Republic of Senegal
MINISTRY OF HEALTH
AND SOCIAL WELFARE
Department of Health
Division of Reproductive Health

National Family Planning Action Plan 2012-2015

Table of Contents

List of abbreviations

BG: Bajenu Gox

CBHW: Community Based Health Worker

CBO: Community Based Organization

CNLS: Comité National de Lutte contre le SIDA [National Committee for the Fight against AIDS]

CPR: Contraception Prevalence Rate

CRMO: Chief Regional Medical Officer

DSR: Division de la santé de la reproduction [Division of Reproductive Health]

DSRSE: Direction de la santé de la reproduction et de la survie de l'enfant [Department of Reproductive Health and Child Survival]

FP: Family Planning

IIO: Initial Injectable Offering

IPC: Interpersonal communication

IPO: Initial Pill Offering

LTM: Long-term method

MDG: Millennium Development Goal

NFPAP: National Family Planning Action Plan

NGO: Non-Governmental Organization

NPHSD: National Plan for Health and Social Development

RGPH: Recensement général de la population et de l'habitat [General Census of Population and Housing]

SDP: Service Delivery Point

TFR: Total Fertility Rate

Foreword by the Minister of Health and Social Welfare

In order to reach the Millennium Development Goals, the government of Senegal has undertaken various projects in the health sector. It has implemented a National Plan for Health and Social Development (NPHSD) 2009-2018, one of the four fundamental goals of which is to reduce maternal, infant and child mortality. With the help of its partners, in 2006 Senegal also developed a Multisectoral Roadmap 2006-2015 to speed up the reduction of maternal, neonatal and infant mortality and morbidity.

From 2005 to the present, there has been a progressive decline in mortality indicators. However, there is still a long road ahead if the MDGs are to be reached in 2015. It has been established that Family Planning (FP) is one of the most efficient methods available today for saving the lives and improving the health of women and children. In addition to the health benefits, increasing the Contraception Prevalence Rate (CPR) would make it possible to better control population growth. This allows Senegal to envision the possibility of developing its economy and its prosperity while reducing the increasing population pressure on sectors such as education, the environment, agriculture, etc. In view of all this, Senegal has made the strategic choice of making FP a national priority with the goal of rapidly reducing maternal and infant mortality, and has set the ambitious goal of increasing the CPR for married women from 12% in 2010 to 27% in 2015.

In order to support these ambitions and reduce the existing obstacles as much as possible, the government of Senegal and its partners have developed this National Family Planning Action Plan (NFPAP), based on the mobilization generated by the Ouagadougou Conference in 2011 on the theme "Population, Development and Family Planning in French-speaking West Africa: the Urgency of Action".

Our principal goal is to offer equal access to quality FP services to all the women of Senegal. That is why the “3D” approach presented by Senegal in Ouagadougou, which today has international consensus, is one of the fundamental principles of this plan. It essentially concerns the decentralization and democratization of health and reproductive services, as well as the task-shifting/sharing.

Operationally, the action plan is based on six priority areas and pillars for implementation:

- A large scale communication plan with specific and varied messages according to target population, mainly for men and young people. The plan envisions introducing innovative approaches to change behavior towards adoption of attitudes favorable to FP, and to combat misconceptions.
- A targeted advocacy program aimed at political opinion leaders, donors and civil society for firmer support for FP through their financing and their commitment. This advocacy will also aim to reinforce the network of religious officials and national and local FP champions.
- Increasing availability of contraceptive products by means of an innovative scale-up strategy.

- The community-based distribution of short-term methods with increased task-shifting/sharing, expansion of the supply to include the initial supply of contraceptive pills and injectable contraceptives so as to reach the most underprivileged areas.
- Involvement of private sector actors in expanding the supply and use of contraceptives, especially by means of social marketing, and establishment of a network of social franchises and mobile clinics.
- Improving supply, particularly for long-term methods and in the public system, for easily accessible quality service which ensures discretion and appropriate treatment of women and especially of young women.

These priority areas have been broken down by region based on goals for Contraception Prevalence Rate, local characteristics and needs, determined in collaboration with Chief Regional Medical Officers, for period up to 2015.

We strive to maintain a horizontal vision of public health actions and are looking for any opportunity to integrate FP services with other programs such as immunization and HIV in the future. We are also studying the possibility of integrating other products in the procurement system established for contraceptives, and we are aware of the need to address supply in a holistic manner across the public, private and community sectors.

The execution of this plan is ensured by the establishment of an implementation organization and monitoring and evaluation mechanisms, permitting efficient execution, immediate readjustment and real-time monitoring of the plan.

However, we are aware that without a strong long-term commitment from the government, all of these efforts will be in vain. We recognize our central role in the success of the action plan, and therefore we made a commitment at the London Summit of July 11, 2012, before the international community, to put the necessary resources on the table to realize this change and to reach our ambitious goal of a 27% CPR in 2015. This unconditional government support is illustrated by three (3) areas of action: financial, organizational and in terms of health policy and reforms of the legal and regulatory framework. In the interests of sustainability, we recognize that the government must take more responsibility in financing and executing this plan.

We thank all stakeholders for their continued support, their precious contributions and their time, which have enabled the development of this action plan. Together we have set out to create strong families, the foundation of a prosperous Senegal.

[Signature of the Minister]

Thanks

This document was prepared by the technical committee in collaboration with and under the direction of the Division of Reproductive Health (DSR) of the Ministry of Health and Social Welfare.

This project was made possible by the technical and financial support of all FP partners and stakeholders, who are resolutely committed to improving the current situation. The work of refining the action plan is based on an approach that is factual and oriented towards impact, while guaranteeing equity among regions and among Senegalese women. It is also the fruit of a consensual and participative process in which all the parties involved took an operational approach focused on concrete and realistic actions.

The Ministry of Health and Social Welfare through the DSR wishes to thank all the organizations, institutions and persons who contributed to the realization of this national action plan by participating in technical committees and/or working groups and by giving their opinions and ideas related to proposed content. These partners have consistently attended many working groups and/or technical committees and have been essential in conceiving and drafting this action plan. These includes especially:

- Structures of the Ministry of Health/Division of Reproductive Health
- National Procurement Pharmacy [Pharmacie Nationale d'Approvisionnement (NPP)]
- World Health Organization (WHO)
- U.S. Agency for International Development (USAID)
- United Nations Population Fund (UNPFA)
- Bill & Melinda Gates Foundation
- Hewlett Foundation
- French Development Agency [Agence Française de Développement (AFD)]
- Embassy of France (MAEE [Ministere des Affaires étrangeres et européennes (Ministry of Foreign and European Affairs)])
- FHI 360
- Marie Stopes International (MSI)
- Agency for the Development of Social Marketing [Agence pour le Développement du Marketing Social (ADEMAS)]
- Senegalese Association for Family Welfare [Association Sénégalaise pour le Bien-Etre Familial (ASBEF)
- Action and Development [Action et Développement (ACDEV)]
- Japan International Cooperation Agency (JICA)
- Siggil Jiggen Network [Réseau Siggil Jiggen (RSJ)]
- IntraHealth International
- Regional Center for Training, Research and Advocacy in Reproductive Health [Centre Régional de Formation, de Recherche et de Plaidoyer en Santé de la Reproduction (CEFOREP)]
- Population Council
- Childfund
- ABT
- Association of Obstetrician – Gynecologists
- National Association of Registered Nurses of the State of Senegal [Association Nationale des Infirmiers et Infirmières Diplômés d'Etat du Sénégal (ANIIDES)]

With their precious contribution, the Chief Regional Medical Officers enabled a meaningful and operational approach, permitting the plan to take the characteristics of each region into account.

Action plan development process

This plan was developed in collaboration with all stakeholders. It went through the different stages described below:

May 29, Technical Committee # 1: A presentation was given on the context of the Ouagadougou conference, the deliverables, the key dates and the roles of actors in order to refine the action plan and prepare for the FP Summit of July 11. In addition, the situation and challenges were reviewed. Finally, the technical committee proceeded to define the main aspects of the plan and its strategic priority areas.

June 5-6, Working groups: Effort was concentrated on finalizing the description of challenges in the area of FP in Senegal. These also helped to map the current situation and ongoing activities for each strategic domain. The working groups then set about defining strategic actions and subactivities. Finally, a first version of the implementation schedule and performance measures for the activities were developed.

June 14, Technical committee # 2: The technical committee reviewed the results from the working groups and approved the strategic actions for each area. It then prioritized the strategic actions and defined a calendar for implementation of actions. Finally, a first definition of regional goals was created.

June 26, Meeting # 1 with the Chief Regional Medical Officers: The state of affairs and the challenges as well as the areas and strategic actions that were approved by the technical committee were shared with the CRMOs. The CRMOs then reviewed and defined the CPR goals for their regions as well as the specific priority regional activities. Finally, the CRMOs reviewed and approved the mapping of the current situation in their respective regions.

June 28, Meeting #1 with the Minister of Health and Social Welfare and the cabinet: During this meeting, the cabinet first approved the state of affairs and impact goals for each region. This meeting made it possible to approve the strategic areas and actions of the plan. Finally, the cabinet approved Senegal's commitments, which were included in the speech given at the 2012 London Summit on Family Planning.

July 9, Technical Committee # 3: The technical committee concentrated on the methodology and process of calculating the impact of costs for each priority activity. The preliminary cost analysis and funding needs were then reviewed.

August 16, Meeting #2 with the Chief Regional Medical Officers: The CRMOs read and evaluated the cost and impact calculations of the plan. They then finalized the specific activities to be deployed in their regions. Secondly, the formalized national action plan was shared and enriched by the contribution of the CRMOs. The latter then reviewed the institutional organization of the implementation and the monitoring and evaluation mechanisms of the action plan.

September 7, Meeting #2 with the Minister of Health and Social Welfare and the cabinet: The cabinet approved the formalized national FP action plan as well as the institutional organization of implementation and monitoring/evaluation mechanisms. Finally, the cabinet shared its recommendations on organizing a forum for launching the action plan with all the parties involved.

Three principles guided the approach to developing the action plan:

Factual, impact-oriented approach:

Factual analyses were carried out to determine the state of affairs based on the available data. Using these elements, efforts were oriented towards high impact activities that would achieve a real return on investment and contribute effectively to meeting the goals.

Consensus and participative approach:

An operational team was 100% dedicated to developing the plan, sharing the work biweekly with the technical committee that includes donors, civil society and implementing agencies. Working groups were also regularly organized with subgroups of the technical committee to prepare the contents of technical committee meetings.

Operational approach focused on implementation:

The action plan developed includes the costs of each subactivity, a timetable, impact indicators and officers in charge of each activity, in order to ensure an efficient and rapid start. The Chief Regional Medical Officers also contributed to the plan during ad hoc meetings to ensure an operational vision and effective implementation on the ground.

A. Vision

We dream of a better and more prosperous life for each of our families. We want each of us to know the joy of having a healthy child and providing a bright future for him or her through good living conditions and education. We dream of a strong and prosperous nation.

Spacing out births through FP is a way of realizing this dream. However, during the last decade, other health priorities overshadowed FP and have also reduced the resources and visibility of this area.

Now is the time to reposition FP as a national priority in order to reduce the rate of maternal and infant mortality and to improve maternal and child health. In effect, FP has become known as the "social vaccine", because it is to maternal health what vaccination is to the health of the child.

This desire fits the NFPAP, the specific goal of which is to identify the priority activities to be implemented and the supplementary resources that will be necessary to offer better quality FP services that are more accessible and more equitable for everyone.

The inherently cross-cutting aspects of public health will be taken into account as much as possible to increase the effectiveness of the actions being implemented. A particular effort will be made to ensure integration of FP activities with those related to other areas and other health problems (counseling activities, training modules, joint product distribution activities, etc.), when it seems pertinent.

On the other hand, the action plan represents a break with the past for several reasons: for example, implementation of formalized coordination mechanisms between partners to ensure optimal coverage of all needs and avoid duplications, and implementation of a monitoring and evaluation system focused completely on FP.

In order to promote sustainability and strong operational anchorage, the regions have been heavily involved in the development of this plan, which ensures not only responsibility of the CRMOs in reaching the regional CPR goals but also integration of the NFPAP activities in the annual regional work plans. In addition, the plan provides for innovative approaches. Among other things, it includes the establishment of a national

advocacy committee, communication activities specifically for rural needs, text message campaigns and utilization of social networks for young people, introduction and extension of mobile units and social franchises and finally implementation of the Informed Push Model.

Therefore, development of this plan was oriented towards three goals:

- To establish a plan that takes the specific needs of each region into account, as well as the region's rural or urban characteristics;
- To establish an exhaustive plan implementing activities across all the major components and priority areas for demand creation, product availability, access to services, and coordination;
- To establish a plan that is operational and applicable in the field, introducing quantified and differentiated goals with a monitoring methodology based on detailed activities.

B. Context of developing the plan on June 1, 2012

FP: a sound investment in the health, well-being and quality of life of the Senegalese people.

Mortality indicators have declined since 2005, but remain below the 2015 Millennium Development Goals (MDGs). In effect, the maternal mortality rate of 392 per 100,000 live births and the infant and child mortality rate of 75 per 1000 children under 5 years old must be reduced by half between 2010 and 2015 if we are to achieve the MDGs.

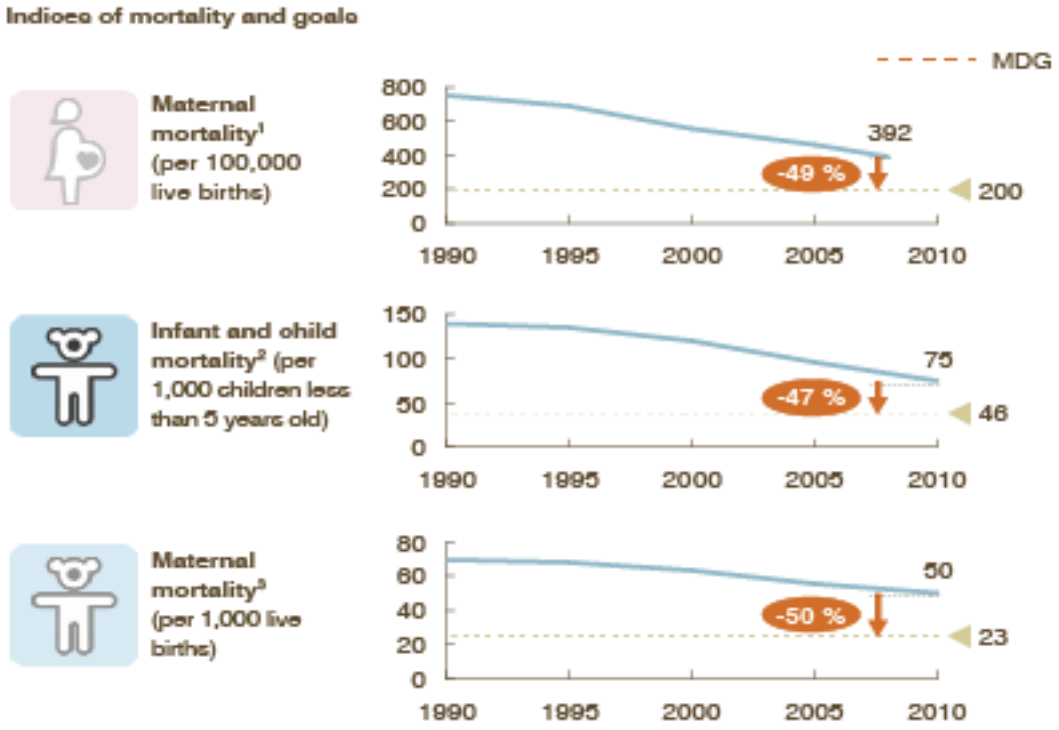


Figure 1: Rate of maternal, infant and child mortality (Source: WHO)

Additionally, the pressure on the indicators is amplified by several demographic and health factors that require urgent action to reverse the trend:

- High fertility rate: 5.0 children per woman (this represents an almost stagnant rate since 2005, which had a fertility rate of 5.3)
- High rate of population growth between 14 and 49 years old: 3% per year
- Low CPR: 12% (compared to 10% in 2005) with significant unmet need (29.4%)
- Large disparities between the CPRs of urban and rural areas (20% vs. 7%) and different social groups (25% for educated women vs. 8% for uneducated women)
- Very high maternal mortality rate with 391 maternal deaths per 100,000 live births (one of the highest in the world).

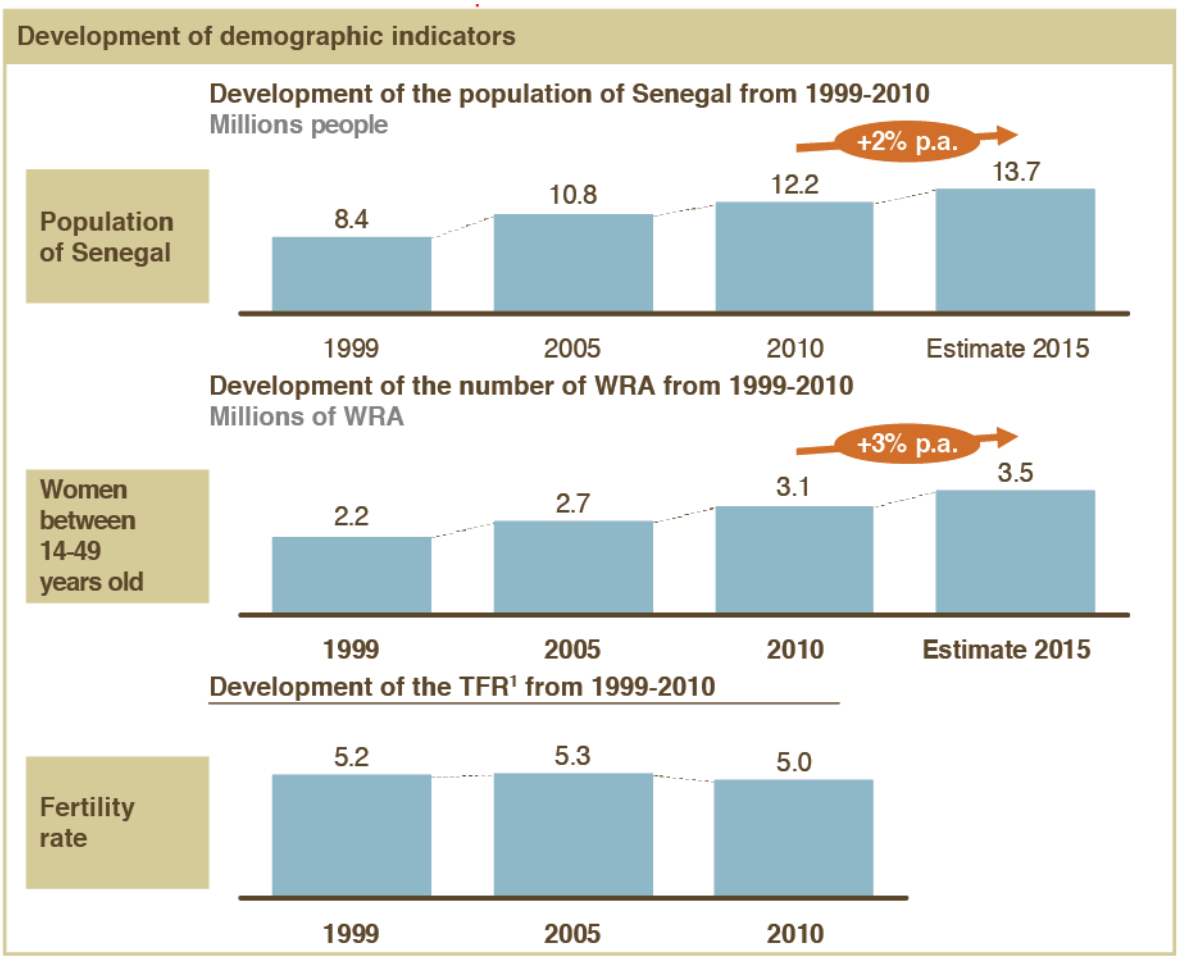


Figure 2: Development of demographic indicators (Source: ANSD [Agence Nationale de la Statistique et de la Démographique (National Statistics and Demographics Agency)], DHS [Demographic and Health Surveys])

This development negatively impacts the indicators but also increases pressure on the health, education and food security systems. FP is among the most effective and financially sound ways to save the lives and improve the health of women and children while contributing to the economic and social development of the country.

Current situation of FP in Senegal

The population of Senegal is increasing rapidly and almost doubled between 1990 and 2010. This high rate of demographic growth (2.5% in 2002 RGPH) is essentially the result of a very high fertility rate (TFR of 5.3 in 2005), a very low CPR (12% in 2010) and a falling infant mortality rate.

In effect, the population has developed more rapidly than socioeconomic indicators (rate of poverty, rate of urbanization, etc...) The CPR, for example, increased from 10% to only 12% between 2005 and 2010, making Senegal one of the countries with the lowest rates in Africa; on the other hand, the GDP per inhabitant went from US$1,800 to $1,900 in the same period (purchasing power parity basis) This should be put in perspective with the fact that many donors and stakeholders are present and active and that many activities in favor of FP have already been implemented in Senegal.

In effect, the action plan is built on significant achievements and efforts made by the government and its partners. In the last few years, the partners have been strongly involved in FP activities in all of the strategic areas. In particular, they have undertaken efforts to create demand through communication activities (including local communication), involvement of young people and advocacy activities, in particular with civil society. The public sector has been strengthened with activities focused on improving the logistical and data management skills of staff, training in FP, SDP equipment, especially for long-term methods, and contraceptive commodity security at the national level. All these efforts are an important base for the action plan and will be reinforced.

The activities of the action plan will be built around research and studies to better understand the target populations and to adapt messaging. The existing arguments and tools for advocacy will be used as a basis for those to be developed in the future; the current networks of champions will be re-energized and extended. In terms of product availability, the activities integrate existing tools such as Channel and Reality Check in order to minimize stock-outs. In the public sector, effort will be concentrated on reduction of existing gaps and shortcomings in training, equipment and personnel as well as on expanding pilot programs for improving the quality of services. Community-based supply will be built around the system that is already in place by re-energizing it and scaling-up certain activities (BG, CBHW...).

However, the action plan also seeks to correct some inefficiencies and fill in some past gaps. The NFPAP also constitutes a break with the past since it aims to simultaneously establish innovative activities (mobile units, social franchises, procurement system...) and an enriched implementation architecture. In effect, the NFPAP emphasizes coordination and monitoring of FP activities at both the central and regional levels, since it relies on the more significant involvement of the regions in the definition and monitoring of activities.

The principal barriers to growth in the area of FP in Senegal are:

- The absence of a single, operational national action plan, focused on FP, that would provide a structure for operations and make them more effective. This work was undertaken but not finalized by the DSR.
- Insufficient coordination between the many actors and partners present in Senegal. This creates various duplicate activities but also gaps in certain areas, and therefore makes the system inefficient to a certain extent.

- Instability in policymakers' actions over time, which makes it difficult to maintain funding and political commitment to FP.
- The issue of FP, although highlighted in the context of plans dedicated to maternal and child health, has seldom been treated in a proper manner, nor has it received all the attention of the competent authorities.
- FP actors are not sufficiently empowered in their actions, data sharing and reporting on activities.
- A lack of human resources and funding in the public health system, including for FP. In particular, lack of a structure with a strong decision-making mandate in charge of monitoring and evaluation of FP activities.

C. Repositioning of FP

Following the declaration of the government of Senegal that it would consider maternal health as one of the two national priorities (together with the establishment of a national health insurance fund), interest in FP has grown considerably.

This renewal of interest was also crystallized in the Ouagadougou Partnership, which is a meeting of eight governments, international donors and NGOs with the goal of acting jointly to improve the FP supply in French-speaking West Africa.

In addition the Minister of Health and Social Welfare, Prof. Eva Marie Coll Seck, reaffirmed her commitment to FP before the whole international community at the international FP summit on July 11, 2012 in London. Taking up the cause of women's health, she emphasized the importance of making FP products and services accessible to all women who need them, in particular the most vulnerable and those who live in the most remote areas.

Thanks to the renewal of interest that resulted from this high impact intervention, the government of Senegal decided to refine its national FP plan, stimulating a real dynamic that has reached the highest levels of the State of Senegal.

D. Issues and challenges of FP in Senegal

FP in Senegal faces a certain number of challenges and constraints that must be resolved for effective repositioning in order to reach the MDGs and the goal of a CPR of 27%.

These challenges, which weigh heavily on the "pillars" necessary for the evolution and development of FP in Senegal, are related to demand creation, product availability, access to services, political commitment and funding, and finally to coordination among the different stakeholders.

14 challenges were identified during the process of developing the strategic action plan:

4 challenges related to demand

- Significant unsatisfied need (29.4% in 2010), regardless of socioeconomic level, age, level of education or region, and a strong disparity in the CPR of rural and urban areas (7% vs. 20% CPR) and among social groups (educated women ~25% vs. uneducated women 8%).
- A decrease in communication concerning FP (39% of women exposed to messages on FP in the media in 2010 compared to 48% in 2005).
- Negative perception of FP among women (20% of women do not use contraceptives for fear that FP might be dangerous to their health).
- Current use is concentrated on short term products, which makes contraceptive coverage more difficult to sustain (43% injectables, 34% pills).

3 challenges related to product availability

- Stock-outs at the national and regional levels (the rate of stock-outs for injectables varies between 25 and 45% in the key cities; it is the same for implants, where stock-outs can reach 80% in the public sector, see data on SDPs for Pikine 2010-11).
- Problems with products reaching service delivery points, which is an important cause of client dissatisfaction (40% stock-out for Depo-Provera in Pikine in 2010-11, 80% for Jadelle in spite of stocks at the national level, see SDP data for Pikine 2010-11).
- Quality control of products is still variable and inadequate.

4 challenges related to access to FP services

- The quality of the supply is very unsatisfactory (52% of clients say they are not very satisfied with the services received, source: Household Survey, ISSU) in spite of efforts made to train FP providers these last few years; in the public sector women feel unwelcome, uninformed and stigmatized (about 1 in 3 women say that the providers/vendors of FP products make them feel uncomfortable when they come to procure contraceptive products, source: Household Survey, ISSU).
- The number of FP access points is still very low in some regions and there are large disparities in the supply of services within the country, in particular for long-term methods.
- In the private sector, it is mainly the difficulty of obtaining contraceptive products and the regulatory framework that pose problems. In effect, a prescription is necessary in order to buy a contraceptive in the private sector, pharmacists are not authorized to deliver certain methods or even prescribe them, and private clinics cannot stock contraceptives.
- Women who use FP services still experience pervasive stigmatization. This is especially true for young women (only 2% of young women between 15-19 years old have received a visit from a field worker who talked to them about FP. The CPR for young married women between 15-19 years old is 5%, compared with 8.4% for those between 20 and 24 years old in 2010).

2 challenges to political commitment and funding

- The status of FP, which has become a simple "office" within the DSR, resulting in insufficient resources, expertise and decision-making power. In addition, the DSR has very limited resources (few human resources and a total budget of CFA 1.5 billion, which represents only 2.5% of the total budget allocated to health); this finally results in a lack of resources for implementation and monitoring and evaluation of FP activities.

- A regulatory framework which is not favorable to widening the system of FP offerings (some people are not qualified to deliver the methods, prescription requirement for pharmacies for ordering pills and injectables, inability of private clinics to stock contraceptives...).

A challenge related to coordination

- There are many actors in the field and donors in the area of FP, and they all contribute in a significant manner to the efforts made. However, there is a certain lack of coordination due to absence of mechanisms that would permit any FP alignment around a single action plan.

National action plan

A. Goals of the action plan

The FP national action plan aims to increase the prevalence of contraceptives in Senegal. Thus, the activities of the plan are addressed to all married women without exception.

Senegal has set itself the ambitious goal of going from a CPR of 12% to one of 27% (for married women) in 2015 and 45% in 2020, which represents an increase of 15 points, equivalent to CPR growth between 1992 and 2010.

Reaching the target CPR means that approximately 350,000 more married women will have to adopt contraception.

With the commitment of the CRMOs, the goals of contraceptive prevalence differentiated by region (figure 3) have been defined in order to better see each region's expected contribution to this fixed goal. The goals were set according to the potential and the characteristics of each region (for example: level of urbanization, presence of densely populated suburban areas, number of women of childbearing age, presence of actors in the field). The potential of each region was determined based on its demographic weight and its level of unmet need.

All of the regions have considerable 3-year augmentation goals, ranging from 60% to 270%, and these require an effective and equitable action plan. This represents a colossal effort to be made in all the regions of Senegal, including those that currently have a weak CPR.

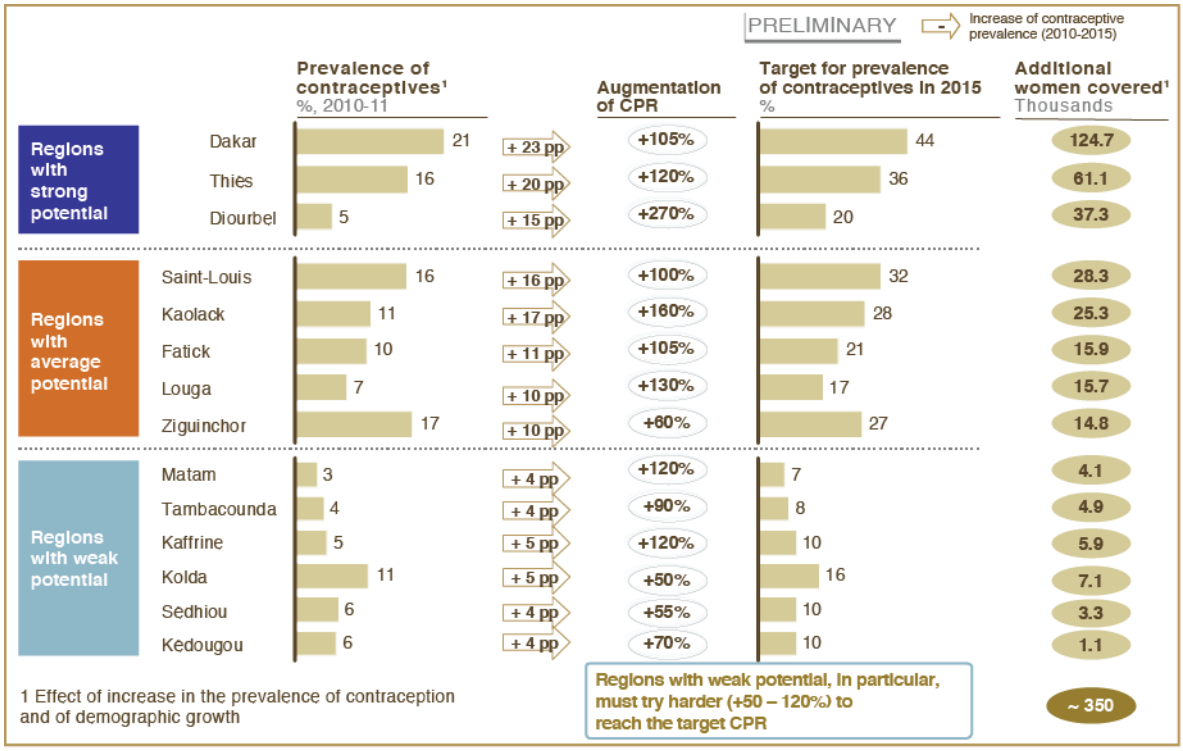


Figure 3: Regional goals defined in collaboration with the Chief Regional Medical Officers

The goals are certainly ambitious but achievable compared with other countries such as Rwanda or Ethiopia (where the CPR has almost doubled since 2005).

B. Summary

The action plan, developed based on analysis of the challenges, is articulated into 51 strategic actions grouped around 6 strategic areas (in addition to the coordination and monitoring mechanisms) defined by all the parties involved:

2 strategic areas related to demand:

- Large-scale national communication plan:
  - Qualitative research on target populations
  - Mass campaign aimed at women
  - Interpersonal communication and community activities
  - Specific activities in rural communities
  - Campaign aimed at men
  - Campaign aimed at young people

- Targeted advocacy program:
  - Creation of a national advocacy committee
  - Advocacy to redefine the position of the DSR
  - Advocacy to adjust the regulatory framework
  - Advocacy for more significant state funding
  - Reinforcement of partner support
  - Advocacy to make FP a national priority
  - Advocacy to obtain the support of leaders in the health sector
  - Advocacy to obtain financial and human support in the private sector

- Advocacy to obtain media support: effective support for media coverage of FP activities and financial support
- Activating and re-energizing the network of political champions
- Activating and re-energizing the network of community champions
- Activating and re-energizing the network of religious champions
- Activating and re-energizing the network of national champions

1 strategic area related to product availability:

- Ensuring availability of contraceptive products, in particular scaling-up the Informed Push Model system:
  - Introduction of a single product ordering channel
  - Guaranteeing the availability/functionality of equipment necessary for long-term methods
  - Progressive extension of the Push Model
  - Improving the logistical skills of personnel
  - Improving the data management skills of staff
  - Filling orders based on actual consumption and monthly inventory tracking using Reality Check and Channel.

3 areas related to access to FP services:

- Improving the public sector supply, especially for long-term methods:
  - Guaranteeing availability of equipment in the SDPs (including strengthening the FP filing system with training and monitoring)
  - Training in long-term methods (including supportive supervision and mentoring)
  - Recruitment of health workers
  - Establishment of revised curricula in training schools
  - Scaling-up task shifting/sharing
  - Skills-strengthening using an online training system
  - Establishing a program for improving the quality of services and monitoring
- Expanding the private sector supply:
  - Implementing a multisectoral structure dedicated to PPP
  - Widening the range of social marketing products
  - Establishment of effective product delivery by the NPP
  - Systematic integration of private sector data
  - Establishment of mobile units
  - Establishment of social franchises
  - Increase the number of private sector service delivery points
  - Improving the regulatory framework
  - Diligence in issuing Marketing Authorizations
  - Direct training of private sector actors, above all in long-term methods
  - Ensuring coverage of FP services by insurance companies and social security
- Generalization of community-based distribution:
  - More extensive task-shifting/sharing
  - Increasing access through distribution by health points with literate CHWs (community health workers)
  - Revitalization of the Bajenu Gox program
  - Increasing utilization of intermediaries to combat discontinued use
  - Increasing CBHW coverage
  - Increasing access through distribution by other categories of community health workers (intermediary, BG)

- Increasing access through distribution by units with illiterate CHWs

Coordination and monitoring and evaluation of the action plan has also been retained as a priority area to ensure success. This provides for the establishment of a strong organization with sufficient resources to implement the action plan and strengthen monitoring mechanisms for activities, thus permitting immediate readjustment and close monitoring of the principal indicators. This priority area also emphasizes coordination of actors and their actions around a single national FP action plan.

With the implementation of these priority actions defined by all the parties involved, including the Chief Medical Officers of the region, it is expected that in 2015, 350,000 additional married women will be reached. A preliminary estimate based on pilots and information from partners has permitted us to evaluate the impact in different areas in the following manner:

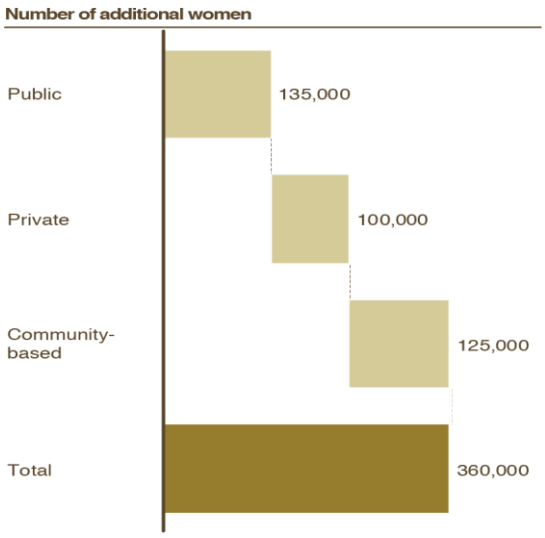


Figure 4: Impact on the main axes of action in number of additional married women

These calculations of impact are not authentic results for the actors, but permit us to explain how we can reach the target CPR of 27%.

The total cost of the plan over 3 and a half years is 16.3 billion CFA (or 31.4 million US dollars) in operational costs (representing the costs of activities, excluding overhead, human resources and agency infrastructures, etc.), and is distributed according to the following scheme:

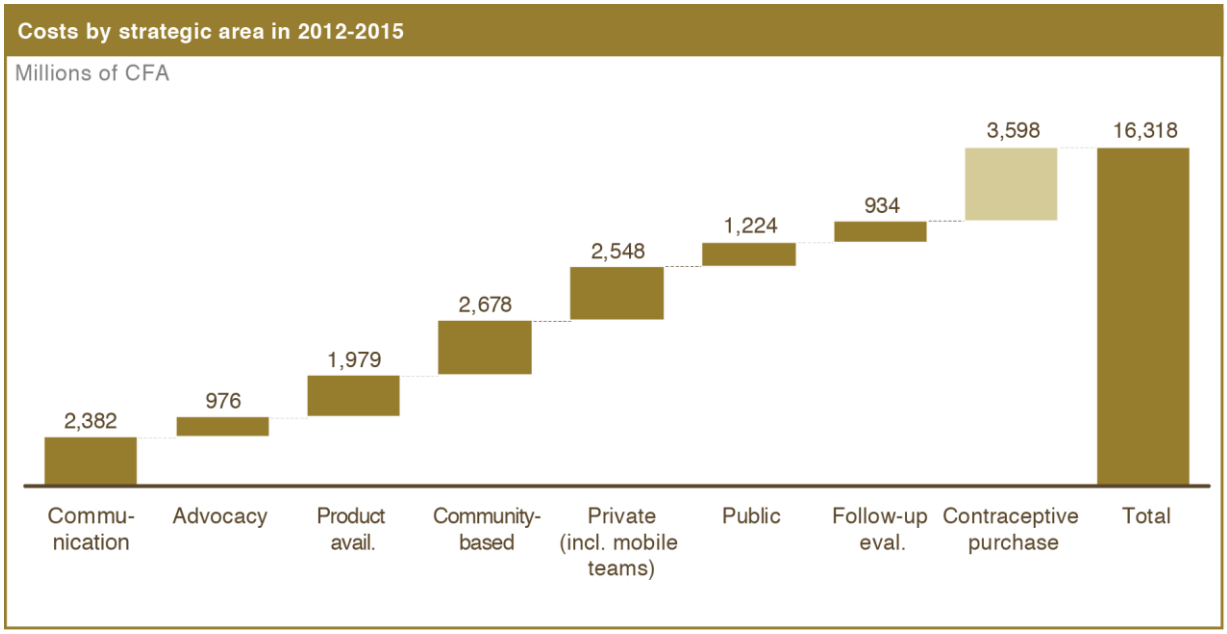


Figure 5: Costs by strategic area for 2012-15

C. Details of the action plan

1. Communication

1.1. *Definition of priority actions:*

Establishment of a large-scale mass communication plan with specific and varied messages according to target population. Emphasis will be placed on informing and mobilizing communities as well as on using high quality multimedia communication to create mass behavioral changes. More than 90% of men and women know of at least one contraceptive method, but the CPR remains low and innovative communication approaches (text message campaigns, communication activities in rural communities, behavioral surveys...) are necessary in order to catalyze discussion on FP among couples (gender approach) and families, to break through negative preconceptions and false perceptions, and to make FP a socially acceptable norm, supported in a transparent manner and widely used.

In this sense, behavioral studies will be conducted to better understand the causes, including social causes, of non-adoption or discontinued use and to adapt messages and channels of communication. These studies are also necessary to better define profiles and messages adapted to men and young people.

Following these studies, various mass multimedia campaigns will be launched, specifically targeting women, men and young people. However, these mass media activities must be reinforced and accompanied by interpersonal communication activities which are also planned, especially in hard to reach zones, in order to better reach women. Civil society will have a particularly important role to play in interpersonal communication activities.

The health of young people is a priority for Senegal. Thus, many activities are specifically for young people, in order to sensitize them to FP and improve their well-being.
In particular, the action plan has the goal of addressing problems related to stigmatization, which young people still suffer from frequently. Revitalization of the family planning radio call-in show, the targeted communication plan and the expansion

of interpersonal communication activities will all help reach young people.

Men will benefit from a mass campaign specifically targeting them, as well as from many outreach activities (e.g. ONCAV [Organisme national de coordination des activités de vacances (National organization for coordinating holiday activities)]), discussion groups, use of religious intermediaries) to sensitize them to the advantages of FP and widen the scope of FP to include the health of the couple.

1.2. *Rollout timeline:*

The mass communication campaigns will be conducted in all regions of Senegal.

The campaigns aimed at men and young people will be undertaken several months later, since more time is needed to understand these target populations and develop the appropriate messages.

1.3. *Cost by priority action 2012-15*

Priority Action	2012	2013	2014	2015	Total CFA
Conducting studies	32,442,280	–	5,949,840	–	38,392,640
Mass campaign aimed at women	130,000	217,449,960	361,449,920	361,449,920	940,480,320
Community activities and IPC	130,000	215,843,160	175,029,920	178,629,880	569,632,960
Specific activities in rural communities	–	38,955,280	38,955,280	39,448,760	117,359,840
Campaign aimed at men	–	33,429,760	210,099,760	354,099,720	597,629,760
Campaign aimed at young people	–	39,340,080	39,340,080	39,340,080	118,020,240
Total	32,702,280	545,018,760	830,825,320	972,968,880	**2,381,515,240**

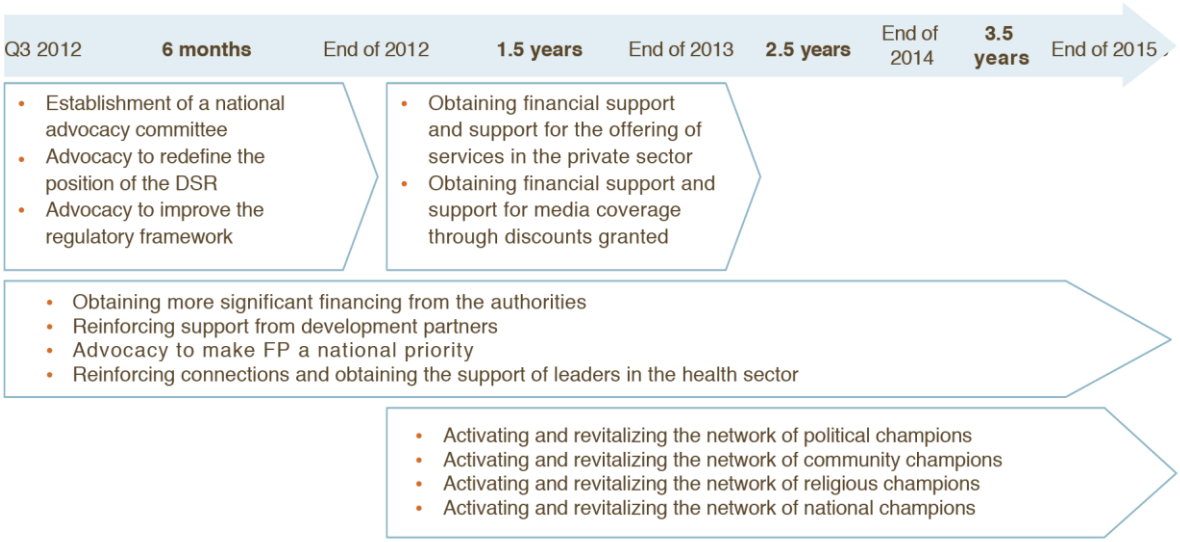
2. Advocacy

2.1. *Definition of priority actions*

A targeted advocacy program will be implemented, aimed at leaders of political opinion, donors and civil society, to support FP with their financing and their involvement using existing and adapted tools (for example, ENGAGE and RAPID). All efforts related to the education and orientation of religious officials and national and local champions will be better leveraged to talk about FP and promote healthy families. Civil society organizations, will have a privileged role to play since they can both carry out a significant number of advocacy activities and also be the targets of certain advocacy activities.

2.2. *Rollout timeline*

The advocacy program will be deployed in all regions of Senegal, paying special attention to zones that are socially less open to FP messages.



2.3. *Cost by priority action 2012-15*

Priority actions	2012	2013	2014	2015	Total CFA
Establishing a national advocacy committee	3,085,160	2,990,000	739,960	739,960	7,555,080
Advocacy to redefine the position of the DSR	260,000	–	0	0	260,000
Advocacy to improve the regulatory framework	5,888,480	11,029,720	0	0	16,919,760
Advocacy for more significant public financing	5,519,800	95,190,160	93,689,960	93,689,960	288,089,880
Reinforcement of partner support	6,400,160	7,920,120	6,540,040	6,540,040	27,399,840
Advocacy to make FP a national priority	49,184,720	48,924,720	48,924,720	48,924,720	195,959,920
Advocacy to obtain the support of leaders in the health sector	–	5,890,040	5,999,760	5,999,760	17,890,080
Obtaining financial and human support in the private sector	–	18,354,960	3,299,920	3,299,920	24,954,800
Obtaining financial support for media coverage	–	5,410,080	6,769,880	6,769,880	18,949,840
Activating and re-energizing the network of political champions	–	45,952,400	28,292,680	28,292,680	127,072,400
Activating and re-energizing the network of community champions	24,535,160	48,987,640	28,292,680	28,292,680	105,572,480
Activating and re-energizing the network of religious champions	–	52,172,640	28,292,680	28,292,680	108,757,480
Activating and re-energizing the network of national champions	–	7,794,800	28,292,680	28,292,680	36,087,480
Total	94,875,040	350,617,280	250,842,280	250,842,280	975,470,080

3. Product availability

3.1. *Definition of priority actions*

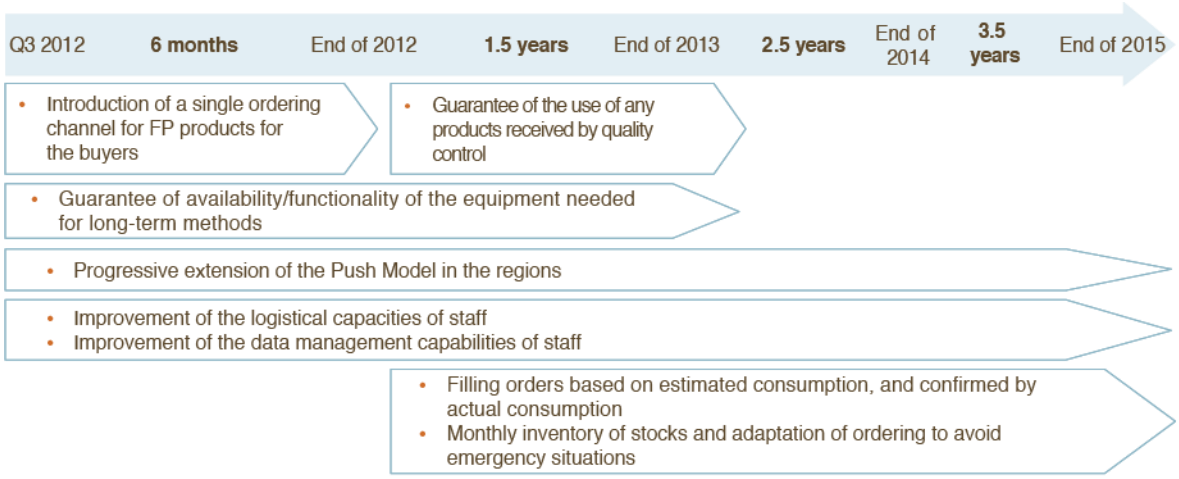
Stock-outs are a recurring problem that directly affects the user. In the past, the program has always recognized the extent to which this represents an obvious barrier to access to services and products, and even a major obstacle in reaching the targeted contraceptive prevalence rate. For example, the rate of stock-outs for injectables varies between 25 and 45% in the key towns; it is the same for implants, where stock-outs can reach 80% in the public sector. There are many reasons for this: poor estimate of consumption based on outdated and incomplete data, past shortcomings in quantifying needs, mismatch between

standardized orders and needs, and sometimes inefficient distribution. The deeper causes of problems with the procurement system at the national and local levels are being studied and solutions using innovative approaches will be implemented.

The system of forecasting the consumption and purchase of contraceptives has been made more clear and effective with Reality Check. At the local level, in pilot regions the informed push model system, which integrates the Channel tool for monitoring stocks, will also be implemented. The goal is to scale-up this system to cover the whole country. The Push Model refers to a procurement system that rationalizes ordering and reporting procedures by letting the distributor manage inventory in the health structures, and relieves the providers of their logistical obligations. The procurement team counts and registers the stocks and fills out the inventory levels. This process has made it possible to reduce stock-outs to zero in the pilot regions.

3.2. *Rollout timeline*

The push model will be progressively extended to all regions of Senegal.



3.3. *Cost by priority action 2012-15*

Priority actions	2012	2013	2014	2015	Total CFA
Introduction of a single product ordering channel	4,237,480	36,410,920	8,474,960	8,474,960	57,598,320
Guaranteeing the availability/functionality of equipment	41,499,640	193,847,680	361,449,920	361,449,920	235,347,320
Progressive extension of the Push Model	96,150,080	347,999,600	494,000,000	473,999,760	1,412,149,960
Improvement of the logistical skills of staff	1,500,200	103,725,960	34,300,240	34,300,240	173,826,120
Improvement of data management skills of staff	21,100,040	47,997,040	10,972,000	354,099,720	95,994,080
Filling orders and monthly inventory tracking		1,300,000	1,300,000	1,300,000	3,900,000
Total	164,487,440	731,281,200	549,047,200	533,999,960	1,978,815,800

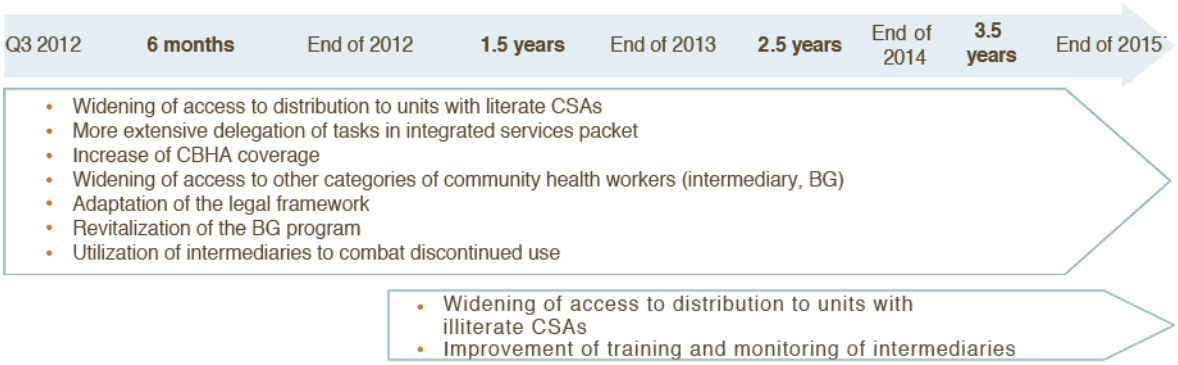
4. Expanding the community-based supply

4.1. *Definition of priority actions*

Scaling-up community-based distribution of short-term methods (including injectables) if feasibility studies show positive results, and scaling-up Depo-subQ in Uniject if acceptability tests show positive results. The community system has not yet been exploited enough and must be expanded to all regions, including the most remote rural regions.

The plan will focus on increased task-shifting/sharing and expansion of the community-based supply. The pill, and perhaps injectables, will be offered by community workers in order to improve access to FP. The community-based supply and communication and sensitization activities will also be supported by re-energizing the Bajenu Gox program and religious intermediaries.

4.2. *Rollout timeline*



4.3. *Cost by priority action 2012-15*

Priority actions	2012	2013	2014	2015	Total CFA
More extensive task-shifting/sharing	62,250,240	173,249,960	–	–	235,500,200
Increasing access through distribution at health points with literate CHWs (community health workers)	25,000,040	106,175,160	128,499,800	32,125,080	291,800,080
Revitalization of the BG program	54,125,240	62,999,560	61,249,760	61,249,760	239,624,840
Improvement the training and monitoring of intermediaries	–	65,000,000	119,999,880	124,999,680	310,000,080
Increasing CBHW coverage	60,499,920	226,999,760	52,000,000	52,000,000	391,500,200
Increasing access through distribution by other categories of community health workers (intermediary, BG)	–	–	8,799,960	765,000,080	773,800,040
Increasing access through distribution by units with illiterate CHWs	–	153,174,840	153,174,840	96,249,920	402,600,120
Using intermediaries	–	12,300,080	2,399,800	19,880,120	34,580,000
Total	164,486,920	799,899,880	526,125,080	1,151,505,160	**2,679,405,040**

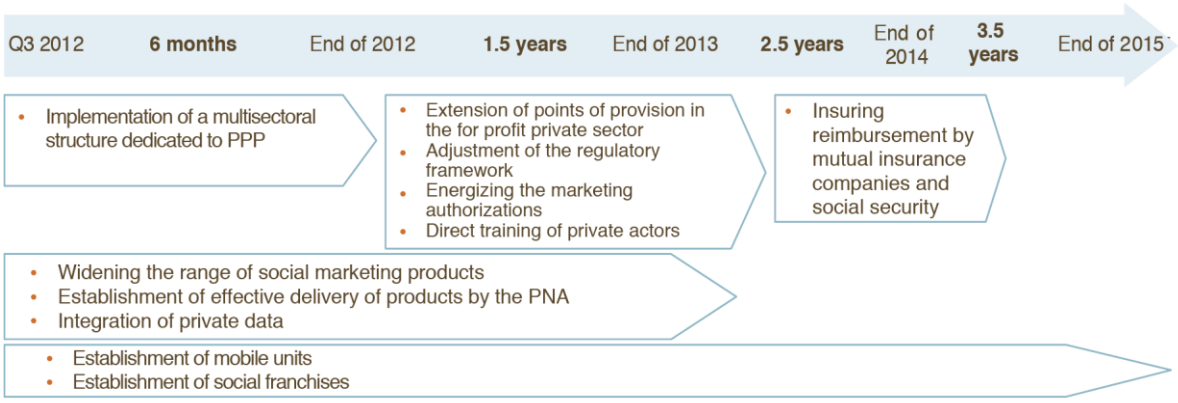
5. Strengthening the private-sector supply

5.1. *Definition of priority actions*

Strengthening the private sector supply by establishing mobile units and social franchises, while adjusting the regulatory framework to encourage distribution of contraceptives by private actors, and increasing the number of private providers. The private sector is only taking its first steps in FP. The plan must concentrate its efforts on the role and impact of private sector actors in expanding the supply and use of contraceptives, especially through social marketing, and in establishing a network of social franchises and mobile clinics. This priority is not just wishful thinking. Action has already begun. Mobile clinics are already in place and are showing encouraging results, especially for long-term methods. This pilot will serve as a reference when accessing zones where access to services is more difficult.

5.2. *Rollout timeline*

Mobile units will be deployed first in the regions of Dakar, Thiès, Diourbel, Kaolack, Fatick and possibly Tambacounda.



5.3. *Cost by priority action 2012-15*

Priority actions	2012	2013	2014	2015	Total CFA
Establishing a multisectoral structure dedicated to PPP	2,380,040	–	–	–	2,380,040
Widening the range of social marketing products	12,160,200	24,579,880	–	–	36,740,080
Establishment of a product delivery system by the NPP	3,259,880	2,640,040	520,000	520,000	6,939,920
Integration of private-sector data	2,999,880	8,465,080	–	325,000	11,789,960
Establishment of mobile units	209,640,080	345,852,000	424,970,000	425,750,000	1,406,212,080
Establishment of social franchises	150,000,240	163,190,040	225,129,840	275,129,920	813,450,040
Increasing service delivery points	–	40,900,080	520,000	520,000	41,940,080
Adjustment of the regulatory framework	–	10,040,160	520,000	520,000	11,080,160
Re-vitalizing marketing authorizations	–	9,750,000	520,000	520,000	10,790,000
Direct training of private sector players	–	127,326,160	72,100,080	–	199,426,240
Ensuring coverage by insurance companies and social security	–	–	6,029,920	520,000	6,549,920
Total	380,440,320	732,743,440	730,309,840	703,804,920	2,547,298,000

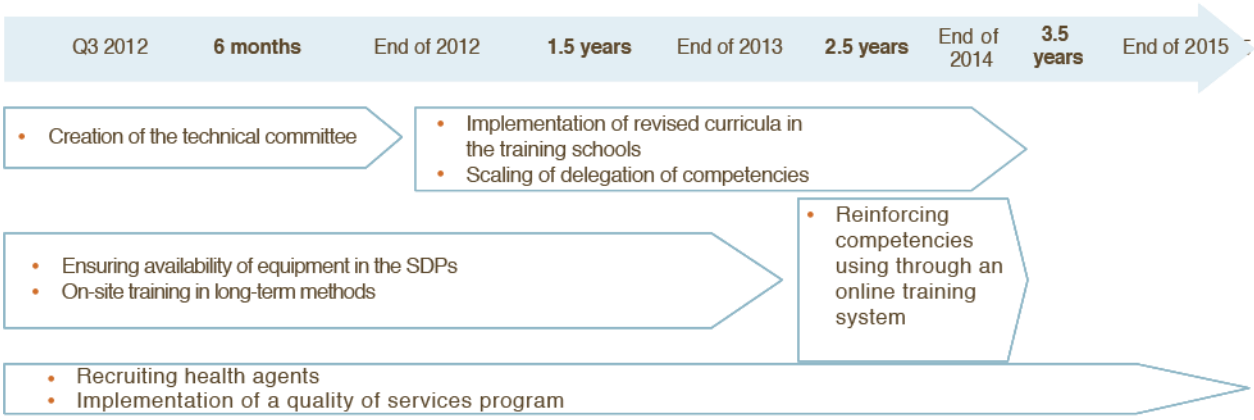
6. Improving the public-sector supply

6.1. *Definition of priority actions*

Improvement of the public-sector supply, particularly long-term methods and the quality of service, by recruiting qualified personnel and ensuring training in contraceptive technology and post-training monitoring of the providers at all service delivery points.

The emphasis will be on quality of service and counseling, while ensuring the availability of equipment and consumables. There will be a particular focus on improving access to FP services for young people, guaranteeing discretion, confidentiality and customized service.

6.2. *Rollout timeline*



6.3. *Cost by priority action 2012-15*

Priority actions	2012	2013	2014	2015	Total CFA
Ensuring availability of equipment at SDPs	36,019,880	455,063,960	520,000	520,000	492,123,8 40
Training in long-term methods	14,890,200	160,759,040	18,270,200	18,270,200	175,649,2 40
Recruiting health workers	6,129,760	124,010,120	124,270,120	124,270,120	378.680,120
Implementing a quality of service program	14,198,600	60,324,680	13,720,200	13,720,200	101,963,160
Implementing revised curricula in schools	–	3,259,880	520,000	520,000	4,299,880
Scaling-up task-shifting/sharing	–	17,999,800	–	–	17,999,800
Skills-strengthening using an online training system	–	–	16,355,040	–	16,355,040
Total	71,238,440	821,417,480	173,655,200	157,300,200	1,223,611,400

D. Institutional organization of implementation

In designing the structure of implementation of the national action plan, the following fundamental principles have been highlighted:

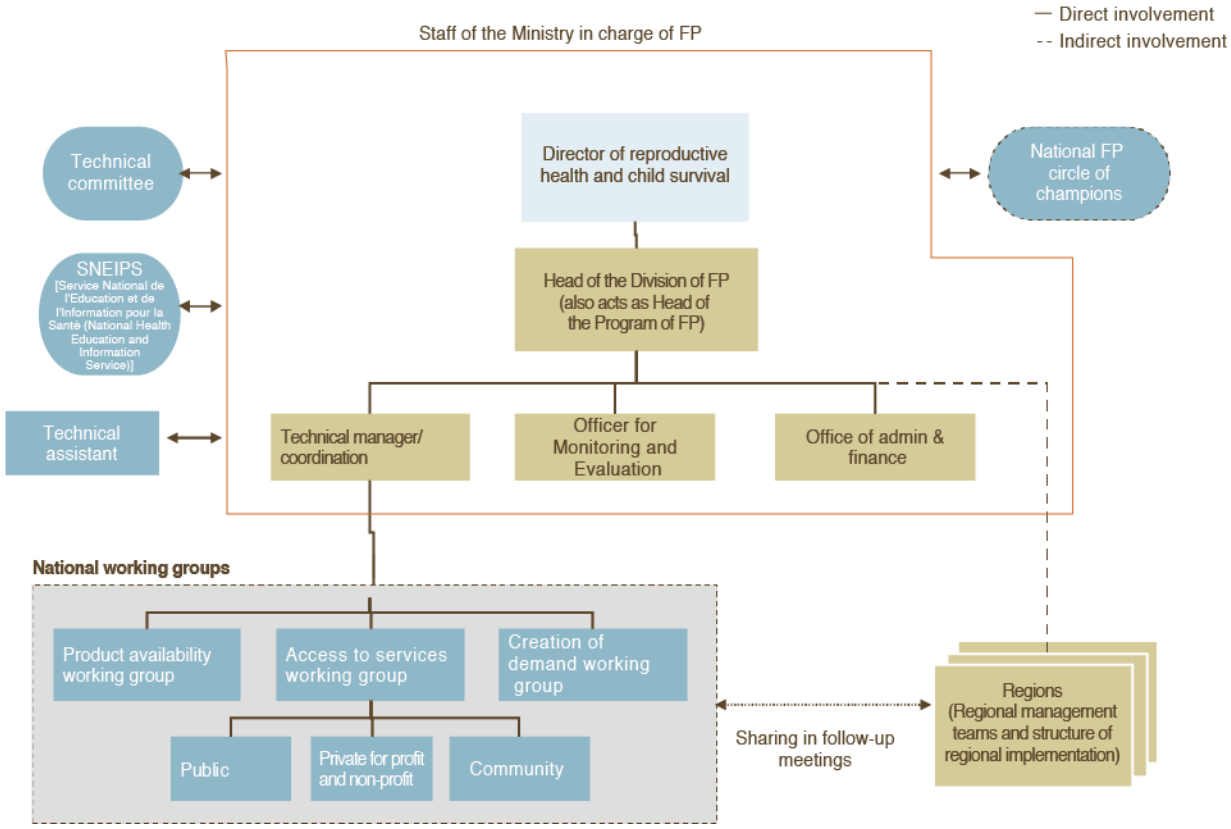
- The structure of implementation must be supple, flexible at the financial and operational level, and it must be integrated into existing structures; in addition, it must take the multisectoral aspect of FP into account. The action plan must be monitored at the highest level by the Minister, since FP is a confirmed national priority.
- The CRMOs are responsible for reaching the regional CPR goals based on clear performance contracts.
- The CRMOs are responsible for creating regional structures for monitoring and evaluating FP activities, which can be integrated into existing structures.
- National working groups continuously support each pillar of FP (product availability, access to services and demand creation).
- The program must be visible, of high quality and it must be achievable with the resources dedicated to FP.
- All of the parties involved are coordinated and aligned around a single national action plan which is evaluated periodically and in a systematic manner.

- Investments in monitoring and evaluation are more significant and focused at the beginning of the program, to ensure and effective and efficient launch of the plan.

The national FP action plan will be implemented under the direction and management of a structure that is part of the Department of Reproductive Health and Child Survival (DSRSE).

After analyzing various options, the parties involved came to the decision to anchor the structure in the DSRSE to receive support from the health system, especially for maternal and infant health, and to be able to give more power to the future Division in charge of FP. It will have the following elements as its principal prerogatives:

- Organizing the launch of the national action plan with all the key stakeholders (donors, actors in the field, government, civil society);
- Coordinating the execution of the action plan;
- Continuously adjusting the action plan;
- Ensuring monitoring and evaluation of the action plan, respect for the timelines and achievement of the goals set;
- Managing the finances of the national action plan;
- Organizing and coordinating communication with authorities and the public.



This structure will be completely dedicated to implementing the program and will be empowered to achieve the goals in the process described below. It will be composed of highly qualified staff dedicated to implementing the national action plan.

It will be directed by a program head who will work in close collaboration with a technical committee to gather together all the involved parties and construct an action plan

that builds on work already done by the technical committee. The program head will coordinate the plan's implementation, ensure continuous communication with the ministries and the media, and must make fundamental decisions such as disbursement of funds and corrective measures for the plan.

He will be supported by three officers with a full-time commitment to the FP program:

- An officer for monitoring and evaluation who will have the role of defining and revising the indicators and ensuring coordination with the regions to retrieve data.
- An officer for technical matters/coordination who will have the role of ensuring the operational implementation of the action plan and ensuring coordination with the implementation agencies and the working groups.
- An Office of Administration and Finance that will have the role of supporting the program head and other officers in their administrative activities.

The operational implementation will be piloted for each region by the CRMOs, who will be highly empowered concerning the CPR goals.

In addition, there will be three structures to support and guide the efforts of the implementation structure:

- A technical committee composed of experts from partners (donors, international organizations, NGOs, implementing agencies, civil society and the Ministry). This committee will be responsible for providing technical assistance to the program head, facilitating dialogue with or between the partners, making decisions on technical trade-offs, reviewing the progress of the action plan and approving major changes in the action plan.
- A national advocacy committee (FP circle of champions) composed of personalities who have weight with decision makers (for example, members of parliament, local elected officials, religious leaders, community members...). Its role is to act as a champion of FP, be the reference committee in charge of advocacy for FP at the highest level, assist the working group in charge of creating demand through its advocacy activities, and ensure multisectoral collaboration and links with other ministries and programs.
- A working group for each strategic domain: each working group includes members from the Ministry and certain technical and financial partners, and has the goal of working to implement the action plan. These working groups will help monitor the implementation of the action plan for their area (support for collection of data and analyses of process indicators, monitoring of implementation within the timeline of activities) and they will provide technical assistance to the officer for technical matters/coordination and to the implementation agencies for implementing the plan.

This structure has a total cost of 934 million CFA.

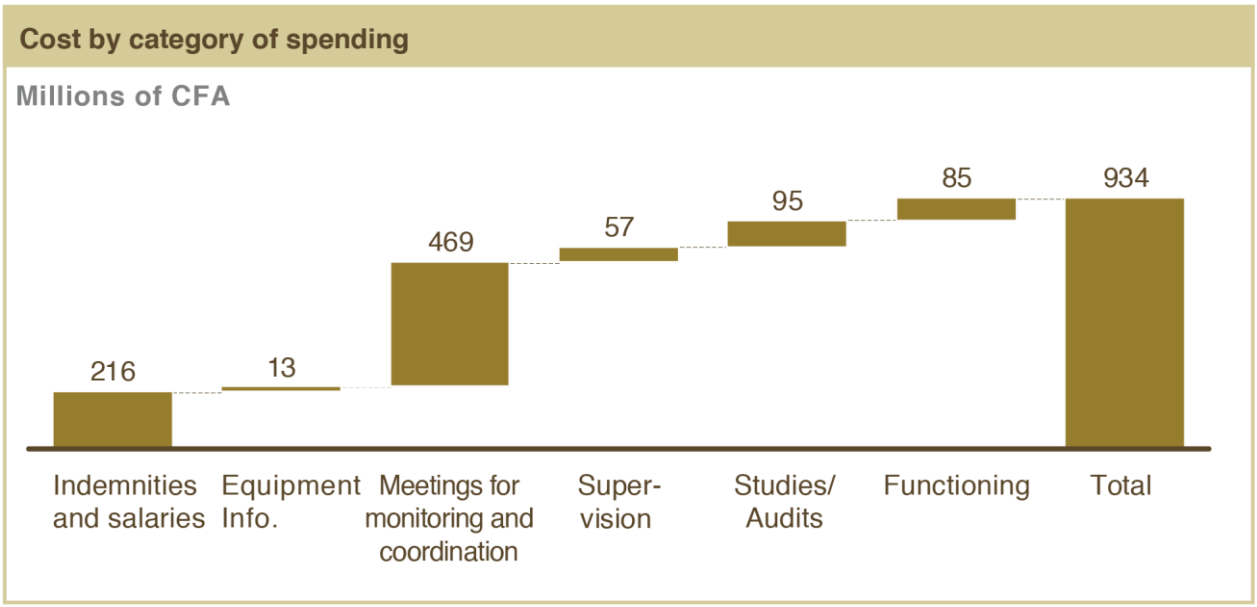
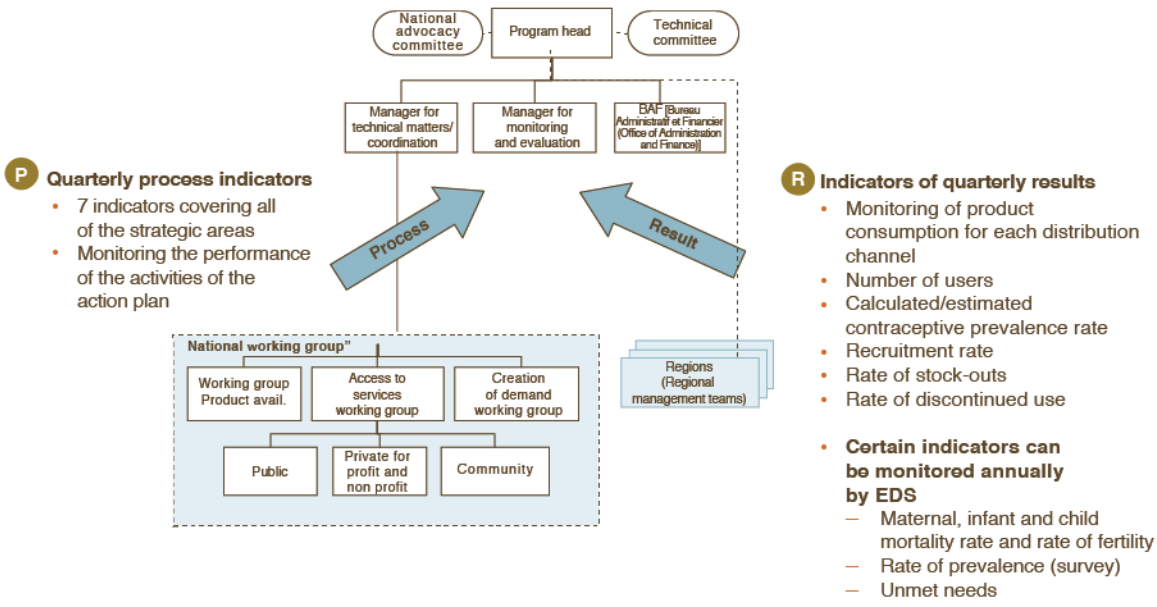


Figure 6: Costs of monitoring and evaluation for 2012-2015

E. Monitoring and evaluation mechanisms

In order to ensure effective implementation of the action plan, the following elements will be put in place:

1. Definition of process and results indicators at the regional and national levels



The quarterly process indicators will receive priority monitoring from the national working groups. These will focus on:

- 7 indicators covering all of the strategic areas (see below)

Area of priority action	**Indicators**	Base value	3rd quarter		4th quarter	
			Targets	Results	Targets	Results
National communication plan	Rate of completion of broadcasting activities in media (television and radio), and poster campaigns relative to the communication plan (%)					
Advocacy program	Number of advocacy activities conducted out of the number planned (%)					
Product availability	Percentage of SDPs covered by the Push Model (%)					
Expanding the Public-Sector Supply	Percentage of providers trained in FP (%)					
Expanding the Public-Sector Supply	Percentage of SDPs equipped for long-term methods according to standards (%)					
Expanding the Private-Sector Supply	Number of FP services offered by social franchises and mobile units (#)					
Expanding the Community-Base Supply	Number of health units able to distribute IPO/IIO (#)					

Indicators which track the completion of activities in the action plan (rate of completion of the action plan)

The following table depicting the monitoring of the action plan will permit an evaluation of the rate of completion of activities:

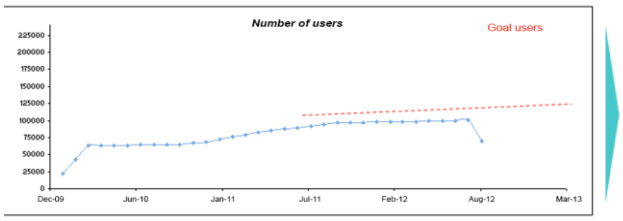
Monitoring of Senegal FP Action Plan
Initiative Timeline
Date: 5/9/2012 17:04

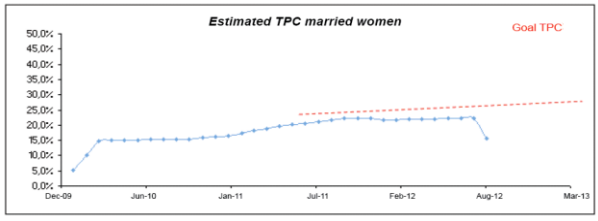
No.	Strategic Actions	Activities	Subactivities	Status	Dates Start	Dates End	2012 July	August	September	October	November	December	2013 January	February	March	April	May	June
P.1.1.a	Establish a national advocacy committee	Identify the stakeholders in advocacy and chose the institutions and persons	Mapping of the actors by an officer of the DSR	Complete	1/10/2012	1/1/2013												
P.1.1.b		Identify all the stakeholders in advocacy and chose the institutions and persons	Hold a meeting to choose the actors and predefine the role of the actors	Completed	1/10/2012	1/12/2012												
P.1.1.c		Identify all the stakeholders in advocacy and chose the institutions and persons	Confirm/validate their participation and their role in the committee with the actors (launch meeting)	Complete	1/10/2012	1/12/2012												
P.1.2.a		Definition of TOR and mode of operation (frequency of meetings, allocation of expected roles…)	Editing of TOR and mode of operation	Ongoing	1/10/2012	1/1/2013												
P.1.2.b		Definition of TOR and mode of operation (frequency of meetings, allocation of expected roles…)	Validation by the committee of the TOR and mode of operation (validation meeting)	Ongoing	1/10/2012	1/12/2012												
P.1.3		Formalization and legitimation of the committee by a note	Sending of the explanatory service note on creation of the committee to the ministry	Ongoing	1/11/2012	1/1/2013												
P.1.4.a		Definition of the goals, expected results and evaluation plan (general framework of evaluation)	Committee workgroup meeting to determine the goals, expected results and broad lines of the evaluation plan (general framework of evaluation)	Ongoing	1/11/2012	1/1/2013												
P.1.4.b			Editing of goal results and evaluation plan	Delay	1/11/2012	1/1/2013												
P.1.4.c			Validation by the committee (validation meeting)	Delay	1/11/2012	1/2/2013												
P.1.5.a		Monitoring of implementation of advocacy and impact	Development of tools to monitor the indicators	Delay	1/11/2012	1/2/2013												
P.1.5.b			Establishment of a dashboard for the review of implementations	Delay	1/11/2012	1/2/2013												
P.1.5.c			Quarterly meetings to monitor the implementations/indicators	Delay	1/11/2012	1/1/2013												
P.1.2.1.a	Obtain public and governmental authorities and more significant funding for FP activities	Identification of target groups within the government authorities	Selection of officer and realization of the mapping of target groups and the political environment	Complete	1/10/2012	1/12/2012												
P.1.2.1.b			Categorization into groups "for" and "against" FP and their centers of interest in order to facilitate development of the advocacy tools	Complete	1/10/2012	1/12/2012												
P.1.2.1.c			Validation by the committee	Complete	1/11/2012	1/1/2013												
P.1.2.2.a		Develop an advocacy tool adapted to target groups for allocation of the budget	Review of existing tools by a responsible expert	Complete	1/11/2012	1/1/2013												
P.1.2.2.b			Creation of advocacy tools (content and format adapted to different targets	Complete	1/11/2012	1/2/2013												
P.1.2.2.c			Validation of the tool by the committee during a meeting	Complete	1/12/2012	1/2/2013												
P.1.2.2.d			Reproduction of the advocacy tool (support adapted to the different targets)	Complete	1/12/2012	1/2/2013												
P.1.2.3		Organize a sharing meeting with the development partners to obtain their support with the government	Prepare the argument and the official request for support from the development partners during a meeting	Complete	1/10/2012	1/12/2012												
P.1.2.4.a		Organize advocacy meetings with the Minister for Economic Affairs and Finance and of Health	Meeting with the cabinet and the Minister for Economic Affairs and Finance	Ongoing	1/2/2013	1/4/2013												
P.1.2.4.b		Organize an advocacy meeting with the Minister of Health (Department of Administration and Management) to obtain a more significant allocation for reproductive health and FP (priority, arbitration is done at this level)	Meeting with the cabinet and the Minister of Health	Ongoing	1/1/2013	1/1/2013												

The following results indicators will receive priority monitoring from the Chief Regional Medical Officers, in particular:

- Some first level indicators, such as the number of users, calculated estimate of CPR for married women and couple-years of protection, will be followed on a quarterly basis. These indicators will be based on the consumption of products, important information that will permit us to gage the effectiveness of the action plan and that will be monitored for each distribution channel (public, for-profit private and non-profit private, community-based). The reliability of the data will be tested during the quarterly supervision missions in each region.

			2012				2013								2014				
	Indicators	Base value	Q3 2012		Q4 2012		Q1 2013		Q2 2013		Q3 2013		Quarter 4		Quarter 1		Quarter 2		Quar
			Targets	Results	Targets	Results	Targets	Results	Targets	Results	Targets	Results	Targets	Results	Targets	Results	Targets	Results	Targets
1st level indicators	Number of users																		
	Estimated TPC for married women (%)																		
	Couple years of protection (CYP)																		





2nd level indicators	Recruitment rate (%)	1.8%	2%		2.4%		2.6%		2.8%		3.0%		3.2%		3.4%		3.4%		3.4%
	Rate of stock outages (%)	40.0%	35%		20%		15%		10%		5%		0%		0%		0%		0%
	Rate of abandonment (%)	2.0%	1.50%		1.30%		1%		0.80%		0.60%		0.50%		0.50%		0.50%		0.50%

- Some second level results indicators, such as rate of new users, rate of stock-outs and rate of discontinuation, using the tables already available and in place. These secondary indicators permit us to understand better understand changes in consumption and to ensure progress is monitored.
- Some indicators, such as unmet need, contraceptive prevalence rate or rate of maternal and infant mortality, can be monitored annually using the continuous DHS which is being developed.

2. Introduction of periodic monitoring missions at every level for data feedback

The results indicators must be discussed during the coordination meetings at the district (monthly), regional (quarterly) and central (semiannually) levels. This review will be included in already existing review/coordination meetings in order to avoid burdening the system.

The tools and standardized dashboards will permit discussion of how products are consumed, as well as other indicators, at the regional and central levels.

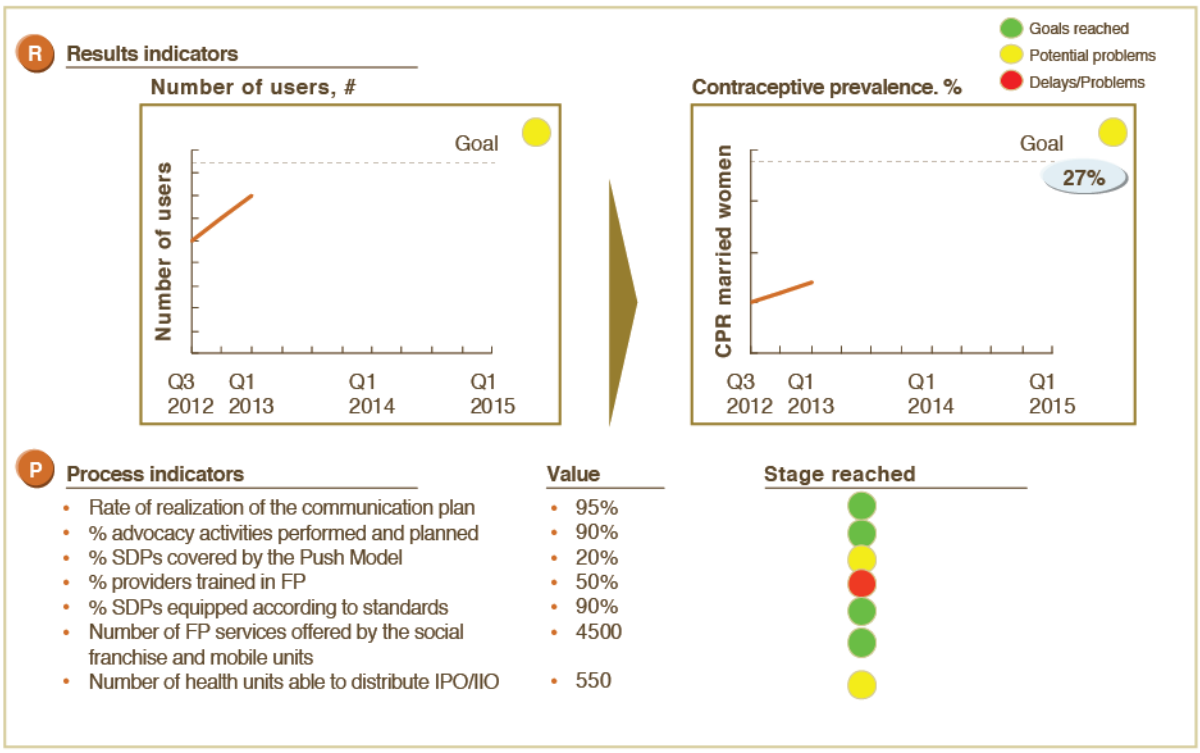
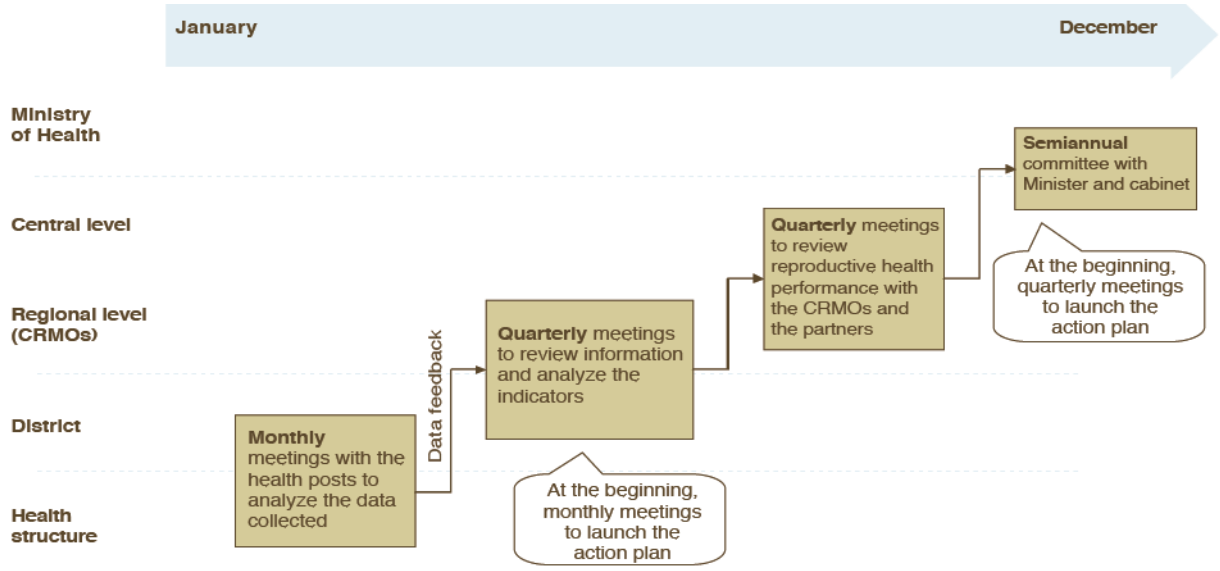


Figure 7: Example of dashboard for central meetings

In order to support the launch of the action plan it has been decided, in consultation with the Chief Regional Medical Officers, to hold monthly meetings at the beginning of implementation, at the district and regional levels, to ensure the launch of the action plan. It has also been decided to organize quarterly meetings at the central level with all the CRMO partners, in order to initiate and support the establishment of the action plan. This pace will slow after the effective, successful launch.



These mechanisms will allow us to highlight monitoring of program activities (inputs) and monitoring of program results (outputs), and can also facilitate corrective decisions.

Involvement of the State and its partners

- **Commitment of the State**

At the international FP Summit on July 11, 2012 in London, the state committed itself to increasing the budget for the purchase of contraceptives by at least 200%, and to doubling the budget for management of the action plan. The state also endorsed the creation of a Department in charge of reproductive health and child survival and a division in charge of FP. In addition, the government committed itself to providing support for organizational reinforcement of the structure in charge of implementing this plan, and to ensuring multisectoral collaboration and integration with other programs (HIV, malaria, malnutrition). Progress on the plan will be reviewed on a quarterly basis at the highest level of the Ministry of Health and Social Welfare by the Minister or the Director of Health. Finally, the state is ready to support the regulatory changes necessary to facilitate FP activities.

- **Commitments of partners**

At the launch Forum of the action plan, partners committed themselves to financing the activities of the national plan.

In order to prepare their commitments, the partners followed a clear and structured process which permitted inclusion of all parties involved.

First the partners met individually with the Head of the Division of Reproductive Health, Dr. Daff, during the week from August 27 to September 3, 2012, to review the action plan as a whole, the strategic actions to be funded, their costs and the financing needs which were not covered. The partners had the opportunity to indicate their interest in specific activities in line with their vision and work plan for the coming years, and to communicate their intended funding. The representatives of the Ministry of Health and Social Welfare had the opportunity to better understand the financing procedure and the next steps necessary to achieve funding.

During the Launch Forum, all the potential partners met in Dakar to make an official commitment to the funding described below and to agree on clear principles of coordination before the Minister of Health and Social Welfare and the Cabinet.

APPENDICES

A. Appendix on challenges

1. Challenges related to demand creation

Unmet need were on the order of 29.4% in 2010. They were very high at every socioeconomic level, age, level of education and region.

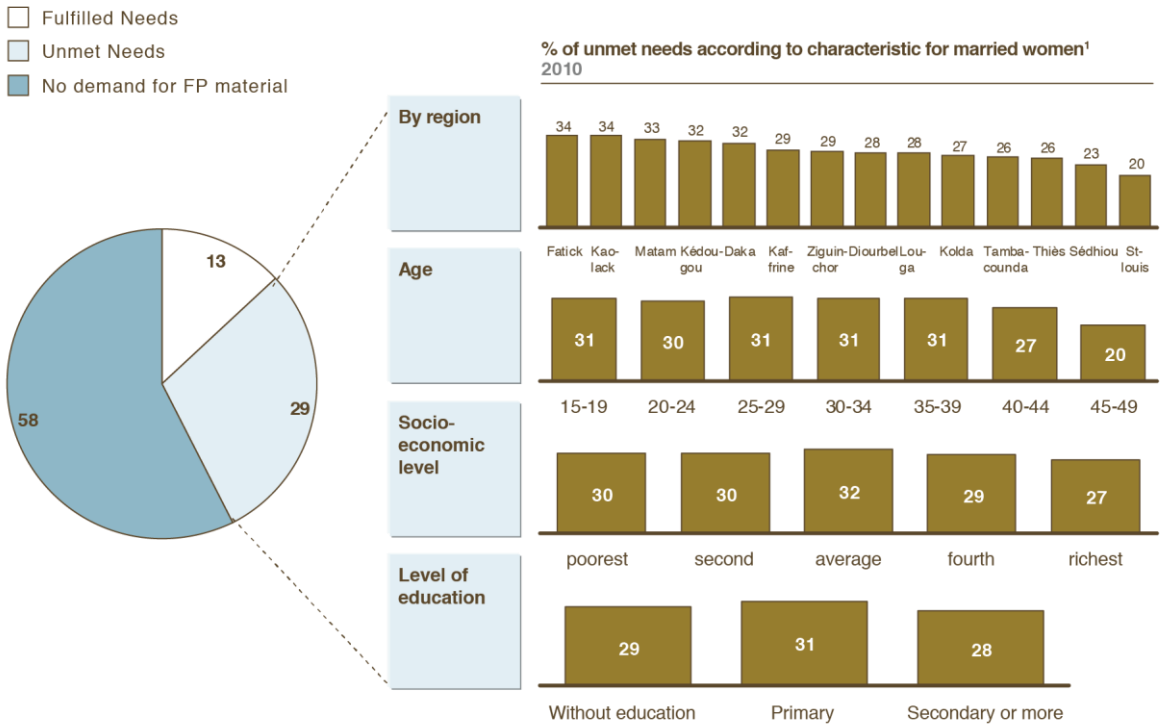


Figure 8: Unmet need of women according to socioeconomic background, source: DHS 2010-11

We note a decrease in communication on FP in Senegal since 2010. This translates into a decrease in the cost of communication, and above all in the number of women reached during the last 5 years (decrease in women exposed to messages on FP in the media from 48% in 2005 to 39% in 2011).

It also appears that in spite of very good knowledge about contraceptives (90% of women know of at least one FP method), the perception of FP remains very negative among women and fear of side effects and health problems is still one of the major reasons for non-use (about 20% of women do not use contraceptives for fear that this is dangerous for their health).

Also, the social taboo connected to FP is still very present in Senegal and constitutes an important challenge for demand creation.

Another major cause of non-use is the desire for children related to sociocultural factors. In order to develop into a prosperous and strong nation, we must address these preconceptions and change behavior towards attitudes favorable to FP. This stigmatization is especially persistent in regard to young people (only 2% of young women between 15 and 19 years old have received a visit from a field agent who talked to them about FP), while Senegal has a high teen fertility (93% at 15-19 years old) and a high percentage of young girls who marry before the age of 16 (24% of young girls between 15 and 19 years old are married).

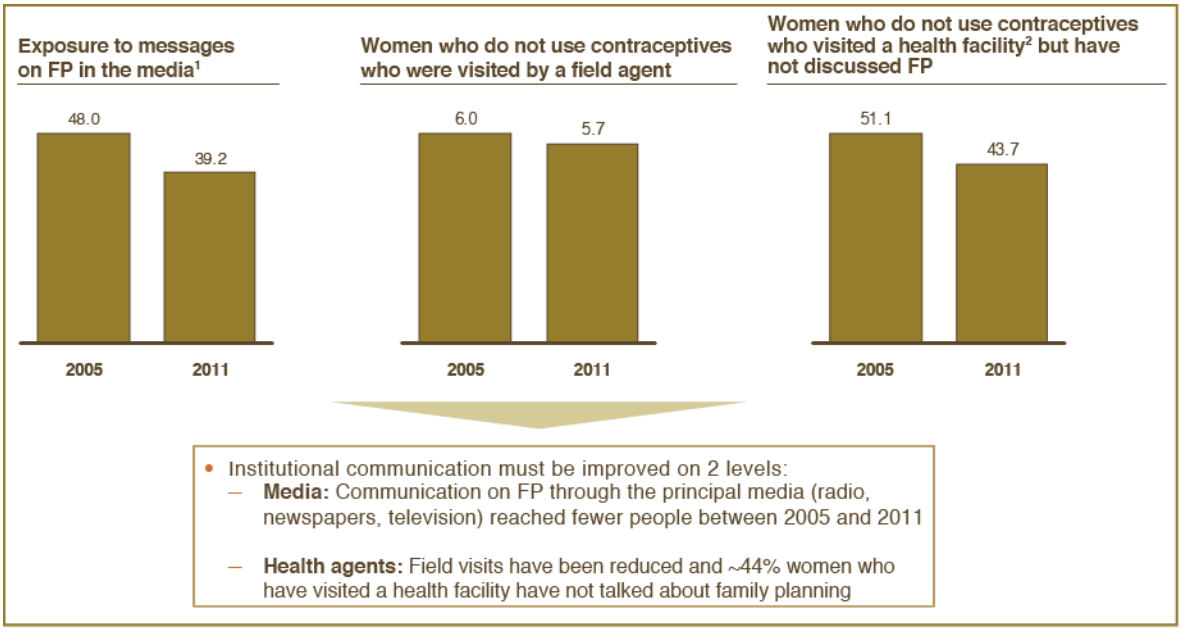


Figure 9: Exposure of women to messages about FP in the media and in the field, source: DHS 2010-11

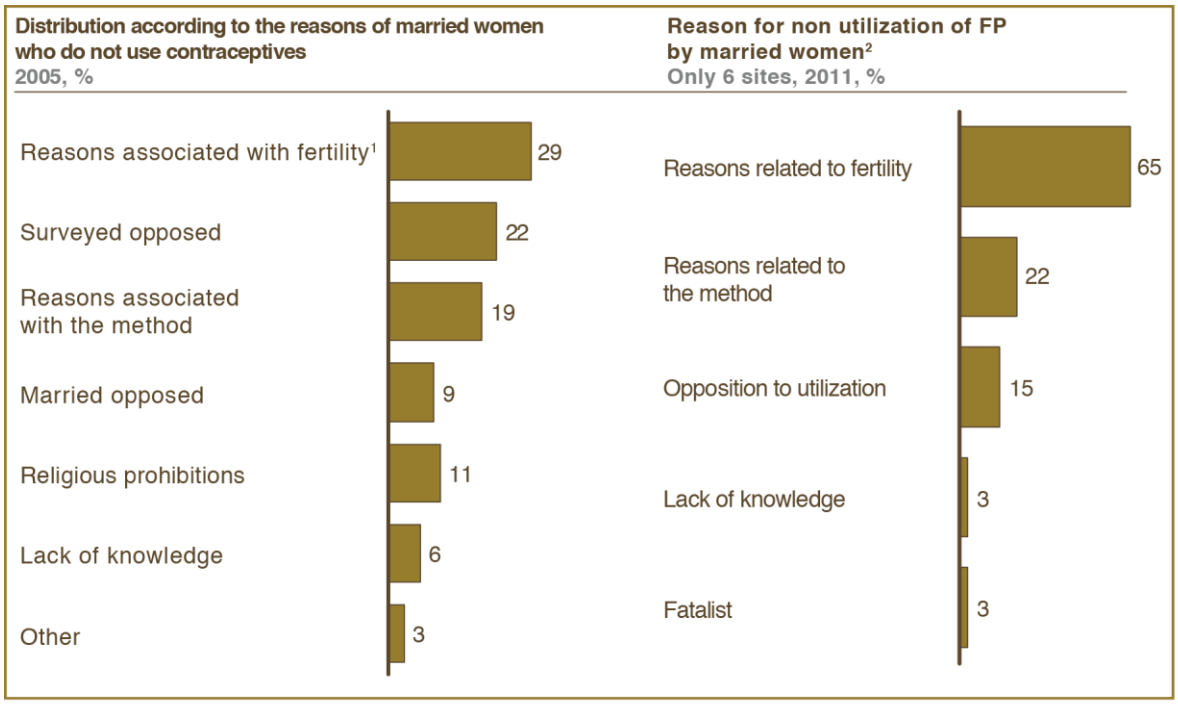


Figure 10: Reasons for non utilization of FP, household survey, ISSU [Initiative Sénégalaise de Santé Urbaine (Senegalese Initiative for Urban Health)], MLE [Measurement, Learning and Evaluation Project]

2. Challenges related to product availability

The procurement system in Senegal faces certain difficulties:

Stock-outs at the national level (the rate of stock-outs for injectables varies between 25 and 45% in the key towns; it is the same for implants, where stock-outs can reach 80% in the public sector).

Distribution problems, which are an important cause of client non-satisfaction (40% stock-outs for Depo-Provera in Pikine in 2010-11, 80% for Jadelle in spite of the stocks at the national level).

Product quality control that remains variable and inadequate.

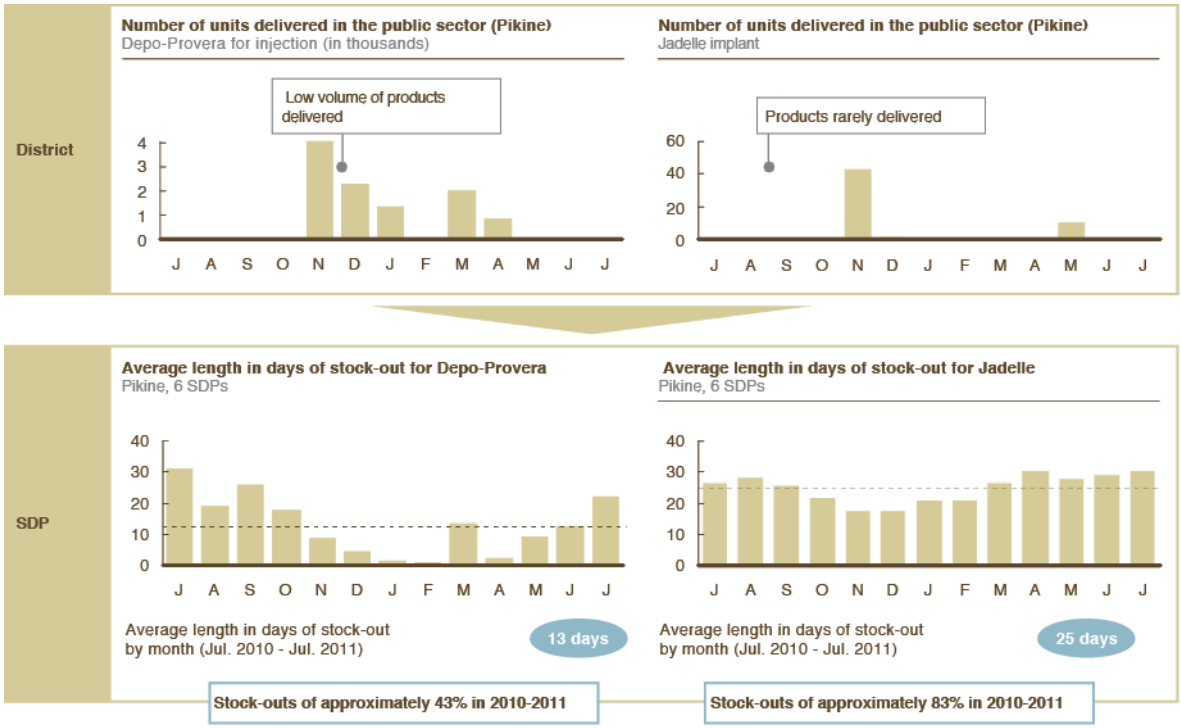


Figure 11: Stock-outs at the level of districts and SDPs, source: SDPs Pikine

3. Challenges related to access to FP services

The quality of supply is very unsatisfactory (52% of clients state that they are not very satisfied with services received) and this is in spite of training efforts for FP providers in the last few years. Women feel unwelcome, poorly informed and stigmatized (about 1 woman in 3 states that providers/vendors of FP products make them feel ill at ease when they come to get the contraceptive products, source: *Household survey, ISSU, MLE).*

In effect there is a strong stigmatization of FP services, especially in the public sector, where 44% of clients feel they are not well treated by providers.

In the private sector it is primarily the difficulty of obtaining contraceptive products that poses a problem. In effect, a prescription is needed in order to buy contraceptives in the private sector, pharmacists are not authorized to deliver the methods or to prescribe them, and the private clinics cannot stock contraceptives.

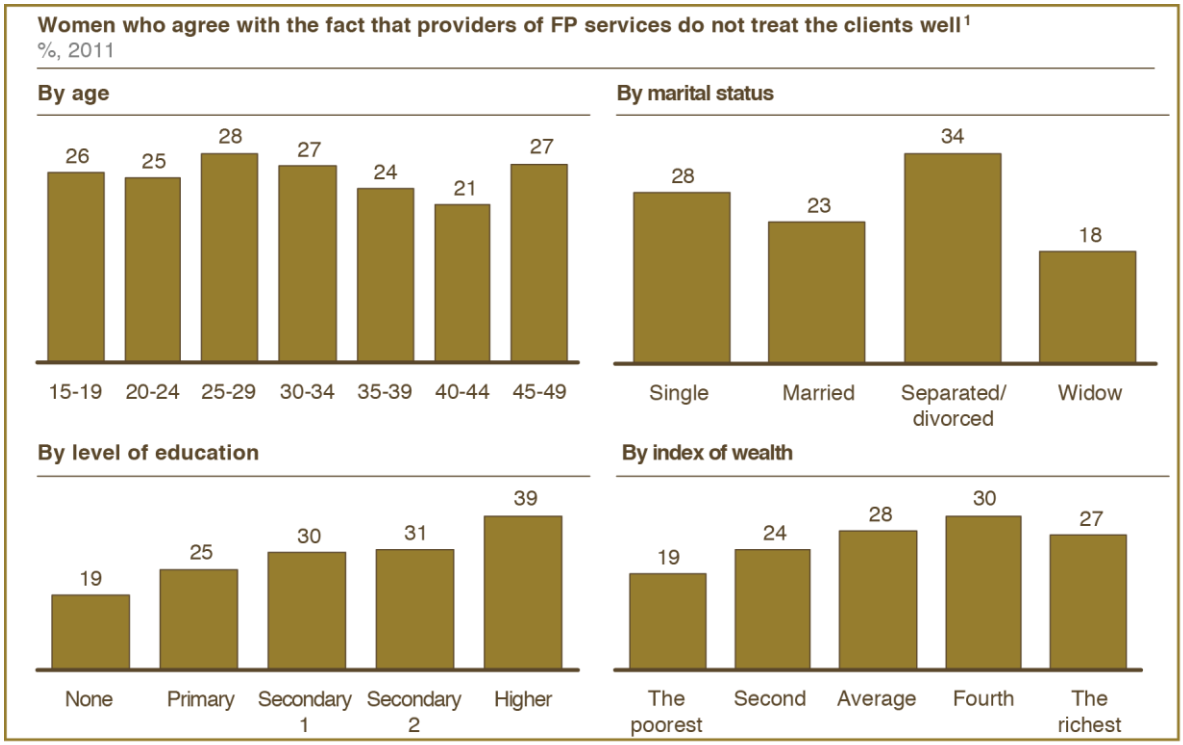


Figure 12: % of women unsatisfied with FP service according to sociodemographic criteria, source: Household survey, ISSU, MLE

B. Appendix on costs

Strategic areas	2012	2013	2014	2015	Total CFA
Expanding the private sector system	380,439,800	732,742,920	730,309,840	703,804,920	2,547,298,000
Expanding community-based supply	201,874,920	799,899,880	526,125,080	1,151,505,160	2,679,405,040
Expanding the public-sector supply system	71,238,440	821,417,480	173,655,200	157,300,200	1,223,611,400
Improving product availability	164,487,440	731,281,720	549,047,200	533,999,960	1,978,815,800
Advocacy program	94,875,040	350,617,280	279,134,960	250,842,280	975,470,080
National communication plan	32,702,280	545,018,760	830,825,320	972,968,880	2,381,515,240
Monitoring and evaluation	64,175,040	274,258,160	287,238,160	308,558,160	934,229,520
Purchase of contraceptives		903,238,440	1,172,586,480	1,522,115,920	3,597,940,320
Total	1,009,793,560	5,158,474,440	4,548,922,060	5,601,095,380	16,318,285,440

Figure 13: Details of costs by strategic area and by year

Details of strategic actions for the 6 strategic intervention areas

A. Communication plan:

1. Qualitative research and dissemination of results:

The goal is to be able to better understand the level of knowledge and the perception of FP (barriers and motivating factors) using focus groups, and to determine target profiles in order to be able to adapt messages to target populations. These should be assigned to research institutions qualified to ensure the quality of the results as well as their analysis. The plan then provides for discussion meetings and printing booklets with target profiles in order to disseminate the results to all parties involved. This research will also use tools and surveys that are already available and focus on aspects that are still unknown or poorly understood.

2. Mass campaigns targeting women:

The first step consists of creating and testing key messages in order to gage their effectiveness. Then, television and radio spots and posters will be created in collaboration with a communications agency. After establishing partnerships with national and local media, the mass media television and radio campaigns will be implemented: one television spot will be broadcast per day for 3 months in each half of the year on 4 television channels and 2 radio spots will be broadcast every other month on 4 radio stations. Also, these activities will be reinforced by a poster campaign with 300 posters per year and distribution of 10,000 booklets per year on experiences of users; the reestablishment of the family planning radio call-in show; and the equipping of 100 health centers with screens displaying advertising spots related to FP.

3. Community activities and IPC:

The goal is to conduct outreach communication in order to mobilize communities and promote open house days on the radio stations. Civil society will be induced to play an important role in these activities. In addition, the plan provides for scaling-up the walking tour of FP promoters in the principal markets of all districts and specific campaigns for community radio stations.

4. Specific activities in rural communities:

Rural communities must be addressed in a specific and differentiated manner. Thus, the plan includes a caravan tour of villages, putting on plays on FP. We plan to reach 6 regions per year. Competitions will be organized on local radio stations in all districts, with prizes for winners.

5. Campaigns targeting men:

Men will be reached by means of a mass radio and television campaign with significant broadcasting of spots until 2015 (1 spot per day for 3 months on 4 television channels, 2 broadcasts per day every other month on 4 radio channels, and specific broadcasts on community radio stations). A poster campaign targeting men will also be carried out in Dakar and other large cities. Finally, the plan will be supported by ONCAV during its events – especially soccer matches – and by focus groups and religious associations promoting FP.

6. Campaigns targeting young people:

Young people are a priority for the government. Also, the NFPAP plans a participative campaign dedicated to young people (organizing a competition for audiovisual productions on FP). These actions must permit us to ensure that messages and channels are appropriate for young people, and to reach them in an innovative manner. Action will be taken to strengthen Counseling and Information Centers and to distribute informational booklets in high schools and universities. Finally, a text message and social networking campaign will be implemented to reach youth directly through age-appropriate channels.

B. Advocacy program:

1. Establishment of a national advocacy committee (circle of national FP champions):

The national advocacy committee will be in charge of supporting the working groups in coordinating and directing advocacy. Composed of personalities that are recognized in their fields and that have significant expertise, this committee will ensure multisectoral collaboration and can also make requests from the working groups known at the highest level. Their primary role is to be FP champions and a potential point of contact in their fields.

2. Advocacy to redefine the position of the DSR:

The action plan calls for securing funds from the cabinet and the Ministry of Health and Social Welfare for the future division in charge of FP, and ensuring its place in the reorganization of departments in the Ministry of Health.

3. Advocacy to improve the regulatory framework:

Implementation of the action plan implies changing the regulatory framework to revitalize FP activities (e.g.: prescriptions for pills, authorizing pharmacists to provide injectables, task-shifting/sharing to community personnel, allowing private clinics to stock contraceptives, etc..). The action plan calls for creating specific advocacy arguments and tools as well as meeting with the principal organizations concerned (State, medical associations, etc.).

4. Advocacy for increased public funding:

The action plan calls for identifying target groups among public authorities, developing adapted advocacy tools, organizing meetings and discussion workshops with the competent authorities, development partners, the Ministry of the Economy and Finances, etc. The focus will be on national and regional authorities (elected local officials, health committees, local collectives, etc.) in order to obtain better financing for FP activities.

5. Advocacy to reinforce partner support:

Having created a map of donors interested in FP, the action includes developing adapted advocacy arguments and tools as well as organizing periodic individual meetings (semiannually) with principal development partners on their involvement in the development and implementation of the national FP action plan.

6. Advocacy to make FP a national priority:

The action plans includes, as its major activity, the institutionalization, organization and promotion of a National FP Day that reaches the greatest number of participants and decision makers. The action plan also calls for meeting with all the ministries that have a role to play in FP (Economy and Finances, Youth, Family...). Civil society, with its multisectoral approach, will be both a target and a privileged actor in this strategic action.

7. Advocacy to obtain the support of leaders in the health sector:

The leaders in the health sector are: doctors, pharmacists, midwives, health directors, Chief Regional Medical Officers, etc. The plan provides for creating advocacy tools focused on health, giving information and data on the current state of FP and the need for change. Also, meetings for distributing information, advances and requests for support to health leaders will be organized on a quarterly basis.

8. Advocacy to obtain the support of the private sector:

The goal here is to be able to obtain effective financial support (sponsoring, direct funding or reductions granted through partnerships) from the private sector. The private sector here includes the medical private sector (pharmacies, doctors, clinics, etc...) and companies as well. In particular the plan provides for sensitizing the medical services of companies so that they will offer FP; organizing meetings with employer organizations and labor unions; and a fundraising day.

9. Advocacy to obtain the support of the media:

The action plan includes partnerships with the principal media in Senegal so that they will participate in media coverage of FP activities and consent to cost reductions for television or radio spots. Finally, it provides for organizing quarterly meetings with the media to share progress in FP and make them champions/promoters of FP.

10. Activating and re-energizing the network of political champions:

After having identified champions to approach at the national and local levels, the plan provides first for training the people in charge of approaching the champions. Subsequently, the champions will receive annual orientation and training. A single session is provided for at the national level while local sessions will be held in each region.

11. Activating and re-energizing the network of community champions:

After having identified champions to approach at the national and local levels, the plan provides first for training the people in charge of approaching the champions. Subsequently, the champions will receive annual orientation and training. A single session is provided for at the national level while local sessions will be held in each region.

12. Activating and re-energizing the network of religious champions:

After having identified champions to approach at the national and local levels, the plan provides first for training the people in charge of approaching the champions. Subsequently, the champions will receive annual orientation and training. A single session is provided for at the national level while local sessions will be held in each region.

13. Activating and re-energizing the network of national champions:

After having identified champions to approach at the national level (artists, athletes...), the plan provides first for training the people in charge of approaching the champions. Subsequently, the champions will receive annual orientation and training.

C. Product availability:

1. Introduction of a single product ordering system:

It is very important to have a single channel for ordering FP products for Regional Procurement Pharmacies (RPPs). There should be communication with buyers concerning integration and new ordering mechanisms. Finally, the plan provides for ensuring training supervision for integration in regions until complete assimilation.

2. Guarantee the availability of equipment:

This action plan contains necessary activities in order to guarantee the availability/functionality of sterilization equipment, especially autoclaves (40 in total). The plan includes purchasing, installation and training in how to use the equipment. In addition, it is imperative that solar panels (250 in all) be installed to guarantee electricity at SDPs that do not have electricity.

3. Progressive extension of the Push Model:

The action plan includes scaling-up the Push Model in 4 waves in all regions. This expansion will take the successful experiences in Pikine, Kaolack and Saint-Louis as a point of departure. In 2012, the pilot will be expanded to the regions of Dakar and Saint-Louis and in 2013 to Thies, Kaolack, Fatick and Diourbel. The objective here is to ensure frequent delivery of products directly to SDPs and to entrust each task to a specialized logistics operator.

4. Improvement of the logistical skills of staff:

In the first place, the plan provides for mapping the medical personnel (PKI, chief pharmacists and/or custodians) who have not yet been trained in the regions not covered by the Push Model, and on-site training in logistical management. In the regions not yet covered by the Push Model, quarterly supervision of district warehouses by the chief pharmacists of the Regional Procurement Pharmacies.

5. Improvement of the data management skills of personnel (Channel):

In the regions not covered by the Push Model, the action plan includes use of information technology for compiling data and orders. In the regions covered by the Push Model, the emphasis will be on integration of Channel in managing data from the Push Model for collections management and implementation of performance management.

6. Filling orders based on actual consumption and monthly inventory tracking:

This includes continued implementation of the Reality Check tool and confirmation of orders by actual consumption data. In addition, this action includes a monthly meeting of the committee for commodity security (SPSR [Sécurité des produits de santé de la reproduction (Reproductive Health Commodity Security)])

D. Expanding the community-based supply:

1. More extensive task-shifting/sharing:

This action proposes including the Initial Pill Offering (IPO) in the integrated service packet for all the functional units (600 units). We will focus on training literate CHWs and midwives in IPO, allocating an initial stock of pills to new units offering IPO, post-training monitoring and supervision of the district by a management team for 10 months.

2. Increasing access through distribution by health points with literate CHWs (community health workers):

This action provides for expanding the initial injectable offering to literate midwives and CHWs in functional units (500 units) in the case of positive results on the feasibility tests. This supports, among other things, finalization of the pilot and evaluation (summer 2012 - January 2013) of the feasibility of the initial injectable offering. It primarily ensures training of trainers and training of CHWs and midwives in the Initial Injectable Offering (IIO), and post-training monitoring as well as supervision by the district management team. Finally, this action provides for allocation of an initial stock of injectables to units offering IIO.

3. Revitalization of the Bajenu Gox (BG) program:

Revitalization calls for an initiative to evaluate the impact of the BG program (criteria of recruited profiles, duration and contents of training...) and reposition the program. Finally, coverage by BGs will be strengthened, as a plan is in place to recruit and train 6500 additional BGs.

4. Use of intermediaries:

The use of intermediaries will be a priority for combating discontinued use. Thus, the activity of users in the SDPs and the health units will monitored. Also, the intermediaries will be used systematically for making contact (visits to the home, calls...) with users who are late in using the contraceptives.

5. Increase of CBHW coverage:

The goal of these activities is to increase coverage by CBHWs offering the IPO and the IIO (1300 in all). We plan to ensure training of these CBHWs in IPO and IIO in the case of positive test results, quarterly supervision in each region and the initial allocation of pills, injectables, working documents and bicycles.

6. Increasing access through distribution by other categories of community health workers (intermediary, BG):

The plan provides for the launch of pilots and evaluation to determine the benefit of extending IPO/IIO to other community health workers. It also provides for scale-up through training for half of the intermediaries and BG (those who are literate). The plan also includes post-training monitoring, supervision by the district management team and allocation of pills and booklets to the intermediaries and BG.

7. Increasing access through distribution by units with illiterate CHWs:

This action provides for the expanding the initial pill and injectable offering to midwives and illiterate CHWs in functional units (500 units). This includes, among other things, finalization of the pilot and evaluation of the feasibility of the initial injectable offering. It primarily ensures training and post-training monitoring of illiterate midwives, CHWs and CBHWs in IPO and IIO, as well as supervision by the district management team. Finally, the plan provides for allocating a stock of pills and injectables to units offering IPO and IIO.

8. Improving the training and of monitoring of intermediaries:

The purpose of this action is to improve training and to strengthen the FP knowledge and monitoring of intermediaries of all types (including religious intermediates). All intermediaries (~10,000) will be deployed to review and refine the content of messages on FP which will be circulated.

E. Extension of the private sector supply:

1. Establishing a multisectoral structure dedicated to PPP:

The goal is to establish a multisectoral unit responsible for managing public-private partnerships (PPP). It must review and adapt existing structures (the private/public partnership cell and the division of private and traditional medicine) in order to establish a structure that permits the private sector to be completely integrated in the health system.

2. Widening the range of social marketing products:

This action provides for widening the range of social marketing products (for example, implants) in order to lower the costs and permit wider distribution. After a price reduction has been negotiated with pharmaceutical laboratories, funding has been secured and a Marketing Authorization has been obtained, integration of the product must be finalized with private wholesalers/distributors and doctors and pharmacists must be sensitized.

3. Establishment of a product delivery system by the NPP:

Here, action will be focused on integrating contraceptives into the list of medications delivered to the private sector by the National Procurement Pharmacy (NPP) (list approved by the DPL [Direction des Pharmacies et des Laboratoires (Department of Pharmacies and Laboratories)]) Promotion and integration of contraceptives into the list of medications delivered to the private sector must then be ensured by means of informational meetings and sensitization. Finally, a memorandum of agreement between the DSRSE and the NPP must be signed for transmission of information on consumption in the private sector.

4. Integration of private for-profit data:

Working groups will be organized to determine the data to be collected and the data collection mechanisms, in collaboration with the SNIS [Système d'Information National Sanitaire (National Health Information System]. This will lead to creation of a data integration system. The working groups will require human resources and techniques which will enable collection and monitoring of private for-profit data.

5. Development of mobile units:

6 mobile units will be operational in the zones decided on with the Division in charge of FP (4 in 2013, 6 in 2014 and 6 in 2015). The Division will first have to identify the target zones and finalize the contract governing relations between the state and the private partner deploying the mobile units. This agreement must be created in the framework of a PPP. Finally, quarterly monitoring of the mobile units will be carried out.

6. Reinforcing social franchising strategies:

200 social franchises will be established by 2015 (60 in 2012, 100 in 2013, 150 in 2014 and 200 in 2015). A contract governing relations between the state and the private partner (NGO, OSC...) to deliver the social franchises must be worked out beforehand in the framework of a PPP. These activities will be reviewed annually.

7. Increasing service delivery points:

This action has the purpose of increasing the number of private SDPs delivering contraceptives (private medical sector or companies). A map of the actors that do not offer FP will be created. The procurement mechanism for these private actors will then be determined.

8. Adjusting the regulatory framework:

An overview of the regulatory framework and requests for modification must be carried out in advance. A meeting is also planned with all the parties involved (medical associations, line ministries, etc...) to approve the changes. Following that, the plan calls for dissemination of regulatory changes to professional associations and monitoring the application of modifications. This action is related to the relevant advocacy activity.

9. Diligence in issuing Marketing Authorizations:

Analysis of contraceptives that do not have a marketing approval in Senegal is planned. The goal here is to encourage and assist private laboratories in their efforts to launch the Marketing Authorization procedure.

10. Direct training of private actors:

This action includes the identification of training needs and the organization of training sessions in contraceptive technologies by private actors (pharmacists, midwives and nurses, etc...) This action also includes the organization of information and supply provision days in private companies. Finally, quarterly supervision missions are planned for the regions.

11. Coverage of FP services by insurance companies and social security:

The plan provides for conducting a feasibility study on coverage of FP services or products by insurance companies and the social security fund. The key activity will be to decide, in consultation with the technical committee and line ministries, upon the most suitable funding mechanism to permit coverage of services and products related to FP.

F. Expanding the public sector supply:

1. Ensuring availability of equipment at SDPs:

The first step consists of identifying and quantifying the needs for equipment at the district level. The next step will be to coordinate delivery of equipment to the SDPs identified, in particular kits for inserting and removing IUDs. A significant budget has also been dedicated to FP filing equipment (consultation dossiers, tool storage, furniture...).

2. Training in long-term methods:

The first step consists of identifying and quantifying training needs at the regional and district levels. The plan also provides for organizing training sessions at the SDP level in order to improve the quality of services and update personnel in offering long-term methods. Post-training monitoring sessions are planned at the region level. This action also includes the formal establishment of a partnership between the private and public sector to better integrate the private sector in training and to permit the exchange of good practices and mentoring. Finally, accreditation mechanisms for health workers who have had training in long-term methods must be taken into consideration.

3. Recruitment of health workers:

Recruitment of 150 health workers is planned, in order to support head nurses in SDPs that are understaffed. This action insists on the definition of a desired profile and the establishment of a recruitment plan which will go into effect in 2013. Monitoring will be conducted on a quarterly basis.

4. Implementing a quality of services program:

Here, we must first define an evaluation plan for the quality of services at SDPs (review of existing programs and evaluation of their effectiveness). The plan must also be deployed in the pilot regions before scaling-up in Q2 2013. The program will be accompanied by an accreditation system for good performance.

5. Establishing revised curricula in training schools:

Since revised curricula already exist, this action will consist above all of monitoring their deployment in training schools through meetings and workshops, in order to speed up their integration. These curricula must cover all contraceptive technologies, including long-term methods and they must be addressed to all medical personnel (nurses, midwives, doctors, etc...).

6. Scaling-up task-shifting/sharing:

The goal here is to scale-up task-shifting/sharing in the public system. The action thus consists of determining which tasks to delegate (insertion of implants...) and to whom they are delegated (assistant head nurses, community workers...). Regulatory changes must also be approved (Standard Policies and Protocols) and the changes must be communicated to medical personnel.

7. Skills-strengthening using an online training system:

This action consists of first determining, together with partners, the IT tools necessary for online training (use of the existing system or new tools). We must then work to create IT tools and test their functionalities. After approval by the Ministry, the tool will be presented and distributed to regions/districts.

G. Monitoring and evaluation:

1. Covering the salaries of coordination staff:

The salaries will take into account the inclusion of 2 additional people from the Ministry and 2 technical assistants to support this action and the implementation structure. Salaries, social security charges, and staff allowances from October of 2012 to the end of 2015 have been taken into account.

2. Supporting the program with computing equipment:

Computing equipment and accessories (computers, printers, etc.), establishment of a data backup system, and the creation of a national FP database for monitoring indicators are taken into account here.

3. Supporting reviews and data sharing meetings:

The action calls for financial support for meetings at the district level, which will take place once a month. Each of the 76 districts will be supported. In the same way, a budget has been created for coordination meetings at the regional level which will take place quarterly. This budget will serve in particular for the collection, consolidation and analysis of data. In collaboration with the districts, a budget has been provided for each of the 14 regions during the support phase of launching the action plan. Finally, a budget has been provided for holding working group meetings.

4. Establishing a monitoring and supervision mechanism:

Here, the action consists of conducting audits to verify the data on-site in order to ensure there are mechanisms of data feedback. Thus, we will have a team of 3 people working for 5 days in charge of implementing this monitoring in each region every quarter.

5. Supporting studies and research:

It seems indispensable to be able to carry out a technical audit at the mid-point of implementing the plan, in order to note things which are working and things that need improvement. This action also includes an operational research study that will be conducted annually.

6. Supporting coordination:

This action is focused on operating expenses, particularly the vehicles used for coordination and supervision and the location of the offices in Dakar in order to give visibility to the new structure.

Details of regional actions

STRONG POTENTIAL

4 Specific priority actions for the regions (1/5)

Number of additional married women

REVIEWED WITH CRMO

Regions	Characteristics	Specific priority actions	Public & Procurement	Private	Community
• Dakar	• Entirely urban population (98%) • Care widely available (8,606 inhabitants per midwife, -53% compared to average). • Wide exposure to FP messages[1] (62%) • High unmet need (32%) • Numerous actors present and easy access	• Introduce the informed Push Model • Create more demand through a massive communication plan (offering services makes it possible to help a greater number of women in need) • Complement supply of services via mobile units (particularly in suburban and rural zones) • Reinforce the quality of services and training in long-term methods, mainly for nurses • Involvement of private sector and companies (accreditation, social franchises and integration of the data system); further reinforce the training of private providers to deliver a better service offering • Use the community system for some rural/suburban zones • Promote and establish the integration of services (HIV, maternal health...)	50,180	68,500	8.000
• Thiès	• Almost equal split between rural (55%) and urban • Availability of care is pretty good (below average for health centers, above average for nurses and midwives) • Strong utilization of injectables (8.5%) • Strong representation of the private sector	• Introduce the Informed Push Model • Reinforce community services to better cover populations that are far removed from health centers • Train service providers to deliver better counseling and a complete suite of services • Reinforce the quality of service and training in long-term methods • Complement the supply of services with mobile units • Build on the existing private sector and further develop social marketing	21,475	10,000	31,000

1 Exposure to one form of media during the last few months (newspapers, television, radio)

STRONG AND AVERAGE POTENTIAL

4 Specific priority actions for the regions (2/5)

Number of additional married women

REVIEW WITH CRMO

Regions	Characteristics	Specific priority actions	Public & Procurement	Private	Community
• Diourbel	• Population considered to be rural (87%), though concentrated around the large town of Touba (50% of the population with very high population growth) • Literacy rate very low (20%) • Limited availability of care • Contraceptive prevalence very weak (5.3%) • Limited exposure to FP messages1 (30%) • Strong representation of the private sector (consignment shops, firms...), but with many illegal services • Strong religious factor (Touba)	• Reinforce community services in order to better cover populations that are far-removed from SDPs • Further involve the legal private sector (social franchises, dedicated training...) • Complete the supply of services via mobile units (around Touba) • Train service providers to deliver better counseling and a complete suite of services, especially for long-term methods • Ensure targeted advocacy activities for religious and community leaders • Reinforce communication to palliate the lack of information, insisting on health advantages (non-economical), and adapt materials, especially in Wolof, and transcription into Arabic • Target men with modified communication activities	6,860	9,000	23.000
• Saint- Louis	• Majority rural population (72%) • Limited availability of services (36.081 inhabitants per midwife +97% compared to the average) • Limited exposure to FP messages (40%) • Vast region	• Better involve the private sector (accreditations, dedicated trainings, allocations) • Further target large companies that are private employers in the region • Reinforce community services to better cover populations that are far-removed from SDPs • Reinforce the quality of service and training in long-term methods (188 nurses and 30 midwives) • Targeted communication on the health advantages linked to FP • Prioritize advocacy to men • Equip health posts with equipment for long-term methods • Reinforce the management of FP files	12,190	2,000	15,300

AVERAGE POTENTIAL

4 Specific priority actions for the regions (3/5)

REVIEW WITH CRMO

Number of additional married women

Regions	Characteristics	Specific priority actions	Public & Procurement	Private	Community
• Kaolack	• Majority rural population (75%) • Limited availability of services (26,555 inhabitants/per midwife, +45% compared to the average); many of the health posts are closed • High unmet need (34.3%)	• Introduce the Informed Push Model • Complement the supply of services through mobile units (particularly in suburban and rural zones) and integrate FP into advanced strategies • Advocacy with local authorities • Reinforce community services to better cover rural populations (including scaling-up of IPO) • Reinforce training in long-term methods with a practical component for new workers (36 midwives) • Organize radio broadcasts on FP	6,850	2,000	17,500
• Fatick	• Majority rural population • Limited availability of services (with inoperative health posts) and large health disparities in the region • High unmet need (34.3%)	• Reinforce community services • Recruit midwives for health posts • Equip posts with equipment for long-term methods • Further harmonize prices in the public system • Improve file-management by providers • Reinforce the training of personnel and training supervision • Complement the supply of services via mobile units (particularly in suburban and rural zones)	6,495	3,000	7,000
• Louga	• Vast region, not very densely populated • Numerous immigrants	• Targeted advocacy to community leaders, immigrant women and religious communities • Reinforce public services with trainings • Improve the private data collection system and equip SDPs with FP files • Reinforce community services by scaling-up IPO in the whole region (scale-up plan) • Collaborate with the developing private sector	5,145	3,000	8,000
• Ziguinchor	• Risky area and difficult to access • Services available for the high public system (health centers, health posts) • High CPR in 2010 (17%)	• Targeted advocacy to community leaders • Reinforce human resources (quality-assurance) for the complete suite of services • Reinforce training, mainly in long-term methods • Improve the supply chain by establishing the Push Model • Equip health posts with equipment for long-term methods • Think of a strategy for reaching SDPs in dangerous zones that are difficult to access	11,085	1,000	3,500

WEAK POTENTIAL

4 Specific priority actions for the regions (4/5)

REVIEW WITH CRMO

Number of additional married women

Regions	Characteristics	Specific priority actions	Public & Procurement	Private	Community
• Matam	• Majority rural population (85%) difficult to access • Numerous nomads, FP considered to be taboo • Large concentration in Matam and Kanel • High unmet need (33%)	• Advocacy to the community leaders • Ensure targeted communication on health benefits • Reinforce the public sector with training and provision of equipment for long-term methods and management of the program • Strengthen distribution and implement IPO on a community basis	2,500	500	1.500
• Tamba-counda	• Majority rural population (83%) with a high index of poverty (78%) • Very vast region, sparsely populated • Low level of education • Region is very difficult to access • Weak participation of women in decision making	• Advocacy to community and religious leaders • Strengthen provision, distribution and implement IPO on a community basis • Complement the supply of services with mobile units (particularly at weekly markets) • Increase human resources and extend training in long-term methods • Communicate strongly on the health advantages of FP and further target men	2,330	500	2,450
• Kaffrine	• Vast region • Very low level of education (16.6%) • Important religious factor	• Reinforce community services • Use targeted channels of communication (television, radio and "louma" gatherings, magal [refers to a celebration in Touba] • Advocacy and targeted communication to religious leaders, men and local authorities • Reinforce trainings in long-term methods, also for KPIs • Equip SDPs with material for long-term methods	2,135	250	3,900

WEAK POTENTIAL

4 Specific priority actions for the regions (5/5)

REVIEW WITH CRMO

Number of additional married women

Regions	Characteristics	Specific priority actions	Public & Procurement	Private	Community
• Kolda	• Vast region • Large proportion of injectable usage (75%) • Large young population (57% of the population less than 20 years old) • Relatively high CPR compared to surrounding areas	• Reinforce community services to better cover populations that are far-removed from health centers • Train 18 nurses and 13 midwives in long-term methods • Advocacy with local collectives, journalists and community interest groups	5,000	250	2.500
• Sédhiou	• Very high unmet need (23%) • Very low literacy rate	• Ensure targeted communication and youth-appropriate services • Create demand using targeted communication, especially to religious communities • Train nurses in long-term methods (more than 30 have yet to be trained due to the arrival of new personnel) • Fill the need for equipment	2,510	250	700
• Kédougou	• Low density, remote zone, difficult to access with a dispersed and mobile population • Communication channels are difficult • Level of education very low • High unmet need (32%) • High female sterilization	• Strengthen the quality of services and human resources with training, mainly in long-term methods (there are still 38 nurses and 3 midwives to train and health personnel that is even less experienced) • Reinforce training supervision • Reinforce community services, especially CHWs and midwives, in IPO • Advocacy to community leaders • Palliate the lack of information through targeted communication	690	50	400

Details of the activities and sub-activities of the national action plan

A. Communication plan

Strategic actions	Activities	Sub-activities
Conduct qualitative research and Disseminate results	Conduct qualitative and participative research on target populations to better understand the level of knowledge and the perception of FP (barriers and motivating factors)	Review studies that have already been carried out
		Create focus groups (according to place of residence, level of instruction)
		Experimental approach in a community to start an intragroup diagnostic dialog on the barriers to using FP (in each region)
		Identify knowledge gaps and develop a protocol for filling these knowledge gaps
		Compile the different results into target profiles
	Dissemination of results	Organize meetings on the analyses of target populations Meetings at the national level
		Organize meetings on the analyses of target populations - Meetings at the regional level
	Dissemination of booklets of target profiles	Produce booklets of target profiles to distribute at the central level in all regions
		Distribute/send the booklets to key actors
	Develop messages and channels for each target population	Central working group with many experts
	Do a mid-term study	Study/survey to see the effectiveness of the key messages (do women understand this message and are they motivated by it)
Mass media campaign aimed at women	Mass television campaign	Identify key messages for experienced and new users draft a brief for a communications agency
		Recruit a communications agency: create TV spots for women and men + translate into radio spots + posters
		Create partnerships with national and local chains
		Campaign for users: Broadcast the spots
Mass media campaign targeting men		Campaign for men: broadcast the spots
Mass media campaign targeting women	Mass campaign: radio	Interview with user champions and broadcast on the radio (1 conception of the spot)
		Campaign for users: Broadcast of interviews + other spots on the radio
Mass media campaign aimed at men		Campaign for men: broadcast spots

Community activities and interpersonal communication	Community activities: community radio	Contract with the districts and Reproductive Health coordinator for radio broadcasts (support the districts in contracting with radio stations)
		Campaign for users: Broadcast on the radio
		Campaign for men: Broadcast on the radio
Community activities and interpersonal communication	Booklets, book and leaflets	Develop a questionnaire and collect the statements of users, share it with partners
		Creation of booklets with experiences of users
		Conceptualize and test leaflets on side effects
		Mass production of booklets with the experiences of users
		Distribute leaflets on side effects, in the form of brochures/IUD in waiting rooms
		Campaign for new users: Distribute brochures at large companies
	Revitalize the family planning radio call-in show	Evaluate the personnel and logistical needs of the family planning radio call-in show
		Finance the restructuring of the show
		Promotion of the show (include number in all publicity posters and spots)
	Publicity in waiting rooms	Conceptualize publicity/information spots on side effects
		Equip waiting rooms with screens and broadcast publicity spots
Community activities and interpersonal communication	Recruitment outreach activities	Communications on JPOs [Junior Professional Officers] (radio broadcasts the evening before, and on the same day a town crier makes the rounds)
		Scale-up FP facilitator tours in the markets of all regions
Mass media campaign aimed at men	Poster campaign	Campaign for men: Posters showing the advantages of FP
Mass media campaign aimed at women		Campaign for new users: Posters with, for example, happy families
Specific activities for rural areas	Specific campaign for rural areas	Organize a caravan that tours villages, putting on a piece of local theater on FP
		Coordinate the schedule of this caravan with mobile outreach
		Radio talent show: Organize competitions on local radio stations with SDPs (activities with prizes to win)

Mass media campaign aimed at men	Use ONCAV to promote FP during events	Campaign for men: Establish a partnership with ONCAV
		Campaign for men: organize stands during soccer matches
Mass media campaign for young people	Build a participative campaign for young people	Organize a competition for the best videos/slogans/posters on FP
		Develop the campaign
	Strengthen listening centers for young people and information centers	Strengthen centers in terms of personnel and logistics
		Promotion of these listening centers and the radio call-in show with a poster campaign in schools, as well as radio and TV spots
		Fliers and posters in high schools and universities
	Use of social networks and new technology to inform young people on FP (facebook, text messages, blogs)	Text message campaign
		Blogs and facebook

B. Advocacy program

Strategic actions	Activities	Sub-activities
Establish a national advocacy committee	Identify stakeholders in advocacy and select institutions and individuals	Mapping of actors by an officer of the DSR
		Hold a meeting to select the actors and predefine the role of the actors
		Confirm/Approve with actors their participation and role in the committee (launch meeting)
	Definition of TOR and modes of operation (frequency of meetings, allocation of roles, expectations...)	Editing of TOR and modes of operation
		Approval by the committee of TOR and modes of operation (approval meeting)
	Formalization and legitimization of the committee by a note	Send to the ministry an explanatory note and a memo on the creation of the committee
	Definition of goals, expected results and an evaluation plan (general evaluation framework)	Group work meeting of the committee to define the goals, expected results and broad lines of the evaluation plan (general evaluation framework)
		Editing of objectives, results and evaluation plan
		Approval by the committee (meeting for approval)
	Monitoring of implementation of advocacy and impact	Development of tools to monitor the indicators
		Establishment of a dashboard for reviewing implementations
		Quarterly meetings to monitor implementation/indicators

Obtaining more significant financing for FP activities from public and government authorities	Identification of target groups in government	Selection of officials and mapping of target groups and the political environment
		Categorization into groups "for" and "against" FP and their centers of interest in order to facilitate the elaboration of advocacy tools
		Approval by the working group
	Develop an advocacy tool adapted to target groups for budget allocation	Review of existing tools by a responsible expert
		Creation of advocacy tools (content and format adapted to the different target populations)
		Approval of the tool by the committee during a meeting
		Reproduction of the advocacy tool (materials adapted to different target populations)
	Organize a discussion meeting with development partners to obtain their support	Prepare arguments and the official request for support from development partners during a meeting
	Organize advocacy meetings with the Ministers of Economy and Finance and Health	Meeting with the cabinet and the Minister of Economy and Finance
	Organize an advocacy meeting with the Minister of Health (Department of administration and management) to obtain a more significant allocation for reproductive health and FP (priority, arbitration takes place at this level)	Meeting with the cabinet and the Ministry of Health
	Organize meetings with principal organizations, the members of parliament and local authorities	Meeting with the CES [Conseil économique et social (Economic and Social Council)]
		Organize meetings with the members of parliament in Dakar in order to convince them to do the advocacy themselves
		Organize meetings at the regional level with elected officials (regional council, mayors...)
		Organize meetings with other target groups
Reinforce support (financial and personnel) from development partners, including NGOs and donors in favor of FP	Mapping of donors/partners interested in FP	Selection of the organization in charge of mapping as well as the format and deadlines to be respected (committee meeting)
		Completion of mapping (determine their effective participation in the past)
		Approval of the mapping by the committee
	Develop arguments for development partners	Review of existing tools
		Create advocacy tool (content and format adapted to different development partners)
		Approval of the tool by the committee during a meeting
		Reproduction of the advocacy tool (materials adapted to different target populations)
	Organize periodic individual meetings with the principal stakeholders on their involvement in the development and implementation of the national FP plan	Determine and confirm planning of meetings (with participants)
		Periodical meetings with development partners

Obtain financial support and support for the offering of services in the private sector	Develop an advocacy tool (key messages and adapted materials) for companies	Review of existing tools
		Creation of advocacy tool (content and format adapted to companies)
		Approval of the tool by the committee in a meeting
		Reproduction of the advocacy tool (support adapted to the different target populations)
	Organize advocacy sessions with employers organizations, labor unions and target companies (for financing FP activities)	Identify employers organizations, labor unions and target companies (meeting with the DSR)
		Organize meetings with employer organizations
		Organize meetings with labor unions
		Organize meetings with target companies
	Identify, among the target companies, those companies that have medical services (in order to offer FP), and those that offer FP services (in order to offer them free of charge), in order to adapt the advocacy	Hold an advocacy meeting for companies that do not have medical services
		Hold an advocacy meeting adapted to companies that have medical services but do not offer FP
		Hold an advocacy meeting adapted to companies that have medical services and offer FP services, to give them for free.
	Establish sponsorship partnerships with the private sector (direct sponsoring or reduction)	Identify target companies (e.g. pharmaceutical laboratories, telephone operator...)
		Write partnership agreements adapted to the sectors of activity (telephone, banking...)
		Meet the target companies, then approve partnership agreements
	Organize fundraising days for FP in companies	Definition of the conditions for organization of fundraising days by an officer
		Meet the companies to have them participate in the operation (individual meetings)
		Select and approve the participation of partner companies in the operation
		Implement the fundraising day for FP
Obtaining financial support and support from the media in the form of reduced fees	Develop an advocacy tool (key messages and materials) for the media	Review of existing tools
		Creation of advocacy tool (content and format adapted to companies)
		Approval of the tool by the committee in a meeting
		Reproduction of the advocacy tool (adapted to the different target populations)
	Identify and then draft the partnership agreements with the target media (newspapers, radios...) in order to obtain their financial support and fee reductions, and in the media coverage of activities	Identify the target media (national, regional/community
		Write partnership agreements
		Meet the target media and then approve partnership agreements
	Organize periodical meetings with the media to share progress on the implementation of FP	Define the format and content of the presentations to be made to the media
		Quarterly meeting to transmit information

Activate and revitalize the network of political champions (national, local elected officials...) to promote FP	Identify champions to approach in collaboration with the competent organizations	Mapping of champions (national and regional)
		Have a meeting to define the number of champions required and select the champions at the national level
	Train persons in charge of approaching the champions	Selection of persons in charge of approaching the champions by the advocacy committee
		Training meeting for the persons in charge of approaching the champions
	Help and support the districts/regions in identifying, selecting, and recruiting political champions	Write a guidebook for recruiting political champions at the local level
		Distribute the guide to the persons in charge of approaching champions
		Have a meeting to select the champions at the regional level
	Orient/train the champions recruited (principally targeting commitment and financing for FP activities)	Planning of training of champions recruited at the national and regional level
		Development of an action plan in collaboration with the champions, by the people in charge of approaching them
		Distribution of the action plan to the selected champions (in orientation sessions)
		Annual orientation session for the champions (national)
		Annual orientation session for the champions (regional)
Advocacy to redefine the position of the DSR	Organize a sharing workshop to ensure resources and positioning for the DSR and FP in the new organizational structure	Prepare the arguments and propositions to be presented to the cabinet, to ensure resources are available to the DSR and FP
		Have an advocacy meeting with the cabinet to review the reorganization of the DSR and FP and the resources allocated
Advocacy to make FP a national priority	Institutionalize FP day	Review organizational modalities of previous FP days
		Meet the Ministry of Health, in order for it to take the project to the Prime Minister
		Organize FP day
	Organize a transversal meeting with the ministries (Economy, Social, Youth, Family, Armed Forces, etc.) that have an important role to play in promoting FP, in order to have them support FP	Transversal sharing meeting with the Prime Minister to make FP a priority (financing, resources...)
		Meeting for discussion and sharing with the Ministry of Youth, Armed Forces and the Family
	Organize a conference with the key decision makers (private companies, labor unions, ministries, prime minister and presidency) on the place of FP in national priorities	Identify the key decision makers
		Organize a conference with the key decision makers (private companies, labor unions, ministries, prime minister and presidency) on the place of FP in national priorities (before or after the FP day)
Advocacy for adjustment to the regulatory framework	Identify the services or institutions concerned by regulatory changes	Meetings with the working groups dedicated to the 5 different strategic areas (product availability, private sector supply, public sector supply of long-term methods, community-based supply, communication) in order to identify the institutions concerned
	Elaborate the advocacy tools to accompany the national action plan adapted to these institutions.	Review of existing tools
		Creation of advocacy tools (content and format adapted to the target populations)
		Approval of the tool by the committee in a meeting
		Reproduction of the advocacy tool (adapted to the different target populations)
	Meet the institutions concerned	Organize meetings to share with the target institutions/groups

Activate and revitalize the network of community champions (community leaders) to promote FP	Identify the community champions to approach in collaboration with the competent organizations	Mapping of champions (national and regional)
		Hold a meeting to select the champions at the national level
	Train persons in charge of approaching the champions	Selection of persons in charge of approaching the champions by the advocacy committee
		Training meeting for the persons in charge of approaching the champions
	Help and support the districts/regions to identify, select and recruit the community champions	Write an approach guide to recruit champions at the local level
		Distribute the guide to the persons in charge of approaching the champions
		Have a meeting to select the champions at the regional level
	Orient/train the recruited champions	Plan training of champions recruited on the national and regional level
		Development of an action plan in collaboration with the champions, by the people in charge of approaching them
		Distribution of the action plan to the selected champions (in orientation sessions)
		Annual orientation session for the champions (national)
		Annual orientation session for the champions (regional)
Activate and revitalize the network of religious champions (religious leaders) to promote FP	Identify champions to approach in collaboration with the competent organizations	Mapping of champions (national and regional)
		Hold a meeting to select the champions at the national level
	Train persons in charge of approaching the champions	Selection of persons in charge of approaching the champions by the advocacy committee
		Training meeting for the persons in charge of approaching the champions
	Help and support the districts/regions to identify, select and recruit religious champions	Write an approach guide to recruit champions at the local level
		Distribute the guide to the persons in charge of approaching the champions
		Have a meeting to select the champions at the regional level
	Orient/train the recruited champions	Plan training of champions recruited on the national and regional level
		Development of an action plan in collaboration with the champions, by the people in charge of approaching them
		Distribution of the action plan to the selected champions (in orientation sessions)
		Annual orientation session for the champions (national)
		Annual orientation session for the champions (regional)

Activate and revitalize the national network of champions (artists, athletes..) to promote FP	Identify the champions (artists, athletes,...) to be approached, in collaboration with the competent organizations	Mapping of champions (national) building on IntraHealth's work, for example
		Hold a meeting to select the champions at the national level
	Train persons in charge of approaching the champions	Select persons in charge of approaching the champions
		Training session for the persons in charge
	Orient/Train the champions recruited (artists, athletes...) to promote FP	Plan training of champions recruited at the national and regional level
		Development of an action plan in collaboration with the champions, by the people in charge of approaching them
		Distribution of the action plan to the selected champions (during the orientation sessions)
		Annual orientation session for the champions (national)
		Annual orientation session for the champions (regional)
Reinforce ties and obtain the support of leaders in the health sector	Develop an advocacy tool focused on health, giving information and data on the current status of FP and the need for change	Review of existing tools
		Creation of the advocacy tool (content and format adapted to health professionals)
		Approval of the tool by the committee during a meeting
		Reproduction of the advocacy tool (adapted to the different target populations)
	Organize periodical meetings with the health leaders to share the progress in implementing FP	Definition of the format and content of the presentations to be made to health leaders
		Quarterly meeting with the health leaders to distribute information, share progress and request help

C. Product availability

Strategic actions	Activities	Subactivities
Filling of orders based on actual consumption and stock inventory	Implementation of Reality Check tools and implementation of a plan for basic procurement for the next three years, updated semiannually	Creation of the Reality Check tool for forecasting consumptions
		Implementation of forecasts for the next three years using the Reality Check
		Updating the procurement plan on a semiannual basis
	Confirmation of orders by actual consumption data	Monthly consolidation of consumption data transmitted by the 14 operators of the Push Model
		Crosschecking of consolidated data and orders
	Monthly meeting of security committee (SPSR)	Determination of national security stocks (minimum and maximum stocks) at the central level
		Monthly inventory of stock levels of FP products at the central level and subtraction of losses (expired products, deteriorated products...)
		Monthly review of stock levels at the central level in regard to these thresholds, in a meeting of the security committee (SPSR)
		Monthly order adjustment if necessary with immediate release of new orders if thresholds have been reached
	Regular and effective quality control (annual) of the entire range of FP products at all levels of the distribution network	Implementation of product sampling at a selection of distribution points at all levels of the network
		Implementation of analyses (requires a purchase input for the chemical analyses)
		Distribution of the results of the monitoring and withdrawal of non-compliant products
Introduction of a single ordering channel	Finalization and integration of the stocks of the NPP and the DSR	Finalization of the transport of products from the stock of the DSR to the stock of the NPP and final accounting integration
	Communication on integration and new communication mechanisms with Regional Procurement Pharmacies	Drafting of a reminder on the single communication channel for FP products via the NPP and sending of the reminder to all Regional Procurement Pharmacies
	Integrative training supervision until assimilation is complete	Joint semiannual NPP/DSR supervisions of all Regional Procurement Pharmacies
	Implementation of Reality Check tools and implementation of a procurement plan for Regional Procurement Pharmacies, updated semi-annually and possibly monitored by the Medical Region	Setting of a consumption goal and contribution to national consumption (= target CPR by region)
		Installation of IT capabilities and maintenance in each Regional Procurement Pharmacy
		Training of the regional management team (including the logistician in each Regional Procurement Pharmacy) in Reality Check
		Implementation of consumption forecasts and an annual regional procurement plan using Reality Check and fixed CPR target (similar to the principle of the national procurement plan)
		Updating of the procurement plan on a quarterly basis
	Confirmation of orders by actual consumption data	Monthly receipt (via email) of an Excel file of actual consumption data furnished by the operator of the Push Model for the region who has collected them during delivery
		Crosschecking of the consolidated data from the operator and the forecasts made by Reality Check

Improvement of the logistical capacities of staff	In the regions not yet covered by the Push Model, mapping of personnel who are not yet trained in logistics management	Mapping of former staff who are not yet trained
		Mapping of new staff appointed
	In the regions that are not yet covered by the Push Model, finalization of the on-site training of medical personnel (nurses, head pharmacists and/or administrators) in logistics management	In the regions not yet covered by the Push Model, finalization of the training of existing medical personnel (nurses, midwives, head pharmacists and/or administrators) in logistics management by on-site trainings (preferable to working groups)
	In the regions not yet covered by the Push Model, quarterly supervision of the district depots by head pharmacists of the Regional Procurement Pharmacies	In the regions not yet covered by the Push Model, quarterly supervision of district depots by head pharmacists of the Regional Procurement Pharmacies
Improvement of the logistics capabilities of the data of personnel	In regions not covered by the Push Model, use of IT to compile data and orders	Creation of the compilation tool for Channel needs
		Equipping all the Regional Procurement Pharmacies and districts with computing equipment (including Dakar and new districts)
		Training of all the new regional and district administrators in use of Channel
		Orientation of district and regional management personnel to using Channel
		Continuous supervision of personnel and retraining to maintain capacities
	In the zones covered by the Push Model, integration of Channel in management of data issued by the Push Model for management of retrieval and implementation of performance management	Implementation of a training in retrieval from the Push Model database managed by the Channel system
		Fine-tuning of a training calendar as the Push Model is rolled out on the ground
		Training of all the district and regional medical personnel in retrieval from the Push Model database managed by the Channel system
		Implementation of a management training in performance management of the Push Model database managed by the Channel system
		Fine-tuning of a training calendar as the Push Model is rolled out on the ground
		Training of all the district and regional medical personnel in performance management on the Push Model database managed by the Channel system
Guarantee of availability of equipment	Guarantee of availability/functionality of sterilization equipment	Mapping of available and functional equipment throughout the country and gaps
		Orders of sterilization equipment (autoclave)
		Establishment of SDPs where necessary
		Training in use of the autoclave where newly installed
	Guarantee of availability of electricity	Mapping of SDPs that are connected and not connected to the electrical grid
		Order and installation of solar panels or connection to the local electrical grid

Progressive extension of the Push Model in the regions	Finalization of the design and evaluation of the Push Model	Finalization of the general architecture of the model with the National Procurement Pharmacy (NPP) and the Ministry of Health for each of the regions
		Launching of a large-scale pilot in Dakar
		Evaluation of the pilots in Dakar, St-Louis and Kaolack up to December 2012
		Establishment of a logistics fund for financing the operator (legal aspects and governance committee, establishment of a logistics fund by the State and the donors)
	Progressive implementation of the Push Model wave 1 in Dakar and Saint-Louis	Informational visit to the buyers by the DSR and the NPP to detail the operation of the model
		Call for bids and selection of operators
		Informational meetings with the Chief District Medical Officer (CDMO), nurses and midwives
		Implementation of initial allocation in all SDPs and launching of the model
	Progressive implementation of the Push Model wave 2 in the regions of Thiès, Kaolack Diourbel and Fatick	Informational visit to Regional Procurement Pharmacies by the DSR and the NPP to detail the operation of the model
		Call for bids and selection of operators
		Informational meetings with the CDMO, nurses and midwives
		Implementation of initial allocation in all SDPs and launching of the model
	Progressive implementation of the Push Model wave 3 in the regions of Ziguinchor, Louga, Kaffrine, Sédhiou	Informational visit to the buyers by the DSR and the NPP to detail the operation of the model
		Call for bids and selection of operators
		Informational meetings with the CDMO, nurses and midwives
		Implementation of initial allocation in all SDPs and launching of the model
	Progressive implementation of the Push Model wave 4 in the regions of Matam, Kedougou, Tambacounda, Kolda	Informational visit to the buyers by the DSR and the NPP to detail the operation of the model
		Call for bids and selection of operators
		Informational meetings with the CDMO, nurses and midwives
		Implementation of initial allocation in all the SDPs and launching of the model

C. Expanding the community-based supply

Strategic actions	Activities	Sub-activities
More extensive task-shifting/sharing	Integration of the IPO in the integrated service pack for all functional units	Mapping of units that have not yet received IPO and units that are "eligible" (midwives or literate CHWs)
		Translation of the tools into local languages
		Training of literate CHWs and midwives in IPO
		Allocation of an initial stock of pills to new units offering IPO
		Post training monitoring
		Supervision by the district management team for 10 months
Increasing access through distribution by health points with literate CHWs (community health workers)	Extension of the initial injectable offering to literate midwives and CHWs in functional units	Finalization of the pilot and evaluation (summer 2012 - January 2013) of the feasibility of the initial injectable offering
		Implementation and printing of training materials for the initial pill offering
		Training of trainers
		Training of CHWs and midwives in the initial injectable offering (IM or Uniject)
		Post training monitoring
		Supervision by the district management team
		Allocation of the initial stock of injectables to units offering the initial injectable offering

Increasing access through distribution by health points with illiterate CHWs (community health workers)	Extension of the IPO to illiterate midwives and CHWs in the functional units	Tracking of the evaluation pilots to approve the pertinence of the extension of the IPO to illiterate midwives, CHWs and CBHWs
		Scaling with the training of illiterate midwives, CHWs and CBHWs in IPO
		Post training monitoring
		Supervision by the district management team
		Allocation of a stock of pills to new units and new CBHWs offering the IPO
	Extension of the initial injectable offer to illiterate midwives and CHWs in the functional units	Launch of pilots and evaluations to approve the appropriateness of the expansion of the IPO/initial injectable offering to other community health workers
		Scaling-up training of illiterate midwives, CHWs and CBHWs for the IIO
		Post training monitoring
		Supervision by the district management team
		Allocation of a stock of pills to new units and new CBHWs offering the IPO
Increasing access through distribution by other categories of community health workers	Extension of the IPO and initial injectable offering to other categories of community health workers (intermediary, BG)	Launch of pilots and evaluation to approve the pertinence of the extension of the IPO/initial injectable offering to other community health workers
		Scaling-up training of half of the intermediaries and BG (literate)
		Post training monitoring
		Supervision by the district management team
		Allocation of pills and book to intermediaries and BG

Increasing CBHW coverage	Increase of CBHW offering the IPO and IIO (2 mixed pairs per rural SDP)	Mapping of the needs for CBHWs offering IPO (e.g. in the zones that do not have enough units to cover the whole population)
		Training of CBHWs in the IPO and the IIO
		Supervision of CBHW
		Initial allocation of pills, injectables, work documents and bicycles
Adaptation of the legal framework	Legislation of the IPO and initial injectable offering for literate personnel	Publication of decree or PNP [Politiques, normes et protocoles (Policies, standards and protocols)] document legalizing the transfer of competencies for IPO to literate midwives/CHW/CBHWs
		Publication of decree or PNP document legalizing the transfer of competencies for distribution of injectables to literate midwives/CHW/CBHWs
		Publication of decree or PNP document defining the list of medications by level
	Legalization of the IPO and initial injectable offering for illiterate personnel if the pilots are conclusive	Publication of decree or PNP document legalizing the transfer of competencies in IPO to illiterate midwives/CHW/CBHWs
		Publication of the decree or PNP document legalizing transfer of competencies in distribution of injectables to illiterate midwives/CHW/CBHWs
	Fixing and harmonizing the prices/margins of paid products at the community level	Legislation on the price of products charged by community health workers at SDPs (cost price)
		Legislation on the price of products for patients charged by community health workers (identical to the price at SDPs)
	Legalization of the IPO and initial injectable offering for illiterate personnel if the pilots are conclusive	Publication of the decree or PNP document legalizing transfer of competencies in distribution of injectables to illiterate midwives/CHW/CBHWs

Revitalization of the BG program	Resizing of the BG program	Evaluation of the impact of the program
		Resizing of the target coverage according to geography (urban, semi-urban, rural zones)
		Mapping of active and inactive BG
	Repositioning of the program	Redefinition of the role of BG, with focus on maternal health, infant health and FP
		Redefinition of the value proposition of BG: information, but also monitoring and support in coordination with the SDP personnel and health units and above all, combating discontinuationn of FP and information on the effects
		Redefinition of the criteria for profiles recruited (academic level, former intermediaries...)
		Prolongation and strengthening of training (competencies in communication, knowledge of subjects treated) with establishment of training tools and monitoring material
		Creation of reminder tools (e.g. BG notebook)
		Establishment of annual refresher training course for all the BG
	Reinforcement and finalization of BG coverage	Immediate refresher training course for inactive BGs
		Precise mapping of coverage and needs by district
		Fine tuning of a recruitment and training plan for maximum coverage
		Initial training of supplementary BGs to reach target coverage in a limited time frame

Improvement of training and monitoring of intermediaries	Reinforcement of intermediaries' knowledge of FP	Revision of the standard training program on FP for all intermediaries
		Continuous refresher training for all FP intermediaries (standardized content)
Monitoring and use of intermediaries for combating discontinued use	Reinforcement of the monitoring of intermediaries in promoting FP	Establishment of regular monitoring of all intermediaries with regard to messages transmitted on FP
	Reinforcement of religious intermediaries	Evaluation of coverage by religious intermediaries and recruitment/ potential training to densify their presence when required
		Continuous training of religious intermediaries in religious arguments for FP
	Tracking of users who are behind schedule by intermediaries	Establishment of monitoring of user activity in SDPs and health units
		Systematic utilization of intermediaries for making contact (house visits, calls...) with users behind schedule

E. Expanding the private sector supply

Strategic actions	Activities	Sub-activities
Establishment of a multisectoral structure (FP, HIV, malaria...) dedicated to managing public-private partnerships	Review and adapt existing structures (the public/private partnership unit the private and traditional medicine division) in order to establish a structure that permits the private sector to be completely integrated in the health system	Review of existing structures
		Define the formal framework and managers for this structure
	Definition of TOR, goals, mandates and mode of operation (frequency of meetings, assignment of roles, expectations...)	Editing of the TOR, goals, mandates and mode of operation of the structure
		Meeting for approval of the TOR and mode of operation by the technical committee and the ministry
Widening the range of social marketing products	Identify products that can be integrated in the social marketing list (Depo-subQ in Uniject, implants...)	Mapping of social marketing products in Senegal and in the world (identify products that are not part of social marketing in Senegal)
		Approval by the technical committee
	Prepare arguments and negotiation strategy with manufacturers	Review the existing arguments
		Elaborate adapted arguments (numerical estimates...) (expert)
	Identify pharmaceutical laboratories manufacturing the products identified that could be on the list of social marketing products	List pharmaceutical laboratories (including Valdafrique) that manufacture the identified contraceptives (expert)
	Meet with the pharmaceutical laboratories to obtain price reductions	Have meetings with the principal laboratories (with the support of the Reproductive Health Supplies Coalition)
		Confirm and formalize the consent of laboratories to advocate at headquarters to obtain price reductions (meeting)
	Organize meeting with donors and prepare arguments to receive subsidies	Determine needs related to financing and logistical aid
		List of donors/Development partners likely to provide assistance (expert)
		Develop adapted arguments (numerical estimates...) (expert): expression of needs
		Hold meetings to confirm the support of donors/partners
	Finalize the integration of social marketing products in the distribution system of wholesalers/private pharmacies	Create a request for marketing authorization and present it to the committee
		Hold a meeting with the Directorate of Pharmacies and Laboratories to discuss mechanisms for integrating the products in pharmacies
		Hold meetings with wholesale distributors and marketing agencies to ensure promotion of the products to pharmacies
		Sensitize private pharmacists, doctors, midwives and nurses via professional organizations
		Approve the list and the price of products with all parties involved

Establishment of mobile units in the framework of a public-private partnership (PPP)	Establish a formal framework in the DSR in charge of coordination and management of public-private partnerships (network of mobile units and social franchises)	Determine the officer, the mission and the resources allocated to management and coordination of the network
		Approval of the technical committee
	Identify the zones in which to install the mobile units	Determine the methodology for identifying the zones in which to install the mobile units
		List/categorize the zones in which to install the mobile units (priority)
		Mapping and planning interventions by mobile units in collaboration with the private sector
		Launch meeting with the technical committee
	Determine the framework contract governing the relations between the state and the private partner deploying the mobile units	Write the framework contract determining the rights and duties of each of the parties (duty of the partners to transmit information on the activities)
		Meetings with the competent authorities in the ministry of health to approve the contract binding the state and the partners
	Establishment of partnerships between the state and partners deploying the mobile units	Meetings with donors to ensure funding
		Meetings with partners wishing to deploy mobile units
		Selection/approval of the partners selected
		Signature/formalization of the partnerships
	Deployment of mobile units in the identified zones	Memorandum of agreement with the districts
		Deployment of mobile units
	Monitoring of action of the mobile units (collection of data, etc...)	Establishment of a system for monitoring activities (indicators to monitor and collect the data of the partners)
		Quarterly review of the activities
Ensuring coverage of contraceptive products and services by mutual insurance companies and social security	Conduct a feasibility study on coverage of FP products or services by mutual insurance companies and the social security fund	Elaborate the TOR and select the providers
		Review of existing studies
		Write a summary and draft the concept note
		Review study results with the technical committee
	Decide on the best adapted financial mechanism	Meeting of the technical committee to select the financial mechanism permitting coverage of services
		Write a report explaining (with supporting figures) the selection mechanism with a view to sharing it with government authorities and mutual insurance companies
	Organize sharing meetings with government authorities (ministry of finance, MSP [mesures sanitaires et phytosanitaires (Sanitary and Phytosanitary Measures)]...)	Meeting with government authorities to inform them of propositions
		Approve and formalize coverage
	Organize sharing meetings with insurances companies (employer organizations and companies)	Meetings with the insurances and mutual insurance companies to inform them of propositions
		Approve and formalize coverage
	Monitor coverage of FP services	Monitoring meetings with the coordinating bodies of concerned mutual insurance companies

Increase service delivery points in the private sector	Identify the private actors that do not offer FP services (private medical sector or companies) or FP products (pharmacies, companies and shops...)	Selection of the organization in charge of mapping as well as the format and the deadlines to meet (committee meeting)
		Completion of mapping of private actors that do not offer FP and that are able to do so
	Determine mechanism for procurement of products by these actors	Editing of the different possibilities and modalities of procurement of products by these actors (free of charge/paying, frequency, places....)
		Selection of options chosen for the different actors (on-site delivery...)
	Determine eligible shops that can distribute condoms (hairdressing salons, hotels...) that are not yet outlets	Select the type of shop in a Technical Committee meeting
		Implementation of distribution of fliers/brochures in the shops in order to create demand
		Approval by the technical committee
	Determine mechanism of procurement of products by shops	Editing of different possibilities and modalities of procurement of products by the shops (free of charge/paying, frequency, places...)
		Selection of options chosen for the different actors (delivery to the site, distribution at the central level...)
	Implementation of monitoring of the activities of these actors	Establishment of a system for monitoring activities (indicators to monitor and collection of data)
		Quarterly review of the activities
Effective implementation of delivery of contraceptive products bought by the NPP in the private sector	Integration of contraceptives in the list of medicines delivered to the private sector by the NPP (list approved by the DPL)	Develop the list of contraceptives to integrate into the list
		Approval by the technical committee
		Develop arguments for DPL and the competent authorities (ministry, NPP)
		Meeting for sharing and approval of the integration of contraceptives on the list of medicines delivered to the private sector
	Promoting integration of contraceptives on the list of medications delivered to the private sector	Informational meetings with private wholesalers
		Meetings for information and sensitization of private providers (doctors, pharmacists, midwives...)
	Monitoring of integration	Implementation of tools for monitoring activities (consumption indicators to monitor and collect data) between the NPP and the DSR
		Memorandum between the DSR and the NPP for transmission of information on consumption from the private sector
		Quarterly review of activities

Adjustment of the regulatory framework in relation to the supply of FP services for better private sector involvement	Meeting with the principal professional organizations (doctors, pharmacists...)	Status update on the regulatory framework concerning supply of services by category
		Develop proposals for targeted regulatory modifications (amendments to the codes and PNP)
		Individual sharing meetings with the parties involved (nurses, pharmacists, doctors...) to review the proposals for regulatory modifications
	Obtain the agreement of professional organizations and their official support for adjusting the regulatory framework	Draft a joint memorandum of understanding summarizing the adjustments granted to each, but also their duties and limits
		Approval of a joint memorandum of understanding during a collective sharing meeting, giving official approval to the regulatory changes
	Obtain the agreement of the supervisory authorities (ministry of health...)	Develop a presentation summarizing all of the propositions
		Sharing meeting with the ministry of health and all the parties to approve the regulatory adjustments
	Distribute the regulations and PNP to all the actors, inform them of the update	Draft a differentiated explanatory note explaining the changes
		Send the note to the professional organizations
	Ensure monitoring of the application of the modified texts	Define a monitoring plan to ensure implementation of texts (checklists, visits to be made...)
		Carry out monitoring of the actors concerned
Accelerating Marketing Authorizations for contraceptives (e.g.: Jadelle)	Status update on contraceptives that do not have Marketing Authorization	Identification of contraceptives and their manufacturers that do not have Marketing Authorization in Senegal (e.g. Sino-Plant)
	Encourage and support private laboratories in the application process for Marketing Authorization	Create and submit Marketing Authorization dossiers
		Meeting for sharing with the laboratories concerned
		Meeting for sharing with the Ministry of Health if necessary to accelerate the process of authorization
	Monitoring of Marketing Authorization	Quarterly meeting with the laboratories until actual placement on the market
Establish a network of social franchises within the framework of a PPP	Determine the framework contract governing the relations between the state and the private partner (NGO, OSC...) delivering the social franchises	Draft the framework contract determining the rights and obligations of each of the parties (especially obligations of the partners to transmit information on their activities)
		Meetings with competent authorities in the ministry of health to approve the contract between the state and its partners
	Identify the zones where the social franchises will be installed	Determine the methodology for identifying the zones where the social franchises will be installed
		List/categorize the zones where the social franchises will be installed
	Establish partnerships between the state and partners that deliver social franchises	Meetings with the partners that wish to deploy social franchises
		Select partners to retain
		Accredit the partners retained
	Deploy social franchises in the identified zones	Deploy social franchises in the identified zones (formalize the contract between the franchisor and franchisee)
	Monitoring of social franchises (quality of services, collection of data, etc...)	Establishment of a system for monitoring activities (indicators to monitor and collect data from the partners)
		Annual review of the activities

Direct training of private actors	Identify the training needs	Develop the protocol for the survey to identify training needs (by type of actors, by category of service...): check list
		Carry out the survey to identify the training needs per professional category
		Listing of zones/regions with the greatest training needs
	Organize contraceptive technology training for pharmacists and other workers in the private sector	Develop training support (curriculum)
		Organize and carry out training sessions by type of actors in the target regions
		Organize and carry out training sessions by type of actors in the target regions
	Organize information and service offering days in private businesses	Develop training support
		Organize and carry out training sessions for the trainers
		Organize and carry out regional information and training sessions
	Ensure post-training monitoring and supervision	Define criteria for evaluation and post-training monitoring tools
		Define a monitoring plan
		Quarterly supervisory missions
Integration of private sector data	Determine the data to collect and the collection mechanisms in collaboration with the SNIS	Identify data to collect in collaboration with the SNIS and develop monitoring tools (meeting, working groups)
		Determine the mechanism for collection and motivation with the SNIS
		Approval by the advocacy committee
	Design data integration system	Seminar to reflect on the implementation of a system for integrating private sector data which includes the MSP (directors and those responsible for services, SNIS...) and representatives of private actors (pharmacists, doctors, private companies)
		Test data collection tools
	Implementation of human resources and techniques to permit collection and monitoring of data	Determine the need for human resources and techniques at the district level
		Identify those responsible for collection and feedback of information
		Effective implementation of monitoring mechanism

F. Expanding the public sector supply

Strategic actions	Activities	Sub-activities
Ensure availability of equipment in all the SDPs	Identify and quantify needs in the SDPs (district) (part of a global study to determine: need for equipment, human resources, training)	Review of existing studies and analysis of districts not covered by partners (e.g. Intrahealth) and define a single tool for all of them in order to identify the necessary equipment for administering long-term methods (checklist of equipment)
		Collection of missing data (districts not covered by partners) and analysis of data
		List/categorize the poorly equipped SDPs
	Organize meetings with the ministry and donors to obtain additional funds	Develop inventory of needs and adapted arguments (numerical estimates)
		Meet with donors to obtain their financial support
		Meet with the ministry to obtain its financial support
	Equip all SDPs	Determine the optimal process for equipping all SDPs (officers, distribution circuits...) and plan the installation of equipment (places, dates...)
		Implement delivery of insertion/removal equipment kits to poorly equipped SDPs
		FP filing equipment (consultation files, storage tools, furniture...)
	Ensure good maintenance of equipment	Implement guides for maintaining each piece of equipment
		Train the maintenance technicians at the district and regional level in equipment maintenance (if they use equipment that requires Poupinel sterilizers, for example)
		Define a supervision and maintenance plan
	Implement monitoring mechanisms	Develop monitoring tools
		Quarterly review of progress in equipment and maintenance
Recruit certified health workers to support the head nurses	Identify the SDPs that lack human resources (districts) (part of a global study to determine: need for equipment, human resources, training)	Review of existing analyses and districts that are not covered by partners (for example, Intrahealth, RSS) to identify the SDPs that lack human resources
		List/categorize the SDPs that lack human resources
		Develop sustainability mechanisms for the human resources activities undertaken by partners; define a plan for retention of personnel made available by the partners
	Organize meetings with the ministry and the donors to obtain additional funding	Develop an inventory of needs and adapted arguments (numerical estimates)
		Meet with donors to obtain their financial support
		Meet with the ministry to obtain its financial support
	Define the desired profile and establish a recruitment plan	Define a targeted recruitment plan including the profile, offer and description of work, and work plan
		Establishment of a continuous training program (at the same level as the trained workers)
	Monitoring of deployment of supplementary human resources	Definition of monitoring tools for deployment (indicators, process...)
		Deployment of supplementary human resources
		Quarterly review of human resource deployment

Establishment of revised models and curricula in training schools including FP and long-term methods	Organize a sharing meeting with the Ministry of Higher Education and officers in training schools in order to accelerate implementation of the revised modules	Develop adapted arguments
		Meet the ministry of higher education and officers in training schools for sharing
	Monitoring of deployment of modules	Determine those responsible in the ministry of education for implementation of new modules
		Quarterly meeting between the DSR and the officer for monitoring deployment
On-site training in long-term methods by the public and private sector	Define the needs and targets for theoretical and practical training in long-term methods (part of a global study to determine: needs for equipment, human resources, training)	Survey of nurses, midwives, trainers, doctors to determine the needs for theoretical and practical training - in districts not covered by surveys done by partners (e.g. Intrahealth)
		Editing/formalization of training needs
		Approval by the technical committee
	Identify the SDPs that need training	Define methodology to identify the SDPs that lack training in long-term methods (review of existing reports) Intrahealth, Ceforep and DSR)
	Select tutors from the health workers that will carry out training in long-term methods, in partnership with CEFOREP (tutoring)	Definition of a selection process
		Implementation of a training program for the trainers
		Editing and distribution of a call for applications to become a trainer in long-term methods
		Choose trainers for health workers
	Define the training format	Define the training modalities
	Determine the mechanisms and forms for accrediting workers who have taken the training	Review existing accreditations (reports from MSH, Intrahealth...) in other health areas
		Determine the accreditation mechanism for long-term methods (number of trainings attended, passing an exam...)
		Approval by the technical committee
	Definition and formalization of the public-private partnership to better integrate the private sector in the training and permit the exchange of good practices and sponsorships	Draft the framework contract determining the collaboration mechanisms (rights and obligations of each of the parties, particularly obligation of the partners to transmit information on activities)
		Implementation of a protocol for coordination of collected data and supervision of training between the public and private sectors
		Meetings with the competent authorities in the ministry of health to approve the contract binding the state and partners
		Editing and distribution of a call for applications for implementing training sessions for the private sector
		Meetings withpartners that wish to participate in training in long-term methods
		Selection/approval of the partners retained
		Signature/formalization of the partnerships
	Organize trainings with direct targets to reinforce competence and confidence in skills	Develop a training plan (jointly with the private sector)
		Organize training sessions in the SDPs identified according to the plan (supervision + filling of registers for indicators)
		Organize post-training monitoring in the identified SDPs

Scaling-up of delegation/transfer of competencies	Determine the competencies to be delegated (insertion of implants...) and the delegators (assistant nurse, community workers...)	State of affairs (document review)
		Define the level of delegation (structure and community) and who to delegate to
		Determine the services to delegate (implants, IUD...)
	Legalization (decree) and communication of transfer of competencies	Publication of the decree or PNP document legalizing the transfer of competencies to different delegates
		Distribution of the decree to medical staff
	Plan for implementation of delegation (scaling-up) and advocacy to donors to ensure funding for scale-up	Organize a sharing meeting with donors to ensure financing
		Review the positive points and points to improve in pilot regions
		Deployment in the rest of the country
Reinforce the competencies of the health workers using a remote training system (online)	With partners, determine the IT tools necessary for online training (use existing system or new tools)	Meeting with the competent institutions to review existing tools
		Determine the specifications of the online training tool (objectives, functionalities, area of training, format...)
		Approval by the technical committee
	Construction of the IT tool and test of functionalities	Development of the IT tool
		Test of functionalities with focus group
		Approval by the technical committee
	Approval by the Ministry of Health	Approval meeting with Ministry of Health
	Present and distribute the tool in regions/districts	Determine schedule for presentation of tool
		Presentation sessions in regions/districts
Implementation of a quality of service program with monitoring	Determine a plan for evaluation of SDP quality	Review of existing quality programs (Intrahealth...) and evaluation of their effectiveness
		Definition/refinement of a quality program including all the aspects related to quality of services (administration, counseling...) and adapted to FP, integrating experiences from tests
		Review the plan with the Ministry of Health
		Harmonize the approach
	Create a rubric defining good quality of service	Review supervision rubrics and improve
		Implementation of a dashboard
	Execution of a plan for a quality of service program	Deployment of the plan in pilot regions
		Report of activities and review of the points to improve in the pilot regions
		Scaling
		Monitoring of implementation
	Establishment of an accreditation system for good performance	Establishment of an accreditation system for good performance at the regional level

Donor letters of intent

[ADD donor letters of intent]

Composition of technical committee

- Dr. Daff, Head of the Division of Reproductive Health (DSR)
- Aissatou Coly, DSR
- Fatouma Ndiaye, DSR
- Dr. Ousseynou Faye, DSR
- Fatim Tall Thiam, WHO
- Dr. Mbow, USAID
- Rama Dioume, USAID
- Dr. Ndoye, UNFPA
- Cheikh Mbacke, Hewlett Foundation
- Dr. Clouzeau, Coopération Française [French Cooperation]
- Dr. Bellefleur, French Embassy (MAEE)
- Barbara Sow, FHI 360
- Siga Diop, FHI 360
- Maaike Van Min, MSI
- Alison Malmqvist, ADEMAS [Agence pour le Développement du Marketing Social (Social Marketing Development Agency)]
- Dr. Sarr, ADEMAS
- Dr Diedhiou, ASBEF [Association Sénégalese pour le Bien Etre Familiale (Senegalese Association for Family Well-Being)]
- Dr Athié, ACDEV [Action et Developpement (Action and Development)]
- Siggil Jiggen Network
- Hawa Talla, IntraHealth International
- Dr Gueye, IntraHealth International
- Thierno Deng, CEFOREP [Centre de Formation et de Recherche en Santé (Center for Health Training and Research)]
- Nafissatou Diop, Population Council
- Sebastiana Diatta, Childfund
- Prof. Moreau, Association of Obstetrician – Gynecologists
- Abdou Gueye, ANIIDES [Association Nationale des Infirmiers et Infirmières (National Association of Nurses)]
- Demba Dione, GMS