SENEGAL PRIVATE HEALTH SECTOR ASSESSMENT: SELECTED HEALTH PRODUCTS AND SERVICES

January 2016

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Recommended Citation:
Brunner, Bettina, Jeffrey Barnes, Andrew Carmona, Arsène Kpangon, Pamela Riley, Erin Mohebbi, and Leslie Miles. 2016. *Senegal Private Health Sector Assessment: Selected Health Products and Services.* Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

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Cooperative Agreement: GPO-A-00-09-00007-00

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ACRONYMS

ASBEF	*Association Sénégalaise pour le Bien-Etre de la Famille*
AcDev	Action for Development
ACT	Artemisinin-based Combination Therapy
ADEMAS	*L'Agence pour le Développement du Marketing Social (PSI Affiliate)*
AFDB	African Development Bank
ANC	Antenatal Care
ANPSCS	*l'Association des Postes de Santé Privés Catholiques du Sénégal*
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	*Agent de Santé Communautaire (Community Health Worker)*
ASPS	Alliance du Secteur Privé de la Santé du Sénégal
CBO	Community-Based Organization
CCMm	Community Case Management of Malaria
cDHS	Continuous Demographic and Health Survey
CDCS	Country Development Cooperation Strategy
CFA	*Communauté Financière d'Afrique, the West African currency*
CLM	*Cellule de Lutte contre la Malnutrition*
CMU	*Couverture Maladie Universelle*
CNLS	*Conseil National de Lutte contre le Sida*
COSFAM	*Le Comité Sénégalais pour la Fortification des Aliments*
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CSR	Corporate Social Responsibility
CSS	*Caisse de Sécurité Sociale du Sénégal*
DCA	Development Credit Authority
DFID	Department for International Development
DHS	Demographic and Health Survey
DPM	*Direction de la Pharmacie et Médicament*
ECOWAS	Economic Community of West African States
ECPSS	*Enquête Continue sur la Prestation des Services Soins de Santé*
EU	European Union
FBO	Faith-Based Organization
FP	Family Planning
FTF	Feed the Future
GDA	Global Development Alliance

GDP	Gross Domestic Product
GHI	Global Health Initiative
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit*
GOS	Government of Senegal
HCT	HIV Counseling and Testing
HIA	Health in Africa Initiative
HKI	Helen Keller International
HRH	Human Resources for Health
iCCM	Integrated Community Case Management
ICS	*Industries Chimiques du Sénégal*
IDA	International Development Association
IFC	International Finance Corporation
iHRIS	Human Resources Information Solutions
ILO	International Labor Organization
IPM	Informed Push Model
IPPF	International Planned Parenthood Federation
ISE	Institute of Environmental Sciences
ISEP	Higher Institute of Vocational Education
ISSU	Senegal Urban Reproductive Health Initiative
ITEV	Thies Incubator for Green Economy
ITN	Insecticide-Treated Net
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraception
LNCM	National Laboratory for Control of Medicines
m4RH	Mobiles for Reproductive Health
MAMA	Mobile Alliance for Maternal Action
MCC	Millennium Challenge Corporation
MDG	Millennium Development Goals
MFI	Microfinance Institution
MII	*Imprégnées d'Insecticide Moustiquaire*
MILDA	Long-Acting Insecticide Treated Nets
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
MSAS	*Ministère de la Santé et de l'Action Sociale*
MSI	Marie Stopes International
NGO	Nongovernmental Organization
OC	Oral Contraceptive
ONPS	*Ordre National des Pharmaciens*
ORS	Oral Rehydration Salt
PLHIV	People Living with HIV
PMAS	*Pool Micro Assurance Santé*

PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNA	*Pharmacie Nationale d'Approvisionnement*
PNDS	*Plan National de Développement Sanitaire*
PNLP	National Malaria Program
POS	Point of Service
PPD	Public-Private Dialogue
PPP	Public-Private Partnership
PSA	Private Sector Assessment
PSE	*Plan Sénégal Emergent*
PSI	Population Services International
PSP	*Pharmacie de la Santé Publique*
PVR	Progesterone Vaginal Ring
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RMNCH	Reproductive Maternal Neonatal Child Health
RSE	Corporate Social Responsibility
SAM	Severe Acute Malnutrition
SANFAM	*Santé Familiale*
SA, SARL	*Société Anonyme, Société Anonyme à Responsabilité Limitée*
SBCC	Social Behavior Change Communication
SHOPS	Strengthening Health Outcomes through the Private Sector
SMS	Short Message Service
STI	Sexually Transmitted Infection
TB	Tuberculosis
TDR	Rapid Test Kit
TFR	Total Fertility Rate
TMA	Total Market Approach
TVA	*Taxe sur la Valeur Ajoutée*
TWG	Technical Working Group
UCAD	*Université Cheikh Anta Diop de Dakar*
UEMOA	West African Economic and Monetary Union
UHC	Universal Health Coverage
UNAIDS	United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
USG	United States Government
VCT	Voluntary Counseling and Testing

WAHO	West African Health Organization
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization
WRA	Women of Reproductive Age

ACKNOWLEDGMENTS

The assessment team is grateful for the support of Bryn Sakagawa, John Bernon, Fatou Ndiaye, and Matar Camara at USAID Senegal for guiding the development, writing, and review of this report. We also thank the World Bank Group for co-financing the assessment, with special appreciation of Khama Rogo and Tshiya Subayi, both from the World Bank Group for their guidance. We thank the *Ministère de la Santé et de l'Action Sociale*, along with the stakeholders from nonprofit organizations, development partners, implementing partners, private clinics and pharmacies, and private sector health associations for sharing their insights about the private health sector with the assessment team. We are particularly thankful to Dr. Papa Amadou Diack, General Director of Health, Dr. Djibril Ba, Director of Planning, Research and Statistics, Dr. Ardo Ba, President of the Private Health Sector Alliance and Mme. Ndiaye Ndeye Fatou Tall, Head of the Partnerships Division, for their assistance.

We are extremely thankful to Jasmine Baleva and Andrea Harris from USAID Washington. We also thank Meaghan Smith and Piotr Korinski of Banyan Global and Francois Diop, Gael O'Sullivan, Vicki MacDonald, and Caroline Quijada of Abt Associates for their thoughtful review of the draft document and recommendations to improve it. Finally, we thank Papa Gagny Sylla for his exceptional support of and contributions to the assessment.

EXECUTIVE SUMMARY

USAID Senegal and Health in Africa (HIA) initiative of the World Bank Group engaged the Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct an assessment of the private health sector in Senegal. The assessment's primary focus is family planning, and its secondary focus is maternal, neonatal and child health (MNCH), HIV and AIDS, malaria, and nutrition. The assessment had the following objectives:

1. Provide an overview of private health sector stakeholders and their respective roles.
2. Assess the level of policy dialogue between the public and private health sectors.
3. Describe private sector contributions to key health markets and health system areas, including health financing.
4. Assess specific markets for key health products and services and describe supply and demand dynamics.
5. Identify existing and potential opportunities for public-private partnerships (PPPs) in health.
6. Provide recommendations on how to best operationalize PPPs in the health sector.

SHOPS and HIA finalized a scope of work with USAID Senegal in April 2015, and a team of five private sector experts conducted the onsite assessments between May and June 2015. The Private Sector Assessment (PSA) team worked closely with Senegalese key stakeholders throughout the process. The PSA team interviewed more than120 individuals from approximately 78 organizations, including the government of Senegal (GOS), donors, USAID implementing partners, private sector umbrella organizations, private insurance companies, faith-based organizations (FBOs), nongovernmental organizations (NGOs), private health care facilities, and private pharmacies.

The private health sector is a growing force in Senegal. Data from several offices in the *Ministère de la Santé et de l'Action Sociale* (MSAS) and statistics from the 2014 Continuous Demographic and Health Survey (cDHS) paint a picture of a private sector that includes 66 private clinics, 1,032 medical offices, 1,812 paramedical offices, and 1,048 pharmacies.

KEY FINDINGS

Through stakeholder interviews and review of government reports and online resources, the assessment team noted the following findings by theme.

Theme	Findings
Service Delivery, including Human Resources for Health (HRH) and Demand	• **Family Planning:** The private for-profit sector plays a weak role in FP service provision, limited to counseling and some services at medium-sized clinics. The NGO sector fills a key FP service provision gap, especially in peri-urban and rural areas through partnerships with community-based organizations (CBOs) and use of community health workers. • **MNCH:** Only 24 percent of private facilities offer all MNCH services compared to 86 percent of all public facilities. The NGO sector is a key provider of child services in peri-urban and rural areas, including vaccination and oral rehydration salts (ORS) treatment. • **HIV:** The private commercial sector provides limited HIV and AIDS service provision and refers to the public sector or NGO sector for testing and treatment. NGOS are more active in HIV and AIDS services, including NGO network AcDev and FBO network APSPCS. • **Malaria:** The private sector mainly refers patients to the public sector for rapid testing and treatment. The NGO sector offers malaria rapid testing and treatment for nominal fees. • **Nutrition** counseling is a part of commercial sector services, although nutrition interventions such as supplementary feeding, Vitamin A supplementation or fortification are typically not provided. NGO networks also play a key role in nutrition counseling, supplementary feeding, and Vitamin A supplementation. • There are 36 authorized medical schools in operation; the vast majority are nursing and midwifery schools. There is high unemployment among midwives and nurses. • Many government agencies are involved in and focus on different aspects of the private health sector, although there is some overlap and redundancy. • Senegal has a history of social behavior change and communication (SBCC) activities to increase demand, particularly for FP.
Access to Essential Pharmaceutical and Medical Commodities	• More than half of the 1,048 pharmacies in Senegal are located in Dakar (July 2015). • There are six authorized wholesalers and five pharmaceutical manufacturers. • In a retail audit of 17 pharmacies conducted by the SHOPS team as part of the assessment, all pharmacies surveyed had ACT for malaria, nutritional supplements for infants, ORS, oral contraceptives, and condoms. Socially-marketed brand availability in surveyed pharmacies included Protect condoms (82 percent), Fagaru condoms (47 percent), Securil oral contraceptives (100 percent), Aquatabs (94 percent), and Milda long lasting nets (76 percent). There were no rapid test kits for HIV, and only one had rapid test kits for malaria. • The *Pharmacie Nationale d'Approvisionnement* (PNA) has adapted the informed push model to its system in an approach it calls *Jegesi Naa*.
Health Financing	• Of the funds managed by private financing agents in Senegal, 77 percent were spent out of pocket, and 21 percent were managed by a prepaid scheme such as health insurance (WHO, 2015). • Financing for private health entrepreneurs is dominated by the formal banking sector. There are 19 banks with approximately 90 percent market share of the commercial lending market. There also were approximately 234 microfinance institutions (MFI) in 2013, with a greater reach in rural areas than banks. • Approximately 32 percent of the population currently has some degree of health insurance coverage (Interview with Cheikh Mbengue, Director General of the Universal Health Coverage (UHC) Agency). • At the end of June 2015, a total of 509,422 people were enrolled in community-based *mutuelles* supported by USAID. The IFC and other donors also support

Theme	Findings
Policy Landscape, PPPs, Corporate Social Responsibility (CSR), Worksite Health	• Most laws in Senegal regarding private providers focus on controlling the entry of private providers and health insurers into the market. • Beginning in 2004, the GOS promoted public private partnerships, although to date few health PPPs have been implemented. • The MOH's Cellule PPP currently is considering a list of more than 30 prospective PPPs, including private hospitals, research institutes, mobile health units, and pharmaceutical manufacturing facilities, among other opportunities. • Senegal's major companies have active CSR programs, many focused on HIV and increasingly, malaria. • RSE Senegal is the most prominent CSR organization in Senegal, funded by several donors. • Companies with more than 400 employees must have a full-time doctor onsite to provide preventive care and avoid occupational, sanitary, and other health risks.
mHealth	• Mobile phone use in Senegal is now estimated to be above 110 percent, and the three largest licensed mobile operators are Orange (65 percent market share), Tigo (26 percent market share), and Expresso (9 percent market share). • Senegal has a moderate level of mHealth investment and activities are grouped around service delivery, demand creation, supply chain, and finance.

CHALLENGES AND OPPORTUNITIES FOR THE PRIVATE HEALTH SECTOR

Based on the findings, the assessment team identified the following challenges and recommends the following activities by theme.

Theme	Challenge	Recommendation
General	• Lack of definitive statistics on the private health sector. • Plethora of government agencies involved in regulating the private sector.	• Conduct private sector census and assist the MSAS to develop an electronic database of the private health sector. • Assess agencies involved with private health sector, explore how to consolidate functions and streamline MSAS management of the private health sector. • Strengthen the capacity of the MSAS to oversee the private health sector.
Service delivery	• The public health sector is the dominant health provider in many health areas with low engagement of the private health sector. • There is high unemployment of nurses and midwives.	• The GOS could accelerate the total market approach (TMA) with targeted demand creation activities that tie into a segmentation strategy and consider diversifying beyond FP into a wider range of preventive and curative services. • Operationalize the May 19 decree requiring payment of interns and encourage task sharing. • Focus on unemployed midwives through better regulation of dual practice, increasing access to finance, and providing incentives for midwives to set up practices in underserved areas.
Increasing Demand	• Little information available regarding challenges that	• Use existing research on social, cultural and gender norms to develop more

Theme	Challenge	Recommendation
	clients face accessing health care in the private sector. • Deficiency in implementing demand creation activities and lack of innovative strategies to reach target populations.	targeted communications about FP, HIV and other health areas. • Integrate demand creation activities at the start of new programs.
Access to Essential Pharmaceutical and Medical Commodities	• Requirement that private facilities and pharmacies be owned by licensed health professional and must be a sole proprietorship impedes growth. • Onerous and lengthy (six-month) pharmacy authorization process. • Poor access to medicines in rural areas.	• Revise laws to allow for corporate ownership and ownership of multiple pharmacies by a single individual. • Streamline the procedures for pharmacy applications to reduce the time needed for authorizations and the amount of up-front investment. • Expand depots in rural areas through hub and spoke model with participating pharmacist. • Consider social franchising and social marketing initiatives.
Health Financing	• Future Development Credit Authority (DCA) loan program should be closely aligned with health goals of MSAS. • Smaller health enterprises are credit risk for banks but still seek financing. • Lack of innovative health business creation due to credit crunch.	• Focus DCA technical assistance on catalyzing consolidation in the private health sector. • Consider microfinance institutions and equipment lending companies in the health lending equation. • Consider the establishment of health innovation funds targeting health enterprises.
Policy, PPPs, CSR	• Slow movement for Cellule PPP and PPP Comité Technique.	• Use the legal and regulatory review to catalyze policy improvements for the private health sector and focus on PPPs that truly fix a health system gap in Senegal. • Strengthen the Cellule PPP's stewardship of the PPP process and streamline the role of the PPP Comité Technique.
mHealth	• Lack of coordination and collaboration among diverse mHealth activities; many fragmented partnerships in mHealth. • Lack of funding to scale up mHealth pilots.	• Improve functioning of the mHealth technical working group through more regular meetings, cataloguing mHealth activities in the country, creating an mHealth vision statement, and reaching out to Ministries of finance and telecommunications. • Build upon existing mHealth partnerships including PPP with Tigo Senegal and *mutuelles* for UHC. • Expand database of pharmacies by region through iHRIS in collaboration with the *Syndicat des Pharmacies Privés du Sénégal* and *Conseil National de l'Ordre des Pharmaciens.*

The expansion of Senegal's private health sector presents the opportune time to focus more resources on identifying challenges and improving private sector engagement. The GOS has shown a clear commitment to private sector engagement. Through the recommendations of this PSA, the GOS and donors have the opportunity to move forward purposely and efficiently in improving the health system.

1 BACKGROUND

FIGURE 1: MAP OF SENEGAL

Senegal, a politically stable country in West Africa, has grown significantly over the past decade, but challenges remain to the country's prospects for future growth. Between 2002 and 2008, the gross domestic product (GDP) per capita more than doubled from $513 to $1,094 (World Bank 2015a). However, Sub-Saharan Africa, which grew at an average rate of six percent over the last decade, outperformed Senegal's growth rate of 3.3 percent. Forty-seven percent of Senegal's population was below the poverty line in 2011, only a slight improvement over the 2005 level of 48 percent. Rising urban migration continues to exacerbate economic inequality with rural areas, particularly between Dakar and the rest of the country, and unemployment stands at 10 percent among the general population (World Bank 2015b; USAID/Senegal 2012). Despite near universal primary school enrollment, illiteracy remains high, and a low percent of children complete basic education. Access to quality health care services is a challenge, particularly for many Senegalese in rural and peri-urban areas. Other potentially limiting factors include low rainfall, degradation of the natural resource base, and a lack of cross-border disease control.

To implement the ambitious *Plan Senegal Emergent* (Senegal Emergence Plan), the country will need to harness all available resources, including the private health sector. The Government of Senegal (GOS) has been a champion of the private health sector in Senegal, but to date little has been known about its role in the health system. This private health sector assessment fills a knowledge gap to assist policymakers and health sector stakeholders better plan their interventions through greater understanding of the size, organization, capacity, and financing of the private health sector.

1.1 HEALTH SECTOR GAINS AND CHALLENGES

Senegal has made significant improvements in the areas of FP, MNCH, HIV, malaria, and nutrition over the past decade. The Government has made strides in repositioning FP as a critical priority for Senegal's future via the Relaunching Family Planning Plan through the regional Ouagadougou Partnership Initiative. Senegal's contraceptive prevalence rate increased from 12 percent in 2010 toward a goal of 27 percent in 2015 and 45 percent in 2020 (Le Partenariat de Ouagadougou 2013).

Despite recent gains in contraceptive prevalence, the 2014 Continuous Demographic and Health Survey (cDHS) shows that much remains to be done in the area of FP. According to the 2014 cDHS, total unmet need for FP is 25 percent, and the total fertility rate (TFR) has remained at approximately five children per mother over the last decade (Agence Nationale de la Statistique et de la Demographie and MEASURE DHS 2013). A recent study conducted by the Guttmacher Institute found that about 31 percent of pregnancies were unintended, and 24 percent of unintended pregnancies (8 percent of all pregnancies) ended in abortion (Sedgh et al. 2015).

Senegal also has made moderate gains in MNCH over the past 10 years. According to the 2014 cDHS, infant mortality has declined from 61 deaths per 1,000 live births in 2005 to 33 deaths per 1,000 live births in 2014, and child mortality from 121 per 1,000 live births in 2005 to 54 per 1,000 live births in 2014 (cDHS 2014). It is estimated that pneumonia is responsible for 18 percent of under-five deaths, diarrhea for 15 percent, and malaria for 8 percent The maternal mortality rate remains around 400 (Maternal and Child Health Integrated Program (MCHIP) 2012).

The people of Senegal have been very committed to managing the HIV epidemic in their country. This commitment, combined with strong political leadership, and the nonprofit NGO sector's active participation and alignment with the government of Senegal's response, has led to HIV prevalence among the general population of 0.7 percent. This prevalence translated to approximately 44,000 people living with HIV in 2014 and a total of 2,400 deaths due to AIDS (UNAIDS 2015). However, HIV prevalence among vulnerable groups, particularly sex workers remains high at 18.5 percent (Avert 2014).

Although deaths from malaria are still relatively high at 57 per 100,000 (WHO 2015b), successful malaria control efforts led to a significant decrease in morbidity from 33.6 percent in 2001 to 4.4 percent in 2013 (WHO 2014). The proportion of households owning at least one insecticide-treated net (ITN) increased dramatically from 20 percent in 2005 to 74 percent in 2014, and the proportion of children under age five sleeping beneath an ITN the previous night increased from seven percent to 54 percent, with similar trends for pregnant women (cDHS 2014). However, the proportion of pregnant women receiving two doses of intermittent preventive treatment with sulfadoxine-pyrimethamine (SP) fell from 52 percent in 2008 to 43 percent in 2014, a decline due to many factors including problems in maintaining supplies of the drug (cDHS 2014). Despite these challenges, a slight increase in pregnant women receiving two doses of SP was detected in 2012 (USAID 2013).

While FP, MNCH, and malaria indicators have improved recently, poor nutrition is a growing problem in Senegal where 14 percent of children younger than age five are underweight (World Bank, Senegal Overview, 2014). The estimated annual caseload of children under five with Severe Acute Malnutrition is 20,000, and for those with Moderately Acute Malnutrition it is 100,000 (UNICEF 2012). The 2014 Global Nutrition Report indicates an increasing prevalence of under-five stunting (19 percent in 2013, up from 16 percent in 2012). Vitamin A deficiency in pre-school age children was 37 percent in 2014, and the rate of exclusive breastfeeding of infants under six months old was 33 percent (cDHS 2014).

1.2 HEALTH STRATEGY IN SENEGAL

To address these public health challenges, many donors have aligned around Senegal's *Plan National de Développement Sanitaire* (PNDS) 2009-2018 which is structured according to the Millennium Development Goals (MDGs). The PNDS discusses the private sector as an important stakeholder and focuses on the following four priorities:

1. Reduction of the burden of morbidity and maternal and infant mortality
2. Improvement of the performance of the health sector
3. Strengthening the sustainability of the health system
4. Improvement of the governance of the health sector

Ouagadougou Partnership

In West Africa, one of the most important developments in recent years has been the February 2011 establishment of the Ouagadougou Partnership Initiative. The partnership includes nine country governments, civil society coalitions, and a group of donors and technical partners, including USAID, the French government, the Bill & Melinda Gates Foundation, and the United Nations Population Fund (UNFPA), among others. The purpose is to accelerate the implementation of high-impact family planning interventions and ensure the coordination of efforts. The key success of the Ouagadougou Partnership has been supporting countries to put in place costed implementation plans and to create momentum around family planning in the process, including engaging civil society and the private sector, and attracting additional donors. Senegal's Relaunch of Family Planning report and renewed focus on FP is a direct result of the Ouagadougou Partnership Initiative.

The following goals are outlined in the PNDS: (1) reduce maternal mortality by 28 percent, (2) reduce under-five mortality by 35 percent, (3) reduce neonatal mortality by 30 percent, (4) increase the modern contraceptive prevalence rate by 50 percent, (5) reduce unmet need for contraception by 50 percent, and (6) reduce the prevalence of underweight children under five by 41 percent (USAID/Senegal 2012). Key GOS health documents include:

- FP: Plan d'Action National de Planification Familiale 2012-2015
- Child Survival: Plan d'Accélération des Interventions pour la Survie de l'Enfant 2013-2015
- Malaria: Cadre Stratégique National de lutte contre le Paludisme 2014-2018
- HIV: Plan Stratégique de Lutte Contre le VIH 2011-2015
- PPPs: Plan Sénégal Emergent 2014-2018

Throughout these national plans, decentralization is a key strategy, with health programs continuing to move from a vertical approach to a more integrated "3D" approach focusing on the district level. Several international development agencies such as USAID, the European Union (EU), *Agence Française de Développement*, World Bank, Gates Foundation, and UNFPA have committed to support these strategies with a total of $982.8 million in 2013, the last year for which information is available (USAID 2015).

1.2.1 UNITED STATES GOVERNMENT STRATEGY IN SENEGAL

Nearly 21 percent of Senegal's development assistance in 2013 came from the United States. Contributions from USAID, the U.S. Department of Agriculture, and other American development agencies in the areas of agriculture, health, and economic and social infrastructure development totaled $203.4 million (USAID 2015).

USAID's Country Development Cooperation Strategy (CDCS) for Senegal (2012-2016) is aligned with the country's decentralization strategy. It includes three intermediate health results (IRs) intent on improving quality and expanding access to services and products at the community and clinical/facility levels. Development Objective 2 of the Senegal CDCS integrates programming from the President's Malaria Initiative, Global Health Initiative, Feed the Future,

and the President's Emergency Plan for AIDS Relief (PEPFAR). Designed and validated by the MSAS, USAID health funds support GOS initiatives meet health-related MDGs 1, 4, 5, and 6. These funds help improve health services and information delivery for vulnerable populations and strengthen health systems and service delivery through programs that reinforce the nation's decentralized authority and decision-making (United Nations 2015; USAID/Senegal 2012).

1.3 PURPOSE AND SCOPE OF THE PRIVATE SECTOR ASSESSMENT

Gathering information about the scope and quality of private sector actors and their contributions to health is a critical step in establishing strong PPPs to improve the Senegalese health system. As part of its commitment to increasing the role of the private health sector, the Government requested that USAID Senegal support an assessment of the private health sector as part of its commitment to PPPs in health. USAID Senegal and the Health in Africa Initiative of the World Bank Group engaged the SHOPS project to conduct the assessment. The *Comité Technique PPP* and the MSAS provided ongoing guidance to inform the assessment. The ultimate purpose of the assessment is to assist USAID, GOS, and other national and international stakeholders to improve private health sector engagement and PPP-focused health sector reforms.

The assessment's primary focus is family planning, and its secondary focus is MNCH, HIV and AIDS, malaria, and nutrition. The assessment had the following objectives:

1. Provide an overview of private health sector stakeholders and their respective roles
2. Assess the level of policy dialogue between the public and private health sectors
3. Describe private sector contributions to key health markets and health system areas, including health financing
4. Assess specific markets for key health products and services and describe supply and demand dynamics
5. Identify existing and potential opportunities for PPPs in health
6. Provide recommendations on how to best operationalize PPPs in the health sector.

1.4 OVERVIEW OF THE REPORT

The report is divided into 10 sections, covering a wide range of technical areas. Section 2 presents the methodology used for the PSA. Section 3 provides an overview of the private health sector including trends in private sector provision, size of the private sector, and key stakeholders. Section 4 focuses on service provision in the private sector by key health area, including FP, MNCH, HIV and AIDS, malaria, and nutrition. In Section 5, access to essential pharmaceutical and medical commodities is discussed, including the structure of the supply chain, government agencies involved in pharmaceutical supplies, retailers, demand, accessibility and pricing of drugs, and supply and access to FP, MNCH, HIV/AIDS, anti-malarial and nutrition commodities. In Section 6, the financial sector in Senegal is reviewed, including trends in supply side and demand side health finance.

Section 7 examines the policy landscape for the provision of private health services including policies and mechanisms supporting the private health sector, regulations influencing the private health sector, PPPs, and corporate participation in health including CSR. Section 8 discusses the role of mHealth and implications for the private health sector, while Section 9 presents the challenges to expand the private health sector in Senegal with recommendations going forward.

Section 10 provides a conclusion to the PSA. The Annexes that follow contain a list of key stakeholders with whom field interviews were conducted, the assessment's scope of work, major public sector agencies engaged with the private health sector, and references.

2 METHODOLOGY

In Senegal, the Strengthening Health Outcomes through the Private Sector (SHOPS) and the Health in Africa Initiative (HIA) of the World Bank Group used a private health sector assessment methodology developed through conducting assessments in many countries. A PSA typically consists of five steps: plan, learn, analyze, share, and act. All five steps emphasize collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations (Figure 2).

FIGURE 2: STEPS IN A PRIVATE HEALTH SECTOR ASSESSMENT

2.1 PLAN

In preparation for the private health sector assessment, SHOPS, HIA, and USAID Senegal finalized a scope of work in April 2015 and identified senior consultants and staff to conduct the onsite assessments between May and June 2015. The PSA team was comprised of five private sector experts: three staff members from the USAID-funded SHOPS project, one HIA consultant with expertise in service delivery, and one Senegalese consultant with private sector expertise.

The PSA team worked closely with Senegalese key stakeholders during the planning phase. Prior to travelling to Senegal, the PSA team held several teleconference calls with USAID/Senegal to finalize the terms of reference for the PSA and identify key stakeholders for interviews. USAID/Senegal and the Ministry of Health (MOH) provided additional guidance, helped organize the stakeholder interviews, and participated in some of the meetings.

2.2 LEARN

To better understand the current political, economic, and social landscape in Senegal, the PSA team began with a background review of gray literature (i.e., unpublished reports and government materials), key laws and policies, program and strategy documents (from USAID, MSAS, United Nations Population Fund (UNFPA), World Health Organization (WHO), World Bank, African Development Bank (AFDB), and International Labor Organization (ILO), and previous studies on the private health sector and public-private partnership (PPP) arrangements in Senegal. In addition, the PSA team conducted a secondary analysis of the 2014 Continuous Demographic and Health Survey. This preliminary analysis and literature review provided an overview of the Senegalese health system and key policies related to private health sector provision of care, current government plans to work with the private health sector, and existing health PPPs. Secondary analysis of the cDHS data provided a quantitative description of the general public‘s utilization of private health care providers. Together, these two streams of

analysis provided a comprehensive picture of emerging issues within the private health sector, pointing to key areas of focus during the in-country stakeholder interviews.

Following the literature review, the PSA team traveled to Senegal from May 22 to June 9, 2015, to conduct key stakeholder interviews and fill in information gaps and gauge stakeholders' willingness to engage in public-private dialogue (PPD). Using a key informant interview guide fined-tuned through previous PSAs, the assessment team met with a broad range of representatives from the public, private nonprofit and private for-profit health sectors. The PSA team interviewed more than 160 individuals from approximately 72 organizations, including government officials, donors, USAID implementing partners, private sector umbrella organizations, private insurance companies, FBO and NGO representatives, industry representatives, and private health care providers in Dakar, Kaolack, Pikine and Mboro. The team relied on the 2014 supplementary DHS survey focused on service delivery to incorporate further data on regions outside of Dakar that were not visited due to time and budgetary constraints. The assessment team selected several key stakeholders based on a number of criteria, including their role in the Senegalese health sector, degree to which they represented their respective fields, and size and scope of their work. A list of all stakeholders interviewed by sector is included as Annex A of this report.

The PSA team held two consultative meetings during the field visit. The first, with the *Comité Technique PPP*, convened early in the assessment process to solicit input and guidance on the proposed list of stakeholders and key themes. The second, with a representative stakeholder group, convened at the end of the trip to present a first-cut outline of findings, priorities, and recommendations.

2.3 ANALYZE

The analysis stage of the assessment began in-country as the assessment team reviewed interview responses in the context of background data which had been collected before the trip. Based on the initial data analysis and stakeholder interviews, individual team members prepared their respective report chapters. The assessment team leader compiled these sections into one consolidated draft and shared it with the PSA team. The team then shared the draft assessment with USAID and HIA for verification and feedback.

2.4 SHARE

Representatives from SHOPS and HIA shared a revised draft of the report with local stakeholders at a dissemination workshop in Dakar in December 2015. During this workshop, stakeholders verified the assessment team's findings and prioritized the report's recommendations for future technical assistance.

2.5 ACT

The assessment team produced a final report that reflects the comments and concerns raised by local stakeholders. The MSAS, USAID, the World Bank Group, and other development partners will be able to use the report recommendations to better leverage the private health sector in family planning, maternal, neonatal and child health, HIV and AIDS, malaria, and nutrition activities in Senegal.

2.6 KEY CONCEPTS AND TERMS

This section offers definitions of two key concepts used throughout the report.

Private Health Sector: The private health sector in Senegal is diverse, comprised of for-profit commercial entities as well as nonprofit organizations, such as NGOs and FBOs that provide health services, products, or information. Private providers in Senegal deliver a range of health services and products in a wide variety of venues; a practice might operate in a single room in a provider's home or in a state-of-the-art clinic. Many larger companies, particularly those in mining and agriculture, offer health care through workplace clinics. Among the nonprofit sector, FBOs play an important role in providing essential services, particularly for underserved populations. Supporting these health care providers are ancillary services such as private laboratories and other diagnostic services.

Key Health Stakeholders: A key health stakeholder is an individual or group who can affect or is affected by an organization, strategy, or policy in health. Below is a list of key stakeholders interviewed as part of the PSA, by major category. Annex A provides a list of stakeholders that the PSA team met with while in-country.

TABLE 1: KEY STAKEHOLDERS INTERVIEWED

For-Profit Private Sector	Nonprofit Private Sector	Public Sector	Development Partners
• Health care providers • Health care facilities • Pharmaceutical distributors • Health insurance companies • Diagnostic services • Multinational companies	• NGOs engaged in health care delivery • Faith-based organizations • Professional and medical associations • Civil society organizations • Business coalitions	• Ministries of health, finance, investment promotion departments • Professional councils and regulatory boards • Central medical stores • Government health dialogue platforms	• International donors • Multilateral organizations

Public-Private Partnership: A PPP in health is any formal collaboration between the public sector (at any level: national and local governments, international donor agencies, bilateral government donors) and the nonpublic sector (for-profit and nonprofit, traditional healers, midwives, or herbalists) partnered to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications or education (Barnes 2011).

3 THE HEALTH SECTOR IN SENEGAL

3.1 OVERVIEW

Senegal's health system is comprised of the public sector and the private sector (including for-profit and nonprofit entities). The public sector has 35 hospitals, 99 health centers, and 1,237 public health posts. Regional hospitals provide specialized care.

District health centers provide first-level referrals and limited hospitalization services. Health posts provide preventive and primary curative services, care for chronic patients, prenatal care, FP, and health promotion/education activities.

Health huts, managed by local communities, are at the base of Senegal's health care pyramid. There are approximately 2,000 health huts covering 19 percent of the country's population. Health huts offer basic services provided by community health workers (CHWs), including an integrated package of maternal and child health, malaria, nutrition, and FP services. The CHWs are supervised by the chief nurse at the nearest health post who is in charge of the area. Figure 3 provides a visual representation of the Senegalese health system.

FIGURE 3: THE SENEGALESE HEALTH SYSTEM

The private health care sector in Senegal consists of a large and vibrant for-profit sector, nonprofit NGO and FBO networks, and civil society organizations. Eighty percent of private sector facilities are concentrated in the capital, Dakar, leaving the interior of the country sparsely covered by the private sector. Compared to other countries in the sub-region, the size and

scope of Senegal's private health sector is relatively large and growing from year to year (Brunner et al. 2014). Private health facilities exist alongside the public health facilities, and they provide both services and products.

3.1.1 SIZE AND STRUCTURE OF THE PRIVATE HEALTH SECTOR

Comparisons between data from several offices in the MSAS and statistics from the 2014 Continuous Demographic and Health Survey paint a picture of a vibrant and growing private sector. Many health facilities are characterized as for-profit medical and paramedical practices, most often headed by a single medical professional. A much smaller, yet not insignificant, number of facilities belong to the nonprofit NGO and FBO sectors. NGO networks are closely linked with nearby public sector health structures and often act as reference clinics for public sector clients. These close relationships can include invitations to public sector trainings that take place in areas where NGO clinics are located.

3.2 KEY STAKEHOLDERS IN THE PRIVATE HEALTH SECTOR

3.2.1 PRIVATE FOR-PROFIT SECTOR

The MSAS estimates that there are approximately 3,900 private facilities in Senegal. These facilities serve as a significant source of health service provision and coverage for the Senegalese, especially in and around Dakar where 72 percent of private facilities are located.

Most pharmacies in Senegal (87 percent) operate on a for-profit basis, and 53 percent are located in Dakar. There also are concentrations of for-profit pharmacies in other urban centers such as Kaolack and Saint Louis.

Current reliable data on the total number of private facilities in the country and their precise geographic distribution could not be obtained. It is therefore necessary to conduct an exhaustive survey of these facilities, in order to collect as much data as possible.

3.2.2 NONPROFIT SECTOR

Numbering more than 150 facilities, the nonprofit sector plays a small but important role in health service provision in Senegal. This is particularly true in rural and peri-urban areas where NGO clinics fill a critical health coverage gap. Conversely, the presence of NGO clinics in urban areas constitutes an arguably competitive overlap with private for-profit services.

The nonprofit sector typically is broken in two groups: *associatif* and *confessionnelle* (faith-based). The *associatif* sector consists of networked clinics belonging to three major actors: Action and Development (AcDev), the *Association Sénégalaise pour le Bien-Etre de la Famille* (the International Planned Parenthood Federation (IPPF) affiliate), and Marie Stopes International's Bluestar network of socially franchised clinics. Within the *confessionnelle* sector, the SHOPS team identified two major actors: the *l'Association des Postes de Santé Privés Catholiques du Sénégal* (APSPCS), and a smaller Protestant network known as Youth With a Mission.

Nonprofit *associatif* and faith-based networks operate hospitals, clinics, and medical practices similar to those described above in the private for-profit sector.

Postes de santé are staffed by nurses or midwives and offer basic preventive and curative services, though they are not allowed to write prescriptions. Private *postes de santé* appear to

exist only within the ANPSCS network which staffs 73 throughout the country with more than 650 providers and support staff.

Table 2 provides the name, size, scope, and challenges of the major actors in the nonprofit private sector.

TABLE 2: MAJOR ACTORS IN THE NONPROFIT PRIVATE HEALTH SECTOR

NGO	Size	Scope
AcDev	5 clinics; 33 health huts	Conducts advocacy and service delivery in partnership with community-based health organizations. AcDev specializes in reproductive health (RH), prevention of mother-to-child transmission (PMTCT) without antiretroviral therapy (ART) and also has higher level services in its Dakar clinic, such as radiology, cardiology and dentistry. Prices for services are generally low, from 2,000 CFA for a basic consultation to 5,000 CFA for specialty services. AcDev clinics focus primarily on FP provision. AcDev's community health center model won an award from the MSAS in 2009.
Association Sénégalaise pour le Bien-Etre de la Famille (ASBEF) (IPPF affiliate)	8 clinics in 7 districts	ASBEF, the IPPF affiliate in Senegal, offers a full range of maternal and child health services, as well as PTMCT and some ART. Its Dakar clinic offers high level services such as dentistry, cardiology, and a soon-to-be available surgery wing. It focuses on FP. Visits to specialists range as high as 15,000-18,000 CFA. ASBEF contracts with local CBOs and works through CHWs to reach rural populations.
Marie Stopes International (MSI)	3 clinics, 50 medical practices, 8 mobile clinics	MSI focuses on FP and RH services delivered from a network of one fixed clinic, two youth centers, 50 Bluestar franchised medical practices, six mobile clinics, and two midwife mobile clinics. The organization focuses on provision of intrauterine devices (IUDs), injectables, implants, oral contraceptives, and condoms. It also focuses on capacity building and training of pharmacists and treatment of post-partum hemorrhaging through promotion of Misoclear. Its fleet of eight mobile clinics is integral to accessing hard-to-reach populations.
ANPSCS (Catholic)	73 *postes de santé* throughout the country	The association operates 73 out-patient clinics across the country. Its sentinel service is an inexpensive package of services (500-2,000 CFA; $0.86-$3.45)[1] consisting of antenatal consultation, vaccination, iron supplementation, and malaria treatment. As an FBO it promotes cycle beads as a form of FP but also counsels on non-natural forms and refers women to other clinics who might want a different FP method. The association runs an ART center in Dakar specifically for HIV and AIDS patients and is heavily involved in nutrition programming, ranging from severe acute malnutrition (SAM) treatment with Plumpy'Nut to ORS.
Youth With a Mission (Protestant)	5-10 clinics	Youth With a Mission private clinics act as virtual extensions of public health treatment centers. Services are inexpensive, from 500 CFA ($0.86) for a general consultation to 2,000 CFA ($3.45) for a specialist. The FBO's Yoff-Dakar-based clinic is an important source of specialty services for Dakar such as dentistry, ophthalmology, and chronic disease treatment, and nutrition. The organization provides FP services such as injectables and implants and collaborates with MSI to provide IUDs. It partners with female artisans to purchase Soungouf, a locally produced fortified flour for children. The Yoff clinic sees 1,200-1,300 patients per week, and its doctors are allowed to participate in public sector trainings.

[1] All currency conversions are based on a rate of approximately 581 CFA to $1.00.

3.2.3 HUMAN RESOURCES FOR HEALTH

Current reliable data on the distribution of health professionals between the public and private sectors do not exist. In order to address this issue, a mapping of the private sector should be conducted to, among other purposes, collect information on the human resources employed in that sector, which will allow for a comparison with the public sector.

Insights into Dual Practice in Senegal: An Important Reality

Dual practice is an important reality in Senegal. Many public health care providers also practice medicine in private sector clinics, typically after working hours, on weekends, or 1-2 days per week. In larger NGO clinics, dual practice is especially common and certain specialty services are offered on days of the week that public sector providers are present. The regulations on practice are fairly clear: a provider who earns a salary as a full-time employee is not allowed to practice in the private sector. However, dual practice is so common that the practice goes largely unreported.

There are both positive and negative impacts to dual practice. Many private practices could not function or would have to charge unsustainable rates if they were not able to hire from the pool of employed public sector workers who are proven and experienced, willing to be paid on the basis of consultations rather than a salary. Further, dual practice helps underpaid government workers earn a more livable salary. On the other hand, dual practice induces public sector workers to leave their jobs early and to encourage clients to see them in the private sector. Many believe dual practice also contributes to the problem of unemployed medical graduates.

In general, health workers in Senegal are concentrated in specific urban centers, particularly Dakar. Whereas the Dakar region has 0.2 physicians per 1,000 inhabitants, the Fatick, Kaolack, Kolda, and Matam regions have fewer than 0.04 physicians per 1,000 inhabitants. The density of midwives and, to a lesser extent, of nurses also varies considerably among different regions in Senegal. In recent years, the Ministry of Health adopted measures to improve the posting, recruitment, and retention of health workers in rural and remote areas. One such measure was the introduction of a special contracting system to recruit health workers which, between 2006 and 2008, contributed to the successful recruitment of health workers in remote and rural regions and the reopening of health outposts (Zurn et al. 2010).

Private Health Training Institutions

In 2010, there were 70 private health training institutions, but currently only six have received written authorization to operate. An additional 36 schools are functioning, having gone through an assessment and whose nurses and midwives participate regularly in national exams. To stay in operation, many schools collaborate to share the necessary material and human resources.

The Association of Private Health Training Institutions indicated to the assessment team that 75 percent of newly trained health sector workers graduate from private schools. The lack of public sector trainers may explain the relatively small number of public medical schools in the country which are commonly attached to public universities. Although private schools are the dominant source of education in Senegal, private schools need to harmonize curriculum to the Economic Community of West African States (ECOWAS) standards so that newly trained Senegalese health workers can work across ECOWAS countries and vice versa.

According to stakeholders interviewed for this assessment, Senegal's major human resources for health (HRH) challenges include suboptimal coordination between public and private HRH actors and unemployment of health workers. In particular, professional associations of midwives and nurses report high levels of unemployment among their members, although they do not differentiate between public and private sector workers.

CIVIL SOCIETY, REGULATORY BODIES, AND GOVERNMENT STAKEHOLDERS

There is a range of civil society of associations, unions, and national boards that represent the interests of diverse health sector providers and practices in Senegal. These organizations play an important part in the health system, as they are able to organize and mobilize their constituents and serve as conduits for information from the GOS and donors in addition to their traditional representative role. These entities vary in terms of capacity, size, and function, and they serve both public and private sector stakeholders. A few examples are provided below by type of stakeholder.

Associations and Unions (*Syndicats*): In Senegal, associations and unions defend the rights and interests of the parties that they represent. These convening bodies organize trainings, carry out advocacy activities at the national level, and recruit new members through marketing activities. In general, associations and unions have both public and private sector members, though there are a handful of associations dedicated specifically to private sector professionals such as the Association of Private Clinics and the Union of Private Doctors. In discussions with the assessment team, associations were unable to quantify the proportion of members that belonged to each sector. Membership is voluntary and based on a yearly fee ranging from 5,000-35,000 CFA ($8.63-$60.38). Some interviewees reported that the unions tend to focus on employment conditions and related issues of professionals in the public sector since that is where the majority of their members are employed.

***Alliance du Secteur Privé de la Santé du Senegal* (ASPS):** An important actor representing the private health sector is the *Alliance du Secteur Privé de la Santé du Senegal* (ASPS), created in 2014, which regroups private health sector organizations including associations and unions into a unified voice.[2] Goals of the association include promoting the creation of a framework for exchange between the public and private sectors and reinforcing the role of the private sector in the development, implementation and monitoring of the health sector. More about the ASPS is found in Section 7 of this report.

National Boards (*Ordres*): In Senegal, national boards have more power to regulate practice and influence national policy than associations and unions. They are sanctioned by the government to represent their respective professions and ensure that providers comply with national laws and ethics. They also advise the MSAS on legislative and regulatory matters. By law, all providers must be registered with their respective Board; therefore, the Board represents both private and public members (Barnes, Bishop, and Cuellar 2009). The *Ordre National des Pharmaciens*—composed of 1,500 pharmacists with roughly 1,200 in private sector—is actively working on several issues, including an initiative to facilitate access to bank loans to set up new pharmacies. The *Ordre* is especially interested in extending the range of service delivery which could be offered by a pharmacist (e.g., FP, Glucose fast testing, and malaria test kits). Section 5 further discusses pharmacists and their role in the supply chain in Senegal.

GOS Stakeholders: There are many public sector entities involved in the regulation of the private health sector. These entities are either MSAS offices or national programs with some overlap and redundancy in roles. The major public sector stakeholders that interface with the

[2] Membership includes representatives from Syndicat des Médecins Privés, Syndicat des Pharmaciens Privés, Syndicat des Chirurgiens-dentistes privés, Association des Cliniques Privées du Sénégal, Association des Paramédicaux Privés, Association des Postes de Santé Privés Catholiques, Réseau santé, Sida et Population, Etablissements Privés de Formation en santé, Unions des Mutuelles de Santé Communautaire du Sénégal, Association des Médecins d'Entreprises du Sénégal, Association des Gérants des Institutions de Prévoyance Maladie, Association des Médecins et Pharmaciens Biologistes, and Conseil National du Patronat.

private health sector are listed below. Annex C provides a more detailed summary of GOS stakeholders and their interface with the private health sector.

- Agence nationale de la CMU
- Caisse de sécurité sociale
- Cellule de lutte contre la malnutrition
- Direction des établissements de santé
- Direction des infrastructures et des équipements médicaux
- Direction des pharmacies et des laboratoires
- Direction de la pharmacie et du médicament
- Direction de la prévention
- Direction de la sante de la reproduction et de la survie de l'enfant
- Direction de l'administration générale et de l'équipement
- Direction des ressources humaines
- Direction de la planification de la recherché et des statistiques
- Direction des laboratoires
- Direction générale de l'action sociale
- Division des établissements privés de santé
- Division partenariat public-privé
- Pharmacie nationale d'approvisionnement
- Programme national de lutte contre le paludisme
- Programme national de lutte contre le VIH-SIDA

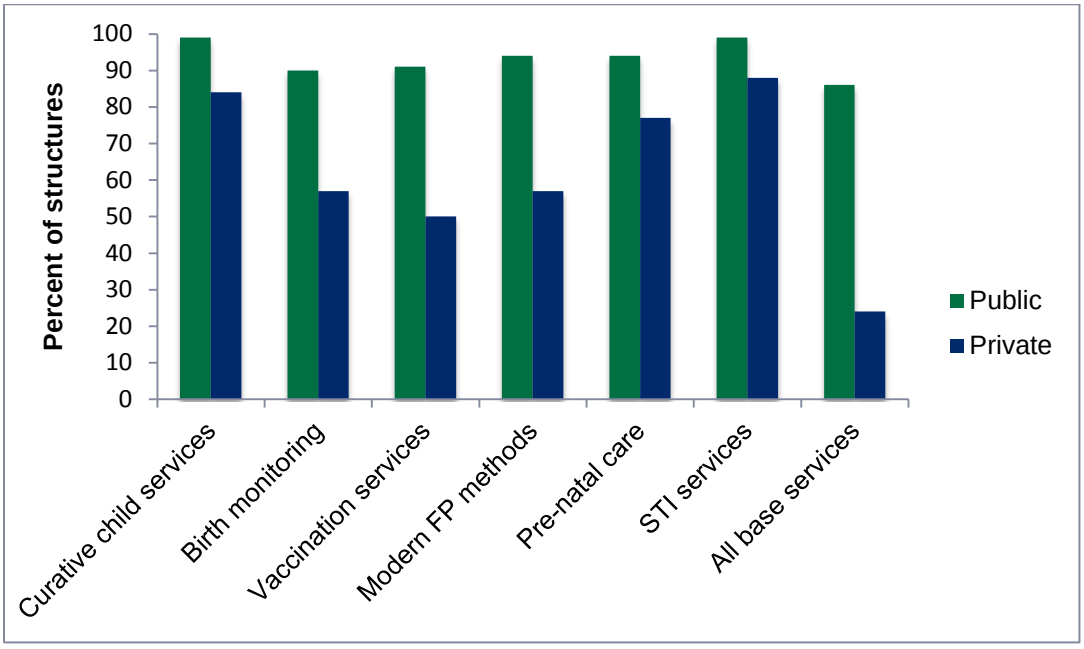
4 SERVICE PROVISION IN THE PRIVATE HEALTH SECTOR

Despite its large number of facilities, the private health sector provides varying degrees of health services and products. This section gives an overview of health service provision in the for-profit and nonprofit sectors and details provision of services in the five key health domains of the PSA: FP, HIV and AIDS, MNCH, malaria, and nutrition. Information regarding products related to these health areas, including availability, supply and demand, and other related topics can be found in Section 5 of this report.

4.1 GENERAL OVERVIEW OF TRENDS IN PRIVATE SECTOR PROVISION

An analysis of the 2014 cDHS shows that of a sample size of 363 facilities (295 public and 68 private), the public sector offered significantly more basic health services than the private sector. Shown in Figure 4, the number of public sector facilities offering basic health commodities and services such as vaccinations and modern FP methods far exceeds the number of private sector facilities offering those same services. However, the disparity in the number of facilities offering sexually transmitted infection (STI) services, prenatal care, and curative child health services is less notable.

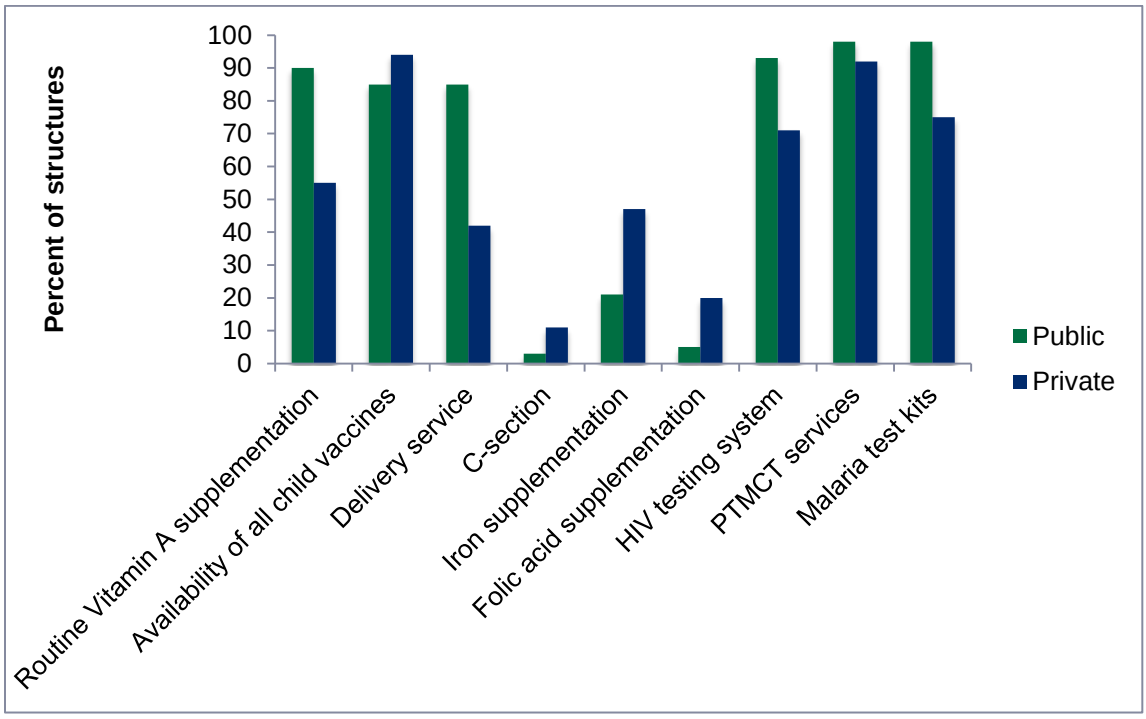
FIGURE 4: FACILITIES OFFERING BASIC HEALTH SERVICES



Source: Ministère de la Sante et de l'Action Sociale and ICF International 2015

In a selection of certain key MNCH, HIV, malaria, and nutrition services, the private sector offers fewer services than the public sector, with the exception of childhood vaccines, iron supplements for pregnant women, cesareans, and folic acid supplements (Figure 5).

FIGURE 5: FACILITIES OFFERING SELECTED SERVICES



Source: Ministère de la Sante et de l'Action Sociale and ICF International 2015

Price of services: The SHOPS team sampled select private sector facilities and found that prices in private NGO networks are significantly lower than in the private for-profit sector. While there was variance in prices among service provider types, particularly for specialty services, FBO networks had the lowest prices for general consultations (500 CFA; $0.86), with specialty services between 2,000-5,000 CFA ($3.45-$8.63). Non-FBO NGO networks charged specialty services at a much higher rate, though typically lower on average than the private for-profit sector (Table 3).

TABLE 3: PRICES OF SELECT SERVICES

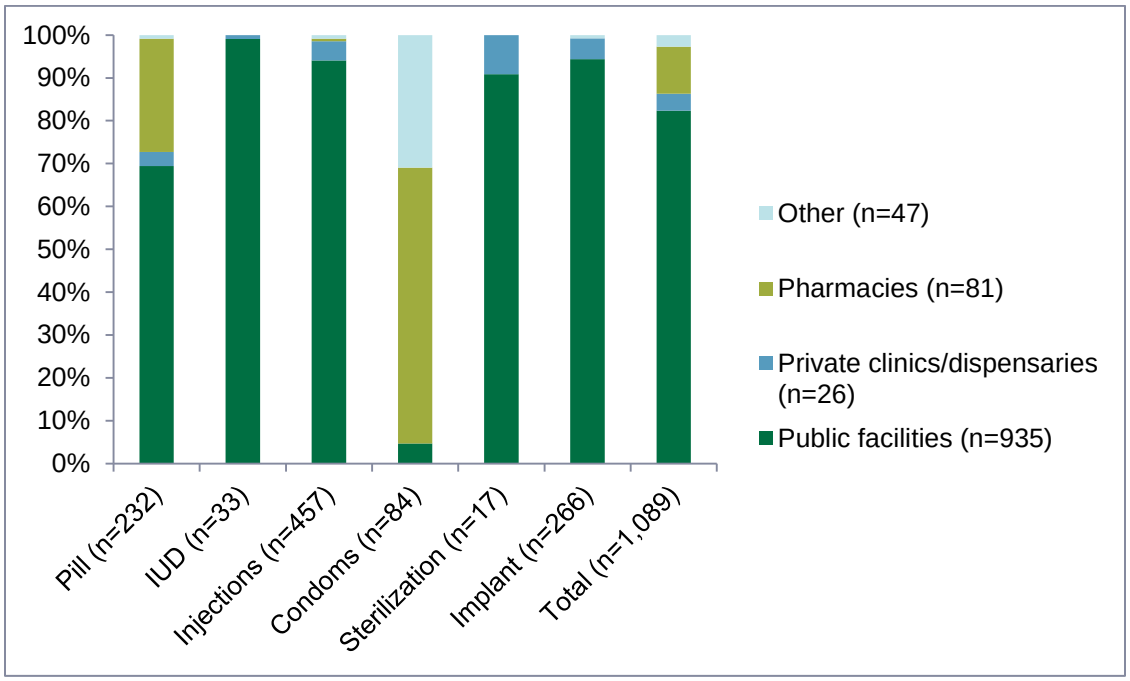
Service	Commercial (n=5)	*Associatif* (n=3)	Faith-Based (n=2)
General consultation	10,000	2,000	500
Specialist visit	15,000−35,000	5,000−20,000	2,000
Delivery/hospitalization	30,000−150,000	30,000−40,000	N/A

4.2 FAMILY PLANNING SERVICE PROVISION

In Senegal, FP is considered a key health focus by the MSAS. Following the establishment of the 2011 Ouagadougou Partnership Initiative, Senegal implemented a robust family planning supply and demand creation strategy through the *Plan d'Action National de Planification Familiale (2012-2015)* with the goal of increasing the contraceptive prevalence rate (CPR) among women of reproductive age (WRA) from 12 percent in 2010 to 27 percent by 2015 (Le Partenariat de Ouagadougou 2013). According to several sources, CPR was raised from 16 to 20 percent within 10 months between 2013 and 2014, representing an increase of nearly 300,000 women using modern contraceptives. The Ouagadougou Partnership office estimated to the assessment team that one-third of the increase in coverage was due to the private sector.

According to the 2014 cDHS, demand for birth spacing is strongest among the highest two wealth quintiles and in the Ouest and Nord regions, particularly among urban populations. Preference among Senegalese women for birth spacing has increased dramatically in recent years from an average of two-year spacing in 2000 to five-year spacing in 2015, with use of long-acting reversible contraception (LARC) methods increasing from five to 12 percent. Figure 6 shows the source of family planning products for women, by type of method choice. Injectables are the FP method most used consistently among all economic quintiles, regions, and urban or rural location. Implants and oral contraceptives follow injectables. Both appear to be purchased in public facilities more commonly than in private clinics and pharmacies.

FIGURE 6: SOURCE OF FAMILY PLANNING, ALL WOMEN



Source: National Population Commission and ICF International 2014)

In the commercial sector, large- and medium-sized clinics appear to focus mostly on high-margin services such as maternity and specialty services. Small *cabinets* are limited to FP counseling and refer to larger private clinics or the public sector for FP services.

In the nonprofit sector, NGO networks ASBEF and Action for Development (AcDev) are heavily focused on FP. They offer a full range of services and methods and work through community-based organizations (CBOs) in peri-urban and rural areas to disseminate FP messaging to hard-to-reach populations. FBO networks APSPCS and Youth With a Mission play an important role in FP provision as well. Though a Catholic network offering only the cycle bead method onsite, APSPCS counsels on all FP methods and refers women interested in non-natural methods to outside clinics. Youth With a Mission, a Protestant network, offers IUDs, implants, and injectables in addition to condoms and oral contraceptives. With funding from the Templeton Foundation, ASBEF, *L'Agence pour le Développement du Marketing Social* (ADEMAS), and several other NGO and civil society organizations, including two Islamic networks, receive funding from 2014-2016 for a project which seeks to expand availability of and advocate for underutilized FP commodities, particularly female condoms, emergency contraception, and implants.

Senegal Family Planning Action Plan 2012-2015

The Senegal Family Planning Action Plan 2012-2015 includes the following recommendations:

- Establish a multisectoral structure dedicated to managing public-private partnerships (PPPs).
- Widen the range of social marketing products.
- Establish a product delivery system by the National Procurement Pharmacy.
- Integrate private for-profit data into the National Health Information System.
- Develop and deploy mobile units to zones outside Dakar.
- Reinforce social franchising strategies.
- Increase the number of service delivery points dispensing FP products.
- Revise the regulatory framework.
- Increase diligence in issuing Marketing Authorizations to private laboratories.
- Provide direct training on FP technologies to private actors.

4.3 MNCH SERVICE PROVISION

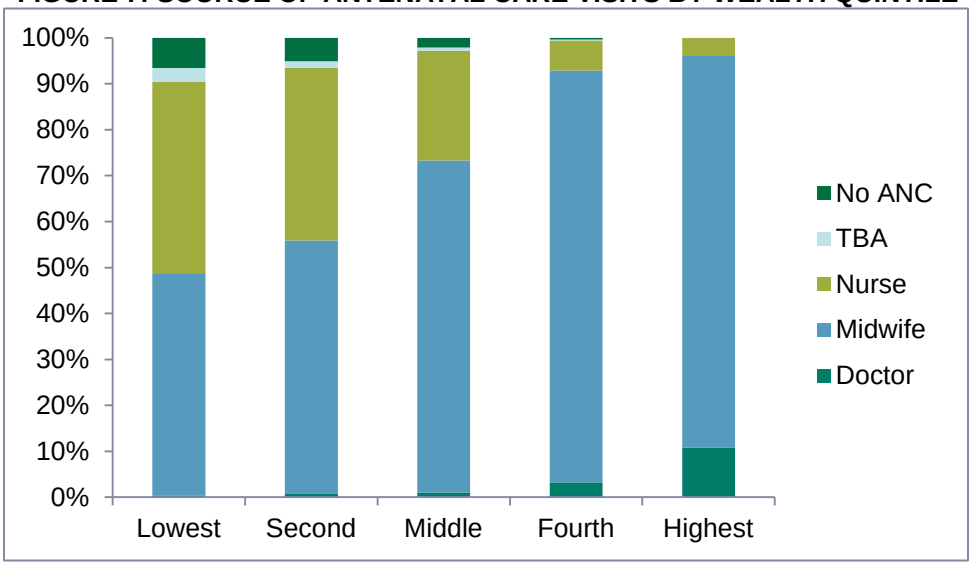
MNCH services are coordinated in the public sector by the Direction of Reproductive Health and Child Survival in the MSAS. Initially, due to a scarcity of resources, the office focused on diseases such as tuberculosis (TB), HIV and malaria. The office has, however, been involved in the recent national commitment to improve FP, recruiting 500 midwives in 2013 and working toward the goal of 350,000 new women initiating family planning by 2015. Per the *Feuille de Route Multisectorielle pour accélérer la réduction de la mortalité et de la morbidité maternelles, néonatales et infantiles*, MNCH efforts target the childhood diseases of diarrhea, pneumonia, and malnutrition. Vaccination and immunization efforts also are part of the GOS's MNCH strategy. Misoprostol is available by prescription in pharmacies and is used to manage post-partum hemorrhage.

In the private for-profit sector, large- and medium-sized Dakar-based clinics also offer high quality MNCH services, especially maternity-related services such as pre- and post-natal care, delivery, and obstetric complication care. Clinic La Madeleine in downtown Dakar, for example, a seven-story polyclinic catering to expatriates and affluent Senegalese, concentrates approximately 80 percent of its services on maternity, especially delivery services. A majority of commercial clinics surveyed stated that they offer basic child services such as vaccinations and pediatrics, and several clinics mentioned child respiratory ailments as the most common illness for hospital visits.

The nonprofit sector offers similar services to the for-profit sector although, importantly, they reach more of the population residing in peri-urban and rural through outreach services. NGO clinics surveyed by the SHOPS team reported offering basic diarrhea treatment services via oral rehydration salts (ORS) as well as routine vaccination as recommended by the *Programme Elargie de Vaccination (*PEV*)*.

Figure 7 shows that midwives are the most common source of antenatal care (ANC) visits regardless of economic quintile, though the lowest quintile uses nurses as often as midwives.

FIGURE 7: SOURCE OF ANTENATAL CARE VISITS BY WEALTH QUINTILE

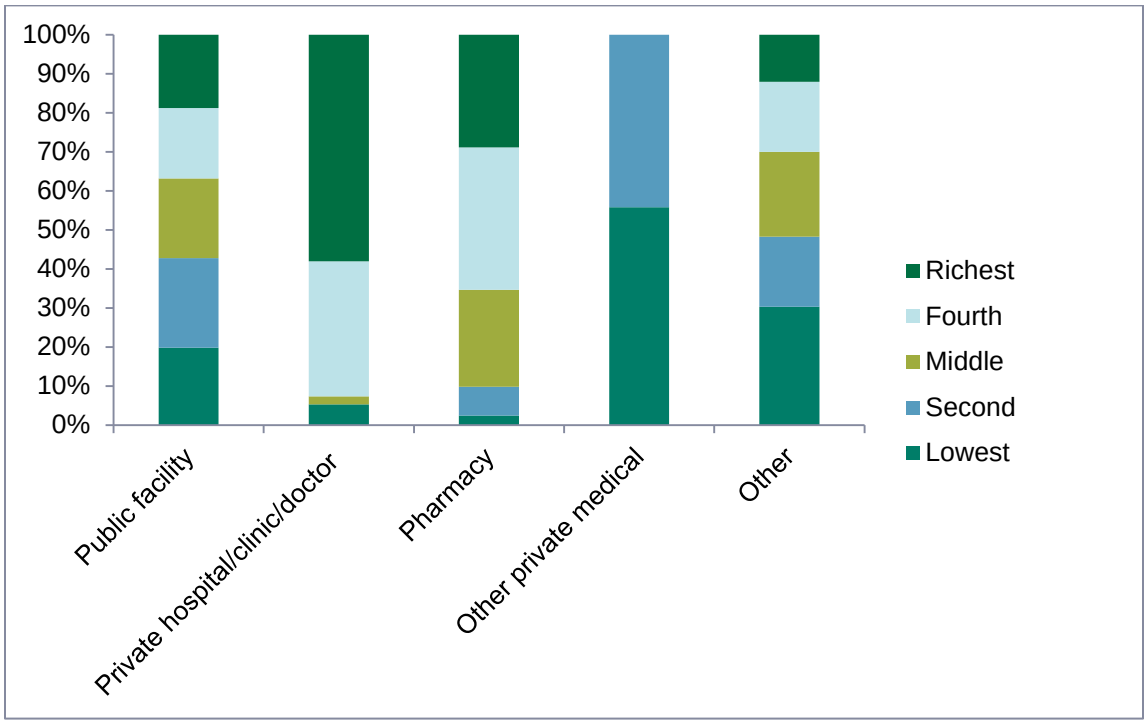


Source: National Population Commission and ICF International 2014

In the area of maternal health, there are major differences between rural and urban areas as well as wealth quintiles. On average, 48 percent of Senegalese women get four or more ANC visits. Variation within wealth quintiles ranges from 32 percent of the lowest quintile getting four visits to 73 percent in the highest quintile. People in the lowest quintile are most likely to deliver at home, but all other quintiles are most likely to deliver in public facilities.

Senegal has a long history of curative services at the community level, through the community owned health huts, dating back to the late 1970s. At a time most countries were reluctant to do so, Senegal adopted and expanded community case management (CCM) of acute respiratory infections (ARIs), malaria, and diarrhea for children under five years of age at the health hut (Maternal and Child Health Integrated Program (MCHIP) 2012). Figure 8 shows that even for the richest quintile, more than 60 percent of Senegalese treat diarrhea by going to a public sector facility.

FIGURE 8: SOURCE OF TREATMENT FOR DIARRHEA BY WEALTH QUINTILE



Source: (National Population Commission and ICF International 2014)

4.4 PROVISION OF HIV AND AIDS SERVICES

The prevalence of HIV in Senegal stands at 0.7 percent of the population, which is significantly lower than the average of 10 percent in Southern Africa so HIV funding from international donors is limited in the country. There is a high level of stigma associated with getting tested for HIV in Senegal, a reality which lowers demand significantly for volunteer counseling and testing (VCT). While HIV testing is guaranteed free of charge by law in Senegal, some clients prefer the private sector and are willing to pay for it.

HIV activities in the public sector are governed by the *Plan Strategique Lutte Contre le VIH (2011-2014)* which has as its objectives to maintain the HIV prevalence rate at two percent or less; to ensure universal access to prevention, care, and treatment; and to improve the socioeconomic status of people living with HIV (PLHIV) and other vulnerable groups. The *Conseil National de Lutte contre le Sida* (CNLS) is a coordinating body in the response to HIV in Senegal. Its mandate is to define national guidelines, oversee advocacy and partnerships at the national level, and ensure compliance with regulations and ethics. In a meeting that SHOPS held with the CNLS, it noted that the private sector is not well-involved in its activities despite the strong political will of the GOS. There remains a larger role for the private sector to play in the fight against HIV and AIDS.

According to the 2014 cDHS, more than 50 percent of all wealth quintiles obtain condoms at private pharmacies. In addition, over half of visits to private pharmacies in Senegal for HIV testing are made in the Ouest region, 70 percent are made in urban areas, and 46 percent are made by the highest quintile. HIV testing, however, takes place overwhelmingly in public facilities (>90 percent) across all quintiles and regions.

In the private sector, large, medium, and small clinics and medical practices interviewed report the ability to administer rapid HIV testing or extract blood and send it out to diagnostic services for testing. For larger clinics that carry out maternity-related services such as pre-natal, delivery, and post-natal care, PMTCT testing also was included in service provision. However, the assessment team found that no for-profit clinics offer ART because treatment of HIV by law is guaranteed for free in the public sector.

Provision of HIV/AIDS services in the nonprofit sector is not much different from the commercial sector, although as noted above for MNCH service provision, there is more reach into peri-urban and rural areas by nonprofits. ASBEF provides ART and APSPCS operates a Dakar-based clinic that is devoted solely to HIV treatment. The APSPCS clinic conducts outreach into surrounding peri-urban areas to do testing and monitoring as well.

4.5 SERVICE PROVISION IN MALARIA

Senegal has achieved significant progress in fighting malaria. As of 2014, more than eight in 10 households own at least one bednet, three out of four households own an insecticide-treated bednet, and seven in 10 own a long-lasting insecticide-treated bednet (cDHS 2014). Rural areas have significantly greater bednet coverage than urban areas, and the highest bednet coverage is among the lowest wealth quintiles. Although many households own bednets, only 36 percent of households achieved accurate bednet coverage in 2014, which is defined as having at least one *Imprégnées d'Insecticide Moustiquaire* (MII) bednet. Among children under age 5 with fever, treatment was sought 54 percent of the time.

To further the country's progress toward greater bednet coverage and a reduction in malaria-related deaths, the National Malaria Program (PNLP), a public sector convening authority, has set an aggressive agenda to raise the coverage of long-lasting insecticide treated bednets from 70 percent to 90 percent. The PNLP's *Plan Strategique de Lutte Contre le Paludisme* also sets goals of protecting 80 percent of pregnant women with bednets, confirming 95 percent of malaria cases with rapid test kits, and making anti-malarial medicines available in 95 percent of health facilities throughout the country.

Through stakeholder interviews, the PSA team found that the private for-profit sector is minimally involved in malaria treatment and prevention activities. A majority of private for-profit clinics visited for the assessment stated that they referred patients to the public sector for free malaria testing and treatment. Of the 17 private pharmacies visited, all sold at least one form of long-lasting insecticide treated bednets (LLINs), with just under three-fourths offering the socially marketed LLINs net for 1,000 CFA ($1.73). LLINs also are available at Total stations and other sales points outside the health system.

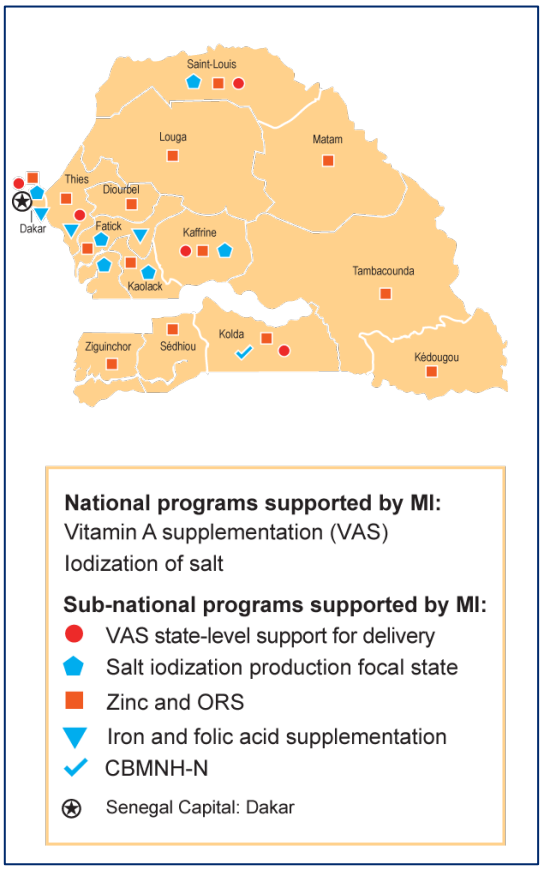
IntraHealth also coordinates a major campaign to mobilize LLINs with the goal of universal coverage. Their bednets are sold for 500 CFCA in public and private NGO sector health huts and *postes de santé* at half the price that for-profit pharmacies offer. Pregnant women are given bednets free of charge. Rapid diagnostic tests (RDTs) are administered in most NGO clinics, and the PNLP works directly with large faith-based hospitals to distribute RDT kits and collect statistics on malaria testing and treatment.

4.6 SERVICE PROVISION IN NUTRITION

Senegal is developing a multisectoral strategic plan for nutrition, called *Lettre de Politique de Nutrition* (2013-2018) which aims to develop a nutrition-sensitive agricultural system by building services and public infrastructure across sectors. Nutrition interventions are coordinated through

the *Cellule de Lutte contre la Malnutrition* (CLM)[3] which is overseen by the Prime Minister's office. The CLM places emphasis on linking nutrition and agriculture, in particular in the identification of pathways that link national or regional availability of food with household food availability and food security (United Nations System Standing Committee on Nutrition 2013).

FIGURE 9: MAP OF THE MICRONUTRIENT INITIATIVE'S ACTIVITIES



Anemia is a critical concern in Senegal, where 70 percent of pregnant women were anemic in 2005 (WHO 2015a). Among the general population, the rate of anemia is between 47 and 60 percent depending on wealth quintile. Severe and moderate anemia is most common among people in the lowest wealth quintile in rural Centre and Sud regions. The consumption of iodized salt is an important way to prevent anemia, but according to UNICEF, only 47 percent of Senegalese consume iodized salt (WHO 2015a).

In addition to anemia, malnutrition is a significant health concern in Senegal. Fifty percent of child deaths were associated with malnutrition in 2014 (cDHS). In meetings with the PSA team, most for-profit clinics mentioned inclusion of nutrition counseling in basic consultation services. Children with moderate or severe malnutrition are referred to the public or NGO sectors.

The nonprofit sector, especially FBO networks, carries out a more robust set of nutrition activities than the for-profit sector. ANPSCS, for example, administers Plumpy Nut, a peanut-based therapeutic food for the treatment of SAM to severely malnourished children and conducts complementary feeding in its facilities. Along with vaccination, malaria treatment, and pre-natal counseling, APSPCS's core consultation package for women includes iron supplements. The organization also works closely with UNICEF in iodized salt distribution through its 73 *postes de santé*. Youth With a Mission, another FBO, also conducts nutrition activities, including treatment of malnutrition with Plumpy Nut and counseling. Youth With a Mission also works with a local artisan women's group to purchase fortified flour called Soungouf which is used for complementary feeding of children six to 24 months of age.

The Micronutrient Initiative (MI) in Senegal, a collaboration of many donors including the Canadian government, WHO, UNICEF, World Bank, and the Centers for Disease Control and Prevention (CDC), serves the entire Sahel, including Senegal. Focused on universal Vitamin A coverage, iron, folic acid, iodized salt, zinc, ORS, and food fortification, MI's goals are to improve the enabling environment and increase service provision of micronutrients, almost exclusively in the public sector. Figure 9 shows the geographical location of MI's current activities in Senegal.

[3] The CLM coordinates its activities with seven Ministries (Health, Education, Economy and Finance, Decentralization, Trade, Industry, and Agriculture) and the National Association of Rural Advisors and Civil Society.

4.7 INCREASING DEMAND IN THE PRIVATE HEALTH SECTOR

For the private health sector in Senegal to continue to grow and play a greater role in delivering critical public health products and services, overall demand for those services must increase, and those services must be available and affordable in the private sector. To better understand the role of demand for private sector health products and services in FP, HIV, and other products, it is useful to review what is known about factors influencing demand for health products in Senegal.

The 2014 cDHS figures reveal that religion and education are important influences in Senegal. The country is predominantly Muslim (94 percent) with a young population (42 percent under the age of 14 years). There is a gender disparity in education levels: 47 percent of females and 70 percent of males over age15 can read and write (Central Intelligence Agency 2013). However, 82 percent of women in the lowest wealth quintile and 76 percent of women in the second wealth quintile cannot read at all. Geographically, women in the country's western region have the highest literacy (54 percent) and women in the mid-region have the lowest literacy (24 percent).

Demand creation uses a variety of channels at different levels including community outreach, key influencers and interpersonal communication, use of mobile phones, and mass media, among others. According to the 2014 cDHS, women in Senegal have the most exposure to radio and television, with 64 percent of women watching TV at least once a week and 61 percent of women listening to the radio at least once a week. For men, this climbs to 73 percent and 74 percent, respectively. In 2012, market penetration of mobile phones was 79 percent and Internet use was 19 percent, although geographic and gender breakdown of usage is not available (Riley 2014).

Table 4 shows that demand generation efforts have had an impact, even though progress was slow. There is still an important gap between the need and demand for and use of health products and services in Senegal. For example, the number of men who reported using a condom during high risk sex was 61.6 percent in 2005 and 62.8 percent in 2011. The use of skilled personnel for delivery increased from 51 percent to 59 percent between 2005 and 2013, and the DPT3 immunization rate for 12-23 months increased from 74 percent in 2005 to 89 percent.

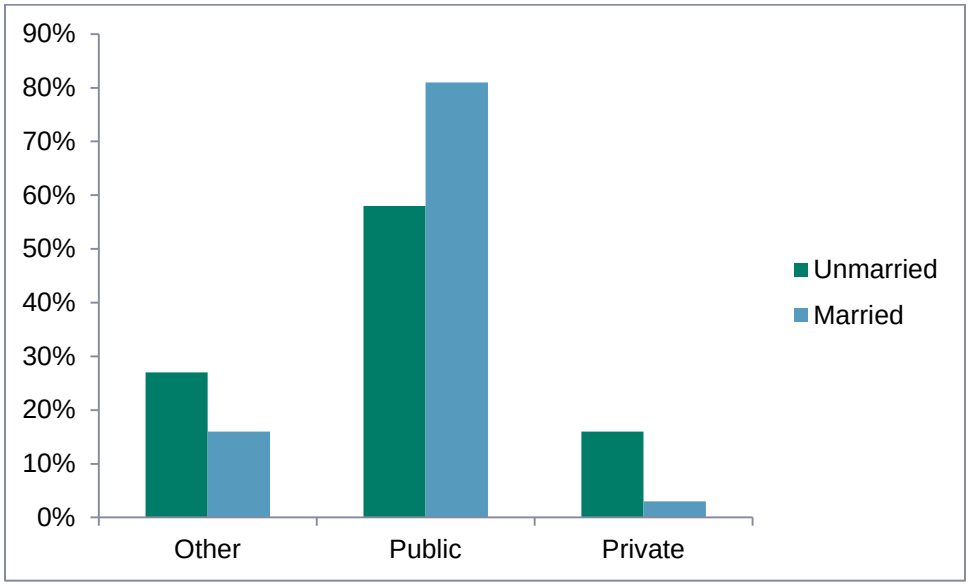
TABLE 4: CHANGE IN USE OF KEY HEALTH PRODUCTS

Critical health area/behavior	Rate/Year 1	Rate/Year 2
Use of modern method of family planning	9% (2010)	20% (2014)
Received an HIV test	3.0% (2005−women) 4.7% (2005−men)	29.6% (2011−women) 18.7% (2011−men)
Use of condom during high risk sex	37.5% (2005−women) 61.6% (2005−men)	41.3% (2011−women) 62.8% (2011−men)
Use of ORS in last diarrheal episode	26.7% (2005)	24% (2014)
Use of skilled personnel for delivery	51% (2005)	59% (2014)
Households owning a long lasting mosquito net	38% (2005)	74% (2014)
Children under 5 sleeping under a mosquito net	14% (2005)	43% (2014)
DPT3 immunization rate for 12-23 months	74% (2005)	89% (2014)

Source: National Population Commission and ICF International 2014)

Focusing on demand for FP, the latest cDHS shows that unmarried women aged 15-24 use the private sector significantly more (27 percent) than married women (16 percent) (Figure 10).

FIGURE 10: SOURCE OF MODERN METHOD BY MARITAL STATUS (AGE 15-24), DHS 2014



According to a 2014 study, within the private sector, barriers to FP access for young women include a minimum age requirement of 18 and a bias towards providing FP services only to married women (Sidze et al. 2015).

As the previous sections have shown, many of the GOS's priority products and services are available in the private sector, although not to the same extent as they are in public sector facilities. This is not surprising since many of those services are offered in public facilities at highly subsidized prices with which the private sector cannot compete.

Targeted demand creation is thus critical to ensuring that private health products and services reach scale. Demand depends on many things, such as the product or service offered, how much it costs, how it is promoted, and the distribution channels used—the standard "4 Ps" of the marketing mix (product, price, promotion, and place).

Demand Generation and Modern Contraceptive Use in Urban Areas of Senegal

The Gates-funded Urban Reproductive Health Initiative in Senegal (2010-2014) provides insight into successful demand generation activities for FP. The project focused on demand generation in conjunction with supply side initiatives and advocacy with a goal to increase modern contraceptive use by 20 percentage points in targeted urban areas. Demand generation activities included:

- Community outreach workers who counseled and referred women to FP services
- Project-engaged midwives who led small group discussions on FP-related topics
- Training religious and community leaders to become FP champions in their local communities and at religious events
- Community theater to promote discussions on FP topics within the community and between the community and religious leaders
- Radio and television programs on local public, private and community stations

Women who reported participating in at least one project-supported community activity were significantly more likely to be modern method users than women who did not report participating in any community activity. The mass media campaign, which focused on strengthening communication on Islam and FP, ensuring greater engagement among men and providing clarification on side effects and dispelling rumors, showed positive results. The evaluation concluded that with Senegal's Muslim profile, working with influential religious leaders can influence contraceptive use directly among men and indirectly among women through their husbands.

There has been a long history of demand creation programs for critical health products and services in Senegal. While many programs have focused on increasing the overall supply of product and service delivery points, the most effective programs have combined strategies of increased supply with education SBCC activities. Senegal has had targeted campaigns in support of FP, malaria, nutrition, maternal and child health, and HIV products and services using a wide variety of SBCC approaches—from radio and television advertisements and soap operas, to opinion leader campaigns, village level discussions, and community mobilization events led by community health workers. For example, the Population Media Center developed a 168-episode radio serial drama which aired from 2008 through 2011 in Wolof. The focus of the drama was to promote a variety of positive behaviors including use of FP methods and condoms to prevent HIV infection. An evaluation of the campaign showed high levels of listenership (52 percent of people surveyed) and improvements in knowledge and attitudes. People who listened to the emissions were 6.5 times more likely to state that “HIV/AIDS can be prevented by using condoms” than non-listeners. Another radio drama using the same approach also was recorded and broadcast. Both dramas were the object of radio debate shows as well (Population Media Center 2015).

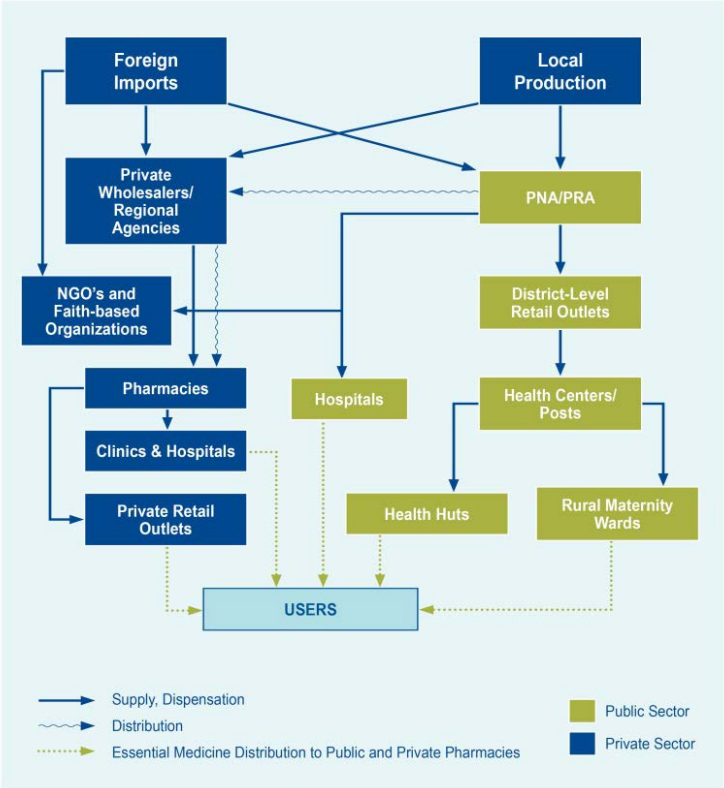
Similar campaigns have been used to target the increased use of bednets to prevent malaria, improve feeding practices for child nutrition, and discourage female genital mutilation.

5 ACCESS TO ESSENTIAL PHARMACEUTICAL AND MEDICAL COMMODITIES

5.1 OVERVIEW AND STRUCTURE OF THE SUPPLY CHAIN IN SENEGAL

The supply chain structure in Senegal is governed by the national pharmaceutical policy. The graphic below illustrates the supply chain system through which essential medicines and commodities are distributed in Senegal. Green boxes represent public sector entities (agencies and other bodies) that function at the different levels of the health system. Blue boxes depict private sector entities which operate at those same levels. In the following sections, we discuss the roles of the public and private sectors and how they intersect so that pharmaceutical and medical products reach the Senegalese population.

FIGURE 11: PHARMACEUTICAL SUPPLY CHAIN IN SENEGAL



5.2 KEY GOVERNMENT AGENCIES INVOLVED IN PHARMACEUTICAL SUPPLIES

Senegal has a well-structured and well-regulated system for importing, manufacturing, storing, and distributing pharmaceutical and medical commodities.

The lead agency for regulation is the *Direction de la Pharmacie et Medicament* (DPM) which governs both the public and private sector supply chains, issues authorizations to import or manufacture pharmaceutical products, and oversees drug quality assurance. The DPM is also supported by the *Laboratoire National de Contrôle des Médicaments* (LNCM), the *Ordre des Pharmaciens du Sénégal* (OPS), and the PNA.

The LNCM assures quality control of pharmaceuticals subject to registration procedures.

The OPS is a public institution whose objective is to guarantee compliance with requirements of the pharmaceutical profession and to ensure the integrity and independence of the profession.

The other key function of the DPM and the OPS is the authorization of pharmacy installations. The DPM sets standards for a minimal distance between pharmacies that is between 200 and 400 meters depending on the locality. This still allows for a heavy concentration of pharmacies in urban areas, especially in Dakar where 53 percent of the pharmacies countrywide are located.

Table 5 shows the number of pharmacies by region in Senegal, illustrating the density in urban areas of the country such as Dakar, Thies, Saint Louis, and Kaolack.

TABLE 5: PHARMACIES BY REGION (JULY 2015)

Region	Number of Pharmacies	Region	Number of Pharmacies
Dakar	563	Louga	39
Diourbel	56	Matam	28
Fatick	21	Saint-Louis	60
Kaolack	58	Sedhiou	3
Kaffrine	3	Tambacounda	25
Kolda	18	Thies	139
Kedougou	3	Ziguinchor	32
Total in Senegal			**1,048**

In its annual plans, the DPM publishes a list of all the communes where there is an opportunity to open a pharmacy. This list is established based on demographic criteria. A 2007 regulation established that there should be a pharmacy for each five thousand inhabitants. Representatives from the OPS indicated to the assessment team that the authorization process to open new pharmacies is long (six months) and can be difficult for pharmacists.[4]

Like pharmacies, a *depot de pharmacie* is also considered an individual enterprise. The relatively small number of *depots* in Senegal can be explained by several factors. A decree dating from 1992 sets the criteria for the establishment and management of a *depot de pharmacie*. This regulation indicates that people who are not in the civil service and who hold a pharmaceutical assistant license, a state nursing diploma, a state midwife or health worker diploma, can establish and manage private *depots de pharmacie.* The individual also must have an affidavit from a pharmacist indicating willingness to supply the *depot*. A pharmacy can be opened only in localities which are 20 kilometers from the nearest pharmacy. An authorization to open a pharmacy voids any authorization to manage a *depot*. In such cases, the *depot* manager is granted a period of three months from the opening day of the pharmacy to liquidate its stock.

The PNA is the technical drug procurement arm of the MSAS at the national level. The PNA organizes the procurement primarily through international tenders and distribution of essential medicines for the public sector in Senegal.

The PNA's procurement cycle is every two years. Whenever possible, the PNA contracts for a range of quantities and staggered deliveries so that it can adapt to increases and decreases in demand for products. Ninety percent of the products it procures are sourced internationally, and 10 percent come from local manufacturers.

Although currently dependent on the MSAS for its management and budget, the PNA is undergoing a strategic reform process. While it is a non-hospital public health institution, PNA still retains its core function to procure medicines and supplies for the public sector. The GOS envisions that it will operate in a way similar to other procurement agencies in the region such as the *Agence National d'Approvisionnement en Médicaments Essentiels et Consommables Médicaux* in Benin or *Pharmacie de la santé publique* in Côte d'Ivoire. In the past, the PNA's ability to procure drugs on the international markets has suffered from its dependence on the national Treasury. This reliance has caused delays in payment for drugs supplied to the public sector and has hurt the PNA's ability to pay its international suppliers. In turn, this has reduced its ability to attract strong competitive suppliers who offer high-quality medicines at reasonable prices. Having financial and managerial independence from the MSAS should allow the PNA to circumvent these issues.

[4] The *Direction de la Pharmacie et du Medicament* indicated six months is common for approval of new pharmacies, although it can take longer. The first step is approval by the *Direction de la Pharmacie et Médicament*, followed by approvals by the *Ordre National de Pharmaciens* and the Secretary of the MSAS.

One strategy the PNA has developed to address the debt problem with the GOS is to set up depot de *vente* units in the public sector hospitals. The PNA delivers the products to the *depot de vente* directly, keeps track of the stocks held and sold, and collects revenues directly.

The PNA has a tracking system for the products it procures. When the PNA imports drugs, its agents verify the *certificat d'analyse* and put the logo of the PNA on the drugs before putting them into circulation. This PNA logo serves as a quality indicator to consumers and providers. The PNA records lot numbers of all products which it puts into circulation so that it can trace any drugs that may have problems and identify which products may be counterfeit.

5.3 COMMERCIAL WHOLESALERS, IMPORTERS, AND PHARMACEUTICAL RETAILERS

In Senegal, the commercial distribution system is extremely effective at ensuring rapid delivery of high-quality products. The DPM has authorized six wholesalers (*grossistes repartiteurs*) to operate in the country. Laborex is the largest wholesaler in Senegal with about 49 percent of the market share. Cophase is second with about 30 percent, and Sodipharm is third (see text box). The remaining market share is split between Duopharm, Sogen, and Ecopharm. Laborex procures 80 percent of the medicines it sells from its central purchasing units in France and England while the remaining 20 percent comes from local and regional production.

The PNA also supplies Laborex and other local wholesalers with lower-cost generics for essential medicines to ensure that consumers have lower-cost choices for critical treatments.

Wholesaler Spotlight

Laborex

Laborex has a high-performing resupply system with five regional warehouses in Thies, St Louis, Kaolack, Zuiguinchor, and Tambacounda. Its main warehouse in Dakar is being upgraded and modernized. Its regional warehouses and extensive vehicle fleet allow it to rapidly resupply any pharmacy in the country in less than 24 hours. In Dakar, pharmacies are resupplied two to three times a day. Laborex does not sell to depot de pharmacies or to hospitals. Laborex staff interviewed by the assessment team indicated that one of its biggest challenges is obtaining financing for operating capital since they have long lead times for procurement of drugs, some coming from suppliers who require at least partial payment up front.

Sodipharm

Sodipharm is a Senegalese medical distributor that works with more than 105 providers (international and local) to supply pharmacies throughout the country. It is the third largest wholesaler, with 17 percent of the national market. With three regional warehouses as well as a Dakar warehouse, it is able to rapidly resupply any pharmacy in the country within 24 hours. It also procures essential medicines from the PNA and private wholesalers with lower-cost generics to ensure that consumers have a lower-cost alternative when they purchase critical treatments. Sodipharm cited access to financing as its biggest constraint.

As part of this Senegal PSA, the assessment team conducted a qualitative retail audit in June 2015 in 17 pharmacies located in Dakar and Kaolack. At each pharmacy, the following sentinel products by health area were surveyed:

- (FP: OCs, IUD, impact insertion
- HIV: Condoms, HCT, ART
- Child health: ORS and zinc, immunizations
- Malaria: LLINs, ACT, rapid tests
- Nutrition: Folic acid and iron for pregnant women, iodized salt.

The retail audit revealed a large number of brand and price options in its selection of products. Water treatment products also were less available, partly because chlorine bleach, which is frequently used for treating water, can be easily found in grocery stores. Figure 12 shows the brands by product type in surveyed pharmacies. Among 17 pharmacies, there were 23 nutritional supplement brands available for

sale, 16 Artemisinin-based Combination Therapy (ACT) brands for malaria, 14 condom brands, and 13 oral contraceptive and iron supplement brands.

FIGURE 12: NUMBER OF BRANDS FOR EACH PRODUCT TYPE IN PHARMACIES (N=17)

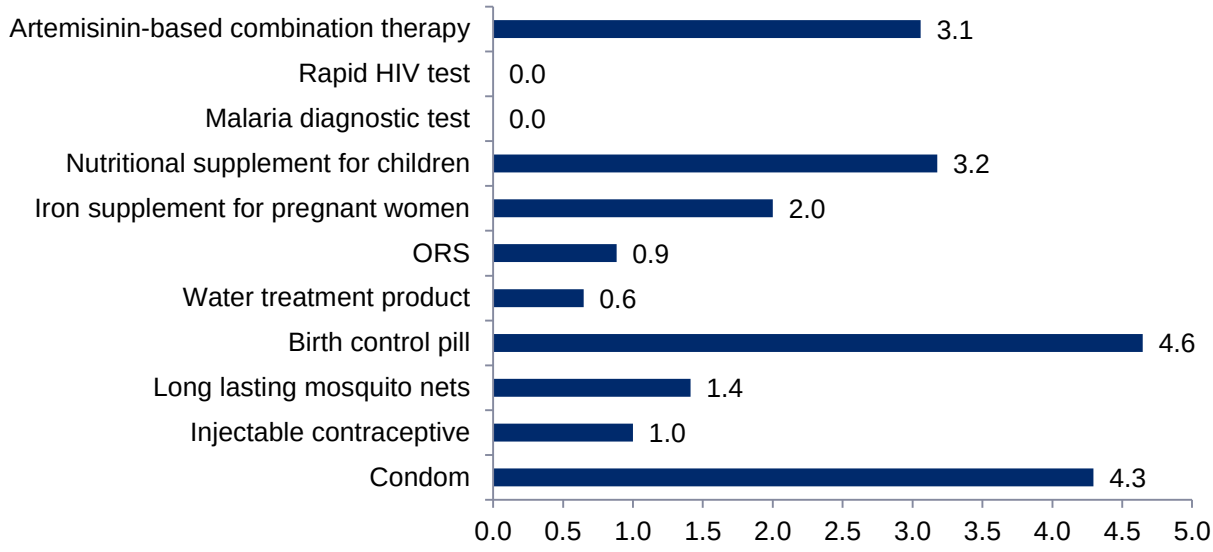
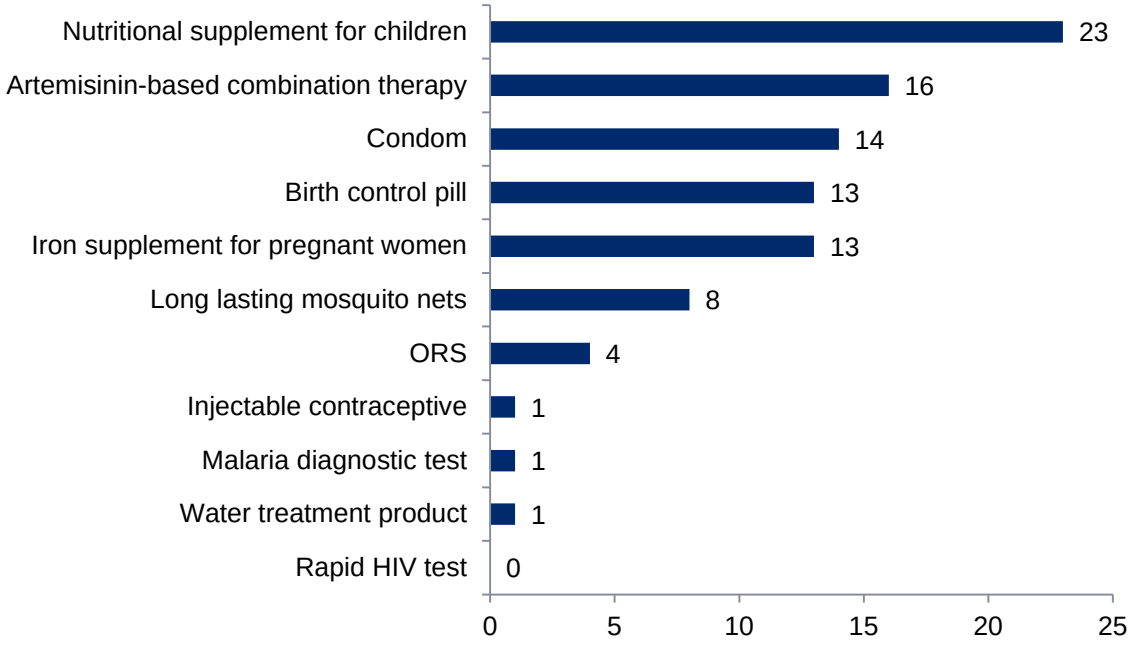


Figure 13 shows the percent of pharmacies carrying selected sentinel product types during the SHOPS/HIA retail audit. All pharmacies surveyed had ACT for malaria, nutritional supplements for infants, iron supplements, ORS, oral contraceptives, and condoms. Water treatment products experienced the most frequent stockouts. Rapid test kits for HIV and for malaria were out of stock in pharmacies surveyed by the SHOPS team. A likely explanation for test kit stockouts is the fact that the kits are available in public health facilities at no cost, eliminating commercial demand for them.

FIGURE 13: PERCENT OF PHARMACIES CARRYING SELECTED PRODUCTS (N=17)



While the pharmacy retail audit did not distinguish between versions of Depo-Provera, the following percentages were noted for other socially-marketed products: Protect condoms (82 percent), Fagaru condoms (47 percent), Aquatabs (64 percent), Securil oral contraceptives (100 percent), and Milda long lasting insecticide treated nets (76 percent).

Senegal also has five local pharmaceutical manufacturers. The four local producers are Winthrop Pharma Sénégal, Pfizer, Valdafrique, West Africa Pharma and l'Institut Pasteur de Dakar. Their production is according to the manufacturer based on the finished dosage forms from raw materials and excipients, packaging and labeling of finished products or repackaging of bulk finished products. The medications produced include antimalarials, antibiotics, yellow fever vaccinations, analgesics, vitamins, and other essential medicines in the form of syrups, pills and gels. Local production contributes to no more than 10 to 15 percent of national consumption, and much of what is sold locally is purchased by the PNA. Senegalese manufacturers also export to other countries in West Africa, but the value of imports far exceeds the value of exports in the pharma sector. As can be seen in Table 6, the value of pharmaceutical exports from Senegal increased swiftly between 2005 and 2006 from $5.7 million to $13.8 million. Between 2007 and 2011, however, the value of exports rose and fell to $11.2 million. Imports to Senegal increased significantly over the past 10 years, starting at $100.5 million in 2005 and peaking at $167.2 million in 2011.

TABLE 6: PHARMACEUTICAL EXPORTS AND IMPORTS, 2005-2011 (IN MILLIONS OF DOLLARS)

Year	2005	2006	2007	2008	2009	2010	2011
Exports Value in US$	$5.6	$13.8	$11.7	$12.9	$13.3	$10.4	$11.2
Imports value in USD	$100.5	$112	$128.7	$141	$135.9	$134.5	$167.2

Source: Index Mundi 2015

It is unclear whether there are good opportunities to expand local manufacturing capacity in the pharmaceutical sector. A few years ago, the government adopted a national requirement that 15 percent of PNA products must be procured locally. However, Senegalese manufacturers did not have the capacity to satisfy the needs of the PNA which led to extended stockouts of many essential medicines. Even with the advantage of being in close proximity to the market, the constraints of high utility costs (e.g., electricity, relatively higher labor costs, basic materials) make it cheaper to import mostly Asian products. Local manufacturers may be able to leverage their proximity to local markets to introduce new products especially designed for Senegalese and other West African consumers which would give them a competitive advantage over foreign producers. However, in this case, one would have to identify products that would allow the manufacturer to achieve scale, since the Senegalese market is still relatively small.

5.4 ACCESSIBILITY AND PRICING OF DRUGS

In Senegal, prices are set and approved by interministerial decree (Arrêté numéro 000188 du 15 janvier 2003) which fixed the method for calculating the price of drugs. Wholesalers can charge a 15 percent margin on medicines, a regulation which has not changed since 1994. Pharmacists, in turn, can charge consumers 28 percent above what they pay to wholesalers. The OPS feels that the margins were squeezed when the CFA was devalued in January 1994.

Since that time, pharmacists have not been able to obtain a revision of this margin. Pharmacists have an incentive to sell branded rather than generic medicines because their 28 percent markup will earn them more on the higher priced branded product and less on a generic product. To prevent this disincentive and encourage pharmacists to promote generics, France adopted a pricing policy in which the margin on branded products and the margin on generic products are equal in absolute and not percentage terms.

There appears to be variance in prices of the same products between pharmacies. Table 7 shows that among the 17 pharmacies that were part of the PSA retail audit, prices on identical products varied considerably. For example, Mannix condom prices varied as much as 248 percent.

TABLE 7: PHARMACY PRICE VARIANCE (N=17)

Product Type	Product Name	Max Price	Min Price	Variance	Variance in %
Oral contraceptive	Stediril	1,350	834	516	61.9%
Condom	Visa	500	350	150	42.9%
Injectable contraceptive	Depo-Provera	1,974	1,838	136	7.4%
Condom	Mannix	3,637	1,044	2,593	248.4%
Condom	Innotex	725	555	170	30.6%
Water treatment product	Aquatabs	300	200	100	50.0%
Iron supplement	Tardyferon	4,475	2,411	2,064	85.6%
Nutritional supplement for children	Pediavit	1,875	1,349	526	39.0%
ACT for malaria	Malacur	4,413	4,035	378	9.4%
ACT for malaria	Artefan	3,663	3,663	0	0.0%
Long lasting mosquito net	Milda	1,000	1,000	0	0.0%
Long lasting mosquito net	Sentinelle Plus	5,792	5,135	657	12.8%

While most of these products are non-prescription, the price variance suggests that even for prescription drugs for which margins are tightly controlled, pharmacists compete on price and may not charge the full margin allowed. For parapharmacy products and nutritional supplements, the tariff multiplier varies from 1.25 to 1.538 according to the type of product, which must take into account when determining the product price.

5.5 SUPPLY AND ACCESS TO MEDICAL COMMODITIES

In Senegal, as in most of Francophone Africa, the strength of the regulatory regime is a secure supply chain and strong quality control. The weakness, however, is reduced access to points of sale (POS), particularly in outlying areas. A review of Ghana's approach in permitting the establishment of second tier drug shops is instructive. Table 8 shows that second tier points of sale facilities are much higher in Ghana than in Senegal, translating to greater access in Ghana.

TABLE 8: ACCESS TO DRUGS IN PRIVATE CHANNELS, COMPARING SENEGAL AND GHANA

	Senegal	Ghana
Population	14,000,000	26,500,000
2nd tier points of sales	172*	9,323**
Ratio population/2nd tier points of sale	35,000	2,842

*DPM estimate of depots de pharmacie

**Number of licensed medical sellers according to the Ghana Pharmacy Council Database of licensed facilities 2015

The PNA procures and distributes 632 items, with a focus on generics. Of these, 67 products are sold to private commercial wholesalers (Laborex, Cophase, et. al). This ensures the availability of a generic option in private pharmacies for all essential medicines. The PNA also sells many products to NGOs beyond the 67 essential medicines. Private for-profit clinics do not have this privilege, and in interviews with the assessment team, several private providers felt this affords NGO clinics an unfair advantage over them. Some of the private clinics are negotiating an agreement with the GOS so that they can be supplied by the PNA for essential medicines.

A recent study by McKinsey highlighted the three main problems with the PNA at the national level: planning, the purchase process, and stock management (McKinsey 2014). The PNA currently has an average delivery time of 11 days between order and delivery of medicines. Table 9 shows the PNA's performance from 2009 to 2013. The percentage of essential health tracer products[5] out of stock was 11 percent in 2009 and returned to that same number in 2013 after peaking at 34 percent in 2011. The average length in days of stockouts started at 10, increased to 43 in 2011, and was at 29 in 2013. Interviews by McKinsey with women currently using contraceptives revealed that 84 percent had experienced a stockout of their preferred method in the past year (McKinsey 2014).

TABLE 9: PNA PERFORMANCE ON STOCKOUTS, 2009-2013

Indicator	2009	2010	2011	2012	2013
Percentage of tracer products out of stock	11%	12%	34%	18%	11%
Average length in days of stockouts	10	10	43	17	29

To address these problems, McKinsey's action plan proposed that the PNA assess the possibility of additional informed push model (IPM) points, including the launch of two target regions to pilot distribution and reinforce capacity to establish a distribution network through the district depots.

The Informed Push Model

The informed push approach is a model in which a dedicated supply team is responsible for delivering a select number of critical commodities to health facilities from a central or regional store without waiting for forecasts and orders to be completed. The delivery team takes a stock count at each delivery to improve tracking consumption and forecasting over time as it builds up data across multiple delivery points and times. This approach also outperforms a pull approach where forecasts and orders have to be made by overworked primary health care providers, which is often the case in Senegal. Through the Project Optimize, PATH, WHO, and the GOS have succeeded in using this model to deliver vaccines in the St Louis region (Ministere de la Sante et de la Prevention, World Health Organization, and Path 2012). In nine other regions, IntraHealth has, with the support of the Gates Foundation and the Merck for Mothers program, used the informed push model to deliver contraceptives. This model has been highly successful in reducing the number and duration of contraceptive stockouts.

Discussions with key stakeholders revealed that the informed push model must be adapted for the pharmaceutical sector. If strong management and cost control measures are not in place, the cost per unit delivered can be excessive or the benefits in improved supply minimal. In the case of Project Optimize, the delivery units were established within the PNA, but the cost

[5] Tracer products are high priority health products that are traced closely because their stockout is of critical concern. Tracer products include the sentinel products of this assessment plus additional health products.

savings was minimal. In the case of the IntraHealth project, project staff managed the distribution system and contracted out storage and delivery to private sector operators. Both experiences are instructive in terms of helping the government decide how and where to integrate the IPM as a complement to its national supply chain system.

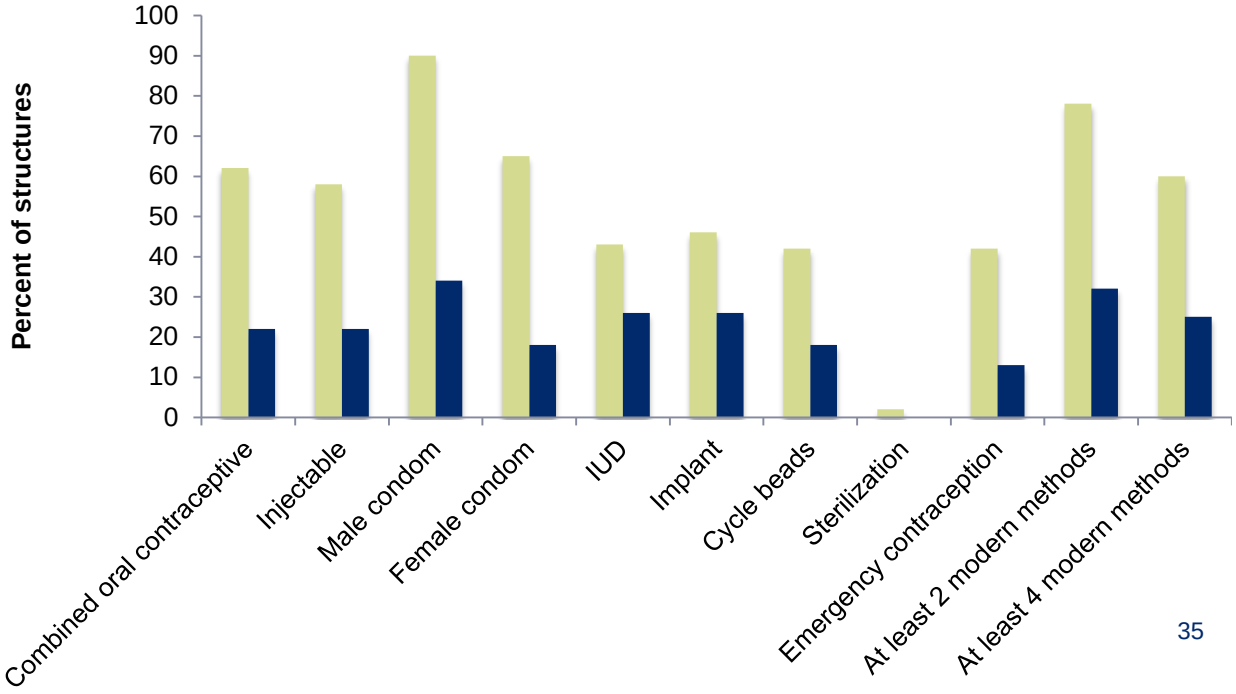
The PNA also has adapted the informed push model to its system in an approach it calls *Jegesi Naa*. It's expected that by the end of 2015, it would have implemented this new system in 28 districts, with another 30 in 2016, and the remaining 18 in 2017. In this strategy, the PNA works through fixed regional warehouses as hubs for distribution called *Pharmacie Regional d'Approvisionnement* (PRA), and the delivery teams use the informed push for critical commodities at the next level in the distribution chain. In some regions that lack adequate storage space, large transport trucks serve as mobile regional distribution channels. Both USAID and UNFPA have supported new investments in trucks, storage, and training since many of their priority health programs for malaria, FP, and HIV and AIDS depend on having a well-performing national logistics system.

5.5.1 FP AND MNCH COMMODITIES

Family Planning

The public sector is the main provider of modern methods of FP in Senegal. Whereas 85 percent of modern method users obtain their method in the public sector, only 15 percent obtained their method in the private sector in 2013-2014 (Securil Press (ADEMAS), n.d.). This public sector dominance is reinforced by data from the 2014 Continuous Demographic and Health Survey (cDHS) shown in Figure 14. A higher proportion of public facilities offer modern family planning methods than private facilities. Women generally obtain their family planning products in the public sector, with the exception of condoms which nearly two-thirds of women obtain at private pharmacies. Among women who obtain a modern method at private clinics, nearly half obtain injections, and 30 percent obtain implants. Among those who seek modern contraception at private pharmacies, 60 percent do so to obtain oral contraceptives and 38 percent to obtain condoms. Thirty percent of people in the highest wealth quintile use the private sector for FP services. Thus, while the private sector's share of the FP commodity market is relatively small, it tends to be frequented more by upper-income individuals.

FIGURE 14: FACILITIES OFFERING SELECTED FP SERVICES AND/OR METHODS, BY PUBLIC AND PRIVATE



Senegal has witnessed the introduction or piloting of three FP products in recent years: Depo-Provera, Sayana Press, and the Progesterone Vaginal Ring (PVR).

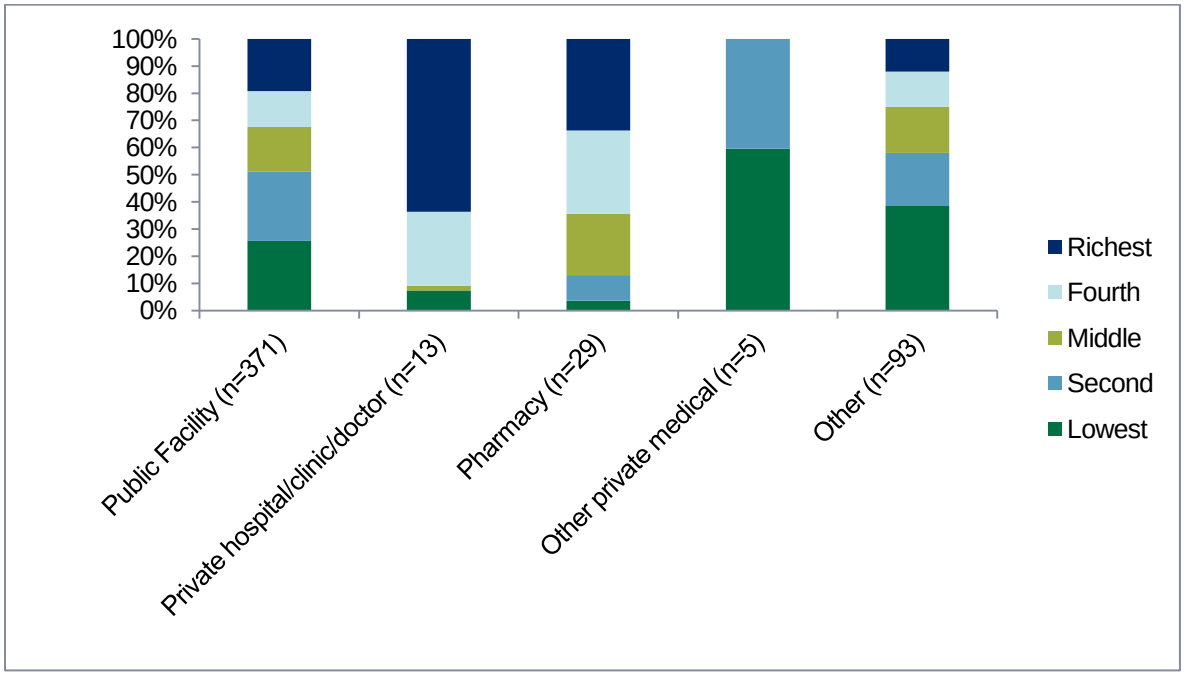
- Depo-Provera: While Senegal has had a network of community health workers (CHWs) for many years, it has only been authorized recently to offer barrier methods and to resupply OCs. A Depo-Provera pilot carried out by the MSAS with partners' support from August 2012 to March 2013 expanded the range of methods available at the community level by training matrons and community health agents. Results showed positive feedback from clients and increased uptake of Depo-Provera. The pilot study demonstrated that community workers could administer Depo-Provera safely, and the MSAS approved scale-up of the practice to 14 regions.
- Sayana Press: Senegal is one of the four countries in the pilot rollout of Sayana Press, a new single-dose subcutaneous injectable. Sayana Press combines Depo-Provera with Uniject™, a special one-use syringe that is completely self-contained. The Ministry of Health has approved the introduction of Sayana Press at 637 health posts in four regions.
- Progesterone Vaginal Ring: The PVR has also been piloted in Senegal. The Population Council recently conducted a three-year project on acceptability the PVR in Kenya, Nigeria, and Senegal. A country mapping exercise confirmed that Senegal is a promising context for the introduction of the PVR.

Maternal and Child Health Commodities

In terms of child health, treatment for diarrhea is largely carried out in the public sector or at the household level. For treatment of fever, the public sector is overwhelmingly used, though the three top quintiles in urban settings use pharmacies for fever (between 20 and 30 percent of these quintiles).

As shown in the Figure 15, among those who use private sector clinics for diarrhea treatment, more than 60 percent are in the richest quintile. Among clients who use the "other private" category, which includes NGOs and FBOs, 60 percent come from the lowest quintile, and the remaining 40 percent are from the second quintile.

FIGURE 15: PROFILE OF CLIENTS AT DIARRHEA SOURCE BY WEALTH QUINTILE



According to the 2014 cDHS, 24 percent of children with diarrhea are treated with any kind of ORS, with no major differences among wealth quintile, though those in the Sud region have a higher treatment rate (32 percent) than Nord and Ouest (21 percent and 20\ percent, respectively). Those in rural regions treat with ORS nearly 50 percent more than those in urban areas.

5.5.2 HIV AND AIDS, ANTI-MALARIAL, AND NUTRITION COMMODITIES

HIV and AIDS Commodities

The overwhelming majority of HIV and AIDS treatment occurs in the public sector. However, according to the 2014 cDHS, 71 percent of private facilities stocked an HIV rapid test kit compared to 93 percent of public facilities. Surprisingly, the assessment team found no HIV rapid test kits in the 17 pharmacies surveyed.

Malaria Commodities

In terms of other malaria treatment, according to the 2014 cDHS, 74 percent of private facilities were found to stock malaria RDT kits, compared to 98 percent of public facilities. When it comes to antimalarial drugs, nearly 9 in 10 Senegalese regardless of quintile, region, or place of residence (urban/rural) have taken an antimalarial drug. Seventy-nine percent have taken SP/Fansidar, and 71 percent received it at a prenatal visit.

Nutrition Commodities

Nutrition products and treatment are not guaranteed to be free in Senegal, and, consequently, the household is the major financier of nutrition purchases. Most nutrition-related products are imported, though a small burgeoning industry of artisan manufacturers exists for the fortification of flour and oil and iodization of salt. While a law exists mandating that all salt is iodized, the Micronutrient Initiative (MI) estimates that only 50 percent of salt is iodized with no enforcement mechanism for this law.

The CLM works with local private artisanal manufacturers to produce iron-fortified flour and iodized salt, although local supply doesn't meet demand. It liaises with the Ministry of Education to ensure that nutrition programming is integrated in schools. The MI supports ADEMAS to socially market several nutrition products focused mostly on iron and Vitamin A supplementation, as well as support to ORS and zinc coverage and iodized salt production. Helen Keller International (HKI) is a major actor in the annual national-scale Vitamin A supplementation campaign. HKI also works closely with COSFAM, the national alliance for food fortification, to ensure that oil is fortified with Vitamin A and wheat flour is fortified with iron and folic acid. They also work on nutritional support for people living with HIV and AIDS.

Illicit Drugs in Senegal

One of the DPM's biggest challenges is eliminating illicit and substandard drugs from the Senegalese market. For drugs found in pharmacies, quality assurance is strong due to the limited number of importers and wholesalers so that monitoring is therefore relatively easy. For individual pharmacists, the potential loss of their professional and business license represents a much greater risk than the potential benefit from selling cheaper drugs from dubious or illegal sources. Nevertheless, there are clandestine imports that are sold in open markets and particularly in some *depot de pharmacies*. The DPM conducts periodic inspections in major towns where it is known that illicit drugs are sold and investigates the distribution of such drugs. Recently it has been successful in making numerous seizures and ensuring that people involved are punished. Last year they seized 3.9 tons of medicines and put 43 people in jail for about 40 days each. DPM's hope is that these police actions, combined with public awareness campaigns focused on the importance of buying drugs from safe sources, will help stop the flow of illicit drugs (Senvideo 2014; Firstlook 2015).

6 HEALTH FINANCING IN SENEGAL

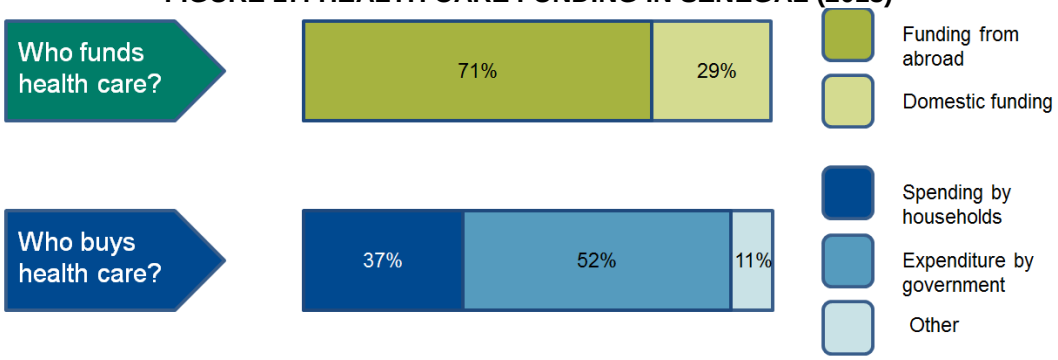
FIGURE 16: GOVERNMENT SPENDING ON HEALTH CARE

Government Spending on Health Care
$644 million in 2013
$46 per capita
37% spent by households

In Senegal, eight percent of government spending is allocated to health, and the country spent $46 per capita on health care in 2013 (WHO 2014).

The private sector and households are important sources of health financing in Senegal. According to the WHO's Global Health Observatory Data Repository, 71 percent of health expenditures came from domestic sources; the rest came from donors.

FIGURE 17: HEALTH CARE FUNDING IN SENEGAL (2013)



Source: WHO 2014

Of the funds managed by private financing agents, 77 percent were spent out of pocket, and 21 percent were managed by a prepaid scheme such as health insurance (WHO 2014). The government of Senegal is working to overcome this reliance on out-of-pocket expenditures with a drive to achieve universal health coverage (UHC). In 2012, the country became one of the first to join a European Union (EU)-WHO partnership committed to achieving UHC. The partnership

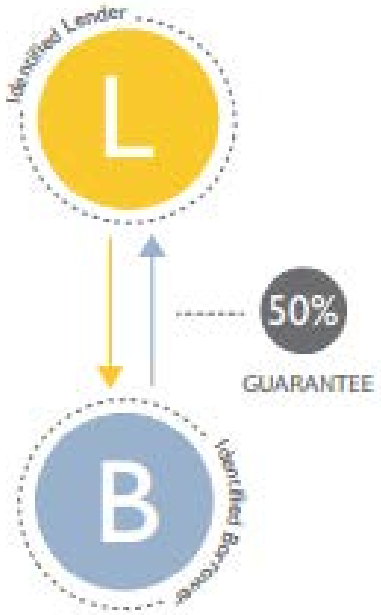
features regular meetings with representatives from the MSAS, WHO, USAID, World Bank, UNICEF, UNAIDS, and other donors to guide UHC reforms (WHO 2015c). In 2013, the Government of Senegal (GOS) announced its strategic approach to achieve UHC. First, it will strengthen existing social health insurance programs that cover formal sector employees and their dependents. It also will use community-based schemes and state/local government funds to expand coverage of informal sector workers and rural populations. Finally, it will strengthen and expand exemption policies to cover pregnant women, the elderly, and children under age five to ensure their access to free health care (Abt Associates 2013). Successful implementation of these strategies will require engagement and improved integration of the private health sector into the overall health system.

6.1 TRENDS IN SUPPLY-SIDE HEALTH FINANCE

Senegal is part of the ECOWAS, and as such, it benefits from a stable low-inflation environment. Banks are closely regulated as are other financial institutions such as MFIs. Financing for private health entrepreneurs is dominated by the formal banking sector. There are 19 banks with approximately 90 percent market share of the commercial lending market. These banks are by and large subsidiaries of French, Nigerian, Moroccan, and regional banking groups. The top five banks hold 66 percent of the assets and 79 percent of the deposits (Imam and Kolerus 2013). Venture capital and the ability to raise funds through equity investments is extremely limited. Currently, only three out of 42 Senegalese companies (Sonatel, BOA-Senegal, Total-Senegal) are traded on the regional stock market in Abidjan.

Islamic lending is starting to grow based on rules similar to equity loans in that no interest rate is applied to loans. The lender assumes a share of the business to which it is lending. Senegal has tried to create a regional market for Islamic lending and the selling of Islamic bonds as a means of attracting investors from the Persian Gulf. However, Islamic lending is still in its early stages, and it is unclear whether such investments would be appropriate for the health sector (Imam and Kolerus 2013).

FIGURE 18: THE DCA PROGRAM



The microfinance sector is much smaller than the formal banking sector, representing only seven percent of total assets in the country. There were 234 MFIs establishments in 2013, with a greater reach in rural areas than banks (Imam and Kolerus 2013). However, 18 of the largest MFIs control 90 percent of MFI assets. Typically, MFIs combine savings accounts with lending in small amounts. The ranges of interest rates and fees vary according to the loan product and borrower profile, but as a general indicator, the highest rate that MFIs can charge on a loan is 27 percent. While banks currently lend to the health sector through their small and medium enterprise divisions, mainly to pharmacies and clinics, the total value is relatively small. There is a growing interest in the health sector from several banks, but none has established a specific marketing strategy for the health sector.

In 2014-2015, the SHOPS project explored the level of interest that Senegalese banks have in obtaining a USAID guarantee under the Development Credit Authority (DCA)

(Figure 18).[6] These activities were part of a field test in Senegal of a Health Lending Toolkit currently under development by SHOPS. As part of the interview process with banks, the SHOPS consultant learned that for some Senegalese banks, repayment was an issue with pharmacies. In general it is difficult to assess credit risk, since there is no distinction between the personal assets and the business assets of the service provider. Banks also indicated that the lack of a secondary market for specialist equipment gives rise to uncertain residual values.

Banking challenges are due to the nature of the private health sector in Senegal, which is dominated by small individual practices that are sole proprietorships. These individual practices are dependent on the owner who may lack management training and be unaware of good management practices. With the DCA guarantee program currently under development through USAID, technical assistance is needed to build provider management skills and help banks and MFIs to better target the health sector.

Health Lending Toolkit

The SHOPS Health Lending Toolkit, which has been field-tested in Senegal, is a resource to support financial intermediaries to enhance their knowledge about the health sector, guide them on how to prudently and profitably serve the market, and increase their capacity and systems for ramping up financing for private health providers. HLT follows a step-by-step modular approach.

As of January 2015, the potential market for lending to private facilities was estimated at $8 million (Banyan Global 2015). This does not include the pharmaceutical sector which has a significant need for borrowing to cover supplier credit or to fund production. Several wholesalers and manufacturers have an affiliation with European owners and suppliers and are able to borrow for their needs at much lower rates through the European market.

6.2 TRENDS IN DEMAND-SIDE HEALTH FINANCE

The GOS is taking serious steps to increase access to health care through a national program of UHC. In the last 10 years, through a combination of free care initiatives and a subsidy for mutual health association coverage, the GOS has built the potential to greatly increase access of all Senegalese to affordable care. Approximately 32 percent of the population currently has some degree of coverage.[7] Since coverage rates are based on the cost of services in the public sector, these initiatives are unlikely to have much impact on increasing demand for services in the private for-profit sector. However they

Transvie: A Promising Model for Low-Cost Health Insurance

One promising model for providing low-cost, unsubsidized health insurance is **Transvie**, a nonprofit "mutuelle sociale." Unlike a *mutuelle de santé*, which is limited to providing health insurance to its members, a *mutuelle sociale* provides a much wider range of financial products, including pension schemes and life insurance. Transvie was created as a nonprofit mutuelles sociale in 2008 with technical assistance from the International Labor Union and 18 million CFA to start its operations. Since then, Transvie has not received any subsidies and has been able to build up a reserve from which it expects to fund the construction of a headquarters and expand into other countries. Currently it employs 40 professional staff, and it has 6,000 members from the transportation industry with approximately 25,000 beneficiaries. Transvie offers multiple levels of health insurance coverage, with annual premiums from 7,200 CFA to 25,000 CFA. Although most members opt for coverage which is limited to public or private centers de santé, they also can obtain care from private clinics and pay the difference between the benefits and the providers' fees.

[6] Through the health DCA guarantee, USAID agrees to cover 50 percent of the banks' loss in case of default over the course of the 10-year program.

[7] According to Dr. Cheikh Mbengue, Directeur, Ministère de la Santé, Health Financing/Demand (UHC), 11 percent of the population is covered by formal sector health insurance, 13 percent is covered through the GOS's policy of free care for all children zero to five years of age, and six percent is covered by the plan "SESAME" which covers citizens sixty years and older. The remaining three percent is covered through association-based "mutuelles de santé."

are likely to increase demand for the subsidized nonprofit sector (NGO and faith-based clinics) since a number of faith-based and nonprofit facilities charge rates that are equal to or slightly above the public sector rate. Private pharmacies also are more likely to experience some increased demand as a result of the UHC since there is a provision that if the health post is out of a medicine, the patient can obtain it from a private pharmacy through payment of 50 percent of the medicine. In theory, consumers also could use this coverage with providers in the private commercial sector, but this would require them to pay a significant balance between what the mutuelle covers and what a private commercial provider will charge.

Still, UHC is a long way from its target of 75 percent coverage. At the end of the second quarter of 2015, a total of 509,422 people were enrolled in community-based mutuelles in the regions supported by USAID (Abt Associates Inc. 2015). This is still a long way off from the UHC's target for enrollment which is that approximately nine million people with mutuelles will need to enroll by 2017.

Commercial health insurers cover a relatively small share of the population working in the formal sector. Government employees are covered by established budgetary allocations (*Imputations Budgetaires souscrites* in French) which are underwritten by the government and not contracted out to private insurers. As is the case in many countries, health insurance represents a smaller share of commercial insurers' revenues and profits than life or property insurance. SHOPS interviews with banks revealed that *Institutions de Prévoyance Maladie*[8] exist but some have run into financial difficulty and failed. While many are well-managed, some *Institutions de Prévoyance Maladie* have significant delays between date of service and payment. Consequently, some doctors and pharmacies only accept to treat patients covered by the most reliable mechanisms.

[8] An *Institution de prévoyance maladie* is a health insurance mechanism that allows the prefinancing of health care and medical, pharmaceutical and hospital costs. Any private sector company with more than 100 employees is required to create one.

7 POLICY LANDSCAPE FOR THE PROVISION OF PRIVATE HEALTH SERVICES

7.1 REGULATIONS INFLUENCING THE PRIVATE HEALTH SECTOR

Senegal, as a member of the West African Economic and Monetary Union (UEMOA), is required to adhere to regional regulations regarding standards of quality, health protection, and harmonization of laws for medical and paramedical personnel. For example, Directive 05/CM/UEMOA allows for free circulation of doctors within West Africa, and Directive 01/2005/CM/UEMOA discusses harmonization of medicines exempt from value-added taxes (TVA).

In addition, many national laws impact the private health sector. Senegal, like many countries in West Africa, has a legislative and regulatory system based on the French model. Laws and regulations governing the health sector have focused on the public sector, although there is extensive and sometimes conflicting regulation for private pharmacies, dentist offices, medical offices, private clinics, paramedical offices, laboratories, private health training facilities, and Ordres.

The World Bank Group's HIA was conducting a robust legal and regulatory review, but it was not complete at the time of this assessment. Table 10 illustrates major laws, decrees, and arretés affecting the private health sector.

TABLE 10: LEGISLATION IMPACTING THE PRIVATE HEALTH SECTOR

National Laws Impacting the Private Health Sector		
Number	Date	Focus
66-69	7/4/1966	Establishment of Ordre de Medecins
73-62	12/19/1973	Establishment of Ordre de Pharmaciens
78-50	8/14/1978	Exoneration of taxes and duties on pharmaceutical products
94-82	12/23/1994	Statutes on the establishment of private health facilities modified by law 2005-03 from 1/11/2005
98-08	3/2/1998	Hospital reforms, modified by law 2015-12 from 7/3/2015
2005-18	8/5/2005	Law regarding reproductive health
2009-11	1/23/2009	Law regarding biological medical laboratories
2010-03	4/9/2010	Law regarding HIV
National Decrees Impacting the Private Health Sector		
Number	Date	Focus
74-139	2/11/1974	Application of law 73-62 from 12/19/1973 creating Ordre de Pharmaciens
77-745	9/20/1977	Establishment of criteria for setting up private clinics
81-234	3/13/1981	Regulations for creation of medical and dental cabinets
94-244	3/7/1994	Organization and function of *Comités d'hygiène sécurité et santé au travail* (CHST's)

96-103	2/8/1996	"Modalities of Intervention" for NGOs
99-851	8/27/1999	Establishment of national pharmacy as a public health enetity
2004-1404	11/4/2004	Organization of Ministry of Health and preventive medicine
2005-29	1/10/2005	Establishment of procedures for opening, running and control of private health training structures
2006-1258	11/15/2006	Establishment of rules and procedures for worksite doctors
National Arretés Impacting the Private Health Sector		
Number	Date	Focus
13943 MDS-DDC-DONG	1989	Creation of an interministerial committee on coordination of NGO activities
5396	1994	Establishing procedures for the creation and transfer of medical and dental offices, paramedical offices and clinics
451	1996	Creation of depots de medicaments

Most laws in Senegal regarding private providers focus on controlling the entry of private providers and insurers (Doherty 2015). Table 11 shows that health professionals must receive pre-authorization to practice. However, the assessment team found significant variation among stakeholders' views on the percentage of non-registered private facilities, from none to 40 percent. It appears that in Senegal, the type, volume, distribution, quality, and price of health care services are not well-monitored or controlled. Of particular interest is the lengthy clinic authorization process, the lack of regulations encouraging health professionals to work in underserved areas, continuing education requirements and regulation of insurers. Also, while legislation exists regarding the price private facilities can charge for services, the amount has not been amended for many years.

TABLE 11: STATUS OF SENEGALESE LEGISLATION ON THE PRIVATE SECTOR BY OBJECTIVE

Objective		
Regulation of health professionals		
Regulation of entry of inputs into the health care market (i.e., registering of health professionals)		Yes[9]
Regulation of private health service provision (i.e., licensing of health professionals to practice in the private sector)		Yes
Regulation of restructuring of human resources in relation to the *carte sanitaire* (i.e., encouraging health professionals to work in underserved areas)		No
Regulation of quality of service provision by health professionals	Sanctions for unprofessional behavior	Yes
	Requirements for continuing education	No
Regulation of reimbursement levels for services provided by health professionals		Yes
Regulations to promote fair competition between privately practicing health professionals (apart from competition law)		Yes

[9] Although this regulation exists, it can take 24-36 months to obtain authorization to open a clinic.

Regulation of organizations: providers		
Regulation of entry of organizations into the market (i.e., authorization of facilities)	Hospitals	Yes
	Clinics	Yes
	Pharmacies	Yes
	Laboratories	Yes
	Medical imagine facilities	Yes
	Dental surgery	Yes
Regulation of number of organizations (i.e., limitation on the number of services in a given area)	Hospitals	No
	Clinics	No
	Pharmacies	Yes
	Laboratories	Yes
	Medical imagine facilities	Yes
	Dental surgery	Yes
Regulation of restructuring health facilities in relation to the *carte sanitaire* (i.e., encouraging organizations in under-served areas)	Hospitals	No
	Clinics	No
	Pharmacies	No
	Laboratories	No
	Medical imagine facilities	No
	Dental surgery	No
Regulation of quality of service provision (i.e., standard-setting, quality assurance and reporting)	Regulation of curricula of training institutions	Yes
	Setting of process norms and standards Hospitals	Yes
	Clinics	Yes
	Reporting requirements Hospitals	Yes
Regulation of prices (i.e., setting of fees for certain services)	Hospitals	Yes (Consultation fees)
	Clinics	Yes
Regulations to promote fair competition between organizations (apart from competition law)	Hospitals	No
	Clinics	No

Regulation of organizations: insurers	
Regulation of entry of organizations into the market (i.e., authorization of insurers)	No
Specific legislation for health insurance	Yes
Regulation of number and distribution of insurers (i.e., limitation on the number of services in a given area)	No

Regulation of quality of service provision (i.e., comprehensive benefit packages, solvency and reporting requirements)	Standardized benefit packages	Yes
	Solvency (specific to health insurance)	Yes
	Reporting (specific to health insurance)	No
Regulation of prices (i.e., setting of premiums and administrative fees)		Yes

7.2 PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH

Given the need for increased investment in Senegal in the face of dwindling development assistance and limited government funds, the GOS is looking to new funding mechanisms to help reach development goals. The GOS opted for a PPP approach in which both the public and private sectors share in the risks and rewards of improved health service provision.

The first step toward the PPP approach was the passing of the Build-Operate-Transfer (BOT) Law #2004-13 which allowed PPPs for the construction and operation of public infrastructure to better meet the needs of the population. The BOT law was passed in 2004 and amended in 2009, 2011, and 2014. The latest version of the law, which was passed by the National Assembly in 2015, is a major innovation since it covers all priority sectors (including health) unlike the original law which pertained more generally to infrastructure. APIX, Senegal's investment promotion agency, lists health as a growth sector and thus indicates that investment opportunities exist in the country to create private health structures (clinics, training schools, laboratories, pharmacies and medical imaging) and develop specialized health services (APIX, n.d.).

Despite the 2011 establishment of a *Cadre National de Concertation sur le Partenariat Public Privé* (CNC/PPP), there was a growing awareness within the GOS that the private health sector was not adequately involved in decisions affecting the health system. In the *Note Technique sur la Promotion du Partenariat Public Privé dans la Santé au Sénégal*, the MSAS noted that "Despite the existence of the political will of the authorities, the private sector is not sufficiently involved in the implementation of health programs, due to the absence of a functional formal collaboration framework. This is due to an error in estimating the private role in providing health services and in health financing. Indeed the contribution of the private sector could help fill the chronic shortage of skilled health workers and public health facilities resources (Direction Planification Recherche et Statistiques, n.d.)." Despite the support of the GOS and workshops to reinvigorate it, the CNC/PPP stalled.

In April 2013, thanks to support from the HIA of the World Bank Group, the GOS strengthened its engagement with the private health sector. This initiative allowed for the simplification of procedures for creating private enterprises, authorizations and inspections and also for the establishment of appropriate incentives to address geographical inequities. This initiative also allowed for the establishment of an effective public-private dialogue platform. In addition, HIA is supporting the private sector through the formation of a private sector alliance to ensure the private sector has a unified voice and a strong dialogue with MOH. The goal is to support the achievement of national health goals in Senegal. To do this, access to financing must be improved and a more concerted review of the legislative and regulatory framework conducted. The World Bank's support for the private health sector can help strengthen the overall health system at every level.

In June 2013, public and private sector actors came together and established seven goals for health PPPs in Senegal:

- Adapt the PPP legal framework to the specific needs/requirements of the health sector.
- Revitalize the national PPP framework and support the PPP environment.
- Identify data collection mechanisms for the private sector.
- Involve the private sector in the definition of health programs.
- Capitalize, popularize, and develop PPP experiences.
- Conduct a feasibility study to help identify eligible PPP projects.
- Set up a large-scale PPP project.

Dakar Medical City

Dakar Medical City is the main health PPP listed in the *Plan Emergent du Senegal*'s Priority Action Plan (2014-2018), with an estimated cost of 15.7 billion CFA ($27.1 million). This flagship health PPP aims to provide international level health care for patients by offering primary, secondary, and tertiary care targeted to the specific needs of the region. The goal of Dakar Medical City is to capture the regional medical evacuations to Morocco, France and elsewhere as well as become a center for medical tourism through partnerships with foundations and private and public service agreements with neighboring countries. The project hopes to accommodate 10,000 international patients yearly. By 2018, Dakar Medical City hopes to establish two to three private clinics with 200 beds. The PPP takes advantage of the Dakar Regional Reference Campus on the Dakar-Mbour, and it benefits from the medical faculties of UCAD, Thies, and AIBD (SENPPP Finance, n.d.).

Although there is significant goodwill on the part of both the public and private sectors to reach these goals, progress has been slow. The PPP Comité Technique is still at the stage of building trust and discussing challenges. A process is needed to identify priority interventions for PPPs and more clearly define the role of the Comité and its technical working group.

7.3 CURRENT PUBLIC-PRIVATE PARTNERSHIPS

To date, health PPPs have had limited success. For example, an effort to establish a PPP for domestic production of "Pranala" alcohol solution was unsuccessful, although efforts appear to be underway to continue the activity in another form with USAID funding to IntraHealth. The Cellule PPP is currently considering a list of more than 30 prospective PPPs, including private hospitals, research institutes, mobile health units, and pharmaceutical manufacturing facilities, among other opportunities. The PPPs fall into two major categories: construction of health facilities (*Institut Cuomo Cardiologie Pediatrique de Dakar, Institut de Recherche en Sante, Formation et Surveillance*) and projects to upgrade health facilities through donor or foundation funding (Rehabilitation of Hospital Principal de Dakar, expansion of PNA).

Other large PPPs are envisioned between the MSAS and the *Syndicat des Médecins Privés* as well as MSAS and the *Pool des Assureurs* (PMAS) for the reconstruction of the *Aristide Le Dantec* hospital for $160 million (SENPPP Finance, n.d.). However, movement has been slow on all the PPP opportunities.

District-Level PPPs

The MSAS, in collaboration with USAID's health program, initiated the signing of memoranda of understanding (MOU) between private providers and health districts. This MOU set forth a plan to increase involvement of the private health sector in all district activities and promote the strengthening of PPPs through:

- Involvement of the private sector in health planning
- Involvement of the private sector in all public sector trainings to allow the private sector to conform to quality standards
- Supervision of the private sector by the health district

- Collection of private sector health data
- Development of a quality assurance plan for private providers

To date, MSAS has signed MOUs with more than 280 different private providers.

The private health sector also engages with the GOS in contracting for health services. Beginning in the 1990s, the *Conseil Economique et Social du Sénégal* recommended the involvement of the private sector in the management of basic infrastructure and social services, which encouraged contracting. However, contracting efforts ramped up more recently, with the Contracting Law of 2004. The types of contracting arrangements described in the law include:

- The purchase of medical services, such as laboratory testing and medical imagery (between public hospitals or between a public hospital and a private facility)
- Cooperation between public hospitals (transferring patients due to lack of space or lack of a particular specialty)
- Performance-based contracting
- Subsidizing the provision of priority health services, such as vaccination and deliveries, in religious health posts

An example of contracting is *Santé Familiale* (SANFAM, an NGO that supports workplace clinics) and AcDev to provide health services with reimbursement schemes (Barnes, Bishop, and Cuellar 2009).

7.4 CORPORATE PARTICIPATION IN HEALTH

7.4.1 CORPORATE SOCIAL RESPONSIBILITY

In Senegal, corporate social responsibility (CSR) is well-developed mainly with multinationals and large local companies in the extractive, telecommunications, banking, and industrial sectors. The social investment by companies is significant. For example, according to the GOS, between 2008 and 2013, mining companies contributed more than four billion CFA ($6.9 million) for education, health and local development (Senegal Business 2013). The origins of CSR in the country can be traced to the *Conseil National du Patronat*'s efforts beginning in 1985 to organize the private sector, which led to support by GIZ and others to launch a CSR initiative in 2008. For many years, HIV has been the top focus of large companies engaged in CSR activities in health. Recently, that focus has shifted to malaria, environment, sports, and youth. Many companies in Senegal still have worksite HIV testing and referral programs as part of their CSR portfolio. The government of Canada is particularly active in promoting CSR, beginning in 2012 when the Canadian prime minister announced the creation of a CSR network, the *Réseau RSE Senegal*, focused on the extractive industries (Government of Canada 2012). Major companies with large CSR programs signed a charter with Senegal RSE pledging to prioritize CSR in their companies.

The *Réseau RSE Senegal* is currently supported by the government of Canada, *l'Agence Francaise de Developpement*, GIZ, and several other donors, with widespread support from multinationals and large industries. The 30 major companies participating in *RSE Senegal* are

potential partners for PPPs in priority health areas (RSE Senegal 2014).[10] Many health companies take part in RSE Senegal.

Several major companies in Senegal have extensive CSR activities, often in HIV and increasingly in malaria.

The National Malaria Control Program has been working with an increasing number of private enterprises on outreach and sensitization programs, LLIN distributions, and malaria case management.

7.4.2 WORKSITE HEALTH PROGRAMS

Decree 2006-1258 dating from November 2006 states that companies with more than 400 employees must have a full-time doctor onsite to provide preventive care and avoid occupational, sanitary, and other health risks. Companies with fewer than 100 workers may share a worksite doctor among several companies in the same vicinity. Larger companies must increase the number of worksite doctors according to the number of employees, capped at one doctor per 1,000 salaried employees for businesses more than 2,500 employees. Companies must provide the services of a worksite doctor free of charge, and many provide free services to family and community members as well. The law states that companies must register with the *Inspection Medicale du Travail* and the Social Security Administration, indicating the personnel, equipment, and administration of the worksite health facility; companies must also have a Hygiene and Security Committee.

In reality, many worksites have a full-time nurse on staff and a doctor may come once or twice a week. At worksites with many women, a gynecologist may also visit from time to time. Inspections are infrequent, and services may be quite limited.

Many worksite doctors appear to do double duty, working in the public sector close to the companies where they also serve as worksite doctors.

[10] Réseau RSE Senegal members by sector include: Mining – Terangagold, Iamgold, Sococim, Idc; Industry – Sodefitex, Fumoa, Cofisac, Siagro Kirène, Batiplus, Cotoa, Simpa; Energy – Wartsila, Energeco Afrique; Banking – BHS, SGBS, Cbao Attijariwafa bank, BICIS, BTP, Eiffage Sénégal; Telecom – Sonatel, PCCI; Logistics – Bolloré Africa Logistics Sénégal; Distribution – CFAO Sénégal; Standards bureaux - SGS Sénégal, Bureau Veritas Sénégal; Hotels – Azalaï, Onomo; Health – Laboratoire BIO24, Optivision, Sanofi.

8 ROLE OF mHEALTH IN SENEGAL

The use of mobile technology in health (mHealth) is a cross-cutting set of interventions that can facilitate engagement among stakeholders in a health system, attract new financial and technical resources for health programs, and strengthen program operations. Mobile phones provide unprecedented opportunities to reach end users and health care providers with life-saving health information, tools, and education. mHealth is a particularly promising application to connect private providers who may otherwise work in isolation by facilitating peer-to-peer communications.

The penetration of mobile phone use in Senegal is now estimated to be above 110 percent; currently there are 14.4 million subscriptions in the country reflecting that many in the population use multiple networks (Budde Comm, n.d.). Phone subscriptions often are shared among families, extending access (GSMA Intelligence 2014). The three largest licensed mobile operators are Orange (65 percent), Tigo (26 percent), and Expresso (9 percent). ART/Senegal regulates the mobile industry.

The versatile characteristics of mobile telephones have led to their use across a wide spectrum of health applications. As documented in the SHOPS report on mHealth in West Africa (Riley 2014), Senegal has a moderate level of mHealth investment and activities, represented by the following examples:

Service delivery**:** Mobile technology is a cost-effective channel for following up with clients and supporting health workers with training reinforcement, decision support, and case management in general.

- NGO RAES is integrating data collection on malaria cases through mobiles with an expected reach of 100,000 people.
- UNICEF is rolling out ChildCount+, a birth registration program.
- IntraHealth and One World conducted a pilot to provide mobile short message service (SMS), voice-based, and Internet refresher training on FP methods.
- Africare has set up a mobile mHealth system application in partnership with Dimagi to support timely data collection by community health workers (CHWs). The main objective is to bring prenatal care services closer to rural women, allowing for early detection of potential problems and quick referrals to centers equipped to manage emergency obstetric care.

Demand creation**:** Mobile services are particularly promising in reaching populations who value its confidentiality and privacy for information of a sensitive nature, lack access to traditional mass media, or have low literacy skills.

- Maries Stopes International collected more than 3,000 phone numbers of young people and broadcast SMS with information on sexual health.
- Helen Keller is using SMS and voice messages to remind mothers about Vitamin A.
- In 2011the SIS Afrique-OWUK consortium (in partnership with FHI360) began implementing SMS prevention messages for the most-at-risk populations and youth on HIV and AIDS and

TB, and it will continue through 2016.

Supply chain: Mobile tracking and automated alerts help prevent stockouts, especially in remote locations, and they improve decision-making and resource allocation.

- IntraHealth's SEDA Automated Health Data Exchange System is using mobile phones to help improve the quality and frequency of the data collected at the district and regional levels. It also uses mobile phones to prevent stockouts of essential medicines and contraceptive products and some products for children under age five.
- MSAS has a pilot for mobile data collection with plans to scale up to six districts. It has demonstrated high rates of acceptability.
- The VOICES project, in collaboration with Sonatel, supports epidemiological data collection and training.

Finance: Mobile money expands access to financial services such as credit, insurance, savings, and vouchers. Mobile money services provide a secure platform for storing and transmitting funds to the vast majority of Senegalese who do not have a bank account.

- Project Djobi improves MNCH using phone-based data collection through mutuelle insurance agents who have introduced maternal savings plans
- Transvie uses SMS texting to communicate with providers and members through Tigo and uses Orange Money to transfer timely payments to providers via mobile money.
- USAID's Health Finance & Governance project is conducting a landscape assessment of mobile money for USAID/Senegal to identify opportunities to improve the Results Based Financing initiative.

In addition to these mHealth examples, Senegal's transition to the platform District Health Information System 2[11] (DHIS2) is an important step in creating the foundation for a more integrated and coordinated digital health environment. However, numerous stakeholders cited poor integration of private provider information, lack of harmonization of reporting tools in the public and private sectors, and lack of timely oversight of the private health sector as issues needing immediate assistance.

[11] DHIS 2 is a Web-based open-source information system. DHIS 2 is typically used as national health information systems for data management and analysis purposes, for health program monitoring and evaluation, as facility registries and service availability mapping, for logistics management and for mobile tracking of pregnant mothers in rural communities. See https://www.dhis2.org for more information.

9 CHALLENGES AND RECOMMENDATIONS

Through interviews with public and private sector stakeholders in Senegal and review of key documents, the Private Health Sector Assessment (PSA) team identified constraints that hinder the private health sector's ability to increase access and efficiency in the health system. Challenges are grouped by theme followed by recommendations to address those challenges. Policy issues, which affect all the themes, will be discussed within each as pertinent. The policy challenges and recommendations section will then focus on public and private partnerships (PPPs) and corporate social responsibility (CSR).

9.1 SERVICE DELIVERY CHALLENGES AND RECOMMENDATIONS

9.1.1 SERVICE DELIVERY CHALLENGES

The list of private facilities and private providers differs between the Government of Senegal (GOS) figures and those of the *Ordres*, making it difficult to get a clear picture of the scope and scale of the private health sector. In addition, within the GOS figures, the private provider list and private facility list obtained by the assessment team through the Directorate of Health Institutions were for different geographical areas. Accurate statistics on the number of providers by cadre and the number of private facilities in the country are essential to guide the GOS and donor activities.

There are many GOS agencies involved in various aspects of regulating the private health sector. There is particular confusion and frustration in both sectors regarding the ability of clinics to offer laboratory services onsite. Many clinics began as medical offices (*cabinets*) and are not authorized to have a pharmacy or laboratory onsite without taking additional steps to register as a clinic. While the situation is clear on the GOS side, there appears to be a communication issue with the private sector.

There is task shifting within the private health sector without the necessary quality controls in place. In addition, there is a surplus of trained midwives who can't find work, exacerbated by the fact that midwives can't set up group practices. There also appears to be considerable frustration around the lack of an *Ordre des Infirmiers* and the lack of clear steps and enabling legislation on the professions of nurses and midwives. The Decree of May 19, 2015 which stipulates paid internships for health professionals in exchange for company tax incentives is not yet operational. Finally, the private sector is by and large excluded from public sector training opportunities.

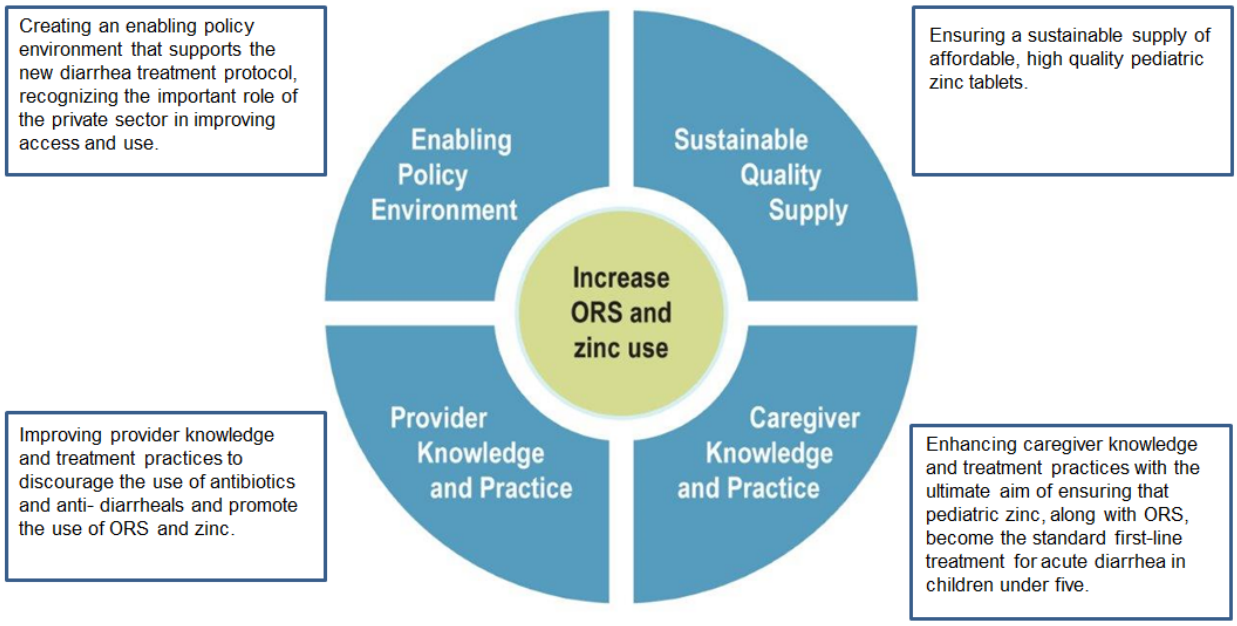
9.1.2 SERVICE DELIVERY RECOMMENDATIONS

Recommendations to improve service provision in the private health sector:

Consider an integrated approach to engaging with the private sector. Service delivery programs are most effective when the public and private sectors are coordinated and the relationship is collaborative. SHOPS has been successful in considering service delivery and policy reform as mutually reinforcing activities. For example, a SHOPS child health team in Ghana is promoting the introduction of zinc alongside the traditional ORS for treatment of pediatric diarrhea through a PPP model. The program encompasses training private providers in new diarrhea management protocols and developing a nationwide mass media campaign to increase awareness of zinc as a diarrhea treatment. SHOPS also partnered with two local manufacturers, M&G and Phyto-Riker Pharmaceuticals, to further catalyze brand promotion activities for their zinc products and expand the reach of their distribution systems into rural areas. After just three years, more than four million treatments have been sold, and coverage reached an unprecedented 36 percent for zinc and 65 percent for ORS.

The program was later expanded to FP and malaria. Senegal could adapt this integrated approach to private sector engagement for future health programming.

FIGURE 19: SHOPS STRATEGY FOR ENGAGING WITH THE PRIVATE SECTOR FOR CHILD HEALTH



Better documentation of private health sector. Currently, it is difficult to understand the scale and needs of the private health sector. A private sector census is needed to develop a baseline of the location and staffing of private health facilities and pharmacies. The primer "Facility Censuses: Revealing the Potential of the Private Health Sector," based on SHOPS' census work in Malawi, Benin, Nigeria, and the Caribbean, provides insights into the rationale and process for conducting a census (Johnson, Graff, and Choi 2015). Additionally, the MSAS needs technical assistance with developing an electronic database or private facilities and private providers that is easy to update.

Use the legal and regulatory review to catalyze change and consolidate agencies involved with the private health sector**.** The sheer number of agencies involved in regulating the private health sector makes it daunting for the private health sector to understand how to operate in compliance with the law. It is important for the public entities involved in the regulation of private facilities to communicate the requirements more clearly. Part of the legal and regulatory review process supported by the HIA could be a task force to identify the regulations that are most misunderstood and conduct targeted outreach to inform private providers of regulations. Focusing on a decree and enabling legislation for the nurse and midwives professions could help move towards an *Ordre des Infirmiers* and *Ordre de Sage Femmes* more quickly. Consolidating the agencies that must approve private health sector activities is highly encouraged.

Accelerate a total market approach. *L'Agence pour le Développement du Marketing Social* (ADEMAS) has supported the development of the terms of reference for a TMA analysis which will seek to identify the major challenges and barriers to coordination, harmonization, and increased supply and demand of modern contraceptive methods across the public and private sectors. ADEMAS believes that the results of the study will allow stakeholders to develop a common strategic framework to maximize use of family planning products and to improve equity, efficiency, and sustainability in the health system. Targeted demand creation activities also are needed that tie into a segmentation strategy of the TMA). This effort should also expand beyond the FP/RH sector to include other service delivery packages where NGOs and public and private commercial providers offer services and compete for urban consumers and reach unserved rural consumers. Expanding total market strategies beyond FP products and services is advised, especially as many of the NGO clinics are diversifying into a wider range of preventive and curative services.

Operationalize the May 19 Decree through targeted outreach. To help resolve the HRH issue, the GOS can coordinate national-level actors responsible for human resources for health to better plan and organize for future demand. The May 19 Decree requiring payment of interns is a step in the right direction, but focused efforts to operationalize the decree through targeted incentives to employers are needed.

Provide incentives to midwives for underserved areas. While unemployed midwives could make gains via better regulation of dual practice and increasing access to finance, one solution to the issue is to provide incentives for midwives to set up practices in underserved areas. These efforts could be more informal, or specific "enterprise zones" could be created that need midwives.

9.1.3 SERVICE DELIVERY RECOMMENDATIONS BY HEALTH AREA

FP: Identify ways to interest private for-profit providers in FP activities such as continuing education after work hours for midwives and nurses.

MNCH: Assess the quality of MNCH services in NGOs. Consider private-private collaboration among NGO and commercial sectors to reduce overlap and competition between the two. Reducing maternal mortality in rural areas through CSR partnerships to increase accessibility to ambulances could provide assistance in emergency obstetrical situations.

HIV: Consider affiliating all private health facilities in the same health district with the district service in charge of PMTCT and set up a mechanism for the private clinics to receive HIV rapid test kits. Assist public sector actors to provide training on care and treatment, particularly in the South. Through USAID implementing partners, tie private sector clinics to NGOs focused on key populations including men who have sex with men (MSM) and sex workers.

Malaria: Assess the potential for commercial pharmacies to stock and administer RDT for malaria. Focus on the two highest quintiles for bednet purchase through a targeted social marketing campaign in private pharmacies, with ADEMAS as a potential partner.

Nutrition: Consider a partnership for fortified foods, which is discussed in the PPP section below.

9.2 DEMAND CHALLENGES AND RECOMMENDATIONS

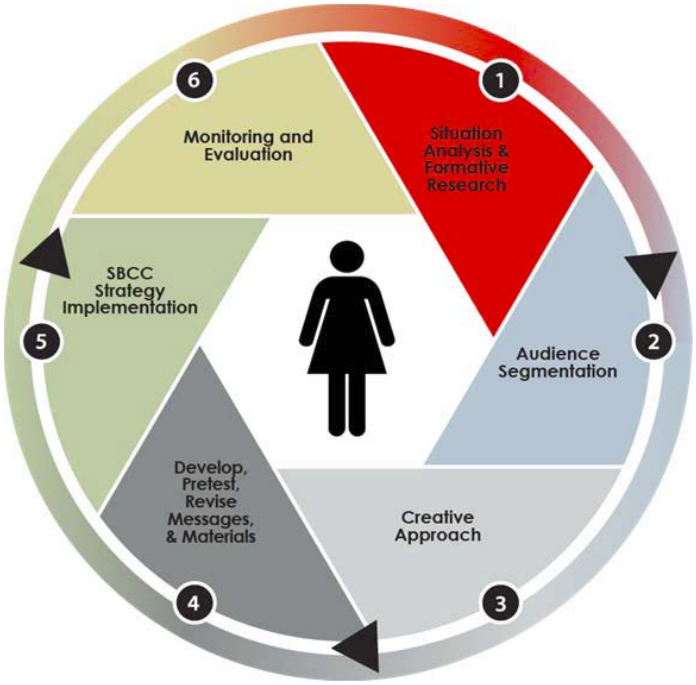
9.2.1 DEMAND CHALLENGES

The private health sector is underutilized for FP, HIV, and malaria products in general, but little information is available about the challenges that clients face accessing health care in the private sector, particularly in rural areas. Additional research is needed on the target audience to better understand ways to expand the role of health huts and the social, cultural and gender norms that constrain communication about FP, HIV, and other health areas.

9.2.2 DEMAND RECOMMENDATIONS

Make demand creation part of the process from the start. Future programming activities in FP, HIV, MNCH, malaria, and nutrition would benefit from demand creation integrated into the process from the beginning, most particularly for supply initiatives. Using the human-centered behavior cycle (Figure 20), it is important to conduct audience research with potential private sector customers to understand how they want to be engaged and how to increase their use of the private health sector.

FIGURE 20: THE HUMAN-CENTERED BEHAVIOR CYCLE



9.3 SUPPLY CHALLENGES AND RECOMMENDATIONS

9.3.1 SUPPLY CHALLENGES

In rural areas in particular, there is poor access to basic medicines and limited presence of *depots de pharmacies*. Under current regulations, the private pharmaceutical practice is seen as an individual practice with the health professional also expected to be an owner/investor and manager. Much more funding could be mobilized for the health sector if the laws permitted external investment with at least partial ownership of pharmacies and/or *depot de pharmacies*. Highly qualified pharmacists may not excel at managing a business or raising capital. Further, if a depot incurs losses during the start-up phase, in all likelihood, the depot owner will go out of business, and the community will remain unserved.

9.3.2 SUPPLY RECOMMENDATIONS

Revise the laws around pharmacy ownership to allow for corporate ownership, and ownership of multiple pharmacies and depots by a single owner. Allowing pharmacists operating in small towns to own depots in nearby villages has multiple benefits. An entrepreneurial pharmacist could create a small hub and spoke network and increase access to quality medicines in rural areas. This level of ownership has the potential to encourage and promote the pharmacist taking a more active interest in supplying and supervising the *depots de pharmacie,* and in the process, create opportunities for employment in rural areas. If one of the depots had to be converted from a depot to a pharmacy, then the owner pharmacist could simply hire a new pharmacist graduate and redeploy the person who had been managing the depot to another rural village. This would make the process of depot conversion much smoother than is currently the case. It would also help to address the problem of unemployed pharmacy graduates.

The pharmacy-depot networks could achieve scale faster if laws permitted corporate investment in such networks. If pharmacists could establish a small limited liability corporation to fund their networks, they could raise capital from external investors, even if the law still required majority ownership by one or more pharmacists. The law could be structured to provide incentives in the form of tax relief in exchange for opening depots in underserved areas. Similar incentives could be offered for employing recent pharmacy graduates. Building larger networks of pharmacies and depots would also permit cross-subsidization which is currently not possible under individual practice.

This strategy also could be applied for networks of pharmacies to help open pharmacies in new communities targeted by the DPM to raise capital for the health sector, achieve scale and cross-subsidization in the system, and employ more pharmacy graduates. Achieving scale in the pharmacy sector will create efficiencies that facilitate quality assurance, larger procurement volumes which bring down prices, and investments in information technology which can improve logistics and stock management. Any revision of the laws would require consultation with the *Syndicat de Pharmaciens* and the *Ordre de Pharmaciens* to address their concerns. It may be desirable to test a model in a given region and assess its performance as a means of informing policy interventions.

Streamline the procedures for pharmacy applications to reduce the time needed for authorizations and the amount of up-front investment. SHOPS recommends that the MOH look for ways to facilitate the issuance of licenses for service providers and pharmacists while keeping in mind the objectives of equity of access and following the “carte sanitaire.” While authorities must ensure that a pharmacist is authorized to operate in a specific location, pharmacists should not be required to own or rent a property before they can use it to generate

revenue by opening their business. Such barriers discourage investment in the pharmacy sector and do nothing to create pharmacies where they are most needed. The government should provide greater guidance to prospective pharmacists up front about where new pharmacies will be authorized and where they will not. For applications to open a pharmacy in areas that the DPM has deemed underserved, the DPM can use an expedited process and offer tax incentives.

Depots have the potential to be critical product delivery points for rural and peri-urban areas. Depots could be linked closely to the better performing and more sustainable private sector supply chain. The government could contract out storage and delivery of IPM teams as IntraHealth has done. If laws on the ownership of Depots are changed, much of their expansion could be achieved through the mobilization of private capital.

Social franchising and social marketing can accelerate the behavior change process through more targeted communications that promote health products and services through private sector brands. MSI has begun to promote the Blue Star brand for its franchising clinics and medical offices. ADEMAS for many years has applied similar strategies for health products including Protec condoms, Securil oral contraceptives, and Milda mosquito nets. The brand appeal, the convenience of for-profit providers, and a reasonable price should help shift some consumers from the public to the private sector. Social franchising also can be an effective way of motivating more private providers to actively promote critical FP, MNCH and HIV services. A social franchise can offer a variety of support services to private providers including access to subsidized training, access to subsidized commodities, management and business support, advertising, advocacy, and quality assurance. The franchisor or network manager could be an NGO or a local institution with a natural relationship to private providers such as a professional association.

9.4 HEALTH FINANCING CHALLENGES AND RECOMMENDATIONS

9.4.1 HEALTH FINANCING CHALLENGES

The UHC program in Senegal is highly ambitious and has the potential to completely transform health systems performance in Senegal. The approach taken by the government to expand through decentralized and community-based institutions will help build local buy-in and consumer understanding of the program. However, it is also likely to mean a much slower implementation of the program due to training union or *mutuelle* staff and officers on enrollment, premium collection, claims administration, data collection, and reporting.

The GOS has opted for the *Plan DECAM* in which citizens have to be a member of a mutual health association to benefit from basic coverage. Unfortunately, not every commune has active *mutuelles* that citizens can join, so the government and its partners are engaged in a major effort to establish *mutuelles* in all the communes and to train staff to administer *mutuelles*. The process is long since *mutuelles* have to elect officers, be duly registered, and adopt statutes in accordance with the associative laws which govern them. Enrolling people and collecting premium payments also takes considerable time.

The majority of private providers operate medical offices, sole proprietorships which they typically run like family businesses. There is minimal formality, poor documentation of revenues and expenses, and limited use of banks for making purchases or holding reserves. These practices are a high credit risk for banks. Helping private health sector entrepreneurs to overcome financing barriers to establish or expand private facilities is a desirable goal.

However, these efforts need to be targeted if they are to result in significant investment in the health sector and efficient use of capital.

9.4.2 HEALTH FINANCING RECOMMENDATIONS

Explore ways to leverage private sector insurance capacity to support national UHC. Commercial insurers have developed efficient systems to manage basic insurance functions and probably have excess capacity that they could "sell" to the GOS through a contracting-out arrangement. Because of the decentralized approach of the UHC, the central government will not be in a position to contract with private insurers, but a regional government authority or even a union of *mutuelles* may be in a position to do so. Private insurers may be concerned that the *mutuelles* could have trouble paying. A more in-depth assessment would be needed to see what the commercial sector's greatest added value is and what the best contracting out arrangement is. The UHC program should aim to standardize data collection and reporting tools. Additional research also is needed on *Imputations budgetaires souscrites* regarding their relative strengths and weaknesses.

Contract out to private insurers. While the community-based approach has important advantages for ensuring community awareness and local ownership, it can make the roll out slower and administratively more difficult. The UHC may wish to explore contracting these functions to private insurers with in-house capacity already in place. While contracting out to private insurers is not a complete solution, it may be a complementary strategy that could help bring more citizens under coverage faster. Some work would be required to help unions design appropriate tender documents to induce private insurers to bid on the work.

Focus DCA program technical assistance on catalyzing consolidation in the private health sector. The DCA program is in the early stages with Ecobank and is on the right track. It is important to foster increased lending across the private health sector. However, technical assistance and small grants could encourage providers to focus on group, partnership, or corporate forms of ownership. The program could also provide legal advice and support to help individual providers form group practices, thereby helping them to qualify for loans. Larger facilities are easier to monitor, provide more services to more clients, and institute stronger quality assurance practices. Also, there is a need for rigorous market research on the private health sector that could be shared among all banks as a common good to encourage health lending in the country.

Factor microfinance institutions and equipment lending companies in the health lending equation. Many private providers are too much of a credit risk for banks. Microfinance Institutions might be a more appropriate source of funding. In Benin, the SHOPS project worked not only with Ecobank, the DCA Bank, but also with MFIs and equipment lending companies. Providers then have more options for funding their facility or equipment purchase.

Allow non-medical investors to own large private health facilities and pharmacies. Currently, a single private provider or pharmacist must have majority ownership in a health facility. The business of health facility and pharmacy ownership should be open to specialists, including non-medical investors, who have both capital and management expertise. Allowing investors to own and manage large facilities or chains of clinics and pharmacies could attract significant capital, increase the access of Senegalese to new facilities in underserved areas, and help to address the problem of unemployment of medical graduates.

Promote co-investment with private equity structures whose purpose is to boost strategic projects particularly in the health field.

Consider innovation fund targeting health enterprises. To encourage investment in health activities such as FP and HIV in Senegal, donors could sponsor an innovation fund to seek out enterprises serving the base of the pyramid and award a grant and technical assistance to those that have the potential to improve health outcomes through increased provision of or access to health services. For example, the SHOPS project conducted a challenge fund activity in Kenya, Ethiopia, and Nigeria with support from USAID and the Department of International Development (DFID), awarding grants and providing technical assistance to businesses demonstrating the potential for sustainability, scale, and replication. Challenge fund grantees provided new life-saving technologies, rolled out new care delivery models, and provided priority health services to tens of thousands of low-income people.[12] In Senegal, the fund could target challenges such as the need for a biomedical waste solution.

9.5 POLICY ENVIRONMENT CHALLENGES AND RECOMMENDATIONS

9.5.1 POLICY ENVIRONMENT CHALLENGES

The GOS's desire to engage the private health sector in health decisions and be part of the PPP Comité Technique is exemplary. The Cellule PPP and the PPP Comité Technique have made significant progress in bringing together public and private sector stakeholders. Though partnerships and dialogue activities have been ongoing, y specific action steps to improve collaboration and bring PPPs to fruition have not been accomplished.

The private health sector is frustrated with what it considers barriers to private health sector expansion. In some cases, laws affecting the private health sector exist, but the enabling legislation is lacking, which serves as a bottleneck for the private sector.

9.5.2 POLICY ENVIRONMENT RECOMMENDATIONS

Use the legal and regulatory review to catalyze policy improvements for the private health sector. The legal and regulatory review, currently underway and supported by the HIA, is an excellent tool to identify specific regulatory barriers that are in need of improvement. The review should provide specific, actionable steps that can relieve the regulatory burden for the private sector and improve relations between the two sectors. Further, recommended actions and changes must be accompanied with a plan for implementation to ensure moving the process forward. A subcommittee of the PPP Comité Technique, composed equally of public and private stakeholders, needs to prioritize interventions and bring recommendations to the larger committee. After the more general legal and regulatory review, it is necessary to drill down to more specific constraints by health area. During interviews, the assessment team heard repeatedly about the following legal issues: the ability of some NGOs to purchase directly from the PNA but not others; the inability of private clinics to buy directly from wholesalers or the PNA; and the requirement that only a doctor can open a clinic.

Focus on PPPs that fix a health system gap in Senegal. The process for determining PPPs could be strengthened in Senegal. A PPP in health should address a need that the health system is not addressing (Barnes 2011). Short-term problems and problems that a single sector can cover are not the focus of PPPs—PPPs in health are appropriate when they can improve

[12] For more information on the Health Enterprise Fund implemented through the SHOPS project, see http://www.healthenterprisefund.org and http://www.shopsproject.org/resource-center/hanshep-health-enterprise-fund-supporting-pro-poor-health-innovations-in-the-private.

efficiency, sustainability, and/or equity in the health system. While PPPs in health provide many benefits—greater value for money, increased access to services, and transference of a significant share of risk to the private sector—caution must be exercised when pursuing PPPs. Use PPPs when single-sector solutions are not successful rather than as a default strategy.

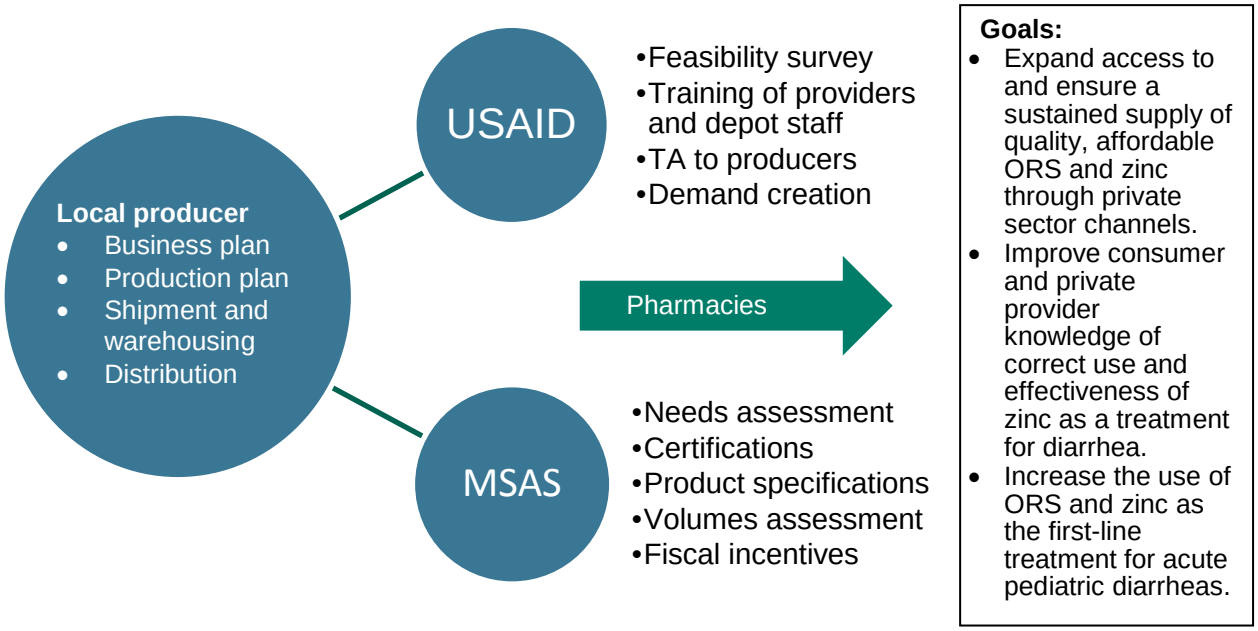
The Cellule PPP is currently considering a lengthy list of health PPP options. While prioritizing the list of potential PPPs is beyond the scope of this assessment, the assessment team recommends focusing on the PPPs that address the greatest health need, benefit the population most, and take full advantage of the private sector's value added such as rural product and service delivery and employment of medical graduates.

Strengthen the Cellule PPP's stewardship of the PPP process. The Cellule PPP at the MSAS needs to clarify its role. A health PPP unit is a point of coordination, quality control, accountability, and health and health-related information. In some countries, the PPP unit also serves as a clearinghouse for updated and accurate information on the private health sector for ministry staff and government priorities for private sector stakeholders. In addition to building knowledge, the PPP unit plays a capacity building role on how and when to enter health PPPs (strategic advice) and how to implement a health PPP (train and build capacity).

Streamline the role of PPP Comité Technique. The current configuration of the PPP Comité Technique was a necessary first step to gain consensus and help connect the public and private sectors more closely. However, now is the time to develop a specific health public-private partnership strategy and move the PPP process to the next level. It would be more productive to separate the public-private dialogue activities from the PPP activities in the Comité Technique, either through separate meetings or subcommittees. Potential subcommittees include: 1) governance, 2) service delivery and human resources, 3) medicines and medical equipment, 4) community-based distribution, and 5) mHealth.

Develop PPP for ORS and zinc. For MNCH, there are several PPP opportunities for micronutrients and local iodized salt production. The PPP unit could assess the feasibility of adapting the SHOPS Ghana model for integrated production and marketing of ORS and zinc (discussed previously) in partnership with the MSAS, pharmacies, depots de pharmacies, and local producers. Currently, zinc is imported from Nurtriset in France, and zinc and ORS copacks are not available for sale. Further, private sector front-line workers need training to better follow zinc and ORS guidelines. Figure 21 shows a simple schematic of the goals, actors, and roles in such a PPP. French-language materials on diarrhea management useful for demand creation are available at http://www.zinc-ors.org.

FIGURE 21: OVERVIEW OF POTENTIAL PPP FOR ORS AND ZINC



Explore PPPs with companies that are members of RSE Senegal. The RSE Senegal membership roster lists the most active CSR companies in the country. The *Programme social minier* subcommittee focused on mining companies has stakeholder forums that would be useful to explore. Once the health gaps and needs for PPPs are clearer, the GOS may consider a PPP with active companies that have previously been involved in health, such as Teranga Gold or ICS. It would be important to focus any worksite programs on an integrated package of health services including FP, MNCH, HIV, malaria, and nutrition at worksite clinics and mobile outreach units.

9.5.3 mHEALTH CHALLENGES

There are many mHealth initiatives in Senegal that harness mobile technologies to improve health outcomes. However, the initiatives are isolated which could result in duplication as well as missed opportunities for collaboration.

Until now, mHealth initiatives in the private sector have not used a common set of indicators. This resulted in non-interoperable applications and wasteful investments. With support from USAID and IntraHealth, Senegal uses the iHRIS suite of software to manage its public sector workforce. Parallel private sector databases exist, but little thought has been given to how these databases could be integrated.

9.5.4 mHEALTH RECOMMENDATIONS

Reinforce the mHealth working group. Senegal has established a mHealth Working Group, with broad participation from MOH, NGOs and mHealth developers. Providing additional structure would strengthen its processes and impact. Recommendations for improving effectiveness of the working group include:

- Securing resources to support frequent and regular meetings with opportunities for demonstrating new applications, sharing promising results, and identifying success stories.

- Conducting a mapping exercise and sharing it widely, to catalogue all mHealth activities in the country. This will set a baseline for identifying duplicative efforts and prioritizing resource allocation.
- Creating a vision statement for mHealth in Senegal—what are the shared goals of the working group in leveraging ICTs and what are the specific objectives?
- Ensuring participation from multiple mobile operators who will benefit from the opportunity to hear directly from the health community about its programmatic needs.
- Developing mHealth training sessions to build capacity of those participating in the working group, for use in their programs.
- Reaching out to the Ministries in charge of finance and telecommunications to promote broad policy changes that can serve the health sector, such as earmarking mobile taxes and fees and adopting reduced prices for mHealth applications.

Build upon existing mHealth partnerships to expand opportunities for improving public private dialogue. Mobile operator Tigo and insurer Bima collaborated to create a mobile insurance product to expand the reach of insurance for the unbanked (Levin 2014). Registration, premium payments, and claims processing for a simple life insurance product are all conducted through mobile phone accounts, introducing the benefits to uninitiated populations. Innovations include free premiums based on mobile phone usage. Based on positive results for its brand and more than three million subscribers within two years, Tigo is expanding its service to include some basic health insurance products. As Senegal's UHC program seeks to increase coverage through *mutuelles*, the GOS could broker a partnership between Tigo Senegal and the *mutuelles*. The *mutuelles* may expand the efficiency of their services, and Tigo could expand its reach through a new cadre of agents.

USAID/West Africa is exploring a regional partnership with mobile operator Orange as well as other options to create a suite of mobile solutions to address family planning challenges in West Africa. Stakeholders from Niger, Côte d'Ivoire, and Cameroon have met to identify regional family planning priorities, and the SHOPS project is currently assessing options for sustainable financing of various applications. In coordination with the Ouagadougou Partnership, Senegalese stakeholders could build upon these initial regional investments to adapt regional msolutions for the Senegalese context.

Sonatel Orange collaborated with *Syndicat des Pharmacies Privés du Senegal* and *Conseil National de l'Ordre des Pharmaciens* to launch an SMS service that provides access to information about out-of-hours pharmacies by geographic location. The project is designed to facilitate relationships between pharmacists as well as to strengthen their service to communities (Orange 2014). The database could evolve to serve as a broader communications platform between public stakeholders and private pharmacists.

HMIS

Given the lack of uniform reporting tools for the private sector, action is needed to harmonize reporting tools in the public and private sectors. IntraHealth's district model of providing incentives for private providers to encourage ongoing reporting and improve private sector engagement is promising and should be scaled up. Assistance to districts is needed to ensure DHIS2 adequately captures private sector statistics.

10 CONCLUSION

The expansion of Senegal's private health sector presents an advantageous time to focus more resources on identifying challenges and improving private sector engagement. The Government of Senegal (GOS) has shown a clear commitment to private sector engagement. Through the recommendations of this private sector assessment, GOS, and donors have the opportunity to move forward purposefully and efficiently in improving the health system.

ANNEX A: LIST OF KEY STAKEHOLDERS INTERVIEWED

TABLE 12: STAKEHOLDERS INTERVIEWED

Sector	Organization	Names and Titles
Business organization	Alliance du Secteur Privé de la Santé du Sénégal	Dr. Ardo Ba, President
Civil society	Ordre des Médecins Privés	Awa Diagne Sy, President
Civil society	Ordre National des Pharmaciens du Sénégal	Dr. Cheikh Oumar Dia, President
Civil society	Association des Biologistes	Dr. Tidiane Siby, President
Civil society	Association des Dispensaires Catholiques	Angèle Ndione, President
Civil society	Association des Cliniques Privées	Dr. Amadou Diallo, President
Civil society	Association des Ecoles Privées de Santé	Oumar Sy, President
Civil society	Association des Gyneco Obstétriciens	Dr. Abdoulaye Diop, President
Civil society	Association des Infirmiers	Dr. Mbengue Ibrahima, President
Civil society	Association des Médecins d'Entreprise	Dr. Marième Babylas Ndiaye, President
Civil society	Association des Paramédicaux Privés	Dr. Babacar Gueye, President
Civil society	Association des Pharmaciens	Dr. Khady CISSE, President
Civil society	Association des Sages Femmes	Marieme Fall, President
Civil society	Association Sénégalaise pour le Bien Etre Familial	Alioune Diouf, Head of Research Unit, Monitoring−Evaluation and Planning ASBEF
Donor	MCA	Abdoulaye Diarra, Manager, Private Sector and Accompanying Measures
Donor	UNFPA/Sénégal	Cheikh Mouhamed Tidiane Mbengue, Assistant Representative Ndeye Diop Niang, Communication, Public Relations Specialist
Donor	UNICEF	Aissata Moussa Abba, Nutrition Specialist
Donor	USAID	Bryn Sakagawa, Health Office Director John Bernon, Deputy Director, Health Office Dr. El Hadji Mbow-Baye, Senior Advisor Dr. Fatou Ndiaye, Maternal & Child Health / Family Planning Specialist

Sector	Organization	Names and Titles
Donor	WHO	Mamadou Ngom, Advisor of Essential Medicines and Health Technologies Ousmane Diallo, Manager, Information and Documentation
Donor	World Bank	Birima Fall, Operations Officer Tshiya Subayi, Operations Officer-Health
Implementing partner	Africare	Boubou Niane, Health Program Director
Implementing partner	Amref	Dr. Mor Ngom, Country Director
Implementing partner	Catholique Relief Services	Nicole Poirier, Country Representative
Implementing partner	Child Fund	Mamadou Diagne, CoP PSSC II Sébastiana Diatta, FP Advisor Dr. Rose Monteil, CCM Advisor
Implementing partner	FHI360	Dr. Abdoulaye Ly , Directeur Adjoint Jean-Paul Tchupo, Conseiller Technique VIH
Implementing partner	Helen Keller International	Dr. Code Thiaw, Technical Programs Coordinator
Implementing partner	IntraHealth	Dr. Ndeye Sougou, Technical advisor, Private Sector Hawa Talla, DCOP Boniface Sebikali, Senior Clinical Training Advisor Elhadji Gueye, COP, Country Director Rodrigue Ngouana, Country Liaison Officer Fatimata Sy, Ouagadougou Partnership Coordination
Implementing partner	Marie Stopes International	Sanou Gning, Social Marketing Director
Implementing partner	Micronutrient Initiative	Dr. Balla Moussa Diedhiou, Sahel Director
Implementing partner	PATH	Phillip Guinot, Country Director Emmanuel Cour, Health Systems Strengthening Coordinator
Implementing partner	Pop Council	Babacar Mane, Senior Program Officer
Implementing partner	Save the Children	Mame Ngone Mbodji, Health Officer
Implementing partner	World Vision	Dr. Agoudtou Gomis, Grant Acquisition and Management Manager
NGO	ADEMAS	Dr. Cheikh Sadbou Sarr, COP
NGO network	Réseau Santé, SIDA et Population/Conseil des Organisations non Gouvernmentales d'Appui au Developpement	Ndeye Fatou Sall, President
Private for-profit	APIX	Moustapha Cisse, Investment Director
Private for-profit	Eiffage	Missira Keita, Director Quality, Health, Safety, Environment & CSR

Sector	Organization	Names and Titles
Private for-profit	ICS	Fatou Banel Dia, Head Midwife
Private for-profit	Nsia Assurance	Dr. Babacar Djigo, Health Insurance Director
Private for-profit	Sodefitex	Abdoulaye Ndiaye, Human Resources Manager
Private for-profit	Sodipharm	Dr. Diedhiou, Procurement Manager
Private for-profit	Teranga Gold	Prica Piot, Public Affairs and Sustainability Manager
Private for-profit	Transvie	Abdou Diagne, Director
Private for-profit	Clinique de l'Amitié	Dr. Amadou Diallo, General Administrator
Private for-profit	Laborex	Jean Claude Dazo, Procurement director
Private for-profit	Clinique Raby	Macktar Ba, General Administrator
Private for-profit	Clinique Madeleine	Moussa Jouni, General Administrator
Private for-profit	Clinique Fannock	Dr. Alipio Raymond, General Administrator
Private for-profit	Clinique Liberté 6	Aïsha Diop, General Administrator
Private for-profit	Clinique NEST	Dr. Abdoulaye Diop, General Administrator
Private for-profit	Clinique Touba	Dr. Al bacha Maiga, General Administrator
Private for-profit	Clinique Djarama	Dr. Adama Gadio, General Administrator
Private for-profit	Cabinet Florence Nightingale	Ousseynou Diop, General Administrator
Public sector	AcDEV/Ministère de la Santé	Dr. Cheikh Tidiane Athier, President
Public sector	Bureau de la Législation	Dr. Fatou Diop, Representative, Regulation and Litigation Department
Public sector	Cellule d'Appui, Partenariats	Ndeye Fatou Tall Ndiaye, Division Head
Public sector	Cellule de Lutte contre la Malnutrition	Abdoulaye Ka, National Coordinator
Public sector	Conseil National de lutte contre le Sida (CNLS)	Mme Jacqueline Cabral, Division Head, Public Private Partnerships
Public sector	Conseil National du Patronat du Sénégal (CNP)	Matar Ba, Health Sector Representative
Public sector	Direction de la Lutte contre les Maladies	Marie Khemes Ngom, Director
Public sector	Direction de la Pharmacie et du Médicament	Prof. Amadou Moctar Dieye, Director
Public sector	Direction de la Planification, de la Recherche et des Statistiques	Dr. Amadou Djibril Ba, Director

Sector	Organization	Names and Titles
Public sector	Direction de la Santé de la Reproduction et du Suivi de l'Enfant (DSRSE)	Dr. Bocar Daff, Director
Public sector	Direction des Etablissements de la Santé	Dr. Faout Diop Ndiaye, Division Head, Regulation and Litigation
Public sector	Direction des Ressources Humaines	Gallo Ba, Director
Public sector	Direction Générale de la Santé	Dr. Papa Amadou Diack, Director General for Health
Public sector	Direction Générale de l'Action Sociale (DGAS)	Dr. Cheikh Ndiaye, Director
Public sector	Ministère de la Santé	Matar Camara, USAID Focal point at the MOH
Public sector	Ministère de la Santé, Health Financing/Demand (UHC)	Cheik Mbengue, Director
Public sector	Mouvement des Entreprises du Sénégal (MDES)	Mbagnick Diop, Director
Public sector	Ouagadougou Partnership	Fatimata Sy, Coordinator
Public sector	Pharmacie Nationale d'Approvisionnement (PNA)/Ministère de la Santé	Matar Dabo, Technical Advisor, Research and Development
Public sector	Programme National de Lutte contre le Paludisme	Mamadou Lamine Diouf, Procurement Manager Dr. Moustapha Cisee, Deputy Coordinator

ANNEX B: SCOPE OF WORK FOR PRIVATE SECTOR ASSESSMENT

10.1 BACKGROUND

Senegal aspires to become an emerging country by 2035. However, it has not shared the rapid growth experienced by many other sub-Saharan African countries over the last decade. Compared to the average growth rate of six percent for the rest of sub-Saharan Africa (SSA), growth in Senegal has averaged 3.3 percent since 2006. The health situation in Senegal has witnessed improvements over the past decade. According to the 2014 cDHS for Senegal, infant mortality has declined from 61 in 2005 to 45 in 2010-2011, and child mortality from 121 in 2005 to 72 in 2010-2011, but malaria and diarrhea still threaten children's health. The maternal mortality rate has not changed much and remains about 400 (2010-2011). In addition, HIV prevalence has remained stable at 0.7 within the general population aged 15-49 years. In 2010-2011, more than nine of 10 mothers (93 percent) were seen by trained medical personnel during pregnancy. For births in the five years before the 2010-2011 survey, 65 percent of mothers benefited from the assistance of trained medical staff at delivery. Immunization coverage among children under age five has improved (63 percent in 2010-2011). Finally, TFR has remained at about five over the last decade (Agence Nationale de la Statistique et de la Demographie and MEASURE DHS 2013).

To accelerate progress to achieve national development goals and international targets including FP2020, UNAIDS' 90-90-90 vision and others, the GOS'HIA National Health Sector Policy has four objectives: a) reduce the burden of maternal and child morbidity and mortality; b) increase the performance of the sector in preventive care; c) build a sustainable health care system; d) improve health sector governance. The public health care system is based on a network of about 2,160 health huts and 1,257 health posts which serve as a first point of contact with people. The PNDS attaches great importance to the following areas: epidemiological surveillance, RH, STDs/AIDS, and control of endemic diseases such as malaria.

The private health sector has a strong and growing presence in the Senegal health system. According to Government of Senegal statistics, there are approximately 1,013 private pharmacies, 923 *cabinets medicaux*, 462 *cabinets paramedicaux*, 45 private clinics, five drug manufacturers, and six drug wholesalers (SHOPS Project 2015). More than 900 doctors practice medicine in the private sector in Senegal, with 81 percent located in Dakar. Further, about 14 percent of current modern contraceptive users source from the private sector (Agence Nationale de la Statistique et de la Demographie and MEASURE DHS 2013).

These factors warrant increased consideration of the key role the private sector could play in helping Senegal better meet national health needs. In 2009, at the request of USAID/Senegal, the Private Sector Partnerships-One (PSP-One) project conducted a rapid assessment to understand better the current and potential market for family planning (FP) products and services in the private health sector and provide USAID with recommendations to strengthen the private health sector in Senegal. The rapid assessment team found a strong private health

sector with engaged, dynamic leaders. However, demand for FP services was found to be stagnant and low. Rural areas were found to have the greatest demand for increased services and service providers, because so few providers are currently found there. The assessment team did not have the means to conduct a thorough assessment of the public and private supply chains, nor delve into other health areas such as maternal and child health, HIV, malaria and nutrition. The rapid assessment did not look into the policy environment towards the private health sector and health financing in Senegal.

Gathering more in-depth and up-to-date information to better describe and quantify the private health sector and its contributions to health is a critical first step in establishing cooperation between the public and private health sectors. The USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project is poised to address this need through conducting an assessment of the private health sector in Senegal. The proposed PSA will be a collaborative effort between USAID/Senegal, the Ministry of Health and other relevant stakeholders, with the goal of identifying opportunities for greater private sector engagement to contribute to a stronger health system in Senegal.

10.2 GOALS AND OBJECTIVES

Goal

The ultimate purpose of the assessment is to determine the extent to which the private health sector could have greater engagement in the health system to achieve USAID goals in Senegal, with a primary focus on FP/maternal child health (MCH) and a secondary focus on HIV and AIDS, malaria and nutrition.

Objectives

To achieve this goal, the private sector assessment will:

1. Provide an overview of private health sector stakeholders and their respective roles
2. Assess the level of policy dialogue between the public and private health sectors
3. Describe private sector contributions to key health markets and health system areas, including health financing
4. Assess specific markets for key health products and services and describe supply and demand dynamics
5. Identify existing and potential opportunities for public-private partnerships in health
6. Provide recommendations on how to best operationalize PPPs in the health sector.

Approach

SHOPS will convene a multidisciplinary team to conduct the private health sector assessment. Team members will be knowledgeable about the private health sector in Francophone Africa, and will be able to address the priority areas presented below:

- Policy environment: The team will review existing and draft legislation and the overall policy environment in Senegal to identify opportunities and potential barriers to greater public-private engagement in health. The team will also review public-private dialogue mechanisms currently in place.
- Health financing: Areas of emphasis will include contracting models and understanding the role of private medical aid schemes, particularly in light of discussions regarding National

Health Insurance. The assessment will look at how private and public health financing mechanisms stimulate demand for products and services in the private sector. The assessment will also look at supply side financing and the private health sector's access to finance, taking into consideration USAID's work on the Health Financing Toolkit.

- Service Delivery: Emphasis will be placed on assessing the demand for and supply of key health services from the private health sector, both for-profit and not-for-profit. The team will also examine human resources for health as it relates to service delivery.
- Supply of health products in the private sector: Given existing challenges in forecasting and procurement faced by Central Medical Stores, the assessment will document the private supply chain, with a focus on priority health area supplies and pharmaceuticals, to identify opportunities for an increased private sector role, as well as increased efficiencies in the system.
- Demand for priority health services and products: The assessment will review public and private efforts to build demand for critical health products and services including those that are supported by USAID and other donors as well as the government**.** The assessment will explore ways that demand creation efforts can be adapted or expanded to ensure that they create demand for products and services delivered by the private for-profit health sector in addition to the public, nonprofit (including social marketing) and faith-based sector.

Since 2009, SHOPS has conducted 23 private sector assessments, including several in sub-Saharan Africa and a macro-level assessment of six countries in Francophone Africa. Many of these assessments have led to field-based programs designed to increasingly engage private sector actors in helping countries address priority health needs, often resulting in innovative programming and partnerships. For PSA, the team will build on the findings from the 2009 rapid assessment mentioned above. As depicted in Table 13, the typical PSA consists of four steps: data collection, data analysis, report development, and validation by local stakeholders. Once the scope of work is approved, the assessment begins with a comprehensive literature review and analysis of available data (such as Demographic and Health Surveys or national health accounts). This provides the team with a basic understanding of the landscape and context, as well as key challenges and gaps in information. This phase is followed by the field work, which entails targeted stakeholder interviews (representing both public and private sectors) and field visits to private sector facilities and initiatives. The analysis step typically begins in country, through nightly debriefings where the PSA team shares information, vets initial findings, and begins to form actionable recommendations. This process continues past the fieldwork, as the team integrates their respective findings, identifies opportunities for greater private sector involvement, and develops appropriate recommendations. The next step is to synthesize findings and recommendations into a draft report, followed by validating findings and recommendations with local stakeholder input, and disseminating the final report.

10.3 DURATION, TIMING, AND SCHEDULE

The period of performance for the assessment will be approximately six months, including preparation time, in-country field work, report writing, and dissemination. Dates for in-country data collection will be determined in consultation with USAID/Senegal and the Senegal Ministry of Health. Preliminary recommendations will be presented to the Mission as part of the PSA field team's exit briefing, and a draft report will be available for review within six to eight weeks after the field visit. The chart below suggests an illustrative timeline for the Senegal private sector assessment.

TABLE 13: PROPOSED TIMELINE FOR THE PSA

Proposed Timeline for the Senegal PSA	Mar '15	Apr '15	May '15	Jun '15	Jul '15	Aug '15	Sep '15
Planning							
Finalize scope of work	X						
Identify team members	X						
Identify key stakeholders	X						
Schedule meetings with key stakeholders		X					
Literature Review and Question Development							
Conduct background research and document review		X					
Develop questions tailored to specific stakeholders		X					
Field Work							
Conduct stakeholder interviews			X				
Conduct field visits			X				
Debrief with key stakeholders			X				
Report Writing and Dissemination							
Develop outline for report				X			
Conduct analysis and draft report				X			
Vet preliminary findings and recommendations with in-country stakeholders				X			
Submit draft report to USAID and other key stakeholders for comment prior to dissemination (early Aug)						X	
Finalize report (late Aug)						X	
Disseminate findings to local stakeholders (early Sept)							X

10.4 DELIVERABLES

In consultation with USAID/Senegal, the SHOPS project will produce:

1. Final scope of work that includes:
    a. Goals and objectives of assessment
    b. Team composition, roles, and responsibilities
    c. Timeline
2. Detailed plan for field work that covers:
    a. Key questions by stakeholder group
    b. Schedule of interviews and site visits

c. Schedule for USAID debriefing

3. Preliminary debriefing toward the end of the assessment trip to present preliminary findings and recommendations
4. Final assessment report
5. Pending sufficient budget, a consultative in-country workshop to share findings and prioritize recommendations with key stakeholders representing the public and private sectors (in-country dissemination is often supported with local funding)

ANNEX C: MAJOR PUBLIC SECTOR DIVISIONS ENGAGED WITH THE PRIVATE HEALTH SECTOR

Name	Role
Division partenariat public-privé	Oversees financial and technical aspects of public-private partnership (PPP) projects in close collaboration with the *Division des etablissements Privés de santé*, located in the *Direction des Etablissements de Santé*
Direction de la pharmacie et du médicament Includes: *la Division des Etudes et de la Documentation, la Division de la Réglementation et du Contentieux, la Division du contrôle administratif des Médicaments, la Division des Stupéfiants et des Substances psychotropes, la Division de la Pharmaco vigilance, la division de la pharmacopée traditionnelle, Bureau de gestion*	National pharmaceutical regulatory authority that oversees the development, implementation, and monitoring in the pharmaceutical and medical fields; collaborates closely with the *Syndicat des Pharmaciens Privés*
Direction de la prévention Includes: *la Division de la Prévention individuelle et collective, la Division de l'Immunisation, la Division de la Surveillance et de la Riposte vaccinale, le Bureau de gestion*	Develops and monitors the implementation of disease prevention and immunization policies; conducts epidemiological surveillance in collaboration with the private sector through district health centers which collect data from some private facilities
Direction de la sante de la reproduction et de la survie de l'enfant Includes: *la Division de la Santé de la Mère et du Nouveau-né, la Division de la Survie de l'Enfant, la Division de la Santé de l'Adolescent, la Division de l'Alimentation et de la Nutrition, la Division de la Planification familiale, le Bureau de Gestion*	Coordinates the preventive and curative activities concerning the well-being of mothers, newborns, and adolescents; implements FP and RH strategies, especially with the nonprofit sector such as NGOs *L'Agence pour le Développement du Marketing Social (PSI Affiliate) (*ADEMAS) and *Association Sénégalaise pour le Bien-Etre de la Famille* (ASBEF)

Name	Role
Direction de l'administration générale et de l'équipement Includes: *la Division de l'Administration et des Finances, la Division de la Programmation et du Suivi budgétaire, la Division des Marchés, la Division du Matériel et du Transit administratif, le Bureau de Gestion du Siège, le Bureau du Contrôle interne, le Bureau de Gestion*	Prepares and executes the MOH and Social Action's budget; procures equipment and constructs infrastructure; procures goods and services; conducts audits
Direction des ressources humaines Includes: *Division de la Gestion du Personnel, la Division de la Gestion prévisionnelle des Emplois et des Compétences, la Division de la Promotion et des Relations sociales, la Division de la Formation, le Bureau de gestion*	Trains and manages the MOH and Social Action's staff; ensures coordination in the recruitment and management of health personnel; oversees the application of rules concerning public and private vocational institutions
Division des établissements privés de santé	Regulates, supports, and monitors clinics and private practices and supports their participation in the health system
Pharmacie nationale d'approvisionnement	Supplies pharmaceutical products to public and private health facilities
Agence nationale de la CMU	Provides financial access to health care through the development of a universal health insurance strategy; strengthens collaboration between universal health coverage stakeholders; regulates prices and tariffs for health services in the public and private sectors
Direction de la planification de la recherché et des statistiques Includes: *La Division de la Planification, la Division de la Recherche, la Division du Système d'Information sanitaire et sociale, la Division du partenariat, le Bureau de Gestion*	Coordinates the activities of development partners; oversees development of the National Health Development Plan and monitors its implementation and evaluation; promotes and coordinates research in the health sector; conducts studies and statistical analyses; develops national health accounts
Direction des laboratoires Includes: *la Division des Etudes et de la Documentation, la Division de la Réglementation et du Contentieux, la Division des Laboratoires publics, la Division des Laboratoires privés, la Division du Réseau national de Laboratoires, le Bureau de gestion*	Develops, implements, and monitors policies and programs regarding laboratories; regulates public and private laboratories
Direction générale de l'action sociale	Develops and implements the National Social Action Policy; promotes health, social, and economic integration of disadvantaged social groups; protects the rights of people with disabilities and the elderly

Name	Role
Direction de la lutte contre la maladie Includes: *la Division de Lutte contre les Maladies transmissibles, la Division de Lutte contre le Sida et les Infections sexuellement transmises, la Division de Lutte contre les Maladies non transmissibles, la* *Division de la Santé Bucco-Dentaire, la Division de la Santé mentale, la Division de la Médecine traditionnelle*	Organizes the national response against communicable diseases such as AIDS, malaria, and tuberculosis; regulates traditional medicine, dentistry, and mental health practices; coordinates with the private sector to combat priority diseases
Cellule de lutte contre la malnutrition	Provides technical assistance in the definition and implementation of national nutrition policy; assists the prime minister in defining political strategies for nutrition; coordinates with other ministries, NGOs, and CBOs on nutrition policy
Programme national de lutte contre le paludisme	Implements the national malaria response while coordinating with actors from all sectors; distributes mosquito nets to the nonprofit sector via district health offices
Programme national de lutte contre le VIH-SIDA	Coordinates the national fight against AIDS
Direction des pharmacies et des laboratoires Includes: *la Division des études, de la réglementation et de la documentation; la Division du contrôle administratif des médicaments; la Division des stupéfiants et des substances psychotrope; la Division des Laboratoires d'analyses médicales; le Bureau de Gestion*	Monitors the implementation of policy and programs in the medical and pharmaceutical fields; ensures compliance with medical and pharmaceutical laws and regulations; regulates traditional medicine
Direction des établissements de santé Includes: *la Division des Etablissements publics de Santé, la Division de la médecine privée, la Division des Etablissements privés de Santé, la Division de la Réglementation et du Contentieux, la Division du Suivi et de l'Evaluation, le Bureau de gestion*	Develops, monitors, and evaluates the implementation of hospital policy; regulates, supports, and monitors clinics and private practices while promoting their participation in the health system
Caisse de sécurité social	Provides family benefits in-kind and in-cash to families and employees of more than 10,000 affiliates; Social Security Fund health centers saw more than 9,000 sick children and 2,000 pregnant women in 2005
Direction des infrastructures et des équipements médicaux Includes: *la Division des Infrastructures, la Division des Equipements, la Division de la Maintenance, la Division des Etudes et de la Programmation, le Bureau de Gestion*	Manages and maintains facilities and infrastructure; collaborates in the acquisition of MOH and Social Action equipment; plans and designs construction projects

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