Young women access and use of contraception: the role of providers' restrictions in urban Senegal

Estelle M. Sidze[1]*, Solène Lardoux[2], Ilene Speizer[3], Cheikh M. Faye[1], Michael M. Mutua[1], and Fandi Badji[4]

Abstract

Gaps are observed in young women's use of family planning and greater depth is needed to understand barriers to their use, including barriers imposed by service delivery providers. Data from the Urban Reproductive Health Initiative in urban Senegal were used to examine the levels of contraceptive use, the method mix, the levels of unmet needs and the sources of contraceptive methods of 15-29-year-old urban women who are currently married or are unmarried but sexually active. The prevalence of eligibility restrictions based on age and marital status among family planning providers is also examined; as well as how these restrictions might affect young women's access to contraceptive methods. The minimum ages required by providers to offer contraceptive methods in facilities show that young people are forgotten in service provision. Restrictions based on marital status are less prevalent than restrictions based on age.

[1] African Population and Health Research Center (APHRC)

[2] Department of Demography, University of Montreal, C.P. 6128, Succursale Centre-ville, Montréal, H3C3J7, Canada, phone: +514 343 6615, Email: solene.lardoux@umontreal.ca

[3] Department of Maternal and Child Health, University of North Carolina, Gillings School of Global Public Health, and the Carolina Population Center, 206 W. Franklin St., CB #8120, Chapel Hill, NC 27516, phone:+919 966-7411, Email: ilene_speizer@unc.edu

[4] Senegalese Urban Reproductive Health Initiative (ISSU) IntraHealth International, Dakar, Senegal, Email: fbadji@intrahealth.org.

Even though the concept of family planning (FP) was introduced in Senegal in the early 1960s at the Private Blue Cross Clinic (Dakar), it was only in 1981 that the Family Health Project was launched by the Government with the goals of developing an administrative structure capable of directing a national program, providing IEC support, and providing family planning services. A key barrier to the introduction of family planning more widely prior to 1981 was the 1920 French law that forbade the promotion of contraceptives1 this law was repealed in the early 1980s.

In1988, the national population policy gave official and political approval of the family planning program and paved the way for progress in family planning in Senegal. But despite changes in Senegal's legal and regulatory environment for family planning, progress in contraceptive prevalence has been slow due to low demand for use as well as supply side barriers. For instance, decades after most African countries began providing oral contraceptives and injectables through community-based distribution by matrons or community health agents, Senegal only began such a program in the last 2 years, a delay caused by illogical restrictions on which cadres can provide oral contraceptives and injectables.[2]

Estimates from the 2010-2011 Demographic and Health Survey (DHS) indicate that only 12% of currently married women use a modern contraceptive method, as compared to 10% in 2005 and 8% in 1997.[3] Notably, 29.4% of currently married Senegalese women have an unmet need for family planning, that is, they want either to postpone their next birth by at least two years or do not want any (additional) children, but are not using a contraceptive method;[3] a slight decline from 31.6% in 2005. The levels of unmet need, especially for spacing, are higher in Senegal (at 29.1% among currently married women) than in other West African countries including Nigeria, Mali, Burkina Faso, and Ghana.[4]

The young, who constitute a key target in reproductive health strategies, appear to have particularly low levels of contraceptive prevalence. For instance, only 1.9% of all women aged 15-19 years (5.0% among the currently married) and 6.0% of all women aged 20-24 years (8.4% among the currently married) reported using a modern method in 2010-2011.[3] Access to reproductive health services remains an issue for the young in Senegal.[5-7] Cultural, medical and financial barriers prevent access to family planning services and contraceptives by young women and men. Some evidence from simulated client studies suggests for instance that health providers tend to promote abstinence for young girls, and are also reluctant to provide pills to unmarried young women.[5,7] Consequences of this failure of access are an increased risk of unplanned pregnancies, unsafe abortion, STDs and HIV/AIDS and early school dropout from pregnancies, by young women.[7] Previous research has stressed the importance of helping young people in developing countries to be effective contraceptive users.[8-10] As the medical mediators between clients' knowledge, fears of contraceptives and their use, health providers are also key to ensuring access to, adoption and continued use of contraceptive methods among the young. Health providers' knowledge and training have been found to influence access to specific contraceptives[11,12] In Tanzania, Speizer and colleagues[11] demonstrated examples of obstacles that prevent women from using modern contraception such as inappropriate contraindications, eligibility restrictions, unnecessary process hurdles, overspecialization of providers, bias and unnecessary regulations.

The present study reports on the role that family planning providers' restrictions play in young women's access and use of contraception in urban Senegal. Norms and policies have been developed over the years in Senegal to ensure that all individuals receive family planning

services without any discrimination based on age, sex, marital status, ethnic group, or religious affiliation.[13-15]

Data and Methods

The study draws upon baseline data collected by the Measurement, Learning & Evaluation project in Senegal as part of the evaluation of the Senegal Urban Reproductive Initiative (ISSU); ISSU is a five-year project (2010-2015) financed by the Bill & Melinda Gates Foundation. The ISSU's plan is to implement specific programs as part of a pilot project to show how using innovative approaches based on quality health care delivery in the public and private sectors, as well as demand creation and advocacy efforts, can significantly increase the use of modern family planning (FP) methods by the urban population in francophone Africa. Our study contributes to identifying and addressing barriers to contraceptive access and use among young women. The MLE project received ethical approval from the National Ethics Committee of Senegal and the Institutional Review Board of the University of North Carolina in Chapel Hill. Clear guidelines were considered to comply with the ethical considerations during data collection, and study participants were requested to sign a consent form. Participants had the right to abstain from participating in the study, or to withdraw from it at any time, without reprisal.

The main results that are presented in the study are the provider level results, derived from data collected from health facilities and health providers serving in those facilities. Only the health facilities that supply reproductive health services were targeted. For the sampling procedure, a list of operational health facilities providing reproductive health services in survey sites (including hospitals, health centers, health posts, dispensaries, community health centers, private clinics and faith-based facilities) was first obtained. This list was updated using different

sources including: Dakar Medical Region, Mbour Health District, Kaolack Health District, National Health Information System and IntraHealth's on the ground work. A total of 269 health facilities were listed, out of which 205 (i.e. 76%) were successfully found and surveyed. This included 153 public health facilities (including 8 hospitals, 22 health centers, 111 health posts, and 12 other public facilities such as dispensaries and community health centers) and 52 private health facilities (including 27 hospitals/clinics, 10 faith-based facilities, 5 NGO clinics, and 10 other private providers.).

This study provides estimates of the prevalence of providers' restrictions for two reasons most susceptible to affect young women' access to contraceptive methods: minimum age and marital status. These estimates are based on responses from health facility staff involved in reproductive health service provision, i.e. doctors, nurses, trained midwives, maternal and child health aides, medical assistants and auxiliary staff. The health provider questionnaire allows us to know the minimum age below which the health provider does not offer or does not advise each method, and whether the health provider offers a method to a woman who is unmarried. For each specific method, providers were asked: "What is the minimum age you would offer the method to anyone?" and "Would you offer this method to an unmarried person?" Providers who did not report any minimum age were considered as not restricting contraceptive methods by age. As regards the minimum age for offering each specific method, a median age and interquartile range was computed. Providers who reported that they would not offer the method to an unmarried person were considered to restrict specific methods based on marital status. Estimates are presented separately for public and health facilities. Although all staff involved in both types of health facilities receive the same training and are required to follow to same

national guidelines of family planning service delivery, differences in the prevalence of restrictions could be observed due to differences in monitoring systems.

Results

Levels of Providers' Restrictions by Minimum Age

Table 1 presents the percentage of providers who reported that they applied any form of restrictions when providing family planning methods and services to women based on minimum age and based on marital status. These percentages are presented as the number of providers applying specific restrictions as a proportion of all the providers who reported that they offered these specific methods at their current facilities of interview. Confidence intervals for all these indicators are also presented to show the level of different or similarity between comparison proportions. Against age, the table also presents the mean minimum age below which providers would not offer a specific method. Interquartile ranges are also presented, a measure of dispersion which is computed as the difference between the 75th percentile (Q3) and the 25th percentile (Q1) given as; $IQR = Q3 - Q1$.

It can be seen from the table that restrictions based on a minimum age are quite common in the public sector for pills and injectables, the two most common methods used by young women. For the pills for instance, a minimum age is required by 59% of providers interviewed in public hospitals, by 47% of providers in public health centers, by 46% of providers in public health posts, and by 47% of providers in other public facilities. As for the injectables, a minimum age is required by 52% of providers in public hospitals, 43% of providers in public health centers, 40% of providers in public health posts and 38% of providers in other public facilities. In private facilities, 49% of providers required a minimum age to offer pills, 41% to recommend injectables, 38% to offer implants, 20% to suggest condoms, and 21% to propose

emergency contraception. About 25% of providers interviewed in public facilities and 20% of providers interviewed in private facilities restrict eligibility by minimum age for condoms; for emergency contraception 24% of providers in public facilities and 21% in private facilities follow age restrictions; and regarding implants, the percentage of providers restricting access by age are 45% in public facilities and 38% in private facilities.

The median minimum age required by the providers who apply restrictions below a minimum age in public facilities is 17 years for pills, and 18 years for injectables, implants, condom, and emergency contraception. Whereas in the private sector, the median minimum age required by providers is 18 years for all the specific methods mentioned.

Levels of Providers' Restrictions for Reason of Marital Status

Table 2 also shows the percentage of providers that impose a marital status restriction on specific methods. Overall, providers' restrictions based on marital status are less common than minimum age barriers for the majority of methods. Providers in private health facilities are the most likely to restrict methods to unmarried women. About 12% and 14% of providers in public health facilities require that a woman be married in order to receive pills and injectables. In private health facilities, higher percentages of providers impose restrictions: about 21% of providers refuse to offer the pill, 28% refuse to recommend injectables, 30% refuse to propose implants and 22% the emergency contraception, to unmarried women. Providers also impose unnecessary restrictions by marital status for condoms; 8% of providers interviewed in public facilities and 12% of providers interviewed in private facilities do not offer condoms to unmarried women.

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