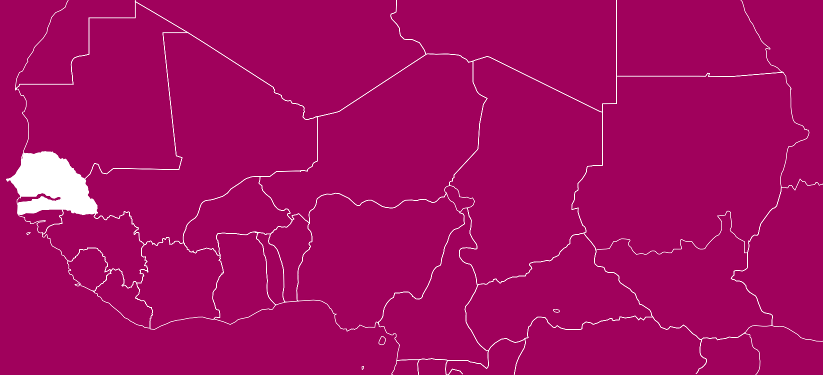


SENEGAL

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of Senegal's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of Senegal's national policy on family planning (FP) and reproductive health (RH) is included in a number of documents, including the 2005 Reproductive Health Law, the National Strategic Plan for the Security of Reproductive Health Products 2011–2015 (2011), and the National Family Planning Action Plan 2012–2015 (2012). This latter document integrates community operational plans and district and regional plans to increase contraceptive prevalence throughout the country. The Reproductive Health Policies and Norms Part 2 and the Reproductive Health Protocols also provide specific guidelines for postabortion care (PAC).

Legal status of abortion

Senegal's criminal code allows abortion to save the life of the woman (Sedgh et al., 2015; Turner, Senderowicz, and Marlow, 2016).

PAC TRAINING AND STANDARDS

Senegal's Ministry of Health (MOH) introduced PAC programs in the late 1990s. By 2006, the majority of medical and mid-level personnel in public health facilities offering RH services had received PAC training, which covers infection prevention practices for PAC, PAC counseling, and use of manual vacuum aspiration (Sedgh et al, 2015; Management Sciences for Health [MSH], 2006). Since then, manual vacuum aspiration has become an integral component of PAC and has been the country's technology of choice for PAC in tertiary and secondary hospitals (Suh, 2015).

In 2015, the MOH, in collaboration with Marie Stopes International and Gynuity Health, trained 2,220 public sector service providers (doctors, nurses, and midwives) in 35 districts on the use of misoprostol (Burke et al., 2016). This enabled the devolution of PAC to the community level, where nurse-midwives in community centers provide misoprostol to women in need.

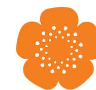
The government also updated the training curriculum to include FP counseling and provision of voluntary methods, as well as community-based healthcare services (Fikree, Mugore, and Forrester, 2014). Healthcare training institutions were involved in revising the basic PAC training curricula (Fikree, Mugore, and Forrester, 2014).

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT

Expanding contraceptive methods and informed choice to PAC clients

USAID

FROM THE AMERICAN PEOPLE



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STRENGTHENING SERVICE DELIVERY

The MOH, USAID, and MSH collaboratively worked to improve PAC access by decentralizing activities throughout the country. PAC, previously provided in tertiary hospitals, is now generally available in rural and urban health centers and health posts (Curtis, Huber, and Moss-Knight, 2010). MSH trained more than 500 health personnel—104 midwives, 254 nurses, 63 regional and district-level supervisors, 6 doctors, and 104 counselors—from 323 facilities across four regions in the provision of PAC (USAID, 2008). As a result, the proportion of health centers with trained PAC personnel increased from 39% in 2003 to 100% in 2005 (MSH, 2006).

The decentralization of PAC services resulted in increased contraceptive counseling and acceptance of a voluntary contraceptive method prior to women's discharge from the facility (USAID, 2008). Contraceptive counseling increased from 36% in 2003 to 78% in 2005, but the number of PAC clients who received a contraceptive method prior to leaving the facility decreased from 56% in 2008 to 47.6% in 2013 (USAID, 2008). Senegal's cost recovery policies, which require clients to pay for emergency treatment and FP services separately, may compel facilities to offer these services separately as well, impeding effective integration of these two components of PAC (Dieng, 2016).

MOH policymakers and the National Supply Pharmacy have contributed to reducing stock-outs. Manual vacuum aspiration kits and contraceptive products have become more readily available at health facilities and the injectable Sayana Press is offered throughout the country (Fikree, Mugore, and Forrester, 2014; FP2020, 2016). Following pharmacist trainings on the correct use and provision of misoprostol, the number of pharmacists stocking the drug increased from 253 in 2014 to 415 in 2015 (Burke et al., 2016).

BARRIERS TO PAC

Women in Senegal face multiple barriers in accessing PAC and FP services. While the government prioritized decentralization in order to increase access, not all facilities at all levels of the health system offer such services. Challenges are particularly acute at lower-level facilities, where providers lack PAC training. PAC equipment and supplies needed are also often unavailable. As a result, only 42% of women in Senegal receive medical services for the treatment of abortion-related complications (Turner, Senderowicz, and Marlow, 2016). Further, women face stigma from religious leaders and groups who morally object to FP. (Turner, Senderowicz, and Marlow, 2016).

FINANCING MECHANISMS

In 1991, Senegal adopted the Bamako Initiative to focus spending on primary healthcare through a cost-sharing mechanism for essential drugs. This initiative created challenges for cost-recovery strategies for FP methods; service providers could only purchase contraceptives at the facility pharmacy where FP costs varied (Fikree, Mugore, and Forrester, 2014).

In 2016, Senegal's budget line for the purchase of contraceptive commodities went from 100 million CFA (approximately $173,269) to 300 million CFA (approximately $519,807) (FP2020, 2016).

SENEGAL		Year	Source
Demographic/background indicators			
Country population	16,484,820	2018	United Nations (UN)
Total fertility rate	4.6	2017	UN Data World Population Prospects
Maternal mortality per 100,000 live births	236	2017	Demographic and Health Survey, 2017
Newborn mortality per 1,000 live births	28		
Infant mortality per 1,000 live births	42		
Under-five child mortality per 1,000 live births	56		
Facility-based delivery	78%		
At least one prenatal visit during previous pregnancy	97%		
At least one postnatal visit during previous pregnancy	77%		
Abortion and FP-related indicators			
Number of abortions	51,500	2012	Guttmacher Institute, 2015
Abortions per 1,000 women	17	2012	Guttmacher Institute, 2015
Number of unintended pregnancies	225,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Proportion of unintended pregnancies that end in abortion (2014)	24%	2014	Guttmacher Institute, 2015
Number of unintended pregnancies averted due to use of modern contraceptive methods	282,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	100,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of maternal deaths averted due to use of modern contraceptive methods	630	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	18.8 %	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Knowledge of FP, all WRA	97.6%	2010	Demographic and Health Survey, 2010
Contraceptive use by type			FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods		2017–2018	
Sterilization (female)	3.0%		
Sterilization (male)	0.0%		
Intrauterine device	7.2%		
Implant	31.3%		
Short-acting methods		2017–2018	
Injection (intramuscular and subcutaneous)	34.9%		
Pill	18.7%		
Condom (male)	3.6%		
Condom (female)	0.0%		
Other modern methods (e.g., female condom, cycle beads, and lactational amenorrhea method)	0.6%		
Unmet need for family planning[1] (2018)	25.3%	2017–2018	Demographic and Health Survey, 2017
Unmet need for spacing	19.3%		
Unmet need for limiting	6.0%		
Percentage of all women who received FP information during their last visit with a health service provider (2016)	27.7%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet

[1] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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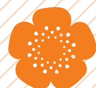

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