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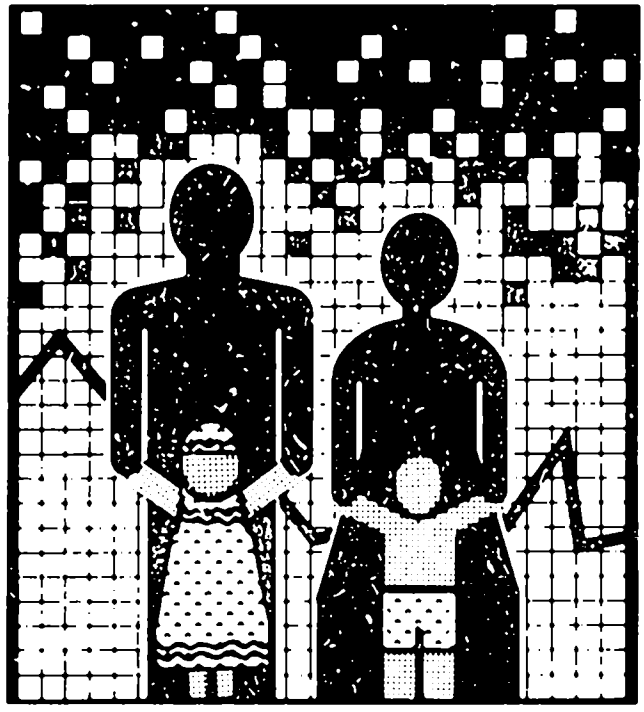

SITUATION ANALYSIS OF THE FAMILY PLANNING SERVICE DELIVERY SYSTEM IN SENEGAL

CONDENSED REPORT

Ministry of Health
and Social Action

National Family Planning
Program of Senegal

The Population Council

Africa Operations
Research and Technical
Assistance Project II

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I. EXECUTIVE SUMMARY

The Executive Summary of this report can be downloaded at the following Internet address: http://www.popcouncil.org. Point your web browser to:

- Council Programs
- Operations research and Technical Assistance Programs (OR/TA)
- The Africa OR/TA Project II
- Executive Summaries

A Situation Analysis was undertaken in 1994 to provide comprehensive descriptive information on the availability, functioning, and quality of family planning services, and to identify particular strengths and weaknesses of the National Family Planning Program (PNPF) of Senegal. The study was carried out by the research staff of the PNPF with technical assistance from The Population Council's Africa OR/TA Project II. The Situation Analysis study in Senegal, the sixth study conducted by The Population Council in Francophone Africa (Benin, Burkina Faso, Côte d'Ivoire, Madagascar, and Zaire), covered all 180 functional service delivery points (SDPs) of the country's 10 regions.

The study findings showed that the clinic infrastructure was generally satisfactory, although in rural areas, electricity and water were lacking in 30% of the SDPs. Training, supervision, and equipment sub-systems had substantial problems: the majority of family planning providers were midwives whose formal training had been limited to the management of pills and IUDs, and 32% of the family planning providers had no training in administering injectables; almost one third of the SDPs had not received a supervisory visit in the seven months or more prior to the study, and an additional one fifth had had no supervisory visits at all; only six out of 87 SDPs in the urban sector had the minimum indispensable equipment, as defined by the PNPF, to provide family planning services. Information, Education and Communication (IEC) materials and activities were not available at most SDPs. Only 6% of the SDPs featured FP talks on site on the day of the research visit, and 60% lacked a visible sign indicating the availability of family planning services. Most SDPs offered a variety of contraceptive methods, with 67% providing injectables and 78% supplying IUDs. Inadequate management of contraceptive stock was partly responsible for method shortages. There was a lack of systematic mechanisms in the record keeping system. Incomplete records in virtually all the SDPs meant that their performances could not be accurately assessed. The study revealed a weak management system, where only 6% of the SDPs had written job descriptions for their personnel, 8% had a plan of activities, and only 2% had an objective in terms of the number of clients to serve.

The quality of services was measured through data from observations and interviews, and interpreted using the Bruce-Jain quality of care framework. The majority of new clients (81%) had access to and obtained their preferred contraceptive method. However, in most cases, other appropriate methods were not discussed during consultations. Client counseling was inadequate, particularly with respect to method side-effects and how to manage them. Only 56% of new clients were asked about their reproductive intentions. Counselling sessions on STDs and HIV/AIDS were practically non-existent. In terms of the integration of services, the study found that health problems unrelated to family planning were rarely addressed during consultation. Most clinic staff demonstrated a moderate level of technical competence during interviews with clients. Non-medical barriers to the utilization of contraceptive methods existed in terms of age, parity, and marital status. In addition, client waiting time was considered long and consultation time short. Almost all women had follow-up appointment dates on their identification cards, and about 95% were told to return to the same clinic for the resupply of contraceptive methods. Despite many shortcomings, the majority of clients were generally satisfied with the services they received.

The results of the Senegal Situation Analysis study were presented to senior program managers at the Ministry of Health and Social Action and the National Family Planning Program, representatives of major funding agencies, and NGOs at a dissemination seminar held in January 1995 in Dakar. A second presentation of the study results took place at a workshop held in February 1995 in Dakar, on the implementation of the Child Survival/Family Planning Project, the third five-year project financed by USAID in Senegal. In addition, dissemination seminars of the Situation Analysis study results were conducted in each of the country's 10 regions.

II. INTRODUCTION

Fertility trends in Senegal have paralleled those in sub-Saharan Africa as a whole. The most recent Demographic and Health Survey placed Senegal's current total fertility rate (TFR) at 6.0 children per woman (1992/93), indicating a consistent decline from the 1978 World Fertility Survey TFR of 7.1. Despite progressive efforts on the part of the Senegalese government, the country's high fertility and growth rates have been accompanied by serious health problems, and, like many West African countries, Senegal has only recently become concerned with demographic issues and their impact on economic development.

Policy developments favoring the expansion of family planning began in 1980, when a French law prohibiting the distribution and use of contraceptives was revoked. This initiative cleared the way for major donors, such as USAID and UNFPA, to begin their population programs in 1981 and 1982, respectively, covering all 10 regions of the country. In 1988, the Government of Senegal officially adopted a population policy, which served as a preamble to the creation of the country's National Family Planning Program in 1991.

The PNPF plays a central role in the coordination and implementation of family planning and maternal and child health activities nationwide. However, it is currently undergoing a period of transition as it is called upon by the Ministry of Health and Social Action (MSAS) to re- address its priorities and resources to improve the quality of FP service delivery. Although previous evaluations have provided some indication of how to improve the quality of services, no study has provided a comprehensive diagnosis of the situation, and no specific interventions based on reliable data have been formulated to date.

III. OBJECTIVES

The 1994 Senegal Situation Analysis (SSA) study is the first of two major studies programmed by the PNPF in collaboration with The Population Council's OR/TA Project II. The study's immediate objectives are to:

1. provide descriptive information on the availability, functioning, and quality of family planning services in Senegal, and to identify particular strengths and weaknesses of the national program;

2. formulate strategic recommendations for the Program on Child Survival and Family Planning, a five-year program funded by USAID;

3. identify and provide indicators of quality to the Ministry of Health and Social Action.

IV. METHODOLOGY

There are three sampling units in a Situation Analysis (SA) study: the Service Delivery Point (SDP), the staff at each SDP, and the clients. Standard data collection instruments covering all sampling units include:

- an inventory of supplies, equipment, and other facility features;
- an observation of provider-client interactions;
- an interview with family planning clients;
- an interview with family planning staff;
- an interview with maternal and child health clients.

The data collection instruments were customized for Senegal during the spring and summer of 1994, and were pre-tested in July of the same year. Data collection took place from August 1 to September 30, 1994.

Whereas Situation Analysis studies were originally intended to generate basic descriptive information, the study objectives have increasingly included more sophisticated analysis as well as research and hypothesis testing. Currently, Operations Research projects at The Population Council attempt to address a substantive methodological issue in each new study.

The Senegal Situation Analysis study has three main distinguishing characteristics:

1. Exhaustive Sample

Unlike most previous SA studies, where large and representative samples were selected for analysis, in Senegal, teams visited each one of the 180 functional SDPs providing family planning services **(Table 1)**. All family planning service providers and clients who were present on the day of the survey were interviewed, as well as several MCH clients.

2. Experimental Approaches

One of the innovative aspects of the present study is the inclusion of special questions concerning abortion and reproductive intentions. Women were asked about their abortion history using direct and indirect approaches, to assess whether different ways of asking abortion questions has an effect on response rates. The second experimental approach involves a panel group of women who were selected and interviewed about their reproductive intentions. The panel will be followed and re-interviewed during the second Situation Analysis study to determine whether they were able to meet their objectives.

3. Control of Observer Bias

In order to investigate whether the presence of an observer biases the providers' performances during consultation, research teams made consecutive return visits of up to two or three days, particularly at clinics with high case loads.

V. RESULTS

The study results are presented in three sections: the first describes the socio-demographic characteristics of FP and MCH clients; the second depicts the functional capacity of SDPs; and the third delineates the six basic elements of the quality of care at SDPs based on the Bruce-Jain quality of care framework.

Table 1: Sample Sizes for the Senegal Situation Analysis Study, 1994

Region	Number of Districts	Number of SDPs	Number of observations/FP client interviews	Number of MCH client interviews	Number of staff interviews
Dakar	8	69	468	237	154
Kaolack	4	13	105	63	29
Fatick	6	10	61	48	13
Ziguinchor	3	11	51	31	25
Kolda	3	12	53	49	15
Tambacounda	4	5	29	26	15
Thiès	7	20	141	100	44
Diourbel	4	11	52	73	17
Louga	3	8	50	57	14
Saint-Louis	5	21	113	153	35
Total	47	180	1123	837	361

1. Socio-demographic Characteristics

Client age varies between 15 and 49 years, with a median age of 29 years for FP clients and 26 years for MCH clients. The grand majority of women interviewed are married, and more than half are in a monogamous marriage. Fifty-two percent of FP clients and 37% of MCH clients are educated. Virtually all women interviewed are Muslim.

Fertility levels are high in both populations: 53% of FP clients and 35% of MCH clients have at least four children. Nonetheless, the number of living children by group varies between 0 and 11. Approximately one out of three women were breastfeeding at the time of the survey. The median age of the latest child is 24 months.

The study reveals that there is a demand for spacing children as well as for limiting their number. In fact, 26% of FP clients and 19% of MCH clients do not desire any more children. Among those who wish to space their next birth (61% of FP clients and 77% of MCH clients), the desired interval is about three years or more. However, only 4.8% of MCH clients were using a contraceptive method at the time of the survey.

The methods most commonly accepted by new FP clients are the pill (51%), injectables (24%), and the IUD (19%). Among revisiting clients, the methods most frequently accepted are the pill (59%), followed by the IUD (26%), and injectables (11%). The recent introduction of NORPLANT® implants as part of a pilot project at five SDPs explains a utilization of this method by 5% of new clients, and 1% of revisiting clients.

2. Functional Capacity of SDPs

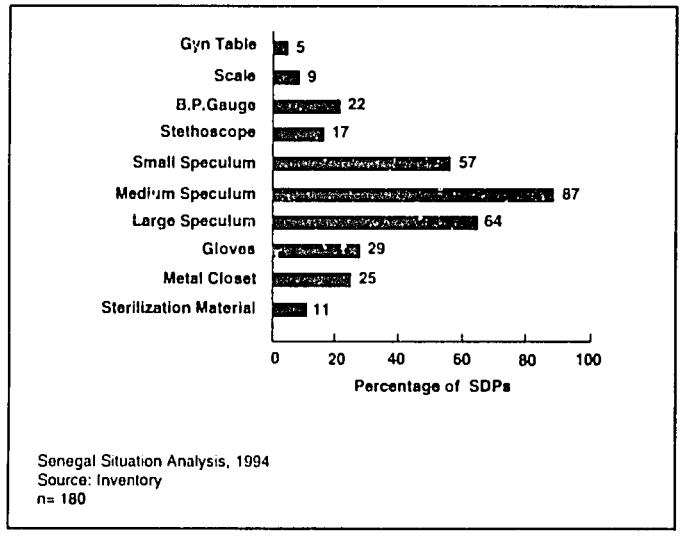
The systematic collection of data at the SDP level permitted insight about the functional capacity of each SDP in accordance with the following five elements:

(a) Facilities and Equipment

Facilities and infrastructure at the SDPs are considered satisfactory. Seventy-nine percent of SDPs have a separate room or area for examinations. The research team judged that in 85% of the SDPs, the examination room had visual privacy, 81% had auditory privacy, 88% were clean, and 84% had adequate light. A lower percentage (67%) had adequate water in the exam areas.

Figure 1 shows the percentage of clinics lacking the "minimum" equipment necessary for providing FP services. Whereas more than half of the clinics are missing the minimum number of specula, significant is the fact that 22% of SDPs are missing a blood pressure gauge, 17% are missing a stethoscope, and 11% are missing a set of sterilization materials.

Figure 1:
Percentage of SDPs Lacking the Minimum Equipment Necessary to Provide FP Services



(b) Contraceptive Supplies and Logistics

While the pill and barrier methods (condoms and spermicides) are available at all SDPs, the IUD and injectables are available at 78% and 63% of the SDPs, respectively. In the six months preceding the study, stockouts of combined oral contraceptives were common, occurring in roughly 8% of clinics providing the main brand, Lofemenal. Injectables had the highest frequency of stockouts, experienced by over 20% of SDPs. It should be noted that this is in part due to the fact that UNFPA was the sole provider of injectables at the time of the study.

Fifty-two percent of SDPs visited had a record system in place for tracking the contraceptive supplies and ordering. In 51% of SDPs, contraceptives were stored correctly by expiration date, and 79% of SDPs had storage areas which adequately protected supplies. The data indicate that while many clinics have available space and store their contraceptives appropriately, management aspects of storage and ordering could be improved.

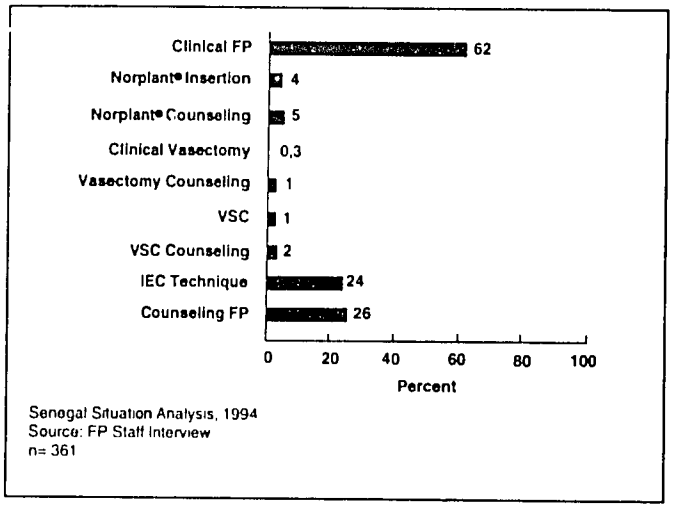
(c) Personnel Training and Experience

In Senegal, 361 staff members were interviewed for the study. The majority of them were midwives

(60%), followed by some community health agents (14%) and nurse's aides (13%).

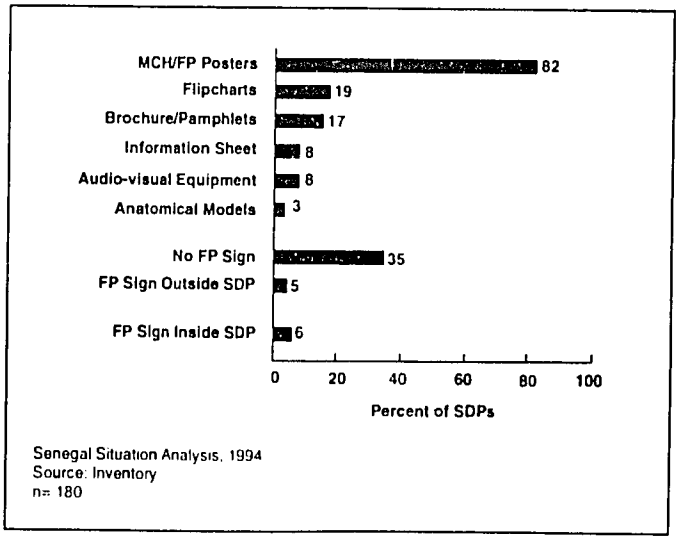
Approximately three out of four service providers reported that their training had been insufficient for them to provide adequate FP services. In addition, Figure 2 reveals the need for diversified training, given that more than half of the providers (62%) claimed to have received training in clinical FP, but very few in FP counseling (26%), IEC technique (24%), or HIV/AIDS counseling (13%).

Figure 2:
Percentage of Personnel Trained by Type of Training



Of the staff who provided a family planning method during the three months preceding the survey, 88% had provided Lofemenal pills, 82% had provided Ovrette (progestin-only) pills, 75% had provided condoms, and 68% had provided spermicides. Over 50% had provided IUDs and injectables, while fewer than 10% had provided voluntary surgical contraception (VSC).

Figure 3:
IEC Materials and Activities Available at the SDPs



(d) IEC Materials and Activities

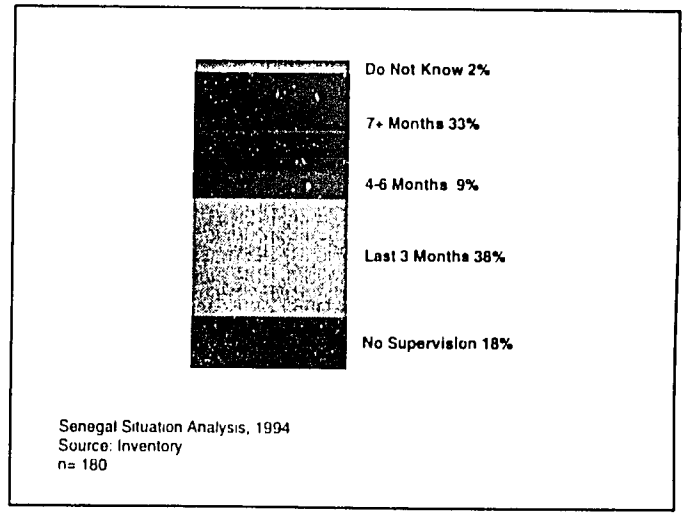
Figure 3 indicates that IEC is one of the weakest points of the Senegal FP program. While a large majority (82%) of SDPs had MCH and FP posters available, the percentage of clinics with other IEC materials was very low. The data also reveal that IEC activities in the SDPs are practically non-existent; only 6% of the SDPs visited held a FP talk on the day of the visit. Finally, 60% of SDPs had no visible sign announcing the availability of FP services.

(e) Management and Supervision

The management and supervision of FP activities at all SDPs presents important weaknesses. Only 6% of SDPs had job descriptions and defined responsibilities for the staff, 8% had a program of activities, and 2% had an established objective as to the number of clients to serve at any given time.

According to norms of the PNPF, each SDP should receive one supervisory visit every three months. Unfortunately, only 38% of the SDPs had been visited by a supervisor during the three months prior to the survey (Figure 4). Thirty-three percent had not been seen by a supervisor in seven months or more, and 18% had not had any supervision at all.

Figure 4:
Time Since the Last Visit by a FP Supervisor



The grand majority of SDPs (94%) have a monthly statistical report of FP activities. However, in the 30 days prior to the survey, only 65% had sent the report to a supervisor. The lack of feedback on the quality and use of these reports by supervisors may be a factor which discourages service providers from complying with the reporting procedure.

3. Quality of Care

This section deals with the actual quality of care provided by SDPs, as defined by the six elements of the Bruce-Jain quality of care framework. The data is measured through observations of client-provider interaction and subsequent interviews with FP clients and service providers.

(a) Choice of Methods

If the client desires to space her next pregnancy, more than three providers out of four recommend the pill or the IUD. It should be noted that prejudice regarding the use of injectables exist among FP service providers in Senegal, since they claim it is offered as a method for limiting the number of births.

First visit clients, in general, come in with a desired method in mind (53%). In more than half of the cases, it is the pill. Besides condoms and spermicides, which have a low demand, clients' personal choice of the pill or injectables is the most respected (81%). Clients' choice of the IUD is respected only in 67% of the cases.

Despite the fact that medical tests prior to the provision of a contraceptive method are no longer required, close to a quarter of the providers still request them. A urine test, blood test, and Pap smear are the most commonly requested tests for prescribing the pill.

A significant number of providers attach certain prejudices to the distribution of specific methods. More than half of the providers claim that a woman should have at least one child to receive a method. Because, in Senegal, injectables seem to be associated with infertility, providers indicated that a woman should have at least three children in order to receive this particular method. More than 80% of the providers interviewed stated that a minimum age of 17 years and a maximum age of 37 years is necessary to distribute the pill. The minimum age, however, is higher for the IUD (19 years) and injectables (25 years). Finally, while only 10% of providers would expect that a woman be married in order to prescribe her a contraceptive method, a more significant proportion (34%) claimed to request the husband's approval, particularly for the pill and the IUD.

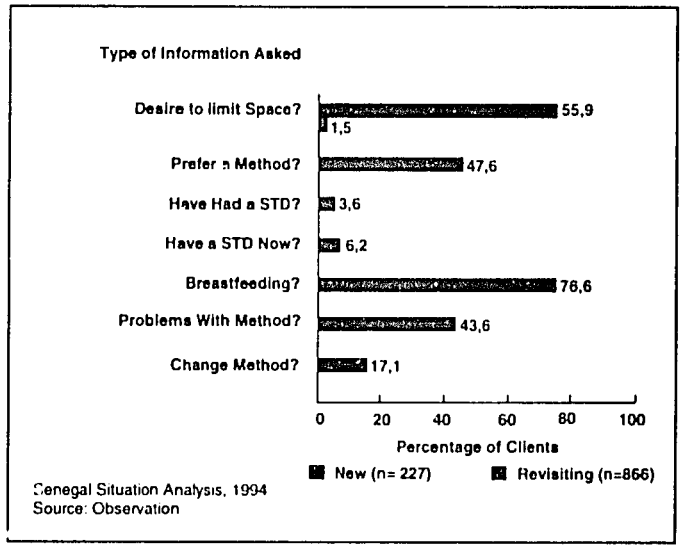
Very few providers encourage a particular method (13%). The methods most commonly encouraged by providers are the pill, followed by the IUD and injectables.

(b) Information Given to Clients

Knowledge of contraceptive options depends not only on the mere mention of a method, but also on the degree of information provided. The provider should focus on determining the client's needs and presenting the range of methods available, along with their contraindications, advantages, and disadvantages.

Figure 5 shows that service providers ask 56% of new clients about their reproductive intentions and 48% about their preferred contraceptive method. Only 44% of revisiting clients were asked about possible problems with their current method. Among those who did report having problems, only 17% were offered the possibility of changing the method.

Figure 5:
Questions Spontaneously Asked by the Service Provider During Consultation

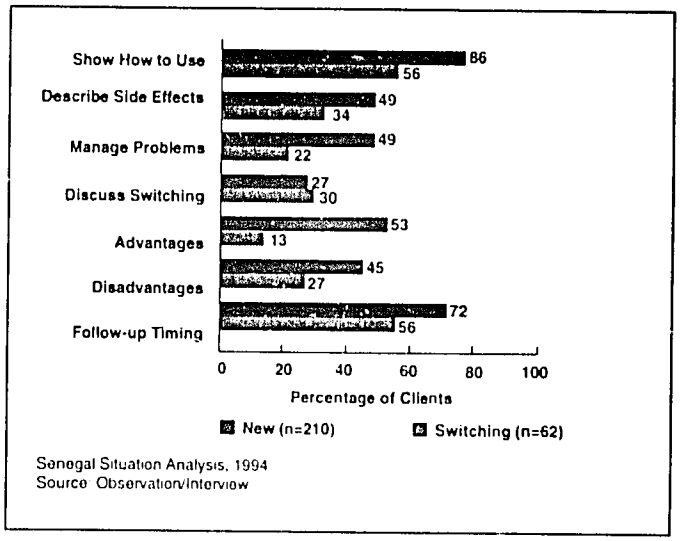


The data reveal that not all methods are systematically mentioned to new clients: the pill was mentioned to 75%, the IUD to 54%, injectables to 42%, and the condom to 25% of clients.

New clients receive more information about the method selected than revisiting clients who have changed to a new method. Information that is most commonly provided concerns how to use the method and follow-up (Figure 6). More than 50% of new clients did not receive any information on the disadvantages or side effects of the method selected, nor on precautions or the possibility of changing methods if any problems arise.

A comparison of the results above with data emerging from individual interviews with clients reveals that clients have, in general, retained limited

Figure 6:
Information Given to FP Clients About the New Method Accepted



information regarding the method selected. Client knowledge about the method they use is particularly low with respect to minor and major side effects.

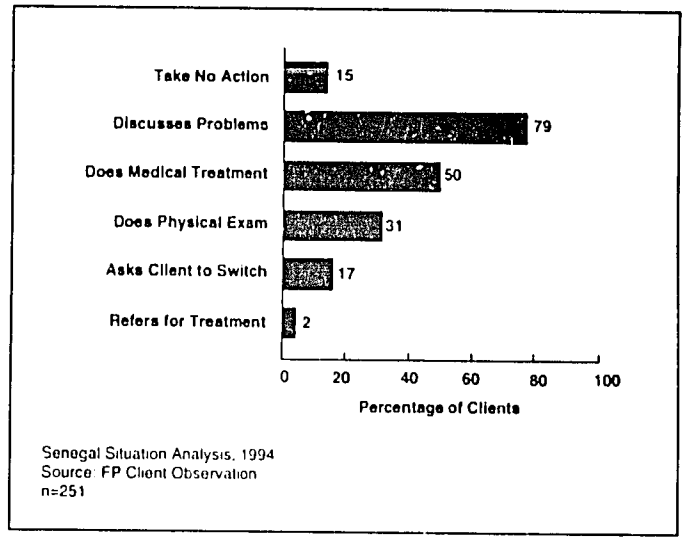
(c) Technical Competence

During data collection, team members recorded the medical procedures followed during client examinations, including the observance of protocols and aseptic measures while performing a pelvic exam and while providing a clinical method (i.e., IUDs, implants).

The grand majority of providers ask their clients about the date of their last menstruation, and proceed to weigh them and take their blood pressure. Pelvic and breast examinations are more frequently performed on new clients (72% and 69%, respectively). Acknowledging and addressing a client's problem with a particular method remains an important element of method continuity. Data from this study reveal that in such cases, only 17% of providers asked the client to change to another method, 2% referred clients for treatment, and another 15% neglected the problem altogether (Figure 7).

Among observed pelvic exams with revisiting clients, a sterile speculum was used 80% of the time, and sterile gloves 65% of the time. Only 10% of providers washed their hands before performing the exam. Approximately 80% of clients are not informed that they will undergo a pelvic examination, and only 30% of new clients and 42% of revisiting clients are informed of the results.

Figure 7:
Provider Actions for Clients with Problems



Providers (mostly midwives and nurses) are well informed on how to use each of the three main contraceptive methods: the pill, the IUD, and injectables, as well as on their minor side effects. However, the level of knowledge on these methods' major side effects represents a significant weakness in their training.

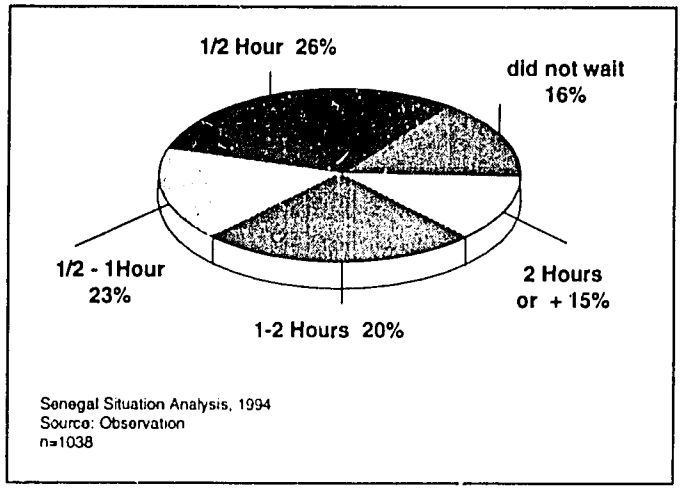
(d) Interpersonal Relations

The section on interpersonal relations refers to the interaction between the provider and the client. Difficulties in measuring this element have been acknowledged by previous researchers. In the Senegal Situation Analysis study, data collection teams attempted to measure interpersonal relations through a number of indicators: client satisfaction, duration of the consultation, and the percentage of clients who received the desired information.

An index of client satisfaction was developed based on the client's perception of her interaction with the service provider and the overall organization of the SDP. More women indicate satisfaction with the organization of services (59%) than with their interaction with the service provider (53%). It appears that waiting time was the most common reason for clients' dissatisfaction with the organization of services. Indeed Figure 8 indicates that 58% of clients wait between 30 minutes and two hours or more to receive FP services.

In general, consultation time was found to be short, particularly when compared to clients' waiting time. The median duration of a first visit is 12 minutes, and of a control visit is 5 minutes.

Figure 8:
FP Clients Waiting Time Before Consultation



Overall, client satisfaction is high, as 96% of them indicated that they received the information and services they desired.

(e) Mechanisms to Encourage Continuity

The Senegal Situation Analysis study indicates that clients usually receive important information to encourage continuity. In fact, all new clients were told when to return for resupply, and virtually all clients (96%) were given a written reminder. Furthermore, almost all clients (99%) were told where to go for resupply. These findings indicate that this is a particular strength in the Senegal national family planning program.

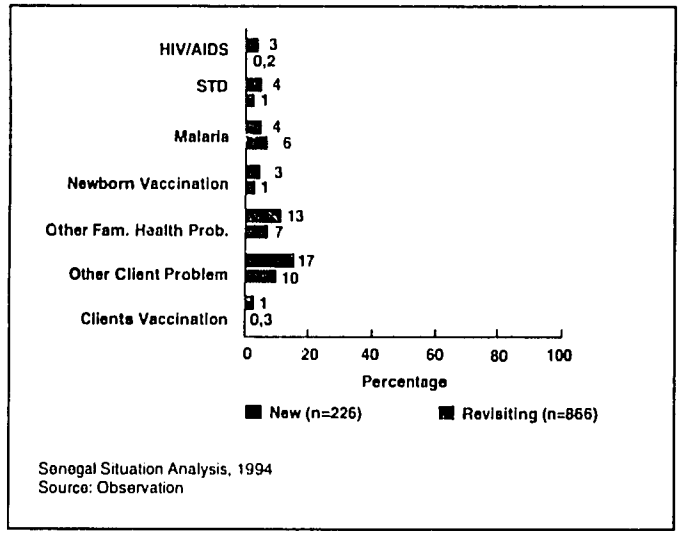
Provider practices with respect to informing the client about method resupply or control visits may also play an important role in encouraging continuity. In Senegal, the norm dictates that new clients receive one cycle of pills. The data indicate that 71% of providers respect this norm. Thirty-four percent of revisiting clients continue to be provided a single cycle of pills, obliging them to revisit the clinic every month for resupply.

(f) Appropriate Constellation of Services

At virtually all public service delivery points, FP services are offered within the context of a wide range of services. In fact, on average, four different types of services were reported to be offered each day. However, the fact that an SDP claims to offer a service does not mean that the service is truly integrated into FP provision. For instance, among MCH clients, family planning was discussed in only 36% of interactions. It is also worth noting that one quarter of the SDPs visited belong to SANFAM, whose mandate in the private and parastatal sectors is to provide FP services only.

Figure 9 presents information on the frequency with which other health issues are discussed during FP client consultations. Overwhelmingly, we find that providers and clients are not discussing other important health issues. Concerns about HIV/AIDS were discussed in only 1% of observed new client visits. Furthermore, while 92% of SDPs claim to offer consultations regarding STDs, new clients were asked about current STD symptoms in only 6% of observed interactions (STD history was discussed in only 3% of new client interactions).

Figure 9:
Other Health Issues Addressed by the Service Provider



VI. RECOMMENDATIONS

The recommendations proposed by the Senegal Situation Analysis study were first formulated by participants at a one-day national dissemination seminar, and later refined by staff members of the PNPF and The Africa OR/TA Project II. The following is a synthesis of the seminar recommendations:

1. Functional Capacity of SDPs

- Improve the infrastructure in the rural sector, particularly the availability of water;
- Provide FP training to all medical doctors and ensure their involvement in FP activities at all levels;

- Assure training of all personnel in clinical FP, counseling, IEC techniques, and management;
- Standardize and implement refresher training courses;
- Ensure that all SDPs have the minimum equipment necessary to provide FP services;
- Implement the use of the FEFO (First Expiration First Out) System to stock contraceptives;
- Develop a forecasting system for contraceptive procurement and adopt a standard logistics system;
- Encourage SDPs to provide all of the authorized contraceptive methods;
- Encourage all SDPs to plan FP activities on an annual basis and in a systematic fashion;
- Develop a guide for supervision, and implement regular supervisory visits of all SDPs every three months;
- Train service providers in the use and maintenance of records and statistical information;
- Define responsibilities of the different levels (national, regional and district) in terms of their overview of FP activities;
- Equip all SDPs with more IEC materials, and encourage the use of these materials during training;
- Integrate IEC activities in the provision of FP services at all SDPs.

2. Quality of Care

- Encourage service providers to reduce medical and non-medical barriers in the provision of contraceptive methods, and observe standard norms more closely;
- Encourage service providers to respect scheduled hours of services;
- Integrate contraceptive products to the Bamako Initiative, and standardize prices;
- Emphasize the need for an integrated training curriculum and for the reorganization of services;
- Provide training on client counseling and integrate counseling as part of daily FP activities.

VII. IMPACT AND UTILIZATION

The results of the Senegal Situation Analysis study were presented at a two-day dissemination seminar in January 1995, which involved national representatives from the MSAS and the PNPF, major funding agencies, NGOs working in FP in Senegal, and FP staff representing the regions. A second presentation of the results took place at a five-day workshop in January/February 1995 on the implementation of the USAID/ Senegal Child Survival and Family Planning Project. At this workshop, study results served as a basis for recommending project strategies, identifying key areas for operations research, and developing quality of care indicators. Following the workshop, a secondary analysis of the SA data was conducted to define quality of care indicators that would serve to evaluate the project in the next five years.

In an effort to maximize the impact of the study and the utilization of the findings, a series of regional dissemination seminars were held during the second half of 1995, covering all 10 regions of the country. During these activities, regional medical doctors, midwives, and supervisors were presented with SA results pertinent to their districts and their region as a whole.Participants were organized in working groups by districts and encouraged to formulate their own recommendations.This activity was followed by group presentations and vigorous discussions, as some of the recommendations had a direct impact on providers' daily practices.This dissemination process culminated in the use of study recommendations to develop regional workplans for 1996 and the development of 10 individual final reports representing each of the regions.

Overall, participants were engaged and appreciative of having been involved in the dissemination process. Many felt empowered to establish new procedures, particularly since some of the changes proposed could be managed at the local level and implemented immediately.This provides clear evidence that a decentralized dissemination of study results is a promising way to maximize research utilization.

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