

Sources of Family Planning

Senegal



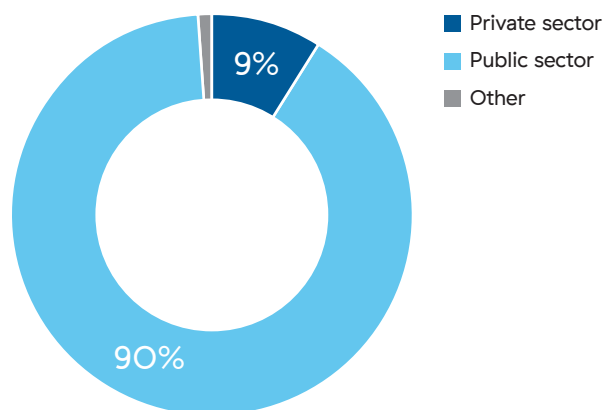
Photo: Javier Acebal

Understanding where women obtain their family planning methods can help programs to better target their resources and increase overall access to modern contraception. This brief is one in a series of country briefs that examines where women obtain modern contraception by method, geography, marital status, and socioeconomic status. Through a secondary analysis of the 2019 Senegal Demographic and Health Survey, the brief explains where modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Senegal.

Key Findings

- The majority (90%) of modern contraceptive users in Senegal rely on public sources.
- Senegal's modest increase in the modern contraceptive prevalence rate among all women, from 15 to 18% since 2015, is due to increased implant use.
- In contrast with global patterns, the private sector is not a common source among pill users (18%).
- Compared with the national average (9%), the private sector plays a larger role among urban (13%), wealthy (14%), and unmarried (18%) users.

Source of modern contraceptives in Senegal



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at PrivateSectorCounts.org.

Modern contraceptive prevalence rate and method mix

Less than one out of every five women of reproductive age in Senegal use modern contraception (18 percent). Among married women, the modern contraceptive prevalence rate (mCPR) is 26 percent. This brief focuses on all women, married and unmarried, to accurately portray contraceptive sources among all users. Senegal's mCPR increased modestly from 15 percent in 2015 to 18 percent in 2019 entirely due to an increased use of long-acting reversible contraceptives (LARCs) and permanent methods (PMs), specifically implants (from 4 to 7 percent), and smaller increases in use of IUDs (0.8 to 1.3 percent) and sterilization (0.3 to 0.5 percent).¹

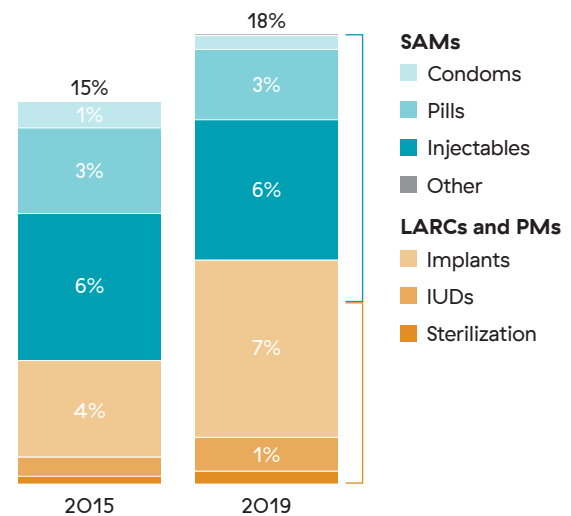
Sources for family planning methods

Among contraceptive users, the public sector is the primary source in Senegal (90 percent, an increase from 84 percent in 2015). Nine percent of users rely on the private sector (a decrease from 12 percent in 2015) and 1 percent use other sources.²

The public sector is the dominant source for SAMs as well as LARCs and PMs. The private sector plays a small role in supplying SAMs to 1 percent of Senegalese women, and private sector LARC and PM provision is negligible. The increase in mCPR between 2015 and 2019 is mainly due to increased use of implants. Nearly all Senegalese women who use implants obtain them from public sources (96 percent), although the percentage of implants sourced from the private sector use increased from less than 1 percent in 2015 to 4 percent in 2019.

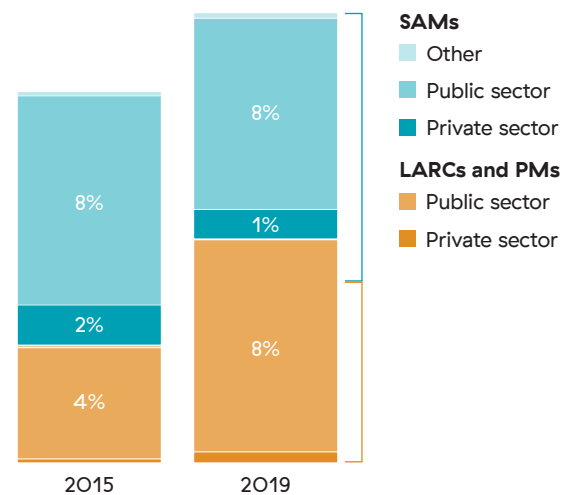
The public sector is also the predominate source of injectables among users, with 94 percent obtaining their method from the public sector and just 5 percent going to the private sector. Use of the private sector is somewhat more common among pill users (18 percent), though this is low in comparison to most other sub-Saharan African countries. Condom use (0.6 percent) is too low to analyze by source.

The increase in mCPR is due to increased implant use, making implants Senegal's most common modern method



Note: Numbers may not add due to rounding.

The public sector is the primary source of modern methods



¹ SAMs include injectables, contraceptive pills, male condoms, emergency contraception, and fertility-awareness methods. LARCs and PMs include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Survey does not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

² Public sector sources include hospitals, health centers, health posts, mobile hospitals and clinics, family planning clinics, community-based agents, and fieldworkers. Private sector sources include hospitals, clinics, and doctors; nongovernmental and faith-based organizations, including mission hospitals, churches, community-based agents, and fieldworkers; and pharmacies and shops. Other sources include friends and relatives. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

Private sector sources

Among all women who go to the private sector for their contraception, 54 percent go to pharmacies or shops, 45 percent to hospitals or clinics, and 1 percent to nongovernmental, including faith-based, organizations. Pills are the method most commonly obtained from the private sector.

Pharmacies and shops, followed by private hospitals and clinics, are the most common private sector sources



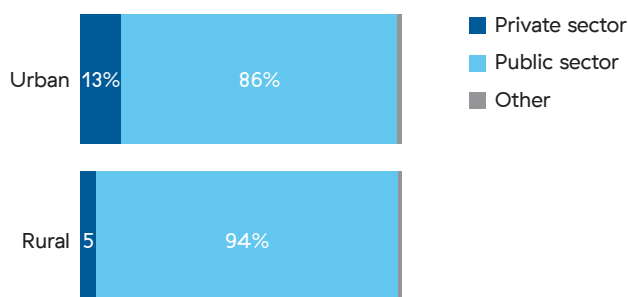
Contraceptive source by geography

The mCPR is slightly higher in urban (19 percent) than in rural (17 percent) areas of Senegal. Urban contraceptive users are more than twice as likely to purchase their method from the private sector than rural users. Injectables and implants, usually obtained from public sources, are the most common methods among both urban and rural users, although use is higher in rural areas (injectables: 35 versus 27 percent; implants: 41 versus 38 percent). Pills, more frequently sourced from the private sector, make up 20 percent of the urban method mix versus 11 percent of the rural method mix. Contraceptive source varies by region as well. Private sector use is highest in Diourbel (14 percent), followed by Dakar (13 percent), Senegal's urban hub. In the remaining areas, fewer than 9 percent of modern contraceptive users rely on private sources.

Contraceptive source by marital status

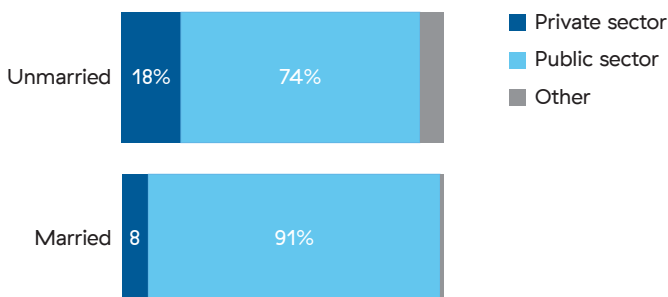
Use of the private sector is more than two times higher among unmarried than married contraceptive users (18 versus 8 percent). Unmarried users are also much more likely to use implants (57 versus 38 percent) and condoms (20 versus 2 percent). Married users, on the other hand, are more likely than unmarried users to use injectables (32 versus 14 percent) and pills (17 versus 2 percent).

Private sector use is more than twice as high in urban than rural areas



Percent of users in each group who obtain modern contraception from each source

Almost 1 in 5 unmarried users obtain their method from a private source



Percent of users in each group who obtain modern contraception from each source

Contraceptive source by socioeconomic status

In Senegal, the mCPR is slightly higher among the wealthiest than poorest women (19 versus 16 percent).³ Among the poorest users, nearly all (95 percent) rely on public sources. In contrast, 14 percent of the wealthiest rely on private sources, and 85 percent use public sources. Women in the wealthiest quintiles live well above the poverty line, and likely have some ability to pay for contraception, highlighting an opportunity for improved market segmentation.

Almost all (95%) of the poorest contraceptive users go to the public sector



85% of the wealthiest contraceptive users go to the public sector



Implications

The public sector in Senegal is the primary source of modern contraception for every population group. Recent increases in the mCPR are primarily due to increased implant use, which are almost entirely sourced from the public sector. While private sector use is higher among urban, wealthy, and unmarried users, it could play a larger role in increasing contraceptive access and choice, thus improving sustainability. For example, 85 percent of the wealthiest contraceptive users rely on public sources, adding to the burden on these government facilities. Additionally, just 5 percent of injectable users and 18 percent of pill users—down from 6 and 23 percent in 2015, respectively—obtain their method from private sources, which is low compared with regional patterns. Low private sector use for pills and injectables could be related to a national policy prohibiting pharmacies from selling pills without a prescription and from selling injectables at all. The country's 2016–2020 National Strategic Framework for Family Planning recognized that this impedes efforts to scale contraceptive access and use and provided a roadmap and budget for lifting these restrictions. A law currently being drafted would allow for pharmacies to provide pills and injectables, which could shift some SAM users to the private sector. Shifting some of the wealthiest users, who presumably have some ability to pay for contraception, to private sources could free up public resources that can be redirected toward reaching rural and other underserved populations as well as sustaining LARC improvements, helping Senegal meet its Family Planning 2020 goal of increasing the mCPR to 45 percent. Expanding the range of social marketing brands and scaling up social franchising models are additional strategies that could help leverage the private sector to improve contraceptive access and choice in Senegal.

References

Republic of Senegal Ministry of Health and Social Welfare, Department of Health, Division of Reproductive Health and Child Survival. June 2016. National Strategic Framework for Family Planning, 2016–2020.

Family Planning 2020. 2019. *Senegal Commitment Self-Reporting Questionnaire 2019*. Washington, DC: Family Planning 2020.

³ The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset-based wealth index. The wealthiest women are those in the top two wealth quintiles.



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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the support of the American people through USAID. The contents are the sole responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

August 2021