input type="checkbox"/></p>	<p><b>Antécéd Obgyn.</b></p> <p>Enfants vivants _____ <input type="checkbox"/> 28 29</p> <p>Enfants décédés _____ <input type="checkbox"/> 30 31</p> <p>Mort-nés _____ <input type="checkbox"/> 32 33</p> <p>Fausse couches _____ <input type="checkbox"/> 34 35</p> <p>Avortements _____ <input type="checkbox"/> 36 37</p> <p>Infection tromp. _____ <input type="checkbox"/> 38 39</p> <p>Age dern. enfant _____ <input type="checkbox"/> 40 41</p> <p>Allaitement _____ <input type="checkbox"/> 42</p>

Antécédents : (O = Oui N = Non, Noter anomalies en détail sous observations)

<p><b>A) - Menstruels</b></p> <p>Durée J _____ <input type="checkbox"/></p> <p>Régularité _____ <input type="checkbox"/></p> <p>Dern. Règle _____ <input type="checkbox"/></p>	<p><b>C) - Médicaux</b></p> <p>Cardiovasc _____ <input type="checkbox"/></p> <p>Varices _____ <input type="checkbox"/></p> <p>Diabète _____ <input type="checkbox"/></p> <p>Gastriques _____ <input type="checkbox"/></p> <p>Tuberculose _____ <input type="checkbox"/></p>	<p><b>D) - Hérités</b></p> <p>Hypertension _____ <input type="checkbox"/></p> <p>Drépanocytose _____ <input type="checkbox"/></p> <p>Test. d'Emmel _____ <input type="checkbox"/></p> <p>Diabète _____ <input type="checkbox"/></p>	<p><b>B) - Chirurg.</b> _____ <input type="checkbox"/></p> <p>Ictères _____ <input type="checkbox"/></p> <p>Epilepsie _____ <input type="checkbox"/></p> <p>Hospitalisée _____ <input type="checkbox"/></p> <p>MST _____ <input type="checkbox"/></p> <p>Autres _____ <input type="checkbox"/></p>
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**II - EXAMEN MEDICAL. (N - Normal, A - Anomalie)**

<p>T.A. _____ <input type="checkbox"/></p> <p>Poids (Kg) _____ <input type="checkbox"/></p> <p>Thyroïde _____ <input type="checkbox"/></p> <p>Muqueuses _____ <input type="checkbox"/></p> <p>Yeux _____ <input type="checkbox"/></p> <p>Langue _____ <input type="checkbox"/></p>	<p>Abdomen _____ <input type="checkbox"/></p> <p>Ganglions _____ <input type="checkbox"/></p> <p>Oedèmes _____ <input type="checkbox"/></p> <p>Squelette _____ <input type="checkbox"/></p> <p>Seins _____ <input type="checkbox"/></p> <p>(App. auto-exam) _____ <input type="checkbox"/></p>	<p>Auscultation</p> <p>Cœur _____ <input type="checkbox"/></p> <p>Poumons _____ <input type="checkbox"/></p>	<p>Laboratoire</p> <p>Urine : Alb _____ <input type="checkbox"/></p> <p>Suc _____ <input type="checkbox"/></p> <p>Hématocrit _____ <input type="checkbox"/></p> <p>BW _____ <input type="checkbox"/></p> <p>GS RH _____ <input type="checkbox"/></p>
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**III - EXAMEN GYNECOLOGIQUE. (N - Normal, A - Anomalie)**

<p><b>Organes externes</b></p> <p>Ecoulements _____ <input type="checkbox"/></p> <p>Ulcérations _____ <input type="checkbox"/></p> <p>Vésicule _____ <input type="checkbox"/></p> <p>Kystes _____ <input type="checkbox"/></p> <p>Malformation _____ <input type="checkbox"/></p> <p>Autres _____ <input type="checkbox"/></p>	<p><b>Examen speculum</b></p> <p>Vagin _____ <input type="checkbox"/></p> <p>Lésions _____ <input type="checkbox"/></p> <p>Pertes _____ <input type="checkbox"/></p> <p>Col _____ <input type="checkbox"/></p> <p>Taille _____ <input type="checkbox"/></p> <p>Couleur _____ <input type="checkbox"/></p> <p>Position _____ <input type="checkbox"/></p>	<p><b>Examen touché</b></p> <p>Utérus _____ <input type="checkbox"/></p> <p>Taille _____ <input type="checkbox"/></p> <p>Consistance _____ <input type="checkbox"/></p> <p>Forme _____ <input type="checkbox"/></p> <p>Position _____ <input type="checkbox"/></p> <p>Sensibilité _____ <input type="checkbox"/></p>	<p><b>Annexes</b></p> <p>Ovaires _____ <input type="checkbox"/></p> <p>Trompes _____ <input type="checkbox"/></p> <p><b>Prélèvements</b></p> <p>Frottis Vag. _____ <input type="checkbox"/></p> <p>Frottis Pap. _____ <input type="checkbox"/></p>
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**IV - METHODE CONTRACEPTIVE CHOISIE**

1 Pilule _____ <input type="checkbox"/>	4 Condom _____ <input type="checkbox"/>
2 D.I.U. _____ <input type="checkbox"/>	5 Diaphragme _____ <input type="checkbox"/>
3 Spermicide _____ <input type="checkbox"/>	6 Autres _____ <input type="checkbox"/>

43

**RAISON DE QUITTER**

- 1 - GROSSESSE
- 2 - VOYAGE
- 3 - AUTRES

57





## Patient Record Form - Infertility

REPUBLIQUE DU SENEGAL

MDS MSP

PROJET SANTE FAMILIALE

Région de _____
Dépt de _____
Centre de _____
Numéro _____

N° \_\_\_\_\_ | 1-6

Date \_\_\_\_\_ | 7-12

**FICHE DE CONSULTATION - STERILITE****I - INTERROGATOIRE**

Prénoms \_\_\_\_\_ Adresse \_\_\_\_\_

Nom \_\_\_\_\_ Age \_\_\_\_\_  13 - 14 **Histoire Stérilité**Primaire \_\_\_\_\_ Secondaire \_\_\_\_\_ **Antécédents Obstétricaux (N = Normal, A = Anomalie - préciser sous observations)****Personnels :**Enfance \_\_\_\_\_ Puberté \_\_\_\_\_ Accouchements \_\_\_\_\_ Fausse couches \_\_\_\_\_ **Familiaux :**Ages \_\_\_\_\_ Maladies \_\_\_\_\_ Fécondité des  
parents \_\_\_\_\_ Frères \_\_\_\_\_ Sœurs \_\_\_\_\_ Oncles \_\_\_\_\_ Tantes \_\_\_\_\_ **Antécédents Gynéco.**Inf. trompes \_\_\_\_\_ MST \_\_\_\_\_ Autre \_\_\_\_\_ **Autres Maladies**Anaémies \_\_\_\_\_ Paracytoses \_\_\_\_\_ Tuberculose \_\_\_\_\_ Autre \_\_\_\_\_ **Chirurgicaux**Abdomen \_\_\_\_\_ Autre \_\_\_\_\_ **Fonctions Génitales****Menstruation :**Périodicité \_\_\_\_\_ Durée (J) \_\_\_\_\_ Quantité \_\_\_\_\_ Aspect \_\_\_\_\_ A la puberté \_\_\_\_\_ Actuel \_\_\_\_\_ Amenorrhoea \_\_\_\_\_ Métrorragies \_\_\_\_\_ Dysmenorrhoe \_\_\_\_\_ Début \_\_\_\_\_ Horaire \_\_\_\_\_ Char/Douleur \_\_\_\_\_ Crise int/men \_\_\_\_\_ Vie sexuelle : \_\_\_\_\_ Rapports compl \_\_\_\_\_ Part varioux \_\_\_\_\_ Fréquence/sem \_\_\_\_\_ Orgasme \_\_\_\_\_ **II - EXAMEN GENERAL**Taille \_\_\_\_\_ Poids \_\_\_\_\_ T.A. \_\_\_\_\_ T (C) \_\_\_\_\_ Type \_\_\_\_\_ Pilosité \_\_\_\_\_ Adiposité \_\_\_\_\_ Pigmentation \_\_\_\_\_ Cardiovasc \_\_\_\_\_ Poumons \_\_\_\_\_ Squel/Nerv \_\_\_\_\_ Alimentaire \_\_\_\_\_ **III - EXAMEN GYNECOLOGIQUE (Noter N - Normal, A - Anomalie)**Date dern règles \_\_\_\_\_ Date dern rapp \_\_\_\_\_ Seins \_\_\_\_\_ **Organes externes**Ecoulements \_\_\_\_\_ Ulcération \_\_\_\_\_ Vésicule \_\_\_\_\_ Kystes \_\_\_\_\_ Malformation \_\_\_\_\_ Autre \_\_\_\_\_ **Examen spéculum**Vagin : Lesion \_\_\_\_\_ Pertes \_\_\_\_\_ Col : Taille \_\_\_\_\_ Couleur \_\_\_\_\_ Position \_\_\_\_\_ **Examen touche**Utérus : taille \_\_\_\_\_ Consistance \_\_\_\_\_ Forme \_\_\_\_\_ Position \_\_\_\_\_ Sensibilité \_\_\_\_\_ **Annexes :**Ovaires \_\_\_\_\_ Trompes \_\_\_\_\_

**IV - EXAMEN PARACLINIQUE (Noter les résultats éventuels).**

GS Rh _____	<input type="checkbox"/>	BW _____	<input type="checkbox"/>
Tx Hb _____	<input type="checkbox"/>	T. Est d'Emmel _____	<input type="checkbox"/>
Glycémie _____	<input type="checkbox"/>	Frottis vag _____	<input type="checkbox"/>
Combe thermique _____	<input type="checkbox"/>	HSG _____	<input type="checkbox"/>
Biopsie endomet _____	<input type="checkbox"/>	Autres _____	<input type="checkbox"/>
Test post coital _____	<input type="checkbox"/>		

Hydrotubations éventuelles: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V - EXAMEN DU CONJOINT**

Age \_\_\_\_\_  Profession \_\_\_\_\_

**Antécédents**

**Personnels :**

Enfance \_\_\_\_\_   
Puberté \_\_\_\_\_   
Oreillons \_\_\_\_\_   
MST \_\_\_\_\_   
Autres \_\_\_\_\_

Chirurgicaux \_\_\_\_\_

Familiaux \_\_\_\_\_

Fonctions Génitales \_\_\_\_\_

**Examen Genital**

Organes externes \_\_\_\_\_   
Testicules \_\_\_\_\_   
Prostate \_\_\_\_\_

**Examen Général**

Cardiovasc \_\_\_\_\_   
Poumons \_\_\_\_\_   
Squel/Nerv \_\_\_\_\_   
Alimentaire \_\_\_\_\_

**Examen Complémentaire**

CS Rh \_\_\_\_\_   
Glycémie \_\_\_\_\_   
Spermogramme \_\_\_\_\_

**VI - OBSERVATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**VII - TRAITEMENTS**

**Antérieurs :** \_\_\_\_\_

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**Actuels :** \_\_\_\_\_

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**Résultats thérapeutiques :** \_\_\_\_\_

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STD (Sexually Transmitted Diseases)

REPUBLIQUE DU SENEGAL

MDS / MSP

PROJET SANTE FAMILIALE

Région de _____
Dépt de _____
Centre de _____
Numéro du centre _____

N° \_\_\_\_\_ | | | | | | | 1-6

Date \_\_\_\_\_ | | | | | | | 7-12

**FICHE DE CONSULTATION - M S T**

**I - INTERROGATOIRE**

Prénoms \_\_\_\_\_ Adresse \_\_\_\_\_

Nom \_\_\_\_\_ Age \_\_\_\_\_

13 - 14

**Histoire de Maladie**

Symptomes MST :

Oui \_\_\_\_\_

Non \_\_\_\_\_

Début :

1 à 7 jours \_\_\_\_\_

7 à 28 jours \_\_\_\_\_

28 + jours \_\_\_\_\_

**Antécédents de MST**

Ecoulement \_\_\_\_\_

Ulcération \_\_\_\_\_

Douleurs \_\_\_\_\_

Vésicules \_\_\_\_\_

Autres \_\_\_\_\_

**Notion de Contage**

Conjoint \_\_\_\_\_

Ami (e) \_\_\_\_\_

Liaison de passage \_\_\_\_\_

Autres \_\_\_\_\_

**Lieu de Contamination**

Zone urbaine \_\_\_\_\_

Zone rurale \_\_\_\_\_

A l'étranger \_\_\_\_\_

Autre \_\_\_\_\_

**Rapports Sexuels**

Fréquence / sem. \_\_\_\_\_

Partenaire / sem. \_\_\_\_\_

**II - DONNES CLINIQUES**

Écoulement Génital :

1 à 28 jours \_\_\_\_\_

28 + jours \_\_\_\_\_

Ulcération \_\_\_\_\_

Douleurs \_\_\_\_\_

Vésicules \_\_\_\_\_

Autres \_\_\_\_\_

**III - DONNES DE LABORATOIRE**

**Gonocoecie**

Examen direct :

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

Culture : \_\_\_\_\_

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

**Chlamydia**

Examen direct :

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

Culture : \_\_\_\_\_

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

**Autres**

Examen direct :

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

Culture : \_\_\_\_\_

Positif \_\_\_\_\_

Négatif \_\_\_\_\_

**IV - DIAGNOSTIC FINAL**

Gonocoecie \_\_\_\_\_

Chlamydia \_\_\_\_\_

Autre \_\_\_\_\_

