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“Always a double-edged sword”: How Women and Health Care Providers Navigate Issues of Contraception in Differing Senegalese Communities

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“Always a double-edged sword”: How Women and Health Care Providers Navigate Issues of Contraception in Differing Senegalese Communities

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Abstract

This paper examines how women and health care providers in two distinct Senegalese settings—Dakar and Mouit, a village located within the Gandiol region—navigate contraception as both a social and medical good. Contraception is an invaluable tool in terms of advancing women’s right to reproductive health, but major discrepancies in its usage exist across a variety of social lines in Senegal, including level of education, marital status, occupation, age, and living in a rural versus urban setting. What socially constructed thought processes and lived experiences contribute to these discrepancies? In a cultural context heavily based upon tradition and Islamic faith, and in a state still feeling the effects of colonialism, how do issues of contraception (both biomedical and ethnomedical) manifest in popular discourse and social understanding? These broad questions of course could never be fully answered over the limited course of this project. In an effort to scratch the surface, however, I sought to hear the narratives of Senegalese women pertaining to the different social systems around them and how they influence their attitudes and opinions about contraception. I conducted twenty structured interviews overall: in Dakar four with health care providers and six with women of the general public, and in Mouit three with health care providers and seven with women of the general public. I also spent time observing in health facilities in both environments to contextualize how health care functions at the service level in Senegal. I found that while very positive dialogues surrounding family planning and birth spacing using biomedical methods of contraception exist in Senegal, this mainstream discourse largely excludes an existing population of sexually active unmarried women as well as women whose husbands do not approve of family planning. Ethnomedical methods of contraception are known, but were not practiced by any individuals that I interviewed. Although these methods were reportedly less trusted and less practiced, for the most part they were also reported to have the same social determinants as biomedical methods—marriage, husband approval, and the desire to protect women from the medical and social consequences of pregnancy.

Keywords: Global Health, Women’s Health, Anthropology, Social Determinants of Health
**Introduction**

Access to and knowledge of contraception and family planning services is an important indicator of the state of women’s reproductive health, as avoiding unintended pregnancy\(^1\) helps women to avoid “poor birth and child health outcomes, unsafe abortion and maternal mortality” (Speizer). Additionally, birth spacing (avoiding consecutive pregnancies within a period of two years), has been associated with lower infant mortality and improved maternal health (Ronsmans). The importance of family planning for the means of birth spacing is important to explore in the Senegalese context, where growing population remains a concern (Foley) and where women’s desires to have children more than two years apart are frequently undermined by repeat pregnancies at short birth intervals (Speizer). Importantly, the notion of birth spacing rather than birth limiting has historically been the explicit preference among Senegalese women and men alike (Gaye). As Speizer points out, “a more nuanced way of examining pregnancy intentions and unintended pregnancy risk is to examine women’s motivations to avoid a pregnancy and how this corresponds to modern contraceptive use and subsequent pregnancy experience.” Following this idea, I first and foremost wanted to explore the question of how women’s reproductive health issues are mitigated with regards to family planning: what aspects of daily life, tradition, religion, economy, and education are weighed in the social equation of which women have access to and utilize which types of family planning methods, in both urban and rural settings? I was particularly interested by learning about experiences from the rural milieu, which is “often shrouded in homogeneity and is thus little studied” (Franckel). I also wanted to explore different manifestations of both biomedicine and ethnomedicine in the sociocultural context of Senegal.

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\(^1\)Unintended pregnancies as defined by Speizer “came sooner than desired or are unwanted (i.e. that were not wanted at all)”
Background

In 1920, when Senegal was still under French colonial rule, family planning was outlawed in the country, and despite the fact that family planning services were introduced as early as the 1960s, this ban was not officially lifted until 1980 (Sidze). The first large-scale establishment to offer family planning services was l’Association Sénégalaise pour le Bien-Être Familial (ASBEF), which--founded by volunteers in 1974-- to this day remains the largest provider of family planning services in Senegal, as well as one of the country’s largest NGO’s (Toure). In 1981, the government also began to officially provide family planning services, but it was not until 1988 when the passing of national population policy (Politique de Population au Sénégal) gave “official and political approval” of family planning that was responsible for “paving the way for progress in family planning in Senegal” (Sidze). In the first two decades after its introduction into Senegal, family planning was “tolerated,” but the passing of this policy rendered it “a major element concerning individuals’ rights in the framework of couples and families” (Toure). Another important piece of legislature, le Programme National de Planification Familiale, passed in 1991, instilled a decentralized approach that gave regional and departmental health centers the responsibility of executing family planning programs and increased the role NGO’s played in implementing family planning programming (Toure). Also beginning in 1991, education about different contraceptive methods was implemented in secondary schools across Dakar (Toure).

Indeed, “in the wake of extremely well-funded programs, Senegal’s contraception prevalence rate (CPR) increased from 4.8 percent in the early 1990s to 14 percent in 2005” (Foley), and as of 2014, 28.8% of women report using modern (biomedical) contraception (Speizer). Even for ASBEF alone, the amount of clinical consultations pertaining to contraception only increased throughout the 90s and by 2000 accounted for one third of the total consultations conducted in the clinic (Toure). In November of 2012, the Senegalese government also announced that it was beginning efforts to introduce a Reproductive Health (RH) Division within the Ministry of Health. Evidently, “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,” giving promise that women seeking care in both the public and private sector will have improved access to the reproductive health services they need (Sidze).

Despite improvements of the health systems in place, women still face barriers accessing the services they require. Young people are becoming increasingly sexually active (Toure), yet pre-marital sex is highly socially stigmatized in Senegal, particularly for women (Teixeira). Thus, many adolescents or unmarried women face barriers to accessing contraceptives, and are sometimes refused contraceptive provision by providers, particularly when the woman seeking contraception is young and when the provider is male (Sidze). Similarly, knowledge about contraception among young people is not widespread. A study in 2003 showed that among young people ages 15 to 20 living in urban areas, only 20 percent were familiar with birth control pills, 38 percent with condoms, 27 percent with abstinence, 4 percent with IUDs, 3 percent with gris-gris (traditional amulets), and 1 percent were familiar with both arm implants and rhythm methods (counting menstrual cycles). Younger children aged 10 to 14 expressed even less familiarity, with 14 percent being familiar with pills, 27 percent being familiar with condoms, and any other given method having familiarity by only 1 percent of this age group. Children 10 to 14, however, reported abstinence much more highly, with 50 percent stating they were familiar with this as a method of family planning (Fall).

While only thirteen percent of Senegalese women report never wanting a child, and thirty percent of Senegalese women reported wanting a child after marriage, many women have more children more frequently than they would like (Speizer). Thus, approximately 30 percent of Senegalese women have an unmet need for family planning, the highest of any country in West Africa (Sidze). A 2011 UN report

Unmet need for family planning as defined by Sidze women who “either want to delay their next pregnancy to past the next two years, or they want to stop childbearing all together and are not currently using a modern method of contraception
also stated that usage of “pre-coital contraception” was low throughout sub-Saharan Africa for a number of reasons, including fears that medicalized contraception equates to the “West controlling demographic growth in countries in the global south,” as well as issues surrounding women’s sexual autonomy (Teixeira). Thus, Senegal’s total fertility rate (TFR) remains high at 4.9 children per woman (Agence National de la Statistique). Despite the fact that this marks a decrease from 6 years ago when the TFR was 5.3 (Foley), it has actually increased since 2014, when it had decreased to 4 in urban settings (Speizer). Large discrepancies exist in the fertility of women across rural and urban settings, with the average TFR being 3.5 children per woman in urban areas versus 6.1 children per women in rural areas. Overall, Senegal’s population is almost evenly divided among those living in urban settings (47.5 %) and rural settings (52.5 % (Agence National de la Statistique). Contraceptive use is higher in urban areas (Kahle), with pills, condoms, and injections being the most commonly used methods (Sidze). In these two settings, women experience different likelihoods of becoming pregnant at a young age, with just under twenty percent of women between 15 and 19 having already given birth to one child in rural settings versus only 6.6 percent of women between 15 and 19 having already given birth to one child in rural settings (Agence National de la Statistique). While the vast majority of women in Senegal have their first child between ages 15 and 24, most women who use contraception do so between ages 25 and 39. That is, the majority of women have at least one child before beginning a method of contraception. Possible reasons for heightened contraceptive use in urban areas, Dakar in particular, could be due to the economic strain of a higher cost of living (Gaye). Many married women in Senegal are financially dependent on their husbands; one study reported that almost 70 percent of married women worked as housewives and thus were entirely financially dependent on their husbands (Gaye). Discrepancies in contraceptive use have historically existed among married women versus unmarried women, with 71.67% of married women using contraception versus 24.17 percent of unmarried women (Gaye). Over eighty percent of women who use family planning state that it is for the purpose of spacing births rather than stopping them, with previously stated reasons among Senegalese women having been
principally to avoid and/or ameliorate health problems, economic reasons, and the desires of the partner. One study showed that the higher the level of education a woman had completed, as well as the higher her degree of financial independence, the less likely she was to incorporate the desires of her partner into the decision to use a method of family planning (Gaye). Less educated women in general are also seen as being “more exposed to rumors about side effects” (Gaye). Family influences have also shown to hold sway in Senegal, where “number of children inspires respect on the part of the spouse and his family” and also in the framework of polygamous households also “constitutes a non-negligible benefit for an eventual passing of heritage” (Gaye). Furthermore, health seeking behavior in Senegal is known to occur within both biomedical and ethnomedical frameworks (Sandberg), and although ethnomedical family planning practices exist, there does not appear to be a wide literature base discussing these particular methods.

Methods

Over the course of three weeks, I recruited interview participants by working with three separate organizations—l’Association Sénégalaise pour le Bien Être Familial (ASBEF) located in Dakar, BEM Management School also located in Dakar, and the Case de Santé de Mouit (District Sanitaire de Saint Louis Région Médical de Tassinère), located in the Mouit Village within the Gandiol region. I chose these two locations because I had already spent time in both (albeit much more extensively in Dakar), which I hoped would give me a more thorough and comprehensive appreciation for the daily factors of life and society that are relevant in these two rather different settings. I lived among Senegalese families in both locations, which although not explicitly related to the research question, also undoubtedly helped in giving me full-time exposure to a fuller scope of life within these two environments.

With the help of my advisor, staff at ASBEF, and language staff at SIT, I developed a set of two different interview guides, one to be administered for general women of the public and one to be administered for explicit providers of health care in the field of women’s health. I also developed a consent form for all interviews since the topics to be covered had the potential to bring up sensitive issues
sensitive to participants. The interviews were structured and organized into categories pertaining to major social institutions that I predicted to be important determinants in a woman’s decision to seek contraceptive services, but I prompted women to use specific examples from their own lives so that their narratives could play the largest role in my analysis. Women were also inquired for demographic information including their age, level of education, marital status, number of children, occupation, and the number of years they have spent living in either an urban or rural setting. Health care providers were not asked for any demographic information. One man was also interviewed as a result of circumstance, being that he was the head nurse of the Case de Santé in Mouit.

I administered all interview questions in French in both study locations. All interviews were audio recorded. All health care providers in Dakar provided their responses in French, as did two out of the three providers interviewed in Mouit. The remaining Mouit health care provider provided answers partially in French and partially in Wolof, which was translated into French with the help of my advisor. In both Mouit and Dakar, women responded primarily in French. In Dakar, when women were more comfortable speaking Wolof, interviews were orally translated into French by the pharmacist working in the clinic. In Mouit, interviews that took place with women in Wolof were translated orally by the community health agent working there. I then translated and transcribed all interviews into English, and coded the transcripts manually. I also spent a great deal of time in both health care facilities practicing general observation and note-taking as to clinic flow and procedures, and gaining exposure to the dynamics of health care culture in different areas of Senegal’s health care system. This report only contains pseudonyms so as to protect the identities and information of those interviewed. Throughout the interviews, I only utilized the term ‘family planning,’ unless the term ‘contraception’ was first brought up by the participant, as these terms can have different meanings when considered in the social context of Senegal. I knew before beginning the project that using the term ‘family planning’ would be the more

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3 Included in Appendix A
sensitive way to speak with interview participants, and I hoped that by using this term initially if not exclusively I was able to better gain the trust and confidence of the women whom I interviewed.

It is important to note the bias implicit in this project. Each interview was randomly conducted, however the women that were interviewed at Clinique ASBEF likely already had a preexisting interest or investment in contraception or at least women’s health more broadly, since they were in the process of seeking out care at the time they were approached for the interview. Students at BEM on the other hand were not inherently biased in this way, and neither necessarily were the women approached for interviews in Mouit, since the Case de Santé provides generalized care and it is possible that they were present there for any number of reasons.

**Author’s Circumstances**

My own social roles no doubt play an influential role in how this project was developed and carried out. Perhaps foremost, my identity as an American student traveling abroad poses a certain immutable barrier in the degree of cultural familiarity and true in-depth understanding I was able to obtain throughout the course of this short project. Being given the time out of my interview participants’ lives in their own locales was an immense privilege that I do not intend to take for granted in any way. I also take into account my status here as a foreigner, who is not a native French speaker, and who comfortably knows only a few words and phrases in Wolof that have been learned over the course of the semester. This dynamic could have made it difficult for my interview participants to fully trust me with their most honest responses. On the other hand, it is also possible that my identity as a woman aided in building trust and solidarity among those that I interviewed. I did have the advantage of being comfortable enough with my French fluency to conduct all interviews, pose follow-up questions and prompts on the spot, and translate all interviews with relative ease. I hope to have presented the results of this project in an unbiased light, but I also recognize that my interpretations and findings inextricably derive from my subjective experience in seeing this project through, and if anything I hope that this in itself can contribute to the information gathered.
Limitations

This project faced several limitations, the largest of which being time, given the broad scope of my research question. Interviews took anywhere from fifteen minutes to forty minutes depending on the individual, with the average interview time taking about twenty-five minutes. Because I approached general women about completing the interview on a random basis, I interrupted the schedule of their day, and it did appear that some women became impatient with the amount of time the interview took, even though they were told before beginning the interview. In Mouit, in particular, women who were interviewed in the morning sometimes expressed wanting to hurry through the interview because they needed to return to their homes to prepare the main meal of the day. I tried my best to work with the time restraints of women’s busy schedules while simultaneously gathering the most information from them possible. Taking this amount of time away from health care workers also proved to be challenging, and I needed to work closely with them to schedule interviews such that they could occur during the intermittent and infrequent times throughout the day when they were not tending to patients. Working with translations from Wolof also proved to be a limitation, as it sometimes appeared that my translators were giving me rough summaries of what had been said, rather than verbatim translation. My incredibly basic Wolof skills, however, did not place me in a position to question the work of my translators, who were invaluable to the project for the sake of including the perspectives of rural women, as well as for the sake of ensuring that women were providing responses in the manner and in the language that was most comfortable to them. Throughout the course of the project, I also came to feel like I did not have enough background information concerning the cultural use of gris-gris, traditional plant-based medications, and Senegalese ethnomedical practices in general. I believe that having had more solid background information about how questions of ethnomedicine and biomedicine are navigated in general in Senegal would have allowed me to develop more poignant questions that would have perhaps led to the collection of more clarified and in-depth data gathered.
Results

Reported Use

Among women who reported having used contraception, pills were the most common method. This was true in both Dakar and Mouit. Other women that reported having used contraception used condoms, injections, and emergency contraception. Providers in both sites unanimously corroborated pills to be among the most popular methods, along with injections. According to providers, these methods derive their popularity from a diverse set of reasons, including the short duration (the desire to have another child), discretion, ease of use, aesthetic reasons (possible weight loss resulting from side effects), and the fact that men dislike the idea that a women have an application (an implant or an IUD) within her body.

Women’s reasons for choosing to use a particular method was also widely varied. The majority of women who had used family planning mentioned the desire to rest and care for their bodies after having given birth:

“I had a difficult birth. The baby died at the same time. That was what pushed me to do it [family planning]. Because when I said I have two children, I said wait, I’m going to do family planning to give myself a little rest”—Aissatou, 41, Dakar

Women who cited this reason did not universally have positive experiences using contraception, though. In Mouit, the two women who used contraception for the sake of resting after pregnancy and spacing future births reported issues with the side effects, experiencing vertigo and feeling sick in general. These women had either stopped using contraception or were planning to stop using it in the near future.

Conversely, the women who cited this reason in Dakar noted the absence of side effects for them and the importance of finding a method that works for your particular body chemistry: “There are no problems for my body” (Coumba), “I feel good with it, and it doesn’t do anything to me. I have my friends who say that it changes you, when you get the injections you become fat, but it does practically nothing to me” (Aissatou). Another observed reason for using family planning included continuing education: “I take it so that I am able to continue my studies at the university” (Anta).

There was also a narrative of fear surrounding undesired pregnancy and the desire to plan in the future:
“I had a non-protected sexual relation, and I was scared, and they told me to go to the pharmacy and ask, and they told me to buy emergency contraception, but I was scared because reading the package it told me that… it’s certain at 90 or 80 percent, but also it told me that it could also not prevent STI’s… I was scared, because there were also negative effects-- stomach aches, headaches, all that. I was so so so scared of becoming pregnant. My period was also 3 or 4 days late, which increased my fear. I was so so scared, but, alhamdoullilah, happily, I had my period… That gave me a lot of stress, I had a lot of problems, I was thinking about a lot of things. I wouldn’t think of using it again. Maybe if I get married in the future, I could use other methods that are more sure than that one… pills, I will take that, or maybe an IUD… what is comfortable for my health, I will use that” – Amy, 20, Mouit

As for women who reported having never used a method of family planning, their reasons for never having used a method included a lack of necessity (the choice to not have sexual relationships before marriage), the desire to have children, and fear.

“Because I’m not apt for that. I cannot use it. I’m not yet married, and I don’t have a need for that. I don’t like to have sexual relationships before marriage” – Khadesia, 19, Mouit

“Me, I have one child, I’m scared to do it. I have one child only. In any case, I want to have more children” – Zeyna, 33, Mouit

*Product Availability*

All providers in Dakar agreed that any contraceptive method (meaning biomedical) a woman would want to use would be available to her at a given health facility. As for Mouit, the methods of contraception readily available at the level of the Case are pills, rings, injections, and condoms. If a woman has a desire to use another method, an IUD or an arm implant, for example, it is necessary for her to seek care at the level of the Poste. The Mouit Village is located in the medical region of Tassinère, and the Poste de Santé de Tassinère is located about 2km away from the village. Transport to the Poste de Santé occurs either by taking a taxi at 200 FCFA (about 0.40 USD) or by foot, which typically takes about 30 minutes one way. All providers in Mouit also noted the inexpensiveness of the contraceptive methods available, saying that condoms were given for free, and that packets of birth control pills and injections are sold at either 100 FCFA (approximately 0.20 USD) or 600 FCFA (approximately 1.20 USD). The community health agent at the level of the Poste de Santé de Tassinère expressed that sometimes materials were lacking at the level of the Poste, possibly due to an increase in the amount of women using contraception.
Dakar women’s perceptions reflected what providers said, with the general consensus that all methods are available in any health facility, and that there are plenty of surrounding health facilities making it easy to access. One Dakar woman believed it could be difficult to access if it posed a financial burden on the woman, but another noted that her belief that contraceptives in fact are too accessible:

“Now almost everyone takes the pill. I don’t know if people are married or not. They sell them everywhere. We need to verify that. And we should not give it to children, not married… Me I have a 17-year-old daughter. She knows a lot of things, but I’m scared. I’m scared because one day she could come here and ask for pills, what are you going to do? She’s going to say a name and you are not going to say that it’s not true. That is too dangerous…They shouldn’t permit it for children…They don’t ask for their identification. There are young women that do it without being married, without having children, and it’s that they we should forbid” – Coumba, 39, Dakar

This quote begins to step away from a sheer question of accessibility and moves toward other questions of societal approval and the social acceptability of contraceptive use for different women. Questions of age, marriage, and social approval and the impact they have on a woman’s decision to use contraception or not will be discussed later. In Mouit, women’s perceptions of contraception’s availability differed more widely. Some expressed that they were not sure about availability as they had never used contraception before. Some believed it was available, stating that it was inexpensive and that midwives were stationed in every health district, and again one believed it to be even too available. Contrarily, certain women also believed that it was not easy for all women to access the method they desire because of interrogation on the part of health care workers:

“You need to come to the Case de Santé and say why you want to do family planning. I think that it’s not at all easy. Because they question you. They ask you. “Are you married? And your husband has he given you his approval? Why do you want to do it? For how long?” If you miss your appointment once, you need to go to the Poste de Santé de Tassinère” – Khadesia

This quote opposes the experience of the women in Dakar, and demonstrates perceptions that health care workers do not necessarily exist as un-opinionated providers of care. This perception contributes to women’s ideas about their own personal ability to access care, even if products are physically available. This idea of questioning on the part of health care workers and needing to state “valid: reasons for wanting to use contraception was also reflected in the responses of Dakar women, illustrating that when it comes to availability, not only physical accessibility but also emotional accessibility come into play.
According to providers, the physical availability of contraceptive products is regulated through placing orders with the national pharmacy, and is filtered through the hierarchical health system. Senegal’s health system is organized into three hierarchical levels, the widest-reaching being the sanitary district, followed by the medical region, and then, most locally-situated neighborhood health centers and health huts. For example, the community health agent at the level of the Case de Santé in Mouit is responsible for placing the order for contraceptive products through the Poste, and at that level the order is placed with the district, and so on. At the level of the Case, it appears that orders are made on an as-needed basis, with the needs of the women served in mind: “I don’t wait until the products are finished, when there are two or three left I go to get more. Because when a person comes, we shouldn’t tell them to wait until tomorrow, because we don’t know, we should give it to them on the spot” (Awa). At ASBEF, a supply of products is stored within the clinic itself, and are replenished via an order through the national pharmacy on a tri-monthly basis. The pharmacist then places orders within the clinic on an as-needed basis. Every health care provider at ASBEF noted that there had never been a shortage of products in their time working there.

*The role of providers*

It appears that the primary mechanism for distributing information about contraception occurs through counseling sessions that primarily take place between a woman and a health care provider who has been specifically trained in matters of family planning. This could be a midwife, as would be the case in a private Dakar clinic or at the level of any given Poste de Santé, or it could be a trained community health agent, as would be the case at the level of the Case de Santé. Providers stressed the importance of giving well-clarified counseling sessions that explained to women all of the different methods as well as their accompanying advantages and disadvantages. Most providers stressed that the decision to use a certain contraceptive method is a personal choice, although as I discovered, cultural constructions of what constitutes a personal choice and a private matter often include a woman’s husband. As for when these counseling sessions take place, at least in Dakar it appeared that a woman is most likely to obtain information about contraception after having already experienced a pregnancy:
“Once a woman comes here for a prenatal appointment, we talk to her about family planning. Even before she gives birth. We’ll educate her, from the start of the process. It’s a new process we’ve started, and we see now that brings its benefits because now there are more women who do family planning now that we have started to talk about it during prenatal consultations. We also do it during postpartum if the woman gives birth and we haven’t had the opportunity to talk about it during the prenatal consultations, or if she comes and brings her child to do vaccinations. If we lose the woman during the prenatal consultations, we’ll catch her during the vaccination. Every time that we have the occasion to see the woman, even if she’s not coming for family planning, we’ll talk to her about it.” – Fatoumata, Dakar Midwife

*Women’s knowledge*

Women reflected varying degrees of familiarity with different methods of family planning; all women interviewed in Dakar reported that they were familiar with pills. The majority of women in Mouit also reported being familiar with pills, although two women reported not being familiar with any specific family planning methods. Counting menstrual cycles (rhythm methods), lactation amenorrhea, withdrawal, and condoms were all methods that were sometimes brought up during other points of the interview as methods that women interpreted as being either traditional or in some cases even as alternatives to contraception, rather than being methods of contraception themselves (“Why don’t men just use condoms? It’s much easier” (Bineta)). In this sense, it seemed that some women’s interpretation of the term “family planning” necessarily implied strictly medical action on the part of the woman, that is to say using a method that explicitly requires a woman to visit a health facility. These methods are consistently perceived as being explicitly “modern methods of family planning”—that is to say pills, injections, IUDs, and implants, whereas others—condoms, cycle-counting, lactation methods, withdrawal—were sometimes perceived as methods of family planning but were also sometimes classified as traditional methods or even as alternatives perhaps tells of the ways in which various methods are viewed by the public and are discussed in social discourse. In any case, there appears to be a distinct disconnect in the level of familiarity that general women hold with the breadth of different methods available in relation to the information that providers report readily giving.

A major reason for this appears to be that women generate much of their knowledge through their lived experiences. Women in both places mentioned having encounters at school, and with friends,
family members, and classmates in addition to encounters with health care providers. More women in Mouit reported having experiences that related to “general talk,” overhearing conversations among older, married women. This perhaps represents a stronger notion of generally held sentiments on the part of the public that could be more easily interpreted given the often more consolidated scope of village life. Women reported encountering information about contraception for the first time across a variety of ages, as young as 10 and as old as 26. Many younger students in both settings recounted experiences with contraception having to do with their own families in some way, whether that be the experience of an older married cousin, observing the spacing between the ages of their own siblings, noticing their mother using pills, or even having explicit conversations with their mothers. In general, women that were in their late twenties and above reported first encounters that more commonly occurred in a medical setting—after having already given birth, for the most part. All women in Dakar reported accepting family planning based on their experiences. When reflecting on their first interactions with information about family planning, women in Dakar had one of three reactions: accepting immediately, accepting after speaking with their husband, and accepting after learning more information.

“I thought, ‘If I do that, won’t I have problems within my body? Won’t my life change?’ After they advised me, they told me how it works. I didn’t have my period, but when I came [to ASBEF] I learned that sometimes you have your period, sometimes you don’t have your period” – Aissatou.

“I was shocked at first. Because I said, to have children, it’s natural. It happens naturally, there’s no need for family planning. At another time, I realized that it’s a good thing because it’s necessary to space the time between births of children so that they can grow normally and be healthy. I was shocked, but it’s not that I didn’t accept it. It’s a good thing for humanity frankly” – Fatou, 20, Dakar

Women in Mouit more unanimously reported having initially negative, critical, or reluctant responses when they heard about family planning for the first time. Different from Dakar, some women in Mouit maintained their negative opinions of family planning, disliking that it interferes with having a child and also even believing that it would cause sterility or blindness. The disapproval of older women was also mentioned. Women that were of this opinion were all married. Similar to Dakar, however, were the
narratives of women that at first felt hesitant about both the morality and the physical side effects of using contraception, but who eventually gained more information and modified their opinions toward it:

“[woman says] said, mama that’s not good. That’s not connected to Islam. Islam does not accept that we space births like that. She said no, no no no, it’s necessary to do it to have good health, it’s to manage her health and not grow old, to revive, but I told her you shouldn’t do it in excess. You should do it one year, two years, but not more. She told me, ‘that’s good’” – Khadesia

“Some people, it’s difficult for them. Because they encounter problems they’ve never seen. Sometimes they don’t see their periods normally, sometimes they have pains they’ve never had, sometimes they gain weight and other things… but to have a pregnancy, it’s difficult to have a very very young child and to have a pregnancy at the same time, that is really hard. I find family planning, really, to be a good act.” -- Zeyna

Clearly in both settings, issues of religion and morality— as well as sheer physical side effects, contribute to the initial reservations that women have about using contraception. Even despite continuing negative perceptions that were held by women in Mouit, contraception was not viewed as something unimportant for the well-being of society; only one woman in Mouit explicitly conveyed that she did not believe family planning to be of value to society at large.

**Existing Education**

“There’s theater, advertisements, billboards, flyers, also women who go in the suburbs to see other woman to talk to them about family planning. I think it’s a very good thing because when you have a message to spread it’s necessary to spread it massively” —Fatou

Women’s initial reactions to and current appraisals of contraception differed, as did their appraisals of and appreciations for the current education that exists surrounding contraception.

Information about family planning is reportedly circulated via television, certain school curricula at the secondary level, (in classes called *science de la vie et de la terre*—life and earth science—and *economie familiale*—family economy) billboards and flyers, theater performances, and of course through *sensibilisations* and *causeries*, where health workers directly give information to people in the form of discussion groups or counseling sessions. In French, the word *causerie* literally means a talk or a conversation, whereas *sensibilisation* comes from the verb *sensibiliser* which means to raise awareness.

Many villages, Mouit included, have these causeries on a regular basis, even as frequently as once a week. Topics vary from session to session and cover not only family planning but also other health issues
like malaria, nutrition, and protection against STI’s. The discussions are typically led by trained community health agents. Different than with mass media communication, the responsibility of recruiting people to participate in these discussions lies directly with the community health agents, who described physically going around the village to extend invitations by visiting families in their homes and passing out information at social gatherings like baptisms. This type of community-based counseling only appears to occur within villages and in some suburbs of Dakar. There was no mention of causeries or specific home-based outreach programs with the midwives in Dakar, possibly because the bulk of the educating that they do takes the form of a counseling session with the woman who has already approached the clinic (most likely due to a pregnancy).

Figure 1. Prompt: “What message should be communicated about family planning in Senegal?”

<table>
<thead>
<tr>
<th>Response</th>
<th>Position, Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate the husbands.</td>
<td>Midwife, Dakar</td>
</tr>
<tr>
<td>Give well-clarified information, and reach women who aren’t educated.</td>
<td>Midwife, Dakar</td>
</tr>
<tr>
<td>Fight against rumors, and approach health personnel for information.</td>
<td>Midwife, Dakar</td>
</tr>
<tr>
<td>Encourage women to do family planning; birth spacing allows for education of children and for you to rest yourself.</td>
<td>Pharmacist, Dakar</td>
</tr>
<tr>
<td>Family planning is good, because it is an organization of birth and of health, of the woman and the child.</td>
<td>Community health agent, Mouit</td>
</tr>
<tr>
<td>Women at a reproductive age can do family planning.</td>
<td>Community health agent, Mouit</td>
</tr>
</tbody>
</table>
Providers discussed that increased education about family planning has resulted in increased use, and the paradigm of women expressing reservations, gaining clarified information, and deciding to accept (given the husband’s approval) was omnipresent throughout the interviews. The medical and social consequences of short birth intervals (“grossesses rapprochées”) appear to be well-integrated into collective understanding in both rural and urban settings, although not to the point where intervening to space births is universally favored. Education interventions focus more so on the inclusion and the involvement of men, namely husbands. Midwives in Dakar discussed encouraging women to bring their husbands to prenatal and postnatal appointments where they would normally also discuss family planning options. At ASBEF, women whose husbands accompany them to the clinic are seen by the midwives first in line, rather than taking a ticket and waiting with everyone else. The community health agents responsible for the causeries in Mouit also emphasized inviting men specifically to their discussions, although they stated it was never a guarantee that people will actually show up to the scheduled meeting. Aside from encouraging male participation in counseling sessions relating to family planning, some providers also discussed the importance of clearly explaining all side effects, and further re-explaining information to women who have already used a method of family planning, so as to curb rumors spread.

Future Education

For the most part, women were enthusiastic about bolstering education about family planning. The majority of women in Dakar thought that education and information available about family planning was insufficient and should be increased. Of the women in Mouit who expressed negative overall opinions of family planning, the sentiment existed that available information was sufficient but was unnecessary or irrelevant for them personally, and one woman expressed how she did not like women coming around the village to distribute information (the work of the community health agents). Women in Mouit who had positive perceptions of family planning also thought for the most part that education and information available about family planning needed to be increased. These women noted positive effects of discussing with women in the causeries, but stated that they thought that men should be integrated, that information should be explained more clearly, that efforts on the part of village health
professionals should be increased. Dakar women expressed desires for clearer information, more health education in schools, and some even suggested the same model as the *causeries*, stating that it would be a good idea to have trained women go into people’s homes, particularly in the suburbs.

**Implicated factors--Religion**

Religion is at the forefront of Senegalese culture, and thus I anticipated it to be the most predominantly mentioned social factor indicative of whether women use family planning, which women use family planning, and when women use family planning. Indeed, most women noted in some form the inextricability of culture and religion in Senegal, in both rural and urban settings. I found, however, that religion as it functions in the social equation of contraceptive usage goes more so to influence other social ideals, such as the purpose of marriage, normalized family structure, normalized number of children to have, and the degree to which this aspect of biomedicine is sometimes seen as actually imposing health consequences rather than ameliorating both health and social conditions. For example, although marriage independently does not necessitate or prohibit the usage of contraception among women, contraceptive use garners a significantly higher degree of acceptability when religious beliefs are taken into account due to inscribed values of preserving virginity. In this way, I found that for the most part religion’s effects are indirect, yet wide-reaching, and have fluid interpretations that can both favor and oppose contraceptive use. The one explicit example of a direct interaction between contraceptive usage and religion relates to the fact that women do not pray throughout the course of their menstrual cycles. For some, this includes times of spotting, and since certain contraceptive methods can induce spotting as a side effect, they can also directly affect a woman’s ability to exercise her religion.

When individuals were invoking sheer religious doctrine, i.e. referencing text from the Coran, I found that women were more likely to use interpretations that spoke favorably of birth spacing, rest for mothers, and proper education of children. When women spoke of the attitudes of men, however, those who disagreed reportedly also invoke religious doctrine, but they rely on the notion that children are gifts given by god, and that god intended people to have as many children as possible:
“Men, here, it’s religion…The problem is especially men. Because men, if you want to do family planning, they say no… Here in Senegal it’s a country, there are more Muslims. If you…say I want to do family planning, we start to tell you religion this, religion that, and between a husband and a wife you don’t want a problem, you leave it…They say that religion, religion asks us to have a lot of children, that’s what they say. That’s what they’re most preoccupied with. Religion asks us to have a lot of children; we should have a lot of children. And, family planning, it’s not to not have a lot of children but to distance the births. It’s necessary to educate people, men especially, to tell them, family planning, is this. If you want to have a lot of children, that doesn’t forbid you from doing family planning.” —Zeyna

This quote invokes the secondary influences that more directly affect the interpersonal reactions that women experience, i.e. the normalized number of children, marital structure, and the interactions between a husband and a wife. In general, it appears that religious and traditional doctrine makes it most difficult to accept contraception methods that involve modifying a woman’s body in some way, whereas more fluidity in interpreting religion is given when natural methods—practicing abstinence, withdrawal, rhythm methods, or lactation amenorrhea.

“Religious men, marabouts, they are a little hesitant about family planning. But family planning exists in Islam, we tell women to space their births over 2 years or to go to their parents’ house and stay there far away from their husband over 2 years to again avoid becoming pregnant. But there are also others who use the method of withdrawal, all of those are family planning methods. But the methods where you use pills, implant, and other things, those are where some men are a little hesitant” —Rokhaya, Dakar Midwife

While Islam’s influence widely reaches across many other social factors, its more concentrated and direct contribution to the current social situation of contraception in Senegal is its development of the mainstream discourse that “family planning is birth spacing not birth limiting”. This is the mantra of almost every woman who spoke favorably of contraception, including all health care providers, and this very well-engrained mindset no doubt finds its roots in the prominence of religion throughout so many facets of everyday life.

“The problem is that the Muslim religion will never want that, to stop births, no. If you do it, it’s your choice, but what the prophet has said, what god has said, is to have children. To stop having children Islam will not agree with that. But to organizes your children, Islam agrees with that” —Ndeye, 41, Mouit
Societal Approval—Marriage

Reasons that women classified family planning as important mirrored each other in both locations. Similarly, women in both Dakar and in Mouit largely invoked the same social caveats placing parameters on the acceptability and importance of contraception at the level of society. The most consistent of these caveats was a given woman’s marital status. Marriage serves as a cultural precursor for the acceptability of contraception because it also serves as a precursor for socially acceptable sexual relationships in both rural and urban settings. The vast majority of women in both Mouit and Dakar stated that women should be married before using contraception. Although many people acknowledge that premarital sex exists, they do not speak of it. Younger women expressed the idea that remaining abstinent is preferred for many but is not always possible, and that they preferred contraceptive usage if a person is going to be sexually active anyway. The most convenient access to accurate medical information, however, is structurally easier for women who are already pregnant (meaning either that the woman is already married or that the information is coming too late), as that’s where counseling sessions reliably take place. Advertisements also appear to be geared predominantly toward married women. There was also a sense of difficulty of speaking about premarital sex for those who are unmarried, even if they themselves are sexually active. Married women are seen as sexual authorities who have earned the right to discuss sexual matters among themselves, but intergenerational sexual discussion, particularly across lines of marital status, is very rare. I frequently encountered the notion that young, unmarried girls should be shielded or protected from information that they, as unmarried women, should not hear, at least in settings that were not academic. This idea was present in both Dakar and in Mouit.

“Because children, they watch too much TV, and when you are a girl, you are scared, because children watching television they could see things that they shouldn’t be watching.”—Coumba

“There are women that are authorized to talk about it, married women, they are authorized to do it and to talk about it among themselves”—Khadesia

“Whether you hear about it on TV or you hear others talk, at home, you don’t dare to talk about that [family planning]. Someone who is not married, for them, shouldn’t know that. Sometimes leaving school if we’ve had a lesson about that we discuss it, but it’s relating to the lesson or relating to the homework. That’s what we discuss but not the other side, we talk about this side only” — Amy
“For us in our society, a woman who isn’t married-- especially girls, girls who aren’t married-- don’t approach married women. Our society demands that if you are not married, you should keep company of women who are not married. If you are married, you should keep company with married women. It’s a manner of society. Because if you’re not married, you frequent people who are married, we are talking about this, we’re talking about that; you arrive there, you hear what people are saying... You’re going to discover what they were saying, what it is… that’s why we avoid. If you are not married, you do not frequent people who are married” – Zeyna

In this way, both undesired pregnancy and information about sex diametrically pose themselves as threats to unmarried women. By having information about sexual relationships before marriage, women are seen as being ‘removed’ from their culturally-accepted place within society, perhaps not with the same weight by which a woman with a premarital pregnancy would be, but certainly by a parallel mechanism.

Because of this, many women reported that they were not in favor of implementing sexual education for unmarried adolescents, because that would not coincide with the values of mainstream society. Even among women who were in favor of sexual education for unmarried adolescents, their reasons for stating this were so that these adolescents could learn about the negative consequences of sexual relationships (pregnancy and STI’s) so that they would be encouraged to remain abstinent until after marriage. These social ideals explain the majority of women in both Dakar and Mouit also believed that marriage should be a prerequisite for contraceptive use. Further, certain women in both locations also specified that women should already have multiple children before beginning contraceptive usage. Due to these societal standards in combination with contradictorily existing premarital sex, rather than determining whether or not a woman will use contraception, a woman’s marital status instead poses a question of secrecy:

There are many women that come [to seek family planning services]. Married and non-married. But it’s a problem of secrecy. The women who aren’t married need to keep it a secret. They come here and they talk about it with me… but I don’t write their name in the register. I give them an appointment card, and they keep it with them.”— Awa, Case de Santé Community Health Agent, Mouit

In general, the girls that aren’t married they hide that they have sexual relations because people will judge you…the problem especially is the look of people when you go to buy something because even the pharmacist, even if they try to seem professional, you can feel anyway that there is still a certain problem. I remember once I had a risky sexual encounter, and I went to buy a morning after pill. But when I went the person that was selling it to me hesitated a lot, saying to me “Are you sure this is
what you want? Do you really know what this does?” People in general seem to judge you. Friends and things like that, because you could have friends who have never had sexual relations and those people think that they’re a little superior to you because they’ve succeeded in preserving themselves until marriage… It’s not very easy to talk about it here, no. Even with friends and family… for example me, I only have one friend that I can talk about it with, only one. And I know that she will not judge me because she is in the same situation as me. But it’s very difficult to talk about it with others, because you never know what they’re going to think, and I prefer to not test that and to just keep it for myself – Saba, 21, Dakar

I found age to hold generally no significance in terms of the acceptability of using family planning when considered independently from marriage. Where age did play a role, though, was in older women’s disapproval of sexual promiscuity and curiosity among teenagers, even within the context of marriage, as well as in the notion that girls are able to get married while they are still in the years of basic schooling. Since marriage often implies subsequent pregnancy in this culture, marriage at a young age can pose a threat to a woman’s education.

“[There should be sexual education beginning at age 15] because now you see children who have babies at 16 years old… you are precocious. You believe that you are a woman even though you are a minor” – Aissatou

I had one classmate who had gotten married just before the start of the school year, now to avoid becoming pregnant during the school year, they gave her pills… As soon as we become pregnant here in Senegal, when you’re in a private catholic school, we don’t have the right as a woman to be pregnant and to come take classes at school. It’s forbidden. So, she was married. She should make love and have sexual relations with her husband, and to not become pregnant she used pills to not destroy her school year—Bineta, 20, Dakar

The Role of Husbands and the Perceived Attitudes of Men

Even among married women, however, a need for secrecy develops when a woman wants to use contraception and a disapproving husband enters the picture. While marriage was the most important response in regards to society’s prescriptions, the single answer overwhelming questions of women’s personal choices was the attitude and approval of her husband. Men’s attitudes toward family planning revealed an intricately woven social web of interrelating factors, but the weight of their opinion in influencing this aspect of healthcare appeared to stem from the fact that in this patriarchal society men are often given the last word, whether that be in terms of religion, finances, or family affairs. According to the Family Code of Senegal, passed in 2000, men are legally listed as the head of the household (Code),
even though many interview participants described the management of the household, including tending toward children and the husband himself, as a wife’s responsibility at the level of society.

“It’s the husband who says to the woman to do or to not do. Sometimes women come to do family planning. We explain to them all of the existing methods, the advantages, the side effects, but they hesitate. They say I’m going to go ask my husband to choose, even though their decision is personal. Every time the choice is personal.”—Rokhaya, Dakar Midwife

For the most part, women were most supportive of other women who had the approval of their husbands. Even constructions of what is ‘personal’ and what is ‘private,’ tended to exist such that they implicitly included the husband. The choice to use a method of family planning is regarded as being simultaneously “personal,” “private,” and “between a woman and her husband” (Awa). The most accepted degree of privacy pertaining to contraception thus exists at the level of a married couple, operating as a single unit, rather than just the woman independently.

According to the women interviewed, men’s attitudes toward family planning overwhelmingly “depend” on a number of factors, including his occupation, beliers that marriage’s purpose is having children, having a favorable opinion of children as a result of religion, believing that religion out-rightly opposes family planning, fearing that his wife’s health will be damaged by side effects, fearing sterility, and even experiencing social shame from having pregnancies that are too close together.

“Men think it’s not good. They will never agree with family planning. We wanted to convince them but they will never agree. Because they say that when a man marries a woman it’s to have children, but when a woman refuses to have children, why are you married? When the woman uses a method of family planning, she could not have children, why are you married?”—Khadesia

“Generally, I think that married women who stay at home who don’t use contraception and I think there are a lot of them, the reason they don’t do it is because their husband does not agree. I see often in the ads they just say, “let your wives do this, let your wives do this “because now in general it’s just them that don’t agree, but I don’t know how they justify why they do not agree”—Saba

“It causes psychosocial problems, familial problems especially, and more. There are women who have a lot of children, as many as 8, who want to stop, whose husbands refuse that they use family planning”—Mame Diarra, Dakar Midwife

“I’m not married, but I think that for those who agree there is not a problem. But for those who are against it they always find a problem, sometimes women are obligated to hide that they do family planning. There are men that understand the utility of family planning, but others do not understand or maybe they don’t want to understand”—Zakaria, Dakar pharmacist
“Because if you had a baptism this year, and you have 2 years or 3 years until the next baptism, it’s good. There are men that say, ‘I’m not announcing my baptism because I had a baptism last year, I’m embarrassed to announce it.’ If you have a baptism in 2015, and in 2017 you have another baptism. Your husband is embarrassed to announce the baptism if it’s very close, not even 2 years. Because if you have a child you raise it for two years, you rest for one year and you have another child, it’s better” — Mariama, Mouit Community Health Agent

“But in any case, it will always be a double-edged sword, you will have men who are okay with it and men who are not okay with it, but for the most part they are really open to adopting family planning…even some accompany their wives to the gynecologist to talk about family planning” — Fatou

Men and husbands in particular do seem to play a consistent role in regards to finances. Half of women in Mouit believed women to be financially independent enough to use family planning since it is not expensive, but the other half sided with the majority of women in Dakar, who expressed uncertainty as to whether or not women were financially independent to access family planning services in the event that worked as housewives and their husbands did not approve. Women also discussed how a man’s financial situation could influence his opinions and approval of contraception, depending on his ability to provide for his wife and children.

“Because if you are pregnant without the child being 24 months, you will get sick. Your child will get sick. Your husband’s pocket will be finished” — Awa

Finances are also important considering the fact that Senegalese marriage structures incorporate polygamy. One man could have up to four wives according to the Islamic faith, and this can also play a role in shaping a woman’s decision to use family planning or not:

“Here there are women, if your husband has a lot of wives, you choose to have a lot of children. Because now we say if the husband has a lot of money, you do not want one child or two children, because it’s the inheritance. Because the wife with lots of children gets a lot more of the inheritance than the wife that has 2 children. Here it’s our custom. “—Awa

Aside from the idea that polygamy would discourage women from using contraception, I also encountered the idea that a man with multiple wives would actually be more likely to encourage his wife to use family planning so as to avoid financial strain. Similarly, since a man with multiple wives is likely to have more children naturally, he might encourage his wife to use family planning for the sake of having the opportunity to “watch his kids grow up” (Bineta).
Perceptions of Rural Use

Although the cultural landscapes of Dakar and Mouit certainly differ greatly, women’s responses to issues of contraception were rather similar in terms of discussing social ideals. The women I spoke with in Mouit did in fact, however, did have more frequent negative perceptions of family planning. I find that women in Dakar, however, attribute this mainly to gaps in available information or a lack of information. If anything, though, it appears to actually be easier to access family planning information in a rural setting, as initiatives toward spreading awareness appeared to occur more at the level of the community, and often involved health care workers physically going into the homes of citizens to counsel them, whereas in the city the onus is on the woman to seek out information (unless she is already experiencing a pregnancy, in which case she will be counseled during her regular prenatal appointments). The walls of the Case in Mouit are covered with posters displaying numerous methods of family planning, and they include information about the side effects and the advantages of each method. This was different from the educational material I encountered in Dakar, which focused more on religious approval getting men invested in family planning\(^4\). One woman in Mouit, who had lived for a year as a student in Dakar at the University Cheikh Anta Diop, explained that she did believe there to be an overall difference in the level of general education across rural and urban settings. More than this, though, was her emphasis on how the effect of this is to influence family dynamics as a result, and that in her opinion this is the more deciding factor as to how family planning is both constructed and perceived in a rural setting.

“Especially in the village…there are people that don’t believe in it. They say no you shouldn’t do family planning it’s not good at all, and they base themselves on religion even though religion hasn’t said that. Even within religion it says that it’s necessary to not have a child for 2 years. It’s especially the husbands even if the woman wants to do it it’s the husbands that don’t want it. In the city, the parents, they have contact with their children. Children aren’t afraid to go to their parents and say this or that. They are like friends. Here in the village there are limits between parents and children, you do not dare to go to them and say this or that, even if you have a boyfriend you are scared to tell them that, the same as if you have had a sexual relation with him, that they’re going to kill you over that. So, in the city it’s much easier…that’s what I find because in the village…our parents did not go to school, but if you we go to the city as soon as

\(^4\) Refer to Appendix C
we meet our friends, them, their parents went to school…so there will be a difference. For me it’s that. They are educated but our parents aren’t educated” – Amy

This quote reveals that women in a rural setting perhaps do face very different degrees of different social influences than do women in urban settings. Perhaps the collectivist nature of the village presents initially more steadfastly supported opposition in the face of initial hesitance about unfamiliar medical products, but it is this same collectivist nature that allows for the success of the community-based education model in the form of causeries that do allow women to get the information and services they need to take increasingly more agency over their reproductive health.

As for providers, I found that while in Dakar they were more unified in their stances-- in particular that any woman of a reproductive age should be able to use contraceptives regardless of marital status or already having had a child, two of the three providers in Mouit believed that women should be married and should have already given birth to children before using a method of contraception. This notable difference in provider opinion across the two settings most likely contributes to discrepancies of use as well.

Traditional methods

Women in Mouit more readily reported knowledge of traditional methods of family planning than did women in Dakar. In fact, only the two oldest women interviewed in Dakar reported knowing of traditional contraceptive methods. All providers except for one in Dakar reported being familiar with at least one traditional method of contraception. One midwife in Dakar classified withdrawal (interrupted coitus) as a traditional method of family planning because it was described by the prophet Mohammed and has been practiced since then. As I mentioned earlier, some women also classified counting menstrual cycles as a traditional method of family planning. Otherwise, it appears that the two principle traditional methods of contraception are gris-gris, corded amulets worn around the waist, and a plant-based drink. The gris-gris are given by Marabouts, religious teachers and leaders, and are worn by women to protect them from becoming pregnant. Ideas about the exact social codes that govern the usage of these gris-gris varied from person to person. Some stated that they are to be worn during sexual
relations and then removed afterward, whereas others stated that they needed to be worn at all times, including bathing. Regions where this is practiced differed—some reported it to be popular in Casamance and the Gambia, whereas others classified it more as differing among religions, being practiced by the Pular, Wolof, and Serer. Another traditional practice was described that involves a woman physically leaving the house of her husband for the first 2 to 3 years after having given birth and returning to her parents’ house to live there. One of the biggest advantages in using a gris-gris is the fact that it is discrete; many considered this method to be more discrete than any western method. Since gris-gris may be worn for a variety of reasons, anyone that happens to see a woman wearing a gris-gris to prevent against pregnancy will not know its purpose from looking at it and will not make the assumption as to what it is being worn for. This was thus listed as one of the ways women are able to use contraception without the explicit approval of their husband. Interestingly, it was noted that these gris-gris are sometimes sought after by the parents of young girls, or by parents who suspect that their daughter may be sexually active, in an effort to protect her from becoming pregnant. In this way, religion not only works rather explicitly in tandem with notions of family planning, but also acknowledges the practice of premarital sexual relationships. Individuals who knew about these methods reported learning about them after hearing elderly women. In general, people reported that traditional contraceptive methods are more practiced in villages and are often less trusted and therefore less practiced than western methods, although they also seem to consistently garner more approval on the part of older generations and work more cooperatively with conservative religious interpretations.

*Intervention or imposition?*

Although I often encountered throughout participant’s responses that people were willing to negotiate the parameters of Islamic tradition for the sake of adopting family planning, I observed that much more rarely did participants bring up an implicit cultural conflict with the fact of biomedical contraceptive methods coming from the west. I attribute this in part to the fact that biomedical systems are so soundly integrated into the formal health care structure of Senegal that for many people it might not have even appeared to be a relevant question (“Because everything that we use that doesn’t come from here, all the
medication that we use comes from elsewhere” (Zeyna)). While many people stated that modern methods of contraception did currently elicit worries on the part of the Senegalese population, they most often attributed this to side effects rather than the fact that these methods were developed in the West. They did, however, almost unanimously recognize a conflict rooted in the mistrust of unfamiliar medical practices coming from the West in the 70s and 80s when contraception was first truly making its way into Senegal’s medical sphere. Regarding contraception through a lens of colonialism, one sees how initiatives to expand contraceptive access and use, particularly early on when information was less readily available, could be interpreted as efforts to limit populations of people living in African countries, if not to control them in one way or another. This sentiment, though not at all the dominant narrative of my findings, was also not absent:

“There are some [men] that don’t want it. They don’t understand anything at all about it —“it’s not good, this is something that we don’t know, and even the people in the health centers that give it to you don’t use it”—Zakaria

“It’s to sacrifice ourselves [to use contraception]. For them, the things that white people have brought here--so easily--because you know that it’s easy, 600 FCFA? It’s easy… Our predecessors did not know that…There are people here that think that people there [in the West] do not use it. You know that there are people that have refused that [contraception] because they say that tubaabs, as the Senegalese say, they brought that to reduce our population. Because they say that Africans are numerous, so to diminish them, to reduce them, you need to bring something that will last for a long time, 10 years 15 years 20 years, the population will decrease. Everyone thinks about that. Not everyone… but if I say everyone it’s because I’ve heard a lot of people say it, a lot of people say it. Because they say that Africans are numerous-- they want to reduce us by bringing them condoms, bringing them pills… That could destroy your family, in the long run, our children, when they get older, they won’t be able to have sexual relations correctly, or they won’t be able to have a lot of children” – Amadou, Mouit Nurse

The conflict brought up within these sentiments lies mainly in a sense of mistrust of the people who are in favor of contraception and their reasons for being in favor of it, as well as a suspicion that its purported benefits are disingenuous. In terms of the relationship between biomedical and ethnomedical methods of contraception, it appears that among Senegalese women in both settings the use of traditional contraceptive methods exists more and more on the fringe, and in the light of biomedical methods might no longer be trusted to work as effectively, at least as the sole method used. It is also of note that
participants’ responses to this question, perhaps more than others, could have been influenced by my own identity as a white American student.

Conclusion

Whether in a rural or urban setting, and whether using an ethnomedical or biomedical method, it appears that women’s motivations for using contraception and avoiding pregnancy remain fairly consistent: taking a socially-approved amount of time to both rest physically and to care for and educate the child (which is viewed as a mother’s responsibility), and providing financial stability for the household at large (in that men will have fewer expenses to pay with fewer and healthier children). Fewer women, though some, also mentioned increased agency on the part of the woman to work in other capacities, continue her education, travel, and have the time to do her own activities. In this way, in both rural and urban settings, family planning in Senegal is accepted as both a social tool and a medical tool, and is important to the women in both of these contexts. Ethnomedical methods of contraception, although much more sparsely used than biomedical methods, contain the same degree of complexity when it comes to the social determinants of seeking out protection from pregnancy. That is to say, that for both ethnomedical and biomedical methods of contraception, women’s perceptions are relegated by a series of socially-guided ideals that are most frequently informed by religious notions of the normal family structures and dynamics, the importance of fertility, and the value of maintaining virginity until marriage. It is also important to note that a certain level of fluidity exists in women’s personal classifications of “traditional” (ethnomedical) and “modern” (biomedical).

Removing contraception from the medical sphere and considering it in a social sphere alone, however, opinions become more selective as to who should be able not only to use contraception but also to access information about it. When it comes to outright opponents of family planning-- even for the sake of birth spacing and improved family management within marriage, tradition, religion, and the favorability of fertility are the most commonly invoked discourses, although many individuals mention the ways in which birth spacing works explicitly in tandem with both religion and
tradition as well. Divided social consensus on the exact parameters of the appropriateness of contraception—including which women should use and why, what methods are considered to be traditional/western, effective/ineffective, etc., can render certain methods socially, emotionally and even physically unavailable to some women.

For example, the medical and social benefits of contraception were discussed predominantly with regards to married women. Viewing contraception in this same light, as a resource for improving society, does not manifest when premarital sex is the arena for use. While contraception is for the most part positively viewed, when it is seen as a promotor of sexual activity it is also seen as a type of dangerous good, given the fact that multiple individuals brought up the dangers of using it in excess. The rhetoric of ‘birth spacing rather than birth limiting’ is well-engrained into the social understanding of contraception in Senegal, and while this helps certain women by providing a caveat for contraception’s opponents—namely men and the religiously conservative—it appears to simultaneously present barriers to care in that it silences unmarried women who may choose to become sexually active. These women then do not fit into the model of “family” planning that is dominantly presented by health care providers and media communications alike. And women do evidently make decisions outside of the mainstream rhetoric—not just about premarital sex but also the decision to utilize family planning services without the knowledge or approval of their husbands. These women are not given the same institutionalized support as those who do fit within what has been approved by the social mainstream. As a population of sexually active unmarried individuals exists silently among mainstream religious culture, it appears to be more challenging for women who could benefit from knowledge of contraceptive methods to receive information because of social stigmas. Carrying a pregnancy, however, can pose a threat to a women’s health, education, agency, and overall quality of life, regardless of marital status.

When one Dakar student explained that contraception in Senegal was a “always a double-edged sword,” she meant it in the sense that certain people will always be for it, and certain people will always be against it. While I agree that in navigating questions of contraception, women and health care
providers alike encounter one ‘double-edged sword’ after the other, it never results from two static, diametrically opposed social forces—pious versus unscrupulous, rural versus urban, men versus women, ethnomedicine versus biomedicine, or anything of the like. Instead, the issues that women face result from the fluidity with which individuals in both Dakar and in Mouit consider parameters for social acceptability, constantly shifting both personal and collective opinions of what is equitable and just. Within the facets of society that I explored, this can lead to conflicting standards that women face at large and within themselves, and the onus is often on them to mitigate the compromises they are willing to make and when.

**Further Studies**

As this project covered a broad range of different social factors, it presents the opportunity for many subsequent studies. Gaining more information from unmarried individuals specifically about constructions of premarital sex and how these individuals navigate their reproductive health while existing in a space of social taboo would be one place to start. A study exploring constructions of virginity, and what that actually means within the scope of adolescent romantic relationships in Senegal would also be very interesting and key to understanding more about social ideals of sexuality. While the perceived attitudes of men make their appearance in this paper, collecting the direct perspectives and opinions of men about their role in the decision as to when and if contraception should be used would certainly also present very interesting and important elucidation as to how to improve this area of reproductive health care within different Senegalese communities. Another interesting area of study would be exploring in further depth the differences in family relationships across rural and urban settings, examining the different language used among parents and children to discuss issues of sex, pregnancy, and family planning, and verifying the claim on the part of the student in Mouit that parent-child dynamics involve more open conversations within urban settings. Additionally, further studies exploring the social parameters of gris-gris used as a method of contraception would add depth to the understanding
as to how this aspect of tradition manifests within Senegalese society, including both how it is used as well as how it is appraised within this society.

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Appendix A

Sample Demographics

This inclusion of this quantitative information merely seeks to provide a supplement to the qualitative data that is the focus of this paper, as the small sample size cannot in any way claim to represent the entire population of either of the two locations studied.

Figure 1. General Information

<table>
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<th>Location</th>
<th>Number of Women Interviewed</th>
<th>Age Range (years)</th>
<th>Average Age (years)</th>
<th>Average # Years Urban Setting</th>
<th>Average # Years Rural Setting</th>
<th>Number Married</th>
<th>Number Unmarried</th>
<th>Number who report having used contraception</th>
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<td>Dakar</td>
<td>6</td>
<td>20-41</td>
<td>27.8</td>
<td>14.5</td>
<td>10.3</td>
<td>3 (one widow)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mouit</td>
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<td>19-70</td>
<td>32.1</td>
<td>2.6</td>
<td>27.6</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Figure 2. Occupations

Mouit

- Student: 28%
- Housewife: 43%
- None: 29%

Dakar

- Vendor/Retail: 17%
- Hospitality: 16%
- Student: 67%
Figure 3. Education

Mouit

- None: 29%
- Student: 28%
- Housewife: 43%

Dakar

- None: 0%
- Secondary: 33%
- University: 67%

Student | Housewife | None

Figure 4. Number of Children

Number of Children

<table>
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<th>Mouit</th>
</tr>
</thead>
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</table>
Appendix B

Sample Contraceptive Usage

Again, including this quantitative information does not rely and a representative sample size and thus merely serves to supplement the paper.

Figure 1. Marriage prevalence among women who use contraception

![Contraceptive Use](image)

Figure 2. Contraceptive Methods

![CONTRACEPTION TYPE](image)
Appendix C

Education Materials

Photograph 1. This informative pamphlet featured verses from the Coran saying that a mother should raise her children and rest for two years after giving birth, and also depicts a husband and wife are depicted seeking counseling from a health professional.


Photograph 2. An advertisement for a consultation hotline for family planning. The speech bubble reads, “Birth spacing, I talk about it with my husband.” The title of this organization is “Moytou Nef,” which in Wolof roughly means, ‘be wary about pregnancies that are close together’.

Advertisement was displayed in the Case de Santé in Mouit, photograph taken by author 24 November, 2016.
Photograph 3. This wooden poster was also available in the waiting area of the Case de Sante in Mouit, meaning anyone who happened to walk in for any reason would have the opportunity to see it. A laminated poster explaining all of the advantages and disadvantages of each method also hangs in the main consultation office, where all patients are seen no matter the reason.

Photograph taken by author 24 November, 2016.

Appendix D

Interview guide for general women

Fiche Technique protocole d'interview/ Clinique du Siège Association Sénégalaise pour le Bien-être familial (ASBEF)

Merci d’avoir accepté de répondre à mes questions. Comme vous savez, je vais vous poser quelques questions à propos de vos expériences, attitudes, et perceptions sur la PF. Ne pas oublier qu’il n’y a pas de réponses incorrectes. Je ne juge pas vos réponses. Je veux juste partager vos expériences de femmes sur la PF au Sénégal afin de pouvoir rédiger mon mémoire qui couronnera ma formation académique.

I. Experiences Personnelles

1. Quel est votre âge?
2. Quel est votre statut matrimonial?
3. Depuis combien d’années avez vous vécu en milieu urbain ?
4. Depuis combien d’années avez vous vécu en milieu rural ?
5. Quel est votre niveau d’étude?
6. Quelle est votre activité professionnelle ?
7. Avez-vous d’enfants ?
8. Si oui, combien?
Alors, tout d'abord, nous allons parler de vos expériences et connaissances sur la PF.

b. Quelles sont les différentes méthodes PF que vous connaissez ?
c. Connaissez-vous des méthodes traditionnelles de PF permettant d'empêcher les grossesses rapprochées?
   - Si oui pouvez-vous me dire en quoi elles consistent ?
d. Avez-vous une fois utilisé la PF ?
e. Quelle est la méthode PF que vous préférez utiliser le plus ?
   Pourquoi ?
f. Comment avez-vous entendu parler de la PF pour la première fois ?
   Quel âge aviez-vous ?
   Quelles étaient les informations fournies ? Qui vous avez donné ces informations ?
g. Quelle a été votre première réaction ?
h. Avez-vous accepté toute de suite la PF ou étiez-vous d'abord réticente ?
i. En avez-vous parlé avec des amies, votre époux, des membres de la famille (qui ?)

II. Éléments Culturels
a. Interprétation Personnel (ce que vous pensez)
   i. Générale
      1. Est-ce que la PF est importante pour vous ?
         Oui/ Non Pourquoi ?
      2. Quelle appréciation la société sénégalaise a-t-elle sur la PF ? *Relance : Expliquez*
      3. Pensez-vous que les utilisatrices de PF souffrent de stigmatisation ?
         *Relance : pouvez vous expliquer ?*
      4. Pensez-vous que les méthodes modernes de PF suscitent encore de la méfiance chez les populations ?
         *Relance : pouvez vous éclaircir cette assertion ?*

b. Représentation (ce que les autres pensent)
Pour les questions suivantes, veuillez me donner ce que vous pensez, ainsi que vos avis sur ce que pensent les autres

   i. Accessibilité
      1. Que pensez-vous sur la disponibilité des méthodes PF ?
         *Relance : est ce que les populations ont-elles facilement accès à la PF ?*
      2. Pensez-vous que les femmes sont indépendantes financièrement à accéder à une méthode PF ?

   ii. Education
      1. Comment appréciez-vous les communications faites sur la PF (source) ?
         Quels sont les messages les plus importants ?
      2. Pensez-vous qu’elle est suffisante ? Faut-il la renforcer ? si oui comment ?
      3. Est-ce qu’il faut promouvoir l’éducation à la Santé de reproduction (SR) et en particulier autour de la PF ?
         *Relance : devrait-on donner une éducation sexuelle aux gens ?*
         Si oui, comment ?
      4. A quel âge l’éducation autour de la SR/PF doit-elle commencer ?
iii. Mariage/Kinship
1. Faut-il être marié pour utiliser une méthode de PF ?
   *Relance : Que pensez-vous de l'idée qu'une jeune célibataire puisse utiliser une méthode PF ? Expliquez.*

2. Pensez-vous que les membres de la famille (mari, belle mère, belles sœurs…) doivent interférer dans le choix d'une femme d'utiliser ou non la PF ? Pensez-vous que la polygamie peut impacter l’adoption de la PF ?
   *Relance : quelle influence l’entourage peut-il jouer sur l’adoption de la PF ?*

iv. Religion
1. Quel rôle pensez-vous que la religion joue au Sénégal dans l’utilisation ou non de la PF ?
   *Relance : quel est l’impact de la religion sur la PF ?*

2. Quelle est la perception des guides religieux sur la PF ?

v. Tradition
1. Quel est l’impact de la culture sur l’adoption de la PF ?
   *Relance : Pensez-vous que l’utilisation de la PF peut-être en conflit avec la tradition sénégalaise ?*

2. Quelles sont les traditions qui encouragent le recours à la PF ?

vi. Age
1. Est-ce qu’il y a un âge approprié pour l’utilisation de la PF ?

vii. Genre
1. Que pensent les hommes de la PF au Sénégal ?
2. Les hommes encouragent-ils l’utilisation de la PF ?
3. Quelle est l’attitude des maris au sein du couple en ce qui concerne le recours à la PF ? Quelle est votre expérience en la matière ?
4. Parle-t-on facilement de PF au sein du couple ?

*Interview Guide for health care providers*

*Fiche Technique protocole d’interview avec les prestataires*
Merci d’avoir accepté de répondre à mes questions. Tout d’abord, nous allons parler de votre travail dans le cadre de la PF.

1. Pouvez-vous me décrire votre travail ?
2. Quelle place occupe la PF dans votre travail ?
3. D’après vos expériences, quelles sont les méthodes les plus utilisées ?
4. Pourquoi ces méthodes sont-elles les plus populaires ?
   *Relance : Pourquoi certaines femmes choisissent une méthode à la place d’une autre ?*
5. Quels sont les difficultés que vous rencontrez fréquemment concernant la PF ?
6. Comment donnez-vous l’information aux femmes à propos de la PF ?
7. À part vous, quelle autre personne ou facteurs sont impliqués dans la prise de décision d’une femme à utiliser une méthode de PF ?
   *Relance :
   a. La famille ?
   b. La polygamie ?
   c. Si elle a déjà des enfants ?*
d. La tradition ?
e. Un manque de confiance à la PF ?
f. La religion ?
g. L’âge de la femme ?
h. L’éducation ?
i. L’indépendance financière de la femme ?
j. La stigmatisation, les tabous, les idées préconçues ?

8. A votre connaissance, y-a-t-il des méthodes PF qui sont traditionnelles ? Des croyances ou des pratiques animistes, par exemple, qui ont les mêmes objectifs, c’est-à-dire arrêter ou espacer les grossesses ?
   Relance : Pourriez-vous les décrire ?

9. Comment les méthodes de PF sont reparties à travers le pays ?

10. Comment appréciez-vous la disponibilité des méthodes PF ?

11. Quel message qu’il faut véhiculer concernant la PF au Sénégal ?

12. Quel rôle joue le genre dans l’accessibilité et l’utilisation des méthodes de la PF ?

Maintenant, veuillez me dire quel est votre avis par rapport à ce que pense la société

1. La PF est-elle importante ?
   Relance : Si Oui, pourquoi ?
   Relance : Si Non pourquoi ?

2. En général, est-ce que les femmes doivent elles utiliser la PF ?
   Relance : Si Oui ; quelles femmes ?
   Relance : A quel âge ?

3. Quelles méthodes de PF faut-il utiliser ? Pourquoi ?

4. quel est l’impact de la culture sur l’adoption de la PF ?
   Relance : Pensez-vous que l’utilisation de la PF peut-être en conflit avec certaines traditions sénégalaises ?

5. Genre
   a. Que pensent les hommes de la PF au Sénégal ?
   b. Les hommes encouragent-ils l’utilisation de la PF ?
   c. Quelle est l’attitude des maris au sein du couple en ce qui concerne le recours à la PF ?
   d. Parle-t-on facilement de PF au sein du couple ?
**Appendix E**

**Consent form**

**Formulaire d’Adhésion**

**Titre du projet :** Etude de l’Impact Culturel de la Planification Familiale au sein Différentes Communautés au Sénégal

**Résumé du projet :** Pendant le mois de Novembre, je mène des interviews auprès des médecins, les infirmiers, les gens qui travaillent sur la santé des femmes, et les hommes et les femmes Sénégalaises de façon générale, dans le but d’apprendre davantage à propos de la planification familiale, et aussi quel rôle joue celle-ci (les pilules, les injectables, les implants, et les condoms) dans la société Sénégalaise. Je voudrais mieux comprendre de quelles manières ces méthodes (de la planification familiale) font parties intégrantes de la culture Sénégalaise, ou s’il y a des éléments qui sont en conflit avec la culture Sénégalaise. Je voudrais explorer les différentes attitudes et croyances à propos de la planification familiale en ce qui concerne les différentes identités sociales, y compris l’âge, le mariage, la religion, la tradition, l’économie, l’éducation, et le genre. Je dirige ce projet à Dakar et à Mouit, dans l’espoir d’intégrer les perspectives en milieu urbain ainsi que les perspectives en milieu rural.

**Introduction du chercheur :** Je m’appelle Angelina Strohbach. Je suis à ma troisième année à Northwestern University, ou j’étudie l’anthropologie et la santé au niveau international. Actuellement, je suis entrain de terminer une formation académique ici au Sénégal à l’institut qui s’appelle SIT World Learning. Vous pouvez me contacter par téléphone 78-4588-82-95 ou par email. AngelinaStrohbach2018@u.northwestern.edu.

**But du projet :** J’espère qu’aller jusqu’au but de ce projet va donner une meilleure compréhension de la façon dont la planification familiale est aperçue dans le contexte Sénégalais. Utiliser une méthode de planification et pouvoir contrôler les grossesses est important pour la santé des femmes, mais aussi pour la santé des enfants, ainsi que les autres aspects principaux de la société, comme l’éducation et l’économie. C’est important de savoir comment cet aspect de la santé est représenté et interprété dans un contexte Sénégalais pour garantir aux femmes une santé efficace et profitable.

**Procédures :** Je vais vous poser une série de questions à propos de vos expériences, vos opinions, vos attitudes, et vos croyances en ce qui concerne les différentes méthodes du planning familial. Je vais vous demander aussi des informations démographiques. Je vais enregistrer l’interview avec mon appareil pour que je puisse m’y référer plus tard et vérifier que j’ai bien compris ce que vous avez dit. Votre nom ne sera pas divulgué dans les informations que j’aurai recueilli. L’interview va durer environ 20 minutes, mais toutes les questions sont ouvertes à votre interprétation, donc la durée de chaque interview peut varier. Vous pouvez donner moins ou plus de détails en répondant à chaque question si vous le souhaitez, tout dépend de vous. Ces interviews ne seront écouter que par mon encadreur et par moi-même.

**Risques encourus :** Pendant l’interview, les questions peuvent toucher des sujets sensibles, et c’est possible que quelques-uns mettent mal à l’aise. Il n’y a pas de réponses correctes ou de réponses incorrectes. Si vous ne souhaitez pas, vous êtes libre de ne pas répondre à la question. Je ne vais pas vous juger à travers vos réponses ; les seuls objectives que j’ai c’est apprendre et avoir plus de connaissances. Votre nom ne sera pas inscrit dans le papier final. L’essai final sera disponible en ligne sur le site de SIT (http://digitalcollections.sit.edu/isp_collection/), mais si vous voulez une copie du papier, faites-le-moi-savoir.
**Avantages** : Il n'y a pas de compensation pour votre participation dans ce projet. Cette interview va vous donner l’opportunité de réfléchir et de partager vos expériences. J’espère que ce projet va encourager d’autres études dans l’avenir, qui pourront aider à améliorer la santé des femmes au Sénégal.

**Confidentialité** : Votre nom ne sera pas divulgué dans les informations que j’aurai recueilli. Je vais utiliser des pseudonymes dans le processus d’analyse des informations, et dans le papier final. Vos réponses ne seront vues que part mon encadreur et par moi-même.

**Caractère volontaire** : Participer à ce projet est entièrement optionnel. Vous avez le droit de refuser n’importe quelle question. Si vous acceptez l’adhésion en bas, vous avez l’option de changer d’avis et d’arrêter votre participation à tout moment. Il n’y aucune conséquence si vous ne souhaitez pas répondre ou si vous décidez de vous arrêter à mi-chemin.

**Contacts et questions** : Veuillez contacter Angelina Strohbach avec les questions ou les soucis, téléphone 78-4588-82-95 ou email AngelinaStrohbach2018@u.northwestern.edu. Si vous voulez parler avec quelqu’un d’autre, veuillez contacter M. Souleye Diallo, le directeur académique de SIT Sénégal, téléphone 33-864-05-04, email souleye.diallo@sit.edu

**Declaration d’adhésion**

Votre signature indique que vous acceptez volontairement de participer à ce projet.

__________________________________________________  _____________________
Signature du Participant                                    Date

__________________________________________________
Signature du Chercheur                                     Date

__________________________________________________
Nom du Chercheur                                           Date
**Appendix F**

**Activity Log**

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<td></td>
<td>Editing consent form, introduction letter, and interview questions</td>
<td>1 pm</td>
<td>5 pm</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(work with language teachers to improve French fluency)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10/11</td>
<td>Write interview questions for providers and edit the French Background</td>
<td>10 am</td>
<td>12 pm</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>IPPF/ASBEF research</td>
<td>1 hour</td>
<td></td>
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</tr>
<tr>
<td>11/11</td>
<td>Meet with Director of ASBEF, check in with advisor</td>
<td>9 am</td>
<td>12 pm</td>
<td>3</td>
</tr>
<tr>
<td>13/11</td>
<td>Redevelop project plan, calendar</td>
<td>1 pm</td>
<td>1:30 pm</td>
<td>.5</td>
</tr>
<tr>
<td>14/11</td>
<td>Meet with ASBEF clinic coordinator Gora to discuss, modify, approve study</td>
<td>9 am</td>
<td>12 pm</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>at ASBEF</td>
<td>12 pm</td>
<td>4 pm</td>
<td>4</td>
</tr>
<tr>
<td>15/11</td>
<td>Meet with Gora, initial clinic descriptions</td>
<td>9 am</td>
<td>11 am</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Interviews with women and midwives, observations and initial data entry</td>
<td>11 am</td>
<td>4:30 pm</td>
<td>5.5</td>
</tr>
<tr>
<td></td>
<td>during down time</td>
<td>5 pm</td>
<td>6:30 pm</td>
<td></td>
</tr>
<tr>
<td>16/11</td>
<td>Clinic observation, interview with pharmacist and midwife</td>
<td>9 am</td>
<td>1:30 pm</td>
<td>4.5</td>
</tr>
<tr>
<td>17/11</td>
<td>Interview transcription and coding</td>
<td>8 pm</td>
<td>12 am</td>
<td>4</td>
</tr>
<tr>
<td>18/11</td>
<td>Interview transcription and coding</td>
<td>6 pm</td>
<td>8 pm</td>
<td>2</td>
</tr>
<tr>
<td>21/11</td>
<td>Meeting with advisor</td>
<td>9 am</td>
<td>12 pm</td>
<td>3</td>
</tr>
<tr>
<td>23/11</td>
<td>Meeting with head nurse at the Case</td>
<td>9 am</td>
<td>11 am</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Interviews with health practitioners</td>
<td>11 am</td>
<td>1 pm</td>
<td>2</td>
</tr>
<tr>
<td>Date</td>
<td>Time spent in Case, interviewing and observing</td>
<td>Transcribing and coding</td>
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<tr>
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</tr>
<tr>
<td>24/11</td>
<td>3 pm, 9 pm, 11 pm, 4 pm</td>
<td>9 pm, 11 pm, 7 pm, 2 pm</td>
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</tr>
<tr>
<td></td>
<td>Interview with nurse</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Time spent in Case, interviewing and observing</td>
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<tr>
<td>25/11</td>
<td>9 am, 2 pm, 7 pm, 4 pm</td>
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<tr>
<td>26/11</td>
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<tr>
<td>27/11</td>
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<td>28/11</td>
<td>10 am, 3 pm, 7 pm, 4 pm</td>
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<td>30/11</td>
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<tr>
<td>2/12</td>
<td>9 am, 8 pm, 11</td>
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<tr>
<td>4/12</td>
<td>9 am, 8 pm, 11</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5/12</td>
<td>9 am, 7 pm, 12 pm, 4</td>
<td>1 pm, 12 pm, 5</td>
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</tr>
</tbody>
</table>

Total hours spent: 148

**Appendix G**

**Expenditures**

120,000 fcfca = homestays

95,000 fcfca = food and water

65,000 fcfca = transportation

20,000 fcfca = total printing and binding costs

Total Expenditure: 300,000 fcfca

**Appendix H**

**Contacts**

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