



**Ministry of Health and Prevention
Senegal**

Office of Health

**Mapping Integration
of FP/MCH and STI/HIV/AIDS services
in Senegal's Kaolack region**

(English Translation from French)

**Advance Africa
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Acronyms

ADEMAS: <i>Association de Marketing Social</i> [Social Marketing Association]	FP: Family planning
AED: Academy for Education Development	GEEP: <i>Groupe pour l'étude et l'enseignement de la population</i> [Group for Research and Teaching on Population]
AIDS: Acquired immune deficiency syndrome	HDD: Head Doctor of a district
ASBEF: <i>Association Sénégalaise pour le Bien être Familial</i> [Senegalese Association for the Well-Being of the Family]	HDR: Head Doctor of a region
BCC: Behavior change communication	HIV: Human immunodeficiency virus
BI: Bamako initiative	HNO: Head Nurse of an outpost
CA: Cooperative agency	HO: Health outpost
CAFS: Centre for African Family Studies	ICPD: International Conference on Population and Development
CBD: Community-based distribution	IEC: Information, Education, Communication
CBS: Community-based service	IMCI: Integrated management of childhood illnesses
CCO: Core community organizations	IUD: Intrauterine device
CEFOREP: <i>Centre d'Etude et de Formation en Santé de la Reproduction</i> [Center for Training and Research in Reproductive Health]	MCH: Maternal and child health
CESAG: <i>Centre Africain d'études supérieures en Gestion</i> [African Center for Advanced Management Training]	MCT: Mother-to-child transmission
CHA: Community health agent	MH: Maternal health
CPR: Contraceptive prevalence rate	MPA: Minimum package of activities
CS: Child survival	MPS: Making Pregnancy Safer
CT: Contraceptive technology	MSH: Management Sciences for Health
DHS: Demographic health survey	NGO: Non-governmental organization
DHSS: Demographic health services survey	OP: Operational planning
DISC: <i>Développement des Initiatives de Santé Communautaire</i> project [Development of Community Health Initiatives]	PAC: Postabortion care
DTT: Deloitte Touche Tohmatsu	PHC: Primary health care
FAWE: Forum of African Women Educationalists	PHR: Public Health Reform
FHI: Family Health International	PLH: People living with HIV
FLE: Family life education	PNE: Prenatal examination
	PSP: Policies, Standards and Protocols
	R: Referral
	RH: Reproductive health
	SONACOS: <i>Société Nationale de Commercialisation des Oléagineux</i> [National

Marketing Company for Oil-
Producing Plants]

SSP: Sector strategy paper

STI: Sexually transmitted infection(s)

UNFPA: United Nations Population
Fund

USAID: United States Aid for
International Development

VCT: Voluntary Counseling and Testing

WBV: Well-baby visit

WHO: World Health Organization

Chapter 1: Context

1.1 Advance Africa and its mandate

Advance Africa is a five-year project financed by USAID. It supports family planning and reproductive health programs in sub-Saharan African countries in the context of the current HIV/AIDS pandemic. It is designed to increase the availability and use of sustainable, quality family planning and reproductive health services. It is being implemented by a consortium of six organizations, of which four are American and two African. The American organizations are Management Sciences for Health (MSH)/Boston, Academy for Educational Development (AED)/Washington, Family Health International (FHI)/North Carolina, and Deloitte Touche Tohmatsu (DTT)/Washington. The African organizations are Centre for African Family Studies (CAFS)/Nairobi (Kenya) and Forum of African Women Educationalists (FAWE)/Nairobi.

Advance Africa's involvement is primarily through bilateral cooperation providing technical and strategic support for USAID missions in Africa and their contractors. In the countries where it has a presence, Advance Africa also tries to rely especially on local development organizations, notably NGOs, women's and youth associations, municipal governments and other decentralized structures to promote and scale up the best reproductive health practices, including family planning. For this purpose, Advance Africa is developing innovative approaches and tools to improve the capabilities and effectiveness of the institutions with which it collaborates. In this context, it has developed a whole set of techniques and practical methods for supporting the family planning/reproductive health and HIV/AIDS programs currently underway in sub-Saharan Africa. One of these techniques, called "mapping," was applied in Senegal's Kaolack region during the months of November and December 2001 to identify in a collaborative way both (1) the gaps in implementing integration of HIV/AIDS activities with FP/RH activities, and (2) the appropriate corrective measures to apply. This report will summarize the technique, the process of applying it in Senegal, the results we recorded, and recommendations for further action.

1.2 General remarks concerning integration of services

Following acceptance of the new consensus definition of reproductive health by all nations present at the International Conference on Population and Development (ICPD) in 1994, it was recognized that basic human rights include the right of men and women to be informed, the right of access to the safe, effective and affordable family planning methods of their choice and the right of access to appropriate care to make pregnancy safer and to give couples the best chance of having a healthy child. Policies and strategies for meeting the objectives adopted by the 187 participating countries were developed by the individual countries themselves. Today, the vertical approach to implementation favored by some programs is drawing severe criticism. The programs are faulted for being extremely expensive, for focusing entire health systems on a single aspect of the many problems that need to be solved, for not sufficiently involving the public, and for not ensuring that their activities are sustainable. They are also said in some cases to favor counterproductive duplication of resources and inefficient over-specialization of staff. For all of these reasons, sporadic attempts to integrate and better coordinate activities have been made in the context of implementing top-priority RH/FP and HIV/AIDS programs.

The term “integration” is used in a wide range of situations. Often, the emphasis is on integration of curative care and preventive care. However, the term can be applied to all aspects of implementing interventions, i.e., the place or time, the person or other resources employed, the activities, or the service recipients themselves. As Bogdan correctly noted, “the question of integration has been widely debated for many years, and most discussions on this subject have generated more heat than enlightenment.” (Bogdan M. Kleezowski, *Cahiers de santé publique* [Public Health Journal], 1985).

“The option of focusing on meeting the needs of the individual person, despite the marked separations between the various vertical programs, seems to be the unanimous choice and to produce promising results. The typical examples in this context are integrated management of childhood illnesses (IMCI) and, to a lesser extent, attempts to integrate home and community interventions among persons living with HIV.” (I. Diallo et al., SSP/WHO, 2002).

“The notion of avoiding ‘missed opportunities’ was launched as a slogan especially intended to promote vaccination in the context of the expanded programs on immunization, with the hope of integrating immunizations with curative medical treatment. The idea did not hold much interest for field workers, faced as they are with a lack of support in carrying out their many duties. It would be difficult for one person to provide both curative care and vaccination services at the same time. The model that has been succeeding since the idea was brought up seems to be the WHO IMCI launched to reinforce the campaign to reduce child mortality, which is still too high. Presently, application of this principle even at the community level is being considered, in the context of implementing community-based services (CBS)” (I. Diallo et al. SSP/WHO).

Integration of STI/HIV/AIDS services with other RH/FP services is based on a series of steps to be taken with regard to policies, programs, communities, points of service and non-health sectors with the objective, again, of providing the client or any individual with access to a minimum package of services. If the ideal (providing clients with continual access to all needed services at a single location) cannot be achieved, clients ought at least to be able to receive a minimum package of information on STI/HIV/AIDS and RH/FP at any point of first contact with the health system, and an efficient referral system should exist to meet these RH needs.

1.3 Context of the mapping exercise in Senegal

The organization of Senegal’s health care system reflects that of other countries in the region: it is organized according to the model recommended by WHO/AFRO’s three-phase development scenario. It is pyramidal, with three levels: the central level (top of pyramid) is represented by the university hospitals (3), the middle level by the regional hospitals (7), and the local level by the district hospitals (health centers/clinics) (52), around which are centered the pillars of the system, the health outposts (820). The dozen or so health programs operate for the most part in a vertical mode. HIV/AIDS and reproductive health efforts are among the country’s top-priority programs. Senegal is very fortunate in being the sub-Saharan country with the lowest incidence of HIV/AIDS (less than 2% according to

the UN AIDS 2000 report) and in which the spread of the pandemic has been best controlled. This is due to a number of factors, of which the most commonly cited is that the government committed to fighting the disease from the very beginning: in 1986, when the first cases appeared, it created a dynamic national program involving all social classes, particularly the religious leaders, who are highly influential in this country. Because of this, any notion of integrating anything whatsoever with the activities of this program leads to considerations of the possible risk of eroding—no matter how slightly—the good results obtained. In contrast, as far as family planning and other RH components are concerned, Senegal is at the same level as most other African countries, with a contraceptive prevalence rate of 8.1% in 1999 (DHSS). However, it does have a remarkable head start in postabortion care (PAC), gained during the past two years.

In particular, programs for general health, AIDS, family planning, and mother child health are strongly supported by numerous lenders such as USAID, UNFPA and GTZ, so there are many stakeholders in the field who have certainly been attracted by the civil peace and democratic atmosphere prevailing in the country, among other factors. In order to optimize these investments and use them effectively—by organizing the use of resources earmarked for the high-priority HIV/AIDS and reproductive health programs, including family planning, as well as possible—Senegal has decided to integrate the activities of these two programs at the operational level. This integration is of great interest to the Ministry of Health authorities and so enjoys special attention from those responsible for managing the two programs at all levels of the health system.

It is for this reason that, in agreement with the USAID mission in Dakar, they have asked the Advance Africa project to initiate a mapping exercise for this integration in order to identify the inadequacies and gaps in its implementation and suggest an appropriate solution.

During a preliminary mission conducted by Advance Africa in October 2001, many concerns were expressed by the various RH stakeholders, of which the most significant were:

- Insufficient integration of STI/HIV/AIDS activities with RH/FP activities in the field.
- The desire for more synergistic action among the various RH stakeholders.

Based on these expectations as expressed by the stakeholders, the Ministry of Health and Advance Africa agreed to carry out this “strategic mapping” of the integration of STI/HIV/AIDS services and RH/FP services before the end of 2001.

Chapter 2: Methodology

2.1 Purpose and objectives of the mapping exercise

2.1.1 Purpose

The purpose of the mapping exercise was to help Senegal's Ministry of Health, the USAID/Senegal mission, and all other RH stakeholders in Senegal to determine practical ways and means that could lead to greater integration of FP/MH and STI/HIV/AIDS activities in the field and to synergistic action by the stakeholders to accelerate the progress of Senegal's overall RH program.

2.1.2 Objectives

- Map the inventory of projects concerning integration of STI/HIV/AIDS activities and RH/MH activities underway in the field.
- Critically analyze the information collected on integration of STI/HIV/AIDS and other RH activities (FP and MCH).
- Map corrective measures recommended to improve integration.
- By consensus, draw up a micro-plan for implementing those recommended solutions that are selected.

2.2 Strategic mapping and its limits

Strategic mapping is a participatory process used to identify the gaps and opportunities of a program, a project or a particular aspect of a program or project, to obtain a consensus concerning the options for filling the gaps and to visualize the whole by means of matrices or maps that make it easy to use the results immediately.

Mapping is often incorrectly considered to be a research exercise. This confusion arises from the fact that one of the steps of the process involves collecting information in the field. In fact, the purpose of this step is essentially to verify information that has already been collected, by analyzing documents and interviewing decision-makers. While this step is indeed rigorous in that it collects qualitative data to ensure the validity and accuracy of the data, this characteristic cannot be extended to the entire mapping process, which is an iterative multi-functional and holistic exchange process leading to concrete, relevant actions tailored to the situation.

Mapping uses all of the results from existing quantitative and qualitative studies relevant to the topic. It compares this information with the opinions of the program's stakeholders and beneficiaries, as well as with observational data obtained in the field. Together with these same stakeholders, it develops a consensus on the gaps, opportunities and actions to take to fill the gaps.

The basic instrument developed by Advance Africa to guide program analysis is the strategic framework diagram (see below), which makes the client the main focus in all considerations concerning the request for services, access to services, the quality of the services, and sustainability of gains made at the various levels of influence, namely, service providers, stakeholder organizations, various sectors, program development, policies, and socioeconomic context. This analysis examines the situation at every level and also allows for identification of connections between the various levels.

STRATEGIC FRAMEWORK FOR ANALYZING PROGRAMS



For the specific case of mapping for STI/HIV/AIDS and RH/FP integration in Senegal, the exercise focused on

- integration of STI/HIV/AIDS with the other RH/FP components on the policy and program levels.
- integration of these services on the point-of-service level.
- client and community perception of integration.
- actions to take to improve integration.

2.3 The mapping process in Senegal

The mapping exercise consisted of two main parts:

The first part was done over two weeks, from November 19 to December 7, 2001, in four phases: review of the literature, work sessions with the stakeholders, collection of information from key people, and field work.

The second part consisted of a wrap-up workshop held March 21 and 23, 2002 in Mbour.

2.3.1 Literature Review

The literature review consisted of extracting—from policies, standards and protocols concerning reproductive health (PSP/RH), reports from existing studies such as DHSS 1997, a situational analysis of UNFPA's emergency obstetrical and neonatal care, the study of the private health sector in the Kaolack region, etc.—elements related to STI/HIV/AIDS, family planning, and other RH components in order to support and explain field observations

2.3.2 Work sessions with the stakeholders at the national and regional levels

The first work session was held in Dakar on Tuesday, November 21, 2001. All of the principal RH stakeholders from the central level participated:

- The National Office of Health, the Office of Reproductive Health and the National Anti-AIDS Program on behalf of the Ministry of Health.
- The Ministry of Plan's Planning Office
- USAID, UNFPA, GTZ and WHO
- Executing agencies: FHI, MSH, EngenderHealth, Basics.
- NGOs: ADEMAs, ASBEF, CEFORÉP, CESAG, ENABLE project, FAWE and SANFAM.

The purpose of the work session was to help the nationals and RH stakeholders to take ownership of the mapping project, to validate the proposed tools, to collect their opinions concerning the status of integration in Senegal, to reach a consensus on what additional information should be collected in the field, and to set up a team to conduct field visits with Advance Africa.

The second work session, held on Tuesday, December 4, 2001, brought together the stakeholders from the regional level (Kaolack region):

- The Head Doctor of the region (HDR) and the four Head Doctors of the district (HDDs).
- Regional-level stakeholders such as ASBEF and MSH
- The private sector
- Representatives of community associations, etc.

The goal was to discuss the regional stakeholders' opinions of the mapping, to compare their opinions with the information already collected during field visits, to reach a consensus on the gaps and the opportunities for integration in the region and on possible actions for improving the situation.

The third work session was held on Thursday, December 6, 2001 in Dakar and brought the stakeholders from the first session together again to inform them of the preliminary results

of the mapping exercise and to reach a second consensus at the central level concerning these results.

2.3.3 Discussions with program administrators

In addition to the work sessions and field visits, there were individual discussions with key people such as the National Director of Health, the RH Director, the Director of the National Anti-AIDS Program, various administrators from the executing agencies and NGOs in Dakar, and the Director of the Kaolack Health-Care Region. These discussions provided further useful information concerning the integration of STI/HIV/AIDS activities.

2.3.4 Field visits

The field visits occurred from November 23 to December 3, 2001 in the Kaolack region, which is one of USAID's intervention regions. This choice is justified by the fact that the region is an important commercial crossroads with the highest incidence of HIV in Senegal. The fieldwork consisted of visits to public, religious, private and community FP and maternal health points-of-service to evaluate the level of integration and to conduct interviews at the community level in all four of the region's health districts (Kaolack, Kaffrine, Kounghoul and Niour).

Four teams were created. Each team included one member from Advance Africa and one or two national representatives from institutions very familiar with the health-care system and the programs underway.

Standardized tools for collecting the data were developed by all of the teams working together, and the data were collected simultaneously in the four districts.

In each health district, the district's health center, a health outpost and a dispensary were visited. In Kaolack, a private practice and the ASBEF clinic were visited.

Structured interviews were held with the following groups:

- Clients of the health-care facilities
- Service providers at points of service for health services and at the community level
- Community leaders, including local elected officials, religious leaders, and representatives of women's and youth groups and associations
- Administrators in the social and educational sectors.

The interviews involved 90 people representing all of these levels, and provided information about their opinions on the integration of reproductive health services.

2.4 Analysis of the data collected

Once the data had been collected, each team performed a primary analysis on the information in order to classify each piece of information as a gap or an opportunity with respect to integration of services.

The primary analysis yielded an initial "map" of opportunities and gaps which was submitted for review to the RH stakeholders at both the regional and central levels during the work sessions mentioned above, in order to reach a consensus on the elements discovered and to work together to find options for action.

After the mapping process had been completed, the Advance Africa team had a primary map of the gaps and opportunities for integration and of the options for action agreed upon by consensus by the various stakeholders and decision-makers.

A secondary analysis, done in Washington by the Advance Africa team, compared the results of the field visits with the data from the quantitative studies and all of the data compiled from the literature. The gaps and opportunities found by consensus were then reorganized around three major themes, namely:

- The level of public knowledge about RH/HIV/AIDS
- The degree to which the public's needs are met
- Support by community organizations for implementing RH services.

2.5 Wrap-up workshop

Once the results had been organized according to the three themes, the wrap-up workshop met on March 21 and 23, 2002 with the goal of validating the final results and formulating an action plan that would immediately involve the various stakeholders in correcting the gaps that had been identified.

The workshop brought together the same stakeholders from the central and regional levels (Kaolack region) that participated in the work sessions in November and December 2001.

Basing their work on the notion of integration as set forth in the PSP document for reproductive health in Senegal, the participants used a simple grid evaluating integration by level of health structure to examine in detail the list of gaps and decision options in the context of the three broad themes. They selected those for which action could be initiated and developed an action plan that will allow some of the gaps identified to be filled within a short time frame.

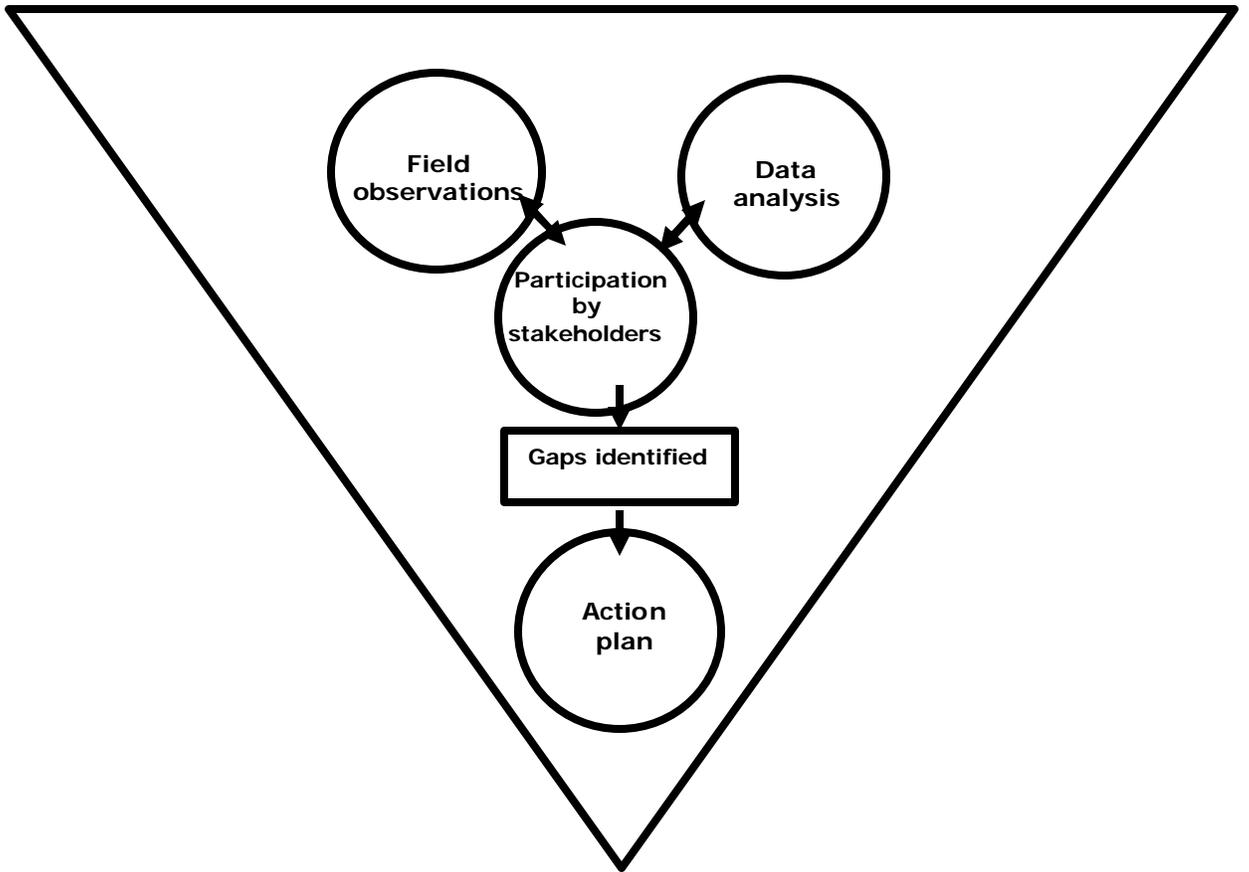
2.6 Distinctive characteristic of the mapping approach used for integration in Senegal

The distinctive characteristic of the approach used in Senegal lies in the triangulation process used on the information collected. This approach is based on reaching consensus among the stakeholders at every stage:

- Identification of the central problem and data collection
- Analysis of data
- Consensus on the gaps identified
- Plan for practical resolution of problems.

(See diagram below.)

The mapping process in Senegal



Chapter 3: Results

Initially, this results section will focus on the notions of integration of STI/HIV/AIDS services and RH/FP services as formulated in the policies and as perceived by the decision-makers, the stakeholders and the service users at all levels of the health pyramid. Later, the three groups of gaps organized around the three broad themes will be presented and explained along with the related opportunities and decision options. The three themes are:

- The level of public knowledge about RH/HIV/AIDS
- The degree to which the public's RH needs are met
- Support by community organizations for implementation of RH services.

The maps of the gaps identified and the micro action plans are included in the Appendix.

3.1 Notions of integration in Senegal

3.1.1 Integration of STI/HIV/AIDS and RH/FP in policies and programs

In the policies, standards and protocols for reproductive health, which had already been approved but not yet distributed when the mapping exercise was done, integration-related aspects are set forth in the components of RH ensuing from the ICPD definition. These documents also clearly state that "All activities must be carried out every business day, at one location and by a versatile staff, at maternity centers and health outposts. At the health center, regional hospital and university hospital levels, services should be geographically integrated, with an internal referral system" (internal RH services policy and standard, 2000 P6). However, the standards give priority to three of the nine components set forth in the policy: Making Pregnancy Safer, Child Survival and Family Planning. Sexually transmitted infections, HIV and AIDS are merely mentioned as components in the policy, which does not develop standards for these services.

At the program level, the approaches taken are vertical and the central stakeholders are organized vertically around three main areas: Family Planning and Maternal Health, Child Survival and AIDS.

On the most peripheral level of the public health system, implementation of the Bamako Initiative introduced the notion of the minimum package of activities (MPA), which requires that a minimum package of services, including curative medical treatment, and MPS, CS and FP services be offered at a single location. While STIs are included in the MPA through a syndromic approach, HIV and AIDS are not yet systematically included due to their complexity.

3.1.2 Perception of integration by the decision-makers and stakeholders

The decision-makers and stakeholders perceive integration as something that should be done at the level on which services are provided. At the central level, more systematic coordination mechanisms should be put in place to reinforce the integration of programs that remain vertical for strategic or political reasons.

3.1.3 Perception of integration by the service providers

The providers' perception of integration of RH services is shaped particularly by their ideas about which services should be offered at the points of service. In their view, RH services are already integrated in that the points of service offer all essential RH services and refer clients to more competent structures when they are not able to meet the demand. Nevertheless, they do agree that their training and available resources do not them to organize services in such a way.

As they perceive it, their idea of integration does not seem to include either the need to provide all services every day at a single location, or the need to take advantage of every opportunity furnished by a client visit to educate the client about aspects of RH other than the problem that brought the client to the health-care facility.

3.1.4 Perception of integration by clients and community leaders

Clients, leaders of public opinion, religious leaders, and group administrators do not perceive the concept of integration as such on their level. Rather, the notion is expressed by specific expectations for quality of service and availability in close proximity to all the services they would like to have. They mentioned X-rays and all the other supplemental examinations that cannot be obtained at the health center.

Everyone strongly expressed the desire to be able to receive all needed services at once, instead of having to make several trips to the health-care facility or be referred to the region's principal city to obtain additional examination services. For example, the women wished to be able to have their child vaccinated when they come for a well-baby visit instead of having to coming back another day.

In general, there was interest in having access to accurate health information so that behavior could be changed accordingly.

The community leaders emphasized the high cost of medications and the need to educate the public on critical and topical subjects such as STI, HIV and AIDS.

In conclusion, there are very different perceptions of the idea of "integration of services" at the various levels of the health pyramid. The idea recommended in the document in the PSP is very ambitious in that it advocates integrating all peripheral health agents in time, place and versatility.

3.2 Level of public knowledge concerning RH/HIV/AIDS.

3.2.1 Data from the literature review

Quantitative studies, in particular DHSS 1997, provided the following known information:

- In Kaolack, the level of overall knowledge of modern contraceptive methods is relatively high (83%),
- Less than half of women (41%) can cite at least two advantages of using family planning (Kaffrine 28%, Koungeul 25%, Niore 41%, Kaolack district 55%).

Among the men of the region, about 46% were able to cite at least two advantages.

- In the town of Kaolack, the fertility rate is 6.4, compared to the national average of 5.2. However, in rural zones, fertility remains extremely high – more than eight children per woman (DHS, 1997).
- Unmet need is estimated at 32% in Senegal and the maternal mortality rate remains high, being estimated at 510 per 100,000 live births in 2001.
- Only 48% of the women in the Kaolack region had at least three prenatal visits, indicating generally low use of services.
- Only 22% of children under the age of two years received all recommended vaccinations.
- Less than half (40%) of all men in Kaolack mentioned the condom as a method of protecting against HIV and only 25% mentioned not having multiple partners, while 58% mentioned fidelity.
- Only 15% of women mentioned the condom as a method of preventing AIDS, 25% mentioned not having multiple partners, and 66% mentioned fidelity.
- Only 35% of men in Kaolack who had an occasional partner had used a condom the last time they had sexual intercourse with that partner. Only 14% of women had done so.
- Only 26% of adolescents in the Kaolack district knew of a health-care facility where they would feel comfortable. The figure was 10% in Kaffrine, 15% in Kounghoul, and 34% in Niore.
- Among adolescent males, 43% knew of a health-care facility in the region where they would feel comfortable (20% in Kaffrine, 18% in Kounghoul, 46% in Niore.)
- About one woman in five (20%) and one man in five (23%) were able correctly to state two or more specific symptoms of AIDS.

This information from the literature demonstrates clearly that general knowledge, which is often hastily judged to be satisfactory with reference to the crude rates exceeding 80%, frequently masks the specific aspects that better describe the weakness of the IEC system. The fieldwork and interviews provided qualitative corroboration of the real lack of information among members of the public, and explained this lack.

3.2.2 Combined results of field visits, interviews and discussions

1) Access to information in the community

IEC campaigns conducted by giving talks in local neighborhoods do not often reach their targets. For example, when the target audience is men, only a large group of children appears at the session. Talks are held only rarely, and because they cover a wide range of topics, those attending a session on pregnancy are not necessarily those who will attend the next session on family planning or HIV/AIDS. This leads to missed opportunities for providing information. Vertical information systems targeting at-risk groups such as truck drivers, prostitutes and young schoolchildren do work, but do not create synergy to help reach a broader public.

The “liaison system” by which community health agents are supposed to provide personalized information to couples and individuals does not work properly, due to a lack of motivation on the part of the agents and a severe shortage of IEC materials observed in the field. In the dispensaries we visited, not a single agent had appropriate posters or image libraries providing accurate information on FP, STI/HIV/AIDS, or even MPS or CS. The agents are apparently frustrated by the lack of resources for activities both in the dispensaries and at the community level. Lack of transportation is nearly always mentioned by community health agents as a serious handicap in providing information to rural communities.

While religious leaders in general support RH promotional activities in the communities, they are not true advocates of family planning or HIV/AIDS prevention interventions. They accept the promotion of condoms for family planning by couples, but not for HIV/AIDS prevention in unmarried couples. Promoting both uses would be unacceptable because the religious leaders support only abstinence and fidelity as a means of avoiding HIV transmission. Other community leaders lack information on RH, and consequently cannot provide the leadership and support necessary to encourage better RH practices in their communities.

2) Access to information at the point-of-service level

At the health center and health outpost levels, the staffs occasionally organize talks on various topics in the mornings before they open for medical services. In this case, again, it is a matter of chance whether the talks on FP or STI/HIV/AIDS topics are relevant to the women who are present on the day when the topic is scheduled. Very few women are reached by the talks because often they do not arrive at the same time in the morning. When service providers meet face-to-face with a client, they generally discuss only the subject that brought the person to the health center. Many clients who had come for a prenatal examination or to have their child vaccinated stated that the provider did not mention FP or STI/HIV/AIDS. There are no posters, brochures or audio-visual materials that might contribute to client education during the hours spent waiting. There are not even any simple signs to guide clients from one service to another within the same establishment, for example, in the health centers, where services are located at a distance from one another.

The service providers acknowledged that in their view, it is the community liaisons who are primarily responsible for providing information to the users. They also stated that they do not talk about AIDS except with those at risk, such as prostitutes.

Furthermore, the few staff members available do not have enough time to provide information on a regular basis. For this reason, it is up to each provider to decide, based on the perceived level of risk, whether or not to take the time to speak to the client. One midwife we visited indicated that she does not provide family planning or HIV/AIDS information at a prenatal visit unless she thinks the client is at risk. She said that because she works alone, she does not have the time to speak to each of the many women she sees each day.

3) Access to information by young people

Outside of the town of Kaolack, there are no services or specialized locations where young people can go to obtain information and assistance. The community health agent (CHA) is trying to provide IEC activities for young people, but these activities are limited for financial reasons and do not reach all of the targeted groups.

4) Access to information in the educational system and other sectors

During our field visits, we found that the young schoolchildren with whom we spoke had more extensive and accurate knowledge of RH in general, FP and STI/HIV/AIDS in particular. In fact, RH-related information has been in schools since 1993. Despite the relatively long presence of health and AIDS programs in Senegal's school system, a lack of teaching materials and time devoted to these subjects has been reported. Time devoted to sports infringes on the talk sessions and health agents do not often have the time to come and support youth clubs or the teachers who provide the information. The numerous messages disseminated in the schools by multiple stakeholders are not standardized. This sometimes results in inadequate RH information being given to young people. The school health program does not work well and there is no coordination between the services of the medical inspectorate and those of the education inspectorate.

In other sectors, the social affairs sector administrator who was visited in Kaffrine says that he has a fairly large group of liaisons available for multidisciplinary information (health, agriculture, education, environment, etc.). From time to time, these liaisons speak on FP and HIV/AIDS, but he considers that in recent years, the Health Department no longer involves him in decisions or in the development of health awareness strategies. In the operational plan for 2000, no funds were allocated to HIV/AIDS coordination activities.

5) Consequences of limited access to information

5-1) Family planning

A large number of women in the Kaolack region, especially in rural areas, run the risk of unwanted pregnancies because they and/or their spouse have insufficient information to make informed decisions about their fertility. The facts show that the majority of men and women, especially in rural areas, do not have appropriate information on advantages, options and risks where reproduction is concerned. This reinforces the cultural beliefs and practices common in the region and explains in large measure the underutilization of health-care facilities (resulting in even more limited access to information). The sometimes-inadequate information furnished directly by insufficiently-trained service providers reinforces the barriers hindering the use of family planning services. In Kaolack, the fertility rate is 6.4, compared with the national average of 5.2, and in rural areas fertility remains extremely high, up to more than eight children per woman (DHS, 1997).

5-2) HIV/AIDS

The lack of adequate information probably leads to an increased risk that HIV will spread among the population of Kaolack and especially among the rural populations, as yet still

relatively protected. It is true that the epidemic is concentrated among high-risk groups, including prostitutes, truck drivers and migrant workers, but recent statistics show that the general incidence in Senegal has probably increased from 1.4% (recorded in 1998) to 1.77% (2000). Among female sex workers, the incidence is rising steadily, reaching nearly 30% in Kaolack. In the Nioro district, we found denial that AIDS exists there. AIDS is still seen as an evil that happens only to “other people.” This low level of awareness of personal risk is a factor that increases vulnerability.

5-3) Making pregnancy safer and child survival

Rates of use for these services, while much better than those for FP, remain low and stagnant because the usual information schemes on these topics no longer seem to influence the public.

6) Some causes of inadequate access to information

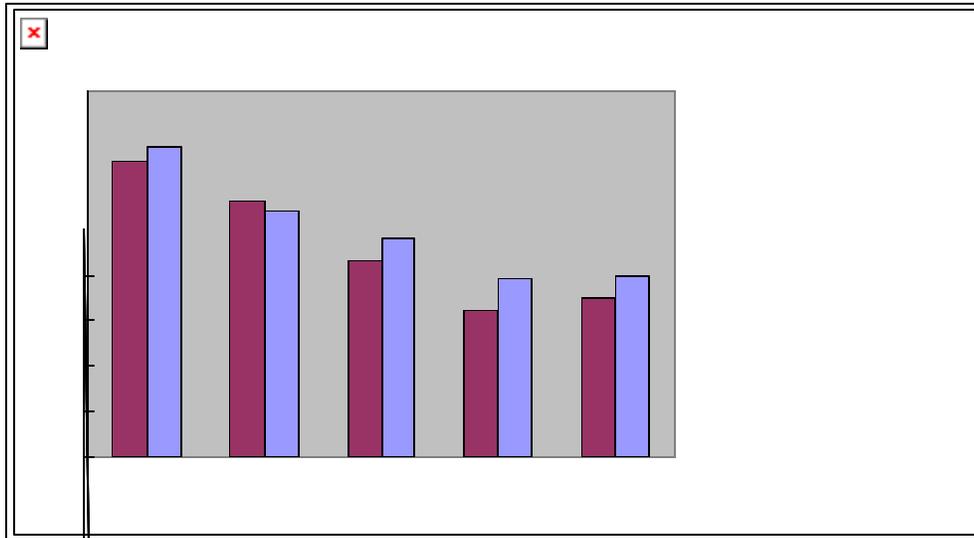
The situation in Kaolack is explained by a number of factors, as described above. The observations made in the field by the Advance Africa team, the discussions with the parties concerned and other program administrators and decision-makers, and data from other sources all helped identify some of these factors.

6-1) Factors related to the way the health system is financed

One of the main causes is related to the inadequacy of available or allocated financing for IEC/BCC activities, which are seen as having a low priority compared to other areas of the program. For example, in 2000, 63% of the financing for the HIV/AIDS operational plan was designated for the purchase of condoms, and only 5% (\$4,910) was spent on IEC activities for the Kaolack region (see diagram below).

In the Kaolack and Kaffrine districts, the amount allocated to IEC for HIV/AIDS was only \$493. Unequal financing among the regions, lenders’ “zoning strategies” and a lack of coordination among lenders also contribute to the problem.

Priority expenses for HIV/AIDS in 2000



Source: "Funding and Implementing HIV/AIDS Activities in the Context of Decentralization: Ethiopia and Senegal, Partnerships for Health Reform, 2001

6-2) Absence of standard approaches for IEC/BCC interventions at the regional level

IEC/BCC interventions do not receive sufficient attention in the region; consequently, there is no IEC/BCC regional strategy for RH in general and FP or HIV/AIDS in particular. Interventions are not adequately supported in health-care facilities or through the strategy used in the community. IEC interventions for family planning and HIV/AIDS at all levels of the district and of the community health system are very limited, even nonexistent in many of the locations observed. There is no minimum package of information that the service provider is required to offer at each level of the health pyramid.

The operational plan for the year 2000 indicates that no funds were allocated for training or counseling concerning HIV/AIDS prevention or for health care for those suffering from AIDS in the Kaolack region. No numerical data exist indicating the level of expenditures for family planning activities in health-care facilities, but some providers indicated that they have not received FP training or a refresher course in prenatal examinations in the last five years.

These data may be summarized in one sentence:

Clients/individuals do not have access to appropriate information about reproductive health, especially about HIV/AIDS and family planning.

7) Opportunities to improve the situation

There are many opportunities and resources in the region that could contribute to filling the many gaps that were identified:

- National and international NGOs such as Africare, ASBEF, Plan International, SANFAM, World Vision, etc. could play a more important role in the context of a concerted IEC/BCC strategy.
- In spite of its current weaknesses, the network of youth liaisons and community health agents is an asset for building an effective IEC system.
- Women's groups and all community organizations are a driving force for a more structured organization of RH information.

3.2.3 Decision options

1) For better access to family planning and HIV/AIDS information

- Refocus program priorities to place more emphasis on IEC/BCC and provide more support to the district-level health-care facilities and to community education activities.
- Target rural populations with a concerted, constant and ongoing IEC/BCC effort.
- Provide an integrated set of simple RH information for clients.
- Implement a coherent and synergistic strategy for distributing the integrated set of RH information through public health channels, mass media, communities, schools and other sectors, etc.
- Increase the staff available for counseling in health-care facilities.
- Train service providers in counseling so they can handle HIV/AIDS cases, clients with AIDS, mother-to-child transmission, and family planning.
- Improve the internal and external referral system for counseling.

2) For better reproductive health information in the schools and other sectors

- Formulate strategies for pleading the cause of RH in non-health sectors.
- Improve coordination between the health sector and non-health sectors where RH is concerned.
- Strengthen support for young people through multiple channels (ASBEF youth centers, mass media, health-care facilities, GEEP, FAWE, schools, etc.)
- Provide additional support for NGOs as resources for information and youth services.
- Strengthen the programs in schools by introducing the integrated set of RH information (also used in the health centers).
- Introduce the integrated set of RH information for young people through youth channels.

3) For decreased influence of sociocultural factors

- Request better support through community leaders, religious leaders and other sectors (agricultural, private commercial, etc.).
- Based on the research, formulate strategies for eliminating cultural barriers.
- Continue to improve education/literacy programs, especially in rural areas.
- Continue to promote condoms through appropriate channels.

3.3. Level at which public RH needs are met

3.3.1 Data from analysis of documents

A general evaluation of the level at which public RH needs are met can be summarized by the fact that **clients do not receive adequate FP and STI/HIV/AIDS services from health-care facilities.**

The document analysis allowed us to evaluate the level of access and use of reproductive health services in quantitative terms.

- The coverage rate for prenatal examinations is only 55% for women of reproductive age.
- During the five years preceding the survey, 35.4% of births involved assisted delivery.
- The percentage of children aged 0-36 months that are weighed each month is only 13.2%. This statistic attests to the poor access to services by the target populations.
- Unmet need is estimated at about 32% in Senegal and the maternal mortality rate remains high: in Senegal, one woman in twelve risks dying during childbirth (UNICEF, 1995) (estimated at between 800 and 1200 deaths per 100,000 live births).
- Only 48% of women in the Kaolack region had at least three prenatal visits.
- Only 22% of children under the age of two years have had all recommended vaccinations.
- Only 25.9% of women aged 15-24 years can name a point of service where they feel comfortable, compared with 43% of men.
- Current use of modern contraceptive methods is well below the national average (5.1% compared with 7.1%). Usage is particularly low in the most rural districts: Kaffrine (2.6%), Kounghoul (1.6%), Niore (3.4%), Kaolack district (10%). Only 2.9% of women in the region were using a method for twelve months.

3.3.2 Cross-tabulated data from the analysis of documents, field visits and interviews

1) Inventory of RH services offered in health-care facilities

1-1) Access to HIV/AIDS testing service

Appropriate counseling for family planning and HIV/AIDS (for mother-to-child transmission, voluntary testing or clients suffering from AIDS) is not regularly offered in the district-level

health-care facilities. A service provider in a health outpost indicated that he had asked an HIV-positive client to come back in a few days so that the provider would have a chance to speak with the district hospital to see what kind of help he could offer the client. The client never returned.

There is no possibility for voluntary HIV/AIDS testing in all of the districts of Kafrine, Kougheul and Nioro. Services for handling STI using the syndromic approach are accessible, but there is a problem with access to medications, which are expensive. Patients and parties interested in voluntary testing are referred to Kaolack, then to Dakar if HIV/AIDS testing is needed. In some health-care facilities (Nioro), blood samples are taken and sent to Dakar for analysis. While this process helps make up for the lack of a testing center, it causes difficulties for clients, who must not only pay for transportation to the center where the blood is drawn, but must also wait for a long time to learn the results. The Kasnak center was the only one in the region that provided HIV testing, which was directed especially toward prostitutes. A voluntary testing center was opened on December 1, 2001, while the mapping exercise was being carried out in the field. While this single regional center is a privilege compared with other regions of the country, which have none, it still does not solve the problem of access to voluntary testing for clients who must contend with the issue of geographic accessibility and who must count on the health-care facilities to be flexible in the process of drawing the blood sample and sending it for the test.

1-2) Family planning services

Family planning services are available every weekday at the health-care facilities. Unlike other reproductive health services, such as prenatal and well-baby visits, which are available only on specific days, they are available every business day. The visit schedule and available documentation revealed that contraceptive products were never out of stock. These products are included in the management pathway for essential medications in the context of the Bamako Initiative.

Nevertheless, it should be noted that in many health outposts the services available to clients are still limited to condoms, pills and injectable contraceptives. Although access to IUDs and Norplant is specified in the standards, it remains rare. The service providers we interviewed expressed a need for training or retraining to meet client expectations.

Community-based services are nearly non-existent in the Kaolack region. In the rest of Senegal, they are still in the pilot stage in the Kébémér district.

1-3) Other RH services

The “other services” category includes all types of reproductive health services for mothers and children other than family planning and STI/HIV/AIDS, which were the focus of the exercise.

It was noted that in terms of integration, these services are not offered every business day, but rather according to a weekly schedule. This state of affairs poses a time problem; for example, a woman who comes for a prenatal visit cannot have another child vaccinated on the same day. In this sense, health outposts and health centers do not always comply with the PSP directive concerning the availability of all services every day at the same location.

At the regional level, PAC services are in their initial stages. The service providers had just been trained and PAC has been introduced at the Koungheul health center, where these services were observed actually to be available.

1-4) RH services for young people

The national policy for integrated RH does address provision of RH services to young people. However, in the region's four districts, we found an absence of services directed toward this segment of the population. In addition, the service providers noted that the absence of legal texts authorizing them to provide such services makes them vulnerable to a refusal and/or negative reaction by the parents, who attack them when they offer FP services to young people. Young people have a hard time gaining access to STI services due to a lack of money and the risk of marginalization and stigmatization by service providers who are not sensitive to their individual situations.

1-5) Documentation for collection of health information

The service providers mentioned difficulties in managing the many documents they must use to collect data in the course of providing the services. The difference in documents means that they have to change from one tool to another each time the client's needs change or a new client comes in to receive a different service. This is even more difficult in the context of certain strategies that have been put forward, which would require the health agent to take all of the records into the field.

Another inadequacy that was raised concerns which additional information should be included in the documentation when a new service is introduced. For example, the introduction of PAC requires that data collection tools and health record booklets be updated to include it.

1-6) Organization of services in health-care facilities

In the context of providing specialized services, internal referrals are very important to ensure that the opportunity to provide services is not lost. In the Kaolack region, a weakness in the referral system was noted in the field. The reduced number of service providers and their lack of qualifications, as mentioned above, means that internal organization is inadequate to provide ideal integration. This fact, in combination with the absence of staffpersons due to vacations, seminars and workshops, creates a real difficulty.

In the context of providing multiple services as recommended in health outposts where there is only one service provider, if this single provider does not have all the required qualifications, there is no other choice but to refer the client to another outpost or to a health center for services which are supposed to be offered on the provider's level. This is often the case with IUDs and Norplant, for example. The service is less accessible to clients, who are confronted with the problem of distance and additional cost. The referring provider often loses the means of following a client sent to a higher service level, because the counter-referral system does not work well.

1-7) RH services in the private commercial and NGO sectors

The private commercial sector is coming into being in the Kaolack region and is concentrated especially in the town of Kaolack. An study is underway to take inventory of

these structures and their organization into associations. The study is intended to allow them to participate in the health program in general and the reproductive health program in particular, in the best possible way. For the moment, they focus essentially on curative care and do not offer promotional services such as family planning.

ASBEF has a clinic that offers all of the services, including a specialized youth department, in the town of Kaolack.

SANFAM has introduced RH services in Kaolack's Village d'Enfant SOS health center. SIDA service, a Catholic NGO, will be managing the voluntary testing center opened in Kaolack in December 2001.

2) Main causes of observed gaps in health care

The number of health agents dropped from 5304 in 1993 to 4813 in 1994, a decrease of 8% (Ellen Wilson, 1998). The shortage, which has not been remedied since then, translates in the field to a critical lack of service providers meeting the norms and standards defined in the national policy document. This situation was observed in Kaolack. During the interviews, it became evident that there is a need for personnel and for training and retraining if integrated services are to be effectively provided in the health-care facilities.

There is a particularly pressing need for training in medical and social handling of people affected or infected by HIV/AIDS, specifically in counseling concerning voluntary testing, because prejudices with regard to the acceptability of voluntary, anonymous testing were observed among the staff members.

The analysis contained in the report entitled "Funding and implementing HIV/AIDS activities in the context of decentralization: Ethiopia and Senegal" (PHR, 2001) shows that the training budget is nearly non-existent.

3.2.2 Possible decisions

Clients

- Promote maintenance of community agents by revenue-generating activities on a micro scale
- Develop youth activities for young people outside of the school system
- Make RH services available to schoolchildren.

Service Providers

- Broad, somewhat broad or semi-specialized integration at points of service through appropriate training of RH service providers, especially for handling STI/HIV/AIDS clients.
- Remodel facilities depending on the specific option chosen for offering integrated services.
- Improve supervisory oversight.
- Make management tools and equipment appropriate for the provision of integrated services available to service providers.
- Reorganize and improve monitoring and evaluation.
- Implement quick HIV/AIDS tests in health services.

- Improve the (internal and external) referral and counter-referral system in the health pyramid.
- Expand PAC services in all the districts.

Organization

- Ensure development and design of an integrated program by involving the stakeholders in the design and planning process.
- Improve interorganizational cooperation and partnership so that programs and aid efforts are complementary.

Sector

- Improve cooperation between the education and health sectors by revitalizing existing structures, such as GEEP clubs and young student associations, for the fight against AIDS.
- Stimulate the partnership between the health sector and organizations of women, young people, traditional practitioners; involve leaders from other sectors in the provision of services.

3.4 Community organization support for implementation of RH services

Client needs are insufficiently taken into account and supported through existing community organizations.

3.4.1 Organization of community participation in Senegal's health program

When the primary health care acceleration program was implemented by the Bamako Initiative (BI), management committees were created for health centers and health outposts to provide community representation for co-management of the peripheral health-care units by the government and the territorial communities. Additionally, in the small villages within a health outpost's area of responsibility, the village communities—often with the support of NGOs—set up a dispensary run by a volunteer midwife and a volunteer community health agent. In principle, health information is transmitted to the villages by a large network of volunteer community health agents recognized by the official health system and serving as liaisons to the public. In Senegal's still-new approaches to community-based services these CHAs are involved in distributing condoms.

Alongside of this structure initiated in large part by the government and supported by the partners, exist numerous community organizations such as women's groups, youth associations, arms of religious associations, and mutual aid groups in all domains.

In the Kaolack region, all of these organizations are active and some of their leaders were interviewed during the course of the exercise to determine their level of involvement with RH, STI/HIV/AIDS and other RH components as seen from the angle of meeting client needs.

3.4.2 Cross-tabulated data from interviews and field visits

In the dispensaries visited, the CHAs (midwives and volunteers) remain very committed overall to their work for the community, but say that they are frustrated by the lack of motivation and materials, and especially by village community's general indifference to its own health problems.

They say that the commitments made by the village chief and notables when the NGO, in this case World Vision, helps them build the dispensary are not kept once the NGO stops following up. People stop coming to the meetings and stop contributing to the operation of the dispensary.

Consequently, materials for the midwife and CHA are not replaced and the modest amounts that are supposed to be repaid to the volunteers are stopped. The CHAs emphasize that a lack of transportation to inform the public is a major handicap to their work.

In the area of family planning, the CHAs received IEC training and from time to time include the subject in their educational talks, but they have no appropriate IEC materials available, and no guide for providing the information. Not a single family-planning poster was found, nor were there any brochures or image libraries on the subject. We did find a few pictures covering prenatal examinations and malaria. These workers are not equipped to handle questions about HIV/AIDS, and admit that they speak little of it. The midwife focuses more on her primary role of monitoring pregnancies, assisting with normal childbirth and making referrals.

Supervisory visits by the nurse from the health outpost are rare and overall the CHAs feel that they have been abandoned to their own resources in spite of their desire to do better.

At the health outpost and health center level, the health committees are functional and the chairmen, along with the HNOs and HDDs, are engaged in managing the health-care facilities. Without having been able to go into detail, it was evident that these entities are concerned more with financial and material management of the health-care facilities than with program issues for resolving community health problems. The major problems in curative treatment, such as the lack of medications and of an ambulance, are indeed understood, but preventive aspects other than vaccination and pregnancy management are not well known to the committee chairmen surveyed. One chairman of a village health committee, an important shopkeeper in the village, said he knew nothing about family planning. He had heard of AIDS but was not worried about the problem. The same committee chairman also admitted that meetings with the village notables to give an account of the health outpost's operations have become rare and that the committee and the HNO are managing the center extremely well, as they have more than 1,600,000 CFA in the bank.

Among community leaders, religious leaders, and leaders of women's groups and associations, family planning and HIV/AIDS are not perceived as high-priority problems.

At the time of observation, the problem of HIV/AIDS was not getting much attention in the community, even though Kaolack is the region with the highest incidence of HIV in the country. We observed a difference in the level of knowledge among community leaders, depending on where the interview took place. In the Kaolack district, where World AIDS Day was being observed as the interviews took place, the leaders were concerned by the recent increase in the incidence of HIV in the region, while the leaders in other places had practically no information on HIV/AIDS. One of the latter indicated that eradicating malaria is more urgent than fighting HIV/AIDS. Certain religious leaders that we interviewed are familiar with the problem of HIV/AIDS, but have not joined in community activities and are maintaining their conservative position on condom use.

Leaders of women's groups focus particularly on revenue-generating activities and are not very interested in becoming involved in promoting health.

Generally speaking, the interface between the community and the health-care structure needs to be better organized with the goal of having the communities take true ownership of their health problems in general, and their reproductive health problems in particular. Knowledge of family planning and STI/HIV/AIDS is vague, and they are practically never considered.

Generally speaking, the community does not actively participate in the design, implementation or management of health programs. When we asked the service providers for their perception of community participation in health-care facilities, they answered that the community contributes to management by paying their share of contributions as required.

This has resulted in a growing shortage of available information and the unavailability of a minimum package of FP and HIV/AIDS services in rural communities. It also explains why these services are so little used even where they are available.

3.4.3 Opportunities for improving community participation in RH programs

- The existence of women's, youth and religious organizations at all levels are opportunities to strengthen community involvement in RH.
- Initiatives of NGOs and many other stakeholders (ASBEF, SANFAM, World Vision, Plan International, SIDA service, etc.) exist in the region. For example, ASBEF is integrating RH activities in the Kaolack district's Women's Association, and in Kounghoul an association of midwives and social promoters supported by World Vision is involved in managing a community bank for conducting revenue-generating activities in order to meet their financial needs.
- The monitoring of health outposts, which is currently getting back on track, presents an opportunity to get the communities more involved.
- The DISC [Development of Community Health Initiatives] project has started up in one district of the region. The goal of this project is to improve the ability to mobilize and manage resources for community health.

3.4.4 Possible decisions

- Implement an appropriate system for ongoing motivation of CHAs.
- Define a minimum package of integrated RH information and services for CHAs.
- Provide appropriate training for CHAs in FP/STI/HIV/AIDS.
- Expand community-based FP services.
- Improve coordination and sharing of experience among the NGOs and other RH stakeholders in the region.
- Improve the IEC/RH capabilities of women's groups and existing community associations.
- Support revenue-generating activities for women to improve their adherence to health programs.
- Set up a network of women's groups in the region so the groups can share experiences.
- Improve monitoring of the dispensaries and the health outposts
- Expand DISC project activities.

Chapter 4: Summary of gaps and micro-plans for implementing corrective measures

4.1 Summary of gaps

During the wrap-up workshop held on March 21 and 22, 2002, a final consensus was reached on the list of gaps provided in Maps I, II et III (see Appendix), summarized as follows:

4.1.1 Clients/individuals do not have access to adequate information on reproductive health, especially HIV/AIDS and family planning

1) Clients and community

- Despite good knowledge of contraceptive methods, the public is not sufficiently convinced when it comes to using them.
- Not enough information on HIV/AIDS reaches populations in rural areas.
- Condom use remains infrequent among people who engage in risky behaviors.
- In rural areas, the existence of AIDS is still denied.

2) Health-care facilities

- A minimum package of RH information (FP and HIV/AIDS) is not regularly given to everyone at the health-care facility.
- Service providers do not possess the required competence to offer HIV/AIDS counseling services.
- Provider access to rural populations is limited by insufficient human, material and financial resources.
- Outside of the town of Kaolack, there are no adequate services directed toward specific groups (PLH and young people).
- There is no IEC material on HIV/AIDS or family planning in most health-care facilities.
- Existing HIV/AIDS information is directed toward prostitutes only.

3) Organizations and donors

- Distribution of donated funds for RH activities is not always based on the greatest needs of the regions or districts.
- A reduction in the funds allocated to family planning during a given period probably contributed to the stagnating contraceptive prevalence rate.

4) Other sectors

- Non-health sectors are not sufficiently informed about or involved in RH issues.
- The private commercial sector is not sufficiently informed about or involved in RH.
- Cooperative efforts between the social and health-care sectors are lagging.
- There are insufficient resources to support RH programs in the schools.
- The lack of health agents in the schools has led to a missed opportunity to bring RH information to young people.

5) Programs

- BCC/IEC is low on the priority list for financing.
- No training programs for HIV/AIDS counseling have yet been implemented in the region.
- Implementation of IEC programs does not sufficiently target men.
- RH PSPs have not yet been distributed in the region.

6) Political and sociocultural context

- There is a low level of literacy among women, especially in rural areas.
- There is resistance to family planning and condom use arising from cultural and religious beliefs.
- Polygamy makes it difficult to inform partners about STI/HIV/AIDS.
- People who are HIV -positive or are suspected of being HIV -positive are stigmatized.

4.1.2 Clients do not receive adequate services from health-care facilities

1) Clients and community

- Clients must travel long distances for voluntary HIV testing.
- Services are not always available to clients depending on the activity schedule.
- Young people, men and PLH do not have access to RH services directed specifically toward them.

2) Health-care facilities

- Service providers do not have the same idea of integration as that presented in the PSPs.
- Voluntary testing services are offered only in the town of Kaolack.
- Referral systems do not always function appropriately.
- Service providers are hesitant to discuss HIV/AIDS testing.
- There is inadequate logistical support to provide integrated services.
- Service providers lack the necessary competence to handle HIV/AIDS.
- Service providers do not offer the client services other than those for which he or she came.
- Service providers have insufficient equipment to integrate RH services.
- Some service providers are prejudiced against accepting voluntary testing.
- Management documentation is inadequate and there is too much of it.
- Some health-care facilities are unsanitary.

3) Organizations and donors

- Partner organizations have programs and projects that are designed vertically based on their mandates or their zones.
- There is little coordination or communication among partners.
- Distribution of donated funds is not based on local priorities.
- A reduction in the funds allocated to family planning during a given period probably contributed to the stagnating contraceptive prevalence rate.

4) Other sectors

- RH services are not generally offered in non-health sectors.
- The weak school health program is a missed opportunity for offering RH services.
- The private commercial sector is not sufficiently involved with provision of RH services.

5) Programs

- The HIV/AIDS training program does not yet cover the entire region.
- The monitoring system is no longer functional.
- There is no retraining program for prenatal examinations.
- Health-care facilities do not meet required standards for hygiene and equipment.
- The lack of coordination of vertical programs slows integration at the operational level.
- The budget for training service providers is low.
- PSPs exist for RH but have not yet been distributed.
- Standards for certain components of RH are not set forth in the PSPs.

6) Political and sociocultural context

- There is a low level of literacy among women, especially in rural areas.
- There is resistance to family planning and condom use arising from cultural and religious beliefs.
- Men do not participate in women's health.
- Polygamy makes it difficult to treat partners for STI/HIV/AIDS.
- People who are HIV -positive or are suspected of being HIV -positive are stigmatized.

4.1.3 Clients' reproductive health needs are not taken into account or supported by community organizations

1) Clients and the community

- Community leaders do not have enough information on RH.
- The community is not sufficiently concerned about the HIV/AIDS problem.
- The community is not sufficiently involved in managing the health-care committee and the dispensaries.
- The members of the health-care committees have little expertise in planning and budgeting.
- Persons with AIDS are stigmatized.

2) Health-care facilities

- The number of CHAs is decreasing.
- CHAs have little motivation due to a lack of revenue and materials.
- Existing CHAs are not sufficiently competent in RH

3) Organizations and donors

- Community organizations are not sufficiently involved in the RH program.
- There is insufficient coordination of NGO activities at the village level.

4) Other sectors

- The village development committees do not adequately integrate RH aspects.

5) Programs

- Community-based services are insufficient.
- There is insufficient RH training for the CHAs.

6) Political and sociocultural context

- There is a low level of literacy among women, especially in rural areas.
- There is resistance to family planning and condom use arising from cultural and religious beliefs.
- Men do not participate in women's health.
- Polygamy makes it difficult to treat partners for STI/HIV/AIDS.
- People who are HIV -positive or are suspected of being HIV -positive are stigmatized.

4.2 Application of the integration evaluation grid

The participants used the integration evaluation grid (see Appendix) in an exercise designed to allow quick visualization of the concrete problems of integration that are currently presenting themselves at the various levels on which services are provided. This evaluation was compared to what ought to be the ideal for integration as developed by the Advance Africa team based on the definition of integration contained in the PSP/RH document for Senegal (Maps Va and Vb).

The structures investigated in order to evaluate availability and integration were as follows: ***dispensary, health outpost, health center, regional hospital, private clinics, private practices, NGO clinics, private pharmacies, communities, schools, the media, and others.***

1) The minimum package of information

The results recorded by consensus with regard to the **minimum package of information** concerning family planning (FP), postabortion care (PAC), HIV/AIDS, mother-to-child transmission (MCT), sexually transmitted infections (STI), maternal mortality rate (MMR) and child survival (CS) showed that the package was not available except in a few public health structures such as the dispensary, where information about three or four of the seven targeted services (FP, STI, MMR, and CS) was available. The situation in the health outposts and health centers was about the same, although in some of them the minimum package of information about HIV/AIDS was also available. Curiously, the minimum package of information about these seven areas is offered neither in the hospitals nor in the private sector. Furthermore, it is hardly ever seen in the communities or the schools. However, for five of the seven areas, it seems to be available to the media. The two areas in which there is no package are PAC and MCT.

2) Counseling

The results for **counseling** activities were obtained in the same manner. The results for the six areas targeted here show that **counseling** was much rarer in the structures studied. With regard to health-care structures, counseling was provided only in health centers and hospitals. At these two levels, it is offered only for FP, HIV/AIDS, STI and persons living with HIV. In the private sector, counseling is offered only in private clinics and only for STI and for persons living with HIV. NGO clinics offer counseling only for STI. This activity is nonexistent in all six target areas at the community level and in the schools and other structures studied.

3) Services and products offered

With regard to the **services and products** offered, we were interested in condoms and spermicides, injectable products, the pill, IUDs, Norplant, PAC, STI testing, STI treatment, MCT and voluntary counseling and testing (VCT). None of these services was available in the dispensaries. Five out of the ten were available in the health outposts: condoms and spermicides, injectable products, pills, STI testing and STI treatment. Except for MCT and VCT, all of the other services were available at health centers and in the regional hospitals. Private clinics and NGO clinics offered six of the ten and seven of the ten, respectively. In particular, they did not offer Norplant, MCT and VCT. Only four of the ten services and products studied were available in private pharmacies, namely condoms and spermicides, injectable products, pills and products for treating STI. The ten services and products targeted were not present in the other structures targeted for this mapping (cf. Maps IVa and IVb in the Appendix).

4.3 Micro-plans for implementing corrective measures

Based on the summary of gaps, the results of the evaluation exercise, and the possible decisions that had been identified at previous meetings, the participants developed a short-term plan to fill the gaps using currently available resources and activities already scheduled in the regional and district operational plans (OP). Because it attempts to be realistic and practical, the plan does not take all of the gaps into account (see Plans I, II and III in the Appendix). The plans were designed around three main groups of gaps.

Conclusions and next steps

The mapping exercise led to three main conclusions:

- The first is that, strictly speaking there is no integration of FP and HIV/AIDS activities according to any of the aspects (temporal, spatial, by service provider) of the concept definition adopted by the Ministry of Health. The obvious lack of availability of HIV/AIDS services in the districts' health-care and community structures attests once again that the lack of decentralization for these activities is hindering any possibility of discussing integration on these levels.
- The second is that the contraceptive prevalence rate remains very low, yet family planning is not considered a priority. Because of this, an increase in the population could set back economic development. This is a strong justification for working to achieve mutual synergy with anti-AIDS activities which, in spite of their inadequacies, are managing to hinder the pandemic's spread through the country.
- The third is that our results did not support the assumption that control of the HIV/AIDS epidemic in the country is the result of activities conducted primarily within the health system, particularly in the districts in which the majority of the population resides. On the contrary, our results show that even STI and HIV/AIDS activities often are not available in the districts' health-care and community structures. Thus, it seems that the HIV/AIDS activities are still centralized, which calls into question the fundamental role attributed to the district health systems in very low-level control of the HIV/AIDS epidemic in Senegal. However, more specific and more detailed studies are needed to better support this conclusion.

It follows from these three conclusions that in the particular context of the Kaolack region, it would not be wise to speak of integrating family planning with HIV/AIDS activities. In order for "integration" to occur, the thing with which one is integrating must exist, function properly, and already have been stabilized. This is not the case for HIV/AIDS activities or family planning in the health-care structures at the district and community levels. Under these conditions, it would be wiser to speak of bringing the two activities together by offering a package of services including HIV/AIDS and family planning activities.

This initial mapping exercise conducted in Senegal yielded a short-term micro-plan. While it is not a cure-all for the problems of integrating RH/FP services and STI/HIV/AIDS services, the plan should be perceived as a first step in finding specific solutions to a concern distinctive to the program context in the Kaolack region. The exercise is not an end in itself. It is simply one step that, in the Kaolack region, should be included as part of an ongoing process of micro-planning and activities monitoring in order effectively to contribute to continual improvement of the quality of services offered to the clients. The concrete actions resulting from this process, which will have been

demonstrated to be effective, can be reproduced in other regions of Senegal and in other countries.

Advance Africa is ready and willing to assist the Division of Family Planning and Maternal Health in following and evaluating implementation of the micro-plans.

Advance Africa is also ready and willing to support the process of having Senegal's Ministry of Health take ownership of the mapping so that it can become an effective tool for making rapid improvements to Senegal's health programs in general and RH health programs in particular.

Appendix

Map I: Clients/individuals do not have access to adequate information on reproductive health, especially HIV/AIDS and family planning

Client/Community	Health-Care facilities	Organizations	Other Sectors	Programs	Political and Sociocultural Context
<p>Despite good knowledge of contraceptive methods, the public is not sufficiently convinced when it comes to using them</p> <p>Not enough information on HIV/AIDS reaches populations in rural areas</p> <p>Condom use remains low among people who engage in risky behaviors</p> <p>In rural areas, the existence of AIDS is still denied</p>	<p>A minimum package of RH information (FP and HIV/AIDS) is not regularly given to everyone at the health-care facility</p> <p>Service providers do not possess the required competence to offer HIV/AIDS counseling services</p>	<p>Distribution of donated funds for RH activities is not always based on the greatest needs of the regions or districts</p> <p>A reduction in the funds allocated to family planning during a given period probably contributed to the stagnating contraceptive prevalence rate.</p>	<p>Non-health sectors are not sufficiently informed about or involved in RH issues</p> <p>The private commercial sector is not sufficiently informed about or involved in RH</p> <p>Cooperative efforts between the social and health-care sectors are lagging</p>	<p>BCC/IEC is low on the priority list for financing</p> <p>No training programs for HIV/AIDS counseling have yet been implemented in the region</p> <p>Implementation of IEC programs does not sufficiently target men</p>	<p>There is a low level of literacy among women, especially in rural areas</p> <p>There is resistance to family planning and condom use arising from cultural and religious beliefs</p> <p>Polygamy makes it difficult to inform partners about STI/HIV/AIDS</p>

	<p>Provider access to rural populations is limited by insufficient human, material and financial resources</p> <p>Outside of the town of Kaolack, there are no adequate services directed toward specific groups (PLH and young people)</p> <p>There is no IEC material on HIV/AIDS or family planning in most health-care facilities</p>		<p>There are Insufficient resources to support RH programs in the schools</p> <p>The lack of health agents in the schools has led to a missed opportunity to bring RH information to young people</p>	<p>RH PSPs have not yet been distributed in the region</p>	<p>People who are HIV-positive or are suspected of being HIV-positive are stigmatized</p>
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	Existing HIV/AIDS information is directed toward prostitutes only				
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Map II: Clients do not receive adequate services from health-care facilities

Client/Community	Health-Care Facilities	Organizations	Other Sectors	Programs	Political and Sociocultural Context
<p>Clients must travel long distances for voluntary HIV testing</p> <p>Services not always available to clients depending on activity schedule</p> <p>Young people, men and PLH do not have access to RH services directed specifically toward them</p>	<p>Service providers do not have the same idea of integration as that presented in the PSPs</p> <p>Voluntary testing services are offered only in the town of Kaolack</p> <p>Referral systems do not always function appropriately</p> <p>Service providers are hesitant to discuss HIV/AIDS testing</p>	<p>Partner organizations have programs and projects that are designed vertically based on their mandates or their zones</p> <p>There is little coordination or communication among partners</p> <p>Distribution of donated funds is not based on local priorities</p>	<p>RH services are not generally offered in non-health sectors</p> <p>The weak school health program is a missed opportunity for offering RH services</p> <p>The private commercial sector is not sufficiently involved with provision of RH services</p>	<p>The HIV/AIDS training program does not yet cover the entire region</p> <p>The monitoring system is no longer functional</p> <p>There is no retraining program for prenatal examinations</p> <p>Health-care facilities do not meet required standards for hygiene and equipment</p>	<p>There is a low level of literacy among women, especially in rural areas</p> <p>There is resistance to family planning and condom use arising from cultural and religious beliefs</p> <p>Men do not participate in women's health</p> <p>Polygamy makes it difficult to treat partners for STI/HIV/AIDS</p>

	<p>There is inadequate logistical support to provide integrated services</p> <p>Service providers lack the necessary competence to handle HIV/AIDS</p> <p>Service providers do not offer the client services other than those for which he or she came</p> <p>Service providers have insufficient equipment to integrate RH services</p>	<p>A reduction in the funds allocated to family planning during a given period probably contributed to the stagnating contraceptive prevalence rate</p>		<p>The lack of coordination of vertical programs slows integration at the operational level</p> <p>The budget for training service providers is low</p> <p>PSPs exist for RH but have not yet been distributed</p>	<p>People who are HIV-positive or are suspected of being HIV-positive are stigmatized</p>
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	<p>Some service providers are prejudiced against accepting voluntary testing</p> <p>Management documentation is inadequate and there is too much of it</p> <p>Some health-care facilities are unsanitary</p>				
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Map III : Clients' reproductive health needs are not taken into account or supported by community organizations

Client/Community	Health-Care Facilities	Organizations	Other Sectors	Programs	Political and Sociocultural Context
<p>Community leaders do not have enough information on RH</p> <p>The community is not sufficiently concerned about the HIV/AIDS problem</p> <p>The community is not sufficiently involved in managing the dispensaries</p> <p>The members of the health-care committees have little competence in planning and budgeting</p> <p>Persons with AIDS are stigmatized</p>	<p>The number of CHAs is decreasing</p> <p>CHAs have little motivation due to a lack of revenue and materials</p> <p>Existing CHAs are not sufficiently competent in RH</p>	<p>Community organizations are not sufficiently involved in the RH program</p> <p>There is insufficient coordination of NGO activities at the village level</p>	<p>The village development committees do not adequately integrate RH aspects</p>	<p>Community-based services are insufficient</p> <p>There is insufficient RH training for the CHAs</p>	<p>Cultural and religious conservatism are present within the community</p> <p>There is a low level of literacy among women, especially in rural areas</p> <p>Men do not participate in women's health care</p> <p>Polygamy makes it difficult to inform partners about STI/HIV/AIDS</p>

**Map Va: Ideal integration according to Senegal's PSPs
by level of service**

	Dis- pen- sary	Health Outpost	Health Center	Regional Hospital	Private Clinic	NGO Clinic	Phar- macy	Community	Schools	Other Sectors	Media
1. Minimum package of information											
FP											
PAC											
HIV/AIDS											
MCT											
STI											
MMR											
CS											
2. Counseling											
FP							R	R	R		
PAC	R						R	R	R		
HIV/AIDS	R						R	R	R		
MCT	R						R	R	R		
STI	R						R	R	R		
PLH							R	R	R		



Service offered



Service not offered

R = Referral

**Map Vb: Ideal integration according to Senegal's PSPs
by level of service
(continued)**

	Dis- pen- sary	Health Out- post	Health Center	Regional Hospital	Private Clinic	NGO Clinic	Phar- macy	Community	Schools	Other Sectors	Media
3. Services/Products											
Condom, spermicide										R	
Injectable										R	
Pill										R	
IUD	R						R	R		R	
Norplant	R						R	R		R	
PAC	R	R					R	R	R		
STI lab	R	R					R	R	R	R	
STI treatment	R						R	R	R	R	
MCT							R	R	R	R	
VCT	R	R			R		R	R	R	R	

Micro-Plan for Implementing Corrective Measures

PLAN I: Clients do not have access to adequate RH information

Structure or level of intervention	Gaps to fill	Action to take	Responsible party/ institution or associated services	Period (deadline)	Means of verification
Community	<p>The system for relaying information does not work well</p> <p>IEC for PAC, MCT and VCT is not done</p>	<p>Train ARPs in RH in 15 districts, incl. Kaolack</p> <p>Contract with the ARPs to create a package of activities</p> <p>Set up management tools to effectively manage their activities</p> <p>Community-based services for local residents near the SONACOS Lyndiane factory</p>	HDD/DCR, all cooperative agencies operating in the region and SANFAM, AFRICARE, World Vision	December 2002	<p>Training reports</p> <p>Service contracts</p>
Dispensary	Dispensaries and CHAs have no IEC material for FP/HIV/AIDS	<p>Inventory of need for the dispensaries and CHAs</p> <p>Equip the CHAs under contract</p>	HDD/DCR, cooperative agencies and SANFAM, AFRICARE, World Vision	August 2002	<p>Inventory report</p> <p>Delivery slip for materials</p>

PLAN I (continued)

Health Outpost	IEC on PAC is not done Some health outposts are closed due to lack of personnel	Give an information packet on PAC to HNOs during AIDS supervisory visits Contract for personnel to operate all of the closed health outposts	HDD/HDR	August 2002	Activity reports
Health Center/District	Health centers function poorly due to lack of personnel	Improve staffing of health centers by contracting	HDD/HDR	August 2002	Activity report
Regional Office	Lack of coordination among NGOs	Organize a meeting once every six months with all health NGOs	HDD	August 2002	Activity report

PLAN I (continued)

Private sector	The private sector offers no RH services	<p>Three forums on RH in the private sector in the Kasnak district</p> <p>A SIG training session for the private sector</p> <p>Provide IEC material</p> <p>Organize two coordination meetings with the private sector</p> <p>Conduct IEC activities at SONACOS, Village SOS, SARR private clinic, CSS</p> <p>Provide IEC/RH material to the private sector</p> <p>Improve IEC activities and counseling at SONACOS, CSS, V SOS and the surrounding community</p>	HDR, MSH, SANFAM	August 2002	Activity report
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PLAN I (suite)

Other sectors 1. Schools	There is insufficient RH information in the schools	Organize two training sessions in RH for 120 family life education teachers Create new family life education clubs in five schools Begin holding GEEP activities monthly Publish a regional bulletin for the GEEPs Distribute GEEP's letter Organize a teacher awareness day for RH Organize a regional youth festival for RH Set up five listening and counseling centers in five FAWE clubs, including the Kaolack club Institute widespread use of listening centers in the 57 FAWE clubs	Academic Inspectorate, GEEP, MSH and FAWE	December 2002	Activity reports for FAWE, School Inspectorate, MSH and GEEP
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PLAN I (continued)

Other sectors 2. Social sector	The social sector is no longer sufficiently involved in solving health problems	Initiate periodic meetings with the social sector at the level of health-care regions and districts	HDR and HDD	August 2002	Minutes from the meetings
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PLAN II: Clients do not receive adequate services at health-care facilities

Structure or level of intervention	Gaps to fill	Action to take	Responsible party/ institution or associated services	Period (deadline)	Means of verification
Dispensary	No IEC services or referral directives for PAC, HIV/AIDS	Informational meeting for CHAs and midwives on referrals for PAC, MCT and VCT for HIV/AIDS Written directives concerning referrals	RH coordinator, HDR, HDD, HNO	June 2002	Meeting minutes Directives available at health outposts and health centers
Health Outpost	No IEC services or referral directives for PAC, HIV/AIDS	Adequate training of HNOs in the three areas according to the Ministry's RH standards	RH coordinator, HDR, HDD, HNO, Head of the DLS, SANFAM and AFRICARE	First half of May 2002	Training report available at health centers, districts and the regional medical office
Health Center	VCT services are not yet available at this level	Train the laboratory assistants of the five health centers and the SOS and SONACOS labs and their equipment	HDR and HDD assisted by the DLS	Second half of May 2002	Training reports and activity reports
Medical region and districts	Inadequate coordination of interventions	Set up a monitoring cell for the OP with all the stakeholders	HDR and HDD	April – December 2002	Minutes from cell meetings
Regional hospitals	<i>All of the services targeted by the mapping exercise for both RH programs and HIV/AIDS programs are available in varying degrees at the Kaolack regional hospital. The level of integration also varies.</i>				

**PLAN II
(continued)**

Private clinics/private practices	Unavailability of condoms, spermicides and IEC services for FP/PAC/HIV/AIDS	Dinner/discussions for training in FP/PAC/HIV/AIDS Initial grants to cover the costs of condoms and spermicides	Regional RH coordinator, assisted by DNSR, ASBEF and MSH	May to June 2002	Report on the availability of the products and service targeted in this sector.
NGO clinics	Unavailability of PAC, MCT services	Train those responsible for this activity in IEC for PAC, MCT	HDD assisted by SANFAM, ASBEF	May 2002	Training reports available at the regional medical office and at DNSR
Pharmacy	No competence in FP	Train the region's dispensary pharmacists in contraceptive technology	HDD assisted by DNSR and ADEMÁS	July 2002	Training reports available at the regional medical office and at DNSR
Schools	No IEC services in the schools for FP/RH, HIV/AIDS (STI)	Set up a medical inspection office in the school inspectorate Institutionalize provision of IEC services for RH/FP and HIV/AIDS in the schools	School and medical inspectorates	April – December 2002	Report on school inspectorate activities

PLAN III: Clients' reproductive health needs are not adequately supported in the communities

Structure	Gaps to fill	Action to take	Responsible party/ institution or associated services	Period (deadline)	Means of verification
Community	Insufficient community-based services in FP	<p>Train 30 liaisons of 10 GPFs in IEC/RH</p> <p>Community-based services by these GPF liaisons</p> <p>Additional IEC/RH training for the association of liaisons grouped as economic interest groups</p> <p>Make 14 community health educators available in the Wack Ngouna <i>arrondissement</i> for IEC/RH/FP/STI/AIDS activities</p> <p>Training of liaisons by these educators</p> <p>Community-based distribution of contraceptive products + ME, etc.</p> <p>Expansion of other communities' activities</p>	HDD of Kaffrine and Nioro, SANFAM, Plan International, Africare, World Vision	December 2002	<p>Training reports</p> <p>Reports on community-based distribution activities</p>
	Community leaders do not have enough information on RH	Organization of awareness and social mobilization days by the health outpost health committees	HDD of Kaffrine and Nioro, SANFAM, Plan International, Africare, World Vision	December 2002	Report on the awareness activity

**PLAN III
(continued)**

Community (continued)	Core community organizations (CCO) do not pay sufficient attention to the various aspects of RH	Organization of awareness and social mobilization days by the health outpost health committees	HDD of Kaffrine and Nioro, SANFAM, Plan International, Africare, World Vision	December 2002	Report on the awareness activity
Dispensary	CHAs and midwives are not adequately trained in RH	<p>Train 8 CHAs/midwives in the rural villages of Paoskoto and Porokhane</p> <p>Train 12 CHAs/midwives in the rural villages of Mbirkilane, Ndiognick and Kathiote</p> <p>Train 8 CHAs/midwives in the rural municipality of Boulel</p> <p>Train 40 CHAs/midwives in IEC/RH</p> <p>Provide medical kits and IEC materials</p> <p>Train 6 midwives, 6 CHAs and 12 liaisons in IEC/RH in the rural municipalities of Sibasor and Koumbal (6 villages)</p> <p>Monthly supervision by HNOs of three health outposts in the Kaolack district, three in Kaffrine, three in Nioro and one in Kougheul</p>	HDD of Kaffrine and Nioro, SANFAM, Plan International, Africare, World Vision	December 2002	<p>Training reports</p> <p>Reports on supervisory visits</p> <p>Delivery slips for medical kits</p>

**PLAN III
(continued)**

Dispensary (continued)	Lack of motivation among the CHAs and liaisons	Set up micro credits for these GPF Contract with this association for IEC/RH activities in the community Profit margin allowed on the sale of products with inclusion of other BI products	HDD of Kaffrine and Nioro, SANFAM, Plan International, Africare, World Vision	December 2002	Activity reports and contracts with the associations
Health outposts, health centers and districts	Insufficient community participation in management of the health committee and the dispensary The members of the health committees do not have the necessary planning and budgeting skills	Involve community leaders more in the monitoring process and in the development of operational plans	HDD, HNO	May – December 2002	Monitoring reports
Health-care region	Disparity between community-based service initiatives in the region	Hold a meeting with the community-based service stakeholders to define a regional strategy	HDR	June 2002	Meeting report

**PLAN III
(continued)**

Private sector	Health services in the factories are not involved with RH in the communities	<p>Provide community-based services for local residents near the SONACOS factory</p> <p>Organize talks by SONACOS service providers trained in counseling for factory personnel and local residents</p> <p>Support SONACOS activities and expand IEC activities for village SOS, CSS, SARR clinic</p>	HDD and SANFAM	December 2002	Activity reports
Other sectors	The liaisons in the social sector are no longer sufficiently involved in IEC/RH	Hold dialogues with those responsible for social action on the level of regions and <i>départements</i>	HDR and HDD	July 2002	Minutes of meetings

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