ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: SENEGAL

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Croix-Rouge sénégalaise / Croix-Rouge française / Guillaume Bassinet

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JSI RESEARCH & TRAINING INSTITUTE, INC.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@advancingpartners.org
Web: advancingpartners.org

ACRONYMS

APC	Advancing Partners & Communities
ASC	agent de santé communautaire (community health agent)
CDSC	comité départemental de santé communautaire (departmental community health committee)
CHS	community health system
CLSC	comité local de santé communautaire (local community health committee)
CNSC	comité national de santé communautaire (national community health committee)
DSDOM	dispensateur de santé à domicile (home-based care provider)
FP	family planning
IUD	intrauterine device
LLIN	long-lasting insecticide-treated net
MNCH	maternal, newborn, and child health
MSAS	Ministère de la santé et l'action sociale (Ministry of Health and Social Action)
NGO	nongovernmental organization
PSSC	Programme santé / santé communautaire (Community Health Program)
TB	tuberculosis
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

SENEGAL COMMUNITY HEALTH OVERVIEW

In 2014, Senegal's Ministry of Health and Social Action (MSAS) developed a single, national strategy to harmonize community health programs and initiatives into one integrated approach. Two main documents outline the national strategy: the *National Community Health Policy* a regulatory framework that outlines the strategy's goals; and the *National Community Health Strategic Plan*, henceforth called the *Strategic Plan*, which guides implementation of community activities through a holistic approach to achieve three main objectives:

1. Improve coverage and quality of community health services.
2. Strengthen community participation in problem-solving of health issues.
3. Ensure sustainability of community health interventions.

Senegal's recent community health strategy aims to overcome challenges including poor health service coverage; inequity in access; insufficient harmonization of service packages; poor integration of community health in the overarching health system structure; a lack of community health actor motivation; and ineffective supply systems for essential medicines and products. The *Strategic Plan* also outlines key information about the financing approach, details a monitoring and evaluation framework, and defines the roles and relationships of a variety of community health actors, from community health providers to health committees to the management bodies responsible for planning and implementing community initiatives. Finally, it details a package of preventive, promotional, and curative community health services and includes a set of annexes describing seven innovative community health projects that will be implemented.

The *National Community Health Policy and Strategic Plan*, along with a number of other policies and strategies, provide guidance across different health areas, such as tuberculosis (TB), malaria, and FP, and detail key elements of community health provider roles and processes, such as selection criteria, training, supervision, reporting, referrals, relationships with community groups, and incentives. There are policy gaps, including an absence of guidance about community health provider selection processes, unclear direction for community data use and decision making, and little mention of the private sector's role in delivering community services.

Bajenu gox are respected female community leaders trained to promote maternal and child health.

There are five main community health provider cadres in Senegal. The *Strategic Plan* separates them into two categories. The first provide promotional, preventive, and curative services and includes: 1) *matrones*; 2) *agents de santé communautaires* (ASC), or community health agents, and; 3) *dispensateurs de santé à domicile* (DSDOM), or home-based care providers. ASC and matrones work from small, community-based facilities called health huts and provide a range of basic health services. DSDOM work within designated areas called home-based care sites where they provide care for malaria, diarrhea, and acute respiratory illnesses in children. The second category of community health providers comprise *relais communautaires* (relais), or community volunteers; and *bajenu gox*, meaning godmothers, who support community maternal and child health initiatives. This category of community health providers conducts promotional and preventive interventions exclusively and refers clients to ASC and matrones for services they cannot provide.

Table 1. Community Health Quick Stats

Main community health policies/ strategies	*National Community Health Policy (Politique Nationale de Santé Communautaire 2014–2018)*		*National Community Health Strategic Plan (Plan Stratégique National de Santé Communautaire 2014–2018)*		
Last updated	2014		2014		
Number of community health provider cadres	5 main cadres				
	Agents de santé communautaire (ASC)	Bajenu gox	Dispensateurs de santé à domicile (DSDOM)	Matrones	Relais communautaires (relais)
Recommended number of community health providers	4,200 ASC and matrones[1]	3,406 bajenu gox	*Information not available in policy*	4,200 ASC and matrones[1]	15,000-23,069 relais[2]
Estimated number of community health providers	3,748 ASC and matrones	7,500 bajenu gox	1,992 DSDOM	3,748 ASC and matrones	7,435 relais
Recommended ratio of community health providers to beneficiaries	1 ASC: 3,000 people[3]	1 bajenu gox: 100 households[4]	1 DSDOM: 1 home-based care site[5]	1 matrone: 3,000 people	1 relais: 250 people
Community-level data collection	Yes				
Levels of management of community-level service delivery	National, regional, health district, community				
Key community health program(s)	Community Health Program (PSSC); Bajenu Gox Program, other programs in health-specific areas (e.g., TB, malaria, HIV and AIDS)				

[1] There are approximately 4,200 ASC and matrones needed. This is a calculation based on an estimation of 3,748 ASC and matrones in 2010 and a gap of about 450, according to the *Strategic Plan*.
[2] Between 15,000 and 23,069 relais, depending on the estimate. The first calculation is from the 1 Million Community Health Workers Campaign, and the second from a national analysis. Both are cited in the *Strategic Plan*.
[3] ASC and matrones work out of health huts, which are intended to cover 3,000 people.
[4] Equivalent to approximately 1,000 people.
[5] Policy stipulates one DSDOM per home-based care site, which covers a village or hamlet.

The 2014 community health strategy provides guidance for Senegal's many community programs and initiatives. One flagship program is the Community Health Program (PSSC) supported by USAID/Senegal and implemented nationally by a consortium of nongovernmental organizations (NGOs). Since 2006, the PSSC has supported the MSAS by helping communities establish, equip, and sustain health huts; training community health providers in health areas like FP, maternal and child health, and nutrition; conducting supportive supervision; and promoting health behavior change communication and community participation in health. 2016 marks the beginning of a new iteration of the program that will focus on the integration of services and health behavior change. While USAID/Senegal funds the PSSC, actors from all levels of the health system—from the MSAS to communities themselves—are accountable for community health initiatives, such as operating health huts.

Another noteworthy community health program in Senegal is the bajenu gox program, which was officially launched in 2009 with the goal to improve uptake of maternal, newborn, and child health (MNCH) services through the support of bajenu gox, who are respected female community members trained to promote maternal and child health. The bajenu gox program is led by the MSAS and steering committees at the national, district, and local levels. In communities, NGOs and development partners provide training as well as technical and financial support to bajenu gox to implement community

health activities at the district and community levels. The program operates in rural, urban, and peri-urban areas nationwide. Other health programs in Senegal, such as those that are specific to certain health areas, like HIV and AIDS, malaria, and WASH, also include community components.

In Senegal, health committees support community health providers and connect health structures with community members. They also help operate health huts and community sites, which are areas in communities where services may be delivered. The *Strategic Plan* indicates that community health actor networks also play a role in organizing and financing community health activities. The MSAS intends to formalize these networks and strengthen their capacity to improve service quality and reach.

Table 2. Key Health Indicators, Senegal

Total population[1]	14.8 m
Rural population[1]	55%
Total expenditure on health per capita (current US$)[2]	$50
Total fertility rate[3]	5.0
Unmet need for contraception[3]	25.6%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	20.3%
Maternal mortality ratio[4]	315
Neonatal, infant, and under 5 mortality rates[3]	19 / 33 / 54
Percentage of births delivered by a skilled provider[3]	59.1%
Percentage of children under 5 years moderately or severely stunted[3]	18.7%
HIV prevalence rate[5]	0.5%

[1]PRB 2016; [2]World Bank 2016; [3]Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], and ICF International 2015; [4]World Health Organization 2015; [5]UNAIDS 2015.

Gender issues are not mentioned in main community health policies but are incorporated into other national health documents. The *National HIV/AIDS Strategic Plan 2014–2017* emphasizes training of community health providers, such as bajenu gox and relais communautaires, to conduct gender-based violence prevention and sensitization through regular community dialogue and home visits. The *National Sexual and Reproductive Health Norms and Protocols* address female genital mutilation / cutting and sexual violence. Furthermore, the *National Sexual and Reproductive Health Action Plan for Adolescents and Youth (2014–2018)* highlights the importance of integrating gender into sexual and reproductive health interventions targeting adolescents and youth.

LEADERSHIP AND GOVERNANCE

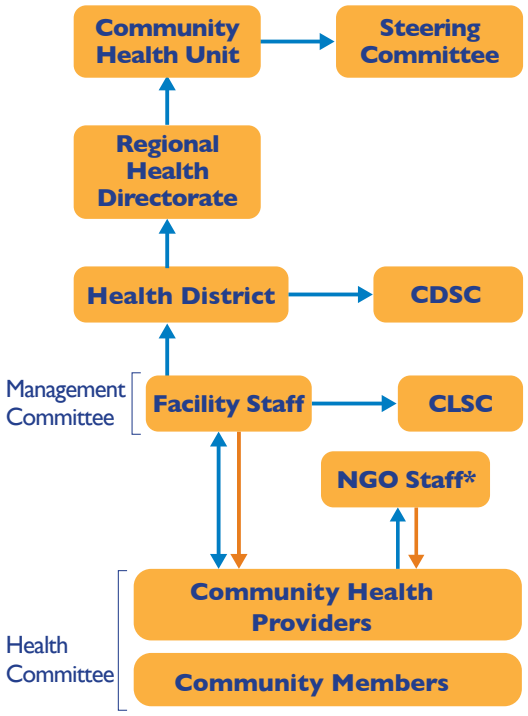
Community-level service delivery in Senegal is coordinated and implemented at the national, regional, health district, and community levels.

- Under the supervision of the Directorate-General for Health, the Community Health Unit is the central community health planning body at the **national level**. It creates community health policy, curricula, and tools; defines the package of services; coordinates community health activities; and documents community health experiences. The community health steering committee, with representatives from civil society, various ministries (health, education, local government, youth, family, etc.), technical and financial partners, NGOs, and local and community authorities, supports the Community Health Unit to produce policies and materials, monitors community health implementation, and ensures sharing of successful community health innovations and experiences. The national community health committee (CNSC), which has similar representation to the community health steering committee, develops a multi-sectoral strategy and provides support, motivation, and validation of community health issues.
- The primary health care (PHC) division of the **regional** health directorate oversees community health and works closely with the Community Health Unit at the national level.
- The departmental community health committee (CDSC), with representation from civil society, various sectors, NGOs, local and community authorities, etc. meets every trimester to monitor and coordinate community health activities at the **health district** level. It also ensures quality of community health data in conjunction with health district officials, who compile the data. The *Strategic Plan* outlines two options for district-level implementation: 1) tasking a district executive team to link the regional level with the health centers and posts; or 2) relying on staff in health facilities and local authorities to implement the strategy if they have the technical capacity.
- At the **community level**, the local community health committee (CLSC), a multi-sectoral body resembling the CDSC and CNSC in composition, is responsible for health activity monitoring and developing an annual work plan. Multiple actors collaborate to implement the strategy:
  - Community members, through networks and organizations, construct health huts; conduct and monitor community health activities; finance activities; and serve on health committees.
  - Community health providers—ASC, matrones, DSDOM, bajenu gox, and relais—deliver health services under the supervision of facility staff at health posts and health centers and NGO staff.
  - Health committees, comprising community members, connect health facilities with communities; support community health providers; conduct health promotion; and contribute to community health financing.
  - Management committees draft budgets, activity accounts, and ensure repairs for community health facilities and sites.

Figure 1 summarizes Senegal's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	Community Health Unit Steering Committee CNSC	National Hospital	
Regional	Regional Health Directorate	Regional Hospital	
Health District	CDSC Health District Officials	Health Center	
Community	CLSC Health Committee Management Committee	Health Post Health Hut Community Site	



* NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

Community health providers in Senegal deliver health services from health huts that are managed by community members.

As previously noted, Senegal has five main cadres of community health providers, which the national community health strategy places in two distinct groups. Community care actors—ASC, matrones, and DSDOM—may provide a variety of promotional, preventive, and curative services. Community promotion and prevention actors—bajenu gox and relais—focus on health promotion and prevention. The summary below provides more information on the services for which each community health provider type is responsible.

- ASC provide an array of basic health services from health huts and in communities, including but not limited to MNCH, adolescent health, FP, nutrition, malaria, TB, HIV and AIDS, and WASH. ASC are often also matrones.
- Matrones also work from health huts and in communities. They provide services to women during pregnancy, delivery, and during the postnatal period. Matrones are often also ASC.

- DSDOM have traditionally worked in malaria prevention and case management but their service package recently expanded to include providing integrated home-based care for uncomplicated cases of malaria, diarrhea, and acute respiratory infections and referring clients to health posts and centers for complicated cases. They are also expected to conduct community mobilization on these three illnesses, community sensitization on early care-seeking, and promote LLIN use for pregnant women and children under five years and indoor residual spraying in targeted areas. They work in specifically designated sites for home-based care in villages or hamlets.
- Relais conduct information, education, and behavior change activities across many health areas, including but not limited to MNCH, adolescent health, FP, nutrition, malaria, TB, HIV and AIDS, and WASH. Relais may also deliver select curative interventions, such as management of acute malnutrition.[1] They work in communities within designated areas or sites.
- Bajenu gox are respected female leaders who are trained—often by NGOs working in partnership with the public health system—to improve MNCH through health promotion and to increase access to and uptake in services through community mobilization, referrals, and follow-up. Specifically, they support other community health providers in conducting promotional activities related to pre- and postnatal care, birth preparedness, institutional delivery, immunization, FP, child nutrition and disease prevention, female genital mutilation / cutting prevention, children's rights, and girls' education.

The *Strategic Plan* acknowledges the roles of traditional medicine practitioners in providing spiritual or alternative health care but does not include detailed guidance for them.

Policies do not explicitly discuss the relationships between all community health providers, but they imply that their roles are complementary.

Table 3 provides an overview of ASC, bajenu gox, DSDOM, matrones, and relais.

1 This information is per the 2014 national community health strategy. Previously, according to a 2010 relais training manual, relais could be trained to provide an even wider scope of curative services. However, because relais are included under the more general "community promotion and prevention actor" category in the new strategy, it is unclear if they now play a strictly promotional role or if there is flexibility in training them to provide select curative services as they previously were. Not all training curricula aligned with the 2014 strategy are available.

Table 3.1. Community Health Provider Overview: ASC, Bajenu Gox, and DSDOM

	ASC	Bajenu Gox	DSDOM
Number in country	3,748 ASC and matrones	Approximately 3,406	1,992
Target number	Approximately 4,200 ASC and matrones[1]	12,000	*Information not available in policy*
Coverage ratios and areas	1 ASC: 3,000 people ASC work out of a health hut, which covers approximately 3,000 people.	1 bajenu gox: 100 households, or approximately 1,000 people	1 DSDOM: 1 home-based care site, which covers a village or hamlet
Health system linkage	ASC are linked with head nurses at health posts, who train and supervise them. ASC refer complicated cases and submit monthly reports to them.	The bajenu gox program is government-led. Government health post staff and sometimes NGO partners train bajenu gox. Head nurses at health posts coordinate their action plans.	Head nurses at health posts train and supervise DSDOM. They also refer complicated cases to health posts.
Supervision	ASC may have three categories of staff involved in their supervision: head nurses and midwives based at health posts; NGO staff involved in community health programming; and midwives from district health offices.[2]	Supportive supervision of bajenu gox is fully integrated into action plans of head nurses at health posts and community development agents from NGOs. During field supportive supervision visits, head nurses and community development agents assess bajenu gox knowledge and current practices and review bajenu gox management tools using a supervision checklist. Head nurses submit supervision reports to district medical offices.[2]	DSDOM may have three categories of staff involved in their supervision: head nurses and midwives based at health posts; NGO staff involved in community health programming; and midwives from district health offices.[2]
Accessing clients	On foot Clients travel to them	On foot	On foot
Selection criteria	Between 17 and 45 years old Able to read and write in French or local language Preferably married Selected by the community Credible, honest, respectful, sociable, discrete, tolerant, available, dynamic, and welcoming Willing to serve community on a volunteer basis From the community that he or she serves Speaks local language Available and can complete many tasks according to a clear description	Resident of the community she serves Proven female leader (and recognized as such by her community) Chosen by community Identified as influential and charismatic Credible, modest, discrete, available, and respectful Good negotiation skills Committed to the development of her community Willing to perform unpaid work	*Information not available in policy*

Table 3.1. Community Health Provider Overview: ASC, Bajenu Gox, and DSDOM

	ASC	Bajenu Gox	DSDOM
Selection process	Authorities, including village chiefs and representatives of community-based organizations such as village associations and women's groups, select ASC. Available policies do not provide details about the specific process.	Selected by communities but available policies do not provide details about the specific process.	The community plays a role in selection and motivation, but available policies do not provide details about the specific process.
Training	At present there is an initial training, but the *Strategic Plan* recommends increasing the number of trainings and expanding ASC scope of work.	Training is not specified in available policy, but the *Strategic Plan* emphasizes it should be standardized and that there should be refresher trainings.	Available policies do not specify training details, but the *Strategic Plan* emphasizes it should be standardized and that there should be refresher trainings.
Curriculum	ASC curricula include: *Participant Manual for ASC, Matrones, and Relais* (2010). Includes modules on child health, reproductive health, FP, nutrition, malaria, and other health areas. *ASC/Matrone Manual* (no date). Includes 6 modules on management of common diseases and injuries; infection prevention; sanitation and hygiene; TB and sexually transmitted infections, including HIV and AIDS; available services; health hut organization and management. *Guide for Community Care Actors* (2014). Comprises modules detailing the services and interventions to be delivered as part of the integrated community health package.	*Training Guide for Bajenu Gox* (2010). Includes program information; maternal and newborn health; health in children under 5 years; advocacy for community mobilization; and managing activities. *Integrated Management of Childhood Illness: Community Prevention and Promotion Actor Manual* (2014).[3] Includes modules on prevention and management of malaria, diarrhea, respiratory infections, and immunizations.	*DSDOM Training Manual on Integrated Management of Diarrhea, Malaria, and Acute Respiratory Infections* (2013). Includes information on diarrhea; malaria; acute respiratory infections; the home-based care strategy; and monitoring and evaluation. *Guide for Community Care Actors* (2014).[4] Comprises modules detailing the services and interventions to be delivered as part of the integrated community health package.

Table 3.1. Community Health Provider Overview: ASC, Bajenu Gox, and DSDOM

	ASC	Bajenu Gox	DSDOM
Incentives and remuneration	May receive financial and non-financial incentives per guidance for all community health providers in the *Strategic Plan*. May be financed by the MSAS, the municipality, the community, NGOs, or as a fee for service. Financial incentives may include cash payments; allowances provided through funds generated by user fees and cost recovery systems; performance-based incentives; and cash from income-generating activities. Non-financial incentives may include membership in a community health provider cooperative; formal social recognition for service; badges; certificates; a commemoration day; and tickets for pilgrimages to holy places. Communities base incentives on the local context.	May receive financial and nonfinancial incentives per guidance in the *Bajenu Gox Program Strategic Guidelines* and the *Strategic Plan*. May be financed by the MSAS, the municipality, the community, NGOs, or as a fee for service. Financial incentives may include per diems; cash payments; loans and income-generating activities through community projects; incentives through contracts with local authorities; performance-based bonuses during social events (e.g., New Year's celebration, start of school year); allowances provided by funds generated by user fees and cost recovery systems. Non-financial incentives may include membership in a community health provider cooperative; formal social recognition for service; means of communication;[5] community support in agricultural or domestic work; uniforms, scarves, badges, bags; certificates; a commemoration day; prizes for high-performing individuals; and tickets for pilgrimages to holy places. Communities base incentives on the local context.	May receive financial and nonfinancial incentives per guidance for all community health providers in the *Strategic Plan*. They may be financed by the MSAS, the municipality, the community, NGOs, or as a fee for service. Financial incentives may include cash payments; allowances provided through funds generated by user fees and cost recovery systems; performance-based incentives; and cash from income-generating activities. Non-financial incentives may include membership in a community health provider cooperative; formal social recognition for service; badges; certificates; a commemoration day and tickets for pilgrimages to holy places. Communities base incentives on the local context.

[1] There are approximately 4,200 ASC and matrones needed. This is a calculation based on an estimation of 3,748 ASC and matrones in 2010 and a gap of about 450, according to the *Strategic Plan*.
[2] The *Strategic Plan* recommends that community health providers be supervised at least once every two months using standardized and integrated supervision tools. At community sites, field supervision visits may include observation of case management, interviews to assess knowledge, and review of management tools. In addition, health posts hold meetings with trained community health providers including DSDOM every two months to analyze bottlenecks that constrain access to services.
[3] This curriculum was designed for community promotion and prevention actors, but it is unclear if bajenu gox may provide all interventions included in this curriculum.
[4] This curriculum was designed for community care actors, but it is unclear if DSDOM may provide all interventions included in this curriculum.
[5] Unspecified whether this means mobile phones or other means of communication.

Table 3.2. Community Health Provider Overview

	Matrones	Relais
Number in country	3,748 ASC and matrones	7,435
Target number	Approximately 4,200 ASC and matrones[1]	15,000–23,069[2]
Coverage ratios and areas	1 matrone: 3,000 people Works from a health hut, which covers approximately 3,000 people.	1 relais: 250 people
Health system linkage	Head nurses and midwives based at health posts train and supervise matrones. Matrones also refer complicated cases to health posts.	Head nurses at health posts train and supervise relais by conducting field supervision visits at health huts and at community sites. Relais refer complicated cases to health posts.
Supervision	Matrones may have three categories of staff involved in supervision: head nurses and midwives at health posts; NGO staff involved in community health programming; and midwives from district health offices.[3]	Relais may have three categories of staff involved in supervision: head nurses and midwives based at the health posts; NGO staff involved in community health programming; and midwives from district health offices.
Accessing clients	On foot Clients travel to them	On foot Clients travel to them
Selection criteria	Between 25 and 50 years old Literate Reading and writing skills equivalent at least the 4th level of secondary education Selected by the community Married and live in the community Credible, modest, discreet, available, dynamic, welcoming, respectful, open, and respectable Trained according to norms and protocols Speaks the community's language Able to easily communicate, inform and educate community on danger signs among pregnant women, postnatal women, and newborns; the advantages of FP and the different methods that exist Able to organize the community to support transportation in case of emergencies	Available Willing to serve the community as a volunteer Able to read and write Chosen by the community
Selection process	Authorities, including village chiefs and representatives of community-based organizations such as village associations and women's groups, select matrones. Available policies do not provide details about the specific process.	Authorities, including village chiefs and representatives of community-based organizations such as village associations and women's groups, select relais. The health post head nurse supports the process. ASC may assist with selection as well, but available policies do not provide details.

Table 3.2. Community Health Provider Overview

	Matrones	Relais
Training	At present, there is an initial training, but the *Strategic Plan* recommends increasing the number of trainings and expansion in the matrones' scope of work.	Available policies do not specify training details, but the *Strategic Plan* emphasizes training should be standardized and there should be refresher trainings.
Curriculum	Matrone curricula include: *Participant Manual for ASC, Matrones, and Relais* (2010). Includes modules on child health, reproductive health, FP, nutrition, malaria, and other health areas. *ASC/Matrone Manual* (no date). Includes 6 modules on management of common diseases and injuries; infection prevention; sanitation and hygiene; TB and sexually transmitted infections, including HIV and AIDS; available services; health hut organization and management. *Guide for Community Care Actors* (2014). Comprises modules detailing the services and interventions to be delivered as part of the integrated community health package.	Relais curricula include: *Participant Manual for ASC, Matrones, and Relais* (2010). Includes modules on child health; reproductive health; FP; nutrition; malaria; and other health areas. *Relais Training: Trainer's Guide* (2010). Includes information on communication; maternal, newborn, and child health; health and sanitation; TB and sexually transmitted infections, including HIV and AIDS; available services; health hut organization and management. *Training Guide on Long-Lasting Insecticide-Treated Nets (LLINs): Relais Communautaires and Supervisors* (2011). Includes information on malaria prevention, including strategies to promote universal coverage of LLINs, logistical management, and behavior change communication. *Integrated Management of Childhood Illness: Community Prevention and Promotion Actor Manual* (2014). Includes modules on prevention and management of malaria, diarrhea, respiratory infections, and immunizations.
Incentives and remuneration	May receive financial and nonfinancial incentives per guidance for all community health providers in the *Strategic Plan*. May be financed by the MSAS, the municipality, the community, NGOs, or as a fee for service. Financial incentives may include cash payments; allowances provided through funds generated by user fees and cost recovery systems; performance-based incentives; and cash from income-generating activities. Non-financial incentives may include membership in a community health provider cooperative; formal social recognition for service; badges; certificates; a commemoration day; and tickets for pilgrimages to holy places. Communities base incentives on local context.	May receive financial and nonfinancial incentives per guidance for all community health providers in the *Strategic Plan*. May be financed by the MSAS, the municipality, the community, NGOs, or as a fee for service. Financial incentives may include cash payments; allowances provided through funds generated by user fees and cost recovery systems; performance-based incentives; and cash from income-generating activities. Non-financial incentives may include membership in a community health provider cooperative; formal social recognition for service; badges; certificates; a commemoration day; and tickets for pilgrimages to holy places. Communities base incentives on local context.

[1] There are approximately 4,200 ASC and matrones needed. This is a calculation based on an estimation of 3,748 ASC and matrones in 2010 and a gap of about 450, according to the *Strategic Plan*.
[2] Between 15,000 and 23,069 relais, depending on estimate. The first is a calculation is from the 1 Million Community Health Workers Campaign, and the second from a national analysis. Both are cited in the *National Community Health Strategy*.
[3] The *Strategic Plan* recommends that community health providers be supervised at least once every two months using standardized and integrated supervision tools. At community sites, field supervision visits may include observation of case management, interviews to assess knowledge, and review of management tools. In addition, health posts hold regular coordination meetings every two months with trained community health providers including DSDOM to analyze bottlenecks that constrain access to community health services.

HEALTH INFORMATION SYSTEMS

Community health providers in Senegal use registers, forms, charts, and reports to collect and compile data related to the services and interventions they provide across a spectrum of health areas, such as FP, growth monitoring, and child immunizations. During planning and evaluation meetings with head nurses and health committees, community health providers participate in data review, self-evaluation, and local health decision-making processes.

Community health providers submit monthly reports to head nurses at health posts, who verify data and send them regularly to the health district in the form of aggregated reports. The head nurse also sends reports to the CLSC, presumably for use in local health planning.

Health district officials are responsible for developing a community health database and a monitoring and evaluation performance framework. Officials at the health district ensure quality of community health data, submit them in the database, and develop and send activity reports to the regional level on a quarterly basis. The district chief medical officer also shares data with the CDSC to inform district-level planning.

Under the regional chief medical officer, a team at the regional health directorate ensures the quality of all community health data reported by the health districts. It also develops a regional community health database and a monitoring and evaluation framework to regularly assess the performance of community health initiatives.

At the national level, the division of health and social information systems within the MSAS receives community health data from the regions and passes the information to a monitoring and evaluation sub-unit of the Community Health Unit. The sub-unit periodically evaluates the performance of community interventions of the regions, contracting with partners like research institutes and civil society structures as necessary. The sub-unit also coordinates with technical partners and NGOs to collect all reports and data on their community health activities. It shares data with the community health steering committee, which meets several times a year to analyze community health inputs, activities, processes, and health impacts to inform future work plans.

Apart from information sharing during community meetings, policy does not indicate if or how data flow back to the community level from higher levels of the health system.

The blue arrows in Figure 1 indicate the flow of community-level data in Senegal.

HEALTH SUPPLY MANAGEMENT

Community health providers manage their supplies, commodities, and medicines using stock management registers. They access supplies from health huts or health posts, and head nurses are responsible for placing orders with district health office for resupply. NGOs also may provide medical commodities to health huts and community sites.

Policies do not specify how community health providers should access emergency backup supplies or how they should dispose of medical waste.

The full list of commodities that community health providers in Senegal provide is not available, but information about selected medicines and products included in the *National List of Essential Medicines and Products of Senegal* (2013) is provided in Table 4.

Table 4. Selected Medicines and Products Included in the *National List of Essential Medicines and Products of Senegal* (2013)

Category		Medicine / Product
FP	☑	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☐	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☑	Insecticide-treated nets
	☑	Paracetamol
	☑	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

The *Strategic Plan* includes a list of community health services and interventions that are in the process of being integrated into one package to be delivered at community sites, health huts, and health posts. The list specifies the types of community health provider responsible for each intervention, organized by health area, including MNCH, reproductive health, FP, disease prevention, nutrition, HIV and AIDS, TB, WASH, and neglected tropical diseases. Table 5 summarizes the modes of service delivery that community health providers use.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Bajenu gox, relais, and DSDOM may refer clients to ASC and matrones for services they cannot provide. ASC and matrones refer clients to health posts. Staff at health facilities may counter refer if needed.

Using FP as an example, community health providers may refer clients to:

- Health huts[2] for information on fertility awareness methods; lactational amenorrhea method; CycleBeads; Standard Days Method; condoms; oral contraceptive pills; and injectable contraceptives.
- Health posts for FP methods available at health huts as well as emergency contraceptive pills.
- Level I health centers for FP methods available at health posts, plus implants and intrauterine devices (IUDs).
- Level II health centers and hospitals for the methods available at the lower levels and permanent methods.

Table 6 details selected interventions delivered by ASC, bajenu gox (BG), DSDOM, matrones, and relais for FP, maternal health, newborn care, child health and nutrition, TB, HIV, malaria, and WASH, according to policy.

2 ASC and matrones provide these methods from health huts, which are based in communities.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP[1]	Condoms	ASC, BG[2], matrone, relais	ASC, matrone, relais[3]	ASC, BG, matrone, relais	ASC, matrone, relais
	CycleBeads®	ASC, BG[2], matrone, relais	ASC, matrone, relais[3]	ASC, BG, matrone, relais	ASC, matrone, relais
	Emergency contraceptive pills	ASC, BG[2], matrone, relais	No	ASC, BG, matrone, relais	ASC, matrone, relais
	Implants	ASC, BG[2], matrone, relais	No	ASC, BG, matrone, relais	ASC, matrone, relais
	Injectable contraceptives	ASC, BG[2], matrone, relais	ASC, matrone	ASC, BG, matrone, relais	ASC, matrone, relais
	IUDs	ASC, BG[2], matrone, relais	No	ASC, BG, matrone, relais	ASC, matrone, relais
	Lactational amenorrhea method	ASC, BG[2], matrone, relais		ASC, BG, matrone, relais	ASC, matrone, relais
	Oral contraceptive pills	ASC, BG[2], matrone, relais	ASC, matrone, relais[3]	ASC, BG, matrone, relais	ASC, matrone, relais
	Other fertility awareness methods	ASC, BG[2], matrone, relais		ASC, BG, matrone, relais	ASC, matrone, relais
	Permanent methods	ASC, BG[2], matrone, relais	No	ASC, BG, matrone, relais	ASC, matrone, relais
	Standard Days Method	ASC, BG[2], matrone, relais		ASC, BG, matrone, relais	ASC, matrone, relais
Maternal health	Birth preparedness plan	ASC, BG, matrone, relais	ASC, matrone	ASC, BG, matrone, relais	ASC, BG, matrone, relais
	Iron/folate for pregnant women[4]	ASC, BG, matrone, relais	ASC, matrone	ASC, BG, matrone, relais	ASC, BG, matrone, relais
	Nutrition/dietary practices during pregnancy	ASC, BG, matrone, relais		Unspecified	ASC, matrone, relais
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Matrone[5]	Unspecified	Matrone
	Recognition of danger signs during pregnancy	ASC, BG, matrone, relais	ASC, BG, matrone, relais	ASC, BG, matrone, relais	ASC, BG, matrone, relais
	Recognition of danger signs in mothers during postnatal period	ASC, BG, matrone, relais	ASC, BG, matrone, relais	ASC, BG, matrone, relais	ASC, BG, matrone, relais

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Newborn care	Care seeking based on signs of illness	ASC, BG, DSDOM, matrone, relais			ASC, BG, DSDOM, matrone, relais
	Chlorhexidine use	Unspecified	ASC, matrone	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	ASC, matrone, relais		ASC, matrone, relais	ASC, matrone, relais
	Nutrition/dietary practices during lactation	ASC, BG, matrone, relais		Unspecified	ASC, BG, matrone, relais
	Postnatal care	ASC, BG, matrone, relais	ASC, BG, matrone, relais[6]	ASC, BG, matrone, relais	ASC, BG, matrone, relais
	Recognition of danger signs in newborns	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
Child health and nutrition	Community integrated management of childhood illness[4]	ASC, BG, DSDOM, matrone, relais	ASC, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[7]	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	Exclusive breastfeeding for first 6 months	ASC, BG, DSDOM, matrone, relais		ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	Immunization of children[8]	ASC, BG, DSDOM, matrone, relais	No	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	Vitamin A supplementation for children 6–59 months[7]	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
HIV and TB	Community treatment adherence support, including directly observed therapy	ASC, matrone, relais	ASC, matrone, relais	Unspecified	ASC, matrone, relais
	Contact tracing of people suspected of being exposed to TB	ASC, matrone, relais	ASC, matrone, relais	ASC, matrone, relais	ASC, matrone, relais
	HIV testing	ASC, BG, DSDOM, matrone, relais	No	ASC, BG, DSDOM, matrone, relais	ASC, matrone, relais
	HIV treatment support	Unspecified	Unspecified	Unspecified	Unspecified
Malaria	Artemisinin combination therapy	ASC, BG, DSDOM, matrone, relais	ASC, DSDOM, matrone	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	Long-lasting insecticide-treated nets	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais
	Rapid diagnostic testing for malaria[4]	ASC, BG, DSDOM, matrone, relais	ASC, DSDOM, matrone	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
WASH	Community-led total sanitation	Relais	Relais		
	Hand washing with soap	ASC, BG, DSDOM, matrone, relais			
	Household point-of-use water treatment	ASC, BG, DSDOM, matrone, relais			
	Oral rehydration salts[9]	ASC, BG, DSDOM, matrone, relais	ASC, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais	ASC, BG, DSDOM, matrone, relais

[1] The *Strategic Plan* characterizes DSDOM as community care providers, meaning they are able to provide certain FP services. However, they are not mentioned in this section because the DSDOM job description indicates that they focus on home-based care for childhood illnesses and the DSDOM training guide from 2013 does not mention FP.
[2] There is conflicting information in policy as to whether or not bajenu gox provide information on FP methods. The 2014 *Strategic Plan* indicates that community prevention and promotion providers, which include bajenu gox, may provide information on FP methods but the bajenu gox manual developed in 2009 indicates that they may only counsel on birth spacing and refer clients to a health facility.
[3] The 2010 relais curriculum indicates that relais may distribute CycleBeads, condoms, and oral contraceptive pills, but the *Strategic Plan* characterizes relais as community prevention and promotion providers, who do not initiate FP methods. It is not clear if relais may continue providing methods after the client has started the method.
[4] Guidance prior to the *Strategic Plan* suggests that relais may have been able to provide this service/intervention, but the recent *Strategic Plan* now characterized as community prevention and promotion providers that do not.
[5] Certain matrones may provide misoprostol if they have received the requisite training.
[6] These cadres provide only selected postnatal care services.
[7] This service/intervention is not included in the training manuals for bajenu gox and DSDOM, but the *Strategic Plan* indicates they may administer it during campaigns.
[8] Includes newborns.
[9] Only for children under 5 years.

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ADVANCING PARTNERS & COMMUNITIES
JSI RESEARCH & TRAINING INSTITUTE, INC.

1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: advancingpartners.org