



The **POLICY** Project

Reproductive Health
Case Study

SENEGAL

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in collaboration with

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Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified the worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations in the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country case studies is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health.

The field work for the Senegal Reproductive Health Case Study was carried out from August 1 to 14, 1997. Interviews were conducted with 35 persons involved in reproductive health programs in Dakar, Senegal. Some additional information was gathered on a subsequent trip in November 1997. Discussions were continued with some of the original respondents, and health personnel and locally elected leaders were interviewed in the Louga, Fatick, and Kaolack regions.

The Directorate of Human Resources Planning (DPRH) of the Ministry of Economy, Finance, and Planning (MEFP), which is the primary organization responsible for planning, coordinating, and evaluating population policies and programs, sponsored the 1988 drafting of the Declaration of Population Policy. Unfortunately, the DPRH is hampered in its role by its low position within the government bureaucracy and a lack of ministerial-level support. Various committees and councils have been created to improve coordination among the different organizations working in population, but they remain largely nonfunctional. The Ministry of Public Health and Social Action (MSPAS) is the primary organization responsible for implementation of reproductive health programs. Most aspects of reproductive health fall under the Directorate of Hygiene and Public Health (DHSP), although the National Family Planning Program (PNPF), created in 1991, is a separate entity attached directly to the cabinet. Such structural division has led to disagreement over lines of authority between DHSP and PNPF. The MSPAS plans to merge all aspects of reproductive health into a single Reproductive Health Service. Other government institutions involved with reproductive health are the Ministry of Women, Children, and the Family (MFEF), which is the lead ministry working to reduce female genital mutilation; the Ministry of Education; and the Ministry of Youth and Sports.

For three reasons, the policymaking process in Senegal is open to the participation of nongovernmental organizations (NGOs). First, cultural traits encourage candid and lengthy discussion to develop consensus. Second, the government has realized it cannot do everything. And, third, donors strongly encourage participation. Moreover, the government's decentralization program has enhanced the potential for regional and community participation. As of 1997, financial resources and planning authority for nine sectors, including health, were transferred to 378 locally elected councils. Although fraught with problems in its first year, decentralization has provided greater opportunities for community groups and individuals to express their needs and interests in the program development process.

Introduced as a consequence of the ICPD, reproductive health is a relatively new concept in Senegal. Even after a number of workshops to disseminate the idea, the concept remains vague to many people. Most respondents felt that reproductive health is replacing family planning as a term and as a programmatic approach. Some respondents were concerned that the new reproductive health focus would overshadow and diminish efforts to reduce fertility; with the total fertility rate still high at 5.7, fertility reduction is an appropriate and important concern. Other respondents perceived an advantage in focusing on reproductive health as more culturally acceptable. Nonetheless, Senegal has been less receptive to the

ICPD *Programme of Action*'s reproductive and women's rights elements than those associated with health.

Senegal is strongly Islamic and socially conservative. Therefore, support for reproductive health tends to be muted. Many respondents felt that most opposition has been overcome in recent years but that political leaders and program managers remain extremely cautious and fearful of undertaking any initiatives that might be seen as controversial.

In the three years since Cairo, Senegal has been developing detailed plans for reproductive health, but implementation is just beginning. Several pilot projects are underway to address specific populations, such as youth or men, or specific components of reproductive health such as female genital mutilation or postabortion care. Increasingly, service delivery sites are moving toward integration, and some pilot sites are now completely integrated.

The government is increasing its funding for health in general, although donors provide the vast majority of funding for reproductive health. Sustainability is not a major concern at the central level, but health committees are increasingly generating enough funds to cover many local recurrent costs at the local level.

Constraints to the implementation of reproductive health programs include the lack of infrastructure, equipment, and personnel; sociocultural considerations such as the low status of women; legal and regulatory issues; health providers' attitudes; entrenched economic interests; and the overmedicalization of health.

The primary challenges for the future are to improve coordination among the various institutions working in reproductive health, generate grassroots support, ensure successful decentralization, and move from planning to implementation. Respondents stressed that only three years had passed since the ICPD and that it will take time for its impact to work into Senegal's health care system.

Abbreviations

AIDS	acquired immune deficiency syndrome
ASBEF	Senegalese Association for Family Well-Being
CBD	community-based distribution
COREPORH	Regional Committee for Population and Human Resources
DHS	Demographic and Health Survey
DHSP	Directorate of Hygiene and Public Health
DPRH	Directorate of Human Resources Planning
HIV	human immuno-deficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
MCH	maternal and child health
MEFP	Ministry of Economy, Finance, and Planning
MFEF	Ministry of Women, Children, and the Family
MSPAS	Ministry of Public Health and Social Action
NGO	nongovernmental organization
PNPF	National Family Planning Program
RTI	reproductive tract infection
SANFAM	Santé et Famille
STD	sexually transmitted disease
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations in the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on their epidemiological significance and recommendations from the ICPD *Programme of Action*, reproductive health care in these case studies is defined as including the following elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services** and safe abortion services where permitted by law;
- prevention and treatment of reproductive tract infections (**RTIs**) and sexually transmitted diseases (**STDs**) and **HIV/AIDS**;
- provision of **reproductive services to adolescents**;
- improvement of **maternal and infant nutrition** including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers**, including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with key individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, NGOs, women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support of and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

Interviews were carried out from August 1 to 14, 1997 with 35 people from 25 different organizations or

departments. Appendix 1 lists the organizational affiliations of the respondents. Some additional information was gathered on a subsequent trip in November 1997. Discussions continued with some of the original respondents, and health personnel and locally elected leaders were interviewed in the Louga, Fatick, and Kaolack regions.

2. Background

Situated at the extreme west of the African continent, Senegal is bordered by Mauritania to the north, Mali to the east, Guinea and Guinea Bissau to the south, and the Atlantic Ocean to the west. The country is medium-sized (75,954 square miles) and flat with sandy soil. The climate is characterized by a rainy season of three to four months and a dry season of eight to nine months.

The economy, which is predominantly based on agriculture (peanuts and millet), has deteriorated in recent years as a consequence of drought and other factors. Growth in the gross domestic product fell from 2.6 percent (1984–1988) to 2 percent in 1994. To reinvigorate the economy, the government of Senegal undertook a structural adjustment program in 1993. This program, together with the devaluation of the CFA franc in January 1994, has begun to bear fruit at the macroeconomic level, increasing levels of investment and bringing inflation under control. Despite these improvements, the structural adjustment program has imposed considerable hardship on much of the population.

The population in Senegal is predominantly Muslim (over 90 percent), with the rest divided between Christians and animists. Polygamy is common (47 percent of married women are in polygamous unions). Average age at first marriage is young (16.6) but rising slightly, particularly in urban areas. Illiteracy is high at 67 percent (World Bank, 1997).

Senegal's total population increased from 6,893,000 inhabitants in 1988 to 8,347,000 in 1995. The population growth rate from 1990 to 1995 was 2.7 percent. Fertility has decreased slightly, from 7.1 in 1978 to 6.6 in 1986, 6.0 in 1992–1993, and 5.7 in 1997. The decrease has been concentrated among young, educated women in urban areas. Contraceptive prevalence remains noticeably low: 8.1 percent of married women currently use a modern method, an increase from 4.8 percent in 1992–1993. In rural areas and among women with no education, contraceptive prevalence is particularly low at 2.1 percent and 3.9 percent, respectively.

Maternal mortality is extremely high, estimated at 510 deaths per 100,000 live births, due to early motherhood, high parity, inadequate pre- and postnatal care, and the low proportion of births attended by health personnel (according to the 1997 Demographic and Health Survey (DHS), 3 percent of births were attended by a doctor and 43 percent by a nurse or midwife).

Child and infant mortality rates have dropped dramatically in the past 25 years, particularly in rural areas, although the decline seems to have leveled off in the past five years. This rate remained high at 140 per 1,000 according to the 1997 DHS.

Concern about AIDS is widespread because the epidemic has hit hard in other countries in the region, although HIV seroprevalence in Senegal is surprisingly low at 1 percent. In fact, prevalence is so low that many involved with AIDS doubt that the statistic is accurate and call for further study to verify the rate. Statistics on the prevalence of STDs are unreliable; nonetheless, STDs are a major cause of infertility, which carries a high social stigma in Senegal.

Little data exist on abortion and postabortion complications. One study estimates that clandestine

induced abortions represented 1 percent of all deliveries and 1.3 percent of all maternal deaths (Traoré, 1992), while another study found that abortions represented 2.2 percent of deliveries and 3.4 percent of maternal deaths (Koly, 1991).

Data are similarly scarce on female genital mutilation. The practice is most common among the Poulard and Mandingue ethnic groups, who are concentrated in eastern Senegal. Overall, an estimated 20 percent of Senegalese women have been excised.

3. Policy Formulation

A. Structures for Policymaking

Population Policy

The Directorate of Human Resources Planning (DPRH) in the Ministry of Economy, Finance, and Planning (MEFP) is the government body responsible for planning, coordinating, and evaluating population policies and programs. According to several respondents and a sectoral assessment conducted by the DPRH (MEFP, 1997), the DPRH's effectiveness has been limited because of inadequate staffing and the directorate's low position within the government hierarchy. According to one technical assistance organization respondent, the DPRH was under the Ministry of Planning and had strong support from the minister. However, when the Ministry of Economy and Finance absorbed the Ministry of Planning in 1990 it did little to bring population issues to the fore; without direct ministerial support, the DPRH lost considerable influence.

In addition to the DPRH, Senegal created several different government bodies to coordinate population activities. According to respondents and the DPRH assessment, however, few of these bodies are functional. The National Council for Population and Human Resources, composed of ministers and presided over by the president, is the supreme authority and is supposed to meet every two years to review all issues and recommendations concerning the Declaration of Population Policy. One technical assistance organization respondent reported that the Minister of Finance, responsible for organizing meetings of the council, has not called a meeting in six years. In addition, an Inter-Ministerial Council—established to improve coordination between ministries involved in different components of a single plan and ensure that activities stay on track—rarely meets and is ineffective, according to some government and technical assistance organization respondents.

The National Commission for Population and Human Resources is a consultative body intended to formulate recommendations. It comprises representatives of all institutions responsible for implementing the Declaration of Population Policy, including numerous ministries and several NGOs and private associations. The commission has not met, however, since 1995.

Somewhat more promising is the Technical Population Oversight Committee, established to assist the DPRH in monitoring and evaluating population projects and programs. The committee is made up of project heads who meet quarterly to discuss issues related to program implementation. A technical assistance organization representative said, "This was very interesting, but the government gave no response to the problems brought up [by the committee], so the members eventually lost interest."

Equivalent to the National Commission for Population and Human Resources at the national level, Regional Committees for Population and Human Resources (COREPORHs) have jurisdiction over each of Senegal's 10 regions. The COREPORHs are a subgroup of the Regional Development Committee,

which is presided over by the regional governor and composed of the regional heads of government programs, department heads, elected officials (mayors and parliamentary representatives of the region), and NGO representatives. Some respondents reported that, in contrast to many of the national structures, these regional committees are highly motivated, active, and effective.

Health

The Ministry of Public Health and Social Action (MSPAS) is made up of four directorates, each of which embodies several divisions and services. Most aspects of reproductive health fall under the Directorate of Hygiene and Public Health (DHSP), as does the entire hierarchy of primary health—from community health posts to regional chief medical officers. Family planning, on the other hand, is a separate program known as the National Family Planning Program (PNPF). Created in 1991, it does not fall under any directorate but instead is attached directly to the Cabinet. The disjunction between reproductive health and family planning is accentuated by the fact that the PNPF and the DHSP are located in separate buildings several miles apart.

A technical assistance organization respondent reported, “The PNPF was essentially created by the [USAID-funded] Child Survival/Family Planning Project. USAID hoped that by separating family planning out and giving it a high placement, it would have greater clout.” Several respondents reported, however, that the arrangement has not worked well. Relations between the DHSP and the PNPF are tenuous, with disagreement over lines of authority. The PNPF’s lack of direct links to clinics has been problematic. Because the PNPF has no medical personnel and relies on the DHSP for technical expertise, it suffers from a lack of credibility with respect to technical capacity. Another difficulty with the division between the DHSP and PNPF, according to one technical assistance organization respondent, is that, although local and regional health personnel usually collaborate with the PNPF because it is a source of funds, the staff is ultimately responsible to the DHSP. At the same time, respondents reported that the PNPF’s high placement within the MSPAS has not provided the direct access to the Minister and Director of Health that had been expected.

According to the *National Health and Social Development Plan, 1997–2006*, a number of poorly coordinated divisions within the MSPAS are responsible for different aspects of reproductive health. Divisions include the PNPF (responsible for child survival, family planning, and AIDS) and, within the DHSP, the National Service for Large Endemics (responsible for immunizations and AIDS), the Division of Maternal and Infant Care (responsible for maternal health), and the Service for Nutrition (responsible for diarrhea control, nutrition, and breastfeeding). In addition, special programs target specific components of reproductive health, such as the National Program for AIDS Control. Several NGO and technical assistance organization respondents commented that both the PNPF and the National Program for AIDS Control are mandated to work on AIDS but do not collaborate. In 1986, MSPAS also made plans for a national program for maternal mortality, but because of lack of funds, it introduced a more modest pilot project to reduce maternal mortality in the Tambacounda region, with the idea of eventually expanding the project nationwide (MSPAS/DHSP, 1997).

Given the problem of poor coordination between programs, the *National Health and Social Development Plan, 1997–2006* proposes a restructured MSPAS and creation of a National Reproductive Health Program that would focus on the integrated reproductive health needs of three target groups as follows:

- children ages birth to 4—vaccination, exclusive breastfeeding, growth monitoring and nutritional supplementation, diarrhea control, and good weaning practices;

- women of reproductive age—prenatal care and vaccination, deliveries, postpartum care, family planning, control of STDs and AIDS, infertility reduction;
- adolescents—reduction of female genital mutilation, prevention of unwanted pregnancies and abortions, and control of STDs and AIDS.

The plan says that other reproductive health target groups, such as men and the elderly, are “less systematized in regards to the health problems identified” but are nonetheless considered in planned interventions. To implement the proposed approach more effectively, the MSPAS would be restructured to eliminate the PNPF and regroup all reproductive health under a Reproductive Health Service. The director of the DHSP would head the program with the assistance of three component chiefs (mother-child, adolescents, and the elderly). The Reproductive Health Service would embody five service bureaus: prenatal care and delivery, postnatal care, family planning, nutrition, and vaccinations.

“Integration will be difficult because people have established ways.”
 Technical assistance organization respondent

Many respondents believed that the planned restructuring of the MSPAS is a necessary and positive step, although they predicted resistance within the MSPAS, owing to staff reluctance to surrender authority and direct linkages to donors. One technical assistance organization respondent said, “Integration will be difficult because people have established ways.” In fact, at least one respondent within the MSPAS opposed the creation of the Reproductive Health Service. He felt that while coordination needed to improve, reproductive health services were better delivered through vertical programs.

Other Government Agencies

In addition to the MSPAS and MEFP, several other government agencies play a role in various aspects of reproductive health. The Ministry of Women, Children, and the Family (MFEF) led the development of the *National Plan of Action for Women, 1997*, which covers a variety of issues related to women, including reproductive health. The MFEF is also the lead organization working to eliminate the practice of female genital mutilation. It would head the proposed national committee on female genital mutilation, which would include the MSPAS and NGOs working in the area. The MFEF has at its disposal official mechanisms, such as a liaison in the MSPAS, to coordinate with other ministries working in reproductive health, although an MFEF respondent reported that coordination is deficient.

Several government agencies are involved with the reproductive health of youth, including the MSPAS, MEFP, Ministry of Education, Ministry of Youth and Sports, and Ministry of Communication, as well as several NGOs. Given the diversity of actors in this area, many respondents commented that coordination is particularly poor.

Participation of NGOs

Most respondents reported that the level of NGO participation in reproductive health policy formulation is high in Senegal for three reasons. First, cultural traits encourage candid and lengthy discussion to arrive at consensus. Second, the government has realized it cannot do everything. And third, donors strongly

“The government integrates [NGOs] in all programs and policies because they provide a lot of services, and because it is pushed by donors.”
 NGO respondent

encourage participation. One NGO respondent said, “The presence of NGOs is particularly pronounced in the area of health. The government integrates them in all programs and policies because they provide a lot of the services, and because it is pushed by donors.” Two technical assistance organization respondents reported that in recent years the creation of NGOs has been made easier and that the number of NGOs has greatly increased. One said, “There is still a rivalry between the government and NGOs, but there is synergy. There used to be more conflict of interest over money and political problems, but now there is an attempt at collaboration.” Respondents also noted that NGOs participated fully in the development of the national reproductive health program and will play a major role in its implementation. An MSPAS representative said, “NGOs are recognized by the state and supported by donors. They are involved in all activities: conceptualization of programs, evaluation, research, training...”

Representatives of NGOs are members of many councils and committees related to reproductive health, including the National AIDS Committee, the National Commission for Population and Human Resources, and the Regional Committees for Population and Human Resources. In 1996, a presidential decree was passed governing relations between NGOs and the government. One NGO representative said, “NGOs are now central; we are full partners.” More recently, the government signed an accord outlining relations between NGOs and the government and specifying guidelines for the allocation of funds and the clarification of roles. Although the government reserves the right to work with independent NGOs, much government collaboration with NGOs is channeled through the Council of NGOs in Support of Development, a network of 94 NGOs working in development, including health and population.

Some respondents did, however, mention limitations to NGO participation. A technical assistance organization respondent said that the government has mustered the political will for partnership, but sometimes encounters problems in the execution. One NGO respondent expressed the view that the government is willing to involve NGOs in developing policies, but is not willing to share resources with NGOs in carrying out activities. Furthermore, several respondents commented that participation is limited to national and international NGOs and that community-level NGOs are not involved. An NGO respondent stressed the importance of grassroots participation. “If policies are to respond to the needs of the population, they [NGOs] must be involved from the beginning, which the state does *very* rarely. Programs can only be sustainable when they respond to felt needs.”

Many respondents stressed the positive role of NGOs as pioneers and noted that they are less bureaucratic, more flexible, and closer to the people than government agencies. Some MSPAS officials commented that NGO coordination is a problem, however. A regional medical officer commented, “NGOs do whatever they want, without taking into account national orientations. There is a need for coordination between actors, but the [MSPAS regional office] has no power over them.”

Participation of the Private Sector

The private sector is not involved as a partner in reproductive health. One technical assistance organization respondent commented that not only does the government not work in partnership with the private sector, it almost entirely lacks information on the private sector that it could take into account in program planning.

Regional and Community Participation

In 1996, the government passed legislation outlining a process of decentralization for nine sectors, including health. As of 1997, the government transferred financial resources and planning authority for these sectors to 378 locally elected councils (10 regional, 48 municipal, and 320 rural community

councils) across the country. Unlike other sectors, the health sector was already decentralized in the sense that MSPAS officers at the regional and district levels had developed plans and budgets responsive to local conditions. Health officers, however, do not represent and are not directly accountable to the populations they serve; therefore, the transfer of authority to local councils is a significant step in giving communities direct control over their own health services.

Decentralization provides both opportunities and challenges for the development and implementation of reproductive health programs. Through the councils, communities will be able to develop programs that are more responsive to their needs. They will likely make a stronger commitment to successful program implementation than if programs were developed by outside sources. Furthermore, many individuals and groups that have never had an opportunity to express their needs and interests will be able to participate in the program development process. A technical officer in one region stressed the positive impacts of decentralization. "Since decentralization, all actors have been mobilized." On the other hand, problems arise because many locally elected leaders lack planning skills and technical understanding of the importance of preventive health in general and reproductive health in particular. Health officials, who are still responsible for contributing to national health goals, are concerned that locally elected leaders will choose to spend resources on activities that have high visibility but low impact or that they may divert funds from health programs to other sectors. As one government technician said, "Politicians are caught up in the short term. They don't think medium to long term."

The process of decentralization is extremely complex, and many details remain to be worked out. During the first year (1997), for example, numerous problems affected implementation. As one donor respondent said, "The challenge is to have a consistent interpretation of the texts on decentralization." Locally

"The challenge is to have a consistent interpretation of the texts on decentralization."
Donor representative

elected leaders' interpretation of their role seems to vary widely from one council to another. In some cases, locally elected leaders seem to be abdicating their responsibilities. Government technicians in one region said, "The locally elected leaders want us to do the planning for them, but we want them to participate in the planning." Other councils are eager to exercise their new authority and therefore resist the interference of health officials. One regional health officer said

that the variability in relations between locally elected leaders and health technicians is often a matter of individual personalities.

Another problem concerns the distribution of funds. Many councils reported that they did not receive any funds from the state while some received funds for an entire health district. In addition, although the texts on decentralization indicate that local councils must respect earmarks for spending in the health, education, and other sectors, some local leaders insist on their prerogative to spend the money as they see fit.

Whatever the problems and possibilities of decentralization, its effects are somewhat mitigated in that locally elected leaders do not control a large proportion of funds. Donors give large amounts of project money directly to the health regions, leading one regional health officer to comment, "Decentralization is not a reality in the field."

B. Evolution of Policies from Family Planning to Reproductive Health

Before 1980, a 1920 French law severely constrained family planning programs by forbidding the promotion of contraceptives. Although some NGOs provided family planning services, it was not until the 1920 law was repealed in 1980 that the government instituted a family planning program. Even then, respondents reported that government officials were extremely cautious in promoting family planning

because they perceived it as politically risky. In 1988, Senegal adopted a national population policy (*Déclaration de Politique de la Population*, hereafter referred to as the population policy), which was the first population policy in Francophone Africa. The policy covers maternal and child health (MCH); fertility and birth spacing; promotion of women, youth, and seniors; preservation of the family; migration and urbanization; and employment. An NGO respondent said the population policy provided official, political approval of the family planning program and thus paved the way for progress in family planning in Senegal.

With limited dissemination, the population policy had little impact in the early years after its adoption. Moreover, Senegal experienced a period of economic and political crisis between 1988 and 1991. In addition, some technical assistance organization respondents reported that many ministries responsible for implementing parts of the population policy were unaware of the policy's existence. Respondents said that since 1992 the DPRH, the agency responsible for dissemination of the population policy, has been involved in a major effort to increase awareness of the policy.

While the population policy covers some elements of reproductive health (MCH and family planning), it does not reflect the new reproductive health orientation adopted after the ICPD. Several respondents mentioned that the population policy needs to be updated to incorporate reproductive health elements, including a gender perspective and reproductive health services for youth (the policy currently mentions only IEC for youth). Respondents also noted that the population policy is a guiding rather than operational policy, thus greatly inhibiting the translation of policies into action. For example, it contained no provisions for funding activities, and some ministries had no resources to carry out the activities assigned to them. Similarly, it does not set out targets for program implementation.

The new reproductive health focus is evident not only in the planned revisions to the population policy but also in all new programs and projects developed since Cairo. Respondents point to a focus on special groups such as youth, particularly out-of-school youth, efforts to involve men in family planning, and an increased awareness of gender. An MSPAS respondent noted more of a multidisciplinary approach to reproductive health, with the MSPAS working in collaboration with other sectors. An NGO respondent agreed. "There is an integration of a nonmedical sensibility. Before there was the view that health is for doctors, but most health problems in Senegal are social." Specific issues such as violence against women are receiving increased attention as well. A government respondent said, "Policies to address violence are in the National Plan of Action for Women, but we are just starting." Postabortion care is another issue that is just starting to be addressed. One technical assistance organization respondent said that until Cairo, the subject was so politically sensitive that the organization could not even say the word "abortion," but an increased awareness now makes it possible to begin to address the issue. Respondents said that female genital mutilation is also drawing more attention. One government respondent said that, for the first time, the practice is now viewed as a health problem.

C. Definition of Reproductive Health

Definition

Perhaps because family planning programs are less well established in Senegal than in other countries, the concept of reproductive health did not so much evolve over time from in-country experiences as it was introduced from the outside. Even before the ICPD, many countries had already developed a widespread understanding of reproductive health, promoting it as a new orientation for family planning programs. In Senegal, however, reproductive health is a new concept adopted as a result of the ICPD. The United Nations Population Fund (UNFPA) has been instrumental in promoting and clarifying the concept by sponsoring a series of

"The spirit of reproductive health has been adopted, but it has not been totally absorbed."
Technical assistance organization respondent

workshops throughout the country to explain reproductive health. Not surprisingly, when asked to explain the definition of reproductive health, most respondents replied that “the definition of reproductive health in Senegal is based on the recommendations from ICPD.”

While respondents agreed that the concept is gradually becoming clearer, some confusion persists. As one technical assistance organization respondent commented, “The spirit of reproductive health has been adopted, but it has not been totally absorbed.” A government respondent emphasized the need for further clarification. “How can we develop programs if the concept is unclear?” Several respondents expressed the hope that the new *Program of Priority Actions and Investments in Population, 1997–2001* would

“It is a new term, but we have been working in family planning, STDs and AIDS, and maternal health for a long time. I am not clear what it means in practice. Maybe it means we will be getting more money?”

Service provider

clarify the concept. Several respondents commented that only upper-echelon program planners understood reproductive health. A donor representative said that probably only the top 20 percent of the MSPAS is aware of reproductive health. An NGO respondent remarked, “The concept of reproductive health has not been popularized. It is discussed only among intellectuals.” Even among the high-level respondents interviewed, levels of comprehension of the concept and its programmatic implications varied. One government respondent asked if reproductive health is supposed to have any programmatic implications, strongly suggesting that he perceived the concept to relate to a change in rhetoric, but with

limited impact on actual programs. A doctor and a midwife in regions outside Dakar had both heard of reproductive health but were not entirely clear what it meant. The doctor said he had not entirely grasped the concept. “It is a new term, but we have been working in family planning, STDs and AIDS, and maternal health for a long time. I am not clear what it means in practice. Maybe it means we will be getting more money?”

While all respondents understood that reproductive health is a term that covers several different components, they frequently equated it with family planning. Questions about reproductive health policies and programs typically generated a discussion of family planning policies and programs. Respondents usually furnished information about other elements of reproductive health such as STDs and AIDS, maternal health, or female genital mutilation only when specific questions addressed these issues.

The perception that reproductive health is replacing family planning as a term and approach elicited different reactions among respondents. Some expatriate respondents (technical assistance organizations and donors) expressed concern that the concept of fertility control may be overshadowed by the new focus on reproductive health and noted that with Senegal’s high fertility and population growth rates, fertility reduction remains an appropriate and important area of concern. More generally, several respondents (including MSPAS and technical assistance organization and NGO representatives) expressed concern that reproductive health is “too vast.” As one technical assistance organization respondent said, “It is dangerous to have it too broad. When it includes everything, it loses all impact.” On the other hand, many respondents perceived an advantage to focusing on reproductive health. One respondent noted, “Even if it is vague, it is at least more culturally acceptable than family planning.” Family planning is frequently associated with birth limitation, which runs counter to Senegalese religious and cultural values. Health, in contrast, occupies a place of supreme cultural importance; therefore, reproductive health, by virtue of its very name as well as its broader health focus, is more palatable.

Senegal is less receptive to the elements of the ICPD *Programme of Action* concerned with reproductive and women’s rights than those associated with health. Nevertheless, the reproductive rights and women’s rights elements are a primary focus of the MFEF but are not an integral part of programs in other sectors. Several respondents mentioned that neither the national family planning program nor the new

reproductive health program addresses reproductive rights. Some respondents believed that the exclusion of reproductive rights is a serious shortcoming, but others defended it. They said that, culturally speaking, Senegal is not ready to accept the concept of reproductive rights, thus making it more productive to frame reproductive health in terms of health in general. One government respondent said he thought the concepts of individual rights and sexual rights (and in particular sexual rights that extend beyond the context of marriage) are Western ideas. He added, “The family is the basic social unit in Senegal, and reproductive health is acceptable only when expressed in terms of the family.”

Priorities

The government has not established clear priorities in reproductive health. Its *Program of Priority Actions and Investments in Population, 1997–2001* (hereafter referred to as the population program) proposes activities for all components of reproductive health—from male participation in family planning to female genital mutilation to breastfeeding. The population program is impressively comprehensive but provides no indication of which among the vast array of proposed activities are government priorities. One technical assistance organization respondent described the program as a “wish list” the government is shopping around to donors. A donor respondent said that for the government, “Everything has remained a priority.” (The population program is discussed further in the section on operational policies and plans.)

“Family planning and AIDS are oversubscribed by donors while other areas are neglected.”

Donor respondent

Respondents generally agreed that for donors, the main priorities are family planning and AIDS. Several Senegalese respondents complained of donors’ overemphasis on family planning and relative neglect of other health issues. While respondents generally agree that family planning is important, some pointed out that malaria, which is the leading cause of mortality, receives much less donor attention. The *Population Strategy Document, 1997–2001* points out that even under the rubric of reproductive health, areas such as maternal mortality and infertility suffer from inadequate attention. Some respondents expressed the view that STDs have fallen victim to the focus on AIDS, and yet they remain an important problem. One donor representative concurred. “Family planning and AIDS are oversubscribed by donors while other areas are neglected.” Some respondents felt that with the development of the national reproductive health program, donors will be forced to adapt to a programmatic approach such that funding will more likely reflect government priorities.

D. Support, Opposition, and Consensus Building

Several respondents commented that building consensus is critical to advancing programs in Senegal. A technical assistance organization respondent said, “When someone is opposed, you cannot force him. You must engage in dialogue.” Building support for reproductive health programs is a slow process, but one that cannot be neglected.

The Public

Many respondents commented that Senegal is a socially conservative country and is therefore resistant to some elements of reproductive health or certain approaches. For example, several respondents commented that the cultural unacceptability of talking publicly about sex, especially extramarital sex, constrains program efforts, particularly programs for youth and for the prevention of STDs and AIDS. For example, condom promotion targets married couples and does not mention extramarital sex because social mores dictate that sex is reserved for the context of marriage. A government respondent also said that some women oppose programs addressing the issue of female genital mutilation because such topics

should not be spoken of publicly. On the other hand, a technical assistance organization respondent said, “The public does not have a problem, but the authorities take no risks.” A recent study shows that authorities do in fact believe that greater circumspection is needed. According to Maynard-Tucker (1997, p. 22), “The current approach to raise people’s awareness was frequently criticized by health personnel and respondents as being too open, too abrupt, and inappropriate to socio-religious norms.” However, the 1997 DHS found that while some women (14 percent) disapprove of family planning messages in the media, the vast majority (71 percent) approves. It would therefore seem that authorities may exaggerate issues of cultural sensitivity.

Religious Leaders

“Political leaders have only superficial influence; the souls of the people are with the *marabouts*.”
NGO respondent

Social conservatism in Senegal is closely linked to religion. Therefore, gaining the support of religious leaders, or *marabouts*, is critical to the success of reproductive health programs and policies. As one respondent said, “Political leaders have only superficial influence; the souls of the people are with the *marabouts*.”

To gain religious leaders’ support for reproductive health, the UNFPA-sponsored Islam and Population Network comprises representatives from all the main religious sects. The network is one of four established by UNICOM (the other networks are Journalists, Parliamentarians, and Troisième Age [Seniors]). The Islam and Population Network assesses reproductive health programs and policies from a religious standpoint and promotes the concept of reproductive health among the faithful. One activity of the network has been the production of a booklet *La Déclaration de politique de population à la lumière des enseignements islamiques*, which reviews the population policy and states the network’s position based on the Koran. It addresses the sensitive issue of family planning and explains that Islam opposes birth limiting but strongly supports birth spacing to enhance the health of mothers and children; therefore, the network condones the use of modern contraceptives. Despite the exclusion of birth limiting, the network’s general support for contraception sends an important signal, as many Muslims believe that the Koran prohibits the use of contraception altogether. Such a belief hurts family planning programs by limiting demand for services and making program personnel cautious in promoting services for fear of offending key religious leaders and creating a backlash. The network has not taken a firm stand on female genital mutilation. One respondent said that some religious leaders support the practice and point out that the Koran does not oppose it. Other leaders say that genital mutilation is a traditional, not a religious, practice and should not be continued. The booklet states that abortion is forbidden under Islamic law; however, one member of the network said that Islam does support postabortion care because doctors are required by the Koran to help anyone in need.

Thus, some religious leaders have become valuable allies in actively promoting some elements of reproductive health. Nonetheless, these leaders do not support all components of reproductive health, and not all religious leaders concur with the fairly progressive stand of the network. At the time interviews were conducted for this study (August 1997), respondents believed that most religious leaders supported reproductive health programs or at least did not oppose them. In November 1997, however, some important religious leaders attacked the network, accusing its members of having been “bought out” by donor money and criticizing reproductive health initiatives such as the promotion of condoms for AIDS control. Respondents were surprised by the attack, and many said that opposition to reproductive health was evidently much stronger in the Islamic community than they had believed.

National Political Leaders

Many respondents expressed the view that in recent years political leaders have become strong advocates of reproductive health. For example, President Diouf has signed several decrees in support of reproductive health and family planning. In addition, in his speech to the nation in April 1997, the president publicly addressed the reproductive health issue for the first time. One donor representative said that President Diouf is the one West African politician most actively involved in supporting family planning and reproductive health. The Minister of Health has also declared his support for family planning and participates in events such as the recent launch of the national family planning IEC campaign. One donor respondent said that the government's commitment to reproductive health is evident in the creation of the Reproductive Health Service in the MSPAS. Another said, "I believe the government's commitment to reproductive health is sincere. They have developed all these plans and programs in reproductive health. What more could we ask of them?"

At the same time, some respondents questioned the depth of commitment on the part of political leaders. While they are at least not actively opposed to reproductive health, political leaders are not particularly aggressive in advancing the reproductive health agenda. A technical assistance organization representative said, "Support for family planning is lacking at the top levels of government. At any rate, there is no sense of urgency." A donor respondent agreed. "Cairo changed the rhetoric, but there is no change in the field—and there won't be, because the political commitment is very superficial. Some technicians are very committed, but not the people with political weight." Several respondents said that Parliament has been noticeably apathetic. A technical assistance organization respondent said that the Parliamentary Network has been the least effective of the UNICOM networks and that no new reproductive health legislation has passed since the ICPD. A donor respondent said that the MEFP is more active and supportive than Parliament, but it has more of a demographic than a reproductive health focus.

Observing that opposition to reproductive health programs and policies is generally no longer a factor, respondents acknowledged that political leaders and program managers nonetheless remain extremely cautious and fearful of taking any initiatives that might be seen as controversial. A technical assistance organization representative said that the evolution of support for reproductive health in the 1990s is much like it was for family planning in the 1980s. For example, the MSPAS is reluctant to engage in programs it perceives as politically risky. It will forge ahead only when it sees that programs have gained acceptance. In some cases, it would seem that such caution has been unfounded. One technical assistance organization respondent reported that many health officials who were initially reluctant to address issues they perceived as sensitive, such as reproductive health services for youth or social marketing for AIDS prevention, found that these issues did not provoke the anticipated backlash. A donor representative expressed the view that while many health technicians are deeply committed, political leaders are primarily concerned about getting reelected and thus are unwilling to take a stand on any politically risky issue regardless of how important it may be for reproductive health. Cited by several respondents, one example of political caution to the detriment of reproductive health programs was the cancellation of the community-based distribution (CBD) of contraceptives program. According to a technical assistance organization respondent, the MSPAS was convinced of the importance of increasing access to contraceptives through CBD and was ready to launch a CBD program. With the distribution scheduled for shortly before elections, however, the opposition took hold of the issue and claimed that the government was engaged in the "anarchic distribution" of condoms. Rather than weather the political storm, the MSPAS canceled the program.

Local Political Leaders

In view of decentralization and the derogation of authority for health programming and spending to local communities, the support of locally elected leaders for reproductive health programs and policies has

become extremely important. Locally elected leaders are a heterogeneous group, with widely ranging levels of education and experience. In addition, very little is known about leaders' attitudes toward reproductive health, although it can generally be assumed that they know little about it. Thus, it remains to be seen how leaders' education levels and attitudes will affect the implementation of reproductive health programs. Some donor and technical assistance organization respondents, discouraged by a perceived lack of commitment at the central level, are more optimistic about the potential of program implementation at the local level.

4. Policy Implementation

A. Operational Policies and Plans

Several different plans address various aspects of reproductive health including, in addition to the previously mentioned population program and national health plan, the *Post-ICPD Action Plan* and the *National Action Plan for Women*. Many of the plans overlap one another, although each has its own focus. The population program, developed in 1996–1997 under the DPRH with funding from UNFPA, comprises three components, or “pillars”: population and development strategies, a national program for reproductive health, and advocacy/IEC. Together, the three pillars represent the most comprehensive reproductive health plan for the country, reflecting elements of reproductive health programs contained in other plans. The first and third of the pillars are the responsibility of the DPRH, whereas the second is the responsibility of the MSPAS. One respondent involved in the development of the national population program said that the DPRH was responsible for setting objectives in reproductive health and that the MSPAS was responsible for developing action plans to achieve the objectives. Respondents said that the program is meant to shift activities from a project to a programmatic approach. By fitting all activities into a single program instead of treating them individually, the government hopes to develop greater coherence in activities and improved coordination among donors.

B. Service Delivery Structures

Family planning services are offered primarily through the public sector (68 percent) and are largely clinic-based. Social marketing of contraceptives is relatively weak, being limited to condoms and only recently expanding sales outlets beyond pharmacies. CBD of contraceptives is nonexistent in the public sector and practiced by NGOs on only a limited scale.

Health structures are organized into three levels: hospitals, health centers, and health posts. In 1991, the MSPAS defined a minimum package of services that should be offered at each level of the health system; however, not all health structures provide the full package. A representative of a regional council mentioned that many of the health posts in the region lacked staff trained in family planning.

According to the national health plan, the minimum package of services at the health post level includes

- primary curative consultation;
- prenatal care;
- well-baby consultation;
- vaccination;
- nutritional recuperation; and
- family planning.

In addition to health post activities, health centers should provide for

- complicated deliveries;
- medical emergencies (intensive care);
- surgical emergencies;
- laboratory examinations; and
- radiology and radiography.

C. Service Delivery Agencies

Community Participation

In Senegal, the promotion of community participation in the delivery of health care services has been closely linked to the promotion of primary health care. Throughout the 1960s and much of the 1970s, the Senegalese health system was modeled after those of industrialized countries, with most resources allocated to hospitals in urban centers (Groupe SERDHA, 1997). A new orientation toward primary health care and community involvement has gradually developed in the past 25 years. The context was set in 1972 with the passage of the Local and Territorial Administration Law, which provided for participation, deconcentration, decentralization, and regionalization of the economic development plan (MSPAS, 1992). However, it was not until the late 1970s that primary health care truly became a focus. The fifth development plan, which spanned the period 1977–1981, emphasized primary health care for the first time, with priority on rural areas. In 1978, the international Alma Ata Conference stressed primary health care and reinforced the new approach. Change in the field was slower, however. Between 1977 and 1984 the USAID-funded Rural Health Project in the Sine Saloum region (now the regions of Fatick and Kaolack) was one of the first major efforts to promote community participation in health care. Its objective was to improve the health of rural populations and to develop a model of community-supported primary health care for replication in other regions. According to one report, "... the project implicated the community in all phases of its development: construction of health huts and maternities, recruitment of community health agents and cost recovery" (Maynard-Tucker, 1997, p. 12). Locally elected health committees were responsible for the management of cost-recovery funds, materials, and equipment. Another early experiment with health committees and community participation took place in the town of Pikine, outside Dakar.

These early experiences were gradually replicated nationwide. In 1983, a Ministerial Circular outlined the principles of management and organization of the health committees. According to MSPAS (1992), the guidelines proved to be inadequate: funds collected were often hoarded while the health establishments lacked medication, funds were misdirected, and health and administrative authorities were not sufficiently involved to avoid abuses. In response, the MSPAS promulgated a law in 1992 to clarify the organization and operation of the health committees.

In 1991, Senegal adopted the Bamako Initiative. First developed in Bamako, Mali, at a September 1987 meeting of African Ministers of Health sponsored by the World Health Organization (WHO) and the United Nations Children's Fund, the initiative has further advanced community participation and the concept of the health committee (McPake et al., 1993; Jarrett and Ofosu-Amaah, 1992). It seeks to rationalize spending on health by focusing on primary health care for the most vulnerable groups, specifically women and children and the populations of outlying communities. A major strategy is the generation of funds at the community level to cover local recurrent costs, including essential drugs. Locally elected health committees are responsible for the management and reinvestment of the funds. The Bamako Initiative also emphasizes the importance of community mobilization for the management of health services, not just for financial contributions. To date, however, respondents reported that health committees have limited themselves to financial management and have had little involvement in

promoting health services. Some projects are now working to encourage health committees to play a larger role.

Respondents agreed that the Bamako Initiative has greatly improved the availability of essential drugs while generating significant resources for the operation of local health facilities. The health committees have not been without problems, however. Maynard-Tucker (1997) found that many health committees are far removed from the populations they serve. Members are no longer democratically elected and women and young people are often not fully represented. Some clients even said that they had never heard of the health committee or had heard of the committee but had no idea of its role. Clients who had heard of the health committees thought they should be eliminated because “they only serve to enrich a group of individuals” (Maynard-Tucker, 1997, p. 17). In the present case study, several respondents pointed to a lack of controls to ensure that funds are properly spent.

NGOs

NGOs play an increasingly important role in the implementation of reproductive health programs. Large, nationwide NGOs, such as the Senegalese Association for Family Well-Being (ASBEF), which is the local affiliate of the International Planned Parenthood Federation, and Santé et Famille (SANFAM) provide only a small proportion of overall family planning and reproductive health services. Nonetheless, respondents said that they set the standard for quality and contribute significant technical expertise to program implementation. Small community NGOs are a significant factor at the grassroots level, particularly in work with AIDS and female genital mutilation. Important, too, are community organizations such as the *groupements féminins* (women’s groups), which were originally organized for political purposes but provide an ideal structure for projects that undertake development work. For example, the MFEF has engaged a network of 500 women’s groups in carrying out IEC in reproductive health. A respondent at the MFEF said that the efforts of the network are extremely important because the MSPAS has trained people in IEC only down as far as the district level. Nurses in health posts have neither the time nor skills to engage in IEC. One NGO respondent remarked, however, that he was surprised that the women’s movement had not been more actively involved in the promotion of reproductive health. He believed that women’s organizations are a force that could serve as a spearhead for change.

D. Integration

In the public sector, MCH services are integrated in that the same person in most health posts provides all services. Services are not integrated, however, in that different services are available on different days. Family planning is further isolated from other reproductive health services; it is often offered in a separate building and not offered at all at many service delivery points. Nonetheless, the number of service delivery points offering family planning has increased in recent year from a total of 180 in 1994 to 350 in 1997. A technical assistance organization respondent reported on efforts to incorporate STD treatment into MCH services. Syndromic algorithms have been developed and health personnel trained in their use, but the algorithms have not yet been incorporated into the MSPAS flow chart, which is what health care providers refer to in practice. Furthermore, the respondent said that some staff members are resistant to addressing STDs.

“We are tending toward integration.”
Service provider

UNFPA is supporting the MSPAS in the integration of services by establishing pilot health centers that offer integrated reproductive health services in each of Senegal’s 10 regions. Staff have been trained in reproductive health and clinics renovated to accommodate the delivery of integrated services. The effort is now entering the final stage of

reorganizing patient flow. The doctor at one health center reported, “We are tending toward integration.” His clinic made all services available on all days, except for vaccinations, which were still scheduled for a specific day. To date, integration in the public sector has only begun at some sites. NGOs such as ASBEF were already providing a range of integrated reproductive health services before Cairo and continue to do so.

A donor respondent said that integration offers two advantages. First, it saves time for clients by eliminating multiple trips to different providers on different days. Second, integration means that MCH clients are potential family planning clients. The respondent commented, however, that integrating services has not been easy. For example, personnel are frequently resistant because they perceive that integrated services will add to their work load, although one midwife respondent reported that she did not experience an increase in her work load when her clinic shifted to integrated services. Another difficulty is that training personnel to provide integrated services takes them away from their work site.

E. Actions in the Field

In addition to the preliminary efforts at integration, some pilot projects have taken reproductive health beyond program development into the implementation stage. Some small projects are focusing on new priority populations or specific elements of reproductive health. For example, the Ministry for Youth and several NGOs have initiated projects that offer reproductive health services to young people. IEC efforts are targeting out-of-school youth not reached by traditional family life education programs. Other new projects, such as a family planning project run by ASBEF, specifically address men and provide family planning information to men in the police and military.

Preliminary projects are also underway in previously neglected areas of reproductive health, such as postabortion care and female genital mutilation. In 1997, the Population Council initiated an operations research study to test an integrated service delivery model for women treated for complications of incomplete induced or spontaneous abortion. Findings from the study should guide the development of a comprehensive postabortion care program. In the area of female genital mutilation, NGOs have taken the lead, although the government is becoming more involved. For example, with support from the African Development Bank, the MFEF is providing training in IEC and funding to a network of 500 women’s groups to create awareness of the harmful effects of female genital mutilation.

F. Constraints

Infrastructure, Equipment, and Personnel

According to the national health plan, Senegal has 52 health centers, or one for every 150,000 inhabitants, far from WHO norms of one for every 50,000 inhabitants. The number of health posts has been steadily increasing since the adoption of primary health care. In 1994, there were 733 health posts, or one for every 11,000 inhabitants, close to the WHO norms of one for every 10,000 inhabitants.

The 1995 situation analysis (Population Council and MSPAS, 1995) found that most service delivery sites have water (82 percent), electricity (90 percent), a waiting room (88 percent), and restrooms (79 percent). However, basic equipment is lacking in a large proportion of service delivery sites: 57, 64, and 87 percent of clinics had no large, medium, and small specula, respectively; 29 percent had no gloves; 22 percent had no blood pressure cuffs; and 17 percent had no stethoscopes.

Even more constraining than the lack of infrastructure and equipment is the shortage of personnel. Several respondents said that available infrastructure frequently goes unused because there is no staff to

operate it. The national health plan reports that the personnel situation is poorly managed—the MSPAS does not keep careful track of either staff departures (resignations, deaths) or recruitment. In general, the number of health personnel in the public sector is decreasing each year; for example, the number of health agents fell from 5,304 in 1993 to 4,813 in 1994—a decrease of 8 percent. The decline is greatest among midwives and nurses. Furthermore, personnel are disproportionately concentrated in Dakar.

Legal and Regulatory Issues

An NGO respondent commented on a significant reduction in the legal and regulatory barriers to reproductive health, but nonetheless mentioned that several constraints persist.

- Abortion is illegal in all cases, although one government respondent called attention to a proposal for legalizing abortion in the case of rape or incest. A technical assistance organization respondent said that abortion's illegal status makes the subject taboo, thereby constraining efforts to promote postabortion care.
- Some technical assistance organization respondents said that a complete “juridical void” regarding AIDS has hampered efforts in that area.
- Some laws have an inadvertent pronatalist effect; for example, providing larger allowances to families with more children encourages couples to have more children.
- No law specifies that health care providers are authorized to provide family planning services to adolescents. As a result, several respondents said that providers are reluctant to deliver such services because they are vulnerable to attack from parents or other community members who disapprove of the distribution of contraceptives to adolescents.

Sociocultural Considerations

In addition to the general social conservatism that constrains program implementation, a variety of sociocultural factors inhibit demand for reproductive health programs. Women play a subordinate role in society and are therefore more likely than men to be uneducated, to control fewer resources, and to exercise less authority in decision making, all of which undermine their ability to demand reproductive health services. Several misconceptions also limit demand, such as the widespread perception that Islam forbids the use of contraception. A technical assistance organization respondent said one of the primary constraints in the area of AIDS is that the disease is not particularly visible in Senegal—victims do not come out publicly—such that the public has even begun to doubt its existence.

Health Providers' Attitudes

Besides concern for their own vulnerability to attack, many health care providers do not provide family planning services to youth because of their own attitudes. One midwife respondent said that until she participated in a recent training course she used to “think it wasn't good to give condoms to adolescents. Now I understand.” In addition, biases against contraception frequently mean that providers impose unnecessary constraints on contraceptive usage. As one technical assistance organization respondent said, “Whether or not laws exist for spousal and parental consent [for contraceptive usage], providers act as if there were.”

Entrenched Economic Interests

Concerned that programs will cut into their market share and hurt profits, some pharmacists have blocked the efforts of social marketing and CBD programs to make contraceptives more readily available. Several

respondents recounted that until recently the social marketing program could market its condoms only through pharmacies. One technical assistance organization respondent said the resistance of pharmacies is particularly difficult to counter because it is covert.

Overmedicalization of Health

Several respondents mentioned that health is overmedicalized, a fact also noted in a 1992 study (Galway, 1992). While some barriers have been falling, such as the requirement for laboratory tests as a prerequisite to prescribing pills, others remain. For example, nurses are not certified to insert IUDs; therefore, the IUD is not a readily available means of contraception. Technical assistance organization and MSPAS respondents reported that the conservatism of the medical establishment is a barrier to CBD. As the MSPAS respondent said, “Pharmacies are not the only opposition. You also need to convince politicians and health personnel,” who tend to believe that pills should be distributed only by qualified medical personnel. The same respondent said that, despite the resistance of the medical establishment, it is particularly important to promote CBD because of the shortage of personnel.

5. Resource Allocation

A. Funding Levels for Reproductive Health

Funding for health in general is increasing. The government has committed to increasing the percentage of the budget devoted to health by 0.5 percent per year to a total of 9 percent in the year 2000. Government contributions to reproductive health programs primarily fund infrastructure, personnel, and operating costs for health structures. A government official commented that the government does not devote many resources to reproductive health. One reason may be that donor contributions to reproductive health free up government resources for allocation to areas less likely to attract outside support.

B. Major Donors

Primary donors in the field of population and reproductive health are UNFPA, USAID, the World Bank, and, to a lesser extent, the United Nations Children’s Fund, the United Nations Development Program, WHO, the French Cooperation, the Canadian Cooperation, and the European Union. The donors interviewed for the case study report satisfactory coordination of donor programs in recent years. A donor committee, currently headed by a representative from the European Union, meets periodically to coordinate activities. In fact, the committee recently reviewed the new population program and prepared a unified donor response. Some Senegalese colleagues expressed the opinion that the donors do not coordinate effectively and that the disjointedness of donor interventions, particularly the division of regions among donors, has led to a fragmentation of the reproductive health program.¹

All respondents agreed that donors are a huge financial presence in Senegal. Such an assessment is hard to quantify because variations in reporting procedures and currencies make it difficult to obtain accurate data on reproductive health financing. Furthermore, reporting from the government is incomplete in that it covers only funds received by Senegal and excludes operating costs for donors and money spent by technical

“Everything is paid for by the donors.”
NGO respondent

¹ Currently, USAID funds health and population activities in four regions. For its next strategy, UNFPA plans to focus on specific regions as well.

assistance organizations. According to one report, however, foreign aid covered over 30 percent of operating costs in the health sector every year from 1990 to 1994. In 1994, after the devaluation of the CFA franc, the proportion soared to 49 percent. One MSPAS respondent said that the proportion of reproductive health covered by foreign aid, as opposed to health in general, is much higher—perhaps as much as 90 percent. A NGO representative commented, “Everything is paid for by the donors.”

In any case, donors heavily subsidize Senegal’s family planning program. According to the *Projet document de stratégie de population, 1997–2001*, the PNPF is funded through three main projects at the following levels:

- Projet Survie de l’Enfant/Planification Familiale: USAID, \$36.2 million
- Projet Appui au PNPF: UNFPA, \$2.249 million
- One component of the project Appui au Programme SMI/PF: the World Bank, \$900,000

C. Financial Sustainability

Cost recovery, which represents a significant source of funds for the operation of health districts, is also increasing. As mentioned, the Bamako Initiative promotes community participation in the generation and management of resources so that communities can provide for their own health needs. Community health committees set nominal fees for various medications and services and then use the associated funds to buy more medications, pay personnel, and cover the general operational budget of health centers and health posts.

In 1996, the health committees generated over \$5 million through cost recovery (MSPAS/DHSP/Division des soins de santé primaires, 1997). The amount has increased steadily from less than \$1.5 million in 1992 and is more than twice the contribution of the government to district operating budgets. Respondents believe that the trend is toward increased cost recovery, which is critical for sustainability. Some, however, express concern over the lack of policy to harmonize prices. Prices are widely variable across communities and, in some poorer regions, may be out of reach for local populations. One respondent commented that for family planning in particular, the program is still trying to spark demand and that contraceptive prices that are too high may pose a barrier to access. Several respondents also commented that health committees require more support in managing resources and, in some cases, need to be more transparent in their procedures.

Several respondents said that they see no move toward increased sustainability at the central level. A donor representative said that only the local level has made a commitment to sustainability and that is because it realizes no benefit from the money flowing into Dakar. A technical assistance organization representative agreed that the health committees represent the only chance for increasing sustainability.

6. Challenges

Respondents agreed that progress in reproductive health has been slow in Senegal, but they were divided in their views on the current situation and the outlook for the future. Some respondents were optimistic, pointing to bases of political support and programs primed to take off. Others were discouraged, noting that the impact of years of effort and millions of dollars has been negligible. They see no reason to believe that programs will have any more effect in the near future.

Whatever their degree of optimism, respondents agreed that Senegal needs to confront a number of challenges in the coming years.

- **Improving coordination.** Reproductive health is an enormous area involving a large number of organizations, including several ministries, donors, and NGOs. Coordination of all these entities is a daunting task. The plans dealing with reproductive health envision a number of coordination mechanisms, but given the poor record of many of the existing coordinating bodies, it remains to be seen how effectively they will operate.
- **Generating grassroots support.** Many respondents stressed that political leaders have been extremely cautious in their support of reproductive health programs and that change will not come from the top. Politicians will act in favor of reproductive health when they see that it is what the people demand and therefore poses no political risk. Respondents underscored the importance of both working with community NGOs that enjoy close ties to the population and using outreach workers to increase the awareness of people at the community level.
- **Making decentralization work.** In its first year of implementation, decentralization was fairly chaotic. In many cases, money was not transferred from the central level, health technicians and locally elected leaders did not understand their new roles, and locally elected leaders lacked the background or skills necessary to fulfill the responsibilities assigned to them. With health services implemented through decentralized structures, reproductive health programs will succeed only if the issues associated with decentralization are resolved.
- **Moving from planning to implementation.** Since the ICPD, Senegal has done much to raise awareness and develop programs, but those programs are just now ready for implementation. So far, only a few pilot projects in reproductive health are underway in the field. As one respondent said, “We have a good plan; the challenge now is to carry it out.”

Respondents were unanimous in the opinion that it is too soon to evaluate the impact of Senegal’s new reproductive health focus, pointing out that only three years have passed since the ICPD. A donor respondent said that one lesson learned to date is that a new approach may be beneficial, but it is not necessarily easy to implement. Reorienting services to reproductive health is a slow process, and it will be a while before Senegal benefits from the change. With the lag between implementation and impact, there is a danger that people will give up too soon and return to the old approach.

Appendix 1

Organizations Represented in the Interviews

Government Organizations	Ministry of Health (various departments); Ministry of Women, Children and the Family; Ministry of Economy, Finance and Plan, Directorate of Human Resources Planning; Ministry of Youth and Sports, Youth Promotion Project
Nongovernmental Organizations	Jamra, Senegalese Association for Family Well-Being (ASBEF), CONGAD, Islam and Population Network, CEFOREP
Donors	USAID, UNFPA, World Bank, UNICEF
Technical Assistance Organizations	POLICY Project, Population Council, MSH/PCS, AIDSCAP, UNICOM, SOMARC
Regional Officials and Health Personnel	Health personnel and elected officials in regions of Louga, Fatick, and Kaolack

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