

Final Report of the Senegal PREMOMA Project
August 2006

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About the PREMOMA Project

The Maternal Morbidity and Mortality Reduction Project (PREMOMA), implemented by Management Sciences for Health (MSH) and the Futures Group International (FGI), presents in this report all the activities carried out during the period from November 2004 to September 2006.

Financed by USAID (US Agency for International Development), this project's mission was to contribute to the efforts of governmental and nongovernmental organizations for the improvement of maternal health by reducing maternal mortality and increasing awareness of family planning. It has provided technical assistance to consolidate the progress achieved by the previous project, Maternal Health and Family Planning, since 2000. PREMOMA's activities focus on improving prenatal service delivery and increasing the number of births attended by health workers and the use of postnatal care and family planning through integration and decentralization of services and increased demand for these services.

PREMOMA has supported the Ministry of Health and Preventive Medicine through its divisions, that is, the Division of Reproductive Health, 6 out of the 11 medical regions of Senegal, and 25 health care districts that cover approximately 432 service delivery points. In two years, PREMOMA has worked with health care service providers, decision-makers and leaders, civil society organizations, and communities in the challenging effort to deliver better reproductive health to the country's women and families.

This report is the summary of a number of activities, some of which have been innovative in their approach and their execution, such as formative supervision, accreditation, natural family planning using the "necklace" method, community health promoters, and Associations of Multifocus Agents, while others stood out because of their effectiveness: postabortion care, intermittent preventive treatment, and logistical management of contraceptives.

Beginning with a summary and a presentation of project performance in terms of indicators, this report is organized in three main sections:

- Service delivery or how to improve service providers' skills and the availability and quality of services;
- Demand for services or how to improve knowledge and acceptance of reproductive health services;
- Availability of contraceptives or how to contribute to ensuring the supply of reproductive health products.

The two final sections share lessons learned and future challenges and opportunities.

PREMOMA

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Contents

Acronyms.....	v
Executive Summary	1
Strategy 1: Improvement of the Delivery of Maternal Health and Family Planning Services	1
Strategy 2: Improvement of Knowledge, Acceptance and Demand for Reproductive Health Services	3
Strategy 3: Increased Availability of Contraceptive Methods.....	5
Monitoring and Evaluation of Project Performance	6
Project Data Management System	6
Service Delivery.....	8
Objectives	8
Maternal Health	8
Family Planning	13
Integrated Formative Supervision.....	18
Accreditation.....	21
Partnerships with the Private Sector	23
Leadership.....	24
Increasing the Demand for Services by Improving Knowledge and Acceptance of Reproductive Health Services.....	27
Objectives	27
Availability of Contraceptives and Essential Drugs	37
Objectives	37
Lessons Learned.....	43
Service Delivery.....	43
Demand for Services.....	43
Logistical Management of Contraceptives	44
Challenges and Opportunities	45

Acronyms

ADEMAS	Agency for the Development of Social Marketing
AMIU	Intra-uterine manual aspiration
ANAFAN	National Association for Adult Literacy and Education
ARPV	Association of Multifocus Agents
ASPF	Senegalese Association for the Promotion of Family
BASICS	Basic Support for Institutionalizing Child Survival Project
BCC	Behavior change communication
CA	Cooperating agency of USAID
CCF-CANAH	Christian Children's Fund
CEPDA	Centre pour le développement des activités populaires
COPE	Client Oriented Provider Efficient
CP	Community promoters
CPN	Prenatal consultation
CPON	Postnatal consultation
CPTS	Table of contraceptive procurement in Senegal
CYP	Couple-year(s) of protection
DEE/ME	Elementary Education Division, Ministry of Education
DHS	Demographic and Health Survey
DISC	Decentralization of Community Health Initiatives
DLSI	Division for the Fight against AIDS and STDs
DSR	Department of Reproductive Health
ECD	District Executive Team
ECR	Regional Executive Team
EFI	Teachers' Training School
EVF	Training for Family Life
FGI	Futures Group International
FHI	Family Health Institute
FP	Family planning
GEEP	Groupe pour l'étude et l'enseignement de la population [Group for Population Study and Training]
GPF	Group for Promotion of Women
ICP	Health Post Head Nurse
IEC	Information, education, and communication
IMAT	Inventory Management Assessment Tool
IPT	Intermittent preventive treatment
ISAARV	Senegalese Initiative for Access to Antiretroviral Drugs
IUD	Intra-uterine device
JICA	Japanese Cooperation Agency
KIR	Key interim results
KIT	Knowledge Improvement Tool
ME	Essential medicine
MH/FP	Maternal health and family planning
MJF	Fixed days method
MSH	Management Sciences for Health
MSPM	Ministry of Health and Preventive Medicine
NGO	Nongovernmental organization
OCB	Basic community organization
PICS	Pills, injectables, condoms, and spermicides
PNA	National Pharmacy

PNIR	National Program for Rural Infrastructure
PNLP	National Program for the Fight against Malaria
PNP	Policies, norms and protocols
PRA	Regional Pharmacy
PREMOMA	Projet réduction de la morbidité et de la mortalité maternelles [Maternal Morbidity and Mortality Reduction Project]
PSM/PF	Maternal Health and Family Planning Project
PTME	Prevention of mother-to-child transmission of HIV/AIDS
RFESPF	Senegalese Women's Network for the Promotion of Family Planning
RH	Reproductive health
SAA	Postabortion care
SANFAM	Family health
SDP	Service delivery point(s)
SFE	Government midwife
SMM	Safe Motherhood Model
SP	Sulfadoxine-pyrimethamine
STD/HIV	Sexually transmitted diseases /Human immuno-deficiency virus
UDTPM	Departmental Union of Popular Theater and Music
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VADC	Targeted home visit
VADI	Integrated home visit
WHEPSA	Women's Health Education and Prevention Strategies Alliance
WHO	World Health Organization

Executive Summary

The USAID project for maternal health and family planning in Senegal, named *Projet de réduction de la mortalité and de la morbidité maternelles (PREMOMA)* and administered by Management Sciences for Health and the Futures Group International, took over from the Maternal Health and Family Planning Project (PSM/PF, 2000–2004) as of November 2004. PREMOMA has made a significant contribution to the efforts of the government of Senegal and local nongovernmental organizations in improving maternal health by decreasing maternal mortality and increasing awareness of family planning. Two key interim results (KIRs) should allow the project to achieve these objectives:

- improved access to prenatal services, assisted delivery, postnatal follow-up, and family planning by integrating and decentralizing services;
- and increased demand for these services.

PREMOMA has continued to use the strategies developed by PSM/PF to achieve these interim results:

- **Strategy 1:** Improve the **delivery** of maternal health/family planning services by:
 - improving the skills of health care agents;
 - increasing the availability and quality of maternal health/family planning services;
- **Strategy 2:** Increase the **use** of these services by improving knowledge and acceptance of and demand for reproductive health services;
- **Strategy 3:** Increase the **availability of contraceptives** and improve the management of essential drugs.

These strategies are employed at 432 service delivery points (SDP) in 25 health districts, corresponding to 6 out of the 11 medical regions of Senegal, as follows:

- maternal health and family planning activities in 22 districts;
- family planning activities solely in the 3 districts of the Dakar region.

Strategy 1: Improvement of the Delivery of Maternal Health and Family Planning Services

Increased availability of postabortion care services (SAA). After training service providers in all health centers, the project trained health post head nurses in SAA. This is how 61% of the 117 health post head nurses (ICP) targeted have been trained in managing abortions in accordance with postabortion care policies, norms, and protocols. Currently, the percentage of service delivery points (SDP) with at least one service provider trained in postabortion care is 100% for the health care centers and 72% for health posts. As for counseling, trainers were selected and qualified in the new postabortion care counseling module: thus all four regions currently have available a regional pool of trainers for SAA counseling. SAA is currently offered at 72% (216/300) of the health posts, and it is currently available 24 hours a day, seven days a week at all the 23 health care centers covered by the project. At the health care centers, the number of patients treated for complications of abortion rose from 1178 in 2003 to 2530 in 2005; the percentage of patients treated with manual intra-uterine aspiration (AMIU) went from 27% in 2003 to 57% in 2005; the percentage of patients who received counseling before leaving the SDP went from 36% in 2003 to 82% in 2005; and the percentage of patients who chose and received a family planning method before leaving the health care facility went from 15% in 2003 to 51% in 2005.

Malaria prevention of among pregnant women by means of intermittent preventive treatment. Public-sector service providers received training in intermittent preventive treatment (IPT). To improve implementation of sulfadoxine-pyrimethamine (SP) intermittent preventive treatment among pregnant women in the USAID intervention districts, a reactivation plan was carried out, which achieved the following results: availability of SP in the consultation room increased to 67%, allowing service providers to provide directly monitored treatment 73% of the time (100% in Kaolack and Ziguinchor). Overall, the rate of SP use during prenatal consultation (PNC) is satisfactory (77%). However, it was noted that only one half of women who took the first dose of SP return for the second dose (39%) and that only 25% of the target population (number of expected pregnancies) received two doses of SP. Actual IPT coverage of the target population is strongly influenced by the adequate use of prenatal consultation services. Any policy to strengthen IPT coverage will necessarily depend on the improvement of PNC coverage.

Prevention of mother-to-child HIV transmission (PTME). Scale-up of PTME began with decentralization in Thiès, Kaolack, Louga, and Ziguinchor: thanks to the joint support of PREMOMA, the Global Fund, and the World Bank, 188 service providers have been trained and 15 PTME sites were put in place in these health care regions. The post-training follow-up data at seven sites in Thiès and Kaolack show that 67% of the service providers suggested the test during PNC1. It has been reported that these results were obtained thanks to the synergy between the Reproductive Health Division, supported by the project, and the Division for the Fight against STD/AIDS, supported by FHI.

Repositioning of the IUD among contraceptive methods. In the global repositioning strategy for family planning, the IUD appears to be one of the most reliable long-term methods and one that ensures the best cost-effectiveness ratio and is therefore best suited for permanent inclusion in the program. A refresher program on counseling and offering the IUD method for midwives involved in FP services from the 25 health care districts covered by the Project succeeded in reaching 221 government midwives (SFE), who also received help in the form of insertion/removal kits. Post-training follow-up already shows an improvement in the use of IUDs, with 8% of the retrained midwives' clients having chosen IUDs as a contraception method.

Broadening the range of family planning services in Senegal with the introduction of a new natural family planning method. PREMOMA, in conjunction with the Reproductive Health Division, began the first phase of the introduction in Senegal of a natural family planning method called the fixed days method (MJF) or the cycle beads method. The program trained 246 individuals, a majority of whom are midwives and health post service providers. Partnerships have been set up with the Senegalese Association for the Promotion of Family and the Christian Children's Fund to strengthen community promotion of MJF. MJF is offered at 56 service delivery points (Guédiawaye, Rufisque, Mbao, Thiadiaye, Joal, Popenguine, and Mbour). Currently, there are 61 active clients using MJF at the 57 sites seven months after the program was put in place.

Introduction of formative supervision to improve service quality. After the successful introduction of formative supervision at 323 SDP, PREMOMA's strategic option was that of taking over supervision by districts. This is how nine health care districts (or 106 SDP) of the Ziguinchor, Thiès, Louga, and Dakar regions (Ziguinchor, Oussouye, Thionk-Essyl, Bignona, Mbao, Tivaouane, Louga, Kébémér, and Linguère) used the formative supervision process to various degrees. The information collected from the five health care districts shows a marked

improvement in performance since the first visit in service management, use of promotional material, and technical performance (PNC, prevention of infection).

Extent of progress in improving service quality through accreditation. Experimenting with the approach of SDP accreditation for reproductive health was brought to completion in Ziguinchor, where health posts agreed to participate in the exercise. In a very short period of time, accreditation allowed the evaluation and strengthening, in a spirit of emulation, of their ability to provide quality reproductive health services in the context of primary health care and decentralization of the management of health care services.

Strategy 2: Improvement of Knowledge, Acceptance and Demand for Reproductive Health Services

Lobbying policymakers for reproductive health. The support given to the Parliamentary Network on Reproductive Health, besides raising the awareness of some 620 policymakers and opinion leaders through the help of the REDUCE model, led to the adoption of a model law on reproductive health by the National Assembly in July 2005. Furthermore, Senegal now has a tool to help make decisions for effective planning in the fight against morbidity and maternal mortality: the Safe Motherhood Model, adapted to Senegalese data, was introduced by PREMOMA and validated by the Ministry of Health.

Partnership with the education sector. Thanks to a dynamic partnership with the Ministry of Education, three reproductive health modules have been created for the initial and continuing education of teachers and for long-distance teaching. Today, these reproductive health modules are in good standing among the Teacher Training Schools' (EFI) multisectoral programs, taught to strengthen the trainers of teachers. Thus graduating teachers (3,500 per year, of whom 300 will be Arabic speakers by 2015) trained on these modules will constitute a critical mass of well-educated agents to ensure the promotion of reproductive health within the schools and more effectively mobilize local society in support of the fight against maternal mortality within their host communities.

Involvement of civil society. Strengthening the capacity of civil society organizations is a key strategy to improve the acceptance of and demand for reproductive health services. Within this framework, reproductive health training of the WHEPSA Senegal teachers by PREMOMA has been a major innovation that will make it possible to reach 1,300 school-age girls. The support given by the Senegalese Women's Network for the Promotion of Family Planning uses the multidimensional approach of the strategy for repositioning family planning that has begun in Senegal. This network, which brings together 600 NGOs, associations, women's groups, and individuals, will be a significant source of mobilization in support of family planning in the future.

Community involvement. To strengthen the community's ability to combat maternal mortality, two groups of traditional community participants, the Associations of Multifocus Agents (ARPV) and community promoters (CP), are involved in the project through complementary approaches. A third group has been targeted: we are speaking of young people, who were involved by increasing community awareness of the search for postabortion care.

- Community involvement in postabortion care materialized in Ziguinchor through the implementation of a theatrical competition on the theme of unwanted pregnancies and unsafe abortions among young people. This activity represented a significant moment in

community mobilization, with over 700 individuals, most of them young people and women, and resulted in increased awareness and knowledge by the troupes' 150 actors and artists (the majority of whom were young people) of the problem of unsafe abortions among young people.

- Activities for raising awareness of young people in a school environment were organized in a dozen institutions in the village of Ziguinchor, with a very significant mobilization of students, teaching staff, and the leaders of the institutions. This program sealed the partnership among health care personnel, the heads of the Ziguinchor Departmental Union of Popular Theater and Music and journalists from the region's print and broadcast media.
- The "Community Promoters" experiment covered four districts. The replication of the approach made it possible to recruit and follow a total of 1,200 pregnant women by the end of the eight-month CP intervention period, supported by the involvement of community leaders and local elected officials. The results are that much more significant since the CP work as volunteers and primarily intervene in rural areas where sociocultural burdens remain very heavy for many aspects of pregnancy and birth spacing
- ARPV were created in a certain number of health care districts to support all the programs put in place by USAID cooperating agencies (CAs). A network of 123 ARPV is currently operating in the districts of the health care regions of Thiès (5 districts), Louga (5 districts), Kaolack (1 district), and Fatick (1 district). These associations have received technical support through formative supervision coupled with a supply of promotional teaching material (reproductive health kits). Guinguinéo agents have also benefitted from a long-distance learning program conducted by radio.



Strategy 3: Increased Availability of Contraceptive Methods

PREMOMA's primary goal is to make contraceptive products available throughout the system by reducing stock-outs to a minimum and also to improve management of essential drugs (ME) in general to facilitate their further integration into a single distribution chain with the National Pharmacy (PNA).

- Logistical supervision of the district warehouses showed a net improvement in contraceptive management both in terms of use of management tools and in the availability of project intervention in the districts: currently, 72% of district warehouses have had no stock-outs of contraceptives during the last half year; in 92% of districts the minimum quantity of PICS contraceptives (pills, injectables, condoms, and spermicides) was available 90% of the time during the six-month period.
- The progress in couple-years of protection (CYP) in the USAID districts over the years shows a 9.6% progression between 2004 (60,022) and 2005 (65,813), which will allow the project to reach its goal. The process of estimating needs and orders by means of the Contraceptive Procurement Tables in Senegal (CPTS) was fully coordinated and implemented by the Reproductive Health Division.
- As for the experience of integrating contraceptives into the national pharmacy system in Kaolack, the results show that PNA is quite capable of integrating contraceptives into its supply system for essential drugs despite lack of compliance with the regulatory framework (compliance with profit margins according to levels).

Monitoring and Evaluation of Project Performance

Project Data Management System

Data sources. Data are collected from PNC, FP, and CPON management tools at the service delivery points (SDP) and from observation of interactions between service providers and clients. Tools were developed to collect the data on training activities. Data collection on community activities was carried out based on a knowledge survey or follow-up sheet.

Data collection methods

- The duration of supervisory visits, which was two days, has been reduced to one day. Supervisors consist of executive teams supported by the project's technical staff and by the DSR. Data collected are reported in the integrated supervisory grids of the SDP, logistics, SAA, and IPT.
- General SDP statistics were collected on a sample of 72 SDP using 3 SDP per district. Data collection was carried out exclusively by the districts' and regions' reproductive health coordinators assisted by the project's technical staff. One collection grid was used to collect reproductive health data.
- Training information was also gathered from participants' attendance sheets.
- Questionnaires enabled collection information about ARPVs' level of knowledge.
- A follow-up sheet made it possible to obtain data on recruitment and follow-up of pregnant women by community promoters.

Data processing. Information is stored in synthesis form on summary sheets for supervisory and database purposes and is fully available in electronic format on the project's network. Tables and figures are also available on the network. This information was prepared with SPSS, EPI-Info, Access, and Excel software.

Dissemination of information. The data are used in project reports prepared every four months for USAID, MSH, DSR, and the other cooperating agencies. The data are also used by the project's technical staff for conferences and seminar presentations to share experiences. They are also shared with DSR, health care regions, districts, and the SDP for strategic planning.

Table 1. Project performance

Indicators	Objectives	Baseline	Results Obtained
Availability of services			
Percentage of midwives retrained in counseling and IUD insertion and removal technique	100%	0%	108%
Percentage of health care districts trained in active management of the third stage of delivery	100%	0%	52%
Percentage of health posts that have available at least one individual trained in SAA	100%	50%	72%
Percentage of health care centers offering SAA services 24/7	100%	95%	100%
Percentage of districts health care centers with at least one person trained in SAA/AMIU	100%	95%	100%
Percentage of ECD trained in IMAT	100%	96%	100%
Percentage of districts where PICS was present 90% of the time during the last six months	100%	72%	92%
Percentage of district warehouses with acceptable availability of essential drugs	80%	91%	76%****
Percentage of district warehouses that experienced no stock-outs of a single contraceptive during the last six months	100%	55%	72%
Service quality			
Average performance of service providers in offering PNC services in compliance with standards	80%	57%	64%
Average performance of service providers in offering FP services in compliance with standards	80%	64%	77%
Average performance of SDP in compliance with PI standards	80%	25%	54%
Percentage of district warehouse managers who keep management tools up to date	100%	73%	92%
Percentage of district warehouses that did not experience a stock-out of a single contraceptive attributable to the managers	100%	88%	84%***
Demand			
Percentage of SDP that have an operational ARPV	100%	0%	98%
Percentage of radio transmissions within the framework of long-distance learning	100%	0%	100%
Percentage of trained and operational CP	100%	0%	100%
Percentage of sites with available trained religious and community leaders and who support activities of the CP	100%	0%	100%
Utilization			
CYP annual increase rate*	10%/year	-	10%/year
Rate of delivery at the health care facilities	100%	48%**	90%
Rate of assisted delivery by qualified personnel*	75%	47%**	60%
PNC 3* rate	85%	-	61%
Rate of IPT 1 coverage	60%	0%	77%
Rate of IPT 2 coverage	60%	0%	39%

Notes:

* Program indicators

** Demographic and Health Survey, 1997

***For the decrease in the indicator of stock-outs attributable to managers from 88% to 84%: this is because the warehouses could not place their order (RTS) in time to be supplied. Rush orders apply especially to IUDs, which were not requested frequently and are now beginning to be used with increasing frequency, and certain warehouses that did not act in time to place rush orders in their respective health care regions.

****Regarding the percentage of warehouses with acceptable percentages for ME availability (91% to 76%), this is essentially due to shortages at the central level (PNA) for certain drugs held back at the IMAT such as erythromycin, flagyl, and bactrim. Vitamin A is also not ordered by warehouse managers because it is provided free of charge and is managed by the PEV managers. All these events concur in causing stock-outs at the district warehouse level.

Service Delivery

This section summarizes how the project improved service providers' skills and service availability and quality.

Objectives

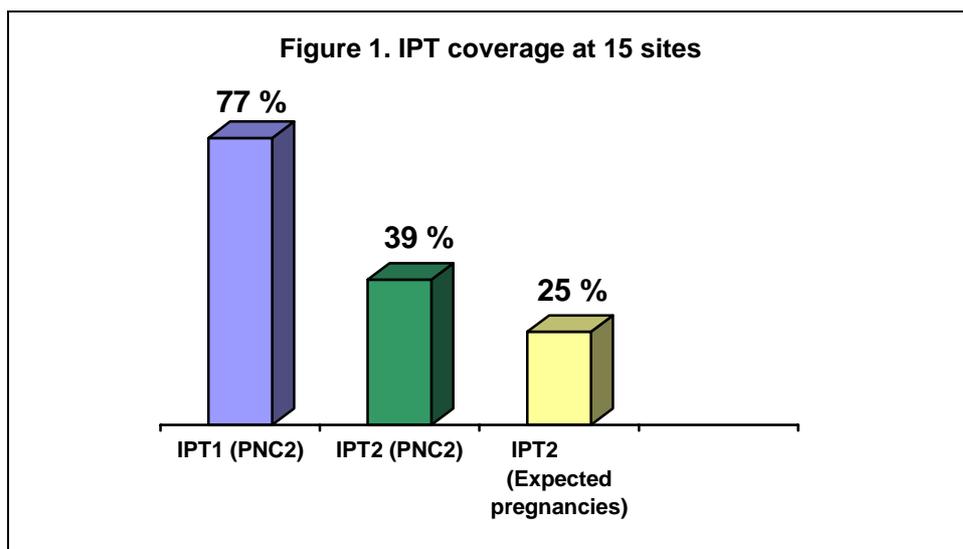
- Strengthen service providers' skills in the key areas of maternal health and FP: prevention of malaria and HIV transmission during pregnancy, postabortion care, prevention of hemorrhage during delivery, natural family planning, IUD, and logistics management of contraceptives and essential drugs
- Improve availability of these services in the public sector as well as the private sector
- Improve the quality of these services by institutionalizing formative supervision and introducing accreditation
- Ensure that the results are maintained by reinforcing leadership skills at the central level of the Ministry of Health

Maternal Health

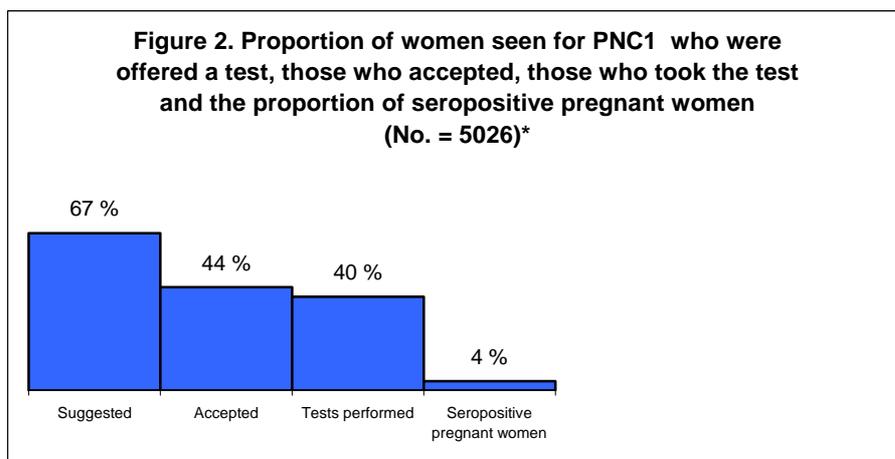
Intermittent preventive treatment. Within the scope of USAID's support of the Ministry of Health, the PSM/PF and PREMOMA projects have carried out since 2002 activities pertaining to chemical prevention of malaria among pregnant women. Intermittent preventive treatment with sulfadoxine-pyrimethamine was adopted at the conclusion of the consensus conference of June 26, 2003. Its introduction was effective at the operational level in August 2003 when the SP originating from the telethon was put in place. National intermittent preventive treatment (IPT) directives were developed by the monitoring committee from recommendations by the consensus conference. With the technical and financial support of PSM/PF, an IPT training manual has been developed and all service providers in the public sector have been trained. A circular that reviews the method for administering SP and the fact that it is free of charge and refilled from funds allocated to all service providers has been distributed since February 2005.

To remedy the deficiencies noted in dispensing IPT, PREMOMA created and carried out jointly with DSR and PNLP a plan to revamp IPT, which includes two phases: a phase of intensive monitoring and collection of PNC and IPT data at 15 service delivery points and a consolidation phase through a quarterly follow-up carried out by DSR and PNLP. Carrying out the first phase took place from February to May 2006 in Thiès, Louga, Kaolack, Fatick, and Ziguinchor. SP availability in the consultation room increased to 67%, allowing service provider to comply with directly observed treatment in 73% of cases (100% in Kaolack and Ziguinchor).

The overall SP utilization rate during PNC is satisfactory (77%). However, it was observed that only one half of the women who took the first SP dosage returned for the second dose (39%) and that only 25% of the target (expected pregnancies) received two doses of SP (Figure 1). The low return rate could be due to the delay in the first prenatal consultation, which most often takes place during the third trimester of pregnancy and to insufficient interpersonal communication on the importance of IPT in the prevention of malaria and its consequences for pregnant women and their fetuses. Effective IPT coverage of the target group will be strongly affected by an adequate use of prenatal consultation services. Any policy to strengthen IPT coverage will necessarily rely on an improvement in PNC coverage.



Prevention of mother-to-child HIV transmission. PTME is one of the five main strategies used in the national plan for the fight against HIV AIDS 2002–2006. In Senegal, the prevalence of HIV among pregnant women in 1995 was estimated at 0.8% (“PTME Reference Document”). Spontaneous TME was estimated at 30.4% for HIV 1 and 3.8% for HIV 2. Within the framework of the Senegalese Initiative for Access to Antiretroviral Drugs (ISAARV), a pilot project for the prevention of mother-to-child HIV transmission was put in place in July 2000 at three sites in the Dakar region. The very convincing results of this pilot phase, specifically a reduction of vertical transmission to 4%, led the Ministry of Health and Preventive Medicine to decide to scale it up. In coordination with the Reproductive Health Division and the STD/AIDS Division, the project took an active part in the decentralization process of PTME services in its various stages, such as evaluating needs at the sites, creating a national PMTE policy document, developing training tools, and implementing decentralized training. Thus, during 2005, thanks to the support of the project, by USAID, the Global Fund, and the World Bank, 188 service providers were trained and 15 PTME sites put in place in the health care regions of Thiès, Kaolack, Louga, and Ziguinchor. The post-training monitoring data at 7 sites in Thiès and Kaolack show 67% of service providers offering the test during PNC1 (Figure 2).



*Hospital St. Jean de Dieu, CHR in Thiès, health care centers in Thiès, Tivaouane, and Khombole, referral center in Kaolack, and SOS village health care center

Postabortion care. A series of operational research studies showed conclusive results regarding the feasibility, acceptance, and the advantages of introducing SAA in hospitals and

health care districts. After PSM/PF, PREMOMA continued to work toward better SAA access in the areas supported by USAID. After training the service providers at health care centers and hospitals in SAA including the AMIU procedure during the previous MH/FP project, PREMOMA focused on clinical training of service providers at health care posts, counseling training for counselors, and follow-up. This is how 61% of the 117 targeted ICP were trained to handle abortions in accordance with policies, norms, and standards for postabortion care. ICP are also equipped to provide emergency treatment for spontaneous or voluntary abortions and to offer counseling and a contraceptive method if necessary.

Currently, the percentage of SDP with at least one service provider trained in SAA has risen from 39 to 100% for health care centers and from 0 to 72% for health care posts. As for SAA counseling, training sessions for instructors were conducted based on a curriculum proposed by PREMOMA and validated by the DSR. This is how all four regions currently have available a regional pool of 15 trainers who have begun their program for the training of counselors (Figure 3). Within the scope of monitoring the SAA/AMIU training program for service providers from hospitals and health care centers, visits which began with the PSM/PF continued during the PREMOMA project. These visits are conducted by the team of instructors (DSR and PREMOMA) accompanied by the regional RH coordinators. These visits involved the maternity facilities of 23 district centers and of CHR in the Thiès, Kaolack, Louga, and Ziguinchor regions.



The tools used were a supervision grid for SAA services, a questionnaire for interviewing clients after abortion and a sheet summarizing the performance of each maternity facility. These tools made it possible to evaluate and strengthen the service providers' performances through coaching and to determine the level and the quality of the SAA offered. SAA is currently offered in 72% (216/300) health posts and is currently available 24/7 in all 23 health care centers covered by the project. At the health care centers, the number of patients treated for complications from an abortion went from 1,178 in 2003 to 2,530 in 2005; the percentage of patients treated with AMIU went from 27% in 2003 to 57% in 2005; the percentage of patients who received counseling before leaving the SDP rose from 36% in 2003 to 82% in 2005; and the percentage of patients who chose and received a family planning method before leaving the health care facility increased from 15% in 2003 to 51% in 2005.

Figure 3. Number of patients who sought a consultation for complications associated with an abortion in the 23 centers in 2003, 2004, and 2005

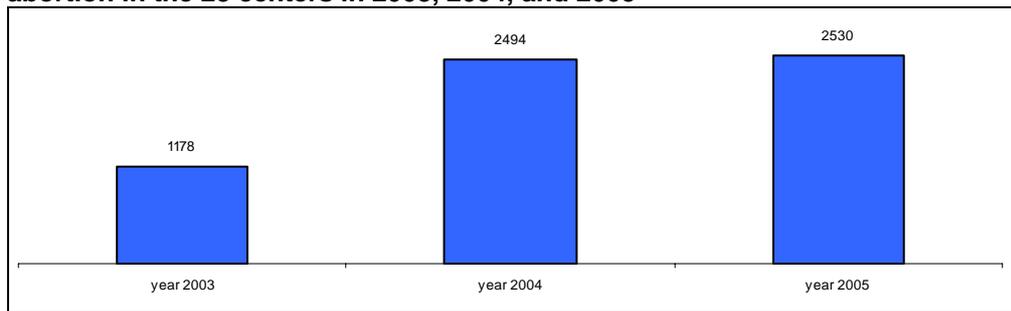


Figure 4. Percentage of patients treated with AMIU in 2003, 2004, and 2005

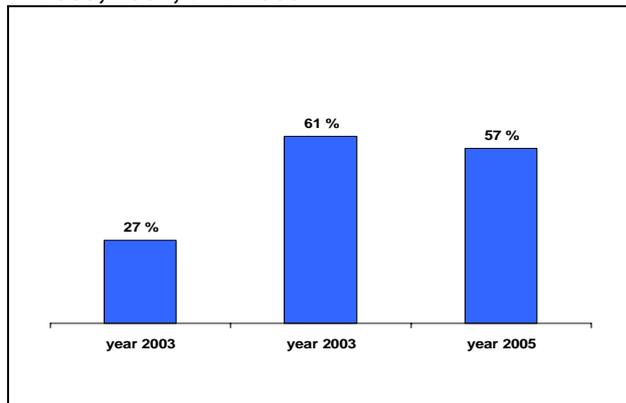


Figure 5. Percentage of patients who received postabortion counseling in 2003, 2004 and 2005 in 23 health care centers

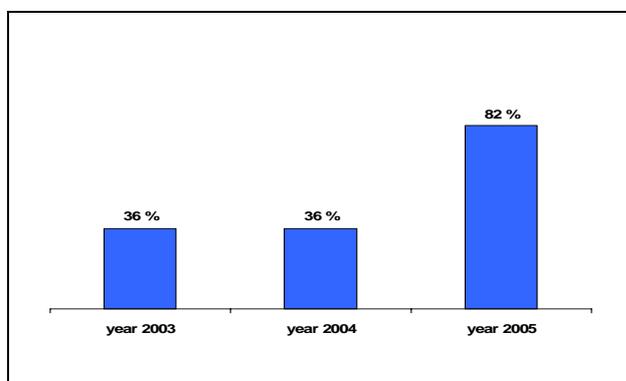


Figure 6. Percentage of patients who chose and received a contraceptive method before leaving the health care facility

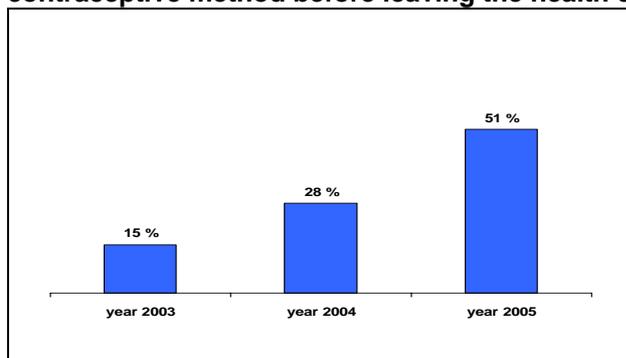
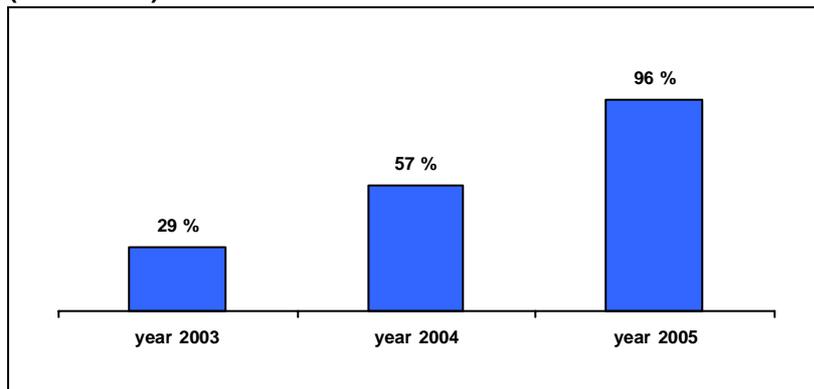


Figure 7. Percentage of health care centers offering rooms, equipment, and adequate material for SAA services (2003–2005)



Prevention of hemorrhage during delivery. Hemorrhage is the primary preventable cause of maternal death. Its prevention through active management of the third stage of labor based on scientific evidence has been integrated into the reproductive health policies, norms, and protocols (PNP) in Senegal. A total of 423 agents representing supervisors and qualified maternity ward personnel from 15 districts have been trained in this technique (see Table in Appendix 1).

Family Planning

Intra-uterine device. The IUD is a family planning method whose rate of prevalence in Senegal, after a significant increase at the beginning of the family planning program, decreased as time went by, dropping from 1.2% in 1992 to 0.9% in 1999 (DHS 1999). The IUD is one of the most reliable long-term methods and one that offers the best cost-effectiveness ratio and it is therefore best suited for inclusion in the institutionalization of the program.

PREMOMA is involved in implementing a policy to revitalize the IUD in Senegal within the framework of an overall strategy to revamp family planning. Dissemination of the results of surveys conducted on the reasons for the decrease in the use of the IUD in Senegal and sharing the experiences of countries such as Tunisia and Kenya allowed the executive teams from six regions to understand the stakes of such repositioning. A refresher program on counseling and offering the IUD method for midwives involved in FP services from the 25 health care districts covered by the project succeeded in reaching 221 SFEs out of the expected 203 (a success rate of 108%). Follow-up six months after training shows that 8% of new clients have chosen IUDs as contraceptive method (see Table 2). Retrained midwives benefitted from support in terms of IUD insertion/withdrawal materials according to their needs as identified at the time of post-training follow-up.

Table 2. Results of post-training follow-up of 68 SFE

Performance	Value
Insertion technique	68%
Removal technique	69%
Average number of insertions after training	4 (0–18)
Percentage IUD clients	8%

Note: 51 SDP in the Thiès, Louga, and Kaolack/Fatick health care regions

Natural family planning: The fixed days method. In spite of efforts to increase access to family planning in Senegal, the prevalence rate for contraceptive remains low at 10.3%. The fixed days method (MJF), a modern family planning method developed and tested by Georgetown University, is a simple and natural method based on a woman's menstrual cycle. Using a colored necklace, the woman avoids pregnancy by abstaining from unprotected sexual intercourse during fertile days. Properly used, MJF has a pregnancy protection rate of 95%. MJF is also affordable: the cost of each necklace is less than one US dollar. MJF is a method that fulfills the unmet family planning needs that still exist in Senegal (35%). It also fulfills the need to have a natural method that can be easily added to the range of contraceptive methods already available.

In September 2005, PREMOMA, with the cooperation of the Reproductive Health Division for family planning (DSR), launched the first phase of introducing the fixed days method in Senegal. DSR integrated MJF into the standards and protocols and into the national RH training curriculum. MJF was introduced in 56 health care facilities in three districts in the Dakar region (Guédiawaye, Rufisque, and Mbao), four districts in the region of Thiès (Thiadiaye, Joal, Popenguine, and Mbour), and two hospitals and a referral center in Thiès. The program has trained 246 individuals, a majority of whom are midwives and health post service providers (see Figures 8 and 9). Currently, there are 61 active clients using MJF at the 57 sites seven months after the program was implemented.

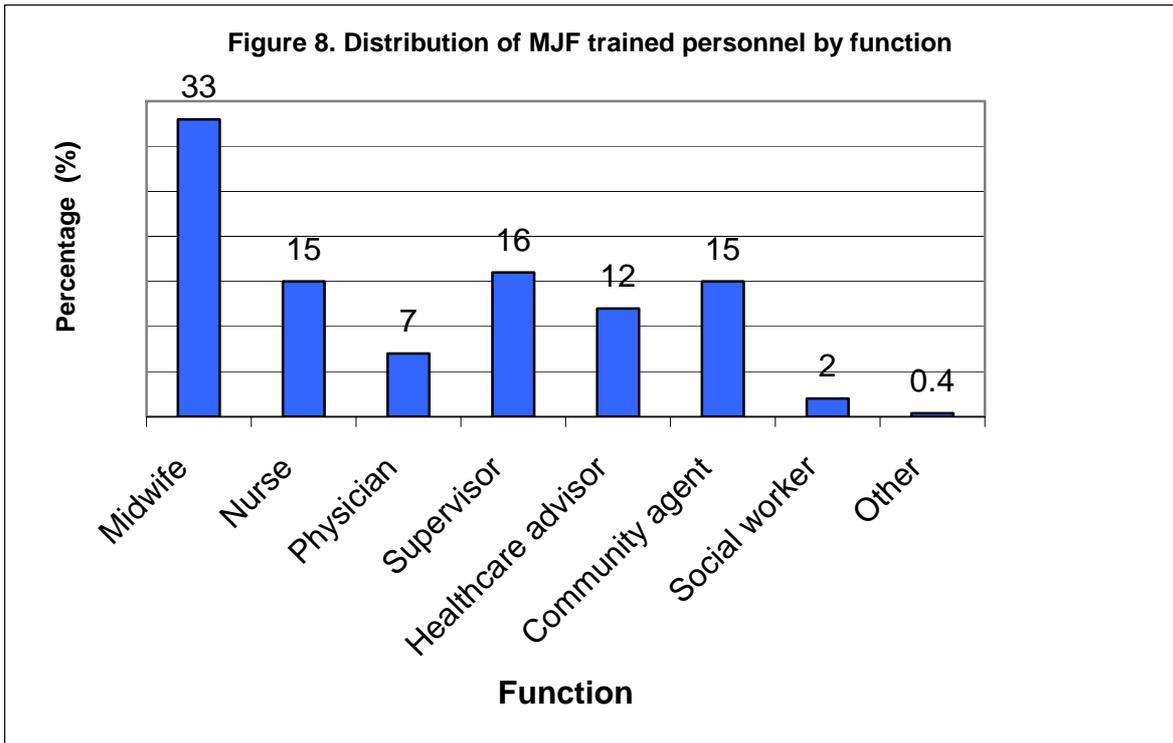
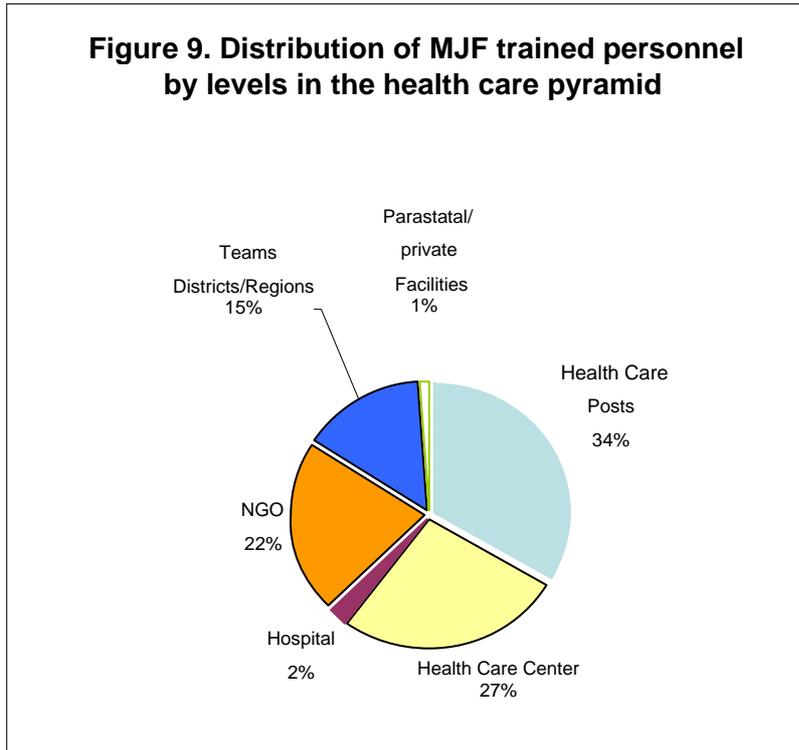
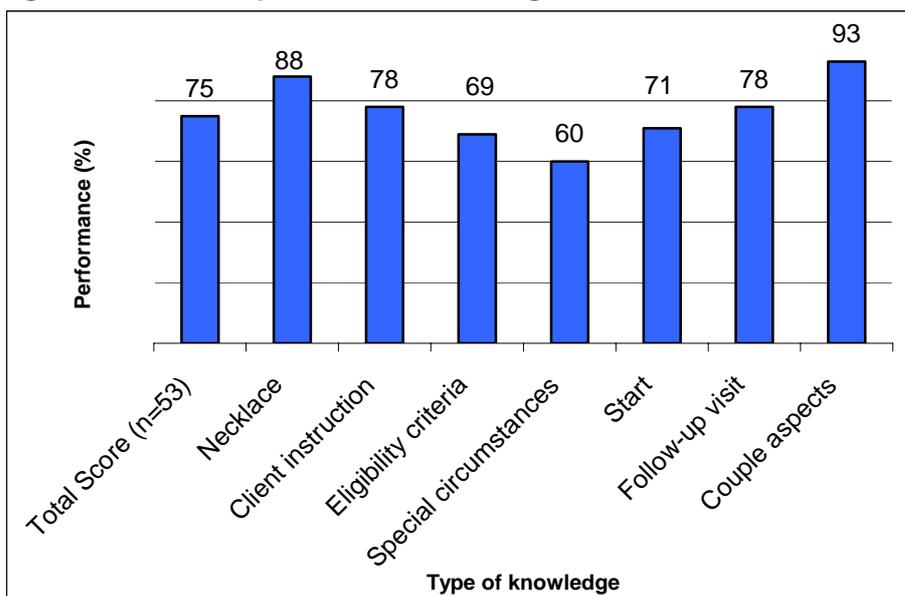


Figure 9. Distribution of MJF trained personnel by levels in the health care pyramid



Post-training follow-up was carried out by introducing two tools: the Knowledge Improvement Tool or KIT (a 56-point questionnaire developed and tested by IRH that evaluates MJF knowledge) and a checklist. The "coaching" approach, a type of practical supervision, was used by 53 service providers who offer MJF in the intervention areas (32 in Dakar, 21 in Thiès). According to the results of this evaluation, the knowledge rate is 75% for the total of supervised individuals (n = 53) (Figure 10). No significant difference in knowledge was found based on gender, service provider function, type of health care facility, or work district. This suggests that MJF can be offered by several types of service providers in each level of the health care system.

Figure 10. Service providers' knowledge of MJF



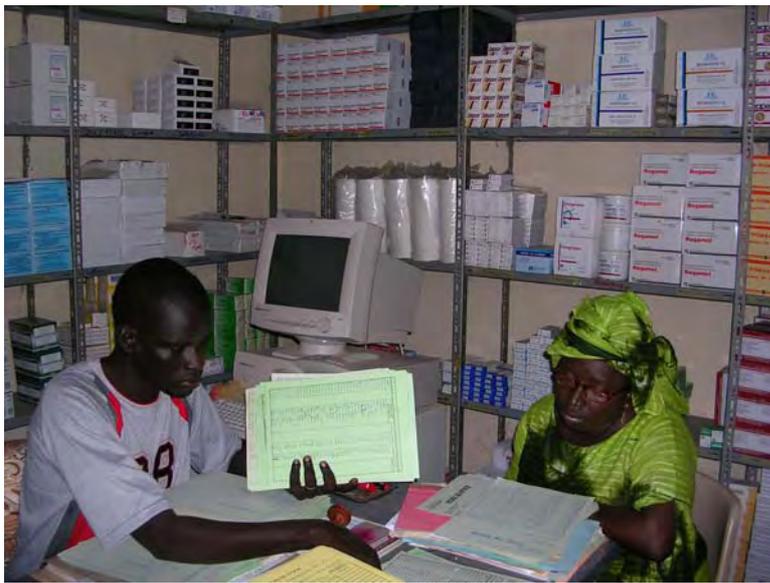
Partnerships have been set up with the Senegalese Association for the Promotion of Family (ASPF) and the Christian Children's Fund (CCF-CANAH) to strengthen community promotion of MJF. The program has trained 40 CCF agents in MJF awareness, and they are active in four districts in Thiès.

Community meetings with CCF coordinators inform the community not only of the availability and operation of a new FP method, but they also stress the importance of the man's involvement in using the MJF. Tools have been provided to CCF agents to better host community meetings: kits with samples of contraceptive methods, posters, picture boxes, and cycle necklaces. Between January and April 2006, 555 community meetings were held in the Mbour, Thiadiaye, Popenguine, and Joal districts. To better follow community mobilization, PREMOMA recently introduced a reference system among CCF agents and the health care facilities. By using a reference book for the health care cases in the CCF areas, the system can quantify, among the women who have been directed toward SDP, the percentage of women who choose MJF.



Logistics management of contraceptives/essential drugs. In PREMOMA's FP component, the strategy is to complete the strengthening of the skills of executive teams not trained during PSM/PF in essential drugs management at the SDP warehouses by IMAT (Inventory Management Assessment Tool). IMAT is the tool used for follow-up of management practices in a drug warehouse. The principle is retrospective follow-up over 100 days of a

selection of 25 products for health posts and 40 products for district warehouses. IMAT evaluates the system's ability to comply with recording procedures (inventory sheet) and to maintain a range of products in inventory (average time of stock-outs and availability). Training at the central level (DSR: eight individuals), of the executive team for the Dakar health care region (eight individuals), and the executive teams for the Mbao, Rufisque, and Guédiawaye districts (eight individuals) made possible the completion of the IMAT training program started during PSM/FP. At this time, managers and supervisors of all executive teams from six regions and 25 districts of the USAID areas have received the necessary essential drugs logistics management skills to allow them to effectively perform the supervision and monitoring of essential drugs inventory, including district warehouse contraceptives.



Integrated Formative Supervision

Increased use of health care services in general and reproductive health services in particular necessarily depends on the improvement in their quality. To take this need into account, and because of the decision to reduce the time frame for training of health care personnel, integrated formative supervision of reproductive health services, with the introduction of the COPE tool and infection prevention, began in 2002 with the support of USAID's PSM/PF. After testing the approach in the Thiès medical region and sharing lessons learned, the tools (supervision grid, COPE maternal health and family planning, summary sheet) were validated by the DSR. So 323 SDP (health care centers and health posts) have been supervised in the medical regions of Thiès, Louga, Kaolack, Ziguinchor, Dakar, and Fatick.

In implementing activities planned by PREMOMA, the health care districts took an important step in the process of learning SF. In fact, after a quick evaluation, one of the recommendations was to leave to the districts the initiative and the active role in the technical preparation of supervision with limited support from the central level. Thus nine health care districts (106 SDP) of the Ziguinchor, Thiès, Louga, and Dakar regions (Ziguinchor, Oussouye, Thionk-Essyl, Bignona, Mbao, Tivaouane, Louga, Kébémér, and Linguère) absorbed the SF process to various degrees. The information collected from the five health care districts (see Figures 11–14) shows a marked improvement in performance since the first visit: management of services, use of promotional material, and technical performance (PNC, prevention of infections).

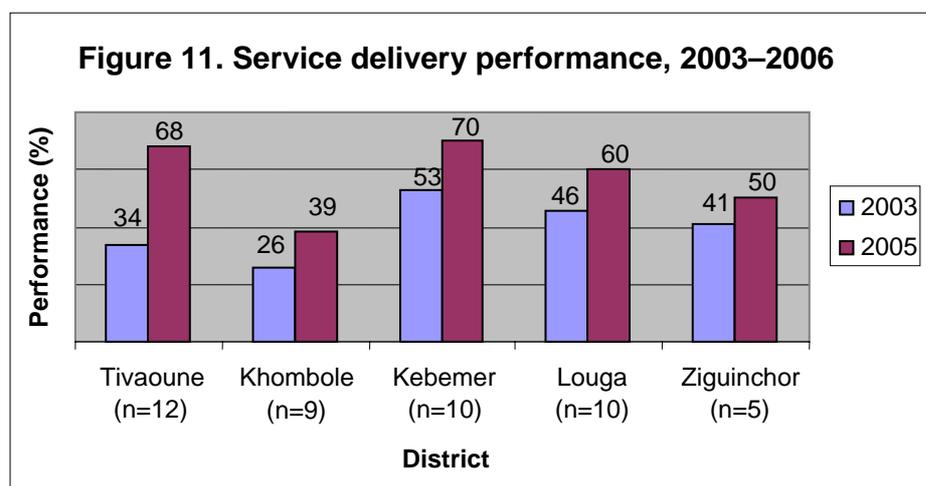


Figure 12

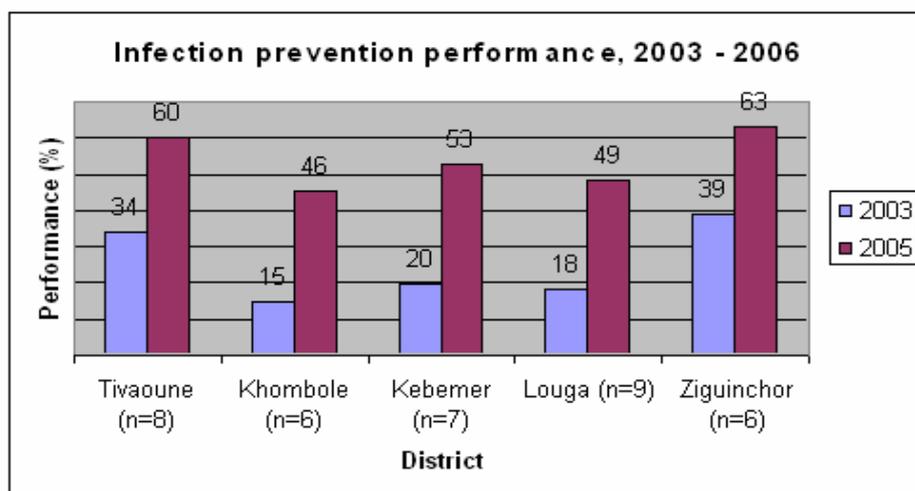


Figure 13

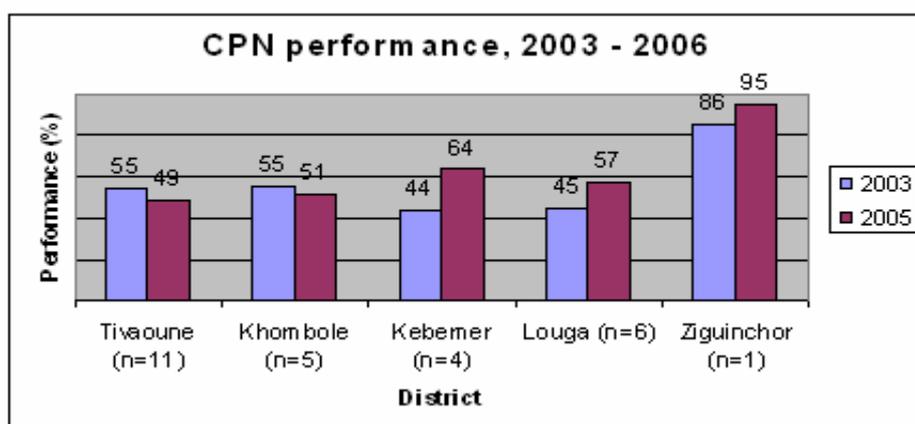
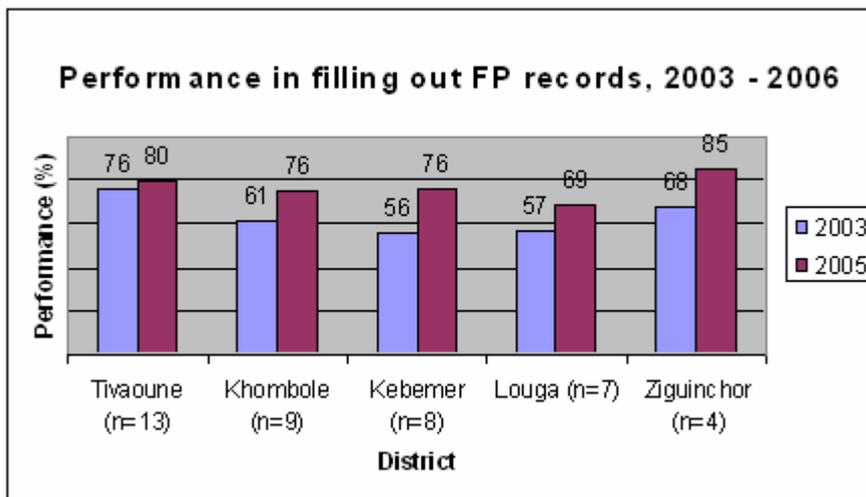


Figure 14



Accreditation

Evaluation of progress in quality of services is an integral part of management procedures for the health care system. To measure progress in service quality, PREMOMA initiated accreditation in reproductive health. Accreditation is an internal and external procedure for the evaluation of service delivery points (SDP). It allows evaluation and strengthening, in the spirit of emulation, of the ability of SDP to provide quality reproductive health services within the context of primary health care and the decentralization of health care service management. After an agreement among DSR, USAID, and its four CAs (MSH, DISC, BASICS, and FHI) about tools (integrated supervision grid, accreditation sheet) and methodology (see Table 3), the Ziguinchor medical region agreed to test this approach in its four health posts (Diouloulou in Bignona, Nema in Ziguinchor, Balinghore in Thionk-Essyl, and Kagnout in Oussouye). This is how, after launching the activity at the four health posts as a formative supervision/COPE exercise, the communities, in synergy with the medical personnel developed an action plan to comply with the frame of reference for RH service quality. A visit by experts (DSR, Ziguinchor medical region, USAID, and CAs) allowed the evaluation and rating of each health post according to the results obtained. A significant increase in service quality was observed at the end of the process (Figure 15).

Table 3. The accreditation process

Steps	Description
Step 1 Introduction of accreditation	Meeting in which the major regional authorities participate: administrative authorities (governors, mayors, prefect...), medical (ECR and ECD), religious, and traditional representatives, the media. All these participants must be made aware of the quality of maternal-child health services as well as the advantages that this approach will bring to regional health care facilities.
Step 2 Commitment to accreditation	This meeting is followed by a meeting at the district level. ECD, the management committee, health care committees, ICPs, participants from the community (OCB, social justice movements). During this meeting, accreditation criteria are validated and commitment confirmed by creating an accreditation steering committee.
Step 3 Launch of accreditation	In each SDP, the steering committee presents the initiative to all participating parties (clinicians, community). District supervisors conduct a formative supervision exercise + COPE involving the community, to develop an action plan to fulfill the accreditation criteria.
Step 4 Monitoring of the action plan	The steering committee evaluates the progress of the accreditation action plan and identifies problems and challenges that must be addressed to achieve results.
Step 5 Evaluation	The designated experts (ECR and central-level supervisors) conduct an evaluation mission consisting of targeted formative supervision to fill out the checklist of accreditation criteria to measure the level of achievement of the accreditation criteria and award a rating to the service delivery point.
Step 6 Festival	Results obtained by the various SDP are announced during a formal ceremony. An accreditation plaque and prizes according to the accreditation level, obtained are awarded to the heads of the various SDP.

Figure 15. PPS changes during accreditation
(from March to June 2006)

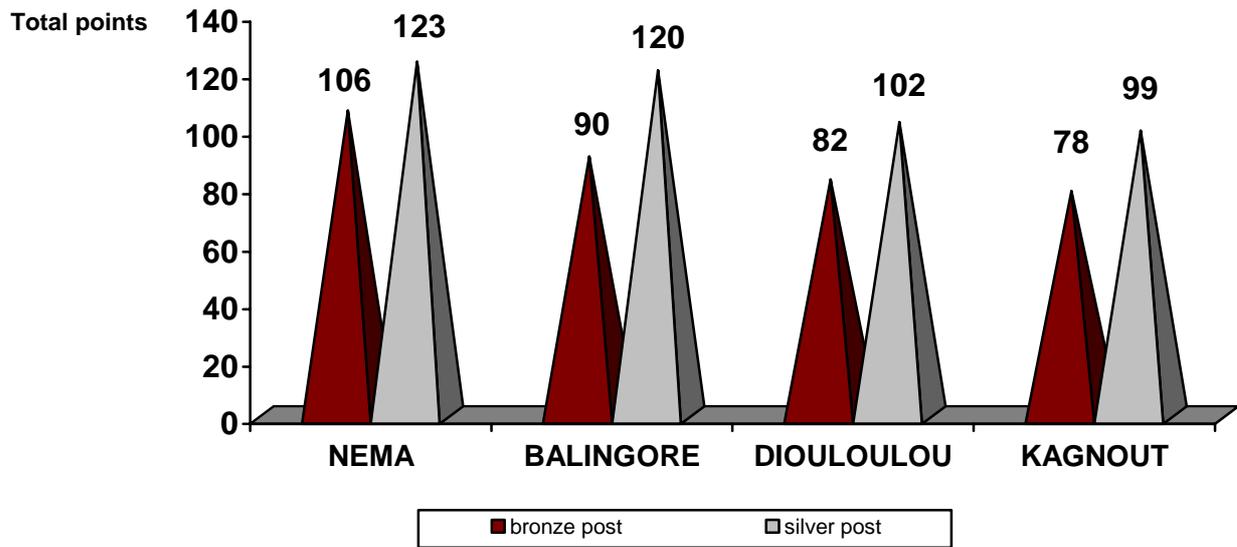
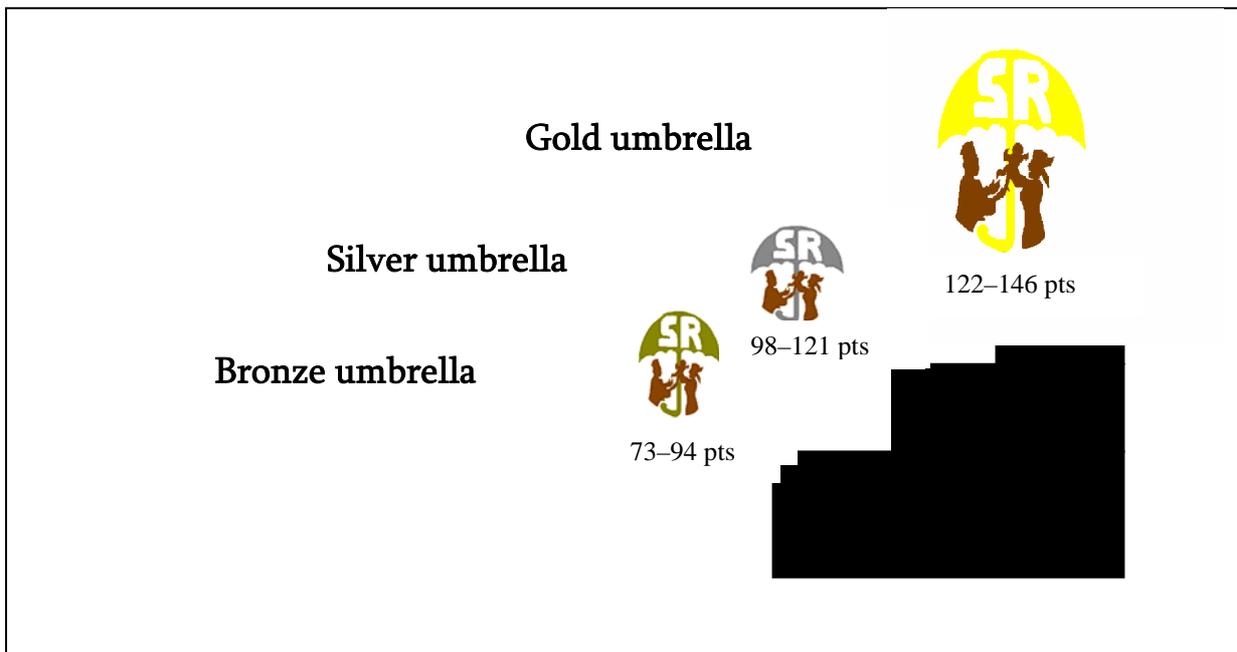


Figure 16. Accreditation in reproductive health: Scale and ratings



Partnerships with the Private Sector

Pilot experiment in Kaolack. To contribute to “better access to quality services for maternal health and family planning,” the PSM/PF has sponsored, among other things, an approach for better cooperation between public- and private-sector services, including:

- organization of meetings and opportunities for permanent dialogue among personnel from public and private health care facilities;
- strengthening of the RH/FP intervention and drug logistics skills of personnel from 17 nursing facilities;
- drug procurement at the district warehouse level by private SDP, organized in accordance with policies and standards;
- offering RH/FP services at the 17 SDP;
- information sharing with health care districts for the purpose of managing the 17 private SDP.

Based on the results obtained at the end of this pilot experiment, PREMOMA, in partnership with ADEMÁS planned to scale it up to the Fatick and Kaolack medical regions with the innovation of extending it to pharmacists and private warehouse managers. For this purpose, two regional working dinners have been organized, allowing 150 participants (physicians, pharmacists, midwives, nurses, and warehouse managers from the public and private sectors) to share the strategies and accomplishments of the Kaolack pilot experiment. One of the outcomes of these meetings was a proposal for a RH/FP training plan for the personnel of private health care facilities in the Fatick medical region, carried out in its entirety by ADEMÁS.

Contraceptive procurement for private facilities. After the withdrawal of the national NGO SANFAM, private and parastatal facilities have experienced difficulties in procuring contraceptives. PREMOMA facilitated the process that led to an alternative procurement system and supervision of 18 private and parastatal facilities through district warehouses under the supervision of region and district executive teams (see the list in Appendix 2). Currently, the supervision system is effective and reports are sent regularly to the respective districts, allowing quarterly procurement.



Leadership

To enable the Ministry of Health to absorb the quality approach initiated by USAID through its CAs, a program to strengthen the leadership skills of high-level Ministry of Health executives was put in place thanks to collaboration between PREMOMA and the Management and Leadership (M&L) Program. This program, which includes the Director for Health, division heads (Reproductive Health, Primary Health Care, Research, STD/AIDS, Food and Nutrition) and their close associates, suffered because of the insufficient availability of agents at the central level and frequent institutional changes at the Ministry's central level.

Even with these challenges, the project succeeded in obtaining the following results:

- A shared view of the major challenges that stand in the way of the MSPM vision ;
- A consensus on the present (or current) and required leadership practices within the MSPM;
- A consensus on a program to strengthen the leadership skills of high-level executives from MSPM;
- A plan to develop the skills needed for greater challenges identified by each division.

Appendix 1. Training summary table (2004-2006)

Subjects	Thiès	Louga	Ziguinchor	Kaolack	Dakar
Maternal health					
SAA clinic (ICP)	71	-	-	-	-
SAA counseling					
• Training of instructors	15	15	15	15	-
• Counselors	32	35	-		
PTME	51	-	26	56	-
Active management of the 3rd stage of labor	151	97	50	-	112
Family planning					
IUD	64	21	31	34	71
MJF	128	-	-	-	114
IMAT	-	-	-	-	21

Appendix 2. Private and parastatal facilities supplied with contraceptives by the districts

1. SM of *Dakar Port Autonome*
2. SM of the *Caisse de sécurité sociale* (Dakar)
3. SM of the *Institut de prévoyance retraite* (IPRES) Dakar
4. SM of the *Société Des Eaux* (SDE) (Dakar)
5. SM of SENELEC (Dakar)
6. Hospital Abass NDAO (Dakar)
7. Dakar Main Hospital I
8. Private Health Center in Dahra Mbayenne (Louga)
9. SM of the Hann National Parks (Dakar)
10. SM of the Postal Services (Dakar)
11. SM of the Chemical Industries of Senegal (Mbao)
12. SM of the *Société Africaine de Raffinage* (Dakar)
13. SM of the Mbao police
14. Nabou Clinic Rufisque
15. Rada Clinic Rufisque
16. Maimouna Clinic Rufisque
17. Jaboot Clinic (Dakar)
18. JAMM Clinic (Dakar)

Increasing the Demand for Services by Improving Knowledge and Acceptance of Reproductive Health Services

Objectives

- To contribute to greater ongoing awareness of the importance of reproductive health by policymakers in the formal education sector, civil society organizations, and opinion leaders
- To involve community health care agents in extending reproductive health services within the communities through ARPV and CPs

Partnership with the Ministry of Education: Teacher training schools in the promotion of RH. To promote reproductive health better in training curricula and in socio-educational activities in a formal environment, PSM/PF, under the aegis of the DSR, has launched a number of lobbying and awareness-raising activities aimed at the Senegalese educational system. These activities target decision-makers (national directors, members of the controlling bodies, and institution heads), participants in the academic community (students and teachers) and social partners (heads of parents' associations and labor organizations).

One of the results of the collaboration with the Ministry of Education was the development of three teaching tools centered on RH content. Thanks to a dynamic partnership with the Department of Elementary Education of the Ministry of Education (DEE/ME), three reproductive health modules were created for initial and continuing training of teachers and for long-distance education. Today, these reproductive health modules occupy a prominent place among the EFI multisectoral programs and are taught to strengthen trainers of teachers. Graduating teachers (3,500 per year, 300 of whom will be Arabic speakers by 2015) trained using these modules will constitute a critical mass of well-educated agents to ensure greater promotion of reproductive health within the schools and to help mobilize local societies in support of the fight against maternal mortality within their host communities.

Involvement of civil society. Regarding civil society organizations, PSM/PF support of the reproduction of the made-for-TV film "FAKASTALU," which deals with the consequences of early pregnancies in a school environment, allowed the NGO Groupe pour l'Etude et l'Enseignement de la Population (GEEP) to broaden the range of promotional and presentation material for its Education for Family Life clubs (EVF clubs). EVF clubs are groups for promoting responsibility and communication on problems associated with young people's reproductive health. Today they constitute a national network of 356 units that cover approximately 70% of Senegal's secondary schools. Overall, reforms and initiatives carried out within the framework of the partnership with the Ministry of Education and GEEP make the political and sociocultural environment more favorable for the promotion of reproductive health for young people in an academic environment.

WHEPSA Senegal: WHEPSA Senegal is an NGO based in the Kaolack region with the goal of preparing young girls in difficult situations for family life. Within this framework, WHEPSA first opened a training center in Kaolack and then identified and re-integrated young people with academic difficulties into teaching facilities set up in Kaolack, Ndoffane, Kaymor, Niore, and Kaffrine. For the current year, WHEPSA has enrolled 1,300 girls/adolescents between 12 and 19 years of age in these activities. In addition to their age, these girls' vulnerability is also explained by their very modest family conditions. These two factors, as those shown by other studies, expose them to the risk of early pregnancy. In fact, according to the DHS III there is a high incidence of early pregnancy among adolescent girls

in Senegal, representing 9% of total pregnancies and involving a sizable percentage of girls between 15 and 19 years of age. Furthermore, early sexual activity also exposes them to STD/AIDS. Also by request of WHESPA Senegal we have promoted, together with DSR, the principle of helping to strengthen these girls in the area of life skills. Thus 30 peer educators have been trained (15 in Kaolack and 15 in Kaffrine), who will in turn train this important target group of 1,300 girls.

Network of Senegalese women for the promotion of family planning (FESPF): Repositioning family planning is today an innovative approach to reaching national and millennium development goals. This is why it was the subject of an international conference held in Ghana in February 2005. On the basis of these recommendations, the Network of Senegalese Women for the Promotion of Family Planning was created in July 2005 during the general constitutive meeting, which was organized with the technical and financial support of the Ministry of Health and Preventive Medicine, UNFPA, and PREMOMA/USAID. The Network brings together 600 NGOs, associations, women's groups, and individuals. Thanks to this support, the Network was able to develop an ambitious three-year action plan to support the efforts of government authorities. The plan was adopted during a national workshop attended by representatives of the President of the Republic, the Prime Minister's office, the National Assembly, and local collectives.

Policymakers and opinion leaders. A greater involvement of policymakers, opinion leaders, and heads of community associations in the fight against maternal mortality has required consciousness-raising coupled with orientation. These two activities concentrate on reproductive health, specifically its components of safer motherhood and family planning with the REDUCE/Senegal module on maternal mortality as a lobbying tool.

Parliamentary network: Thanks to the decentralization of lobbying activities organized by the network with PSM/PF support, a critical mass of 620 individuals—made up of policymakers (members of the territorial administration and local elected officials), religious leaders, traditional authorities, and heads of women's and young people's movements—have been made aware of safer motherhood practices and the promotion of family planning. Furthermore, partly thanks to PREMOMA's support, the network has successfully carried out the adaptation process for the model law on reproductive health, the result of which was the adoption of a reproductive health law by the National Assembly in July 2005. Currently, the process to adapt and adopt the model law on HIV/AIDS is under way.

Religious leaders' network: A translation into the Arabic and Wolof languages of the REDUCE/Senegal model with a religious promotional leaflet is available. These tools made it possible to inform a total of 125 religious leaders in six health care districts about safer motherhood and family planning (Table 4).

Table 4. Religious leaders who received orientation on maternal health and family planning in the health care districts

Districts	Number of informed leaders
Guinguinéo	9
Kongheul	27
Kaffrine	26
Tivaouane	10
Bignona	25
Thionk-Essyl	28
Total	125

Religious leaders who received orientation have effectively supported CP activities in the 12 sites of the Guinguiné, Kongheul Bignona, and Thionk-Essyl districts through sermons and informal discussions in favor of a greater involvement of men in the promotion of RH/FP.

Religious Leaders Spread the Word on Health Issues

KAFFRINE, Senegal—Imam Habib Thiam looks up as another Muslim community leader from across town enters his room to discuss a woman’s medical problem that kept him up all night. Women’s health has become more of an issue to Thiam, who has decided to take life-saving messages to the mosque.

Thiam is just one imam who is talking to his community about health issues since participating in a USAID-funded workshop last November. Now he often addresses health issues affecting women at public gatherings like weddings, funerals, baptisms, prayers, and religious holidays.

Thiam discovered through the USAID workshop that some 15,000 Senegalese mothers were likely to die between 2001 and 2007, many of them young girls who bleed to death giving birth because of poor medical care. “This is 10 times the number of people who drowned on the Joola ferry,” he said, referring to a ferry that sank off the Atlantic coast in 2002 and is considered the greatest national tragedy in living memory. “I don’t even dare contemplate the magnitude of it.”

The day after the meeting, the imam preached at the mosque next to his home, bringing in a nurse from the nearest health post to discuss the importance of birth spacing and maternal health issues. USAID has invested about \$120,000 in efforts to inform religious leaders about reproductive health issues and the risks of HIV/AIDS. This includes printing information kits in Arabic and the most widely spoken local language, Wolof, outlining what Islam says about birth spacing.

More than 90 percent of Senegalese are Muslim; about 5 percent are Christian. “Islam forces no one to have a dozen children,” said Bashir Niass, Arabic teacher at the Waldiodio Ndiaye High School in Kaolack and regional coordinator of the local USAID-assisted Islam and Population Network. “Marriage in Islam is conditional. If you have the means, you can get married. At a minimum, you must have a small house and enough money to support your wife and your children,” he said. “Islam does not reject birth spacing,” added Niass, who accompanies the USAID team during presentations to religious communities.



Imam Habib Thiam, second from right, explains to members of the religious community in Kaffrine, Senegal, that Islam supports women’s health and a healthy family life.

Richard Nyberg, USAID/Senegal

“Everyone knows that birth spacing is a necessity now.”

Religious leaders are also urging their congregation members to be in faithful relationships in order to avoid infectious diseases. “It’s not the condom that is bad—it is wrong to have sex outside marriage,” said Abdou Aziz Kébé, an Islamic scholar with the Islam and Population Network.

Preliminary results from a USAID-supported demographic and health survey last year put the national contraceptive prevalence rate at 10 percent—indicating limited access to family planning services. Last year the Agency supported reproductive health dialogue sessions with more than 30,000 people, focusing on fidelity and women’s rights, and the number and spacing of children. USAID also supported 600 sessions on reproductive health issues using a life skills manual. These sessions were attended by nearly 6,000 youth, more than half of them women.

The Agency has worked with 3,500 religious youth leaders, who were issued faith-based life skills manuals in Arabic. “The religious nature of our life skills training has greater impact,” said Louise-Anne Ciss, a Catholic member of the Coalition of Religious Youth Organizations against HIV/AIDS. “We have to communicate with religious youth on the basis of faith. During the training, some people didn’t believe HIV/AIDS existed. Now they do.”

Safe Motherhood Model: A tool to help in policymaking in the fight against maternal mortality. PSM/PF has heavily distributed the REDUCE/ Senegal model to policymakers and opinion leaders to promote greater commitment in favor of the fight against maternal mortality. On the basis of the results obtained and upon authorization of the Ministry of Health and Preventive Medicine, PREMOMA considered making available a tool to help in decision-making with the application of the Safe Motherhood Model (SMM) in Senegal. A total of 150 participants took part in the four workshops: a national workshop for the validation of the data collected on the “WHO Mother-Child Package” integrated with SMM and three regional workshops (Saint Louis, Kaolack/Fatick, and Tambacounda) for outreach and promotion of the tool. At the end of these meetings the data collected were considered reliable and sufficiently representative of the national level and SMM was acknowledged as a pertinent tool for helping in decision-making for effective planning in the fight against morbidity and maternal mortality.

Extension of reproductive health services by the community. BCC activities conducted at service delivery points to contribute to the increased utilization of available services have long suffered from an absence of planning, inadequate scheduling, insufficient resources, and scarce support by health care personnel, decision-makers, and local elected officials. To correct these problems, Associations of Multifocus Agents (ARPV) were created in a certain number of health care districts to assist with all the programs implemented by the USAID cooperation agencies. In the districts that do not have this tool, it is the responsibility of each CA to develop its own approach. Thus PREMOMA’s BCC activities are carried out by ARPV, artists, and actors, along with policymakers and religious leaders.

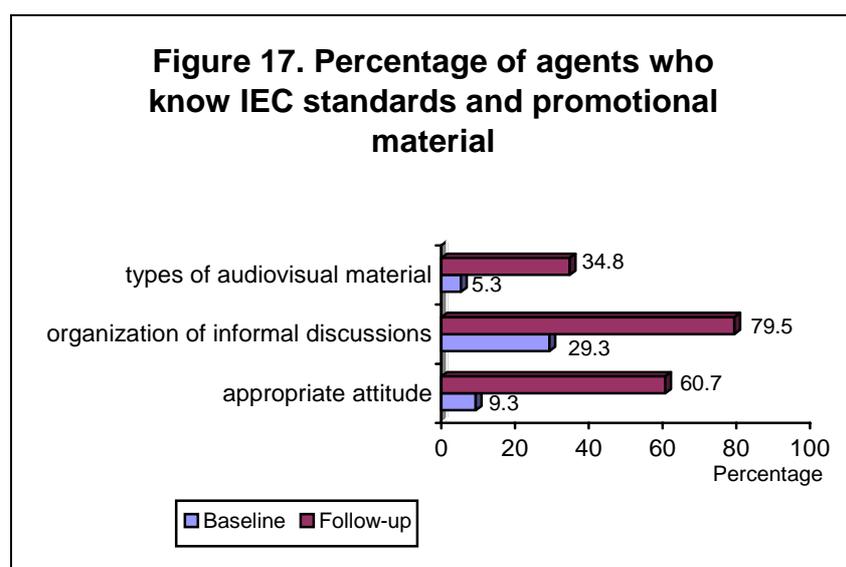
A network of 123 ARPV is currently operational in all the districts of the Thiès (five districts), Louga (five districts), Kaolack (one district), and Fatick (one district) health care regions. Pursuant to an annual action plan agreed upon with the mayors of the municipalities and the presidents of the rural communities and under the supervision of health care personnel, they carry out informal participatory discussions, integrated (VADI) and targeted (VADC) home visits, and social mobilization of the centers and health posts in their localities (see Table 5). These associations received technical support through formative supervision

coupled with the supply of teaching material (RH kits). For the planning and management of their technical and financial activities, the ARPV also have the standard tools.

Table 5. Summary of ARPV activities during the 1st quarter of 2006

District	Informal discussions	VADI	VADC
Darou Mousty	142	271	117
Dahra	199	412	334
Louga	314	840	444
Kébémér	177	521	256
Linguère	205	473	234
Thiès	220	2393	722
Tivaouane	167	868	3334
Mékhé	157	713	267
Thiadiaye	91	318	372
Popenguine	38	458	155
Joal Fadiouth	50	222	77
M'bour	55	1353	563
Khombole	99	754	272
Kaolack	245	1658	784

This partial view of activities conducted by the ARPV during this period demonstrates the importance of people's responsibility in taking charge of their own health problems but also the viability of the ARPV tool in terms of development and during the BCC activities at the service delivery points. To strengthen the ARPVs' skills, PREMOMA initiated a pilot program for long-distance learning completed in the Guinguinéo health care district to update ARPV training. In this approach the innovation consists of the combination of long-distance and face-to-face interaction with the participants, who are health care technicians. The five ARPV of the Guinguinéo health care district where this pilot program was carried out and other community agents, specifically from CEDPA and PNIR, followed the sessions with great interest and regularly carried out the application exercises, specifically within the community. The agents' knowledge was decidedly improved thanks to this approach (Figures 17 and 18).



A significant improvement had been noted in agents' knowledge and attitudes, organization of informal discussions, and types of audiovisual materials to be used for conducting informal discussions.

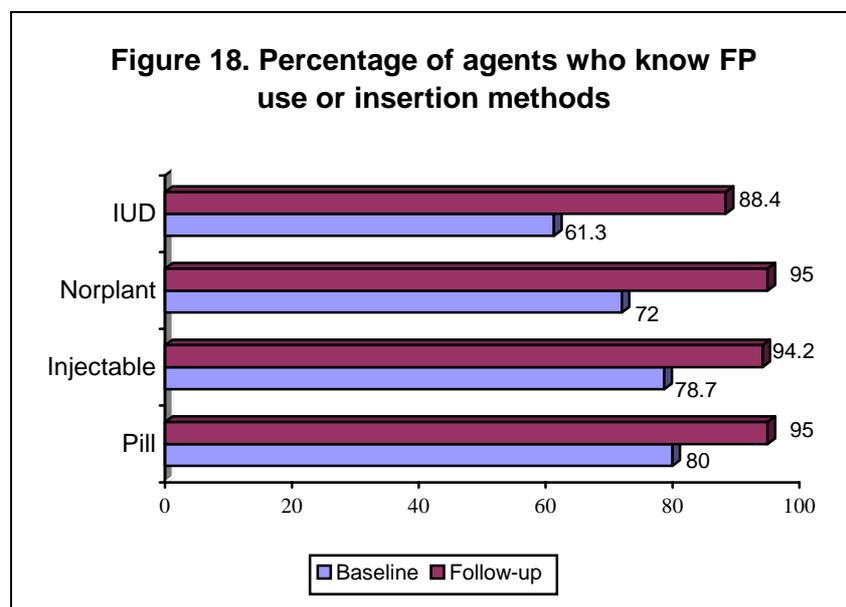


Figure 18 shows a significant improvement in the agents' knowledge of the methods for use or insertion of contraceptive methods. In the first visit as well as the second, it was noted that over half of the agents know the method of use or insertion.

Community promoters. Within the scope of the fight against maternal mortality in Senegal, several strategies for information, education, and communication (IEC) and behavior change communication (BCC) have been used in projects and programs for decades. To make corrections in the significant gap between the acceptable rate of knowledge and the population's still low level of use of the services, the Division for Reproductive Health of the Ministry of Health and Preventive Medicine (DSR/MSPM), together with PSM/PF, conceived and implemented an experiment called "community promoters" (CP). Conceptually, the CP experience is an approach that contributes to putting in place a workable and sustainable mechanism for census, follow-up, and reminders for pregnant women, for surveillance of pregnancy, delivery, abortions, and postpartum care and greater participation in family planning.

- The field activities of community promoters are managed through tools made available to CP (badges, record books for census and follow-up of pregnant women, and reference books) and to the agents in charge of supervision (monitoring and evaluation sheets). PSM/PF implemented the CP approach directly in the first four districts (Linguère, Thiadiaye, Kaolack, and Guinguinéo). Based on the results obtained at the end of this first phase, PREMOMA, together with the DSR, planned its extension to four more districts (Kongheul, Nioro, Bignona, and Thionk-Essyl). This extension was carried out in two sites per district and 10 CP per site, for a total of eight sites and 80 CP. With a view to institutionalization, this extension was decided by the Groups for Promotion of Women (GPF) in a subcontracting process with the participation of civilian organizations such as ANAFA and the Senegalese Red Cross. The replication of the approach made it possible to follow a total of 1,200 pregnant women by the end of the eight-month CP intervention period supported by an actual involvement of community leaders and local elected officials. The results are that much more significant since the CP work as volunteers

without pay and essentially intervene in rural areas where sociocultural burdens remain heavy for many aspects of pregnancy and birth spacing.



The community is mobilized through theater. Community mobilization activities have proven to be indispensable to promote better utilization of SAA services. The high number of unsafe abortions is alarming in the Ziguinchor region, as demonstrated by the figures obtained from post-SAA training follow-up visits to service providers. In the same vein, it should be remembered that an area study carried out in October 1997 to set up a counseling center for adolescents revealed that sexual intercourse began

early in Ziguinchor (from the age of 12) and that pregnancies often occur outside marriage (85% according to the interviews and 46% according to health statistics). To fight this major problem, following the return of results of the community survey on SAA, the participants proposed some innovative solutions for better community awareness and education of communities about the problems associated with abortions.

Theater has been one of the activities proposed by young people and those in charge of Ziguinchor's Departmental Union of Popular Theater and Music (UDTPM). It is now known that acquiring knowledge is not sufficient to lead to the adoption of healthy behavior or to change unsafe behavior. Theater is an interactive form of communication very popular in Senegal's southern region and may constitute an appropriate method to reach young people in both academic and nonacademic environments.

Therefore six Ziguinchor theater groups (with 25 artists and actors per group, the majority of whom were girls and boys) were selected and given an orientation to conduct consciousness-raising activities for young people and adolescents on the risks associated with early pregnancies, unwanted pregnancies, and unsafe abortions. These activities focus on the causes, consequences, and means of preventing early pregnancies and abortions.

A black tie gala created an opportunity to select and give awards to the best groups, among those that had been given the task of conducting consciousness-raising activities in academic institutions. The gala was a high point of community mobilization, with over 700 people, most of them young people and women, with strong audience participation and an intense rapport with the participants. The activities to raise the consciousness of young people in an academic environment were organized in some ten establishments in the municipality of Ziguinchor with a huge mobilization of students, faculty, and the heads of learning establishments. This program forged a partnership among health care personnel, the heads of the Ziguinchor Departmental Union of Popular Theater and Music, and journalists from the region's print and broadcast media. Within the framework of this cooperation, medical authorities and health care personnel supported and actively participated in the performances of the theater companies, whose activities were disseminated and broadcast by the media.

Skits Show Young People in Senegal the Risks of Unwanted Pregnancy and Unsafe Abortion

A procession of 150 actors, musicians, and dancers passes by a market. The women of the community laugh and dance together with the group. The men look at the banner: "The District of Ziguinchor in Partnership with USAID and MSH Is Organizing an Evening Gala Event."

These 150 women and men, belonging to different theater groups, spent many days rehearsing before this announcement. They participated in a competition, in which the theater groups that would present skits in the gala event were chosen.

The mayor affirmed that maternal mortality was a priority: "Yes. It is really a problem—you have my support." Two radio stations held interviews, and the press posed some good questions: "How will you approach the use of postabortion care services? Aren't you afraid that people will misinterpret this event as a promotion for abortion itself?"

It is not easy to answer these questions in a country where abortion is illegal and the maternal mortality ratio is 510 per 100,000 live births. An investigation carried out in four hospitals of Dakar revealed that, of the women hospitalized for postabortion care, 87% had not wanted their pregnancies. Of these women, about two-thirds were less than 25 years old. The core problems, then, are how to prevent unwanted pregnancies, especially among young women, and encourage them to use health services.

To address these problems, MSH's Project for the Reduction of Maternal Morbidity and Mortality (PREMOMA), supported by USAID, is working closely with reproductive health programs in 23 health districts in nine regions of Senegal. The objective is to improve the quality and use of postabortion care services. Doing so requires developing partnerships between communities and services, managing obstetrical emergencies better, and providing counseling, family planning, and other services to meet health needs.

PREMOMA selected three districts, and the quality of postabortion care services was improved through clinical training programs. However, people were not using the services. A challenge emerged: How could the community, especially the young people, be mobilized?

The project decided to pursue a partnership with theater groups, a first in Ziguinchor, to dramatize the problem of unwanted pregnancies and unsafe abortions among youth. After the play, health professionals would talk about prevention, answer questions, and invite the young people to visit the health services to learn more.

In Ziguinchor, where people have endured military conflict for many years, 31% of the population is between 10 and 24 years old. Data from the Counseling Center for Teenagers (CCT) show that many youth engage in sexual intercourse as early as 12 years old. The CCT indicates that 83% of pregnancies occur out of wedlock. Adolescents prefer traditional healers over health services. Further, socioeconomic factors such as population migration and tourism encourage risky behavior among youth. At the same time, Ziguinchor has a great tradition of theater, music, and dance, so a theatre contest was a promising strategy to mobilize young people and the community.

The first meeting of the partnership brought together people from the regional health directorate, Division of Reproductive Health, Departmental Union of Popular Theater and Music, and PREMOMA. They formed a committee to manage the theater initiative.

The president of the Departmental Union of Popular Theater and Music gave his support. He invited the groups to compete and promised the district's support in providing health

information for the skits. One actress said “I thought abortion is like giving birth in that it is not possible to have another pregnancy immediately after one...I was wrong. After eleven days if you don't have contraceptives, you could become pregnant again...I didn't know that.”

Six theater groups presented their skits over the course of more than four hours. The entire audience stayed through the evening. All the plays were in the local language, and all finished with songs and dances about maternal mortality, youth, abortion, and unwanted pregnancies.

The Troupe Agueue Jambogne dramatized a story about a conservative father and mother. When the daughter begins to menstruate, the mother does not talk with her about it.

The second group, Troupe Joola, presented a skit on male education. The father is a poor role model, and his son impregnates his girlfriend. With the complicity of two friends, the couple goes to a traditional healer for an abortion.

From Troupe Kareng came a story in which poverty and a mother's absence appeared as the bases of risky behavior. An unwanted pregnancy and unsafe abortion result in the death of a teenager. A beautiful folkloric scene about abstinence concluded this sketch.

In the skit by Troupe Boussana, the members of a family see a possibility of improving their economic situation by marrying their daughter to a wealthy cousin. The daughter does not want to marry this man, and her boyfriend convinces her to become pregnant to avoid the marriage. The mother tries to arrange an abortion by asking a nurse who has helped other women in the past. The nurse explains the difference between spontaneous abortion and unsafe abortion.

In another skit, by the Troupe Ballet Africain, a teenaged student is being sexually harassed by a teacher. She talks with her mother, but the mother does not believe her. The teenager “consents” to have sex with her teacher, and the story concludes with the teenager's having an unsafe abortion.

The Troupe Ifambondi presented a story in which an imam's daughter does not follow her mother's advice about sex. She becomes pregnant with a neighbor, a teenager like her. The mother is afraid of the father's reaction and decides that the daughter must have an abortion. As a result of the abortion, the daughter hemorrhages. While at the hospital, the family learns about unsafe abortions.

During the evening gala, the winner was awarded a contract to present the play in many communities. The president of the women's community association made a public commitment to support the winning group in each community presentation. The health district told the audience that a health worker would be available after each presentation to answer questions.

That night there was more than one winner. The winners were not only the 150 actors and actresses and their families but the entire community as well. For the first time in Ziguinchor, the community was speaking up about unwanted pregnancies, unsafe abortion, and prevention of maternal mortality. Two radio stations talked about the event on the air, and one radio station has begun to discuss the idea of an on-air soap opera based on the plays. The political authorities gave their full support. The partnership between the health services and the community is becoming a reality in Ziguinchor.



Availability of Contraceptives and Essential Drugs

This section examines how the project contributed to securing RH products.

Objectives

- To make contraceptives products available throughout the system by reducing stock-outs to a minimum
- Improve management of essential drugs in general to facilitate their further integration in a single distribution circuit with the PNA

Context. In Senegal, essential drugs (ME) are ordered and distributed by the National procurement pharmacy (PNA), which is a public, semi-autonomous, central purchasing agent of the Ministry of Health. PNA supplies its regional agencies (PRA), which in turn supply the health care districts in their intervention areas. It is to these districts that service delivery points (SDP) go for supplies to fulfill their clients' needs. As for contraceptives, they are provided free of charge by the partners, such as USAID, UNFPA, and the JICA, and are delivered according to a system paralleling that of ME as far as the districts, through DSR and supported by the partners. At the district level, SDP receive supplies and ME according to a cost recovery scheme, with proper integration of distribution and management.

Procurement of contraceptives. The contraceptive procurement tables constitute a major exercise for the expression and the planning of requirements for all programs in which contraceptives are financed by USAID (DSR, DLSI, ADEMAs). PREMOMA's role is to coordinate this activity in order to make contraceptives available and to provide planning support for the programs. For this purpose all planning has been done from 2006 to 2008 and the requirements for the country forwarded to USAID and other partners. The installation of PIPELINE software and follow-up training after orientation allowed the various logistics managers to analyze their own data and to plan requirements in accordance with their program managers. Coordination of contraceptive procurement allowed diversification of procurement partners for the DSR.

Table 6. Status of contraceptive supply for the DSR between 2005 and July 2006 according to the partners

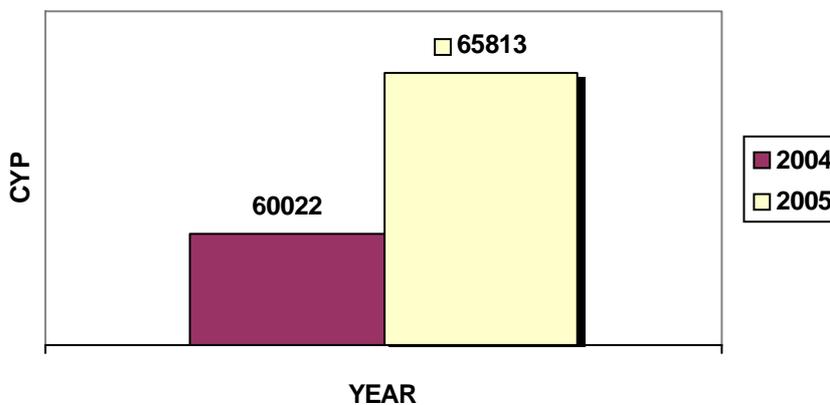
	UNFPA	JICA	USAID
Condom No-Logo	0	0	1,950,000
Conceptrol	0	0	182,400
IUD	8,600	0	10,000
Depo-provera	231,000	0	371,200
Lofemenal	81,000	400,000	544,000
Norplant	0	0	12,050
Ovrette	0	0	258,000
Pregnon (CU)	55,000	0	0
Female condom	40,000	0	0

USAID is the major supplier of contraceptive products, and its efforts are complemented by those of UNFPA and JICA. It should also be noted that, within the framework of securing reproductive health products, the government of Senegal has listed and allocated to the DSR a budget item for FCFA 45 million for the purchase of contraceptives in 2006. PREMOMA has made the specifications of the order by the DSR easier at the PNA level by issuing a call for competitive bids for the supply of contraceptives in 2006.

Distribution of contraceptives. All orders planned by USAID have been received and centralized at the DSR warehouse level to be routed to recipient programs (ADEMAS, DLS, DSR). The DSR, with the support of the project, distributes contraceptives throughout the country in accordance with its system, which uses the medical regions and district warehouses which in turn supply hospitals and parastatal and private facilities. In the USAID intervention areas, the project helps routing and distribution in the districts. In areas not covered, procurement is ensured with the help of PNA logistics and also that of the medical regions, which obtain their products at the central warehouse. In the Kaolack region the contraceptive integration system managed by the PNA continues although the pilot is over.

Changes in CYP. Changes in couple-years of protection (CYP) in the USAID districts by year show a 9% progression between 2004 and 2005.

Figure 19. Changes in CYP in USAID districts



Supervision of district warehouses. With PREMOMA’s support, the DSR had begun the logistics supervision of ME in district warehouses; earlier supervision was focused only on contraceptives. Logistics supervision is performed once every six months, with a team consisting of the central level and the medical region, using an itemized grid that allows monitoring ME inventory conditions, use of management tools, contraceptive inventory position, inventory, integration of contraceptives in the Bamako Initiative, and prices of contraceptives and ME pursuant to the interministerial decree. IMAT is also used on this occasion to monitor inventory management indicators for each district warehouse. An action plan was developed for the solution of problems that were identified, and it will be monitored in coming visits. Supervision involved visiting the 24 districts in the USAID intervention regions and very recently the newly built Thionk-Essyl district, which has had an operating warehouse since March 2006.



Contraceptive management. Monitoring the performance of the various districts showed a sharp change in the logistic indicators previously set up for district warehouses during the six-month period (Figures 20–25). Monitoring of the action plans to solve problems that were identified during supervision showed an improvement in drug management and also in inventory conditions at the warehouses.

Figure 20

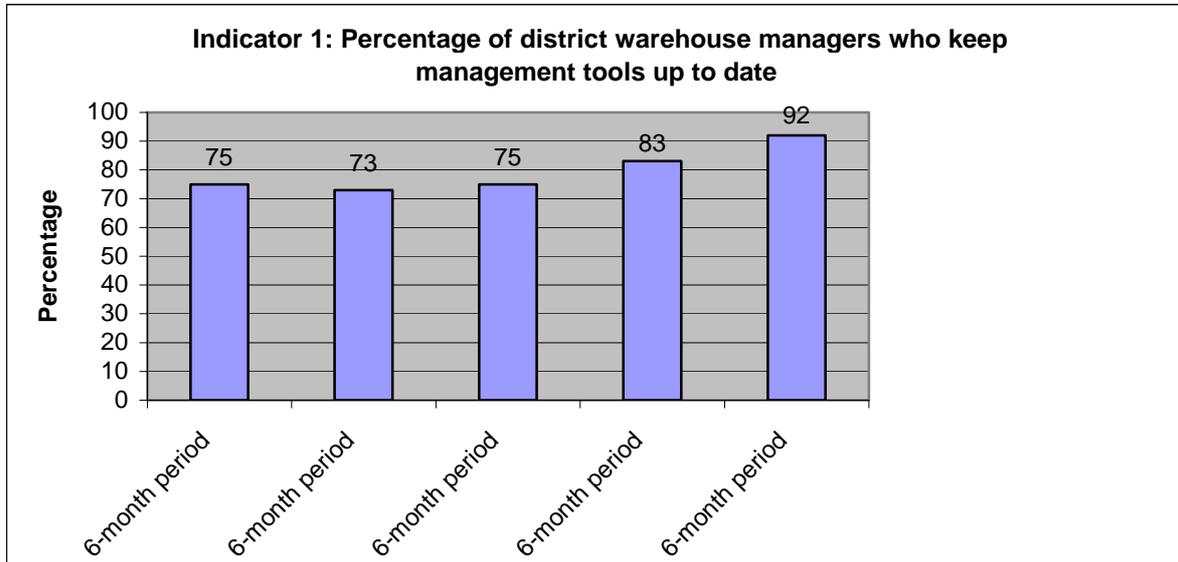


Figure 21



Figure 22

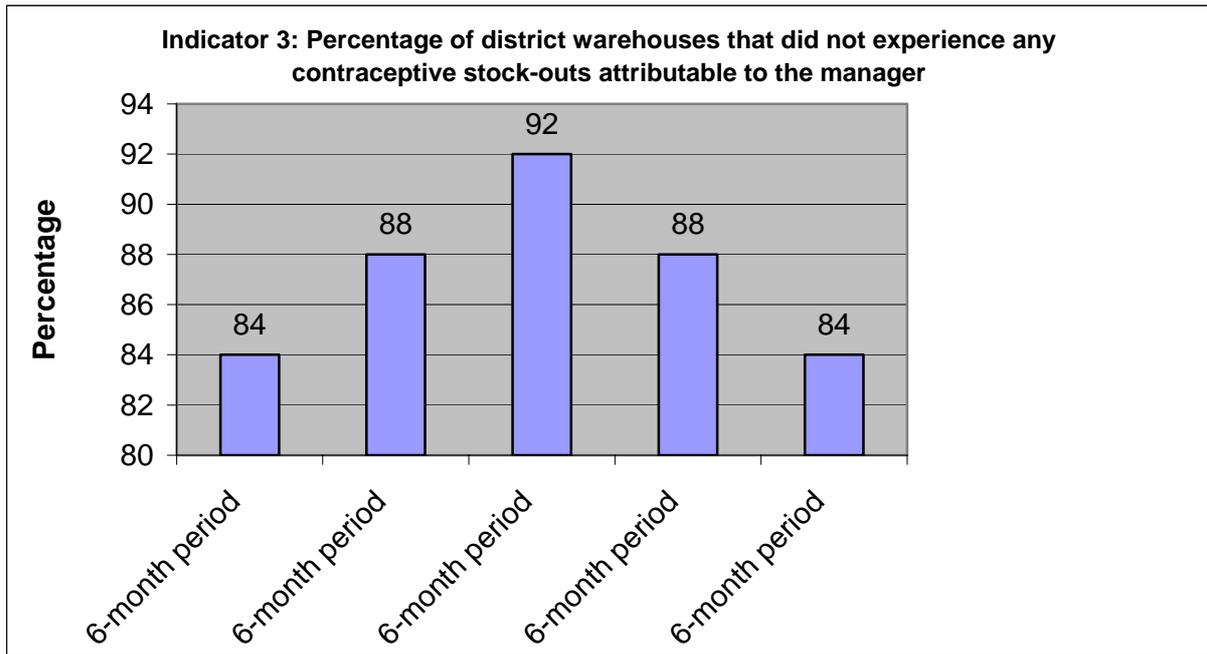
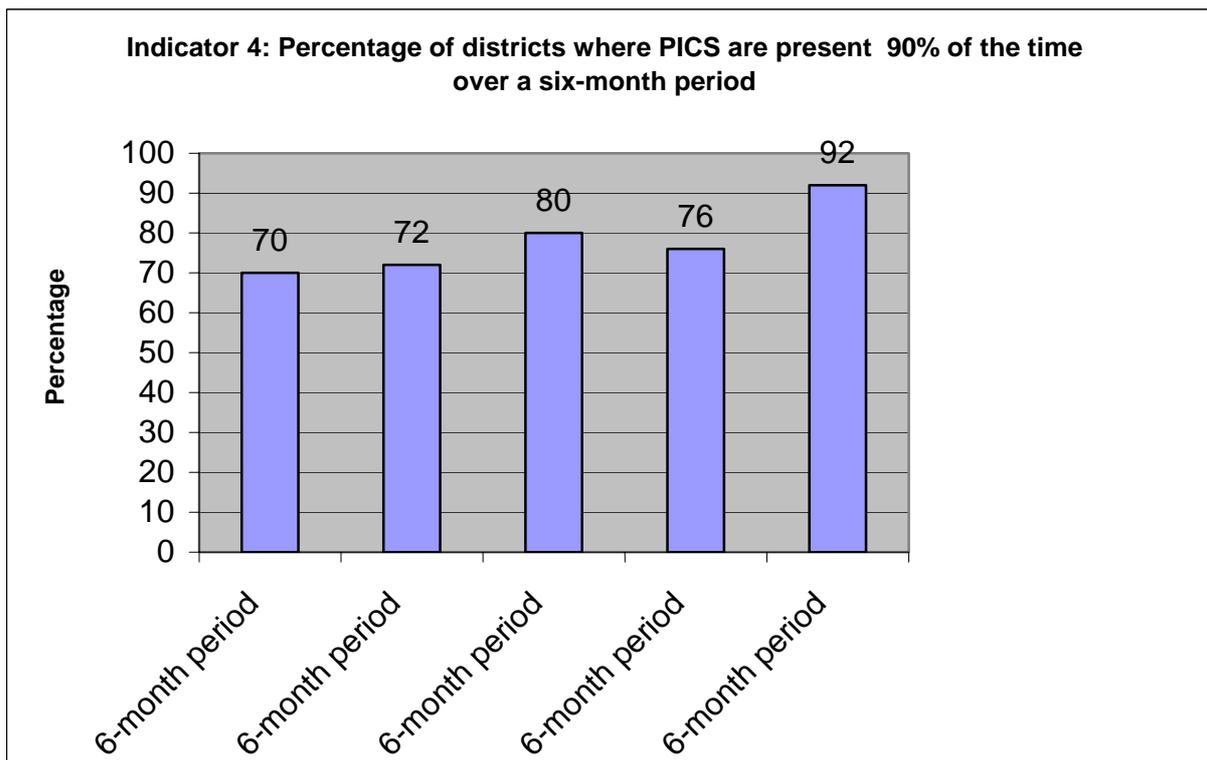
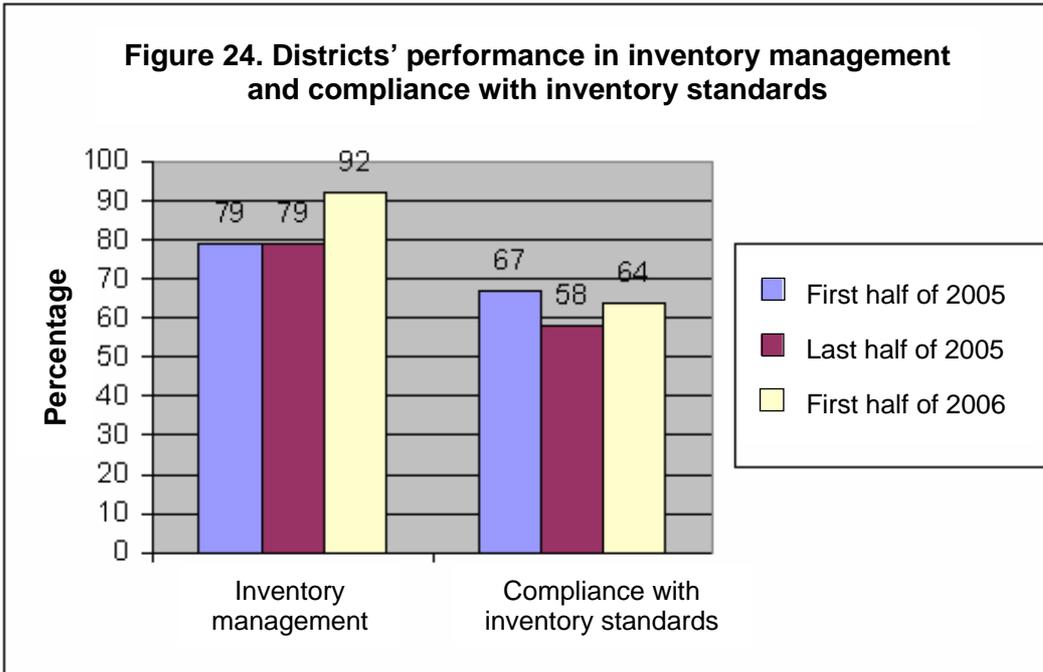
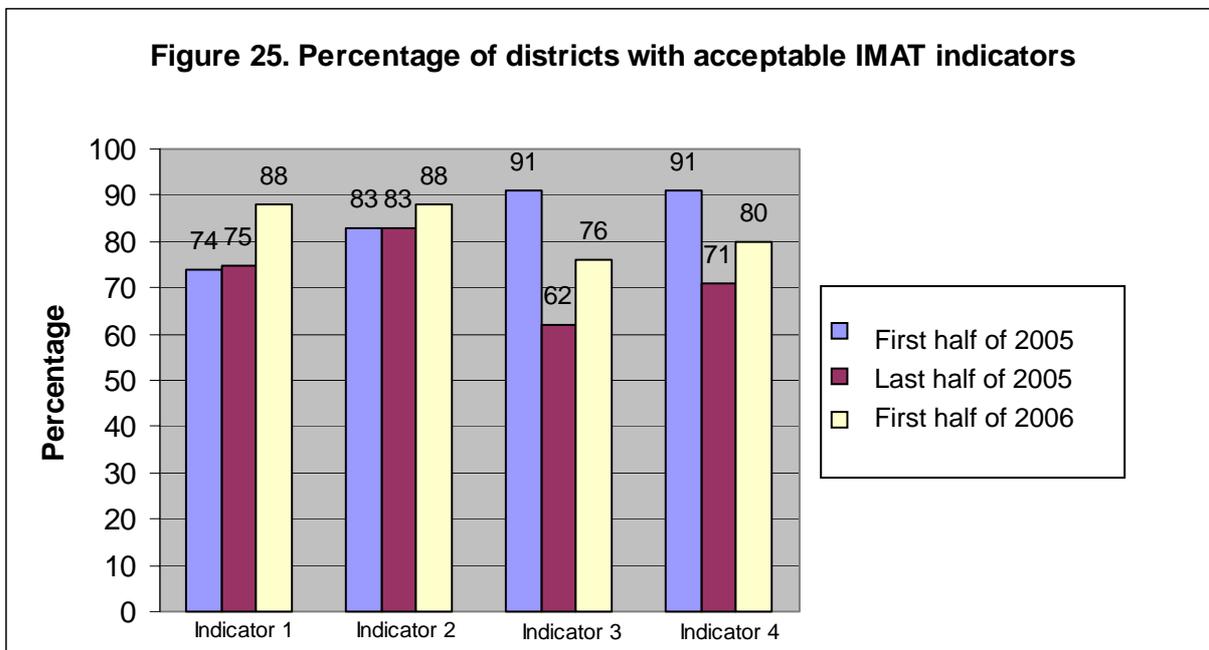


Figure 23





Essential drug management. Using IMAT improved ME management both in terms of tool use and availability. Sharing reports from logistics supervision with the PNA and the participation of their pharmacists in certain regions (Kaolack and Ziguinchor) improved availability of the drugs used in the treatment of STDs (bactrim, doxycycline, erythromycin, cifram), PCIME (carbocysteine, bactrim, flagyl, paracetamol), and malaria.



Recording indicators :
 Ind. I = percentage of correct inventory records
 Ind. II = percentage of change in inventory compared to physical stock

Indicators of inventory verification:
 Ind. III = percentage of available products
 Ind. IV = average percentage of periods of stock-outs

Contraceptive integration process. In 2001, a pilot project to integrate the management of contraceptives with that of essential drugs was put in place in the Kaolack and Louga regions. It consisted of the integration of warehousing, transport, and distribution in a single system managed by the PNA and its regional procurement pharmacies (PRA). In order to document the contraceptive integration process in the ME cost recovery, the DSR has continued the experiment in the Kaolack region from 2002 to the present. The purpose of this exercise was to evaluate the PNA's ability to ensure regular and appropriate supply of contraceptive products to the PRA, the districts, and the service delivery points.

PNA, PRA, all district warehouses in the Kaolack region, and health care centers in various sites were included in the experiment. By choice, the Ziguinchor and Diourbel districts were used as control sites. Their inclusion was motivated by the desire to compare the experiences of an area with a high prevalence of contraception against an area where the prevalence of contraception is low. An analysis of the data resulting from formative supervision of the districts and SDP produced some interesting results.

Strengths

- Of all the districts, only Nioro experienced a stock-out of injectables and spermicides during the evaluation period for all methods combined.
- A single stock-out of pills was noted, at the Kaolack PRA (1.6% of the time during the six-month period).
- Inventory levels for contraceptives complied with the required standards (min-max) in the experimental districts compared to the PRA.
- No inventory loss was noted either at the PRA or the warehouses in the experimental districts.
- All district warehouses at the experimental sites complied with inventory standards (> 70%).
- Use of management tools by the district warehouse managers is satisfactory (> 80%).

Points to be improved

- Compliance with contraceptive prices among districts and SDP
- Compliance with inventory standards for contraceptives at the SDP warehouses
- Adequate use of spermicides and condoms at the SDP to avoid inventory losses.

In conclusion, the experiment showed that the PNA is capable of integrating contraceptives into its essential drug procurement system within a regulatory framework (price of contraceptives) that will need to be enforced.



Lessons Learned

Service Delivery

Integrated formative supervision and accreditation of service delivery points

- Formative supervision by committed and competent executive teams, rather than the traditional approach, is essential for the attainment of health goals.
- Use of formative supervision and executive team leadership are deciding elements in the improvement of quality and sustained utilization of services.
- Communities as well as well-informed and empowered local collectives contribute effectively to the achievement of goals.
- The “accreditation of reproductive health services” approach leads to mutual emulation and encouragement of participants as well as community commitment and involvement at every level in the effort to improve service quality.

Revamping intermittent preventive treatment

- Coupling formative supervision with collection of data makes it possible to identify the causes of poor IPT coverage, to strengthen service providers’ skills in various IPT components, and to ensure regular and geographically targeted monitoring of the progress of IPT coverage.
- Putting in place a framework for cooperation by grouping interested partners and engaging regional managers facilitates regular supervision.

Fixed days method

- MJF is accepted by service providers and can be integrated into all levels of the health care system in the Thiès and Dakar regions.
- Coaching is a simple and practical supervision method that, through immediate feedback, contributes to the improvement of service providers’ knowledge about and skills in MJF.
- Monitoring of CCF-CANAH coordinators shows that community health care agents can provide information and awareness of MJF.

Demand for Services

Association of Multifocus Agents

- Holding local elected officials (mayors and rural community presidents) and populations accountable in contract-based solutions is a factor in the development and success of BCC activities.
- Multifocus agents made better utilization of resources and more effective interventions possible.
- The availability and use of basic information on community needs form a good platform for launching relevant, effective, and efficient activities.
- Regular formative supervision of ARPV by health care workers is indispensable to strengthen their skills and increase their motivation and performance.
- Long-distance learning by radio coupled with training evaluation is a credible alternative to traditional training (in the form of seminars or workshops) in terms of increasing the knowledge, skills, and enrollment of a very large number of trainees.

- Teaching materials must take into account the low level of education or illiteracy of a large part of the agents in charge of BCC activities by relying mainly on images instead of writing.
- Involvement of artists and actors in BCC activities can be a great help in carrying messages on sensitive issues such as voluntary abortion and its consequences.

Private sector

- A partnership of the public and private health care sectors in seeking better coordination of interventions is possible, provided an appropriate approach centered on leadership of the health care district is conceived and implemented.
- The census record of private SDP (one of the components in the approach seeking better collaboration between the public and private health care sectors) constitutes, for the medical and health care authorities concerned, a control panel that ensures greater visibility of facilities and private health care participants in their respective areas of responsibility.
- Organizing meetings and opportunities for operational dialogue among private service providers, including pharmacists, has proven effective in starting a dialogue among personnel from public and private health care facilities for the development of standardized programs and information sharing for management purposes.

Logistical Management of Contraceptives

- The involvement of potential partners in the CPTS exercise allowed much information sharing regarding the country's estimated contraceptive requirements and diversification of procurement sources.
- Systematization and regular logistics supervision led to a decrease in stock-outs of essential drugs, improvement of inventory standards, and a greater compliance with profit margins.
- The experiment conducted in Kaolack showed that the integration of contraceptives in the ME system can contribute to the institutionalization of DSR logistics activities.

Challenges and Opportunities

Integrated supervision and accreditation of service delivery points

- Institutionalization of formative supervision and accreditation at every level involves a synergy of actions through monitoring and through the national program for quality assurance.
- Putting in place a reproductive health information management unit at the DSR will facilitate the use of data for strategic planning and monitoring of the progress of activities being carried out.

Revamping intermittent preventive treatment

- Extend training on malaria prevention among pregnant women to hospitals and the private and parastatal sectors.
- Create a permanent procurement and internal management system for sulfadoxine-pyrimethamine.
- Strengthen coordination among PNLP, the DSR, medical regions, and health care districts for the regular performance of all activities pertaining to the second phase of the plan to revamp IPT and insecticide-impregnated mosquito nets.

Fixed days method

- Maintain collaboration between CCF-CANAH and Tostan to promote MJF at the community level. Integration of the method into the two bodies' various activities could create an interesting synergy to strengthen knowledge at the community level.
- Develop the partnership with ASPF and other associations or organizations.
- Evaluate the introduction phase in view of scaling up.

Association of Multifocus Agents

- Consolidate and extend the contract-based experience with ARPV to areas that still do not have them.
- Strengthen and extend the scope of partnership among persons in charge of local collectives, health care personnel, and the population in general for planning, managing, and monitoring community activities, taking advantage of the achievements of the ARPV tool.
- In updating the training of the ARPV give preference to formative supervision and long-distance learning by radio.
- Institutionalize and extend to other sites the partnership created in the Ziguinchor municipality between health care personnel and popular education participants within the framework of raising the population's awareness of and level of information about reproductive health, especially among young people and adolescents.
- Develop a frame of reference for BCC participants that integrates maternal health, including family planning and neonatal health, in the image of MH/FP and STD/AIDS.

Religious leaders and community promoters

- Make the sections of the religious leaders' networks and associations more dynamic at the regional and local levels.
- Create and implement an orientation program on reproductive health/family planning for their members.
- Consider a gradual scaling-up of the CP strategy.

- Implement areas of institutionalization (put in place equipment for the creation and strengthening of revenue-generating activities) when scaling up takes place.



Logistics

- Integrate the management (procurement) of contraceptives into the national PNA system.
- Institutionalize logistical supervision of ME (districts warehouses and SDP) jointly with PNA.
- Support development and implementation of a strategic plan to secure reproductive health products and increase government involvement in their purchase with a view toward institutionalization.

Private sector

- Set up a systematic census of service delivery points to make available within each medical region, health care district, and health post a comprehensive record of established, legally constituted, and operational health care facilities. Making this tool available will contribute, without doubt, to increasing the visibility of medical and health care authorities in private health care institutions serving in their respective areas of responsibility.
- Continue to set up meetings and opportunities for dialogue within the private health care sector and help create a permanent dialogue with public-sector service providers.
- Strengthen the involvement of private health care service delivery points in training and supervision programs to offer quality reproductive health and family planning services.
- Maintain the dynamics of information sharing for management purposes between public and private health care facilities.