LESSONS LEARNED FROM THE EVALUATION OF THE INFORMED PUSH MODEL IN SENEGAL

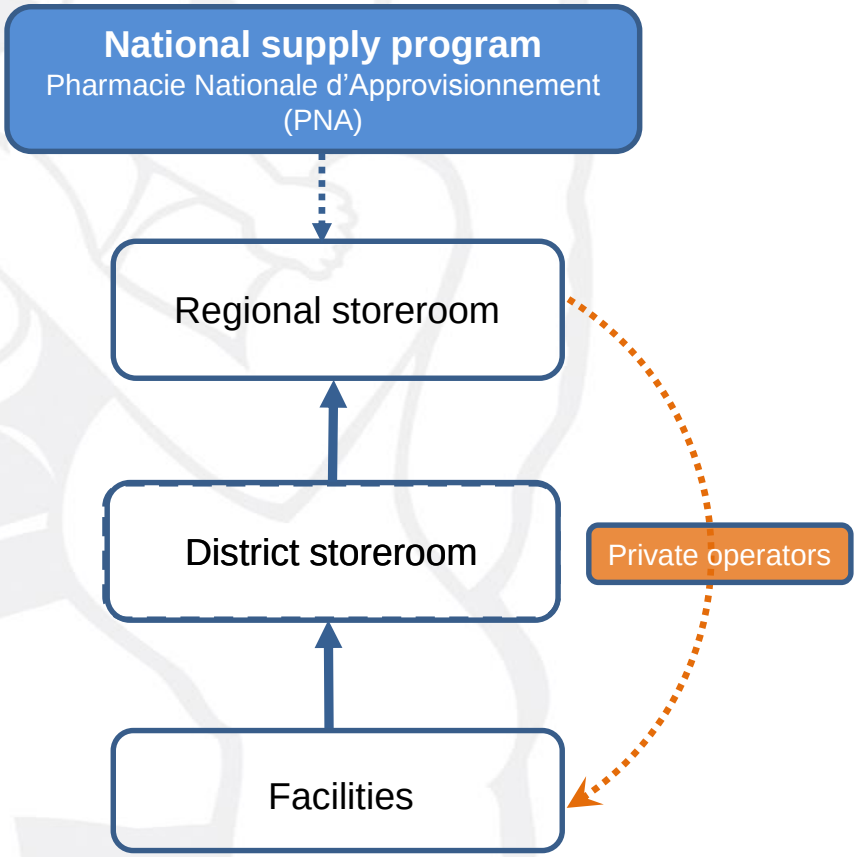
22nd March 2018 | Reproductive Health Supplies Coalition meeting
Brussels

Francesca Cavallaro, Diane Duclos, Tidiane Ndoye, Sylvain Faye, Loveday Penn-Kekana, Jenny Cresswell, John Bradley, Christian Yao, Issakha Diallo, Elizabeth McElwee, Macaire Bakeu, Adama Faye, Caroline Lynch

Family Planning in Senegal

- Increase in contraceptive use slower and later in sub-Saharan Africa than other regions – particularly West Africa
- In Senegal, 12% of married women used modern contraception and 30% had unmet need for FP in 2010-11
- The Ministry of Health and Social Action introduced the National Family Planning Action Plan – including the Informed Push Model launched in 2012
- Contraceptive stock-outs are a concern in sub-Saharan Africa, and knowledge of “best practices” in supply chain management is limited

What was the Informed Push Model?



Three key innovations:

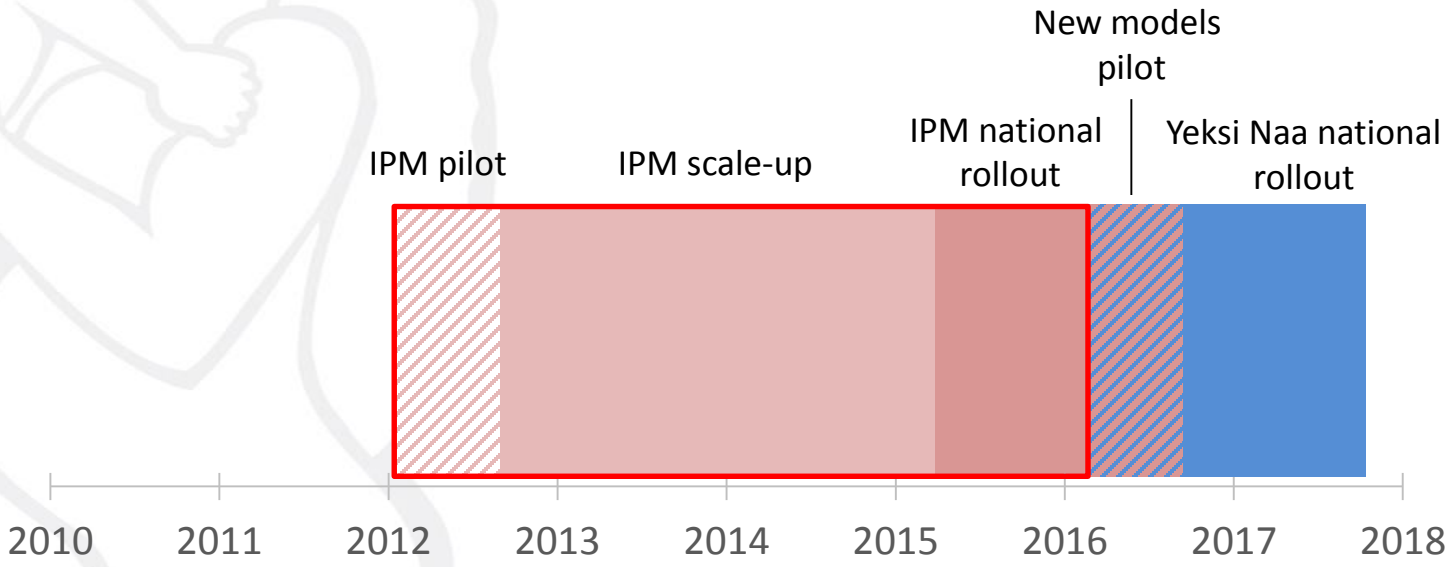
- Outsourcing distribution to Private Operators with pay-for-performance contracts
- Payment in arrears
- Electronic data system and standardised calculation for stock quantities

COMPREHENSIVE EVALUATION APPROACH

- Importance of comprehensive, independent evaluations
  - Impact evaluation
  - Process evaluation
  - Economic evaluation

Research question	Methods used
1. How did the IPM function?	• Theory of change • In-depth interviews
2. Did the IPM work?	• Analysis of continuous DHS and SPA • Analysis of stock cards and FP registers collected in facilities
3. What was the context in which the IPM was implemented?	• In-depth interviews • Focus group discussions • Observations of private operators
4. How much did the IPM cost?	• Survey of health facilities • Document review

TIMELINE


New models pilot
IPM national rollout
Yeksi Naa national rollout
IPM pilot
IPM scale-up
2010
2011
2012
2013
2014
2015
2016
2017
2018

KEY FINDINGS

- The availability of contraceptives in health facilities has improved substantially since the IPM was implemented
- Intensive supervision and involvement of health system actors were key factors in the successful implementation of the IPM
- However, the IPM did not have a direct impact on contraceptive use at the national level

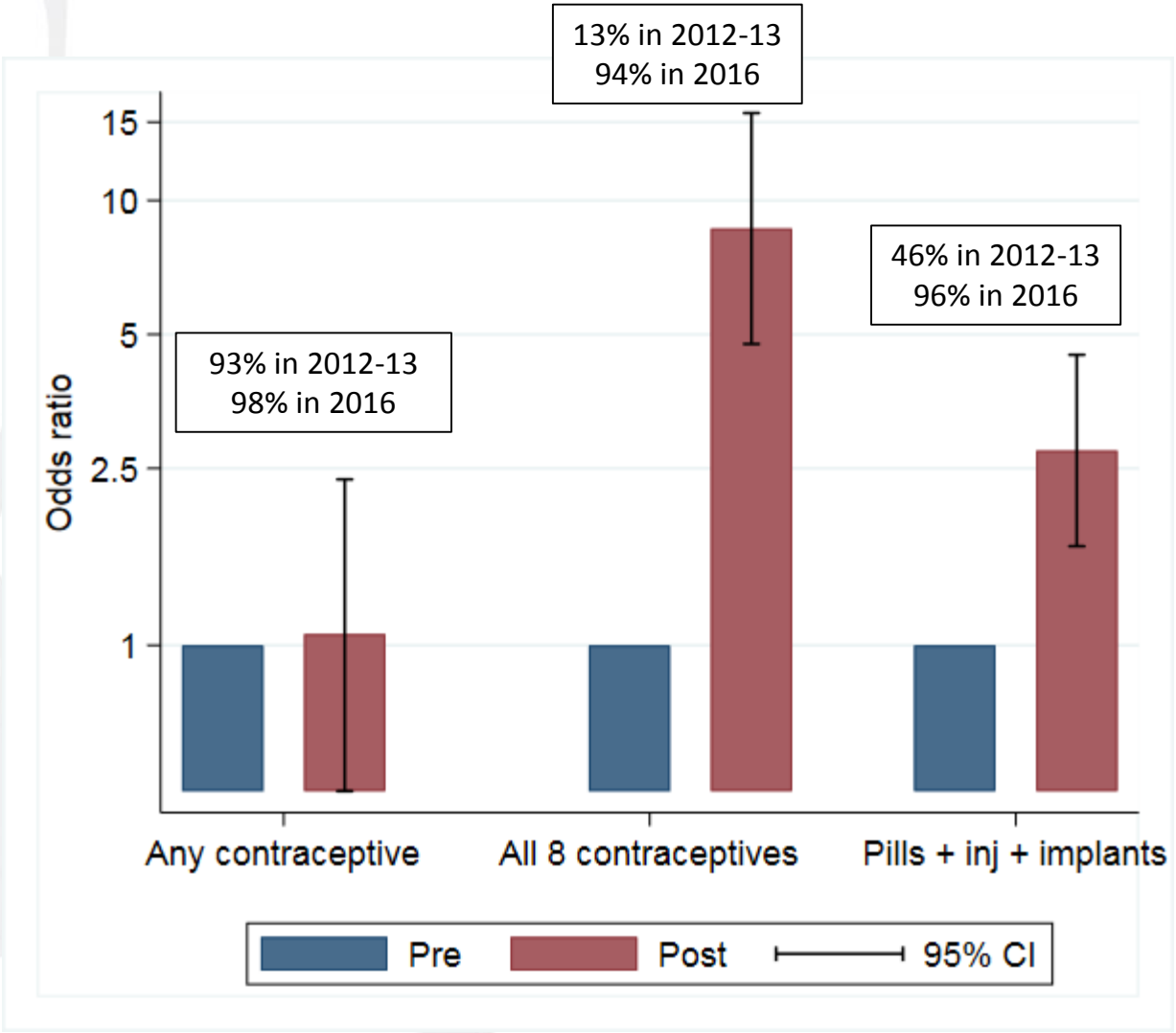
What was the effect of the IPM on stock availability?

Different start dates by region

Pre: 2012-13, 2014

Post: 2012-13, 2014, 2015, 2016

8 contraceptives:
- Combined pill
- Progesterone-only pill
- Injection
- Implant
- IUD
- Male condom
- Female condom
- Collier



What factors facilitated the implementation of the IPM?

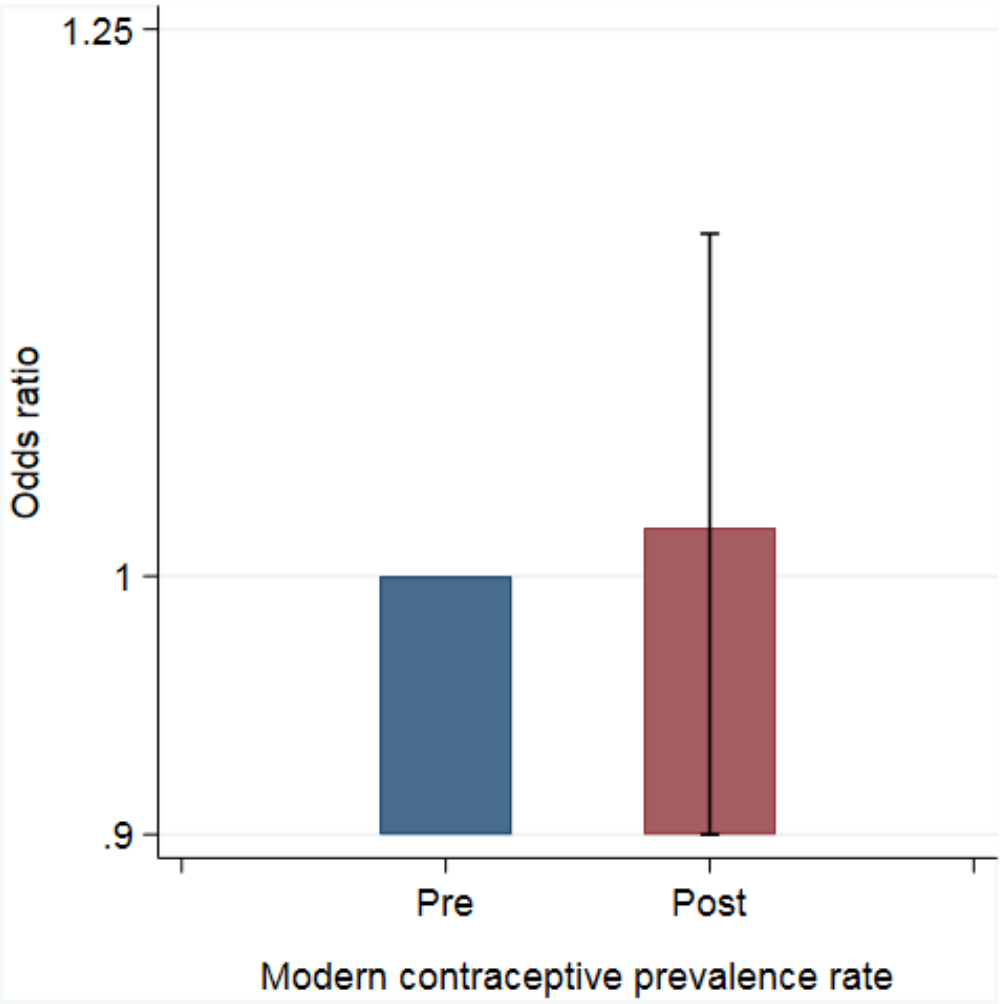
- Strong commitment from the Ministry of Health and Social Action, as well as accreditation with incentives and training of public health providers
- Time-intensive supervision and support for POs provided by pharmacists and assistant logisticians, most of whom had worked in the Senegalese public health system, and continuous presence on the ground
- Responsiveness of implementer to national and local contexts
- Importance of relationship between POs and health personnel, in particular with stockists (*dépositaires*)
- Data management system feeding information up to implementer M&E department in real time; however delays reported in information reaching local health system actors

What was the effect of the IPM on contraceptive use?

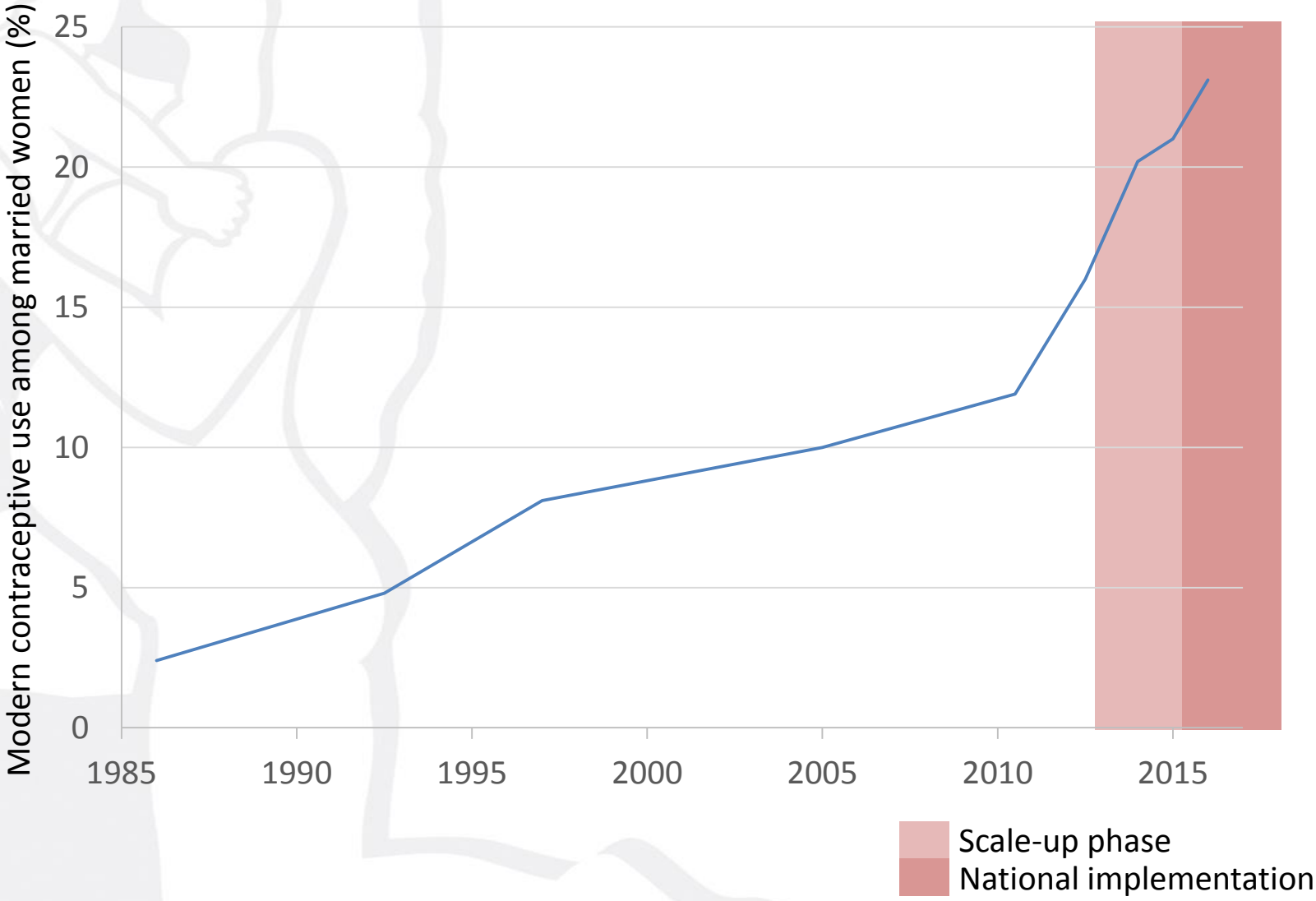
Different start dates by region

Pre: 2005
- 2010-11
- 2012-13
- 2014

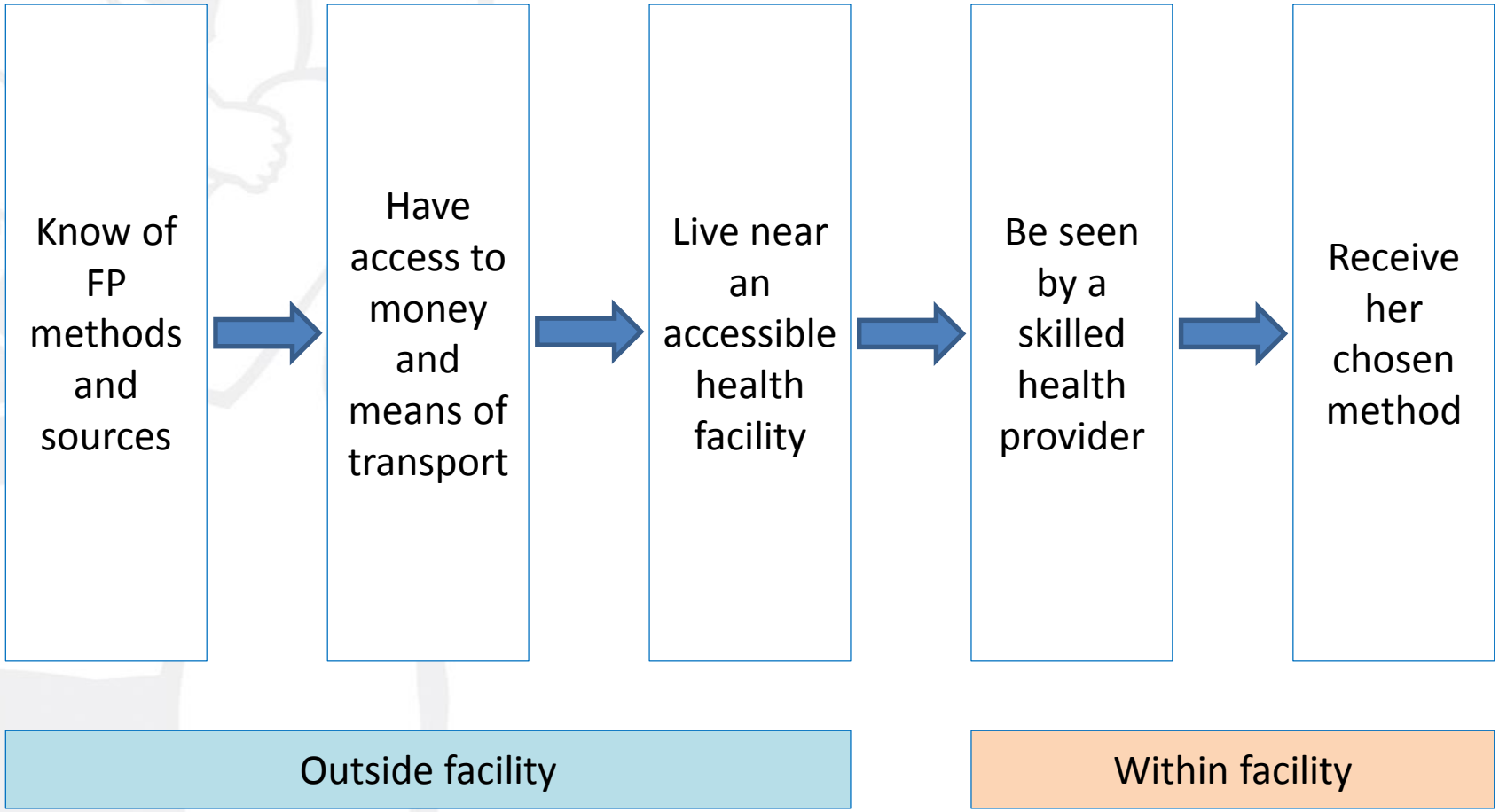
Post: 2012-13
- 2014
- 2015
- 2016



What was the underlying trend in contraceptive use?



PATHWAY TO ACCESSING CONTRACEPTIVES



What remaining supply-side barriers might prevent the translation of stock availability into contraceptive use?

- Frequent problems with operating hours of FP services and storeroom
- Stock-outs commonly reported for auxiliary products (not included in IPM)
- Costs for consultation fee, auxiliary products and consultation cards not harmonised
- Occasional reports of gaming by private operators

LESSONS LEARNED

- The IPM addressed problems with transport, cash flow and stock forecasting, thereby tackling the multiple causes of stock-outs
- MoHSA leadership and involvement of public providers helped create buy-in from key players in the health system
- Time-intensive supervision of private operators by supervisors with prior experience in health system was critical for successful implementation and for the required flexibility in rolling out the intervention
- Ensuring contraceptives are available in facilities is not sufficient to ensure that women receive them

POLICY RECOMMENDATIONS

- Supervision and tailored adaptation to the health system is key for success of supply chain management
- Auxiliary products should be included
- Important to assess and improve the availability of FP service provision within facilities
- Other supply-side interventions (e.g. targeting cost) and demand-side interventions are needed

THANK YOU

met-lshtm.com

met@lshtm.ac.uk

@MET_LSHTM

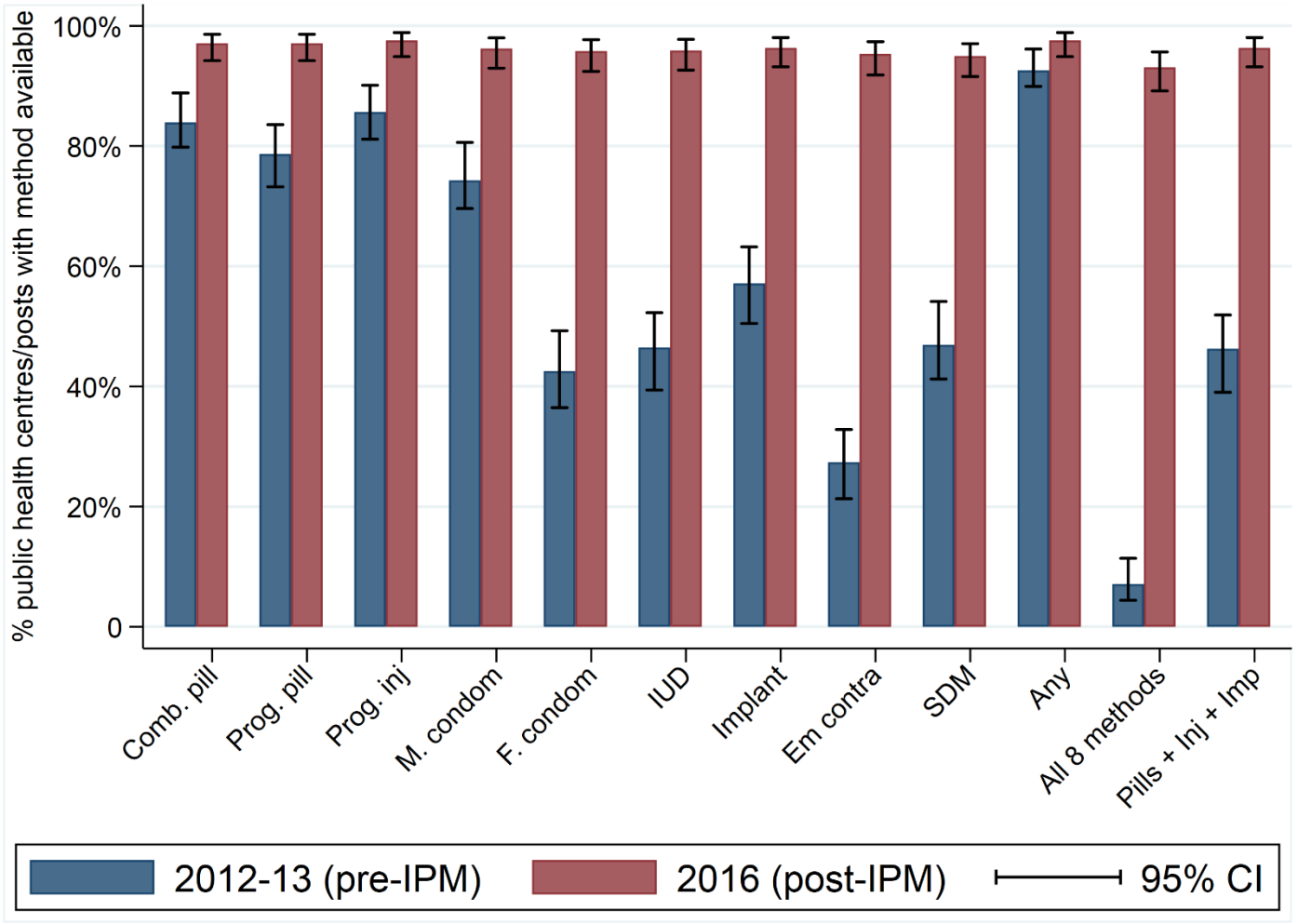
The research in this presentation was supported by funding from MSD, through its *MSD for Mothers* program. MSD had no role in the design, collection, analysis and interpretation of data, in preparation of the presentation, or in the decision to submit the manuscript for publication. The content of this presentation is solely the responsibility of the authors and does not represent the official views of MSD. *MSD for Mothers* is an initiative of Merck & Co., Inc., Kenilworth, N.J., U.S.A.

MSD

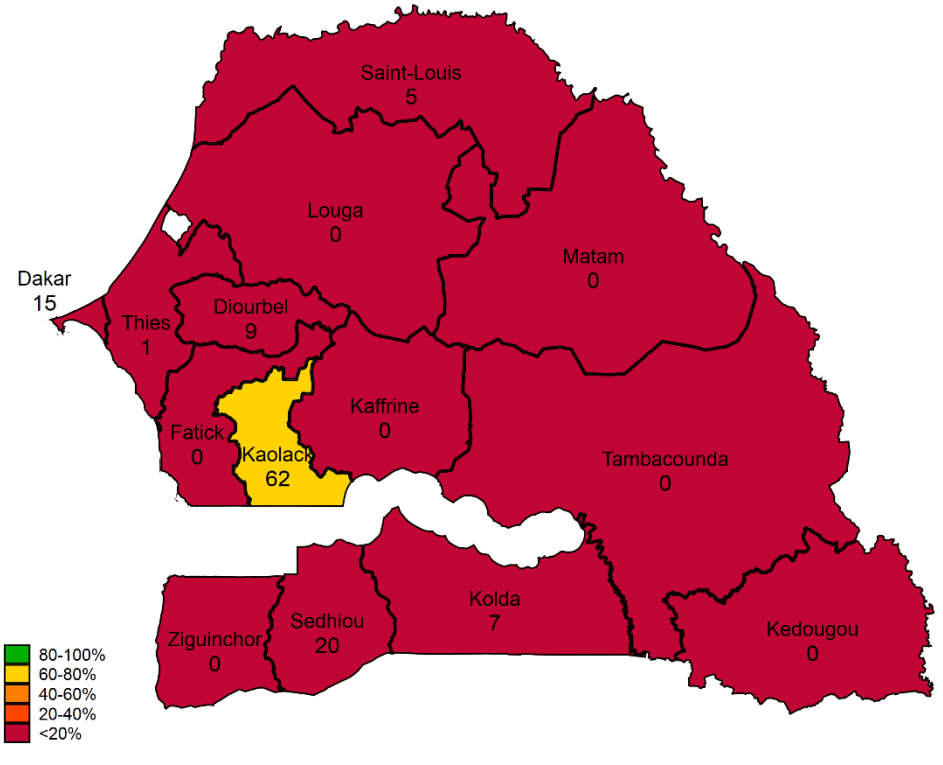
MSD for mothers

Committed to Saving Lives

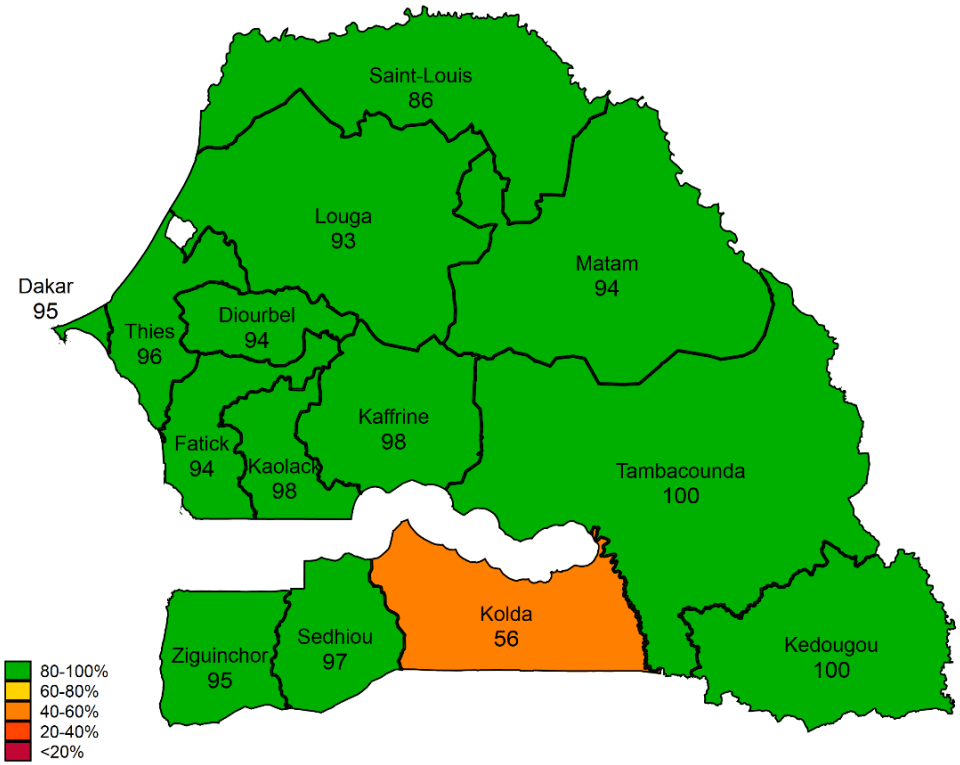
STOCK AVAILABILITY BY METHOD



STOCK AVAILABILITY (ALL METHODS) BY REGION

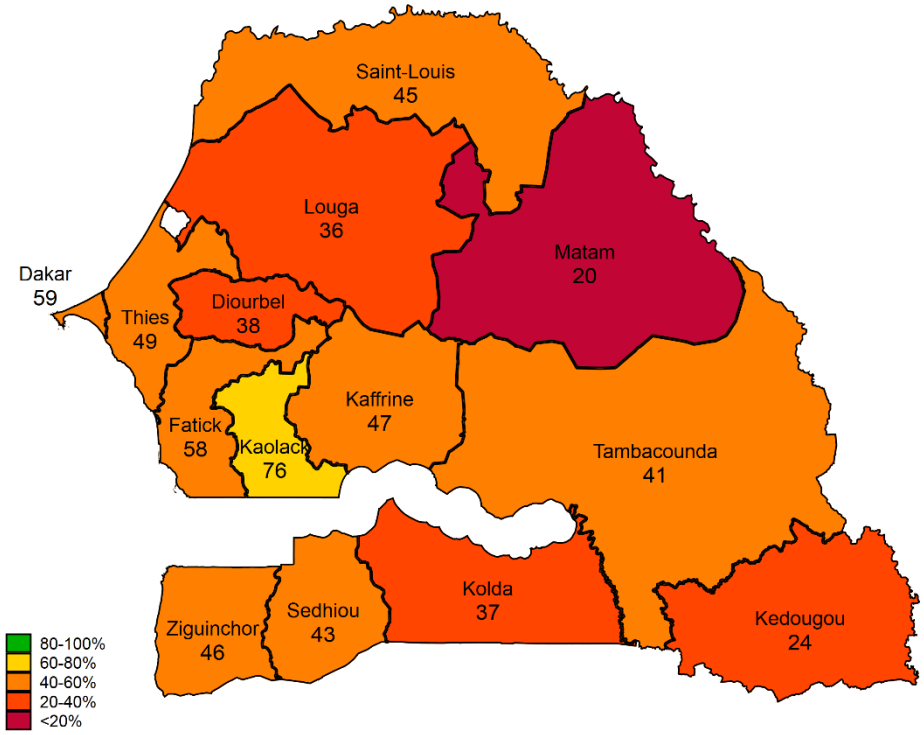


All facilities in 2012-13 (pre-IPM)

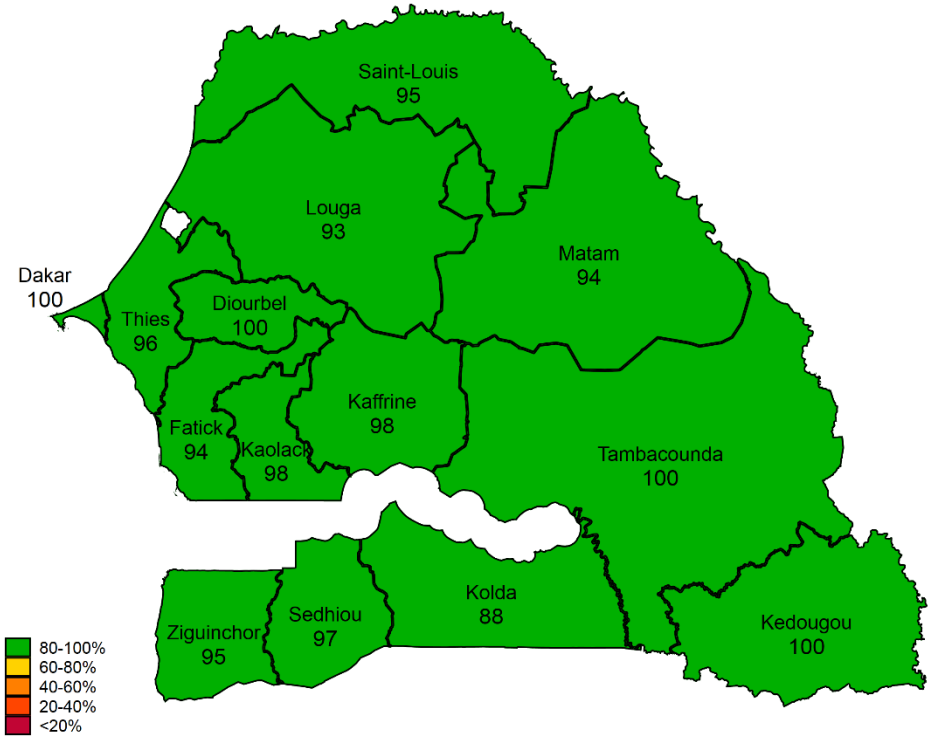


All facilities in 2016 (post-IPM)

STOCK AVAILABILITY (PILLS + INJECTABLES + IMPLANTS) BY REGION



All facilities in 2012-13 (pre-IPM)



All facilities in 2016 (post-IPM)