THE FUTURES GROUP

OPTIONS II Project

Family Planning Regulatory Activity in Senegal

Regulations and Procedures that Undermine Service Delivery and Encourage High Fertility: Observations and Suggested Activities

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Executive Summary

There is substantial concern in Senegal that laws and regulations play an important role in undermining family planning service delivery and in encouraging high fertility. Though the importance of legal and regulatory constraints to contraceptive use and reduced fertility is recognized, there is not an adequate understanding of which regulations impact fertility, nor has there been a concerted movement to alleviate constraints and bring about change.

In light of this need for further legal and regulatory work the OPTIONS II project proposed a range of activities to address both supply-side and demand-side regulations.

Supply-side regulations are those which affect the supply of contraception by: restricting who may provide contraception (e.g., nurses may not insert IUDs); encumbering access (e.g., an extensive medical examination is required); and limiting who may receive (e.g., nulliparous women may not receive pills). Supply-side regulations may affect both public sector and private sector provision (e.g., sterilization is illegal), or regulations may affect one sector more than another (e.g., condoms may not be sold in stores or by street vendors).

Demand-side regulations are those which encourage preferences for high fertility (e.g., retirement waivers granted to parents of young children, or inheritance which is divided among polygamous wives based on the number of children they have). A key aspect of the OPTIONS II agenda has been to focus on the *impact* of regulations rather than on whether a regulation is officially prescribed: an unofficial rule that is imposed is more important than an official rule that is ignored.

This report provides information on the current legal and regulatory climate in Senegal, some of the key regulatory constraints that have become apparent, and some of the activities that may be appropriate to address these constraints.

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Background

Senegal's population is growing so fast that it will double in 25 years. The lack of quality family planning services in many areas and the cultural attitudes of Senegalese men and women which favor a large family both contribute to high fertility. There is substantial concern in Senegal that laws and regulations play an important role in undermining service delivery and in encouraging high fertility. The importance of legal and regulatory constraints to contraceptive use and reduced fertility are recognized, and a substantial number of projects have tried to address the issue (e.g., the 1988 National Population Policy called for a study of the regulatory situation; the World Bank demanded regulatory changes as a condition precedent to its new project; CERPOD sponsored a review of laws and regulations across a broad spectrum of population policy issues such as education, women's rights, and female labor force participation). While these projects have pointed out the importance of regulations to policy development, they have not yet followed through to alleviate the regulations which impose a constraint. Much of the work has been a technical review of documents without an assessment of the magnitude of the fertility impact of regulations, and without a set of activities to bring about change. In the few instances where there has been follow-through to change a regulation (e.g., the 1991 Decree which states that laboratory analyses of blood are not required for a pill prescription), dissemination of information and confirmation that behaviors have changed have been inadequate.

In light of this need for further legal and regulatory work the OPTIONS II project proposed a range of activities:

- to research which regulations are being imposed;
- to identify priority regulations which have the greatest potential to undermine service delivery and encourage high fertility; and
- to suggest activities which could alleviate these constraints.

OPTIONS II proposed activities to address both supply-side and demand-side regulations because both types play a significant role in Senegal. Supply-side regulations are those which affect the supply of contraception by: restricting who may provide contraception (e.g., nurses may not insert IUDs); encumbering access (e.g., an extensive medical examination is required); and limiting who may receive (e.g., nulliparous women may not receive pills). Supply-side regulations may affect both public sector and private sector provision (e.g., sterilization is illegal), or regulations may affect one sector more than another (e.g., condoms may not be sold in stores or by street vendors).

Demand-side regulations are those which encourage preferences for high fertility (e.g., retirement waivers granted to parents of young children, or inheritance which is divided among polygamous wives based on the number of children they have). A key aspect of the OPTIONS II agenda is that OPTIONS II is more interested in the impact of

regulations than whether a regulation is officially prescribed. An unofficial rule that is imposed is more important than an official rule that is ignored.

These proposed activities are described in OPTIONS/CERPOD Population Policy Strategy: Senegal by Galway, Knowles and Dicko following their May 1991 visit to Senegal, and in a document Suggestions for Activities to Alleviate Long Term Constraints to an Expansion of Family Planning in Senegal submitted to USAID/Dakar by Galway and Knowles, June 1991. It was agreed that OPTIONS II central funds would be used to support an activity to research and identify regulations and procedures at public sector clinics which may be constraining increased contraceptive use, and to propose activities to alleviate these constraints. The research approach included a review of documents, discussions with key officials, and interviews with service providers in four regions of the country. This activity has been carried out. Interviews were conducted with providers in 17 clinics in the regions of St. Louis, Kaolack, Ziguinchor and Dakar. The results of these interviews are documented in Trip Reports of October 1991 and January/February 1992, and in a report entitled OPTIONS II Project Family Planning and Regulatory Activity in Senegal: Notes and Reflections on Interviews with Family Planning Service Providers. Funding for further regulatory activities are envisioned to come from other sources. The following report presents an overview of the key regulatory constraints that have become apparent, and some of the activities recommended to address these constraints.

Laws, Regulations and Procedures that Appear to Impose a Constraint

Supply-Side Regulatory Constraints

Many laws, regulations and standard protocols affect who may provide contraception; how family planning services are delivered; and who may have access to contraception.

Sterilization is Illegal Both male and female sterilization are illegal in Senegal. However, there are a few sites that can perform a sterilization (e.g., Dantec Hospital), and there is a way that couples can absolve the surgeon from legal liability. Couples go to the police and sign documents to officially register that they have voluntarily requested the sterilization, and that they will not hold the surgeon liable for their sterility. Most Ministry of Health and other officials do not think that legalizing sterilization needs to be given a high priority. They claim that it is so rare for a couple to want a sterilization, and so rare for personnel to be trained to perform a sterilization that legalizing sterilization would have little impact on practice.

Nurses Are Not Allowed to Insert IUDs Nurses are the sole source of modern medicine for many women yet they are not allowed to insert IUDs. At this moment there is a critical debate about whether nurses should continue to be excluded from IUD insertion training. The World Bank has made a condition for its loans that family planning be included in the basic training of all public health workers. However, the document that responds to this requirement specifically states that nurses will be excluded from training to insert IUDs. The debate over this clause is splintered: one group states that nurses are not sufficiently high level health professionals to do IUD insertions; another group states that it is the stature of the clinic in which the nurse works that should be the determining factor. The latter group focuses on whether the clinic has the resources to cope with possible IUD complications. However this issue is resolved and codified will make a great difference to access to IUDs.

Husband's Approval is Requested Providers usually ask if the woman's husband approves of her contraceptive use. It is rare that the provider asks for proof of the husband's approval, and in several cases (especially when the woman's health is in jeopardy) providers give women contraception even if they know the husband disapproves. Both at the clinic level, and among persons in the Ministry of Health and the Ministry of the Woman, Child and Family, officials agree there is no document or regulation which requires that the husband approve of contraception. Most officials agreed that activities to stop providers from inquiring would bring attention to an innocuous habit and cause a backlash; their recommendation is to ignore this issue.

Over Medicalization of Provision Provision of contraception in government and other public sector clinics is inordinately medicalized. Staff call clients "*les malades*" and usually do as thorough a physical examination as their medical environment permits (including requesting blood, urine, STD and Papanicolaou smear tests). The examination is personally intrusive, and may require women to spend substantial time, money and effort. Providers not only search for contraindications to the selected method, they often deny pills or an IUD to a woman unless she is in perfect health. Given that women hardly ever come in specifically for the health examination itself, it is possible that substantial numbers of women refrain from seeking contraception because they do not want the health tests.

Once a woman has passed the health screening she will only be allowed to receive pills if she is menstruating at that moment, and for at least the first few months she will receive only one cycle of pills at a time. This is to control for correct use. Nulliparous women are often denied pills because staff are concerned that women who have not "proved themselves" may turn out to be sterile and will later blame them for their sterility.

This medicalization and fear of contraception imposes regulatory constraints to family

planning: in terms of the user it makes access to contraception more time consuming, expensive, and personally intrusive; it limits many viable users from obtaining their preferred method it sends a message to the user that contraception is dangerous, and it belittles family planning; in terms of the provider the effort and time required per client is increased, and the personal importance and health benefits of family planning are diminished.

Senegal faces important policy decisions in this regard. A key issue is whether to give priority to identifying a range of health ailments or to facilitate access to contraception and meet fertility desires. Many MOH staff are pleased that contraception brings in women to be medically examined, and they believe it is worth the price of losing some potential contraceptive users. A related issue is whether family planning should be integrated into existing health services. This approach is vocally supported, and written into both the National Population Policy and official Ministry of Health planning documents. However if access to contraception is burdened by other health interventions the policy of integration may be a detriment to family planning, and maybe provision of contraception could be more successful outside of such a medical environment.

Decision makers and managers are also faced with policy choices about the direction and form for improvements in quality of care. Clinic staff want to give a larger battery of tests: this is what they were trained to do, and they perceive it as an improvement in the quality of their service. Tough choices will need to be made about what is quality of care, and whether more is better.

Officials who decide about procedures for providing contraception may be better able to assess their policy options if they understood the relative benefits of their choices. Officials may not know that contraceptive technology is not dangerous; that the health hazards of giving birth may be far greater than the other ailments for which they test; that women are deterred by these tests; that these tests are not required in developed countries; and that family planning is very important for the woman, for the family, and for the country. At least one AID review of these issues has postulated that officials may be aware of these issues, and that they thoughtfully use family planning resources to provide other services which they feel are more important.

Condoms May Not Be Sold Outside of Pharmacies The private sector is very important to the provision of contraception. Close to half of all women who use modern contraception obtained their method from a private sector source. Restrictions on how the private sector may expand, and restrictions on the creative alternatives which may be used can undermine an important resource for family planning supply. In addition to many of the regulations that also constrain the public sector (e.g., sterilization is not legal), the private sector has its own constraints to provision.

Presently Senegal is investigating the possibility of using social marketing as a means of distribution, and has requested designs for a pilot CSM project. Regulatory constraints stand in the way, and need to be resolved before the project can be launched. First, condoms were recently classified on the "essential drug" list so they would be tax-free, however, this constrains them to be sold only in pharmacies. Creative distribution beyond pharmacies is needed both to allow a greater range of access, and to stimulate better competition in pricing. There are too few pharmacies- only 230 pharmacies in a population of almost 8 million persons (one pharmacy per 35 thousand persons). Therefore legislation is needed to change the classification of condoms to allow them to be sold in shops and kiosks, outside of pharmacies.

Another major concern for social marketing is that the pharmacies have an extremely strong hold on the distribution of medical supplies and have affected legislation in a way detrimental to affordable and easy access. The association of pharmacists recently sued the government over the Bamako Initiative, and demanded the removal of statements that generic drugs should be given a priority. The pharmacists do not want to have the cheaper generic drugs competing with them. These pharmacist have tried to disallow any distribution of contraception (including condoms) outside of pharmacies. Pharmacists have written a position statement that supports social marketing of condoms only if distribution is through pharmacies. A strong and creative effort is needed to bring about new regulations that will allow others to distribute contraceptives outside of a pharmacy.

Demand-Side Regulatory Constraints

The importance of regulatory incentives to high fertility has been recognized in Senegal. Though there have been calls to address this issue (e.g., the national population policy called for a study of the regulatory situation) there is not a consensus about which legal and regulatory factors actually stimulate fertility, and substantial changes have not been achieved. Examples of factors that have been mentioned include:

incomes that increase with the number of children;
retirement waivers granted to parents of children under age 10; and
inheritance which is divided among polygamous wives based on the number of children they have.

The first step is to identify the regulations and benefits which encourage couples to have many children. Research is needed, including data analysis or focus group discussions, to assess how a regulation or tax code may increase incomes and benefits, or reduce financial burdens or other risks.

Possible Activities to Stimulate Changes in the Regulatory Framework

To Resolve Constraints to the Supply of Contraception

Build policy support for family planning Following are suggestions for analyses and presentations to build support for family planning which could play an important part in easing restrictions on supply.

Show the magnitude and severity of men's and women's unmet need for family planning to build awareness of the importance of contraception to avoid unwanted births.

Compare the relative health and mortality risks of contraception and of a birth to show that contraception should be given a greater health priority.

Show the epidemiological importance of births in relation to the other health ailments that are being monitored by the exams (e.g., breast cancer).

Estimate the probability of receiving care for an ailment, in comparison with the chance that use of contraception will have a health benefit.

Contraception has the further health benefit that if high risk births are avoided, and if there are fewer births in general, there will be more health resources per capita.

Raise questions about which tests are given. For example temperature and listening with a stethoscope may be very important to young and middle-aged women, especially with tuberculosis and other respiratory diseases.

Invite a French or American clinician to come and explain the procedures used in the US or France (e.g., that women are give 13 cycles of pills at their first visit).

Empower a central medical/health committee that could design and bring about regulatory change A main focus of discussions on possible activities to alleviate constraints from over medicalization has been on developing and empowering a committee. This committee would be comprised of high level persons in the medical and health communities, and would have oversight responsibilities for regulations and procedures that affect family planning provision. This committee seems timely given that the committee formed to supervise the introduction of NORPLANT has recommended that a more permanent, and more encompassing committee be formed. The committee would be formed at the request of the Minister of Public Health &SA to

ensure that recommendations of the committee would be adopted. Policy activities targeted to this committee would intend to increase committee members' commitment and skill to give family planning a greater priority, and to remove restrictions and encumbrances on its provision and access. Examples of policy presentations to this committee can include presentations of: the relatively low health hazards of taking contraception compared to having a birth; the few contraindications of methods and the limited interventions needed to recognize them; the simplicity of standard procedures used to obtain contraception in developed countries such as the US or France. Immediate areas of impact for this committee could include revising the curriculum of nurses and mid-wives, rewriting the standard form clients fill-out when seeking contraception, and developing a providers' manual.

Interview women to determine which procedures encumber access the most To develop a greater understanding of which regulations actually affect women, and to have empirical information to prove to officials that changes are needed, it would be useful to directly interview women about their opinions on clinic procedures. Dr. Viola Vaughn, an independent consultant, and Caroline Mane of the PSFP, who recently conducted interviews with women to determine rates of contraceptive discontinuation and failure expressed an interest in this research and suggested the following agenda.

Three types of women need to be interviewed:

1. women who have not approached a clinic for contraception
2. women who have gone to a clinic for contraception, but who have discontinued
3. women who continue to use contraception from a clinic.

Five women of each characteristic should be interviewed (perhaps with more women of the first two categories, because it is these women that are the most interesting). Women should be interviewed in each of the four regions where OPTIONS II interviewed service providers. Though it would be preferable to interview women who are in the catchment area of each of the clinics, in the interest of saving time and money it was proposed to focus on the catchment areas of only one large and one small clinic in each region. Women who currently and formerly used the clinic would be obtained from recent records; women who never used would be found through contacts of the women who used clinic (on the assumption that they would be roughly socio-economically comparable, and therefore potential clients of the clinic).

Disseminate and assure the adoption of regulatory changes Carry out seminars and workshops in each district to disseminate the meaning and implications of regulatory changes. For example, the conclusions of the research, and the mandate of the 1991 Decree concerning laboratory tests for pill prescriptions has not been adequately disseminated and adopted. Key officials believe that excessive testing is an important constraint to family planning, and that dissemination of information is needed to change

this practice.

Develop support for legalization of sterilization Short of changing the law that prohibits sterilization, the procedures to absolve the surgeon of liability could be made better known, and could be simplified. This would involve communicating to doctors how to counsel their patients about what to do, and communicating to the local police and other relevant entities how to receive a couple's request.

Ultimately the law will need to be removed. This would occur more easily if it follows substantial dialogue about couples' desires to limit births, and the national benefits of fertility reduction. Many official documents which Senegal upholds contain statements that couples have a right to choose the number and timing of their children (e.g., the National Population Policy states "..droit des individus et couples à choisir la taille de leur famille et à maîtriser leur fécondité...", the N'Djamena declaration states "...les Etats devrait veiller à ce que tous les couples ou individus...avoir accès aux services de planification familiale et y avoir recours..."). Presentations could be developed to point out this fact, and assert that leaders should provide couples with the means to achieve their right, and that leaders should not disdain couples who do choose to limit the number of their children. Lead this discussion to the conclusion that couples should also have more liberal access to sterilization.

Sterilization may also be more acceptable if it is seen as healthy and cost-effective. Presentations could be developed for persons in the medical community and in key legal positions to show that sterilization is far safer for a woman than a birth, and that among alternatives for long term contraception sterilization has the least risk of death and the least side effects. Presentations could also be developed that show the costs of providing a sterilization compared to the cost of providing a woman with years of protection from alternative methods to indicate that sterilization is a very cost effective alternative.

Change the Classification of Condoms so They May Be Sold Outside Pharmacies
Condoms were recently reclassification to be included on the "essential drug" list so they could be freed from taxation. Decision makers who approved this classification may not have been aware that as an "essential" product condoms may only be sold in pharmacies. This fact should be brought to their attention, and the classification should either be changed or an exception should be given so they may be sold in the market.

The first step is to research the legal and political situation. This includes a review of the key documents, and an identification of the individuals and institutional groups that are key actors in advancing or blocking reclassification. A plan should be developed for each of the steps, documents and signatures required for reclassification. Whenever needed assistance should be anticipated to draft memoranda and walk documents around for signatures. If there is resistance to the idea of allowing condoms to be sold

outside of pharmacies, several appeals can be developed. It can be asserted that more affordable and ready access to condoms supports national policy goals to increase family planning, and to reduce the prevalence of STDs and AIDS. Arguments that market sales will decrease the quality of the condoms being distributed can be countered with information about the success and high standards of quality that have been maintained in other countries. Moreover, Senegal already has a black market in condom sales, and legal sales in the market could ensure better quality of condoms.

Pharmacies may try to prevent distribution of condoms outside of pharmacies even if it becomes legal. Pharmacies may band together and boycott any distributor who provides to a non-pharmacy distributors. Carrying out such a boycott may be illegal; this should be researched and pointed out if so. If it appears very unlikely that condoms could be sold outside of pharmacies in the near future, alternatives can be used to initiate a social marketing program through the pharmacies. If the pharmacists are even wary about advertising and reduced prices they may be urged to try it if they are presented with information that assures them that their profits will not be diminished. Presentations can be prepared with data from other social marketing projects that document the "halo effect": where social marketing efforts have been shown to increase the sales of all products in the same category.

To Resolve Constraints to the Demand for Contraception

The first step of this activity is to identify the regulations and benefits which encourage couples to have many children (such as those included in the CONAPOP study). The magnitude of the impact on fertility of each regulation can be assessed through data analysis or personal interviews and focus group discussions. A model can be used to study behavior differences with differences in regulations; or focus groups can be used to inquire how people would act if regulations were different, or if inherited wealth were distributed differently. The one or two main regulations can be identified. Once these most important legal and regulatory constraints have been identified, the key individuals who uphold these constraints can be identified (e.g., Ministry of Economy, Finance and Plan administrators who uphold salary supplements to large families).

The National Population Commission CONAPOP, housed in the Planning Division of the Ministry of Finance, Economy and Plan is an interministerial advisory committee on population policy with responsibility for proposing changes to laws and regulations which affect population and family planning. Senegal is fortunate to have CONAPOP as an established mechanism for recommending and reviewing proposed legal and regulatory changes in population matters. CONAPOP could be the audience for expert working group recommendations on legal and regulatory changes in a certain area. CONAPOP could consider and in turn recommend the proposed changes for GOS approval as soon as possible.

A plan of activities can be designed to reorient the perspective of these key individuals, and to facilitate change. For example, a seminar may be arranged for tax or social security officials to reflect on the mandates of the 1988 population policy and how research has indicated that existing regulations favor large families, and to discuss the costs of providing salary supplements to cover an employee's children.

The next step is to identify who makes the laws- what is the process to change the regulation, is it a large process or is it simple? Who are the key individuals that need to be addressed? CONAPOP could play an important role at this stage. An analysis can then be developed on the impact of altering the regulation (e.g., an analysis of age and salary to identify the financial impact of requiring all employees to retire at age 55). Dissemination of the analyses and findings needs to be emphasized through seminars, publications, media discussions and other fora.

Monitoring and Evaluation

Changes in supply-side and demand-side regulations have a large potential to increase contraceptive access and demand in Senegal. Appropriate performance indicators for this legal and regulatory work are important to measure the change. Output indicators might include a report identifying the two or three key legal and regulatory constraints to current FP service delivery expansion, including rough estimates of the magnitude of increased FP services which might result from their removal. Other performance indicators might include studies conducted to examine issues surrounding the removal of key legal and regulatory constraints and reports of seminars or workshops conducted to review proposals concerning their removal (e.g., draft revisions to laws and regulations). Appropriate outcome indicators might include the approval of actual changes in laws and regulations undertaken as the result of the activities undertaken.

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