

An Evaluation Of Informed Push Model In Senegal

An outsourced private sector supply chain for contraceptives in Senegal

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Public-Private Relationships What Does It Take To Succeed
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Why Do The Intervention?

- Very low use of modern contraceptives
- Stock outs were a huge problem
- Bottlenecks: commodity flow, data flow, financial flow
- Contributing factors: reliance on care providers, complex system

Key Findings

Stockouts weren't such a huge problem

Availability of a range of contraceptives in health facilities has improved substantially

Commodity flow, data flow, financial flow improved

IPM Intervention still quite complex

Intensive supervision and involvement of health system actors at all levels

Stockists – not health care workers – did a lot of the work

IPM did not have a direct impact on contraceptive use at the national level

Evaluation of IPM-3PL

Mixed-methods approach using a **Theory of Change (ToC)** framework

Quasi-experimental quantitative design

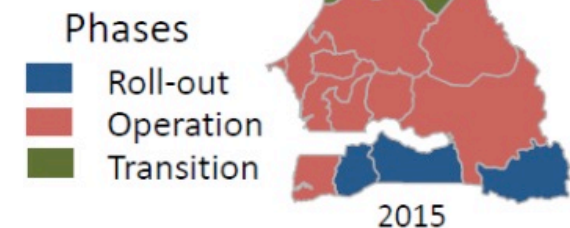
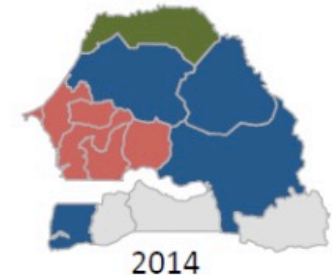
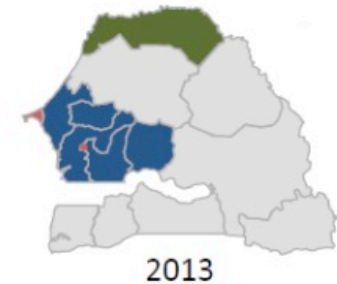
- Secondary data
- Primary data collection – stock cards in 9 regions

Qualitative

- Participant Observation
- In-Depth Interviews
- Reflective Diaries

Costing components

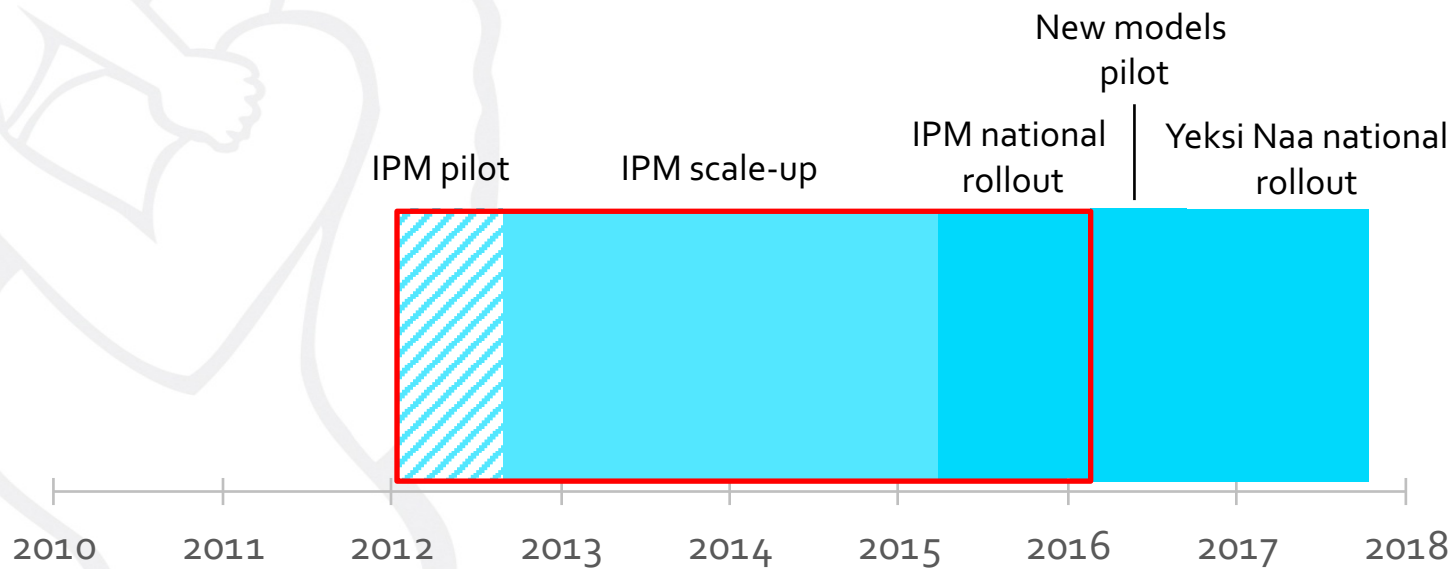
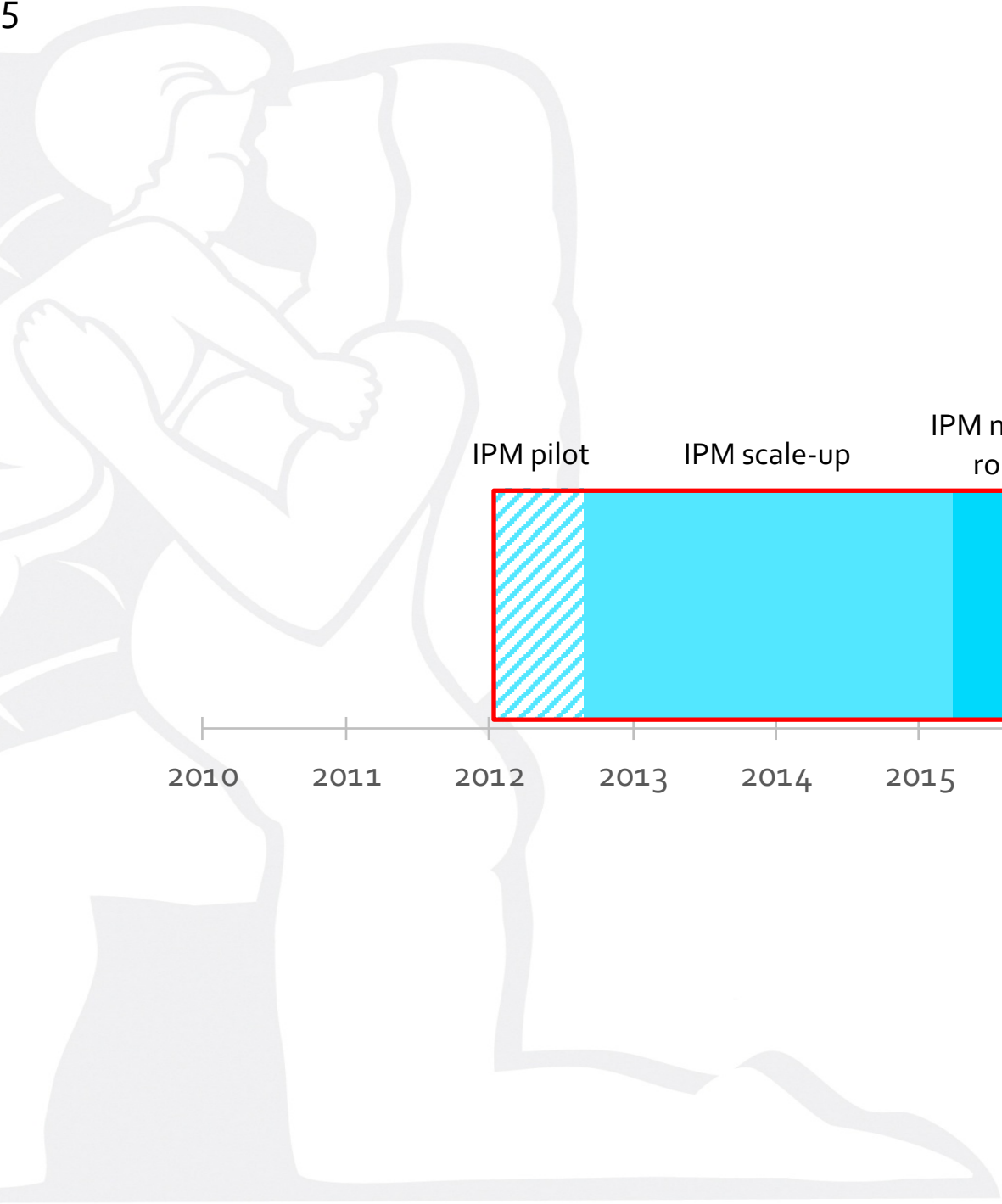
- Survey, document review, interviews



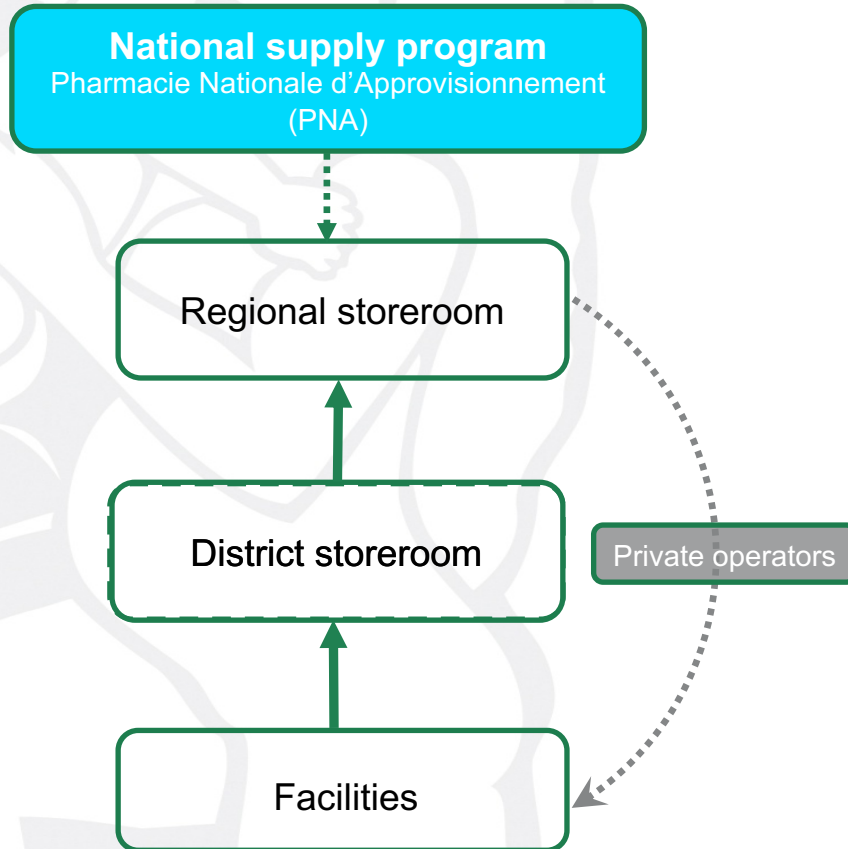
COMPREHENSIVE EVALUATION APPROACH

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

Research question	Methods used
1. How did the IPM function?	<ul style="list-style-type: none">• Theory of change• In-depth interviews• Participant observation/ Reflective Diaries
2. Did the IPM work?	<ul style="list-style-type: none">• 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?	<ul style="list-style-type: none">• In-depth interviews• Focus group discussions• Observations of private operators
4. How much did the IPM cost?	<ul style="list-style-type: none">• Survey of health facilities• Document review



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

What was the effect of the IPM on stock availability?

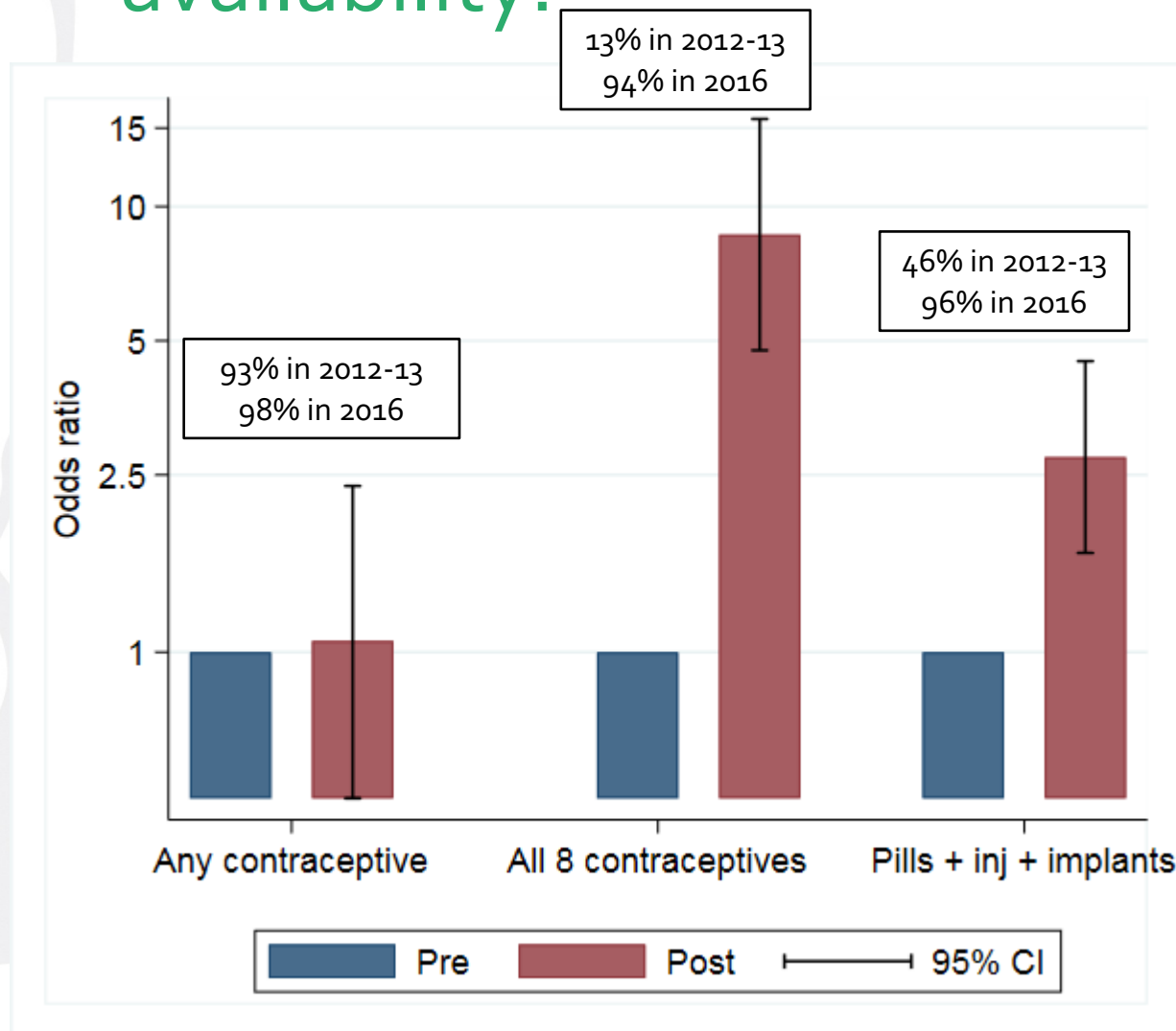
Different start dates by region

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



How The Programme Worked On The Ground

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A contract signed to avoid stockouts

PO have **signed a contract** with IntraHealth to avoid the stock outs <2%

- In theory, IntraHealth staff controlled Private Operators performance through auditing mechanism
- Private Operators did not operate independently
- ***IntraHealth pharmacists and assistant logisticians** at regional level were the interface between public and private*
- ***Private operators entry and functioning*** relied on public health experience of Intrameal teams at all levels
- Not a private sector intervention, but a mixed system with a common goal to eliminate stock-outs
- Overstocking an issue



No record of penalisation during the fieldwork

- Assistant logisticians and pharmacists valued their **role as supervisors and mentors** rather than **auditors**

Temporal dimensions of partnerships

- Over time, POs *were well accepted* into the system.
 - The relationships built over time
 - In a context where it takes time to develop ***relationships and expertise***, this temporal dimension is key to understand and redefine private sector “performance”

Important Factors For Successful Implementation

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

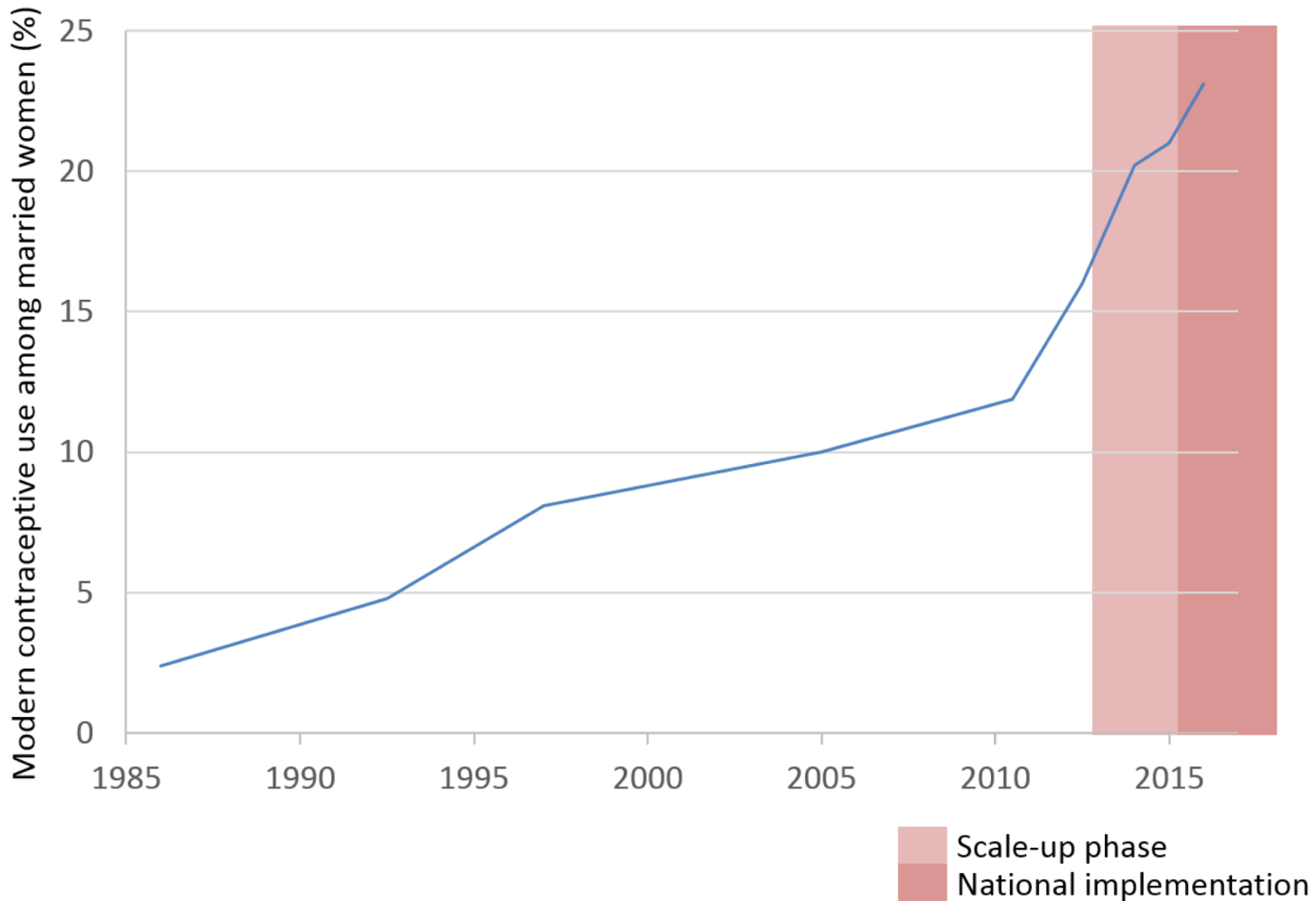
Responsiveness of implementer to national and local contexts

- Importance of involvement of the district e.g. in cost-recovery
- District involved in the “rayon privé” for private facilities and difficult to access public health posts

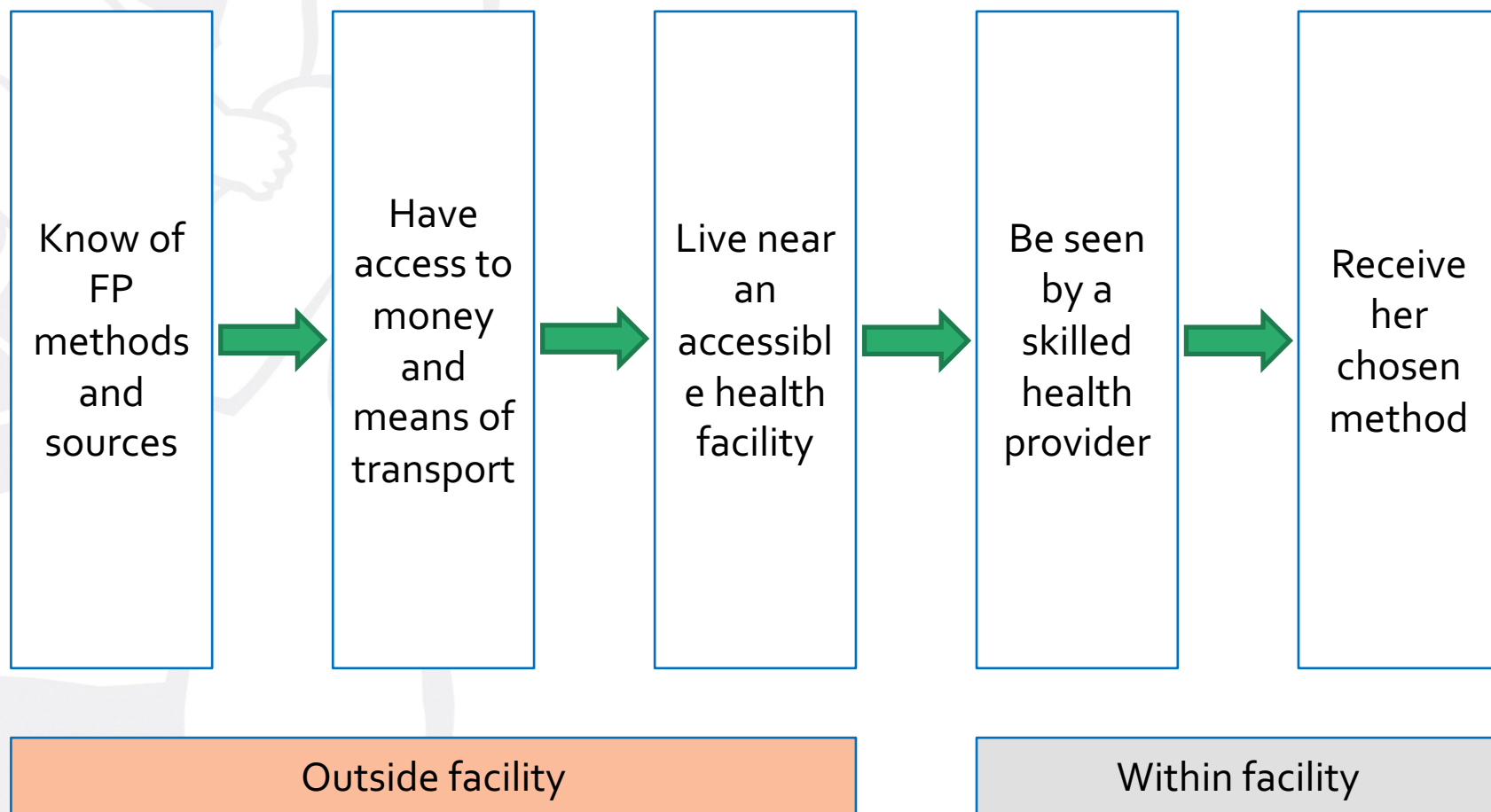
Importance of relationship between POs and health personnel, in particular with stockists (*dépositaires*)

Data management system feeding information up to implementer M&E department in real time; however delays were reported in information reaching local health system actors

Did IPM-3PL increase MCPR?



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
"Sometimes you see someone who misses their appointment for days and who tells you [...] they couldn't come because of the opening hours"
Matrone
- Stock-outs commonly reported for auxiliary products (not included in IPM)
"Sometimes there are also stock-outs of xylocaine [local anaesthetic] which cause problems." Midwife
- Costs for consultation fee, auxiliary products and consultation cards not harmonised
"Auxiliary products patients have to pay for and it is more expensive for women" Regional reproductive health coordinator
- Occasional reports of gaming
"Once, I had patients when we only had 3 boxes left, and the delivery was planned 3 days later. In this situation, X asks us not to use them to avoid stock-outs." Stockist

The IPM addressed problems with transport, cash flow and stock forecasting, thereby tackling the multiple causes of stock-outs

Improvements took time, skilled management and money

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

Transparency and flexibility important

Ensuring contraceptives are available in facilities is not sufficient to ensure that women receive them

Key Lessons For Public-Private Partnerships

- The private sector is varied and not always active in areas where “last mile” efforts need to be focused
- Many public-private initiatives – including IPM and the Social Franchise models we - involve dedicated staff at the NGO putting in a lot of work and costs into making the programme work (or not) – the cost and other implications of this for scale up of such programmes is often not openly discussed & impacts sustainability issues
- Huge experience in the public health system – public bureaucratic – private efficient – is gross simplification
- Contracting/regulating private health care provision is challenging – needs financial and intellectual resources
- If as much time/resources invested in public sector – would they have achieved as good results
- Or is the private sector too constrained by intermediaries

Thank You

To all the Senegalese health care workers who work in often challenging conditions, for little pay, who make the system run – and had to spend ages answering our questions

To the Senegalese women who have so much to do – but answered our questions on private and personal issues

To everyone involved in the IPM at all levels

To the funders and implementors who were brave enough to allow an external evaluation



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