SENEGAL PRIVATE HEALTH SECTOR RAPID ASSESSMENT

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ACRONYMS

AcDev	Action and Development
ADEMAS	Agence de Développement du Marketing Social
APSPCS	Association de Postes de Santé Privés Catholiques du Sénégal
CAFSP	Cellul d'Appui au Financement de la Santé et au Partenariat
CFA	Communauté Financière d'Afrique
CME	Continuing Medical Education
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DHS	Demographic Health Survey
DMPMTMT	Division de la Médicine Privé, Médicine du Travail, et Médicine Traditionelle
DPL	Direction de la Pharmacie et des Laboratoires
DSR	Division de la Santé Reproductive
ECOWAS	Economic Community of West African States
FP	Family Planning
GDP	Gross Domestic Product
GOS	Government of Senegal
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education, and Communication
IDA	International Dispensary Association
IPM	Institutes de Prévoyance Maladie
IUD	Intrauterine Device
MCH	Maternal and Child Health
MH	Maternal Health
MHO	Mutual Health Organization
MOPHSA	Ministère de la Santé Publique et de l'Action Sociale
MSP	Ministère de la Santé et de la Prévention
NGO	Nongovernmental Organization
OC	Oral Contraceptive
ONMS	Ordre National des Médecins du Sénégal

PDIS	*Programme de Développement intégé de la Santé et l'Action sociale*
PNA	Pharmacie Nationale d'Approvisionnement
PNDSS	Plan National de Développement Sanitaire et Social
PNFP	Programme National de la Planification Familiale
PPP	Public-Private Partnership
PSP-*One*	Private Sector Partnerships-*One*
RH	Reproductive Health
SANFAM	Santé Familliale
SMO	Social Marketing Organization
SOMARC	Social Marketing for Change
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAEMU	West African Economic and Monetary Union
WHO	World Health Organization

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EXECUTIVE SUMMARY

At the request of the United States Agency for International Development (USAID)/Senegal, the Private Sector Partnerships-*One* (PSP-*One*) project conducted a rapid assessment to understand better the current and potential market for family planning (FP) products and services in the private health sector and provide USAID with recommendations to strengthen the private health sector in Senegal.

The PSP-*One* team found a strong private health sector with engaged, dynamic leaders and heard examples of entrepreneurial endeavors. Despite the many encouraging signs of a strong private sector, there are key constraints limiting its expansion, including:

- Limited purchasing power of potential private sector clients;
- The cost of, and restrictions on, bank credit to finance creation or expansion of medical practices;
- Limited business management skills of providers, which can inhibit their success or growth;
- Low demand for FP products and services; and
- Weak supply mechanisms to reach rural village or communities of fewer than 5,000 people.

Demand for FP services was found to be stagnant and low. Rural areas have the greatest demand for increased services and service providers, because so few providers are currently found there. Interestingly, demand seems to have grown more in rural areas than in urban ones: In the latter, the contraceptive prevalence rate (CPR) declined slightly, from 19 to 18 percent, in 2005, while CPR doubled to 5 percent in rural areas. Although the assessment team did not have the means to conduct a thorough assessment of the public and private supply chains, the team's overall impression is that the combination of public, private commercial, and social marketing channels are more than adequate to meet the existing and increased levels of demand in cities and towns with populations in excess of 50,000.

Based on the findings of the assessment, PSP-*One* developed the following short- and long-term recommendations to strengthen the private health sector.

Short-term recommendations:

- Mobilize additional resources for a communication campaign focused on FP and reproductive health.
- Conduct advocacy activities involving the public and private sectors to increase understanding, build trust, and promote effective approaches for the public sector to leverage the private sector. In particular, through training, documentation, and advocacy, USAID and its partners should help to make more FP methods available at the health hut level.
- Support the promotion and distribution of CycleBeads and other fertility awareness methods through the Association of Private Catholic Health Posts in Senegal (*Association de Postes de Santé Privés Catholiques du Sénégal,* APSPCS) network.

- Improve private provider knowledge by supporting a new policy to require continuing medical education (CME) credits as a condition for renewal of medical licenses.

Long-term recommendations:

- Support a policy change to allow pharmacists to own and open *depots de pharmacie* in underserved areas and establish other regulations that would encourage consolidation of pharmacies and "second-tier" drug shops at the community level.
- Establish a public-private partnership (PPP) against illicit, uncontrolled drugs.
- Strengthen capacity of the PPP Unit (*Cellul d'Appui au Financement de la Santé et au Partenariat,* CAFSP) within the government to lead dialogue with private sector representatives and create effective PPPs.

1. INTRODUCTION AND BACKGROUND

The United States Agency for International Development (USAID) has a strong interest in meeting the unmet need for family planning (FP) in Senegal and in expanding the private health sector's involvement in efforts to achieve this goal, particularly by strengthening the local social marketing organization ADEMAS (*Agence pour le Développement du Marketing Social*, or Agency for the Development of Social Marketing). According to the most recent Demographic Health Survey (DHS) (2005), the modern contraceptive prevalence rate (CPR) stands at just 10.3 percent, which represented only a 0.3 percent increase over 1997 levels. Additionally, the maternal mortality rate has remained high, at 401 deaths per 100,000 live births (Ndiaye and Ayad, 2005), making it of particular concern for the Government of Senegal (GOS), donors, and implementing agencies (Say, Inoue, Mill, and Suzuki, 2005). Given the strong link between increased use of FP methods and reductions in maternal mortality, the need to increase the CPR in Senegal is clear.

1.1 OVERVIEW OF THE ECONOMIC SITUATION

Senegal, a former French colony located on the Atlantic Coast in West Africa, is home to about 12 million people and is growing at a rate of about 2.3 percent annually (UNFPA, 2005). Islam is the most commonly practiced religion in Senegal (94 percent), with Christianity second at 5 percent and indigenous religions third at 1 percent[1]. Senegal is classified as a Least Developed Country and though the economy grew at 4.3 percent between 1995 and 2003, this will not be sufficient for sustained improvements in the country's development, due in part to the high growth rate of the population (Ndiaye and Ayad, 2005). The gross domestic product (GDP) in 2006 was US$ 9.194 billion using current prices. Also in 2006, the GDP per capita using current prices was US$ 770.11 (IMF, 2007).

Senegal's economy is based mostly on services such as trade, transport, and tourism. Its main industrial activities focus on the processing of local resources (fish, groundnut oil, and phosphates) and building materials (UNFPA and PRB, 2005). As a member of the Economic Community of West African States (ECOWAS) and the West African Economic and Monetary Union (WAEMU), many of Senegal's trade and monetary policies are decided at the regional level, though the country does maintain a certain degree of autonomy in these areas (WTO, 2003).

1.2 OVERVIEW OF THE POPULATION SITUATION

Much of Senegal's population is concentrated in urban locales, with the remaining 59 percent of the population living in the country's vast rural regions. Though Dakar, the capital, accounts for only 0.3 percent of the surface area of Senegal, it is home to about 23 percent of the total population and 75 percent of the total urban population (Ndiaye and Ayad, 2005). It is also in these urban areas that the population growth rate is highest. Between 2000 and 2005, the urban population increased at a rate of 3.9 percent per year, whereas the rural population grew at just 1 percent per year. The rural population also consists of some of the country's poorest inhabitants: 65 percent of poor households are found in rural areas (Ndiaye and Ayad, 2005).

[1] https://www.cia.gov/cia/publications/factbook/index.html

The Senegalese population is young, though the average age has slowly been growing older over the past 15 years (measured most recently in 2005 at 18.2 years of age). Those between the ages of 0 and 15 years account for 42.6 percent of the population, while the age ranges of 15–59 and 60+ years of age represent 52.5 percent and 5.3 percent of the total population, respectively (United Nations Department of Economic and Social Affairs, 2005). Between 2000 and 2005, the growth rate of the population under the age of 15 was estimated at 1.4 percent per year, which continues a slow but steady decline in the growth rate for this age cohort. Meanwhile, the population between the ages of 15 and 59 has been increasing slowly. The growth rate for this age group was most recently estimated at 3.2 percent per year. This population shift may present problems for Senegal in the future. With increasing life expectancy, a greater percentage of the population within the ages of reproduction, and a high total fertility rate (TFR), Senegal's population will grow quickly, putting pressure on already scarce resources (United Nations Department of Economic and Social Affairs, 2005). This population growth will become a serious issue confronting policymakers in years to come and should be taken into consideration when developing future population policies. For these reasons, USAID/Senegal has supported a 2008 update of the RAPID model, which would provide helpful demographic and population data to advocate for financing changes in support of FP and reproductive health (RH) efforts.

1.3 OVERVIEW OF THE HEALTH SITUATION

In 2005, the TFR was 5.3 births per women, a decrease of almost two lifetime births per women from 1978. In urban areas, the TFR is lower, at 4.1 births per women, whereas rural areas register a TFR of 6.4, which is still a decrease from previous levels (Wickstron, Diagne, and Smith, 2006). One potential contributor to the high TFR is the common practice of polygamy in Senegal, which has a tendency to promote larger families. Forty percent of married women are in polygamous relationships and these women typically have 1.43 more children than those in monogamous unions. Within these types of unions, women with more children—and in particular, with more male children—will inherit more than wives with only female children or none at all. This leads to a competitive environment among the co-wives to have the most children (Wickstron, Diagne, and Smith, 2006).

Maternal mortality is a major concern in Senegal, as is infant mortality. The DHS found infant mortality to be 121 deaths per 1,000 live births. In urban areas, infant mortality is lower (91 per 1,000 live births), but as with other indicators, infant mortality in rural regions is not as favorable: 160 deaths per 1,000 live births (Ndiaye and Ayad, 2005). Malaria is one of the primary causes of death for pregnant women and children under the age of five and is also the most common cause of death of hospitalized patients. Fortunately, the HIV prevalence rate is low: only 0.7 percent of the general population between the ages of 15 and 49 is infected.

Eighty-seven percent of women in Senegal benefited from at least one prenatal care visit with a health professional and 62 percent of women delivered in a health facility. Once again, however, the difference between urban and rural indicators is great: 88 percent of urban deliveries took place in a health facility, while only 47 percent of rural women had this opportunity (Ndiaye and Ayad, 2005). The DHS also found that 52 percent of women were aided by a skilled birth attendant, an increase from 48 percent in 1999.

There are only .06 physicians per 1,000 people and, at a slightly better ratio, .07 midwives. Nurses are the most common provider type at .25 nurses per 1,000 people, and pharmacists are the least common at just .01 per 1,000 (WHO, 2006).

The CPR in Senegal has been low (10.3 percent for modern methods), and has been increasing at a very slow pace. Interestingly, the CPR has increased the most in rural areas in recent years, from 2.1 percent in 1997 to 5 percent in 2005. During the same period, the CPR actually declined in urban areas, from 19.3 percent in 1997 to 18 percent in 2005. The increase in rural areas is easier to understand than the decline in urban areas. Rural areas had a much lower base and there have been concerted efforts by USAID and its implementing partners to extend the reach of FP programs to rural areas. The decline of CPR in urban areas merits further investigation as it could be linked to provider bias, supply constraints, or myths about FP methods circulating among potential users with unmet need.

Among women who have ever used contraception, oral contraceptives (OCs) are by far the most common hormonal method (10 percent), with injectables coming in second place at 7.3 percent and condoms in third place at 5.2 percent. The female condom, emergency contraception, and female sterilization were the least common modern methods (0.1 percent, 0.2 percent, and 0.3 percent, respectively).

1.4 DONOR ACTIVITIES IN FAMILY PLANNING AND WITH THE PRIVATE SECTOR

USAID has been supporting FP efforts in Senegal since the late 1970s, when it included a FP component in the Sine-Saloum Health project. Later, USAID developed projects focusing specifically on FP, such as the Family Health and Population projects that ran from 1982 to 1992. USAID-funded population activities have covered a wide range of issues, from assistance to enlarge RH services offered by municipalities, to advocacy with Islamic leaders to gain their support for FP initiatives, to in-service provider trainings and community-based distribution of certain FP methods.

USAID has also been supporting ADEMAS, a local social marketing organization, since its inception in 1989, assisted by the Social Marketing for Change (SOMARC) project. ADEMAS is responsible for USAID/Senegal's social marketing activities and conducts information, education, and communication (IEC) activities, supports provider trainings, and socially markets two products: *Protec*, a male condom, and *Securil*, an OC. ADEMAS has also been working with Pfizer over the past three years to add an injectable to its basket of goods. In September 2008, USAID/Senegal and Pfizer signed an memorandum of understanding to move this process forward.

USAID's current FP activities include: support to a consortium of nongovernmental organizations (NGOs), led by the Christian Children's Fund, for community-based distribution of products and services, including a pilot for supplying OCs; purchase of contraceptives for the national public health system; continuing support to ADEMAS; a behavior change communication campaign designed by Population Media Center focusing on four key topics: FP, HIV and sexually transmitted infections, nutrition, and tuberculosis; and support to public and private (workplace clinics) sectors for improved FP counseling, communication, and service delivery techniques. USAID also funds decentralization and improvement of post-abortion care services, which include FP as an essential component.

Like USAID, the United Nations Population Fund (UNFPA) has a long history of supporting FP initiatives in Senegal. UNFPA's first FP program began in 1979 and, over the course of the past 30 years, it has helped establish RH service delivery points in UNFPA's focus regions; supported projects focusing on improving obstetric care; donated contraceptive products; addressed youth issues and HIV/AIDS; and

worked to reduce the incidence of female genital cutting, among others (Wickstron, Diagne, and Smith, 2006).

The World Health Organization (WHO) has been working with the Ministry of Health and Prevention (*Ministère de la Santé et de la Prévention,* MSP) and the Department of Reproductive Health (*Division de la Santé Reproductive*, DSR) to develop and finalize maternal health (MH) and RH roadmaps. These roadmaps were developed in partnership with USAID, UNFPA, the World Bank, and the African Development Bank and will be used to guide all RH and maternal and child health (MCH) activities in Senegal.

1.5 OBJECTIVE OF THE ASSESSMENT

At the request of USAID/Senegal, the Private Sector Partnerships-*One* (PSP-*One*) project conducted a private health sector rapid assessment to better understand the current and potential market for FP products and services in the private health sector and provide USAID with recommendations to strengthen the private health sector in Senegal.

1.6 ASSESSMENT METHODOLOGY

The assessment focused on the analysis of four key interrelated dimensions that impact both FP and the private sector: supply and demand; products and services; the public and private sectors; and urban and rural environments. The team also examined Senegal's applicable policy regime and policy environment, defined as the formal legal and regulatory policies and informal support for implementation of these policies, respectively.

In the first phase of the assessment, the team reviewed secondary data from donors, implementing agencies, and government entities prior to traveling to Senegal. The second part of the assessment was conducted in-country and consisted of key informant interviews with representatives of the private, commercial, NGO, and public sectors as well as donor organizations and implementing agencies (the detailed list can be found in the Annex). The PSP-*One* team had limited time in country so it was not possible for the team members to meet with every representative of each sector or visit all regions of the country. However, the team was able to interview primary representatives from the various areas covered by this report, including: provider professional associations, health financing groups, donors, consulting agencies, commercial distributors and manufacturers, government agencies, and NGOs.

The key questions that guided the assessment were:

- What are the constraints and opportunities to increase use of FP?
- What is the current state of the private health sector?
- What barriers impede the expansion of the private sector? What are the opportunities to strengthen it?

This report is the result of these efforts and details the team's findings as well as recommendations regarding next steps to be considered by USAID/Senegal as its moves forward with supporting FP activities and the private health sector.

2. PUBLIC POLICY: FAMILY PLANNING AND THE PRIVATE HEALTH SECTOR

2.1 HEALTH POLICIES IN SENEGAL

The history of FP in Senegal is a relatively short and variable one, characterized by frequent changes in policy and restructuring of the health system. Over the past 20 years, Senegal's FP program has been relocated 11 times, often due to decentralization and integration efforts. Leadership transitions at the highest level have also affected program continuity—the Minister of Health has changed six times in the last eight years.

FP efforts began in earnest in 1980 when the GOS repealed its anti-contraception laws, making contraception legal for the first time. From that point until 1991, FP could be described as having been over-medicalized, because laboratory tests were required for all women wanting to use OCs and intrauterine devices (IUDs).

With regard to the health system, the process of decentralization has been in place since the 1980s and was accelerated in 1989 when the National Health Policy was adopted. The GOS's adoption of the Bamako Initiative principles led to a system based on user fees for health services and products, including FP. Starting with the decentralization law of 1997 and the texts that followed, the government also decentralized planning, management of some funds, and implementation of public health activities to the regional and district levels. One of the current unintended consequences of this decentralization appears to be that more medical providers are now moving into management and administrative positions in the regions, thereby aggravating the shortages of trained medical providers.

In 1990, the then-Ministry of Health and Social Action (*Ministère de la Santé Publique et de l'Action Sociale*) designed one of the government's first FP programs, called the *Programme National de la Planification Familiale* (PNFP), which began operation in 1992 under the direction of the Cabinet of the Minister of Health. As another first, the GOS developed and implemented service-delivery guidelines for FP in 1996. These guidelines were drafted by a working group representing a broad range of stakeholders from both the public and private health sectors as well as from training institutions. The development of these guidelines was further confirmation of the government's realization of the need to expand access to FP services.

A year later, in 1997, the GOS implemented the 1996 Decentralization Code, which created parallel local and national units to manage government funds and activities. Under this new system, the central government ministries suggested how local units should allocate their funding, but ultimately, spending allocations across nine areas (including health, population, and social affairs) were left to local representatives. As a result of this new process, almost 30 percent of the health budget was spent on non-health sectors as the funding was allocated elsewhere. This situation was temporary and corrected after locally elected officials and health district management teams became more informed about their roles and responsibilities in implementation of the decentralized system.

In 1998, the PNFP was integrated into the 10-year (1998-2007) strategic National Plan for Health and Social Development (*Plan National de Développement Sanitaire et Social,* PNDSS), which transferred the

responsibility of decreasing the national fertility rate to the DSR. FP became part of the Integrated Health and Social Action Development Program (*Programme intégré de déveleppement de la Sante et l'Action sociale*", PDIS), the implementation plan for the first five years (1998-2002) of the PNDSS. The PDIS merged the regional and district development plans and then detailed implementation plans with specific activities, funding contributions from the central and local governments, as well as from donors, and monitoring and evaluation efforts. In keeping with the guidelines put in place by the Decentralization Code, funding levels and priority areas were determined at the local levels (Wickstron, Diagne, and Smith, 2006).

2.2 CURRENT POLICY REGIME AND ENVIRONMENT FOR FAMILY PLANNING AND THE PRIVATE SECTOR

Decentralization continues today in Senegal with health programs still moving from a vertical approach to a more integrated one focusing on the district level. FP continues to be housed within the DSR under the current government. The DSR orients and provides guidance to local-level representatives on national health initiatives and policies and coordinates macro-level activities. Not all RH activities are housed within the DSR, as other programs such as those focused on HIV and malaria, incorporate aspects of MH into their own activities.

Besides decentralization efforts, the GOS is working with donor agencies on the development and implementation of roadmaps for RH and MH activities. These roadmaps will serve as the guiding documents to coordinate all donor and government RH and MH activities in Senegal.

Some feel that decentralization may have hindered effective FP programming and argue that FP has suffered because of program integration. While decentralization increases accountability at the local level, it can also mean that broad solutions such as FP are less likely to emerge as priorities for addressing the most urgent health problems (e.g., maternal mortality). Those concerned feel that lack of central leadership has left FP with few advocates and little visibility and that the creation of hundreds of district-level health representatives has further diminished the focus on FP (Wickstron, Diagne, and Smith, 2006). Though it seems clear that Senegal's decentralization policies will not be changed, FP stakeholders need to be aware of the special challenges of revitalizing RH programming when leadership is so decentralized.

With FP under the leadership of the DSR, it is framed within the context of RH and MH priorities and initiatives and is rarely discussed as a stand-alone health area. Improving MH indicators are clearly first priority and certainly there is considerable need to improve the RH and MH status of women in Senegal. However, it seems that the strong connection between MH and FP is not always made. Even though FP is an appropriate strategy for reaching Millennium Development Goals 4 and 5, there does not appear to be a champion at the central level to ensure that this connection is addressed in program strategies.

Without a champion for FP at the national level and few dedicated resources, there is little incentive or capacity for regional health officials to invest in public campaigns in support of FP. Additionally, according to numerous informants, many providers fail to see the importance of FP. It may be that government representatives and providers in all sectors are uncomfortable promoting FP because they are concerned about cultural and religious antipathy towards "birth control." It may be more acceptable to implement FP activities under the RH/MCH banner than to have stand-alone programs.

This is not to say that the GOS is opposed to FP in any way. Indeed, the government's commitment to FP programming is stronger than that of many governments in West Africa. However, even with a generally supportive government, FP programs should not count on central government support for introduction of new methods or highly visible campaigns focused on FP.

Community-level distribution of FP products is nascent: While most MSP resources focus on district health centers and village health posts, the government continues to direct policies towards community-level programs, such as expanding the number, and increasing the capacity of *agents de santé communautaire* (unpaid, trained health workers) who operate health huts. However, because these *agents de santé communautaire* receive relatively minimal training, FP products and services are often restricted at this level by the workers' limited medical training. Currently, only condoms and resupplies of OCs are available through health huts through a pilot program. Moreover, the coverage is limited to areas where health huts are supported by USAID or UNFPA. There is currently a pilot activity underway for *matrons* (community birth attendants) to give initial supplies of OCs.

Some key informants expressed skepticism of this pilot. This conservative attitude may present a barrier to scale-up and expansion to other FP products even if the pilot is deemed a success. Furthermore, mentioning the possibility of community-based distribution of injectables using the uniject technology (a pre-filled, single-use syringe) brought clear discomfort among a number of key informants. Long-term advocacy would be needed for any FP strategies that involve demedicalization or redefining scopes of practice.

The National Organization of Senegalese Doctors (*Ordre National des Médecins du Sénégal,* ONMS) plays an important role in the policy regime and environment: The policy regime and environment in Senegal is strongly influenced by the ONMS. The ONMS is a semi-public institution established in 1966 to "control the practice of medicine in both the public and private sectors" and is recognized as the highest professional authority in medical affairs. It serves a similar function to medical councils that are typically established in Anglophone countries. While not a government entity, it benefits from a government mandate to fulfill a regulatory function. Its objectives are to "preserve the principles of morality, quality, and dedication that are indispensible for the practice of medicine" and aim to "defend the honor and traditions" of the medical field (Ordre des Médecins 1966). The *Ordre* also serves as the consultative body for the MSP and is responsible for providing guidance on any legislation related to the practice of medicine. It often functions as an advocacy group to protect the professional interests of doctors.

According to Senegalese law, it is mandatory for doctors to be enrolled in the ONMS and pay annual fees. The fee amount depends on whether a doctor belongs to Section A (doctors employed by the government and public universities), who pay 12,000 CFA per year, or Section B (doctors working in the private sector, for NGOs or private companies) who pay 18,000 CFA per year. According to the President of the National *Ordre*, about 35 percent of doctors are currently enrolled (about 420 out of 1,200), the majority of which are from the private sector. Most Section A providers are not aware off that fact they should be enrolled and pay the fees. Those who are informed but do not pay their dues argue that this is something for which the government should pay. Private doctors feel that these exceptions are unfair and discriminatory.

Restrictions on scopes of practice: Though laws define the services each genre of provider can offer, some are reportedly offering services beyond their legal scope of practice. This may be done out of necessity in rural regions, where lower-level providers represent the only access to health services. For instance, private nurses are not permitted to write prescriptions, but the team was informed that virtually all rural nurses are in fact offering these services. In fulfilling the needs of the community, these providers put themselves at risk by offering services they are not legally authorized to offer. Furthermore, such laws limit the number of providers who could potentially offer these services, especially with nurses being the most decentralized level of public sector healthcare provider in Senegal. In short, some of the policies regulating service provision may not be aligned with the realities of healthcare needs and available service providers.

The ONMS acknowledges that not all providers operate in conformity with the law and that it is often necessary given the shortage of providers in rural areas. As a result, the *Ordre* reluctantly accepts that midwives and nurses can prescribe drugs, but only on the condition that they do so under the supervision of the MSP or a medical doctor. At the community level, the *Ordre* also accepts that birth attendants and community health agents provide some services, but also with the stipulation that they are under the supervision of an institution or organization. However, the ONMS clearly stated that there is no legal protection for nurses or midwives that provide services reserved for doctors. In summary, the *Ordre* accepts the flexibility of laws in rural areas where there are few doctors and other health providers to respond to the health needs of the population, but in general, they are opposed to shifting tasks normally reserved for doctors to lower scopes of practice.

Depots de pharmacies: These lower-level drug outlets appear to be an important source of products and services in Senegal. Although the assessment team was not able to obtain information on the exact number and distribution of depots, key informants indicated that in some regions, they are the most accessible source of medicines. Typically, second-tier providers like the *depots* are able to reach rural populations because they have lower operating costs than pharmacies. Informants in the government indicated that most depots are found in urban or peri-urban areas. Policies that might encourage the creation of more *depots de pharmacie* in rural areas could greatly increase access to contraceptives and other medicines.

However, there is limited support for *depots de pharmacies* in the current policy environment. The Department of Pharmacies and Laboratories (*Direction des Pharmacies et des Laboratoires*, DPL) informed the team of their desire to phase out depots by discontinuing authorizations to open new ones and replacing them with health huts. One of the problems under the current system is that while a supervising pharmacist (who is not located at the depot) is required to open a *depot,* they cannot own the *depot* or employ the *depot* manager. Consequently, the authorizing pharmacists have no leverage or incentives to ensure that products sold are of good quality from trusted sources and that the *depot* manager is providing appropriate advice to consumers; this may be one reason that pharmacist supervision is ineffective.

A number of informants cited problems with private *depots* being opened without any supervising pharmacist or formal registration. In some areas (e.g., Touba), it is known that these depots often sell drugs of dubious quality that they have not obtained from the formal pharmaceutical channels. Most of the *depots* in Touba operate in the urban area and advertise themselves as pharmacies. The DPL seems to lack the resources to monitor and police the offending *depots*; this may be another reason the

government is not interested in encouraging their growth. While the scope of practice of the depot has potential for expanding access, the reality as practiced is quite different and may not offer good programming opportunities.

Contracting-out policy: The MSP is also currently implementing a contracting policy, the content of which recognizes the important contributions of the private health sector in improving the health status of the Senegalese population and shows its desire to involve them in public health efforts. The policy goes on to describe informal contracting efforts that have been undertaken in the past and the need to formalize such arrangements. It also details a wide range of contracting options and describes, in broad terms, the steps needed to implement these partnerships, though the specifics are to be decided upon by the parties involved. The types of contracting arrangements described in the policy include: the purchase of medical services, such as laboratory testing and medical imagery (either between public hospitals or between a public hospital and a private facility); cooperation between public hospitals (transferring patients due to lack of space or lack of a particular specialty), performance-based contracting, and potentially subsidizing the provision of priority health services, such as vaccination and deliveries, in religious health posts, to name just a few (MSP, 2004).

The most commonly cited examples of the implementation of this policy were the contracts given to *Santé Familiale* (SANFAM, an NGO that supported workplace clinics) and Action and Development (AcDev, an NGO with polyclinics in multiple locations) to offer health services with reimbursement schemes. Most people interviewed considered these successful relationships and hope to see further application of the policy in the future.

3. THE HEALTH SECTOR IN SENEGAL

3.1 THE PUBLIC HEALTH SECTOR

In order to fully understand the context in which the private sector operates and the opportunities to increase FP use, it is helpful to understand the public healthcare system. The public sector in Senegal operates in compliance with the Bamako Initiative, charging a minimal fee for services and medications, decentralizing the healthcare system, and involving the community in public health efforts.

Size and structure: Three managerial levels oversee the public health system. The first level consists of 63 health districts, which are responsible for *centres de santé* (health centers) and satellite *postes de santé* (health posts). The health district, via the *postes de santé*, also has responsibility for supervision of community-operated *cases de santé* (health huts) and rural *maternités*. Each district is responsible for serving between 150,000 and 250,000 people. At the second level is the health region, which coordinates health activities for the region (each region having 3–5 health districts). The highest tier of the public health system is the central level and includes national MSP programs and services as well as national hospitals (CAFSP 2005).

The public sector consists of (in descending order, based on types of services offered and qualifications of staff) (*Direction de la Santé*, 2006):

- 20 public health facilities
- 60 *district centres de santé*
- 813 *postes de santé*
- 16 *maternités*

Maternités conduct IEC and preventive health activities, and simple deliveries; distribute condoms, and resupplies of OCs and essential medications; refer to higher-level facilities; and treat uncomplicated illnesses such as diarrhea. *Postes de santé* are staffed by nurses and midwives and can offer care for common illnesses, pre- and postnatal care, uncomplicated deliveries, FP, and basic emergency obstetric care, in addition to some educational and counseling activities.

The district health centers provide services for complicated deliveries, medical and surgical emergencies, diagnostics (laboratory testing, radiography, and echographs), house calls, and medicalized health evacuation. Public health facilities offer the same services as the health centers, plus emergency obstetric and neonatal care, surgery, psychiatry, preventive care, health counseling and education, and other specialized services.

3.2 PRIVATE HEALTH SECTOR

The PSP-*One* team found a strong private health sector, engaged with dynamic leaders. The team also heard examples of entrepreneurial endeavors, such as the midwife who opened her own school for midwives when she was unable to find quality staff to work in her clinic, or the Ob/Gyn who started her

own association to offer trainings to others on new technology. Despite the many encouraging signs of a strong private sector, there are key constraints limiting its expansion.

Size and structure: The private health sector is concentrated in Dakar, where about 85 percent of private service providers are found (MSP, 2004). Disaggregated by type of facility, the private for-profit and private not-for-profit sector in Senegal consists of:

- One private hospital
- 20 private clinics
- 23 workplace clinics (*Direction de la Santé*, 2006)
- 76 *postés de santé*
- 1,788 *cabinets médicaux*
- 17 *cabinets de soins infirmiers* (*Direction de la Santé*, 2006)
- 1,760 *cases de santé*
- Over 700 private pharmacies

The number of pharmacies and *depots de pharmacie* fluctuates frequently, as new ones open and others close, but ADEMAS shows 767 active pharmacies and 133 *depots* in their database as of May 2008 (see Table 1).

TABLE 1: DISTRIBUTION OF PHARMACIES BY REGION

Region	Number
Dakar	448
Diourbel	30
Fatick	11
Kaolack	38
Kolda	16
Louga	27
Matam	18
Saint-Louis	41
Tambacounda	18
Thies	90
Ziguinchor	30
TOTAL	767

Cases de santé, or health huts, play an important role in the public health system, though they are not staffed by MSP personnel. Throughout Senegal, there are about 1,760 health huts and are often the only accessible health facilities in certain areas. They are staffed by a community health worker chosen by members of the community and then trained to provide basic health services and products. These services may include simple deliveries, FP (condoms and resupply of OCs), growth monitoring and

nutrition activities, and curative care of acute respiratory infections, malaria, and diarrhea. They are also an important source of health counseling and education (*Direction de la Santé*, 2006). Though health huts are technically not part of the public health system, the GOS recognizes their importance to the goals of the public health system, and makes efforts to link the public sector facilities with community health huts in order to ensure referral and counter-referral, regular supervision, and data collection at health huts.

Private *infirmaries* and *postes de santé* offer the same services as those in the public sector. *Postes de santé* are staffed by nurses and midwives and can offer care for common illnesses, pre- and postnatal care, uncomplicated deliveries, FP, and basic emergency obstetric care, in addition to some educational and counseling activities. The private *postes de santé* are often well integrated into the public health system. *Infirmaries* are headed by nurses and offer basic preventive and curative care, as well as simple deliveries, but are not allowed to write prescriptions.

At the next highest level are the *cabinets médicaux*, which are typically run by a single doctor, either a generalist or specialist. Since there is such a wide range of providers found within this level, it is difficult to specify the types of services offered.

Private clinics are often owned or run by a group of 2–3 doctors, are larger in size than *cabinets médicaux*, and offer a wider range of services, including inpatient care. The highest level of private facility is the hospital, of which there is only one in Senegal.

In addition to these structures, Senegal has private workplace clinics, private pharmacies, and *depots de pharmacie*. Workplace clinics have reportedly not yet been incorporated into the formal organizational structure, which has presented some problems for these facilities as implementers have found instances where legal and regulatory issues are not well defined for them. Workplace clinics focus on problems and illnesses that result from the particular work environment to which employees are exposed. Providers must obtain special training and certification in workplace health issues in order to be a provider at one of these clinics.

Nearly two-thirds of private retail pharmacies are found in Dakar, but they are also found in rural settings. Each year, the DPL conducts an inventory of the pharmacies currently in operation, and based on their geographic location and the needs of the population, decides where the new facilities can open. According to staff of the Strengthening Pharmaceutical Systems Project, a USAID-funded program working on drug management, pharmacists are often the first source of healthcare sought out in Senegal.

Below pharmacies are an unknown number of *depots de pharmacie* that sell a more limited range of products. The 133 depots in the ADEMAS database is likely to be an underestimate since many of them are established without formal registration and many are established outside the major urban areas. According to official regulations, depots must be opened under the supervision of a pharmacist, who neither staffs nor legally owns the depot, but is responsible for its daily supplies. The reality is that many depot managers sell products obtained through commercial channels including many drugs of poor quality. Unfortunately, no analysis has been conducted regarding the number of depots operating, where they operate, and whether they are properly registered and supervised.

The Catholic Church also plays an important role in the provision of health services by the private sector: the only private hospital, Saint Jean de Dieu, and most of the private *postes de santé* are Catholic.

These Catholic *postes de santé* are dispersed throughout Senegal, provide the same services as those in the public sector, and are overseen by the public sector district supervisor. Given that the *postes de santé* are run by the Catholic Church, only natural FP methods are offered.

Opening a private health facility: The process of opening a private facility is relatively straightforward and the requirements are easily accessible on the MSP's website. The requirements differ depending on which type of facility one plans on opening, though there are commonalities in the application requirements. To open a private medical office, for instance, an applicant must submit a formal request to the MSP with the exact address of the facility, a certified copy of the provider's diploma, birth certificate, criminal record, enrollment in the professional *Ordre,* proof of the applicant's Senegalese nationality and that he or she is not working in the public sector, and a certificate of health.

3.3 PROVIDER ASSOCIATIONS

Each category of provider in the Senegalese healthcare system has some type of professional representation that falls into one of three groups: organizations (*Orders*), syndicates (*Syndicats*), and associations (*Associations*). They play an important part in the public health system, as they are able to organize and mobilize their constituents and serve as a conduit for information from the GOS and donors, in addition to their traditional representative role.

Professional councils, such as the ONMS, are government-sanctioned entities that represent the profession to the National Assembly, ensure providers comply with laws and rules of ethics, and provide advice to the MSP on legislative and regulatory matters. By law, all providers must be registered with, and pay a membership fee to, their respective *Ordre*; that is, if one exists, for not all levels of providers have this representation. As such, the *Ordre* represent both public and private sector providers. Despite this law, as mentioned earlier, few public doctors are currently enrolled.

The *Syndicats* and *Associations* have essentially the same purposes, which are mainly to defend the rights and interests of their constituents, though their activities have not been limited to this area. These groups have extended beyond their original mandate into providing guidance for the future of their professions, organizing trainings, and developing partnerships with the government. *Syndicats* and *Associations* may have members from both the public and private sectors, though some are exclusively for those working in the private sector. Several of the professional associations reported that most of their members were in fact from the private sector. Membership is voluntary and is based on payment of membership fees.

Private doctors are represented by the Private Doctors' Syndicate (*Syndicat de Médecins Privés)*. The *Syndicat*'s purpose is to "defend the moral and material interests of doctors in private practice and those working in private companies."[2] There are between 500 and 800 private providers currently enrolled in the *Syndicat*, which requires an annual fee of 25,000 CFA.

Ob/Gyns are organized through the Association of Gynecologists and Obstetricians (*Association des Gyneco/Obstétriciens)*. The *Association* was established in 1993 with several aims: reduce maternal mortality in Senegal and organize Ob/Gyns; establish linkages with similar organizations from other countries and with international organizations; implement training activities; and perform outreach

[2] Personal communication with Dr. Ardo Ba, President of *the Syndicat des Médecins Privés*, April 2008

activities for underserved populations outside of Dakar. There are about 80 active members, the majority of whom are located in Dakar. Members are equally divided between the public and private sectors.

The Midwives' Association of Senegal (*Association des Sages Femmes du Sénégal*) includes about 600 midwives from both the public (90 percent) and private (10 percent) sectors. Most private sector members are former MSP employees who now own private clinics. The purpose of the *Association* is to promote the midwifery profession and improve its members' knowledge and skills to deliver high quality services. One of the *Association*'s long-term goals is to have a *Syndicat des Sages Femmes* that would play a similar role to the existing one for doctors. The *Association des Gyneco/Obstétriciens* and the *Association des Sages Femmes du Sénégal* have an agreement under which members of the midwife association can be associated members of the Ob/Gyn association.

3.4 BARRIERS TO PRIVATE SECTOR EXPANSION

Considering the relative poverty of the Senegalese population, the private health sector is well developed in Senegal and does not face an overly restrictive or adverse environment. It has had the opportunity to grow over time and is a critical source of health services and products in Senegal. In the past, the private sector's growth was aided by a slow-down in hiring by the GOS, which left many providers looking for employment; several opened their own practices, some operated out of their homes, others were employed by private companies with workplace clinics, and some remained unemployed. Despite the positive environment, there are still constraints that prevent the private sector from reaching its full potential.

Limited purchasing power limits the number of potential private sector clients: In a country with gross national income per capita in purchasing power parity terms of only US$1,830, and a high share of health expenditure coming from out-of-pocket payments,[3] there are a limited number of Senegalese consumers who can pay the full commercial price for their healthcare. Even in Dakar, where it is safe to assume that incomes are higher, a number of providers interviewed reported that the private health sector has stopped growing due to a saturated market. There are fewer private practices in rural areas, where incomes and population density is lower, so it is unlikely that there are good market opportunities for private providers outside the major cities.

Senegal has many health financing schemes, including community-based mutual health organizations (MHOs), and workplace-based private insurance (*Instituts de Prévoyance Maladie,* IPMs). In theory, such schemes could increase demand for private commercial services, but many of the MHO schemes restrict reimbursements from private commercial providers. The focus of MHOs is to reduce the burden of out-of-pocket payments for drugs and users fees for clients obtaining their service in the public sector. Moreover, it is estimated that less than 300,000 people are covered under MHOs and about 700,000 are covered under IPMs. Please refer to the Health Financing section for current and potential financing options in Senegal.

Providers interviewed during the assessment said that the majority of their clients are covered by private insurance (e.g., IPM), through their employer. Without this insurance, many people might not be able to afford the service fees charged by private providers. Thus, the private sector is constrained by the relatively small number of formal sector workers as well as by people's income. One private

[3] In 2003, 55 percent of total health expenditures were out of pocket (WHO 2006).

provider from Kaolack told the team that if it were not for the insurance reimbursements, he would not be able to survive. Without more effective demand-side financing schemes, the only viable private health operations in rural areas are likely to be traditional providers or ones that are heavily subsidized by donors.

The requirements for private sector facilities are the same in rural areas as in urban ones, even though the health services requested are often more basic and the possibility of cost recovery and profit less likely in rural areas. Some private providers might be induced to move into rural areas if they could open facilities with slightly downgraded scopes of practice and with slightly more relaxed operating requirements than in urban areas while still maintaining the quality of services. This could help facilitate the creation of networks or otherwise reduce operating costs in low-density areas.

Difficulties in obtaining credit: Prevailing interest rates are perceived by providers to be high relative to their opportunities for generating profitable returns (the discount interest rate is currently 4.75 percent, though banks are allowed to apply interest rates up to 18 percent for a loan) (Dem, 2008). To open a private facility, a lot of capital is needed to obtain office space and purchase equipment and materials; most providers do not have ready access to enough investable capital. Loans are needed to assist private providers in this endeavor, but some have difficulty in obtaining loans, and others appear to be suspicious of them. Banks will typically make significant collateral requirements for loans and providers may be afraid of losing their assets if they cannot maintain their loan repayments. Prospects for generating a profit is better in Dakar, so loans may be more accessible to providers opening up businesses there; however, as previously noted, providers perceive the market to be saturated.

In order to be given a loan, a private provider must:

- Provide data or studies to convince the bank that it is a worthwhile investment and one with limited risk;
- Put forth 25–30 percent of the total value of the loan in personal capital; and
- Provide collateral or a guarantee for the loan, such as a house.

One representative of the financial industry stated that many medical provider applicants do not provide adequate data to support their applications and convince banks that there is limited risk associated with opening the new facility. This may be because the data are simply not available or because the applicant does not understand how to present the information in a persuasive and clear manner. Secondly, the requirement of 25–30 percent of the total value of the loan is a large sum of money that is often unattainable, especially for newly graduated providers.

Fortunately, some positive steps have been made to increase access to loans for private providers. Realizing that capital is essential for providers to open private practices, the *Syndicat de Médecins Privés* has negotiated a partnership with two banks to offer special terms for loans to its members. If a provider obtains one of these loans and begins having financial difficulties, the *Syndicat* can draw on funds in a special account developed to help ensure that the provider does not default on his or her loan. Of the provider associations interviewed by the assessment team, this was the only one that had developed such a partnership.

Providers report having limited business management skills: Providers reported that lack of business management and marketing skills often are a hindrance to their success. Business management skills are not included in current medical training curriculums, despite their necessity in ensuring that private providers manage their business practices in an efficient and effective way, enabling them to invest in quality improvement, add services, and grow as a sector. Providers specifically mentioned their desire to strengthen their ability to manage data to track income and expenses, more accurately price services, and manage client files more effectively. Also critical to the success of private practices is steady client flow. Providers need to know how to attract new clients to their practices using accessible marketing techniques, such as promoting word-of-mouth recommendations from current clients.

Legal and regulatory barriers to service provision: Though the current legal and regulatory framework for the private sector is not overly burdensome, there are some impediments. Private nurses, for instance, are not legally allowed to prescribe medications, while their public sector counterparts are. This does not mean that private nurses never prescribe medications, as some do, but they are putting themselves at risk for government sanctions. It should be noted that there were divergent opinions among informants regarding the nature of this restriction on nurses. Some were categorical that nurses were not allowed to make any prescriptions under any circumstances, while others maintained this was possible. As another example, pharmacists are not allowed to own *depots de pharmacie*, which creates little incentive for private pharmacists to ensure the quality of their services or help them avoid stock-outs.

In a country with a shortage of higher-level providers, particularly specialists, certain services are not readily available throughout the country. For example, only Ob/Gyns and surgeons are legally allowed to conduct Cesarean sections and are the only providers trained in this procedure. However, there are only about 100 Ob/Gyns for the entire country and few surgeons (located mostly in Dakar) to meet the needs of all pregnant women in need of this procedure. Often this procedure is simply not available as there is no provider within a reasonable distance capable of doing it.

Additionally, providers report that they are burdened by fees required by government policies, which cut into their profits and their ability to stay financially viable. Private providers must pay yearly registration fees, fees to local governments, yearly membership fees to the *Ordre* (in some cases), and other tariffs. The assessment team was not able to judge how large a percentage the cumulative affect of the various fees is on the average private practice.

3.5 RELATIONS BETWEEN THE PUBLIC AND PRIVATE SECTORS

The Senegalese government understands that the private health sector can make important contributions to public health goals and is engaging the private sector to a certain degree. Most of the stakeholders interviewed by the team reported a relatively congenial relationship between the public and private sectors although there is some mistrust of the government by private providers.

It is encouraging that there exists the Department of Private, Workplace and Traditional Medicine (*Division de la Médecine Privé, Médicine du Travail, et Médicine Traditionelle,* DMPMTMT), and the Public-Private Partnership (PPP) Unit (*Cellul d'Appui au Financement de la Santé et au Partenariate,* CAFSP), but their resources are limited. The DMPMTMT has a mandate to work with projects implicating the private sector, to bring the private sector "into the mix," ensure proper application of laws, and authorize

new private facilities. Unfortunately, this division is staffed by only two people and has limited financial resources. While they have developed an operational plan detailing future activities, implementation will likely suffer from these constraints. Additionally, representatives mentioned that they are unable to play a supervisory role for the private sector and have no current database of private providers in Senegal. With such limited means, the DMPMTMT is only able to authorize new private facilities, despite their desire to do more and realize their mandate.

CAFSP is supposed to foster dialogue between the public and private sectors and address issues related to health insurance, but has only one staff person to manage this large effort. In January 2008, CAFSP released a protocol for the elaboration of national health accounts in Senegal, with a section focused specifically on RH. Such a broad scope of work seems to make it difficult to address and achieve all its goals. When asked about priorities, increased funding and resources was cited first, along with the desire to see greater application of the contracting policy and initiatives to increase financial access to the private health sector.

PPPs: Recently, the private sector has been invited more frequently to participate in government- and donor-sponsored working groups. Private sector representation typically consists of private provider professional associations that attend these meetings on behalf of their members. For instance, the DPL works mostly with the private sector and has partnered with the *Syndicat des Pharmaciens* to combat the sale of counterfeit pharmaceuticals. However, there does not yet seem to be great consistency in involving the private sector, as some private sector representatives mentioned not being invited to certain GOS events.

The team was given other examples of PPPs, such as the practice of private providers purchasing essential drugs from the National Supply Pharmacy (*Pharmacie National d'Approvisionnement,* PNA) to sell in their facilities at a pre-established price, which is less than the cost of name-brand pharmaceuticals. This is done not only to address issues around financial access, but also in an effort to reduce the likelihood that people will purchase drugs from the illicit market. The team visited the clinics of two midwives and spoke with a representative of AcDev, who explained that they offer FP commodities provided by the PNA through their respective health district offices. When they sell products obtained from the PNA, they send information on users and the products sold to the health district offices for monitoring purposes. One private midwife showed the team a free refrigerator she received from her health district for cold chain vaccination storage.

Finally, GOS representatives mentioned that all government-sponsored provider trainings are open to the private sector and that they are willing to hold the trainings on weekends. However, it is unclear how many private providers have taken advantage of such trainings or whether any have happened on the weekends as suggested.

There is need for further relationship building between the public and private sector: Not surprisingly, the public and private sectors do not always collaborate well. The GOS has ongoing needs to collect data from the private sector, but has not been successful in getting consistent reporting from private providers. The private sector feels it has largely been ignored by the government for years and has not benefitted from donor investments in the health sector. Some private providers are reluctant to report data to the government out of fear that it will be used to increase tax assessments. As a result, private sector providers often refuse to provide the requested information. Some informants reported

that the public sector sees the private sector as a source of competition. Whether well founded or not, such perceptions reflect a lack of trust between the two sectors.

Fortunately, the GOS has already taken the necessary preliminary steps to engage the private sector, and is in some ways more progressive than other West African countries. Progress in PPPs will require improved communication and understanding between the two sectors, as well as introduction of new models for PPP.

4. SUPPLY AND DEMAND OF FAMILY PLANNING

4.1 DEMAND FOR FAMILY PLANNING PRODUCTS AND SERVICES

Demand for FP services is stagnant and low. Rural areas have the greatest demand for increased services and service providers, as so few providers are found there. Although the 2005 DHS reports that Senegal has an unmet need of 30.2 percent for all women, it is not an accurate indicator of effective demand for contraceptive products and services. Many women may indicate a hypothetical desire to postpone their pregnancies, but are not prepared to actively seek out contraception or even accept it when it is proposed. The factors that determine whether potential demand becomes effective demand are numerous; a few select ones are detailed below.

Factors that influence demand for FP: One of the key drivers of contraceptive use, female education, seems to have made little progress in recent years. Sixty percent of women in the 2005 DHS sample received no formal education as compared with 65 percent in 1999, and 67 percent in 1997. Even in the 15–19 age category, 47 percent have received no formal instruction. Female illiteracy is also about one and a half times higher for women than for men: 65 percent versus 44 percent.

Lack of knowledge does not appear to be a significant barrier to effective demand. Over 90 percent of men and women know modern methods of contraception and over 80 percent know methods that are most commonly available: OCs, condoms, and injectables. Direct knowledge through use has also increased since the last DHS, from 17 percent of women having ever used modern methods to 26 percent in 2005. This is still low, however, compared with knowledge of contraceptives, which suggests that encouraging trial may be one effective strategy.

Cultural resistance to FP and contraception still seems to be strong in Senegal. Though the influence of the Islamic religious leaders (*marabouts*) is often cited as a factor limiting use of FP, only 10 percent of non-users cite religion as a reason for non-use in the 2005 DHS. By contrast, 22 percent of non-users simply say they are opposed to FP, which suggests more broadly held pronatalist beliefs. Further evidence of this is the slight difference between what married women cite as the ideal family size and the actual number of children per woman.

A strong stigma against open discussion of sex, contraception, and fertility persists in Senegal. On more than one occasion, the assessment team remarked on the lack of visible point-of-purchase materials advertising *Protec* or *Securil* (ADEMAS' two products) in pharmacies, and the fact that the products themselves were not clearly displayed. Additionally, pharmacy staff interviewed by the team said that consumers prefer to be discrete when purchasing condoms and that many consumers are too embarrassed to ask for the product by name. Instead, they simply put 150 CFA on the counter, which is understood to be a request for *Protec*. These examples point to the need to change social norms around RH and contraception as well as related influences such as gender norms and couple communication.

Changes in demand for FP products: Interestingly, demand seems to have grown more in rural areas than in urban ones, where CPR has declined slightly, from 19 to 18 percent in 2005, while CPR doubled to 5 percent in rural areas. This shift in demand could explain, in part, why ADEMAS' sales and Couple Years of Protection (CYP) have essentially been flat (Table 2). Although ADEMAS' sales have increased or remained stable, a slight decline in urban CPR is still possible. Even when sales increase in the range of 5 percent, CPR will not increase since the number of women entering into reproductive age increases every year. Social marketing programs tend to reach urban populations more effectively than rural ones, but it is impossible to determine where social marketing products have been consumed. It is quite possible that increased public sector and NGO efforts have driven most of the increase in rural demand.

The minor increase in *Protec* sales in 2006 and the decline in 2007 may also have to do with the lack of brand promotion and the emergence of other brands on the market that are only slightly more expensive, such *Visa*, which is also sold by ADEMAS' distributor, Valdafrique. Although the assessment team was not able to obtain total market figures for condoms and pills, there is no evidence of any sharp increase in sales that would reflect a general increase in demand.

TABLE 2: ADEMAS COUPLE YEARS OF PROTECTION

	2003	2004	2005	2006	2007
Protec	34,928	36,286	39,450	40,377	37,603
Securil	2,879	3,826	4,898	7,632	10,018
Total CYPs	37,806	40,113	44,349	48,009	47,621

Current communication efforts: This shift may also reflect the lack of highly visible mass media promotion in favor of FP. Recent efforts in support of FP have emphasized integration of FP into broader RH and MCH initiatives. In addition, the main channels of communication about FP appear to have been through community-based organizations and provider counseling. While perhaps more socially acceptable, these strategies may have left a gap in reaching all potential modern contraception adopters, potential urban ones in particular.

USAID and UNFPA have begun to address the mass media gap by investing in radio serial dramas through the Population Media Center. The center will be employing state-of-the-art techniques for a radio drama that should be effective in attracting audiences. However, the radio dramas will cover a variety of health themes including HIV, tuberculosis, MCH, and RH in addition to FP. Besides the diversity of health and social topics, the need to maintain dramatic interest may mean that the FP messages are diluted. Given deep-seated resistance to FP in Senegal, a broad-based approach (such as that employed by the center), which addresses underlying cultural and social issues, is appropriate. However, it is clearly part of a longer-term strategy. On its own, the radio drama's impact will not be great enough to incite many women with unmet need to try a modern contraceptive or to destigmatize its purchase and use, as it takes some time for people to change their perceived social norms. Even after that has been achieved there are likely to be many barriers around self-efficacy.

Many women do not feel they can use contraception without their husband's approval, or otherwise do not feel empowered to control their fertility; as such, they do not plan to use contraception, even if they feel it has generally become more acceptable. In the short-term, there is still a need for communications

that appeal to urban audiences where potential users already feel that they could use contraception, but need to be reminded of the ease of use or need to have their myths about side effects dispelled. Such potential users will respond to communications that address issues around FP and contraception more directly. One very positive sign is that USAID and the GOS have recently launched a National Family Planning Day campaign with the MSP and the First Lady. In addition, the Ministry of Finance is sponsoring large communications and events for World Population Day. These efforts combined with social marketing efforts to support specific methods may also help to convert more potential users into current users.

One might expect a social marketing organization such as ADEMAS to be a more visible agent in favor of FP and pushing the agenda for social change. However, during 2007, the organization spent less than 15 million CFA (around US$36,000) for all public relations and promotion for both *Protec* and *Securil*. A figure many times that amount would be needed to conduct a large-scale campaign of the level that might influence current attitudes and practices, or even to stimulate "intenders" to become users.

4.2 SUPPLY OF FAMILY PRODUCTS

Although the assessment team did not have the means to conduct a thorough assessment of the public and private supply chain, the team's overall impression is that the combination of public, private, commercial, and social marketing channels are more than adequate to meet the existing levels of demand. This is not to say that there is no need for improvement in the existing supply chain, but in general, the low levels of use do not appear to result from poor supply systems.

The distribution system for FP products: As is desirable to achieve contraceptive security, FP products can reach the end user through multiple channels. The public sector used to supply contraceptives through the DSR's parallel distribution system for government facilities. More recently, they have integrated contraceptive supplies into the system of procurement and distribution managed by the PNA.

The PNA was set up as a parastatal with capital from the government, but it is able to operate autonomously. It has 11 regional warehouses throughout the country and may supply directly to public sector entities on an order system. In addition to distributing medicines, medical products, and supplies to the public sector, it manages the processes of tendering, importing, and testing medicines and products obtained on the international market. Most drugs distributed and sold through the public sector are subject to Bamako Initiative policies, meaning that consumers are required to pay for their products to ensure sustainable supply; there are some drugs and products that are highly subsidized or free to users.

Given time constraints during the assessment, the team was not able to assess average resupply times in the public sector. Since 35 percent of contraceptive users obtain their products from public sector *postes de santé* (DHS 2005), if the PNA can procure and supply contraceptives that reach the *postes de santé*, they could become an important player in achieving contraceptive security. Up until this past year, it has not procured any contraceptives, but PNA reports that it will begin purchasing OCs this year.

Since January 2003, the PNA has been able to procure and sell approximately 30 generic medicines to the commercial pharmaceutical channel. This is done partly to ensure that consumers who obtain their medicines from retail pharmacies have the option of using a generic product at a lower cost rather than

a more expensive branded one. Currently, about 16 percent of the PNA's sales are through the private commercial channels.

Commercial wholesalers contacted by the team seemed unhappy with this arrangement, but they clearly understood that their role was to fulfill the requests of retail pharmacists and their clients. On the one hand, they expressed dissatisfaction, due in part to the competition the PNA creates for their higher-margin products. However, they also cited well-founded concerns that the PNA does a poor job of supplying medicines in consistent packaging and doses as a result of their procurement practices. Currently, the PNA obtains all of its medicines through international tenders, which means they often switch manufacturers of the same drug. The variation of the packaging, format, and dosage can lead to confusion among the prescriber and consumer. Of course, the PNA must continue to source through open, competitive tenders, but it is important to understand how the types of products the PNA will distribute will compare with those distributed through the private sector and why consumers may prefer the commercial brands.

Commercial channels for product supply seem to be simpler and more efficient than the public sector. There are four major pharmaceutical wholesalers: Laborex, Cophase, Sodipharm, and Sogen. The largest of these, Laborex, operates throughout West Africa and is affiliated with a French company. The products it distributes are obtained through a central purchasing office located in France. The other three wholesalers are affiliated with internationally recognized manufacturers whose drug quality is high. Because these wholesalers do not have to procure products through competitive tenders, their procurement processes are faster and their products more consistent in quality and presentation than those of the PNA. Moreover, each wholesaler has three to four regional warehouses (Kaolack, St. Louis, Zuiginchor, or Thies) and is able to resupply any pharmacy in the country within 24 hours. Pharmacies in Dakar or other cities are resupplied in a few hours at most; this was confirmed by a number of pharmacists, including some in Kaolack.

The wholesalers also complained of the unregulated *depots de pharmacie* that are supposed to be regulated by the DPL, but whose supervision is ineffective. According to the wholesalers and other pharmacists, the unregulated *depots* are the main outlet for counterfeit, low-quality drugs that come into Senegal via Mali and clandestine importations. This problem is particularly acute in Touba. According to Sodipharm, the illicit medicine trade is worth 10 billion CFA per year. Laborex and other wholesalers have indicated their willingness to support public campaigns against "*medicaments de la rue*," but are skeptical that there is the political will to seriously address the problem.

Opportunities to improve distribution of FP products: Overall, the assessment team did not see a shortage of product delivery points in Senegal. The "platform" for access to contraceptives is present nationally and fairly well distributed. By using data from the public sector on the distribution of pharmacies and *cases de santé* and combining them with data from the ADEMAS sales database on the distribution of boutiques and other outlets, one can see that the ratio of consumers to outlets does not vary tremendously from one region to another. As one would expect, the ratio is lowest in Dakar (Table 3). The highest ratio is 3,900 people per outlet in Kolda, which is likely to be an overestimate since that region did not report registered *cases de santé* to the government data service.

TABLE 3: ACCESS TO PRIVATE OUTLETS

Region	Population	Pharmacies	Boutiques	Other Outlets	Health Huts	Total Outlets	Ratio of Pop/Private Outlet
DAKAR	2,564,892	420	1671	255	26	2372	1081
Thies	1,442,338	79	326	55	255	715	2017
Louga	761,005	24	145	54	388	611	1246
Saint Louis	812,412	35	254	67	131	487	1668
Kaolack	1,171,428	37	312	63	296	708	1655
Fatick	675,486	11	210	43	279	543	1244
Ziguinchor	468,897	27	154	42	117	340	1379
Kolda	951,779	15	211	18	0	244	3901
Matam	514,469	18	167	10	53	248	2074
Diourbel	1,271,742	31	323	22	74	450	2826
Tamba	708,820	16	145	20	141	322	2201
Totals	11,343,268	713	3918	649	1760	7040	1611

Source: ADEMAS Database 2008, MSP Statistiques Sanitaires de Base 2007

It should be noted that Table 3 does not represent the universe of outlets selling FP products; it shows the universe of outlets that could be selling them. The purpose of this analysis is to assess whether the basic distribution infrastructure is sufficient for making FP products more accessible. While this is a rough indicator, an average of 1,611 people per outlet should mean that the infrastructure for access is sufficient.

Even if the number of product delivery points is sufficient, this does not mean that there is not work to be done on the supply side. For instance, more effort can be made to increase linkages between retail delivery points and the various sources of supply. According to DHS data, very few consumers procure their contraceptives from pharmacies, in spite of the fact that these are widely accessible delivery points. This may reflect consumer preferences to obtain contraceptives from a trusted provider in a clinical setting. It may also be a reflection of the embarrassment both male and female consumers have in asking for contraceptive products in a retail outlet where confidentiality is less certain. ADEMAS could help to address this issue by working to destigmatize the purchase of contraceptives.

4.3 SUPPLY OF FAMILY PLANNING SERVICES

The team found the overall level of private sector engagement in the supply of FP services to be low. Private doctors, mainly general practitioners and Ob/Gyns, and midwives are the main sources of supply. As mentioned previously, most private service providers are concentrated in Dakar, limiting supply in certain locales. Also mentioned earlier, in the section on barriers to expanding the private health sector, were the unnecessary limitations on certain provider types to offer specific services. Restrictions on the prescription of contraceptives by nurses are of particular concern.

The largest private, nationwide healthcare network is the association of Catholic health posts, which appear to be well run and of good quality, but do not offer hormonal FP methods. If the public sector system were to fail in its provision of FP services, there would be few or no reliable back-up sources of services in the private sector, either not-for-profit or for-profit, operating outside of Dakar.

4.3.1 SERVICE PROVISION IN THE PRIVATE COMMERCIAL SECTOR

Private sector FP services are reportedly most commonly delivered in the private sector in the 90 offices of general practitioners and the 40 offices of Ob/Gyns. FP services, in addition to MCH care, are also being provided by private midwives who own private clinics (about 20 facilities). Another potential source of services is the 17 *cabinets de soins d'infirmiers*. If they were allowed to prescribe OCs or injectables, they could serve as another potential source of FP services, though some are reportedly doing so at present.

Advertising private sector services: The issue of advertising, which is restricted by the ONMS, appears to be a controversial one. Currently the ONMS does not permit any media advertising of specific clinics or health facilities. Though a relatively common regulation throughout francophone Africa, it does constrain a social franchise strategy that depends on creating a perception of quality around a brand. Those who seem to be most affected by low demand expressed their desire to see this restriction eliminated. Providers with greater demand for their services prefer to maintain the current prohibition, citing the potential for unfair competition and abuse of advertising as their reasons.

Pricing of services: Until 1975, the GOS had full control over the pricing of services in the private sector. This policy was changed when the government recognized private providers as a "liberal profession," shifting pricing decisions to the providers themselves. Currently, pricing is determined with input from medical insurance companies. Under the present pricing structure, a medical visit with a general practitioner costs 4,800 CFA and 9,400 CFA with an Ob/Gyn. The *Syndicat* explained to the team that they recommend using judgment in the application of the pricing list, as prices are flexible and negotiable with individual clients.

The impact of demand for private sector and FP services: FP represents a small portion of private providers' business because demand is low and stagnant—and this stagnant demand for private sector services (FP services in particular) is a key barrier to expanded private sector service provision. Informants included several reasons for the stagnant demand, including client inability to pay for services, cultural and religious issues around FP, the tendency to access FP from the public sector or pharmacies, and low demand for FP services in general.

Issues related to quality of services: Despite the need for more quality-trained providers, key informants reported that current curriculums are out of date and are too lengthy in their time requirements for many types of providers. The reportedly excessive time requirements for the completion of medical studies limit the number of graduating providers each year. Without consistent updates to providers' training curriculums, they are not being informed of advances in medical technology to replace outdated knowledge. It also indicates a potential need for continuing medical education (CME), even among recently graduated providers.

However, there are currently no requirements for CME or for re-licensure of a provider or facility, measures that can help to improve quality of services. Many key informants mentioned their frustration

with the lack of clinical training opportunities available to them. This limits their ability to stay abreast of new treatments and technology and, thus, their ability to offer quality services.

A shortage of Ob/Gyns: There is an obvious and serious shortage of Ob/Gyns in Senegal. Each year, only about 10 graduate from a university, which does not come close to meeting current needs or demand for this type of provider. The *Association des Gyneco Obstétriciens* regards this as a major issue stemming from the duration of training programs and the limited absorptive capacity of the MSP for newly graduated Ob/Gyns. As a result, the *Association* feels that midwives can and should play an important role as female healthcare providers in helping to address this shortage. Members of the *Association de Sages Femmes* are also of the same opinion and have been supporting midwives in the provision of certain services, such as IUD insertion and the prescription of contraceptives.

The role of midwives in service provision: Representatives from the midwives association stated that midwives are well prepared to offer FP services. However, they did mention concerns about the quality of midwifery schools that have recently opened. There are now about 17 schools of midwifery in Senegal, the majority of them located in Dakar, that offer training of various levels of quality. Most of the schools are training programs for *Sage Femmes d'état* (state-certified midwives) and require students to pass a state-issued exam at the end of their studies in order to become practitioners. Some of the new schools have yet to have any of their students pass the final exam. Since no one is responsible for overseeing the quality of the instructors and curriculums, the *Association* is concerned about the quality of training being offered. They also expressed concern over the absorptive capacity of both the public and private sectors to employ the number of midwives who are now entering the workforce (there were 166 graduates in 2007).

The team visited two private midwife clinics during the assessment. The first was established 19 years ago in Dakar by a former public sector midwife. The clinic offers a wide array of MCH care services, including FP and deliveries. Private doctors are brought in as consultants on an as-needed basis. The clinic operates 24 hours a day, 7 days a week, with the support for three midwives and supporting staff. In 2003, this midwife opened a school for state-certified midwives above her clinic after she experienced the effects of a shortage of quality-trained midwives. The first and second graduating classes numbered 42 and 23, respectively. All but two have found employment in either the public or private sector.

The second clinic in Dakar was also owned by a former public sector midwife. The clinic is staffed by three midwives, four nurses, one full-time general practitioner, one part-time Ob/Gyn, and one part-time pneumologist. FP services are provided most frequently by clinic midwives, who offer OCs, injectables, condoms, and IUDs. The owner explained to the team that contraceptive commodities, vaccines, and supplies that are part of the national immunization program are obtained from the PNA through the nearest health district office. Each month, the clinic submits a statistical report on products sold to the health district office.

4.3.2 SERVICE PROVISION IN THE PRIVATE, NOT-FOR-PROFIT SECTOR

At present, there is no single, major provider of modern FP services. According to some informants, ASBEF, the International Planned Parenthood affiliate, no longer plays the dominant role in the provision of FP services that it once did. However, they report having served over 80,000 clients in 2006 through 16 service delivery points. During the assessment, the team visited two NGOs involved, to different

degrees, in the provision of health and FP services: the Association of Private Catholic Health Posts in Senegal (*Association de Postes de Santé Privés Catholiques du Sénégal,* APSPCS) and AcDev.

APSPCS: Established in 1967 by the Conference of Episcopal Bishops of Senegal (*Conference Episcopale des Eveques du Sénégal*) as an association, APSPCS works in coordination and collaboration with the MSP, the Ministry of Social Development and Solidarity (*Ministère de la Développement Sociale et de la Solidarité*), and the Institute for Health and Development (*Institut Santé et Développement*). APSPCS was created to organize competent and functional health facilities that are able to address health problems using preventive and curative means; coordinate activities and facilitate the exchange of experiences; and harmonize interventions with the country's development objectives. Specifically, the *Association*'s mission is "to support the GOS's prevention, education, MCH, environmental health, and the utilization of essential drugs efforts."[4] Their target population is defined as all Senegalese, with a focus on the poor, regardless of race or religion.

APSPCS affiliates operate 76 *postes de santé* nationwide, 35 laboratories, 160 *cases de santé*, and 18 AIDS service units. The network of facilities provides an integrated package of preventive and curative services with a focus on addressing prevention and control of such endemic health concerns as malaria, HIV/AIDS, tuberculosis, and leprosy. Natural FP methods are also included in their services. Prices of curative services vary by location. For instance, a curative visit to the *Dispensaire Saint Martin* in Dakar costs 500 CFA, exclusive of medications, while the cost increases to between 800 and 1,000 CFA (medications included) at a similar *dispensaire* in Kaolack.

The most important service offered by APSPCS to its affiliates is the provision of essential drugs, which are purchased in bulk twice a year. Local procurement is done through the PNA, local manufacturers, and wholesalers, while international procurement is done through the International Dispensary Association (IDA), based in Holland.

Finally, APSPCS opened a midwifery school in 2002, which currently has 111 enrolled students and has already seen three classes graduate. Though APSPCS does not promote hormonal methods of contraception and does not offer them in its facilities, the school must include information about them in their curriculum, as there are questions on the state exam about these methods. The APSPCS network is strong, but as previously mentioned, because it does not include hormonal methods, it leaves Senegal lacking a strong private sector network for the provision of FP services if the public sector fails.

AcDev: AcDev is an NGO dedicated to vocational training, income-generating activities, micro-credit, and the provision of health services. AcDev has established five polyclinics located in different regions of Senegal, two of which are still under its management. The others have been handed over to the local communities that manage the clinics. AcDev reports that all of these polyclinics are fully sustainable, which is the main thrust of all their activities. Under its current structure, AcDev is able to take revenue from its polyclinics if the NGO does not meet its own revenue needs. AcDev later returns the funds to the polyclinic.

The polyclinics provide a comprehensive package of preventive and curative services, including deliveries and FP, which is provided by midwives. Ancillary services include laboratory tests, x-rays, and mammography. FP commodities and other drugs are obtained from the PNA through the local district

[4] APSPCS informational brochure

health office. Prices of services range between 500 and 1,000 CFA with medications included and are based on the age of the client. AcDev is only willing to expand further its geographic reach with new polyclinics if achieving sustainability is certain.

4.4 HEALTH FINANCING IN THE PRIVATE SECTOR

One of the drivers of expansion of private sector provision of health products and services is the utilization of health financing strategies, including contracting out, voucher schemes, health insurance, prepayment schemes, and MHOs. Senegal has examples of several of these.

MHOs in Senegal: As noted, there has been a slow expansion of mutual health schemes throughout the country. Although MHOs are a potential source for FP funding, their focus may be different—they seem to be concentrating on reducing the burden of Bamako Initiative fees on lower-income groups, who receive services from the government *postes de santé* and do not encourage consumers to use private, for-profit providers. The MHOs contacted by the team in Kaolack said that while some of their members requested using private, commercial providers, their premiums (membership fees) were nowhere near enough to cover services from theses providers and thus, were not an option.

Moreover, the MHOs contacted admitted to being challenged by many operational problems. In spite of using volunteer labor for much of their management and administration, membership fees were reportedly not sufficient to cover payouts and, as a result, the MHOs were steadily drawing down on their reserves. Furthermore, their membership suffered from problems of adverse selection, because the schemes try their utmost to satisfy membership desires, even when that means having to work with a small risk pool of self-selected members. Far from supporting private sector provision of care, these MHOs themselves may struggle to survive. The biggest beneficiaries of the MHOs appear to be the government *postes de santé*, which do not have to record as many of their cases as social cases and have recovered more of their operating costs as a result.

The potential for voucher schemes for health: The USAID-funded NetMark project is currently implementing a program in seven regions using vouchers to facilitate purchase of insecticide-treated nets. While it was beyond the scope of the assessment team to judge the effectiveness of this project, the mere fact that the scheme is operating is progress in terms of how consumers and the health establishment understand how to work with the private sector. With this experience fresh in people's memory, it may now be possible to design and implement voucher schemes for service packages or other health products. If there is interest in such an effort, voucher schemes for RH services are currently being financed in Kenya with some success, so a similar model may be replicable in Senegal.

Quality improvement linkages to financing schemes: Thus far, there do not appear to be any programs that have linked quality improvement to financing schemes. Typically, quality improvement (i.e., training, certification, accreditation) schemes are most effective in engaging the private sector when the financing can also serve as an incentive for achieving and maintaining quality standards that can be verified by public sector stakeholders and communicated to consumers. Examples of such schemes include health insurance that accredits private providers before they can participate in the scheme. The attraction of being able to get new clients with an ensured ability to pay for services provides motivation to private providers to meet the quality standards set by the insurance program. Another approach, being piloted in East Africa (Kenya and Uganda), involves output-based aid in which providers must

be certified to provide a defined package of services (e.g., safe motherhood) and clients are given a subsidized voucher that can be redeemed only at approved providers.

Finally, while there are some private health insurance and prepayment schemes for employees of private companies, these are relatively small and serving a population that has greater ability to pay. Moreover, contraceptive supplies and FP counseling are not a covered benefit in these schemes.

5. RECOMMENDATIONS

5.1 SHORT-TERM RECOMMENDATIONS

Mobilize resources for a communication campaign focused on FP: Greater investment in demand-creation efforts for FP is greatly needed. The CPR has been stagnant and has declined in urban areas. Reaching urban groups is traditionally the comparative advantage of a social marketing campaign. However, so little mass media advertising has been done, it seems that some rural groups may be more exposed to FP messages than are urban youth. Instead of taking a low-key, broad long-term approach—as has been the tendency in the past—a more visible campaign is needed, targeted at "low-hanging fruit" that have the greatest potential of adopting modern contraceptives. The investment being made in the Population Media Center is wise, but will not have short-term benefits for FP use. Although FP is one of the subjects, it is a small part and it is still important to address some of the underlying barriers to FP use such as gender and violence against women.

The existing budget under the USAID project will not permit a large-scale mass media campaign. However, ADEMAS could take the lead in fundraising, negotiating reduced air-time costs, and possibly using KfW funds (if the grant permits) to implement a broad-based campaign that could destigmatize condom use (whether for FP or HIV), address the concerns of the non-users with unmet need, and raise awareness among youth coming into their sexually active years.

The KfW project is preparing a campaign targeting youth, which would seem to provide an overarching communications structure to disseminate these messages. *Protec* advertising should increase as well, but need not be the focus of the campaign. As the assessment team understood it, the upcoming campaign will create an umbrella brand that it uses to promote a new condom; this also 'houses" the concept of healthy, mature youth. The name of the campaign is "*fagaru jotna*," which youth are supposed to understand to represent healthy, responsible attitudes and all relevant behaviors: counseling and testing, abstinence, condom use, and fidelity, as appropriate. There would appear to be no reason why these concepts should not include contraception use as well. A series of radio and television spots could be produced and aired that would address all of these different demonstrations of responsible RH with the *fagaru jotna* brand, logo, and jingle serving as the federating element. If existing KfW funds are inadequate or restricted to HIV messages, ADEMAS should submit proposals to UNFPA and foundations focused on RH to leverage the investment of KfW into FP.

Other options include a general category campaign along the lines of the "Condom, Bindaas Bol" Campaign in India (which reversed declining condom sales in the northern part of the country) or repositioning FP as a MH initiative. Given the focus on MH initiatives in Senegal and the tendency to avoid FP for socio-cultural reasons, positioning FP as a MH intervention may strike a chord among potential users and healthcare providers. This would also allow for tie-in with government MH efforts. Moreover, framing FP in this way may offer opportunities for behavior change communications to encourage people to have smaller families. However, this would be a weighty undertaking since desired family size is close to actual family size.

Promote CycleBeads and fertility-awareness methods in the APSPCS Network: Although the APSPCS does not offer hormonal contraception, it does promote and counsel on natural FP methods. These efforts are somewhat limited, however, and these efforts could be strengthened by including CycleBeads and offering more promotional literature on other fertility-awareness methods. Given the size and reach of the APSPCS Network of clinics, and the number of female clients receiving maternal care from APSPCS, this is a significant missed opportunity. In addition to promoting fertility awareness methods, communications materials on the importance of birth spacing for MCH could also be disseminated through APSPCS. Users of natural FP methods (who may be apprehensive about trying a hormonal method) are more likely to begin using modern methods than those who have never used any methods and who may not yet appreciate the importance of birth spacing. Once women using natural FP are convinced of the benefits of birth spacing, they may switch to a modern method that provides greater protection and peace of mind.

Institute relicensure requirements and link them to CME credits: To help maintain an adequate level of quality in the private sector, efforts should be made to institute relicensure requirements. Currently, private providers need only apply for and obtain an initial license to operate a private facility. Private physicians should be expected to renew their medical licenses every two to three years and a condition for doing so should be to demonstrate participation in medical education. Requiring CME credits will help to ensure that providers access trainings to update them on techniques and changes in technology and offer their clients higher-quality services.

5.2 LONG-TERM RECOMMENDATIONS

Support a policy change to allow pharmacists to open *depots* in underserved areas: As noted above, the number of product/service delivery points in the country is adequate and is not, in the view of the team, a significant barrier to increasing CPR. However, there are always underserved areas and the lack of consolidation at the retail level makes it difficult for pharmacists to achieve any economies of scale. It also increases the likelihood that low-quality drugs can come into the circuit because of the level of unregulated *depots de pharmacie*. To address this, the team recommends allowing pharmacists to own *depots* so they will have the power to hire and fire *depot* managers, and enforce sourcing from appropriate supply channels and proper dispensing procedures. Pharmacists would also have an incentive to make sure that *depots* are not found in urban or peri-urban areas where they would undercut their pharmacy business, but would instead be found in truly outlying areas serving consumers who cannot easily reach pharmacies.

This would require that existing *depots* find pharmacists to take an ownership stake in the *depot* or go out of business. Some in government already think that *depots* should be closed because they feel that this scope of practice is being abused. Yet there is an economic need for less expensive drug shops carrying quality-assured essential medicines at the community level. If the formal *depots* are banned, it seems that many of the illicit *depots* will continue to operate since many of them are already in violation of the law. In either case, better enforcement of the laws on pharmacy and *depots de pharmacie* practices is needed. As with most significant policy and advocacy work, further study of the issue is required to determine the level of interest of pharmacists in owning *depots* and expanding their businesses and assess the best opportunities to test the policy under pilot conditions to control for possible unintended effects.

Changing ownership requirements for *depots* may lead to a broader discussion about ownership and staffing rules of pharmacies, which may also be too restrictive. One of the best mechanisms for creating sustainable subsidies for rural provision of care is to allow private providers to own and operate chains of pharmacies and second-tier drug shops. The expanded ownership opportunities could also be combined with requirements to open outlets in underserved areas. This would mean that the opportunities for increased profit from achieving economies of scale could be at least partially reinvested in serving areas where the current system does not allow providers to earn enough profit to stay in business.

Support a policy change to allow nurses to prescribe OCs and injectables: Engaging in a policy dialogue with the public and private sectors in support of allowing nurses to prescribe OCs and injectables is a potential means of increasing access to FP services. Policy changes often take time, but since some nurses are already providing this service, efforts should be made to harmonize the law and reality. This will help nurses access training in FP service provision, potentially increase the number of nurses prescribing FP methods, and eliminate their chances of being punished for providing a needed service. However, the team would not expect this policy change to have a major impact on use or CPR since most providers seem to be operating around this restriction.

Begin advocacy in favor of providing injectables at the community level: Another related policy change that will require a two-to-three-year advocacy effort would be to shift injectable provision to even lower scopes of practice, such as to community health workers. This change should become possible as the new technologies for delivering injectable methods, such as Uniject and other subcutaneous forms of injection, become more available. It was clear from discussions with many informants that policymakers in Senegal tend to be conservative about change, so dialogue should begin now if the provision of RH in Senegal is not to fall too far behind global trends. The first stages would be to draw attention to some of the successful uses of Uniject with community-based providers and then advocate for similar, well-controlled, and well-documented pilots in Senegal.

PPP against *médicaments de la rue*: Efforts have been made in the past to combat the use of counterfeit drugs in Senegal. However, these interventions have resulted in little success, leaving much work remaining to be done. To effectively combat the counterfeit drug market, all those impacted by its existence should be included in the solution. Developing a strong PPP between government regulating agencies (the DPL, Ministry of the Interior (*Ministère de l'Intérieur*), National Drug Enforcement Office (*l'Office Central de Repression de Traffic de Drogues Illicits)*, and local government representatives where the black market is strongest), the private sector (pharmaceutical manufacturers, distributors, and provider associations), and the community (community leaders and civil organizations), would enable efforts to take a holistic approach to addressing the problem.

Under such a partnership, stakeholders could determine the strengths each member could contribute and then develop an action plan for a campaign against the use of these drugs. For instance, the government may be able to contribute some funding as well as regulatory inputs; the private sector could provide some funding too, plus medical knowledge and authority to convey messages about the dangers of counterfeit drugs; and community-level representatives could help disseminate messages to their peers and serve as change agents.

The exact mechanics of this type of partnership would need to be developed with input from stakeholders to attain full buy-in and commitment. If funding is required for the campaign, efforts should be made to leverage funds from various sources so as not to place a financial burden on one or two stakeholders or give the impression that the major funder has greater control over the partnership than others do.

Strengthening the PPP Unit: The GOS has taken the first step in formalizing PPP by creating the *Cellul d'Appui*, a key step in strengthening the private sector and engaging it in public health initiatives. The next step is to strengthen it to support activities like the ones described above. The PPP Unit should serve as a resource or coordinating agency to help guide policy initiatives supporting the private sector or for PPPs that require ownership.

With only one staff person currently, whose attention is divided between multiple duties, it may be difficult to achieve many lasting results. Hiring another staff person, or revising the current staff's scope of work to focus solely on PPPs, would be one way of doing this. Another option would be to begin strengthening the relationship between the public and private sectors by building trust and goodwill. This could be done by meeting with various stakeholders and inquiring about their priorities for PPPs, as well as how to improve the public-private relationship. PSP-*One* has found that public-private working groups are an effective way of building support around a particular issue and engaging all stakeholders in implementing solutions.

Additionally, depending on the staff's experience and knowledge of PPPs, some degree of capacity building may be needed. PSP-*One* recently held a workshop in Addis Ababa, Ethiopia, for African PPP Units to share lessons learned, challenges, and best practices. Some individual technical assistance to impart this knowledge upon the *Cellul d'Appui* may help it to become more effective.

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ANNEX: ASSESSMENT TEAM SCHEDULE

ORGANIZATIONAL AFFILIATION	*CONTACT*
USAID/Senegal	**Ramatoulaye Dioume, Mary Cobb, Sylva Etian**
Abt Associates Inc./Senegal	**Dr Malick Niang**
UNFPA, Head of Reproductive Health Programs	
DIVISION DE SANTE DE LA REPRODUCTION	**Dr Fatou Nar Mbaye Diouf**
PNA	**Dr Daouda Chef Sce Technique + Mr Ndao-Raf**
WHO, Head of Reproductive Health Programs-OMS	**Mme Santos**
Sodipharm	**Dr Diaw-DGA**
SPS -MSH	**Dr Diagne**
LABOREX	**Mme Thiané Niang-Directrice de l'Approvisionnement**
Direction de la Sante	**Pr Oumar Faye**
FHI	**Mrs Hann et Mbaye**
Village SOS de Kaolack	**Dr Maïga**
Bureau Régional des Mutuelles de Santé de Kaolack	**Mme Cissokho**
Clinique Médicale Privé TAW FEX	**Dr Filbert Koly**
DIRECTION DE LA PHARMACIE	**Pr Papa Amadou Diop**
INTRAHEALTH	**Dr Manuel Pina**
AcDEV	**Mr Cheik Tidiane Adji**
Acquire Project/Engender	**Dr Abdoulaye Diagne**
Mid-Assessment debrief presentation at USAID	
UNION NATIONALE DES CHAMBRES DE METIERS DU SENEGAL	**Mr Ibrahima NDIAYE**
BASICS PROJECT	**Dr Aboubakry Thiam**
Association des Gyneco Obstétriciens-	**Dr Rose Wardini**

ORGANIZATIONAL AFFILIATION	CONTACT
ORDRE DES MEDECINS PRIVES	**Dr Ismaïla Sy**
SYNDICAT DES MEDECINS PRIVES	**Dr Ardo BA**
SYNDICAT DES PHARMACIENS	**Dr Aboubacry Sarr**
CLINIQUE MARIE	**Mme Mboup**
NETMARK AED	**Mme Fana Sakho**
VALDAFRIQUE	**Mrs Gamaury & Pasquale**
AFRICARE SENEGAL	**Mr Bonaventure Traoré**
SYNDICAT DES PHARMACIENS	**Dr Aboubacry SARR**
ASSOCIATION DES SAGES FEMMES	**Mme Mariéme Fall**
Ass. Professionnelle des Banques et Ets Financiers du Senegal	**Mr Abdoul Mbaye**
Association of Catholic Dispensaries	**Sœur Angéle Ndione**
Projet de Promotion des Investissements Privés (PPIP)	**Mr Mabousso Thiam**
UNACOIS	**Mr Ousmane Ndiaye SY**
ASSOCIATION DES MEDECINS D'ENTREPRISE	**DR Marème NDIAYE**
L'Association des infirmiers -Médecine du travail du secteur privé	**Mr Mamadou Diouf**
CCF	**Dr Mamadou DIAGNE**
CLINIQUE JABOOT	**Mme Codou S. Kane**
MINISTERE DE LA SANTE	**Dr FALL & Dr DIOP**