JUNE 2017

GAINING TRACTION: EXECUTING COSTED IMPLEMENTATION PLANS

EXPERIENCES AND LESSONS FROM SENEGAL

During the CIP implementation period of 2012-2015, Senegal's national FP program averted approximately

800,000
unintended pregnancies,

290,000
unsafe abortions,

1,700
maternal deaths, and

saved more than

$40 million
in direct healthcare costs.

BACKGROUND

In West Africa, the Ouagadougou Partnership emerged from a 2011 conference where countries agreed to reach at least 1 million additional women in the region with family planning (FP) services by 2015. Since the London Summit on FP in 2012, 39 countries have committed to making high-quality, voluntary FP services, information, and supplies more available, acceptable, and affordable for an additional 120 million women and girls in the world's 69 poorest countries by 2020. Meeting the commitments of this initiative, known as FP2020, and of the Ouagadougou Partnership will ensure that every woman and every girl has the right, and the means, to shape her own life — to grow, to thrive, and to plan the family she wants.

Costed implementation plans (CIPs) are multi-year action plans that contain detailed resource projections for achieving the goals of a FP program, thus enabling countries to operationalize and monitor progress toward their commitments. Thus far, close to 30 countries in Africa and Asia have developed CIPs at either a national or subnational level, with new CIPs being developed on an ongoing basis.

Translating CIPs into action, and ultimately into results, requires a sustained, deliberate approach to the execution process. This notion may sound simple and straightforward, but it can be complex. Strategic planners agree that planning seldom fails; it is the implementation that fails. Extensive literature describes the factors that can stall a plan, including lack of buy-in and ownership, unclear lines of responsibility and accountability, lack of dedicated efforts to mobilize resources, inability to recognize and facilitate change processes, poor communication and coordination among stakeholders, and inadequate leadership and management skills to effect execution.

Senegal was one of the early countries to develop a CIP for its national FP program, launching it in November 2012 following the historic London Summit on FP in July of that year. Over the subsequent three years, through December 31, 2015, the government worked alongside various partners and stakeholders to efficiently coordinate and monitor implementation of the plan. This case study gives an account of the process of translating the plan into sustained action and measurable results — what worked, challenges, and lessons learned — to benefit other countries that are developing and executing CIPs and to contribute to the identification of best practices in CIP execution.

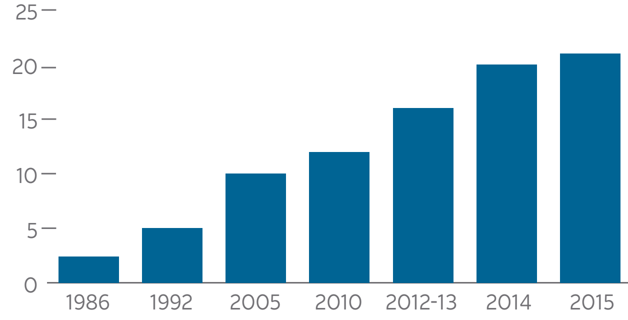
FAMILY PLANNING IN SENEGAL

Although the use of contraception was officially outlawed until 1980, FP services have been available in Senegal since the mid-1960s. However, focused attention on making contraceptive services available to the population began in earnest in the mid to late 1980s, in part through the help of large, donor-funded FP projects. In 1988, the Declaration of Population Policy became the first demographic policy to promote birth spacing in West Africa, and the National FP Program was launched

in 1991, followed by the creation of the National Service for Reproductive Health in 1997. From that service, the Division of Reproductive Health (DSR) was created in 2001, and a national reproductive health law outlining the rights of all citizens to access reproductive health and FP services was created in 2005. More recently, high-level policy documents have identified FP as an important strategy for reaching health and development goals. These include the Multi-sectoral Road Map to Accelerate the Reduction of Maternal and Neonatal Mortality and Morbidity in Senegal (2006–2015), the National Health and Development Plan (2009–2018), the Economic and Social Policy Document (2011–2015), and most recently the Emerging Senegal Plan, which sets a vision for Senegal to become a middle-income country by 2035. It was amid this increasing attention to FP that the first CIP was developed in 2012.

In parallel with the increasing formalization of national FP services, Senegal has seen growth in the contraceptive prevalence rate (CPR). The first demographic and health survey (DHS), from 1986, notes a modern CPR of only 2.4% among married women. That rate grew to 5% in 1992, 10% in 2005, and 12% in 2010. Since then, it has grown substantially, from 16% in 2012–2013 to 20% in 2014, to 21% in 2015 (Figure 1). Similarly, the country has seen reductions in maternal mortality, from 510 deaths per 100,000 live births in 1992 to 392 deaths per 100,000 live births in 2010, and in infant and child mortality, which decreased 43% from 2003 to 2010. Although these are meaningful health gains, it is important to note that total fertility decreased only marginally, from 5.3 children per woman in 2005 to 4.9 per woman in 2015, that unmet need remained somewhat elevated at 22.5% in 2015, and that marked differences exist in CPR across demographic groups including urban versus rural residents, age groups, and wealth quintiles.

Figure 1. Contraceptive prevalence rate (CPR) in Senegal, 1986-2015



Source: The DHS Program.

OVERVIEW OF SENEGAL'S CIP

The Honorable Minister of Health officially launched Senegal's Plan d'Action National de Planification Familiale (2012–2015), or PANPF, at a large gathering in Dakar in November 2012. The PANPF included six strategic technical domains: communication/demand creation, advocacy, contraceptive security, extending community-based services, strengthening private-sector services, and improving public-sector services. During a relatively short period of about five months leading up to the launch, the Ministry of Health and Social Action (MSAS), specifically the DSR, and FP stakeholders reviewed key health and development policy documents, identified the priority technical domains for the PANPF, and articulated and costed major activities under each domain. The MSAS set an ambitious goal in the PANPF to increase the national CPR for married women from 12% to 27% by 2015. This jump in percentage points would require providing contraceptive services to an additional 350,000 women at an estimated cost of US$31.4 million over the three years of the PANPF.

MOVING FROM A PLAN TO SUSTAINED ACTION AND RESULTS

It is often the case that national strategies are produced and announced with much fanfare, but then sit on a shelf somewhere collecting dust. The story in Senegal is different. MSAS and partners were well-positioned for a smooth transition from CIP development to execution. During development of the plan, they formed several working groups to coordinate the process: a large FP Technical Committee and three smaller working groups aligned to the major thematic areas of the CIP. The three working groups focused on 1) increasing access to FP (including at the facility and community levels and through the private sector), 2) increasing demand for FP (through communication and advocacy activities), and 3) ensuring contraceptive security. Once the plan was launched, these structures remained in place to coordinate implementation and to hold all FP stakeholders, including the decentralized levels of the health system, accountable for success. The transition to action was made possible in large part by clear support from the highest level of the Ministry of Health (MOH) and ongoing leadership and engagement by the government.

The Power of Country Ownership

Family planning as a national priority. The London Summit served as a highly visible platform for countries to demonstrate their commitment to meeting the FP needs of their citizens and to hold each other accountable. In the case of Senegal, it also served to catalyze growing support for a national FP strategy and provided the impetus to develop the country's CIP so that the Minister of Health and the Government of Senegal could credibly announce their FP goals and objectives. The interest and support from the minister and higher authorities made it both possible and desirable for all stakeholders to come together in support of the CIP. Soon after the London Summit, a new president reorganized ministerial structures, including elevating the DSR to a directorate — the Reproductive Health and Child Survival Directorate (DSRSE) — the highest administrative level within the MSAS structure. The president also promoted the head of the former DSR — a dynamic FP champion — to the helm of the DSRSE. The visibility of Senegal's CIP in the post-summit environment and the elevation of the DSR to the DSRSE subsequently allowed the promotion of the FP unit to a FP division with a division head, which meant more visibility and resources for implementation of the PANPF.

High-level government champions. The Minister of Health and the director of the DSRSE remained engaged and invested in the successful execution of the PANPF and often promoted it within and outside of Senegal, including at meetings of the Ouagadougou Partnership and FP2020. The minister felt personally accountable for achieving the goals set forth at the London Summit and in the CIP. This provided an additional incentive for FP stakeholders and partners to rally around the PANPF and remain active in its coordination and monitoring. All partners wanted to demonstrate their support for the country's vision for FP programming and ensure that their contributions were accounted for as part of monitoring.

Engagement of subnational stakeholders. Country-level ownership of the PANPF was not limited to the MOH, the Dakar-based headquarters of implementing partners, or other entities at the central level. Although chief regional doctors were consulted during the development of the CIP, their involvement in the development of the PANPF was limited because of the short time line. Therefore, immediately following the CIP launch, the DSRSE organized meetings across the country with representatives from the health management teams of all 14 regions and all their districts to orient managers and supervisors, as well as implementing partners, representatives from other sectors of government, the private sector, and civil society, to the PANPF. During these meetings, each district identified its priority strategies and activities for achieving its portion of the national goal of 27% CPR by 2015, captured in what are called district FP acceleration plans. Although the PANPF was developed primarily at the central level, the fact that the acceleration plans were developed by district management teams meant that the plans reflected the reality on the ground and were realistic in scope, and that district leadership felt much more accountable for their projected results. These district acceleration plans have served as a reference point and foundation for subsequent monitoring efforts.

> *Some sources also point to the fact that in the implementation of the PANPF, far from a top-down approach, there is real involvement of the community level and by the regions to achieve the objectives. This involvement is reflected in the commitment of the Chief Regional Doctors to increase and achieve regional targets, and through the development of regional action plans, which health structures have been implementing since 2012.*
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> *Source: PopCouncil, 2015 (translated from French)*

Governance and Coordination: Strengthening Implementation

Clear structure at the central level. The FP Division of the DSRSE, created toward the end of 2012, became the "home" for the PANPF. The FP Technical Committee was led by the FP Division, and each working group was co-coordinated by a partner organization and included members from implementing partners, donors, and civil society groups. All committees met routinely — every two to three months — following standardized agendas. The working groups would meet first to assess the status of the activities within their part of the plan, applying a simple traffic signal rubric — green for on track, yellow for risk of delay, and red for delay. Each working group would then report on the status during FP Technical Committee meetings, and discussions would

Etat d’avancement des activités de création de la demande

- (green) avancent conformément au plan
- (yellow) activités risquent un retard par rapport au plan
- (red) activités en retard par rapport au plan

Domaines stratégiques	Statut	Défis / opportunités
Plan de communi-cation	▪ Au niveau national, **préparation de la campagne PF finalisée :** – Présentation du contenu de la campagne lors du groupe demande et itérations avec la DSRSE pour le finaliser – Lieu et date du lancement décidés (Mbour, 3eme semaine d’aout)	▪ Les matériels de communications développés par les différents acteurs doivent être partagés pour en assurer la cohérence (par exemple partage par email)
	▪ Au niveau régional – les OCB ont été sélectionnés et le travail va démarrer – **Manque d’informations sur l’avancement des activités au niveau des districts**	▪ Besoin d’un suivi rapproché des activités déroulées sur le territoire par les différents partenaires afin d’identifier les zones pas suffisamment couvertes
	▪ Des **gaps de financement** ont été recensés et compilés par le SNEIPS	▪ Cette analyse des gaps doit être partagée lors du groupe de travail pour que chaque partenaire s’exprime sur sa capacité à les combler

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Example slide from meeting of FP Technical Committee reviewing implementation status of PANPF activities by strategic priority area. *Source: DSRSE and Working Groups*

be held regarding how to address delayed or potentially delayed activities. Participants would also discuss the recommendations that each working group had made during its presentation. The commodity security working group operated slightly differently in that it existed before the PANPF was developed and was simply absorbed into the larger coordination mechanism. Notes from all committee meetings were circulated to all members via a distribution list that also served a knowledge management function with FP stakeholders providing updates on key FP activities, sharing documents and resources, and inviting members to relevant meetings.

Provision of guidance and technical assistance. The clear structure at the central level enabled the DSRSE and the FP Division not only to coordinate and monitor overall implementation of the PANPF but also to provide guidance and technical assistance when needed (e.g., to clarify the conditions under which illiterate community health workers can initiate clients on contraceptive pills or offer injectable contraceptives). Similarly, the demand-creation working group and the FP Technical Committee provided technical guidance and input into the first National FP Communications Campaign, Moytou Nef. The structure also served as a platform to involve all partners in joint activities, such as conducting an inventory of trainings received and required by health personnel in all regions of the country. However, despite these efforts at coordination, it is impossible for the FP Technical Committee to know of and monitor all activities. For example, while the service-delivery subgroup coordinated official approval and organization of mobile services across the country, one partner integrated FP services into HIV mobile testing services without any discussion in the group.

Subnational coordination. At the decentralized levels, responsibility for overseeing execution of the PANPF was incorporated into existing structures — namely the regional and district management teams, each of which included the chief medical doctor, the reproductive health coordinator, and the health educator. The district FP acceleration plans provided a road map that could be revisited each year during the development of the district annual work plans. Regional and district management teams could seek technical assistance from implementing partners as well as the central-level DSRSE to implement activities, address gaps in coverage, or mobilize resources.

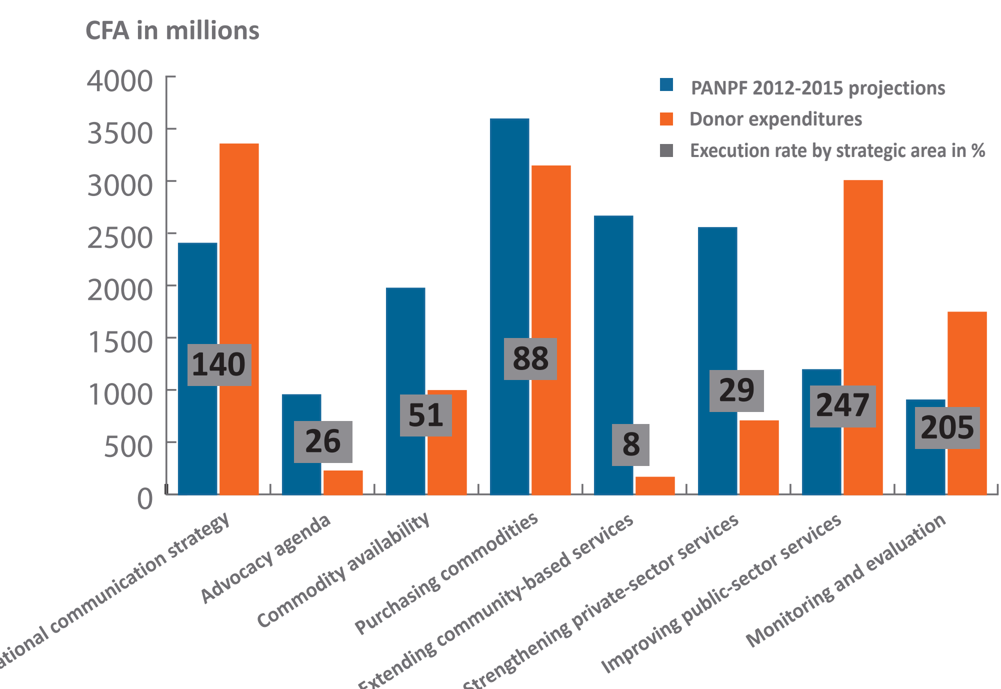
> *“Today we see mayors using local budget lines to buy FP products. I’ve seen it in Pikine West, Djidah Thiaroye Kao, in Guediawaye, mayors who buy products and make them available in their local health centers. That is an example of commitment because at the beginning everything that was in a budget portfolio, or an endowment fund, FP was not included, so if today mayors really feel interested such that they buy products, they fund mobile outreach or support NGOs who are doing it...then that’s something.”*
>
> – NGO Representative
> *Source: PopCouncil (translated from French)*

Resource Mobilization: A Challenging Aspect of CIP Coordination

Increase in overall resources but insufficient funding of some priorities. During the development of the PANPF, the DSRSE and stakeholders identified and costed specific activities under each strategic technical domain in order to arrive at the estimated total cost of achieving the stated goals and objectives. Although many of the activities that were included were already planned for under existing partner budgets, it was still necessary to mobilize a substantial portion of the total US$31.4 million price tag. At the London Summit, the Minister of Health committed to increasing domestic spending by increasing the annual budget allocation for reproductive health from 2.5% to 5%, increasing the total allocated funding for contraceptive commodities by 200%, and doubling the budget for the national FP program. According to a report by the Population Council, these high-level commitments were partially realized, as government spending on commodities increased by 100% rather than 200% and a specific budget line item for FP and reproductive health was created. A report published in December 2014 that assessed resource mobilization for the PANPF during 2012–2014 noted that funding for the DSRSE remained at 2.5%, and thus did not double. That report also concluded that the overall resource mobilization goal for the PANPF (US$31.4 million or 16,318,285,440 CFA) was actually surpassed by December 2014, with financial and technical partners providing 156% of the originally predicted value of the plan, or a total of 25,385,295,827 CFA. However, even though overall funding surpassed the original predictions, the report noted that spending was not consistent across the strategic priority areas, with some areas left underfunded, including expansion of community-based services, strengthening of the private sector, and advocacy (Figure 2).

Informal monitoring of resource mobilization. No specific subgroup was tasked with overseeing resource mobilization in relation to the PANPF and, as the report prepared for the mid-term review noted, it was difficult to align the financial systems of partners with those of the government. This was because partners' fiscal calendars differed from those of the DSRSE, and because many partners did not record or report expenses by the priority activities identified in the PANPF. Although challenges existed for the MOH to align donor and partner priorities with those outlined in the PANPF, the DSRSE and FP Division focused as much as possible on coordinating partners' separate funding streams to ensure adequate and efficient use of available resources. During FP Technical Committee and working group meetings, partners were asked to report on budgets and spending related to specific planned activities that were linked to higher-level strategic priority areas. In addition, during meetings with subnational representatives, regional and district management teams reported on the amount of money spent on each technical domain. However,

Figure 2: PANPF projections and expenditures by strategic area



Source: Groupe ISSA and Abt Associates; 2014.

this was not done consistently, in part because it was difficult for management teams to routinely obtain this information from implementing partners (who furnished the majority of funding but whose financial systems did not allow reporting on expenses by region). Nonetheless, these meetings provided opportunities for regions and districts to identify gaps in funding and to advocate in front of partners for additional support. After one regional meeting, a new partner began contributing financial resources for activities in the region of Kedougou, which previously had limited financial partners. In some instances, local governments used their own available budgets to support FP programming, by purchasing contraceptive commodities and funding outreach activities. Advocacy targeting national and subnational decision makers (e.g., parliamentarians, governors, mayors) with messages encouraging funding for FP programs to reach the country's economic, political, and social development goals were likely helpful in this regard.

Although there was no routine mechanism for monitoring resource mobilization, the ad-hoc efforts described above, including the assessment done as part of the mid-term review, did prove useful for decision making. The assessment was the first (and only) instance in which resource mobilization for the PANPF was examined overall and in terms of how resources were being spent according to strategic priority areas, priority activities, and regions. This was a central focus of discussion during the mid-term review meeting, and it served as the basis for several recommendations on how to ensure equitable financing until the end of the PANPF and how to prepare for the next CIP.

Key Performance Indicators

Original indicators from PANPF

- Monitoring of consumption of products for each distribution channel
- Number of contraceptive users
- Calculated/estimated contraceptive prevalence rate
- Recruitment rate
- Stock-out rate
- Discontinuation rate

Indicators from demographic and health surveys

- Maternal and infant-child mortality rates
- Fertility rate
- Contraceptive prevalence rate
- Unmet need

Original indicators evolved into these for use in routine data collection

- # of new users (by method)—both completely new and those new to the particular facility
- # of continuing users (by method)
- # of inactive (those users who missed follow-up appointments during period)
- Rate of those who stopped using for reasons other than wanting to get pregnant (users who stopped/total users)
- Recruitment rate (new users/target)
- # of each product provided
- % of stock-outs (# of sites with stock-out/ total # of sites)

Performance Monitoring and Accountability: Keeping Track of the Plan

Routine family planning service statistics prioritized. The DSRSE made a conscious decision to closely monitor implementation of the PANPF and to hold all FP stakeholders, including the decentralized levels of the health system, accountable for its success. In particular, the DSRSE wanted access to FP service data that had not been available for the past five to seven years because health workers had been withholding them from the central level in protest of work and employment conditions. Because the DSRSE did not have a clear idea of the performance of health clinics, districts, or regions and therefore of the overall FP program, the DSRSE decided to focus its monitoring efforts on selecting key FP performance indicators and facilitating the collection and reporting of routine FP data from the lowest levels to the central MOH.

A standardized reporting form. With support from the U.S. Agency for International Development (USAID), a monitoring and evaluation (M&E) officer was seconded to the M&E unit of the DSRSE with an initial focus on strengthening a monitoring strategy and framework for the PANPF that would include process and outcome monitoring. Although some key outcome indicators were included in the PANPF, given the long pause in data reporting, the first task was to harmonize and prioritize FP indicators into a standardized FP data reporting form

that districts could use to collect and report data. Key FP indicators included the number of new FP users (total and by method), number of continuing FP users (total and by method), and number of women who quit using any method or who were lost to follow-up. The form built off of past routine data collection tools and was agreed upon and endorsed by FP stakeholders via a series of consultations. During this time, the DSRSE created a fourth working group under the FP Technical Committee, focused on M&E, in order to facilitate the process of developing this standardized performance-monitoring tool and to play a role in reviewing, validating, and interpreting the FP data that would be coming into the DSRSE. The DSRSE also oriented key reproductive health staff at the regional and district levels, specifically the reproductive health coordinators and the head doctors, to the new tool — including the definition of indicators and the method of calculation — over several months.

> *"We held the mid-term review of the PANPF and we felt some friendly competition between the medical regions, but also it has translated to the level of the districts ... at the regional performance review meetings, you will realize that there is healthy competition between the districts and I think it is something that is extraordinary."*
>
> – Government Representative
> *Source: PopCouncil (translated from French)*

Routine reviews at the subnational level. Once districts and regions had their own implementation plans in place and were equipped with data collection tools, the DSRSE supported meetings at the regional level, which brought together the district management teams along with central-level MOH representatives, implementing partners, donors, civil society, and local political leaders. At these meetings, held approximately every three to six months, participants reviewed implementation of the FP acceleration plans, examined FP data, and discussed challenges, successes, and any needed corrective actions.

Although the DSRSE initially supported these meetings at the regional level, there were not always sufficient human (and financial) resources to ensure that all 14 regions could hold quarterly FP performance review meetings. In the second year of PANPF execution, the DSRSE initiated quarterly FP performance review meetings in Dakar. Using a standardized presentation format, each regional management team presented a summary of its FP performance by sharing key FP data alongside the implementation status of its FP acceleration plan.

Better monitoring leading to better coordination. Whether at the regional or central level, these meetings helped to improve coordination among the government, partners, and donors, as demonstrated by a review meeting held in the southern region of Kedougou during which a gap in funding led to the involvement of a new donor partner. The meetings also provided an opportunity for regional and district management teams to seek technical assistance from each other, from FP partners, and from the central MOH. For example, after one regional meeting held in the St. Louis region, a particularly successful strategy for training providers to provide long-acting reversible contraception was expanded from one district to all the districts in the region after participants saw an increase in the use of long-acting reversible contraception in the original district. Finally, as

Using a Continuous Demographic and Health Survey to Complement Routine Family Planning Service Statistics

Senegal is one of several countries that has benefited from a continuous DHS as a means to access nationally representative health data. When originally selecting performance indicators, the DSRSE identified certain indicators, namely CPR and unmet need, that would be better collected via surveys such as the DHS. Once it was certain that the DHS would occur annually, the choice was made to glean only CPR from these surveys, rather than attempting calculations from routine service statistics (which was the original plan). The DSRSE largely used the continuous DHS as an opportunity to double-check the validity of routine service statistics, noting any major discrepancies in FP use, particularly at the regional level. Three continuous DHSs had taken place: 2012–2013, 2014, and 2015.

The government (specifically the DSRSE and the National Agency for Statistics and Demography) held two meetings to dive deeper into the FP data in the 2012–2013 and 2014 surveys. Although the first survey grouped several regions together into clusters, which was not ideal for an in-depth analysis, the second survey included statistics for all regions. Nonetheless, stakeholders were happy to have the routine service statistics to demonstrate a fuller picture of the state of the national FP program.

Analyzing Implementation at Mid-term

The DSRSE organized a mid-term review meeting on February 5–6, 2015, in Dakar. The meeting was opened by the Minister of Health, and participants included financial and technical partners, civil society organizations, regional head medical doctors, and representatives from countries within the Ouagadougou Partnership. The overall objective of the meeting was to share and analyze the status of implementation of the PANPF from December 2012 to June 2014. Sub-objectives were to:

- Present implementation status of activities related to: FP service delivery, the availability of FP commodities, and demand creation (communication and advocacy).
- Present national and regional performance levels in relation to objectives.
- Analyze bottlenecks in the implementation of activities and formulate relevant recommendations for the remaining implementation of the PANPF.

To prepare for the mid-term review, the FP Technical Committee reviewed relevant documents, including reports from its meetings and the meetings of its subgroups, reports of performance review meetings, DSRSE quarterly reports, and implementing partner reports. The committee also reviewed key study and assessment reports, including the continuous DHS, the report assessing resource mobilization for the PANPF, the pilot study reports for Sayana Press and the Informed Push Model, and the evaluation of the national mass media FP campaign, and interviewed key stakeholders at the national and regional levels. The meeting itself was a mix of presentations, discussion, and small group work and was organized largely around the priority strategic areas of the PANPF. Data collected as part of the routine M&E efforts (regional and central-level performance review meetings) were shared alongside other key results, including data from the continuous DHS. Panels discussed major successes and challenges of implementing activities in the priority strategic areas. During one session, the regional head medical doctors individually reported on their own challenges and made suggestions for improvements by the central-level MOH and partners.

A report from the meeting summarized recommendations by priority strategic area for the remaining implementation period.

the regions presented their results to each other during meetings at the central level, it incited a sense of "friendly competition." For example, at a meeting held in Dakar to review performance from July to September 2015, the region of Fatick was a clear standout, showing the largest increase in active FP users (39% higher than the previous quarter) while also demonstrating drastic improvement in the recruitment of new FP users over the same period.

Gauging mid-term progress. In early 2015, the DSRSE and partners organized a mid-term review of the PANPF to examine the first two years of execution. Several recommendations coming out of this review were related to evaluating and strengthening the quality of FP data reporting. As a result, the DSRSE, with partner support, initiated a series of data quality assessments (DQAs) to measure the timeliness, accuracy, and reliability of routine FP data as they move from the subnational to the central level of the health system. Through the M&E working group, the DSRSE built on an existing DQA tool used by a partner and designed an approach that built the capacity of reproductive health coordinators within the DSRSE and at the regional level to implement the DQAs. From August 2015 through July 2016, central and regional DSRSE staff conducted DQAs in six regions of Senegal (i.e., Dakar, Thies, St. Louis, Fatick, Diourbel, Kaolack). Through these efforts, the DSRSE identified districts requiring additional support to improve the quality of their FP data reports, and provided that support both during and after the DQAs. In addition, there is now a core group of reproductive health coordinators at the regional level, and key staff at the central-level DSRSE (in the M&E unit as well as the FP Division) who have the capacity and the mandate to implement DQAs in the future.

REFLECTIONS AND LESSONS LEARNED

Senegal developed the PANPF in approximately five months and then shifted immediately into execution. Since its execution, stakeholders within and outside of the country have remarked on the results that were achieved: the government demonstrated leadership in rendering FP a visible priority, partners coordinated activities to avoid duplication and to leverage available resources, and together these partners put into place mechanisms to monitor execution of the plan as well as FP performance. Execution of the PANPF necessitated a revamped approach to FP data collection, which led to improved communication between the central and decentralized levels of the health system and resulted in the routine

availability of FP performance data — something that other divisions within the DSRSE and other directorates within the MSAS do not always have.

Senegal's experience executing the PANPF highlighted challenges and provided many lessons learned that are relevant to Senegal, as it embarks on executing its next CIP, and to other countries.

High-level political support is important, but sufficient operational staff are essential. A champion within the DSRSE was critical for garnering support within and outside of Senegal for the prioritization of FP via the PANPF. It was equally important to elevate the FP unit to a division with staff and a head, in order to support implementation of the CIP. However, the FP Division still had staff shortages that made some aspects of coordination and execution difficult. Given the lack of human and financial resources at the DSRSE, partners' assistance via seconded staff helped ensure consistent meetings of the FP Technical Committee and effective coordination and communication both across partners and with the decentralized levels. Although partners provided the seconded staff, the DSRSE was always the lead, thus facilitating cooperation among partners and mitigating perceived competition.

Sustaining multi-stakeholder mechanisms over time can be difficult. Although very strong for the first year after the CIP was launched, momentum around working groups faded over time, leading to less frequent communication among partners. Organizations reverted back to individual consultations with decision makers in the DSRSE, resulting in less coordinated efforts and less transparency. Although the PANPF provided high-level guidance regarding priority technical areas for program implementation, specific projects remained tied to their own project-level mandates and to meeting deliverables. This sometimes meant that individual projects would prioritize tasks and activities required to meet deliverables over tasks and activities that may have been prioritized in the PANPF, with less overall participation in coordination meetings.

Aligning and monitoring the CIP's resource requirements is challenging. Although it appears that the overall required resources for implementing the PANPF were reached by the end of 2014, there was an imbalance across strategic priority areas, with some overfunded and others underfunded. The DSRSE experienced difficulties in accessing information about available financial resources from partners and in coordinating donor and partner resources to ensure alignment with priority areas for the DSRSE. Furthermore, little private-sector funding was mobilized to support the PANPF. Finally, although Senegal has decentralized many aspects of health care delivery, funding streams are still in flux and stakeholders need to better access decentralized funding streams in support of FP.

Performance monitoring can be key to motivating individuals at all levels. From providers to district management staff to implementing partners, everyone wants their work to be quantified and recognized. The emphasis on performance monitoring via routine data collection of key FP indicators and the sense of "friendly competition" motivated staff at all levels of the health system, as well as partners, to demonstrate quality and to support the M&E efforts under way. The focused technical assistance to district and regional management teams, the frequent communication of central-level DSRSE M&E staff with those regional and district staff, and the inclusion of partners in the M&E working group also helped these individuals understand the overall goal of the M&E efforts and their particular role in data collection, reporting, and analysis. It was also important to have opportunities to compare and validate the routine service statistics with results from other sources, specifically the continuous DHS . Secondary analysis workshops and meetings allowed health personnel and implementing partners to further delve into the available data, discuss them in relation to the available service statistics, and generate suggestions for future areas of research.

Interim strategies for obtaining routine family planning service statistics may be appropriate, but a long-term vision is also necessary. Immediately following the development of the CIP, and in the wake of a several-year gap in routine data reporting, the DSRSE wanted to focus on collecting FP data and analyzing them at a central level. This led to the development of a specific FP data collection tool. However, such a tool could be only a short-term solution. Simultaneously, the DSRSE was developing a comprehensive reproductive, maternal, newborn, and child health (RMNCH) data collection tool and working with other government agencies to include key indicators in the district health information system (DHIS2). Senegal's experience highlights the tension between data collection siloed by health area (e.g., FP-specific data collection) and the move toward integrated data collection. Although the DHIS2 is expanding in the country, the overall health management information system (HMIS)

is still largely paper-based. Therefore, data reporting is slow and fraught with errors, making evidence-based real-time decision making difficult. Furthermore, decentralized management teams often lack the resources and skills required to analyze data at their level, or do not prioritize it among other competing priorities. Divisions in charge of FP in many countries are left to decide whether to spend time and resources to ensure effective FP data collection — which often means putting into place separate, or siloed, efforts — or whether to rely on the national HMIS for FP data. Senegal has opted to include FP data within somewhat-siloed RMNCH data collection efforts, even while the country looks to incorporate RMNCH data collection into the national HMIS.

Opportunities for implementers and the government to collectively assess progress and discuss challenges can improve execution, but they require dedicated time and resources, particularly at the subnational level. The regular performance review meetings that the DSRSE held with health staff and partners provided an opportunity for participants to express challenges, identify solutions, and learn from each other. The meetings held at central and regional levels combined review of progress in implementation alongside review of FP performance data, rather than separating the reviews, which helped provide a fuller understanding of the FP programmatic landscape. This close coordination and monitoring permitted the DSRSE and partners to adjust project work plans and to redirect funding to meet specific regional needs.

Specific resources — both financial and human — have been required to organize and hold such meetings. The resources required to organize regular regional review meetings proved to be fairly substantive; thus, the shift was made to central-level meetings. However, central-level meetings were not able to fully absorb the objectives of regional meetings — specifically, they did not allow for districts within a region to share and learn from each other. Ideally, regional management teams would organize such meetings independent of the central level, but that was not the case in most regions. Furthermore, ensuring ongoing coordination and communication between central and subnational levels was made more difficult by the shifting of staff in leadership positions at the subnational level. As staff retire or are moved to other regions, the central level must reinvest in orienting replacement staff to the overall PANPF and the region's FP acceleration plan, and in conducting advocacy so that new leaders prioritize the FP program within the overall health services in the region.

CIP implementation remained largely focused within the health sector, to the exclusion of other sectors that could potentially have played a role. The coordination mechanisms put into place for the CIP did not include representatives from other development sectors or from priority ministries such as the Ministry of Economy, Finance and Planning or the Ministry of Environment and Sustainable Development. Stakeholders in Senegal identified this as a weakness during the mid-term review, noting that more involvement of other sectors could complement the strengths of the health sector and help address certain challenges (particularly related to financing and human resource management). The stakeholders also identified mutli-sectoral engagement as a priority focus for the next CIP (2016–2020).

CONCLUDING THOUGHTS

Senegal has been a leader in repositioning FP — introducing important FP strategies like community-based provision of FP and innovative management systems like the Informed Push Model, hosting exchanges and study tours as part of the Ouagadougou Partnership, and seeing substantial increases in CPR over the past several years. It is not far-fetched to presume that efforts aimed at coordinating and monitoring CIP execution helped lead to these positive outcomes. The experiences of Senegal echo those documented in the first case study in this series (focusing on Tanzania's CIP) and help validate the four factors that support effective execution: country ownership, governance and coordination, resource mobilization, and performance monitoring and accountability. As Senegal moves into executing its second CIP, the global community will have to stay tuned for additional insights into how to effectively coordinate multi-stakeholder engagement around a shared vision for national FP programs.

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Contact Information:

All comments and questions can be directed to publications@fhi360.org

FHI 360
359 Blackwell Street, Suite 200
Durham, NC 27701 USA
www.fhi360.org

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