AWARENESS Project
Senegal Country Report
2004–2007

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The Institute for Reproductive Health
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The *Institute for Reproductive Health* with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods of family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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The AWARENESS Project
Institute for Reproductive Health
Georgetown University
4301 Connecticut Avenue, N.W., Suite 310
Washington, D.C. 20008 USA
Email: irhinfo@georgetown.edu
URL: www.irh.org

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Acronyms

CA	Cooperating Agency
DSR	Ministry of Health
IRH	Institute for Reproductive Health
MSH	Management Sciences for Health
PREMOMA	Prevention of Maternal Mortality project
SDM	Standard Days Method®
TOT	Training of Trainers
UNDP	United Nations Development Program
USAID	United States Agency for International Development

Country Program Summary
Senegal

In late 2004, the Senegal USAID Mission requested that IRH provide limited technical assistance to MSH, its main reproductive health coordinating agency, and the Ministry of Health (DSR) to introduce the SDM into the family planning program. USAID/Senegal provided a small amount of funding to IRH to cover staff time and costs for a trip to conduct a training of trainers (TOT), one monitoring trip, and long-distance technical assistance. In August 2005, MSH – as part of the Prevention of Maternal Mortality (PREMOMA) project – launched the SDM program with a TOT at central and regional levels conducted by two IRH representatives. With the DSR, MSH then trained health providers and community agents in 8 districts in the regions of Dakar and Thies. About six months after the initial TOT, IRH conducted a monitoring trip that showed both great provider and client interest and the need to raise community awareness about new services.

MSH trained 38 trainers and 256 providers from 58 government clinics in the two project regions. MSH also worked with IRH to implement a quality monitoring system of regular visits to providers, using IRH's Knowledge Improvement Tool (KIT) and an MSH coaching guide. Unfortunately, MSH had difficulty obtaining data on the number of SDM acceptors, and therefore, this information is unavailable. MSH also trained 40 community agents from the Christian Children's Fund (CCF) and 12 trainers from a local FBO, Senegalese Association for the Promotion of the Family.

The PREMOMA project ended in September 2006, and the Mission included the SDM as part of the next reproductive health project, awarded to IntraHealth. IRH oriented IntraHealth staff in the U.S. and Senegal to SDM activities in Senegal, but had no funding or contact after that point for any needed follow-up. To maintain momentum between projects, IRH funded a local community based organization, Tostan, to conduct awareness-raising in the areas around the pilot sites. IRH trained 75 Tostan trainers who subsequently trained approximately 850 community mobilizers.

Because of the pilot nature of SDM introduction in Senegal, progress toward full integration into norms and protocols, and management information, supervision, procurement, and distribution systems was limited. As mentioned, MSH implemented a supervision system for the pilot series. It also adapted provider job aids from IRH samples. Neither the government nor NGOs have included the SDM in their information systems, nor are CycleBeads part of the commodities management system. IRH understands that the DSR included the SDM in its revised norms and protocols.

The Mission instructed their CAs, including IntraHealth and CCF, to include the SDM in their portfolios, both in clinics as well as in a proposed community-based distribution program. The Mission has also provided funding to purchase CycleBeads, further strengthening the potential for SDM scale-up. An assessment is planned for 2008 to determine the status of SDM in Senegal and identify potential needs for further assistance.

I. Introduction

Source: CIA World Factbook 2008

In late 2004, the USAID/Senegal mission requested that Georgetown University's Institute for Reproductive Health (IRH) provide limited technical assistance to Management Sciences for Health (MSH), its main reproductive health cooperating agency (CA), and the Senegalese Ministry of Health (DSR) to introduce the Standard Days Method® (SDM) into the family planning program. In Senegal, only 12% of married women reported using contraception in the 2005 Demographic and Health Survey, with 10% using modern, effective methods. The total fertility rate was high at approximately five children per woman.[1] Most of the country's 12.4 million residents lived in rural areas and[2] 95% of the population was Muslim.[3] The United Nations Development Program's (UNDP) Human Development Index ranked Senegal at 156 of all countries included.[4] Given these characteristics, the USAID mission felt that many Senegalese women could benefit from simple, accurate information about their fertility and when to avoid unprotected intercourse to prevent pregnancy.

IRH met with MSH and its partners to develop a workplan during a brief planning visit in March 2005. USAID/Senegal provided funds to IRH to cover staff time and costs for a trip to conduct a training-of-trainers (TOT) workshop, one monitoring trip, and long-distance technical assistance. IRH and MSH launched the SDM program in Senegal in August 2005, as part of the Prevention of Maternal Mortality (PREMOMA) project, with a TOT at central and regional levels conducted by two IRH representatives. Subsequently, in collaboration with the DSR, MSH trained health providers and community agents to offer the method in eight districts in the regions of Dakar and Thies. IRH worked with MSH to develop a supervision system that MSH and DSR staff applied. About six months after the initial TOT, a staff member from headquarters and an IRH consultant from Benin conducted a supervision and monitoring trip to Senegal to offer on-site, south-to-south technical support to MSH and the DSR.

Although the PREMOMA project ended in September 2006, the USAID mission included SDM activities in the scope of work for the next reproductive health/family planning project, awarded to IntraHealth.

It is difficult to quantify the progress of SDM integration in Senegal due to challenges MSH encountered in collecting data and the subsequent transfer of the project to IntraHealth. However, based on IRH's March 2006 monitoring visit, providers were accepting of the SDM, as were community members who had heard of it, although general awareness of the method was minimal. Soon after, IRH contracted with Tostan, a local community-based organization, to

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[1] Ndiaye, Salif, et Mohamed Ayad. 2006. *Enquête Démographique et de Santé au Sénégal 2005.* Calverton, Maryland, USA: Centre de Recherche pour le Développement Humain [Sénégal] et ORC Macro.
[2] 2007 World Population Data Sheet. Washington, D.C.: Population Reference Bureau.
[3] Background Note: Senegal. *Bureau of African Affairs*, State Department, July 2007. http://www.state.gov/r/pa/ei/bgn/2862.htm
[4] 2006 Human Development Index. *Human Development Report 2006.* New York: UNDP.

conduct community mobilization and awareness-raising in villages and communities surrounding the pilot sites offering the SDM. According to reports from Tostan, the population was very interested in the method as it was natural, low cost, and effective.

II. Objectives and Strategy

IRH, the DSR, MSH, and USAID/Senegal collaborated to achieve the objective of piloting the SDM in selected national reproductive health/family planning services in the capital and surrounding areas. MSH was to lead the project, with IRH technical assistance and mission funding. However, upon completion of the PREMOMA project, MSH left Senegal and IntraHealth became the mission's new reproductive health implementing partner. IntraHealth's mandate included SDM activities, specifically introducing an itengrated package of maternal and child health and family planning services, which includes the SDM, to health service delivery points and centralizing all family planning comoodities, including CycleBeads, in the Pharmacie Nationale d'Approvisionnement (PNA). IRH oriented IntraHealth staff in the U.S. and in Senegal on SDM activities in Senegal, but was not contacted after that point regarding follow-up needs. IRH continued to inform the mission and IntraHealth of Tostan's ongoing awareness-raising activities. Funding for IRH technical assistance was not renewed.

III. Activities and Accomplishments

In support of MSH's introduction of the SDM into selected national health facilities, IRH staff traveled to Senegal three times. These visits covered an initial orientation for key decisionmakers and MSH staff; adaptation of materials; a TOT in selected pilot sites; training of providers; and a supervision and monitoring visit. IRH also traveled to Senegal to train Tostan trainers responsible for training community mobilizers. IRH provided long-distance assistance to Tostan in the form of materials, tools, and day-to-day communication and feedback. From the time that IntraHealth assumed responsibility for the project in October 2006 until January 2008, IRH had limited contact with the in-country team and with the mission regarding SDM activities. In January 2008, IRH was able to renew contact with IntraHealth and learned of SDM activities that had been conducted since their project began, as outlined in the table below.

Table 1: Summary of Partners, Activities, and Accomplishments

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health (DSR)	• Orientation session • Pilot site selection • Training of trainers • Training of providers • Supervision visits • Method integration into national norms • Publication of scholarly article on SDM in regional journal	• Assisted in scheduling and coordinating activities/logistics with MSH and IRH • Identified pilot sites as well as participants for trainings • Participated in supervision visits • Included SDM in norms and protocols • Co-authored publication	• Conducted orientation session • Conducted TOT • Provide all materials for TOT, including CycleBeads® • Provided technical support for provider trainings • Co-conducted supervision visits • Co-authored publication	• Cadre of 38 national trainers trained • 256 providers trained • SDM in the national norms and protocols • Supervision visits conducted • Article published in regional journal

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Management Sciences for Health (MSH)	• Orientation session • Pilot site selection • Materials adaptation • Training of trainers • Training of providers • Training of community agents • Supervision visits • Purchase and distribution of CycleBeads • Data collection • Publication of scholarly article on SDM in regional journal	• Scheduled and coordinated all activities/logistics • Funded SDM activities • Coordinated provider and community-agent trainings • Purchased and distributed CycleBeads and other materials • Coordinated supervision visits • Collected data • Co-authored publication	• Conducted orientation session • Conducted TOT • Provided all materials for TOT, including CycleBeads • Facilitated purchase of CycleBeads • Provided technical support for provider trainings • Co-conducted supervision visits • Co-authored publication	• Cadre of 38 national trainers trained • 256 providers trained • CycleBeads and provider materials made available to sites • Supervision visits conducted • Supervision tools adapted • Promotional poster created and disseminated • Data collected (as feasible) • Article published in regional journal
IntraHealth (in collaboration with IRH)	• Orientation sessions	• Attended orientation sessions	• Present on SDM and activities undertaken to date in Senegal • Provide electronic version of materials, including CycleBeads order form	• Unknown
IntraHealth (independent of IRH)	• Baseline situation analysis of reproductive health (RH) services, including SDM • Integration of SDM into training materials • Capacity building of supervisors and peer-trainers in package of RH services, including SDM • Technical assistance to the DSR to obtain and distribute CycleBeads to the regions of Dakar and Thies • Integration of SDM into revised RH tools • Ordered 20,000 CycleBeads	• Conducted baseline situation analysis of reproductive health (RH) services, including SDM • Integrated SDM into training materials • Trained supervisors and peer-trainers in package of RH services, including SDM • Provided technical assistance to the DSR to obtain and distribute CycleBeads to the regions of Dakar and Thies • Included SDM into revised RH tools • Ordered 20,000 CycleBeads and delivered to the DSR	• None	• A session on the SDM included in training materials to be used to train supervisors, peer-trainers and providers • Nine supervisors and nine peer-trainers in the region of Thies were trained on the full package of RH services, including the SDM (other regions to be trained later) • SDM included in all RH tools (registers, report templates, etc)
Tostan	• Development of plan to raise awareness of method in areas surrounding pilot sites • Materials adapted and	• Adapted and translated IRH materials into local language • Coordinated logistics of all trainings	• Provided funding for all activities • Provided electronic versions of materials • Conducted TOT	• 75 trainers trained • 850 community agents trained • Materials translated and distributed in

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
	translated into local language • TOT for community agents • Training of community agents • Community mobilization activities • Assessment of community mobilization activities	• Liaised with DSR • Conducted training for community agents • Distributed materials to community agents • Supervised community agents • Provided funding for community mobilization activities • Assessed community mobilization activities	• Provided long-distance technical support for training community agents	local languages • Many varied community mobilization activities undertaken (community theater, talks, radio shows, etc.)

A. Building awareness of and support for the SDM

As indicated in Table 1, IRH provided an orientation on the SDM to key policymakers and program managers during its initial visit to Senegal in 2005. This helped build support for SDM introduction, which MSH maintained by continually updating the DSR and partners via regular partner meetings. MSH also worked with the DSR to include the SDM in the national norms, revised in 2006. They also presented on SDM experiences at the 2006 annual meeting of the African Ob/Gyn Society, which provided a forum for increasing awareness of the SDM in Senegal and other countries.

Once the DSR expressed support for the SDM, IRH and MSH worked to raise awareness about the availability of the SDM. In addition to conducting training sessions for partners and providers, MSH created a multimethod poster featuring the SDM that was distributed to all participating clinics. Although MSH did not specifically engage in activities to increase public awareness of the SDM, IRH collaborated with Tostan to conduct awareness-raising activities in communities surrounding the pilot sites. Tostan trained community mobilizers to hold information sessions and refer interested clients to participating health centers. To aid them in their efforts, Tostan translated the CycleBeads insert into the local language, Wolof, and created poster-sized images of CycleBeads with an explanation in Wolof. Tostan also brought together several villages and the local health personnel to discuss family planning, including the SDM, and included the SDM in a monthly radio show broadcast in local languages.

> **Yro Sow, a chief in Darou Sallam 2 on the outskirts of Thies, Senegal**, learned about the SDM from promotional activities conducted by Tostan. He is favorable towards using it as a birth-spacing method because, *"anything that improves a person's health also contributes to our country's development."*

B. Developing the capacity of local organizations

This project focused largely on capacity building: IRH was to build the capacity of MSH to implement the SDM pilot project, and MSH, in turn, was to build the capacity of the DSR to continue with SDM integration beyond the pilot project. The majority of MSH's capacity-building efforts focused on provider trainings and supportive supervision in the public sector, through the DSR. Specifically, MSH trained 38 trainers and 256 providers (doctors, nurses,

midwives) from 58 government clinics in two regions of the country. MSH also worked with IRH to implement a monitoring system which included regular supervisory visits to providers to monitor and maintain service delivery quality, using both the Knowledge Improvement Tool, developed by IRH, and a coaching guide developed by MSH. Unfortunately, MSH had difficulty obtaining data on the number of SDM acceptors in these clinics. MSH also trained 40 community agents from the Christian Children's Fund and 12 trainers from a local faith-based organization, the Senegalese Association for the Promotion of the Family.

A community group learns about the SDM from a male trainier in the Thies region of Senegal.

IRH built Tostan's capacity by training 75 trainers grouped into several training sessions. These trainers subsequently trained approximately 850 community mobilizers. Again, Tostan was unable to obtain data on the number of SDM acceptors linked to the mobilization activities of these community agents.

As part of IntraHealth's project, supervisors and trainers in two regions have been trained on an integrated package of maternal and child health and family planning services, which includes the SDM. IntraHealth will train providers in these two regions and continue these trainings in the remaining five regions of the country.

C. Generating commitment of resources to SDM from governments, NGOs, and donor agencies

The USAID mission in Senegal provided funds to IRH for the initial SDM introduction. MSH, funded by the mission, paid for their personnel time, trainings, materials production, supervision, and the purchase of CycleBeads. The DSR contributed in-kind support in the form of staff time during the collaboration with MSH. While IRH provided some funding to Tostan, Tostan used its own resources to go beyond the originally outlined activities, incorporating additional communities and mobilizers into their awareness-raising efforts. IRH understands that, at the time of this report, several agencies, including IntraHealth and the Christian Children's Fund, have included SDM activities as part of their USAID mission-funded workplans. IRH has also recently learned that the mission purchased 20,000 CycleBeads, presumably in support of these activities, which were transferred to the DSR.

D. Status of the SDM in Senegal

Because of the pilot nature of SDM introduction in Senegal, limited progress has been made toward full integration into national norms and management information, supervision, and procurement and distribution systems. As previously mentioned, MSH implemented a supervision system for pilot sites and adapted provider job aids from IRH samples. IntraHealth has expanded training activities beyond the pilot sites, training supervisors, peer-trainers and

providers seven regions of the country. The DSR included the SDM in its revised norms and protocols. The government, with support from IntraHealth, has also included the SDM in their information systems and in family planning tools (registers, report templates, etc). In addition, IntreHealth is providing TA to the DSR to include CycleBeads in the central commodities warehouse (PNA) and CycleBeads will be included in an upcoming Contraceptive Procurement Table (CPT).

Despite the limited scope of IRH's activities in Senegal, SDM capacity in terms of training, service provision, and awareness-raising exists in country through the DSR and Tostan, as well as certain former MSH personnel who currently work with IntraHealth. The Mission has instructed their CAs, including IntraHealth and the Christian Children's Fund, to include SDM activities in their portfolios, both in the clinic setting as well as in a proposed community-based distribution program. The mission has also provided funding to purchase CycleBeads. Thus, the potential for SDM scale up is strong.

VI. Challenges

The SDM introduction began with a strong relationship between IRH and MSH, although the objectives and strategy for the pilot introduction were somewhat vague. MSH provided a dedicated point person, which facilitated communication between IRH and MSH and allowed MSH to focus and closely monitor their SDM activities. Nonetheless, there were certain obstacles, largely in the form of strikes among Senegalese health workers and overall lack of coordination within the DSR. These obstacles made conducting supervision visits—as well as collecting any type of service statistics—challenging. This, in turn, made it difficult to judge the progress made after trainings and to tailor programmatic interventions to specific needs.

The relationship with Tostan was similarly strong, but because IRH had to liaise with the mission, CAs, and Tostan, collaboration was not always optimal. Communication and collaboration with the DSR, which was already overwhelmed with day-to-day activities, was difficult; they seemed frustrated by the addition of yet another partner in the form of Tostan. Because IRH did not have a presence in Senegal, it could not optimally facilitate coordination among all partners.

Given the SDM introduction's limited scope and vaguely defined goals and objectives, there were no clear indicators to mark success. Thus, when the MSH project came to a close, there was nothing against which to measure progress made to date or to use to determine next steps. The change in actors from MSH to IntraHealth further posed a communication challenge at a time when the future of the program was unclear.

V. Lessons Learned

In the context of an SDM pilot introduction, clear communication between the implementing partner and IRH would facilitate the exchange of materials to avoid duplication of efforts, aid in trouble-shooting, and provide a means to assess progress and plan for improvement. Facilitating efficient and timely communication with the overburdened DSR is equally important. Frequent

and focused follow-up with DSR personnel can help ensure the quality of services, coordination of activities, and smooth project implementation.

Behavior change communication/information, education, and communication efforts are particularly crucial to the success of an SDM pilot introduction. The SDM appears to be an appealing family planning choice for Senegalese men and women. In an environment in which few couples are aware of the SDM, concerted and coordinated awareness-raising activities are essential to establishing the method. Tostan began this task, but would need to be sustained if the SDM is to succeed in Senegal. Furthermore, data collection on SDM users needs to improve to better determine method acceptance and use within the country.

In general, integrating a new method requires substantial coordination that can best be achieved through an SDM point person, whether housed with the implementing partner or the government. This point person can maintain communication among all partners and facilitate SDM integration into national norms and systems.

VI. Future Plans

As a result of the SDM pilot introduction, some in-country capacity exists for SDM integration: training and supervision capacity among some DSR, IntraHealth, and Tostan staff, and awareness-raising capacity within Tostan. Senegalese men and women and providers have shown interest in the method. If the mission and the DSR identify SDM integration as a priority, IRH recommends that they develop a strategic plan for scaling up and achieving sustainability which would focus on: training and supervision, awareness-raising, monitoring, management information systems, logistics, and the inclusion of the SDM in norms and reference documents (i.e., policies, procedures, curricula). IRH recommends that a SDM point person be designated to coordinate activities until the SDM is well integrated into national systems.

USAID/Senegal appears to support continued SDM integration into clinic and community public health services through the work of CAs including IntraHealth and the Christian Children's Fund. If SDM services are expanded to community health workers as is planned, IRH foresees a possible need for technical assistance to tailor training, provider materials, and supervision techniques for this cadre. In addition, the SDM should be included in awareness-raising activities as well as the management information, procurement, and distribution systems.

SDM programs exist in Mali, Benin, and Burkina Faso and offer opportunities for south-to-south technical support, using resource people from the region. IRH is also available to provide technical support, as needed.