



2011 Baseline Survey for the Senegal Urban Health Initiative (ISSU) Household Survey: Final Report

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Ministère de la Santé et de la



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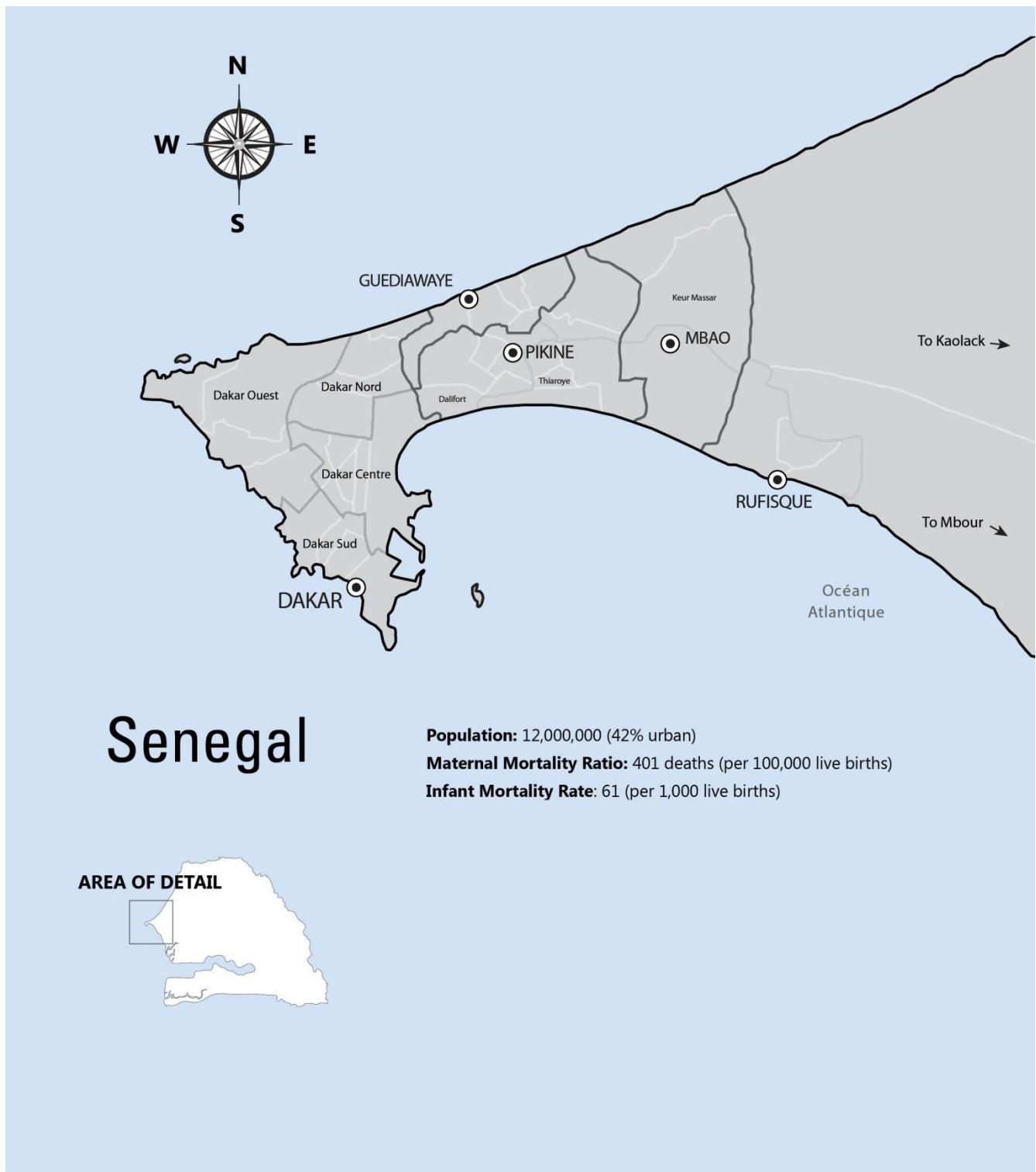
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MAP OF SENEGAL



LIST OF ACRONYMS

ANSD	National Agency of Statistics and Demography
APHRC	African Population and Health Research Center
BMGF	Bill & Melinda Gates Foundation
CD	census district
CPC-UNC	Carolina Population Center from the University of North Carolina in Chapel Hill
CRDH	Research Center for Human Development
DHS	Demographic and Health Survey
DSR	Division of Reproductive Health
FP	family planning
GPHC	General Population and Housing Census
HIV	human immunodeficiency virus
HN	head nurse
ISSU	Senegal Urban Reproductive Health Initiative
IUD	intra-uterine device
LAM	Lactational Amenorrhea Method
MICS	Multiple Indicator Cluster Survey
MLE	Measurement, Learning & Evaluation
MNCH	maternal, neonatal and child health
NGO	nongovernmental organization
RH	reproductive health
STI	sexually transmitted infection
TFR	total fertility rate
UR	unreported/unavailable
USAID	United States Agency for International Development

PREFACE

In order to achieve the Millennium Development Goals (MDGs), the Senegalese Ministry of Health and Social Action through its Division of Reproductive Health (DHS) is implementing the road map for the reduction of maternal and neonatal mortality in order to improve the health and well-being of the Senegalese population. The Senegalese Urban Health Initiative (ISSU) is a five-year project (2010-2014) that is supporting the Ministry of Health in repositioning family planning in order to reduce the risk of maternal and neonatal mortality in Senegal.

The ISSU project is aimed at improving the quality of life of the urban poor across Senegal through the increased access, quality and use of family planning services. The project serves as a “testing field” and its goal is to prove that innovative approaches based on quality health care delivery in the public and private sectors, as well as demand creation and advocacy efforts, can significantly increase the use of modern family planning methods by the urban poor in francophone Africa. The ISSU project is implemented through a cooperative agreement between IntraHealth International and the Bill & Melinda Gates Foundation in six cities in collaboration with a consortium of partners.

Prior to the implementation of these interventions, the ISSU project conducted a DHS-type quantitative survey in the six cities in order to collect and analyze baseline information that will provide a better understanding of the family planning issues and needs in urban areas. The survey revolves around two components: a household component and a service delivery component. The following report deals with the household component. This area of the quantitative survey focused on various topics, including the socio-economic and demographic characteristics of households, marriage, fertility preferences, family planning, maternal and child health, as well as communication between spouses. It provides key data on crucial reproductive health issues in urban areas. Finally, this survey provides access to a wide range of updated (or even new) information that is needed for economic and social planning purposes. Throughout this report, the Ministry of Health and Social Action will find essential tools that may be used as part of the monitoring and evaluation of the 2009-2017 National Health Development Plan (PNDS).

Following the submission of this report, a national conference will be held in order to present and share the results from the survey. All the documented results will also be available online in order to make this data more accessible to the scientific community, and especially to the government and its development partners. I am convinced that all these stakeholders will leverage this valuable information in order to better plan their activities.

This survey was conducted by the Human Development Research Center (CRDH) with the technical assistance of the Measurement, Learning and Evaluation (MLE) team. The success of this survey conducted by the CRDH shows that the government chose the most relevant approach by trusting local experts. I would like to congratulate the CRDH for their achievement and thank the MLE team for its precious support.

The implementation of this survey mobilized significant financial resources. I would like to thank the Bill & Melinda Gates Foundation for funding this initiative. I would also like to thank all our partners at the institutional level and all the individuals who contributed to the success of this large investigation. Finally, I would like to express my deepest gratitude to the population and the civil servants for their availability throughout the data collection process in the field.

Pr. Eva Marie Coll Seck

Ministry of Health and Social Action

FOREWORD

The Urban Reproductive Health Initiative was launched by the Bill & Melinda Gates Foundation as a component of its global strategy in the area of family planning/reproductive health (FP/RH). The initiative's main objective is to significantly increase the use of modern contraceptive methods in targeted urban areas in Kenya, Nigeria, Senegal, and the State of Uttar Pradesh in India. The Measurement, Learning & Evaluation (MLE) project is one of the components of this initiative and is in charge of data collection and analysis. The MLE project also supports the implementation and monitoring of the various interventions. In order to meet these obligations, the MLE team developed and conducted baseline surveys in each target country.

It is our pleasure to submit this report on the household baseline survey that was carried out in Senegal by the Research Center for Human Development (CRDH) with technical support from the MLE project—including the Carolina Population Center from the University of North Carolina in Chapel Hill (CPC-UNC) and the African Population and Health Research Center (APHRC) based in Nairobi—and in collaboration with the Senegalese Urban Reproductive Health Initiative (ISSU). This baseline survey was conducted in six sites targeted by the ISSU, including Dakar, Guédiawaye, Pikine, Mbao, Mbour, and Kaolack.

We would like to thank Dr. Bocar Daff, head of the Division of Reproductive Health at the Ministry of Health and Medical Prevention, and Mr. Salif Ndiaye, head of the CRDH, for the roles they in the successful implementation of the baseline survey.

We would also like to thank the MLE team, including Pr. David Guilkey (project director), Jean-Christophe Fotso (main researcher), Dr. Gwendolyn Morgan (technical coordinator), Ms. Meghan Corroon (technical assistant), Dr. Estelle Sidzé (technical assistant) and Mr. Cheikh Mbacké Faye (MLE local representative in Senegal).

Finally, we would like to acknowledge the support of the ISSU staff, including Mr. Baka Tambouri Ndiaye (monitoring, evaluation and research manager) and Mr. Djimadoum Koumtingué (monitoring & evaluation assistant).

We hope that this report will help the ISSU, as well as other programs, better inform their interventions in order to increase demand and provide improved access to family planning in Senegal.

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Reproductive Health Initiative
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ACKNOWLEDGMENTS

The household part of the baseline survey of the Senegal Urban Health Initiative (ISSU) was implemented by the Research Center for Human Development (CRDH) with the technical assistance of Measurement Learning Evaluation (MLE).

This survey mobilized considerable financial resources and required the availability and competence of several people.

This is why I would like, on the occasion of the publication of this report, to express my sincere gratitude to the Government of Senegal whose various divisions were of great help in this research.

I would also like to thank:

- The technical and administrative personnel of the Ministry of Health and Medical Prevention, at central and peripheral levels, for their valuable contribution
- The personnel of local authorities for their considerable support in household sampling and enumeration as well as data collection
- The researchers of the technical team (CRDH, MLE, ISSU) for their competence and availability
- Field staff: interviewers, team leaders, and supervisors. Their professionalism, dedication, and resilience were crucial to the success of the survey.
- The IntraHealth office staff for their efficiency.

Finally, I would like to thank the populations of the localities surveyed as well as administrative, local, and tribal authorities for the warm welcome extended to field staff.

El Hadj Babacar Gueye
Head of Mission/Resident Representative
IntraHealth International Senegal

EXECUTIVE SUMMARY

The baseline household survey was commissioned by IntraHealth International as part of the Senegalese Urban Health Initiative project (ISSU) and was conducted by the Centre de Recherche pour le Développement Humain (CRDH) with technical assistance from the Measurement, Learning and Evaluation (MLE) project and ISSU. Both ISSU and MLE are financed by the Bill & Melinda Gates Foundation as part of the Urban Reproductive Health Initiative being implemented in Senegal, Nigeria, Kenya, and the state of Uttar Pradesh in India.

Methodology

The household survey was conducted in six cities (Dakar, Pikine, Guédiawaye, Mbao, Mbour, and Kaolack) to provide information needed to develop evidence-based family planning (FP) interventions and to establish a baseline for the evaluation of these interventions. Data were collected from a representative sample of 5,523 households. Interviews were conducted with 9,614 women aged 15-49 in all households in all cities and with 2,270 men aged 15-59 in half of the households in four cities (Dakar, Pikine, Guédiawaye, Mbao).

Main Findings

The population is young with about a quarter of the population between 15-19 years. More than three in ten people have completed their primary education. In most sites, the proportion of women who have attained a primary level of education is higher than that of men. However, women are less likely to have completed secondary school, or higher, than men. More than four in ten women have been employed in the past twelve months in all sites.

Despite significant disparities, the fertility level is relatively high: in all sites, more than a quarter of women have at least three living children. The proportion of women with four or more children ranges from 17% to 26%.

In all sites, about half of women are living in union. The percentage of single people is higher for men than women. The percentage of women who entered into marriage at the age of 17 or younger is generally between 20 and 30% across the sites. The percentage of people who had sexual intercourse for the first time before age 18 ranges from 29% to 41% (women) and from 22% to 32% (men).

In terms of fertility, the total fertility rate, that is the average number of children a woman would have if she experienced the current fertility rates, ranges between from 3.14 in Dakar to 4.54 in Pikine. Between 8% and 17% of teenage women surveyed (ages 15 to 19) have been pregnant at least once. The breakdown of women according to whether or not they want (more) children shows that 31% to 37% want a child but only after they get married. In total, 35-40% of women want more children but at a later, unspecified date. Conversely, the percentage of women who claimed they wanted more children within the next 24 months, almost identical in all cities, is 20-22%.

In all sites, the need for spacing is far greater than the need for birth limitation, the only exception being the wealthiest segment of women in Guédiawaye where there is a slightly greater need for limiting births. Unmet need for FP ranges from 21% to 28%. Almost all women (97% to 98%) are aware of at least one contraceptive method. In the majority of cases, modern methods were cited spontaneously, while in many cases traditional methods had to be described before they were

recognized. The percentage of women who used a contraceptive method at some point in their life is above 45% among women living in union.

Between 20%-32% of women currently in union were currently using a modern method of family planning. The most commonly used methods among women in union are, oral contraceptive pills and injections; only a small percentage of women in union use male condoms, implants, and the IUD. The public sector is the main source of all methods. The private sector, including pharmacies and private clinics, are also an important source of family planning but this varies from city to city.

Barriers to FP

Certain beliefs and misperceptions are likely to deter women and men from using contraceptive methods. Many women surveyed believe that: contraceptives are hazardous to a woman's health and the health of a future baby; that they can damage the uterus; reduce sexual desire; cause cancer; and that getting a contraceptive injection makes women permanently sterile.

Although more than 50% of women in union have discussed the subject of FP with their husband/partner, more than two in three women claimed they needed the consent of their partner or family before they could use FP.

Results on future use of contraception reveal that between 13% and 22% of women 13%-25% of men who did not use a contraceptive method at the time of the survey do not know whether they will use a contraceptive method in the future. In all sites, approximately 80% or more women claimed they had access to contraceptive products and would use an FP method even if none of their friends/relatives used them. However, a significantly lower proportion of women would go against their partner's wishes (30% to 40%) and, between 10% and 23% of women report that they could continue to use a method if they experienced side effects.

Opinions and perceptions on the quality of contraception services show that a percentage of women (as high as 28% in Guédiawaye) believe that FP service providers in their community do not treat customers well.

Maternal and child health

The breakdown of women who have had a live birth since 2009 by place of delivery indicates that, in all sites, the vast majority of women (more than three in four) gave birth in a public health facility. The integration of FP services into maternal and child health services and sexually transmitted infection (STI)/HIV services was evaluated. In all sites, more than three quarters of women did not receive FP information or counseling during their last visit to a health facility for maternal health care purposes. The vast majority of women (six or more in ten) who have given birth in a health facility since 2009 received no FP information or advice before or after the birth. The proportion of women who were prescribed a contraceptive method during their last visit for STI/HIV treatment in a health facility was extremely low.

Summary of Conclusions and Recommendations

- **Strengthen and scale interventions that improve FP services (both quality and integration):** By allocating additional resources to these interventions it is expected that more providers will be able to offer quality FP products and services throughout the health system.

- **Focus FP communication on spacing messages:** Research in the six cities has shown that unmet need for spacing is greater than unmet need for limiting births.
- **Explore the role of pharmacies in the provision of FP methods:** Although Senegalese law limits the sale of contraceptives to those who have a prescription; the development of the private sector (especially pharmacies) is a priority to expand access.
- **Reduce barriers to the adoption of FP:** Pervasive myths and misperceptions about FP and contraceptives must be addressed, and potential users must be provided accurate information on FP and feel that products are reliable and safe.
- **Seek the public endorsement of FP by religious leaders:** Although very few people mentioned religious interdictions as part of the reasons for not using FP, Islam is a major influence on Senegalese social and cultural environment, and religious leaders need to be involved so that they can provide accurate information on FP to their followers.

CHAPTER 1: INTRODUCTION

Geography

Senegal is part of West Africa's Sudano-Sahelian region, situated between 12°8 and 16°41 north latitude and 11°21 and 17°32 west longitudes. Its western point is the most western of continental Africa. The country covers a surface area of 196,722 km², bordered on the north by Mauritania, on the east by Mali, on the south by Guinea Bissau and Guinea Conakry, and on the west by the Atlantic Ocean. Gambia, situated between the Kaolack, Tambacounda, Ziguinchor, Sédhiou, and Kolda regions, forms an enclave along the Gambia River. Surface water resources consist of four major rivers (Senegal, Casamance, Gambia, and Saloum) and their tributaries, plus a few intermittent streams.

Senegal is a flat country where the altitude rarely exceeds 100 meters. Mount Assiriki, in the southeast of the country is the highest peak (381 m). Its Sahelian climate includes a rainy season which lasts three to four months from July to October, with a peak in August-September, and a dry season from November to June. The rainy season varies depending on the latitude (less rainfall in the north than in the south).

The country is administratively divided into 14 regions¹, with each region subdivided into departments (45 in total), which are themselves subdivided into districts (121 in total) and rural communities.

Economy

Senegal is a mostly rural Sahelian country with relatively limited natural resources. It features among the world's Least Developed Countries and qualified for the Highly Indebted Poor Country Initiative in April 2004. The poverty phenomenon appeared and grew in the 1990s with the continuous deterioration in households' living conditions despite an increasing economic growth rate. The trend over the past five years shows a constant level of poverty, despite improved access to certain essential social services. It should however be noted that Senegal is above the maximum threshold of Least Developed Countries according to IMF figures (per capita income of \$967 for a threshold of \$965).

The global economic crisis curbed Senegal's economic growth, down to 1.7% in 2009. It recovered in 2010, up to 2.7%, and should reach 4% in 2011. The economy suffered from the rise in global prices, difficulties in the energy sector, and government arrears vis-à-vis the private sector. Inflation remains high due to soaring prices of basic foods and oil, despite the subsidies and tax measures adopted by the authorities in these two sectors. Human development indicators remain extremely low (144th out of 169 countries in 2010), and more than 50% of the population is living below the poverty line.

Compared with other African countries, Senegal has very few natural resources. Most of its revenue comes from fishing and tourism. However, in light of its geographical situation and political stability, Senegal is one of Africa's most industrialized countries and hosts mostly French and, to a lesser extent, US multinationals.

The primary sector (13.7% of the GDP in 2010, 50% of the labor force) is vulnerable to natural conditions and the volatility of global prices. The fisheries sector suffers from the depletion of fish

¹ In alphabetical order: Dakar, Diourbel, Fatick, Kaffrine, Kédougou, Kaolack, Kolda, Louga, Matam, Saint-Louis, Sédhiou, Tambacounda, Thiès, Ziguinchor.

resources. Secondary activities (20.5% of the GDP) rely on the extraction and processing of phosphates, food processing, construction and the cement industry, supported by the diaspora's real-estate investments. The tertiary sector (65.7% of the GDP, including public services) remains largely informal. Tourism is affected by intensified competition between world destinations. The banking and insurance sector is particularly dynamic and competitive. Financial transfers from the Senegalese diaspora (emigration toward Europe and the USA) currently represent a significant investment. The cash flow generated by Senegalese emigration is estimated to be at least equal to the volume of international cooperation aid (i.e., \$37 per capita per annum).

Large-scale reforms seem to have helped improve the business environment, notably the privatization of state-owned companies. In November 2007, Senegal gained access to the IMF's Policy Support Instrument program. Senegal is a member country of the World Bank, the World Trade Organization, and the West African Economic and Monetary Union.

Population and Urbanization

The population of Senegal was estimated at 12,855,153² in 2011, i.e. 65 inhabitants per km². The country is characterized by a rapid growth in population (2.6% per annum) and a high proportion of young people: 58% of the population is under 25. Although the total fertility rate (TFR) decreased between 1978 and 2010 from 7.2 to 5.0, fertility remains relatively high in Senegal. According to the data of the 2010 Demographic and Health Survey (DHS)-V-Multiple Indicator Cluster Survey (MICS), fertility is high in rural as well as urban areas. Procreation occurs at a younger age in rural areas. In addition, the fertility of 15 to 19 year-old adolescents represents 9% of total fertility; the corresponding percentages are respectively 10% and 7% for women in rural areas and those in urban areas.

Although Senegal is comprised of more than 20 ethnic groups, more than 90% of the population belongs to five dominant groups: Wolof (38.7%), Pulaar (26.5%), Sereer (15%), Joola (4%), and Manding (4.2%). The population of Senegal is essentially Muslim (95.4%). Christians represent 4.2% of the population while animists and followers of other religions account for 0.4%. (MICS-DHSV, 2010-2011).

The literacy rate is strongly correlated with the level of urbanization. For a national average of 65% of illiterate individuals, the lowest illiteracy rate is found in Dakar (35%), followed by Ziguinchor with 43%. In other regions, outside of Saint-Louis and Thiès, illiteracy exceeds 75%.

With a 41% urbanization rate, the Senegalese population is strongly concentrated in cities, in particular the capital: Dakar occupies 0.3% of the national territory and is home to 22% of the population. Conversely, in the eastern part of the country, the Tambacounda and Kédougou regions cover 30% of the country's surface area and host only 6% of its population.

² Forecasting and Statistics Directorate, General Population and Housing Census, 2002, Population projection, January 2004.

Family Planning Policy

Family planning (FP) was introduced in Senegal in 1960 at the Blue Cross Clinic. The Family Welfare Association inaugurated its first model clinic in 1975. Other projects and programs were launched within the Ministry of Health: the Family Health project in 1981, the national FP program in 1982 and the Family Welfare project in 1984. The structure responsible for implementing the program has undergone significant changes. In 1997, it was established as the National Reproductive Health Department before becoming the Division of Reproductive Health (DSR) in 2001. The objective was to improve the health of the population in general and reduce maternal and child mortality in particular by controlling fertility to prevent high-risk and unwanted pregnancies and manage infertility and sterility.

Since the Population Policy adopted in 1988 was updated in 2001 to include reproductive health, Senegal has put in place health development plans, the latest being the phase II health development plan (2008-2015). Part of this population policy's strategy was to legalize FP. Reducing maternal and child mortality also became one of the priorities of this plan. This political desire became a reality in the form of a progressive increase in the State's operating budget allocated to health, from 8.25% in 1999 to 9.8% in 2004, and the construction and development of infrastructures.

As part of the implementation of the multi-sectoral roadmap developed and validated in 2006 to accelerate the reduction in maternal and neonatal mortality, different initiatives were undertaken with a view to increasing the availability, use and quality of services (including broadening the product range and introducing FP at community level).

ISSU Project

The Senegalese Urban Health Initiative (ISSU) is a five-year project (2010-2014) aimed at promoting FP in Senegal's disadvantaged urban areas. It is financed by the Bill & Melinda Gates Foundation as part of an extensive reproductive health (RH) initiative including India, Nigeria and Kenya. It is implemented in six Senegalese cities (Dakar, Pikine, Guédiawaye, Mbao, Mbour and Kaolack) by a consortium of partners led by IntraHealth. The consortium includes FHI360, Marie Stopes International (MSI), Environment and Development in the Third World (ENDA), *Action et Développement* (AcDev), the National Association of State Midwives (ANSFES), the Islam and Population Network (RIP), the Association of Journalists in Health Population and Development (AJSPD) and IntraHealth International.

The project's objective is to significantly increase the prevalence of modern contraception in certain urban areas. The two major success indicators are: 1) contraceptive prevalence increases by 20 percentage points by the end of the five-year Initiative in the four cities (Dakar, Pikine, Guédiawaye, Mbao, from 18% to 38%) and 2) contraceptive prevalence in the three lowest welfare quintiles increases by 20 percentage points (from 12% to 32%).

These results will be achieved by introducing new and improving existing FP services and interventions to create demand which improve FP quality. More specifically, the purpose of the project is to:

- Integrate FP into maternal and child health and HIV / AIDS
- Increase the demand for contraceptive methods
- Increase the role of the private sector in the supply of contraceptives

- Mobilize resources and develop a favorable political environment to improve access to FP supplies and services for the disadvantaged populations of Senegalese cities and in French-speaking West Africa
- Disseminate the results of the Initiative.

This approach will be evidence-based and implemented in close collaboration with the Ministry of Health via the DSR. These interventions will be fueled by the basic research which will be implemented by the Measurement, Learning & Evaluation (MLE) project, adapted to requirements and tested using strict operational research methodologies.

The DSR, project leaders, and the members of the consortium will share evidence-based approaches, models, and tools enabling progress towards the achievement of the project's objective. The project will also collaborate with the USAID-funded Progress project, and other appropriate groups, to ensure that the evidence required to reform the national FP policy is available and used to facilitate the transition from policy to practice for increased use of modern contraception among the disadvantaged populations of urban areas.

The Measurement, Learning & Evaluation project

The Measurement, Learning & Evaluation (MLE) project is the evaluation component of the Urban Reproductive Health Initiative implemented and financed by the Bill & Melinda Gates Foundation. This Initiative is implemented in three sub-Saharan African countries (Nigeria, Senegal, and Kenya) and one southern Asian country (State of Uttar Pradesh in India). The objective of the MLE project is to promote an evidence-based decision-making process with a view to designing integrated FP and RH interventions as part of the Urban Reproductive Health Initiative.

In Senegal, the MLE project is responsible for evaluating ISSU. The MLE project uses rigorous methods to assess the impact of the Initiative on the use of modern contraception by various population categories.

The MLE project will evaluate the Initiative by:

- Explicitly examining the intra-urban differences in the impact of the program via a comparison between the populations of the formal urban sector and those of the informal urban sector, and a comparison between the rich and the poor
- Using a pertinent program framework to examine all stages of the process and evaluate the likelihood of the program's effects on the results
- Using a longitudinal approach to ensure the best possible evidence with as little disruption as possible in the implementation of the ISSU
- Developing surveying tools and methods enabling extrapolation across the project's intervention sites and countries.

The MLE project was put in place one year before the activities of the ISSU started, so that the baseline situation in the sites concerned could be documented.

A baseline survey was conducted from April to August 2011 in all six sites (Dakar, Guédiawaye, Pikine, Mbao, Mbour, and Kaolack) to assess the situation with a view to the evaluation. This baseline survey

was conducted by the Research Center for Human Development (CRDH), with technical support from MLE.

The data was collected from a representative sample of more than 5,000 households. All women aged 15 to 49 in the households selected were interviewed individually by questionnaire. The same applied to men aged 15 to 59 in half of the households selected. Men were surveyed in only four initial intervention sites, i.e., Dakar, Guédiawaye, Pikine, and Mbao. The other two sites, Mbour and Kaolack, are control areas for the first years of the ISSU.

A mid-term survey will be conducted two years after the baseline survey among the same women, as will a final survey four years after the baseline survey, again among the same women. Longitudinal data must enable MLE to carry out an in-depth analysis of the impact of the ISSU on women's fertility and the use of contraception. Moreover, data will be collected in a cross-sectional manner among men in the four initial intervention sites (Dakar, Guédiawaye, Pikine, Mbao) during the mid-term survey and the final survey with a view to determining how much their knowledge, attitudes, and practices in terms of contraception have changed. This will enable MLE to evaluate the effect of demand-creation activities on men.

The data of the baseline survey will be used to help implement the activities of the ISSU and provide MLE with crucial information on FP and RH issues before the activities start.

The results of the baseline survey are presented in this report.

CHAPTER 2: BASELINE HOUSEHOLD SURVEY

Organization of the Survey

The baseline survey among households and service delivery points (EBMPPS, 2011) was commissioned by IntraHealth International as part of the ISSU, and conducted by the CRDH with the technical assistance of the MLE project. The survey was financed by the Bill & Melinda Gates Foundation. It was conducted in urban areas, in the six intervention sites of the ISSU, i.e., Dakar, Guédiawaye, Pikine, Mbao, Mbour, and Kaolack.

Type of Survey and Sample

The baseline household survey uses a longitudinal approach. This DHS targets the urban population of the six sites of the ISSU. A sample of 5,523 households was selected for this study. As the disadvantaged urban population is the main target of the project, each site was stratified into privileged areas and disadvantaged areas, except for the Mbao site, regarded as a disadvantaged area. Eleven (11) strata were therefore configured.

The sample was drawn from a two-stage stratified area sampling procedure. The primary sampling unit, also known as a cluster, is the census district (CD) or part of a CD, when the CD is very large; it was derived from the 2002 General Population and Housing Census's (GPHC)'s list of CDs updated in 2009. In each stratum, the clusters were selected in the first stage, drawn by probability proportional to size, the size of the CD being the number of households. In total, 268 clusters were selected. These clusters are distributed between the sites as follows: 64 clusters in Dakar; 32 in each of the Guédiawaye, Pikine, and Mbao sites; and 54 clusters in each of the Mbour and Kaolack sites. The enumeration of households in each of these clusters provided a list of households (see table 1a). Based on each of these lists, a sample of 21 households with equal probability was chosen in the second stage.

In all households selected, all identified women aged 15 to 49, habitual residents or visitors, were eligible for an individual interview. The same applied to all identified men aged 15 to 59 in every other household in the four sites of the Dakar region (Dakar, Guédiawaye, Pikine, and Mbao), as the Mbour and Kaolack sites were not concerned by the men's survey.

Table 1a. Number of Primary Sampling Units (Clusters) Selected and Number of Households, Women and Men Expected in the Household Survey, by Site

Site		Expected sample size ³			
Region	Department/City	Clusters	Households	Women	Men
Dakar	Dakar	64	1344	2567	1105
Dakar	Pikine	32	672	1284	552
Dakar	Guédiawaye	32	672	1284	552
Dakar	Mbao	32	672	1284	552
	Sub-total	160	3360	6419	2761
Thiès	Mbour/Mbour	54		2279	
Kaolack	Kaolack/Kaolack	54		2279	
	Total	268	5628	10977	2761

Questionnaires

Three questionnaires were used for the survey: a household questionnaire, a women's questionnaire, and a men's questionnaire. The three partners (CRDH, MLE and ISSU), adapted the standard questionnaires to the Senegalese context over several technical meetings. These changes took into account information to inform certain specific ISSU objectives. The content of these questionnaires is summarized below.

The **household questionnaire** was used to list all members and visitors of the households selected. This questionnaire was a tool to identify the men and women eligible for individual interviews. This questionnaire also made it possible to collect basic information on the characteristics of households and every individual's, age, gender, residency status, marital status, and education. Furthermore, the household questionnaire helped collect information on the characteristics of the household, such as the main source of drinking water supply, number of rooms in the home, type of toilet, type of floor and roof material, ownership of certain durable goods, the household's consumption expenditure, and telephone contact details for subsequent follow-up surveys.

The **women's questionnaire** was used to collect information on all women of childbearing age (aged 15 to 49) listed in the households. The information collected relates to the following themes:

³ Based on information from the initial data collection : the number of women in each household is estimated at 2.21 for women ; the number of men per household as 1.92. The numbers are increased based on the expected response rates based on the 2005 Senegal DHS survey: Dakar: Household 95.3%; Women: 90.5%; Global response rate for women: 86.2% (that is the number of women surveyed by the number of eligible households in Dakar was 1.91). Men: 86%: Total response rate for men: 82.0% (that is, the number of men surveyed divided by the number of eligible households in Dakar was 1.57). Total urban: Household: 97.2%; Women: 93.5%: Total response rate for women: 90.0% (that is the number of women surveyed divided by the number of eligible households in urban areas is 2.01). 21 households per cluster; one household out of every two included for male survey.

- Women's sociodemographic characteristics
- Reproduction
- Awareness and use of contraception
- Maternal and child health
- Marriage and sexual activities
- Preferences in terms of fertility
- Communication between spouses and interpersonal communication
- Gender-based inequalities
- Exposure to the media
- Migration patterns.

Like the household questionnaire, the women's questionnaire helped collect women's specific contact details for the purposes of follow-up surveys.

The **men's questionnaire** was administered to all men aged 15 to 59 listed in half of the sampled households in the four sites of the Dakar region. The men's questionnaire helped collect the same type of information as that contained in the women's questionnaire, with the exception of information relating to maternal and child health and communication between partners.

Household Mapping and Enumeration

As the sample frame available was old (2002), even after the 2009 update, households were counted in each of the clusters to obtain an up-to-date list from which the sample of households was selected. The maps of clusters used were updated on this occasion.

Mapping implementation involved the recruitment of 15 cartographers, including a supervisor whose role was to provide cartographers with technical support, verify the files that came back from the field, and number the households following the controls carried out by MLE supervisors. The cartographers attended a five-day training course before field activities started.

Mapping activities were carried out in the six sites, from February 26 to 20 April 20, 2011, in three phases: pairs of cartographers all started in the four Dakar sites, after which they moved on to the Kaolack site and finally the Mbour site. In total, 266 clusters were enumerated out of the 268 of the sample. One of the non-enumerated clusters (Guédiawaye site) is no longer inhabited and, for the other (Kaolack), no cartographic documents were available for its enumeration.

In addition, three clusters were excluded from the study even though they were enumerated, as the number of households enumerated is less than the required number for the sample (21 households per cluster).

The GPS (Global Positioning System) coordinates of the clusters were determined as part of the enumeration process. MLE mobilized its staff in real time to verify and validate the mapping files before selecting the sample of households.

Pilot Survey

The pilot survey, aimed at testing the collection tools and methodology, was conducted in two areas selected outside the sample: a disadvantaged area (poor) and a privileged area (not poor). The data of the pilot survey was collected by 13 interviewers, divided into two teams, from July 25-29, 2010.

The objective of this pilot survey was to test the questionnaires' acceptability by the populations and take corrective measures, essentially in terms of awareness, presentation of the survey's objectives, and formulation of the questions for the main survey. It also helped assess the workload.

Based on lessons learned from the pilot survey, questionnaires and manuals were updated.

Recruitment and Training of Field Staff

The recruitment of field agents took into account the following criteria: age, gender, languages spoken, and work experience in the sites to be covered (for optimal adaptation to the socio-cultural context). The interviewers were recruited from those who had past experience in similar surveys. The CRDH recruited 77 data collection agents.

The interviewers attended a ten-day training course on survey techniques and the content of collection tools. The training course, organized from March 21-31, 2011, was provided by the CRDH's technical team with support from the MLE team.

At the end of the course, 72 agents (27 men and 45 women) were selected for data collection tasks.

Organization of Field Teams and Data Collection

Following the training course, the interviewers selected were divided into 15 teams of five. Each team consisted of a team leader, three female interviewers, and one male interviewer. The tasks were shared between team members as follows:

- **Team leader:** in addition to his specific tasks (coordinating work, allocating tasks to interviewers, managing equipment, etc.), he was responsible for overseeing the quality of the data.
- **Female interviewers:** were responsible for administering the household questionnaires and individual women's questionnaires.
- **Male interviewers:** were responsible for administering the household questionnaires and individual men's questionnaires.

Data was collected from April 3-August 13, 2011, in two phases. The 15 teams initially covered the four sites of the Dakar region for the first two months. After collecting data in these four sites, the top 30 agents (6 team leaders and 24 female interviewers) were selected to continue the collection in Mbour and Kaolack. As there was no men's survey in these two sites, each team only consisted of one team leader and four female interviewers.

The MLE team, made up of six supervisors working closely with the interviewers, provided technical support for the verification of completed questionnaires and identification of the households to be surveyed.

Data Input and Processing

Data was entered and processed using the CsPro software (Census and Survey Processing System). Data input and control programs were developed by MLE. Data input, performed by eight operators, began two weeks after the start of the collection in Dakar following a six-day training course. The agents were supervised by the MLE consultant with the help of the CRDH's information technology specialist.

After a few weeks of data input, 12 additional data entry agents had to be recruited to reinforce the staff. This new team meant that there were two teams of ten operators. The input of household data was completed on October 30, 2011.

Five agents (three recruited by the CRDH and two on loan from MLE) were mobilized to check the files that came back from the field, codify open-ended questions, and carry out editing work. All questionnaires completed in the field were entered twice to reduce data input errors to a minimum.

Finally, once the input was completed, six MLE agents audited the data to verify whether the number of questionnaires entered corresponded with the number of questionnaires found in the cluster bags and to ensure that all questionnaires were entered.

Ethical Aspects

The launch of the survey was subject to the authorization of National Ethics Committee of Senegal. The interviewers were given adequate training and clear guidelines so that they were suitably equipped to comply with the ethical considerations. Interviewers signed a confidentiality agreement prior to their recruitment and at the beginning of the field work phase of the survey.

Participation of the different targets in the survey was on a strictly voluntary basis. Before starting the interview, interviewers clearly explained the purpose of the survey and that interviewees were volunteers and entirely free to accept or refuse to participate in the survey.

To ensure that the survey was conducted in compliance with ethical standards, each participant was requested to sign a consent form. It was strictly forbidden to conduct an interview in a location which did not guarantee confidentiality. Interviewers and other field staff were not allowed to destroy or discard a questionnaire, even if it was incomplete.

Furthermore, all individual data collected was processed in a confidential manner and was not disclosed. Access to the data processing department was strictly regulated. Once the data were processed, all completed questionnaires and other documents were archived and sent to the MLE. During the analysis, all results were aggregated, and it is impossible to associate a result with any particular individual.

During the collection, all pertinent information designed to contact the individuals surveyed, such as their name, address, phone number (mobile or land line) as well as other identifiers potentially useful for subsequent surveys, are noted on specific follow-up forms which were stored separately in sealed and secure envelopes.

Response Rates

During the baseline survey among households and service delivery points (EBMPPS) household survey, 4,950 households, 9,614 women, and 2,270 men were successfully interviewed. The response rates of

households, women, and men are respectively 90%, 89%, and 71%. Detailed response rates for each type of survey are indicated in the table below.

Table 2b. Results from the Household Survey and from Individual Interviews with Men and Women

Site	Households				Women			Men		
	Sample	Identified	Completed	Response rate %	Eligible	Completed	Response rate %	Eligible	Completed	Response rate %
Dakar	1344	1344	1120	83,33%	1949	1704	87,43%	1027	745	72,54%
Guédiawaye	651	651	593	91,09%	1425	1246	87,44%	727	509	70,01%
Pikine	672	672	587	87,35%	1265	1105	87,35%	722	517	71,61%
Mbao	672	672	590	87,80%	1323	1154	87,23%	717	499	69,70%
Kaolack	1134	1113	1028	92,36%	2649	2369	89,43%	0	0	-
Mbour	1134	1134	1032	91,01%	2209	2036	92,17%	0	0	-
Total	5523	5586	4950	88,61%	10820	9614	88,85%	3193	2270	71,09%

CHAPTER 3: HOUSEHOLD CHARACTERISTICS

The survey information relating to household characteristics is presented in next table: electricity supply, sources of drinking water, floorcovering, walls and roofs of the homes, types of toilet, and assets owned.

Electricity and Running Water

In the Dakar region, the vast majority of households have electricity (nearly 9 in 10 households). The absence of electricity is essentially found in the Mbour and Kaolack sites where the proportion of households without electricity reaches 25% and 15%, respectively.

Most households (over 90%) have running water in Dakar sites. In Mbour and Kaolack, these proportions are nearly 68% and 76%, respectively. A significant percentage of households in Pikine (15%), Mbao (23%), Mbour (26%), and Kaolack (22%) are dependent on an external source of water (neighbor's tap or public fountain). In addition, 3% of the Mbour households use water from uncovered wells or another source, which can have a negative effect on the health of the population, due to the possible presence of bacterial agents likely to cause water-borne diseases such as diarrheal diseases.

Floors, Walls, and Roofs of Homes

The characteristics of homes analyzed via the nature of floor materials, external walls, and type of roof can be a good indicator to assess each household's comfort level. Across all sites, in almost all cases flooring is rudimentary (around 90% or more), walls are well-built in more than 93% of households, and roofs are in good condition in more than 98% of households.

Types of Toilet

The type of toilet can help assess the level of sanitation in the household's environment. Nearly 73% of households in Dakar are connected to the wastewater system, unlike the households of the other sites where this proportion ranges from 1% to 30%. In most sites, with the exception of Dakar, a flushing system connected to a pit is the norm. This type of sanitary system is found in 96% of households in Mbao, 86% in Mbour, 78% in Pikine, 77% in Kaolack, and 70% in Guédiawaye.

Durable Goods

Mobile phones are the most commonly owned equipment in households (over 90%), regardless of the site. Dakar and Guédiawaye top this list with 97% and 96%, respectively, followed by Mbour and Kaolack with 95%, and Pikine and Mbao (91% to 92% of households). The second most popular durable goods are televisions. These are available in 87% of Guédiawaye households and 80% of Dakar households. In other sites, the percentages in Pikine, Mbao, Kaolack, and Mbour are 79%, 79%, 78%, and 72%, respectively. More than seven in ten households own a radio in Guédiawaye (80%), Kaolack (76%), Pikine (71%), and Mbour (71%). The lowest percentage is found in Mbao (65%) and Dakar (66%). There are computers in households, in particular in Dakar and Guédiawaye (24%), but they are fairly rare in other sites (8% to 14%). Similarly, access to the Internet, although very limited, is more frequent in sites with the highest proportion of households equipped with computers, i.e., Dakar (15%) and Guédiawaye (14%). There are few carts except in Mbour (4%); two-wheeled vehicles are mostly observed in Kaolack where 17% of households have motorcycles or scooters. Finally, cars are available

in 15% of households in Guédiawaye and 13% in Dakar. The corresponding percentages are 10% in Mbour, 9% in Kaolack, and 7% in each Pikine and Mbao.

Table 3. Distribution (%) of Households Based on Housing Characteristics, by Site

Characteristics	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Electricity						
Yes	93.9	93.4	89.9	86.6	75.1	84.4
No	3.5	3.5	8.3	12.0	24.7	15.2
Not determined	2.6	3.1	1.8	1.4	0.1	0.4
Source of drinkable water						
Faucet at home or bottled water	37.9	51.8	47.8	26.8	27.1	31.5
Faucet available in group of houses	53.5	42.0	37.1	48.1	40.6	44.4
Neighbor's faucet	3.3	3.1	6.1	8.7	6.2	5.6
Public fountain	5.1	2.6	8.8	14.6	19.5	16.7
Covered wells	0.0	0.3	0.0	0.8	3.4	0.3
Non-covered wells or source water	0.0	0.0	0.1	0.9	3.1	0.9
Other	0.1	0.1	0.1	0.0	0.2	0.8
Missing	0.1	0.1	0.1	0.1	0.0	0.0
Flooring material						
Natural	0.9	1.6	10.5	2.9	13.2	13.1
Basic	98.8	98.3	88.8	97.0	86.8	86.9
Improved	0.1	0.0	0.0	0.0	0.0	0.0
Missing	0.2	0.2	0.7	0.1	0.0	0.0
Main material used for external walls						
Natural	0.1	0.3	0.1	0.0	3.8	3.2
Basic	0.8	0.2	0.6	0.9	1.7	2.8
Improved wall	98.4	98.9	98.6	99.0	93.8	92.9
Other	0.2	0.4	0.0	0.0	0.7	1.0
Missing	0.4	0.2	0.7	0.1	0.0	0.1
Roof material						
Natural	0.0	0.0	0.3	0.0	1.6	1.3
Basic	0.9	0.0	0.5	0.0	0.2	0.2
Improved roofing structure	99.0	99.9	98.5	99.7	98.2	98.3
Other	0.0	0.0	0.0	0.2	0.0	0.0
Missing	0.2	0.2	0.7	0.1	0.0	0.2
Type of toilet						
Flushing system linked to the sewage	72.8	29.0	20.0	2.9	0.9	10.5
Flushing system linked to a septic tank	26.4	69.8	77.8	95.6	85.8	77.4
Flushing system linked somewhere else	0.1	0.0	0.7	0.5	3.6	3.6

Characteristics	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Latrines	0.1	0.2	0.7	0.2	5.5	3.9
Other	0.2	0.0	0.8	0.8	4.0	4.1
Not determined	0.5	1.0	0.1	0.0	0.1	0.5
Durable material assets						
Radio	66.1	79.5	70.8	64.7	70.6	75.9
Television	79.8	87.2	78.7	78.6	71.6	77.9
Mobile phone	97.1	95.7	90.7	91.8	94.5	94.5
Computer	23.6	24.2	11.4	8.1	10.3	13.5
Home internet connection	15.3	14.4	7.4	4.8	4.8	7.6
Bicycle	5.5	7.0	3.5	2.5	4.7	7.3
Motorcycle/Scooter	7.4	5.5	7.1	5.8	5.6	17.2
Cart	0.6	1.9	1.2	1.4	4.3	2.6
Car	12.6	15.3	6.7	6.9	9.7	9.2
Number of households	1120	593	587	590	1028	1032

CHAPTER 4: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Women aged 15 to 49 and men aged 15 to 59 are the populations targeted by the 2011 EBMPPS. The first two tables in this chapter indicate the breakdown of women and men according to certain sociodemographic characteristics, i.e., age category, gender, marital status, number of co-wives for women in union, level of education, economic welfare index, religion, nationality, place of residence, ethnic group, and number of children.

Age and Gender

In all sites, the age structure reveals a considerable proportion of young people. This proportion is more pronounced for women aged 15 to 19, notably in Kaolack (25%), Mbao, and Mbour sites (23%). The percentage of women aged 20 to 24 exceeds 22% and 23% in the Dakar and Pikine sites. For men, the proportion of 15 to 19 year-olds is higher in the Guédiawaye site (25%). The percentage of men aged 20 to 24 exceeds 20% and 19% in the Dakar and Pikine sites.

Marital Status

Both women and men were asked questions on their marital status. For this survey, legally married women or men, or those living together in a consensual relationship, are considered to be in union. According to this definition, in all sites, the percentage of men in union is lower than that of women. In all sites, except for Dakar (49%), the percentage of women in union largely exceeds 50%. Conversely, the percentage of single people is higher for men than women. There are more divorced women than men. The differences between the proportions of single people from one site to the next may be explained by the age at which people enter into their first union, as Dakar and Guédiawaye, which have a lower proportions of women aged 15 to 19 than Mbao and Kaolack (20% compared with 23% and 25%) also have higher percentages of single people (44% and 43%) than Mbao (38%) and Kaolack (37%).

Level of Education

The population's level of education is a key factor in behavioral change, particularly in terms of health. For women, it can notably influence reproductive behavior and the use of preventive behaviors such as contraception, children's vaccination, nutritional monitoring, and hygiene. Results from education-related questions are presented in the next table.

In Dakar, the level of education is lower for women than men. The proportion of women with no education is 28% compared with 17% for men. In Guédiawaye, this proportion is 25% for women compared with 19% for men. In Pikine, 37% of women and 27% of men are in this situation; in Mbao, the corresponding percentages are 40% and 26%. The proportion of women with no education exceeds one third in Kaolack (37%) as well as Mbour (39%). Apart from men in the Dakar site, more than three in ten people have attained a primary level of education. In all sites, with the exception of Mbao, the proportion of women with a primary level of education is higher than that of men. This situation may be attributed to efforts by the Ministry of Education to increase the enrollment of girls in schools. However, there is an obvious drop in attendance by girls at lower secondary and upper secondary levels, where the proportion of men is higher than that of women in all sites. Also in all sites, the proportion of men who reached a higher education level is greater than that of women. The lowest proportion of women who reached a higher education level is found in Pikine (3%), Kaolack (2%) and Mbao (less than 2%).

Economic Welfare Index

The population's economic welfare is calculated based on a composite index which integrates several variables supposed to contribute to the level of welfare, such as the type of housing, sanitation, access to water, ownership of certain goods, household savings, and access to certain essential social facilities. This index helps classify the interviewees' households into five categories (quintiles) according to the households' socioeconomic level, from poorest to richest.

Analysis shows that the Dakar site has the highest proportion of women in the first quintile, i.e., the poorest (21%, compared with less than 19% in other sites), while Mbour (less than 17%) has the lowest proportion. For men, Guédiawaye (27%) and Pikine (25%) have the highest proportions of individuals in the first quintile, while Mbao has the lowest (under 20%). For women, the sites with the largest proportions of individuals in the highest quintile (the richest) are Mbao (24%) and Mbour (23%); those with the lowest proportions of the richest individuals are Dakar (20%) and Guédiawaye (19%). For men, the highest proportions of richest individuals are found in Guédiawaye (24%), while the lowest are found in Pikine (under 15%). The proportion of women in the middle quintile hardly varies from one site to another. Conversely, the second quintile is more represented by Dakar and Guédiawaye.

Religion

The majority of the Senegalese population is Muslim (over 90%). More than 95% of the women in Pikine, Mbour, and Kaolack and more than 95% of the men in Pikine are Muslim. The lowest percentages of Muslims are recorded in Dakar (87%-88%) and Guédiawaye (88%-90%).

Table 4. Distribution (%) of Men and Women Based on Their Socio-Demographic Characteristics, by Site

Characteristics	Dakar		Guédiawaye		Pikine		Mbao		Mbour		Kaolack	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Age												
15-19	20.0	12.6	20.1	24.7	18.3	14.8	23.3	19.3	23.0		25.1	
20-24	22.0	19.7	20.7	16.2	22.8	19.4	21.5	19.7	22.3		20.1	
25-29	18.9	21.8	20.0	17.6	17.9	15.5	15.3	15.0	17.0		16.9	
30-34	13.7	12.4	14.8	14.7	13.0	14.2	13.4	11.9	13.3		13.0	
35-39	11.8	13.0	11.2	9.6	12.1	11.1	12.1	12.7	10.9		9.8	
40-44	8.3	8.4	8.2	4.8	10.6	8.3	8.2	5.7	7.6		7.9	
45-49	5.3	6.4	5.2	6.0	5.4	6.6	6.2	6.7	6.0		7.3	
50-54		3.9		4.6		6.5		4.5				
54-59		1.8		1.9		3.6		4.5				
Marital Status												
Single	44.0	62.5	43.1	60.4	34.1	54.9	37.5	57.7	35.8		37.2	
Married	49.0	36.1	51.9	38.0	58.4	39.2	58.2	40.0	58.3		56.1	
Separated/Divorced	5.6	1.4	3.6	0.6	6.3	5.3	3.3	2.0	4.5		5.1	
Widow(ers)	1.3	0.0	1.4	0.0	1.0	0.4	0.9	0.0	1.2		1.5	
ND	0.1	0.0	0.1	1.0	0.2	0.2	0.1	0.4	0.2		0.1	
Number of co-spouses*												
0	77.2		74.2		73.8		65.1		65.9		67.3	
1	18.3		21.9		21.4		26.9		27.4		23.6	

Characteristics	Dakar		Guédiawaye		Pikine		Mbao		Mbour		Kaolack	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
2	4.4		2.6		4.0		4.7		5.0		6.7	
3+	0.1		1.2		0.7		3.3		1.4		2.3	
Missing	0.0		0.1		0.0		0.0		0.2		0.1	
Level of education												
None	28.2	16.5	25.3	18.7	37.1	27.4	40.0	26.3	38.6		36.8	
Primary	30.6	23.8	36.6	30.7	37.3	32.4	35.2	36.2	33.2		33.0	
Secondary 1	21.8	26.1	23.5	25.8	16.7	22.4	16.5	22.5	17.9		19.7	
Secondary 2	9.3	18.2	9.8	12.8	5.6	10.8	6.8	9.0	7.9		8.6	
Higher education	10.2	15.4	4.8	12.0	3.3	6.9	1.5	5.9	2.4		1.9	
Missing	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0		0.0	
Economic well-being index												
Poorest	21.2	21.7	17.8	26.3	19.0	25.1	17.9	19.5	16.7		17.5	
Second	21.0	20.3	22.2	14.8	18.6	16.7	18.8	19.4	19.2		18.8	
Average	19.5	16.6	19.7	15.7	20.4	18.6	20.1	23.3	20.3		19.4	
Fourth	18.4	21.6	20.9	19.0	20.3	25.1	19.4	18.8	20.7		21.9	
Richest	20.0	19.9	19.4	24.2	21.8	14.5	23.8	19.0	23.1		22.4	

Nationality and Ethnic Group

The information relating to the nationality and ethnic group of surveyed individuals features in the next table. Generally speaking, the proportion of individuals who are not Senegalese nationals is very low. The most significant proportions of foreign nationals are recorded in the Dakar site with 9% of men and 6% of women. In other sites, this proportion is around 2%; it is lower than 1% (for women only) in Mbour.

Senegal has approximately 20 ethnic groups (Wolof, Lebou, Poulars, Toucouleur, Sérér, Diola, Mandingue, Bambara, Soninké, Balante, Mandjak, etc.). The importance of each ethnic group varies dramatically within the total population. The next table indicates their respective importance in the different sites. In all sites, the proportion of Wolof people is the highest, followed by Poulars and Sérérs.

Number of Living Children

In all sites surveyed, the proportion of interviewees (women and men) with no children is very high (more than 40%) and even exceeds 60% for men in the Dakar, Guédiawaye, and Mbao sites. The proportion of childless individuals is high because there are approximately forty single women in the sample. The proportion of women with one child only is also significant in all sites. Despite significant disparities, the fertility level is relatively high: in all sites, more than 20% of women have at least three children. The proportion of women with four or more children is 17% in Dakar, 19% in Guédiawaye, 24% in Pikine, and 26% in Mbao.

Table 5: Distribution (%) of Women and Men Based on Their Socio-Demographic Characteristics, by Site

Characteristics	Dakar		Guédiawaye		Pikine		Mbao		Mbour		Kaolack	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Religion												
Muslim	87.4	87.8	87.6	89.8	95.1	95.5	92.7	93.5	95.3		97.6	
Christian	12.0	12.0	12.1	10.2	4.9	4.3	7.3	6.6	4.7		2.3	
No religion/Other	0.6	0.2	0.2	0.0	0.0	0.2	0.1	0.0	0.0		0.1	
Nationality												
Senegalese	94.0	91.0	96.7	97.6	98.2	97.6	97.8	97.5	99.2		98.9	
Other	6.0	8.9	3.1	1.7	1.8	2.2	2.2	2.3	0.8		1.0	
Missing	0.1	0.1	0.2	0.7	0.0	0.1	0.0	0.2	0.0		0.0	
Ethnic group (among Senegalese)												
Wolof/Lebou	31.1	29.4	42.8	39.6	39.0	34.8	44.0	48.1	37.1		48.0	
Poular	16.9	19.9	19.9	17.6	26.9	27.3	27.4	17.1	17.9		20.2	
Serer	22.9	20.1	14.9	9.7	18.0	21.5	12.0	11.5	28.5		17.7	
Diola	8.4	12.7	2.4	1.5	1.1	0.9	6.0	10.2	3.9		3.6	
Mandingue	6.7	5.9	6.2	20.3	4.2	6.4	2.1	6.2	6.3		3.2	
Soninke	3.2	4.6	2.2	0.9	3.5	0.6	1.5	2.4	1.6		2.0	
Other	10.6	7.3	11.7	10.2	7.4	8.2	7.0	4.5	4.6		5.1	
Missing	0.1	0.1	0.0	0.3	0.0	0.4	0.1	0.2	0.1		0.2	
Number of living children												
0	46.1	64.1	47.3	62.6	39.0	56.6	43.2	62.2	40.9		43.5	
1	16.2	7.6	12.7	7.5	15.2	10.5	12.1	8.8	12.5		13.5	
2	12.1	6.9	11.9	9.5	12.5	7.7	9.9	8.0	11.1		9.6	
3	8.4	5.8	8.6	4.4	9.6	4.0	9.0	5.7	10.4		9.8	
4	6.2	5.7	5.6	5.0	6.3	6.6	6.5	4.4	7.3		6.4	
5	4.1	3.0	6.1	4.0	6.7	6.2	5.7	2.1	5.9		5.8	
6+	6.8	7.0	7.8	7.1	10.6	8.4	13.7	8.8	11.9		11.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		100.0	
Total number	1704	745	1246	509	1105	517	1154	499	2036		2369	
* Percentages calculated using the sub-sample of married women (or living as a couple).												

Employment

The next table presents the results of the survey on employment for two periods and for different individuals within the household. It relates to the employment of individuals in the seven days preceding the survey and employment in the past twelve months.

The proportion of women in employment in the past seven days varies from one site to the next. It is highest in Dakar (43%) and lowest in Pikine (28%). More than four in ten women have been employed in the past twelve months in all sites. For Dakar, over half of the women have been employed in the past twelve months. Self-employment seems widespread in all sites. With the exception of Dakar

(38%), proportions of self employed women range from 57% to 67%. Among women in union, more than eight in ten partners are currently working. For these women in union, almost all working partners are paid in cash.

Table 6. Distribution (%) of Women Based on Their Job and Their Spouse's Characteristics, by Site

Characteristics	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Work over the past seven days						
Yes	43.4	31.2	28.3	33.2	36.4	36.6
No	56.5	68.6	71.4	66.6	63.4	63.2
Not determined	0.1	0.3	0.3	0.2	0.3	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1704	1246	1105	1154	2036	2369
Work over the past 12 months						
Yes	55.1	45.7	48.8	46.8	48.6	45.0
No	44.8	54.1	50.9	53.0	51.1	54.8
Not determined	0.1	0.3	0.3	0.2	0.3	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1704	1246	1105	1154	2036	2369
Employer (among women who have worked over the past 12 months)						
Family member	4.2	5.7	5.7	6.9	3.5	4.1
Someone else	57.7	37.0	27.3	34.3	33.7	30.0
Self-employment	37.7	56.7	66.5	58.8	62.6	65.7
Not determined	0.4	0.6	0.5	0.0	0.2	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	939	569	540	540	990	1066
Level of education reached by the partner (among married women)						
None	29.7	24.1	32.9	43.5	44.2	38.9
Primary	11.5	18.4	12.7	9.7	9.5	8.8
Secondary 1	10.1	12.7	7.6	8.9	5.6	7.7
Secondary 2	8.3	10.4	7.4	5.7	5.5	6.9
Higher Education	15.3	10.4	5.5	3.7	5.7	7.8
Does not know	24.5	23.6	33.5	28.2	29.4	29.8
Not determined	0.5	0.4	0.4	0.3	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	835	646	646	672	1187	1332
Partner currently working (among married women)						
Yes	91.5	90.3	86.1	88.7	93.2	91.8
No	7.8	8.0	13.4	9.8	6.0	7.8
Does not know	0.2	1.4	0.3	1.3	0.7	0.2
Not determined	0.4	0.3	0.2	0.2	0.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	835	646	646	672	1187	1332
Partner paid in cash (among the partners who are currently working)						

Characteristics	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Yes	97.3	98.7	99.3	100.0	99.7	99.5
No	0.4	0.2	0.4	0.0	0.3	0.4
Does not know	2.2	0.4	0.0	0.0	0.0	0.1
Not determined	0.0	0.7	0.3	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	764	582	556	596	1106	1223

CHAPTER 5: SEXUALITY, FERTILITY AND FERTILITY PREFERENCES

In Senegal, fertility has steadily dropped since 1978 but still remains high (Bongaarts, 2003, Lardoux and Walle, 2003, Ndiaye and Ayad, 2006). In the 1980s, Senegal implemented health, family, and population policies to improve maternal and child health as well as reduce fertility. These policies include: the Promotion of Women and Family Planning Policy, the Family Code (Law of 12 June 1972, which came into force in January 1973) guaranteeing women's rights, the Family Health Project launched in 1981, the Family Health and Population Project, and the Declaration of the Population Policy in April 1988.

This chapter presents some of the results concerning two major fertility factors, i.e., marriage rate and sexual activity. This chapter also presents the level of certain indicators relating to the fertility level and preferences in terms of fertility such as the age-specific fertility rate, the total fertility rate (TFR), the adolescent fertility rate, FP over the past three years, the desire to have children, the ideal family size, and the fulfillment of needs in terms of the spacing and limiting of births.

Age of First Union

The next table presents the breakdown of non-single women according to the age of their first union and the level of education, for each site.

The percentage of non-single women aged 15 to 49 at the time of the survey who entered into a union before the age of 15 is low in all sites (7% or less), in particular in Guédiawaye and Dakar (less than 4%). Overall, 22%, 23%, 30%, 32%, 32%, and 33% of non-single women in Dakar, Guédiawaye, Mbao, Kaolack, Mbour, and Pikine, respectively, entered into their first union before the age of 18.

Table 7. Age at First Wedding Based on the Level of Education among Currently Married Women, by Site

Level of education	Age at first wedding						Total
	<15	15-17	18-20	21-23	24-26	27+	
Dakar							
None	8.7	30.7	27.2	14.9	10.4	8.1	100.0
Primary	3.5	14.2	31.9	18.7	17.6	14.1	100.0
Secondary 1	0.7	14.5	29.0	19.7	20.5	15.6	100.0
Secondary 2	0.0	12.8	18.8	17.0	13.1	38.2	100.0
Higher education	0.0	3.6	11.8	21.6	23.9	39.2	100.0
Total	3.9	18.1	27.3	18.0	16.4	16.3	100.0
Guédiawaye							
None	4.9	23.8	35.5	14.6	7.9	13.3	100.0
Primary	4.0	20.7	31.3	23.8	11.1	9.1	100.0
Secondary 1	2.3	17.4	29.4	33.6	12.0	5.4	100.0
Secondary 2	0.0	2.0	28.6	35.4	18.8	15.2	100.0
Higher education	0.0	0.0	7.6	16.2	13.4	62.8	100.0
Total	3.7	19.3	31.6	22.9	10.8	11.7	100.0
Pikine							
None	9.1	33.3	25.4	12.8	11.4	7.9	100.0

Level of education	Age at first wedding						Total
	<15	15-17	18-20	21-23	24-26	27+	
Primary	5.3	25.5	25.0	22.5	10.4	11.4	100.0
Secondary 1	4.0	20.1	31.1	22.4	12.9	9.5	100.0
Secondary 2	0.0	4.1	19.2	50.7	7.7	18.3	100.0
Higher education	0.0	0.0	4.9	14.7	39.8	40.6	100.0
Total	6.4	26.8	25.2	19.2	11.8	10.7	100.0
Mbao							
None	8.0	35.5	29.0	18.3	4.0	5.2	100.0
Primary	3.6	15.5	37.5	24.1	10.5	8.8	100.0
Secondary 1	0.0	19.7	32.2	32.6	4.9	10.6	100.0
Secondary 2	0.0	19.5	30.9	13.4	7.5	28.7	100.0
Higher education	0.0	0.0	0.0	27.8	35.4	36.8	100.0
Total	5.1	25.0	32.4	22.0	7.1	8.4	100.0
Mbour							
None	8.6	35.1	27.3	16.2	6.9	5.8	100.0
Primary	4.3	21.2	30.8	20.2	12.4	11.1	100.0
Secondary 1	0.9	20.3	29.6	18.6	19.6	11.0	100.0
Secondary 2	0.0	6.6	23.9	18.1	19.1	32.3	100.0
Higher education	0.0	16.8	0.0	15.1	28.8	39.4	100.0
Total	5.5	26.3	28.2	18.1	11.6	10.4	100.0
Kaolack							
None	11.0	33.2	31.9	11.9	7.3	4.7	100.0
Primary	4.2	21.3	29.4	24.8	9.9	10.3	100.0
Secondary 1	4.2	19.7	30.8	19.0	13.6	12.7	100.0
Secondary 2	0.0	13.1	23.0	16.1	24.3	23.5	100.0
Higher education	0.0	4.7	8.4	16.8	30.1	40.0	100.0
Total	6.8	25.4	29.7	17.9	10.6	9.7	100.0

Sexuality

As a determinant of fertility, the age of first sexual intercourse is as important as the age of first union. This is why the individuals surveyed were asked how old they were when they had sexual intercourse for the first time. The next table presents the breakdown of women who have had sexual intercourse by quintile, in each site.

In Dakar, 4% of women became sexually active before the age of 15; 26% between the ages of 15 and 17; 32% between ages 18 and 20; and 15% between 21 and 23. Nearly one in ten women (9%) was over 26 when they had sexual intercourse for the first time. Early sexuality (up to age 17), regularly decreases as the level of welfare increases. In other words, the richer the girls' households, the later they become sexually active. This correlation between the level of welfare and women's age when they become sexually active is extremely apparent in Mbour, and to a lesser extent in Kaolack. The percentage of women who had sexual intercourse for the first time before the age of 18 is the highest in Mbour (41%). It is 37% in Pikine and Kaolack, 35% in Mbao, 30% in Dakar, and 29% in Guédiawaye.

**Table 8. Age at First Sexual Intercourse among Sexually Active Women 15-49
Based on the Economic Well-Being Index, by Site**

Sites	Percentage of women who had a sexual intercourse by age group						Do not know/not determined	Total
	<15	15 - 17	18 - 20	21 - 23	24-26	27+		
Dakar								
Poorest	7.5	36.2	34.2	10.6	7.8	3.4	0.4	100.0
Second	4.5	30.0	35.4	13.5	10.8	5.6	0.3	100.0
Average	3.1	23.5	30.5	17.7	15.0	9.7	0.6	100.0
Fourth	2.6	18.8	32.4	18.2	14.9	13.2	0.0	100.0
Richest	2.2	15.9	26.3	17.1	20.5	17.5	0.7	100.0
Total	4.2	25.7	32.0	15.1	13.3	9.3	0.4	100.0
Guédiawaye								
Poorest	5.4	28.3	34.5	19.4	10.0	2.5	0.0	100.0
Second	4.5	21.4	47.2	8.1	10.6	8.2	0.0	100.0
Average	1.9	27.1	31.1	21.3	10.4	7.4	0.9	100.0
Fourth	6.4	18.2	29.8	19.8	13.5	12.2	0.0	100.0
Richest	2.5	29.8	36.7	12.3	9.7	9.0	0.0	100.0
Total	4.3	24.6	36.4	15.9	10.9	7.8	0.2	100.0
Pikine								
Poorest	12.0	33.7	28.8	11.9	6.9	5.8	1.0	100.0
Second	8.5	33.1	32.5	15.2	6.8	2.7	1.2	100.0
Average	4.7	29.6	31.9	14.9	7.4	9.9	1.6	100.0
Fourth	2.0	33.2	26.9	18.9	9.9	9.2	0.0	100.0
Richest	2.8	25.8	30.8	14.0	12.7	13.9	0.0	100.0
Total	6.1	31.1	30.1	14.9	8.7	8.3	0.8	100.0
Mbao								
Poorest	8.6	40.5	36.0	10.6	3.1	0.4	0.9	100.0
Second	4.7	25.5	39.9	18.2	6.8	4.9	0.0	100.0
Average	4.3	31.0	32.7	18.8	5.5	7.0	0.9	100.0
Fourth	3.1	28.4	31.5	25.6	5.4	5.9	0.0	100.0
Richest	5.9	23.4	29.4	20.9	11.6	8.9	0.0	100.0
Total	5.3	29.4	33.7	19.0	6.7	5.6	0.3	100.0
Mbour								
Poorest	11.3	43.3	31.0	7.0	5.5	1.9	0.0	100.0
Second	8.4	40.3	31.6	11.7	4.6	3.5	0.0	100.0
Average	8.0	33.0	32.8	13.0	8.3	5.0	0.0	100.0
Fourth	6.6	30.2	28.3	17.8	9.0	7.9	0.2	100.0
Richest	3.8	18.9	27.0	19.9	13.6	15.6	1.3	100.0
Total	7.6	33.1	30.2	13.9	8.2	6.8	0.3	100.0
Kaolack								
Poorest	10.7	41.4	33.6	8.5	4.2	1.7	0.0	100.0

Second	6.0	35.4	31.1	13.3	7.1	7.1	0.0	100.0
Average	5.9	31.9	35.3	11.3	8.2	7.2	0.2	100.0
Fourth	4.1	26.2	33.7	17.0	10.1	8.6	0.4	100.0
Richest	3.6	20.1	34.7	20.1	9.1	12.4	0.0	100.0
Total	6.0	30.9	33.7	14.1	7.8	7.4	0.1	100.0

Unlike the results observed for women, the correlation between the level of welfare and men's age when they become sexually active is fairly mixed in all sites. However, overall, the differences between cities are notable.

In Dakar, 6% of men became sexually active before the age of 15; 26% between the ages of 15 and 17; 30% between ages 18 and 20; and 16% between 21 and 23 (see the next table). Nine percent of men were over 26 when they had sexual intercourse for the first time. In Guédiawaye, these percentages are 14% before age 15; 14% between ages 15 and 17; 29% between 18 and 20; and 15% between 21 and 23. The highest percentage of men who had sexual intercourse for the first time before the age of 15 was observed in the Guédiawaye site (14%). The percentage of men sexually active before the age of 18 is 22% in Mbao, 25% in Pikine, 27% in Guédiawaye, and 32% in Dakar.

Table 9. Age at First Sexual Intercourse among Sexually Active Men Based on the Economic Well-Being Index, by Site

Sites	Percentage of men who had a sexual intercourse by age group						Do not know	Missing	Total
	<15	15 - 17	18 - 20	21 - 23	24-26	27+			
Dakar									
Poorest	3.9	21.8	32.0	14.5	13.6	9.0	0.0	5.2	100.0
Second	2.7	22.1	31.8	18.6	9.0	13.3	0.0	2.5	100.0
Average	9.7	25.7	24.6	15.9	15.9	7.2	0.0	1.0	100.0
Fourth	6.4	21.0	32.5	17.3	10.9	8.6	1.4	1.9	100.0
Richest	9.9	40.2	27.7	10.3	5.4	6.0	0.0	0.4	100.0
Total	6.1	25.7	30.1	15.5	10.9	9.1	0.3	2.4	100.0
Guédiawaye									
Poorest	21.8	11.4	24.6	12.7	14.2	13.3	0.0	2.2	100.0
Second	5.6	14.5	18.8	32.7	3.3	25.0	0.0	0.0	100.0
Average	10.7	10.0	27.9	16.1	16.4	17.6	0.0	1.4	100.0
Fourth	0.5	18.2	40.4	12.4	9.5	11.5	0.0	7.4	100.0
Richest	19.7	15.1	34.8	6.4	13.4	9.8	0.0	0.7	100.0
Total	13.5	13.6	28.8	15.3	11.7	14.9	0.0	2.2	100.0
Pikine									
Poorest	5.5	16.1	33.5	3.0	11.9	28.8	0.0	1.3	100.0
Second	8.9	23.9	19.3	12.3	13.9	17.1	0.0	4.7	100.0
Average	5.6	27.8	27.8	11.8	12.0	11.1	0.0	3.9	100.0
Fourth	4.7	15.6	31.3	17.3	14.5	16.5	0.0	0.0	100.0
Richest	2.1	13.0	39.0	23.1	5.7	15.6	0.0	1.3	100.0
Total	5.5	19.1	30.1	12.2	12.2	18.9	0.0	2.0	100.0

Sites	Percentage of men who had a sexual intercourse by age group						Do not know	Missing	Total
	<15	15 - 17	18 - 20	21 - 23	24-26	27+			
Mbao									
Poorest	4.4	9.5	40.0	9.3	7.8	29.0	0.0	0.0	100.0
Second	4.8	17.4	25.3	17.5	17.2	16.7	0.0	1.0	100.0
Average	5.5	15.1	39.5	12.8	17.9	9.2	0.0	0.0	100.0
Fourth	3.1	21.7	35.4	9.6	17.4	11.5	0.0	1.4	100.0
Richest	15.4	17.5	28.4	9.7	14.4	14.6	0.0	0.0	100.0
Total	6.2	15.8	34.1	12.0	14.8	16.6	0.0	0.5	100.0

Frequency of sexual intercourse

The frequency of sexual intercourse is a factor in exposure to the risk of pregnancy, in particular when the prevalence of modern contraception is low, as is the case in Senegal. The next two tables present the sexual activity of women and men.

Overall, 33% to 37% of women and 25% to 38% of men have never had sexual intercourse. The last sexual intercourse dates back to more than 12 months for less than 8% of women and less than 11% of men. Sexual intercourse last occurred in the past four weeks in more than 37% of cases. The situation, however, varies somewhat from one site to the next.

In the Dakar site, 39% of women had their last sexual intercourse in the past four weeks while for 18% of women the last sexual intercourse was in the past 12 months. The respective percentages are 43% and 12% in Guédiawaye; 45% and 15% in Pikine; 45% and 14% in Mbao; 50% and 12% in Mbour; and 42% and 16% in Kaolack. The lowest percentage of women who have never had sexual intercourse is found in Pikine (32%).

For men, the last sexual intercourse occurred in the past four weeks in 38% of cases in the Dakar site; it occurred in the past 12 months in 25% of cases. The respective percentages are 39% and 18% in Guédiawaye; 40% and 19% in Pikine; and 43% and 13% in Mbao. The Mbao site has the highest percentage of men who claim they have never had sexual intercourse (38%); the lowest is observed in Dakar (25%).

Table 10. Distribution (%) of Women Based on the Date of Their Last Sexual Intercourse

Women						
Date of the last sexual intercourse	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Over the past 4 weeks	38.8	42.8	44.9	45.0	49.5	42.3
Over the past 12 months	18.0	11.7	15.4	14.0	11.7	15.6
Over a year ago	7.3	7.7	7.1	5.7	5.1	7.1
Never had sexual intercourse	35.1	37.4	31.9	35.1	33.3	34.7
Missing	0.8	0.4	0.7	0.2	0.4	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 11. Distribution (%) of Men Based on the Date of Their Last Sexual Intercourse

Men				
Date of the last sexual intercourse	Dakar	Guédiawaye	Pikine	Mbao
Over the past 4 weeks	37.6	39.4	39.5	42.6
Over the past 12 months	25.4	17.8	18.8	12.7
Over a year ago	10.6	5.5	9.4	5.4
Never had sexual intercourse	25.0	35.8	31.2	38.1
Missing	1.4	1.5	1.1	1.1
Total	100.0	100.0	100.0	100.0

Fertility

So as to yield results comparable with those of demographic and health surveys, this study collected information on women's reproductive history in order to assess the level of fertility in all six sites covered. Thus, all women aged 15 to 49 in sampled households were asked how many live born children they had, how many were living with them and living elsewhere, and how many were still alive and had died. Subsequently, a complete history of births was established, from the oldest to the most recent, by recording, for each birth, the type of birth (simple or multiple), gender, date of birth, and current age. This section also tackles adolescent pregnancy and maternity as well as FP measures in the past few years.

Fertility level

Age-specific fertility rates are calculated by comparing the births of women from each age category with the total number of women in the corresponding age category. The TFR, which is a cyclical fertility indicator, is obtained from the sum of all age-specific fertility rates. It corresponds with the average number of children a woman would give birth to by the end of her childbearing years if current fertility rates remain unchanged. For current fertility, fertility rates and TFR have been calculated for the three-year period preceding the survey. This three-year reference period was chosen to provide fertility indicators as recent as possible while having a sufficient number of cases to reduce sampling errors.

The chart that follows shows that the sites covered are classified in decreasing order of TFR: Pikine (4.6 children per woman), Mbao (4.4), Mbour and Kaolack (4.2), Guédiawaye (3.6), and Dakar (3.1). The Dakar site has the lowest fertility rate while Pikine has the highest. For illustrative purposes, the preliminary results of the 2010-2011 MICS-DHS estimate the TFR for the entire Dakar region at 3.7 children for the three years preceding the survey. The cities of Dakar and Guédiawaye are below the regional average.

In terms of overall trend, fertility structure according to age, as highlighted by figure 1 and figure 2 following the table, shows that age-specific fertility rates are lowest in the cities of Dakar and Guédiawaye, and highest in Pikine and Mbao. It also appears that the maximum fertility level is between 25 and 39, with a peak at 30 to 34 in Dakar, Guédiawaye, Pikine, and Kaolack. This peak is observed earlier (25 to 29) in the Mbao and Mbour sites. Adolescent fertility (under 20 years old) seems higher in Pikine and Mbour; fertility in Mbao at this age is quickly offset after the age of 20. Although fertility is at an intermediate level in the Dakar site at ages 15 to 19, it remains at a generally lower level at other ages. The end of childbearing years, which starts after the age of 40, is also more sudden in Dakar than elsewhere (fertility rate of 111 per thousand for 35- to 39-year-olds, 38 per

thousand for 40- to 44-year-olds and less than 2 per thousand for 45 to 49 year olds; Mbour is in the same situation to a lesser extent. At 45 to 49, fertility is very low (14 per thousand to 30 per thousand) in the cities of Mbao, Mbour, and Guédiawaye, and almost zero in Dakar, Pikine, and Kaolack.

Table 12. Fertility Rate by Age and Total Fertility Rate by Site

	Site					
	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Fertility rate by age (per 1,000)						
15 -19	54.0	36.3	65.8	33.7	59.9	52.1
20 - 24	102.8	132.1	166.3	184.1	167.1	175.1
25 - 29	142.9	161.0	210.7	203.2	212.0	203.2
30 - 34	179.2	184.5	219.1	189.6	167.4	219.9
35 - 39	110.6	101.3	145.9	155.3	144.4	104.4
40 - 44	37.8	70.5	100.9	102.8	78.8	77.1
45 - 49	1.5	28.7	0.0	13.9	15.0	3.4
TFR	3.14	3.57	4.54	4.41	4.22	4.18

Figure 1: Total Fertility Rate by Site

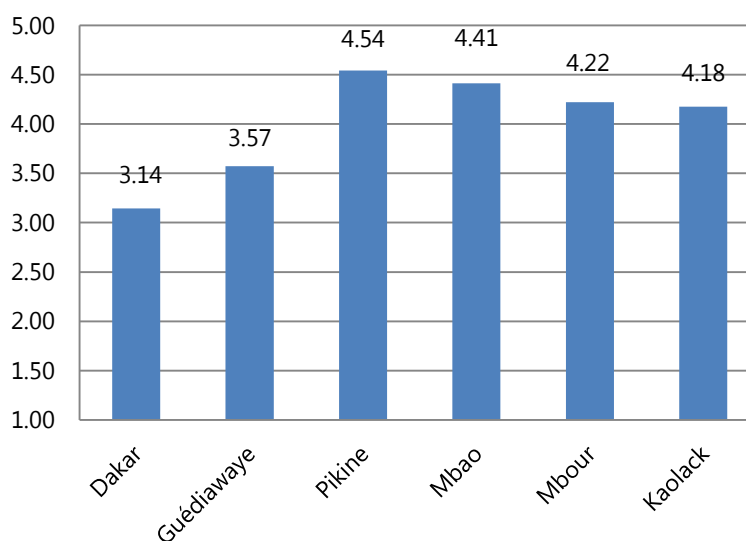
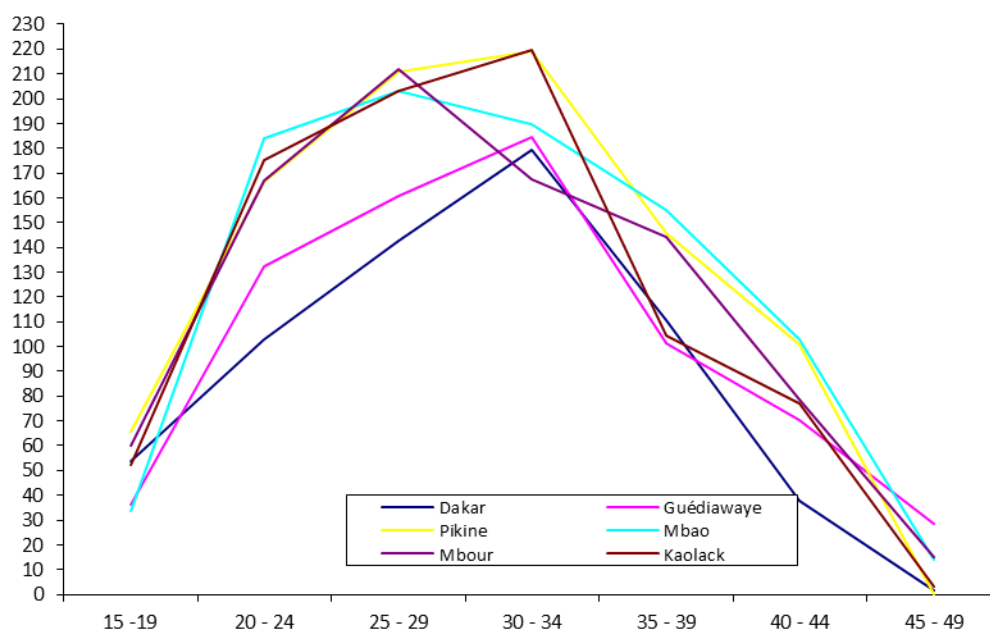


Figure.2 : Age specific fertility rates by site – Senegal 2011



Adolescent pregnancy and maternity

Children born of young mothers (under 20) generally run a greater risk of dying than those born of older mothers. Similarly, early pregnancies and deliveries increase the risk of death in female adolescents.

Adolescents account for 18% to 25% of all women of childbearing age in the cities surveyed. The next table provides, for each year from 15 to 19 years old, the proportion of adolescents who have already been pregnant at least once. Eight percent (Mbao) to 17% (Pikine) of these women have already been pregnant at least once at some point. The lowest percentages are observed in Mbao (8%), Dakar (10%), Kaolack (10%), and Guédiawaye (10%) while the highest are found in Mbour and Pikine (14%-17%).

The percentage of 15-year-old adolescents who have already been pregnant is low but not zero. More than 10% of 18-year-old women have already been pregnant: 17% to 20% in Mbour, Pikine, Dakar, and around 12% in Guédiawaye, Mbao, and Kaolack. At age 19, 38% of the women in Pikine and 28% of those in Mbour, compared with 14%, 18%, and 20% in Mbao, Dakar, and Guédiawaye, respectively, have already been pregnant.

The results according to the level of economic welfare show that adolescent fertility decreases with the economic level of the households, with the exception of the cities of Dakar, Guédiawaye, and Mbao. In Dakar, the number of female adolescents who have already been pregnant is relatively higher in the middle quintile (14%) than in the second quintile (8%). Conversely, in Guédiawaye the number of female adolescents in this case is relatively higher in the second quintile (21%) than in the first quintile—the poorest—(13%). Finally, in Mbao the number of women who have already been pregnant is higher in the richest households than in the middle class and the fourth quintile. Generally speaking, in all sites, the risk of adolescent pregnancy is much lower in the richer than in the poorer classes.

As might be expected, in all cities early fertility (measured by the percentage of women who have already been pregnant) is related to low levels of education (more than 20% everywhere except in Mbao, 15%). The percentage of women who have already been pregnant decreases with the level of education and is almost zero at the upper secondary education level.

Table 13. Distribution (%) of Women Age 15-19 Who Have Already Been Pregnant, Based on Various Characteristics

	Site					
	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Age						
15	5.7	0.3	5.4	3.3	1.7	0.5
16	6.4	15.6	3.4	1.0	8.0	3.8
17	1.2	4.7	19.6	9.0	9.1	11.9
18	18.8	11.7	17.8	12.1	16.9	12.5
19	17.5	19.6	38.1	14.4	27.9	19.5
Total	10.0	10.3	16.7	8.1	13.6	9.7
Number of women (15-19)	340	250	202	268	468	595
Economic well-being index						
Poorest	17.1	12.5	35.6	15.0	25.8	15.8
Second	7.8	21.2	26.3	12.7	13.7	15.1
Average	14.2	10.0	14.2	5.7	14.5	9.4
Fourth	4.8	8.4	7.6	1.2	11.9	6.3
Richest	4.5	0.0	5.5	6.4	4.4	4.5
Total	10.0	10.3	16.7	8.1	13.6	9.7
Number of women (15-19)	340	250	202	268	468	595
Level of education						
None	21.0	30.6	39.8	15.4	26.8	34.8
Primary	17.4	14.4	21.2	11.3	15.8	19.0
Secondary 1	0.9	6.3	3.6	1.3	5.1	6.4
Secondary 2	4.3	0.0	0.0	0.0	3.8	2.3
Higher Education	0.0	0.0	0.0	0.0	0.0	0.0
Total	10.0	10.3	16.7	8.1	13.6	9.7
Number of women (15-19)	340	250	202	268	468	595

Family planning over the past three years

During the survey, women were asked whether the pregnancy previous to their last live birth was intended, unwanted, or whether they would have wanted it later. The next table indicates the breakdown of live births over the past three years (since January 2009) according to these categories.

It should be noted that, for 2% to 3% of the births in question, no response was given or recorded by the interviewer. Generally speaking, 2% to 6% of women claimed they did not want to get pregnant at the time they became pregnant with their last child. The lowest percentage is found in Dakar (2.5%), followed by Mbao with 4.1%. The percentage in other cities is approximately 6%. Conversely, 19% to 25% of the women would have wanted to get pregnant later; in other words this pregnancy was unplanned. The lowest percentages are observed in Dakar and Kaolack (19%), while the highest are found in Pikine (25%) and Guédiawaye (24%). Consequently, in all sites, more than two-thirds of births were planned.

Table 14. Planning of the Last Birth since 2009 by Site

Site	Planning of the last birth (percentage)				Total	Number of births
	Desired at that time	Desired later	Unwanted	Unavailable		
Dakar	76.0	19.1	2.5	2.4	100.0	442
Guédiawaye	67.7	23.7	5.9	2.7	100.0	306
Pikine	67.0	25.0	5.9	2.1	100.0	395
Mbao	75.0	19.5	4.1	1.5	100.0	376
Mbour	71.1	20.6	6.0	2.2	100.0	714
Kaolack	73.0	18.4	6.1	2.5	100.0	749

* Including current pregnancy

Preferences in Terms of Fertility

The baseline survey collected information on preferences to assess how successful couples were in controlling their fertility and measure future needs for spacing or limiting births. This section tackles three topics: the desire to have more or no further children, the desired number of children, and contraception requirements.

Desire to have (more) children

Women aged 15 to 49 were asked whether they wanted children or more children in the future. The next table indicates, for each site, the breakdown of women according to whether or not they want children/more children.

These results reveal that 31% (Pikine) to 37% (Dakar) of women want a child/another child but only after they get married. In total, 35% to 40% of women want more children but at a later, unspecified date (after they get married or do not know when). Conversely, the percentage of women who claimed they wanted more children within the next 24 months, almost identical in all cities, is approximately 21% (20% in Mbour and Mbao; 21% in Dakar, Guédiawaye, and Pikine; 22% in Kaolack). Those who want their next birth within at least 24 months, who can therefore be considered potentially eligible for FP, represent a proportion of 25% to 31% (Kaolack and Guédiawaye: 25%; Dakar: 26%; Mbour and Mbao: 28%; and Pikine: 31%). The other category of women potentially interested in contraception is comprised of those who do not want any/any more children in the future (11% to 12% in Dakar, Guédiawaye, and Pikine; 13% in Kaolack; and Mbao and 15% in Mbour). Around 2% of the women claimed they were unable to get pregnant and are not concerned by a future pregnancy.

Table 15. Distribution (%) of Women Based on Their Current Desire to Have Children, by Site

Women						
Desire for children	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Wants another one soon (<2 years)	20.8	20.7	21.1	19.8	19.5	22.2
Wants another one later (+2 years)	26.1	24.9	30.8	27.9	27.5	24.7
Wants another one after the wedding	36.6	35.9	31.1	34.3	32.4	33.6
Wants another; doesn't know when	2.8	4.4	3.5	3.0	4.5	4.0
Doesn't want any more children	11.5	11.0	11.6	12.9	14.5	12.7
Sterilized	2.2	1.6	1.6	1.9	1.2	2.5
Not determined	0.2	1.5	0.4	0.2	0.5	0.3

Women						
Desire for children	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Total	100.0	100.0	100.0	100.0	100.0	100.0

The next table presents the same results for men aged 15 to 59. Like women, a lot of men want to have their next child after they get married (35% in Guédiawaye; 36% in Pikine; 48% in Mbao; and 49% in Dakar). However, the percentage of men who claimed they wanted more children within the next 24 months is very similar in all cities (14%-15% in Dakar, Guédiawaye, and Mbao; 20% in Pikine). The proportion of men who want to wait at least 24 months before their next pregnancy, who are therefore potentially eligible for FP, varies somewhat from site to site. This proportion rises from 25% in Dakar to 30% in Mbao, 31% in Pikine, and reaches 41% in Guédiawaye. Unlike women, the other category of men potentially interested in contraception (men who do not want any/any more children in the future) is very small (5% in Dakar and Guédiawaye, 4% in Pikine, and 3% in Mbao).

Table 16. Distribution (%) of Men Based on Their Current Desire to Have Children, by Site

Men				
Desire for children	Dakar	Guédiawaye	Pikine	Mbao
Wants another one soon (<2 years)	15.1	13.7	19.5	13.5
Wants another one later (+2 years)	25.1	40.7	31.0	29.8
Wants another one after the wedding	49.1	34.9	35.6	48.4
Another one; doesn't know when	5.3	4.2	9.2	4.8
Doesn't want any more children	5.3	5.3	3.7	2.8
Sterilized	0.2	0.6	0.4	0.2
Not determined	0.0	0.6	0.5	0.4
Total	100.0	100.0	100.0	100.0
Effective	745	509	517	499

Ideal family size

A woman's reproductive behavior can be influenced by what she or her husband considers to be the ideal number of children. To determine this ideal number, women were asked the following question according to their situation at the time of the survey:

- For women with no children: "If you could choose the exact number of children you could have in your life, how many would you like?"
- For women who had children: "If you could go back to the time when you had no children and you could choose the exact number of children you could have in your life, how many would you have liked?"

These apparently simple questions can be embarrassing, in particular for women who already have children, as they are invited to express their opinion on what they consider to be the ideal family size, independently of the number of children they currently have. Therefore these women may be tempted to declare an ideal number of children which is not less than the current size of their family.

The next table presents the responses to the questions asked. This table shows that the ideal number of children does not vary much from site to site. For women, all marital statuses combined, it is 4.5 children per woman in Dakar, 4.6 in Guédiawaye, 5 in Mbao, 4.7 in Mbour, and 4.8 in Pikine and Kaolack. In all sites, the ideal number of children is slightly higher for women in union than women in all marital statuses combined.

The breakdown of women according to the ideal number of children shows that, regardless of the site, the proportion of women who want one child or no children at all is practically zero. The highest percentage of women who want two to three children is observed in Dakar and Guédiawaye (20%); this percentage is 13% in Mbour and 12% in Pikine, Mbao, and Kaolack. Conversely, the proportion of women who want a lot of children (five or more) is higher in Pikine (40%), Mbao and Kaolack (39%); it amounts to 36% in Guédiawaye, 34% in Mbour, and 33% in Dakar. Last but not least, it should be pointed out that a significant percentage of women did not respond to the question with an actual figure but gave answers such as "it depends on God," "what God will give me," etc. The percentage of women in this case is 14% in Guédiawaye and 18% in Dakar, and exceeds 20% in other cities.

Table 17. Distribution (%) of Women Based on the Ideal Number of Children and the Average Number of Children, by Site

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Ideal number of children						
0	0.1	0.0	0.0	0.1	0.0	0.1
1	0.0	0.1	0.1	0.1	0.2	0.2
2	4.8	4.9	3.9	2.4	3.5	3.4
3	14.9	14.9	8.1	9.6	9.1	8.8
4	28.8	30.3	26.7	24.2	28.3	24.2
5	16.9	18.1	19.3	16.1	16.4	19.5
6+	16.1	17.5	20.5	22.6	17.8	19.0
Non-numerical answers	18.1	14.0	21.1	24.6	24.5	24.7
Missing	0.3	0.1	0.3	0.2	0.4	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1704	1246	1105	1154	2036	2369
Average number of children						
All women	4.5	4.6	4.8	5.0	4.7	4.8
Number of women	1704	1246	1105	1154	2036	2369
Married women	4.7	4.9	5.1	5.3	5.0	5.0
Number of women	835	646	646	672	1187	1332
*The average numbers are calculated by excluding the women giving non-numerical answers.						

Unmet need

To evaluate the potential demand for FP, unmet need was divided into two categories; those women who have no unmet needs in terms of FP and those who have unmet needs in terms of spacing and limiting births.

Women who have an unmet need for birth spacing include women whose pregnancy did not occur when they wanted it, and fertile women, who are not pregnant, do not use any contraceptive method, and claim they want to wait two years or more before having their next child. Unmet need in terms of limiting births concern women whose pregnancy was unwanted and fertile women who are not pregnant, do not use any contraceptive method, and do not wish to have any more children. Pregnant women who got pregnant while using a contraceptive method are excluded from unmet need.

The next table represents the breakdown of women, according to the type of needs in terms of FP, for each economic quintile. Generally speaking, unmet need decrease as the level of welfare increases. Furthermore, the need for birth spacing is far greater than those for birth limitation, the only exception being the last quintile in Guédiawaye (8% for spacing and 10% for birth limitation). The unmet need observed in each site are as follows, in decreasing order: 28% in Mbao, 26% in Dakar, 25% in Pikine, 24% in Mbour and Kaolack, and 21% in Guédiawaye.

In Dakar, more than one in 4 women (26% overall, 20% for spacing, and 6% for birth limitation) have unmet need for family planning. The greatest needs are those of women from the poorest quintile (33% for spacing and 8% for birth limitation), and the lowest need for family planning in in the richest category or last quintile (17% overall, 11% for spacing, and 6% for birth limitation). In Guédiawaye, the correlation between the level of unmet need and the level of economic welfare is far less clear-cut than in Dakar. However, the greatest need for family planning are found once again in the first quintile (27% overall, 18% for spacing, and 9% for birth limitation) and the lowest need for family planning are in the last quintile (17% overall, 7% for spacing, and 10% for birth limitation). In the fourth quintile in this city, unmet need is greater than in the middle quintile (20% compared with 17%). In Pikine, women from the first two quintiles are at a similar level in terms of unmet need (27%-29%), these women mainly want to space their next births (20%-22%). However, these needs are greater in the richest quintile (26%) than in the previous two quintiles (22%-23%). In Mbao, the situation is more diversified. Unmet need, in particular for spacing, are lower in the first quintile (20%) than in the next two quintiles (22%-28%) but, from the second quintile, a downward trend is observed for quintiles, particularly from the fourth to fifth quintiles. The greatest unmet need for limiting is found in the poorest quintile (11%) and middle quintile (10%). In Mbour, overall unmet need decreases as the level of welfare increases. This trend particularly concerns unmet need for limitation, as spacing fluctuates with the welfare quintile. Finally, the same pattern is observed in Kaolack as in Mbour.

Table 18. Distribution (%) of Married Women with an Unmet Need in FP* Based on the Economic Well-Being Index, by Site

Sites	Women who are currently married			
	No unmet need	Need for birth-spacing	Need for birth limitation	Total of unmet needs in FP (spacing or limitation)
Dakar				
Poorest	59.3	32.7	8.0	40.7
Second	75.8	16.1	8.1	24.2
Average	76.0	22.5	1.5	24.0
Fourth	78.3	13.1	8.6	21.8
Richest	82.9	11.1	6.0	17.1
Overall	74.0	19.6	6.4	26.0
Guédiawaye				

Sites	Women who are currently married			
	No unmet need	Need for birth-spacing	Need for birth limitation	Total of unmet needs in FP (spacing or limitation)
Poorest	73.4	17.5	9.2	26.7
Second	78.0	18.4	3.6	22.0
Average	83.4	10.8	5.8	16.6
Fourth	80.2	12.3	7.5	19.8
Richest	82.6	7.7	9.7	17.4
Overall	79.4	13.6	7.0	20.6
Pikine				
Poorest	73.3	20.1	6.6	26.7
Second	70.7	22.1	7.2	29.3
Average	77.5	20.7	1.8	22.5
Fourth	77.8	16.6	5.6	22.2
Richest	73.7	17.9	8.4	26.3
Overall	74.6	19.4	6.0	25.4
Mbao				
Poorest	69.5	19.6	10.9	30.5
Second	67.6	28.4	4.0	32.4
Average	68.7	21.7	9.6	31.3
Fourth	71.8	23.1	5.1	28.2
Richest	82.5	10.4	7.1	17.5
Overall	72.4	20.2	7.4	27.6
Mbour				
Poorest	71.7	20.4	8.0	28.3
Second	74.5	16.8	8.8	25.5
Average	75.0	18.2	6.8	25.0
Fourth	75.2	18.1	6.7	24.8
Richest	83.9	11.2	4.8	16.1
Overall	76.0	17.0	7.0	24.0
Kaolack				
Poorest	70.4	18.1	11.5	29.6
Second	76.2	14.5	9.3	23.8
Average	75.9	16.5	7.6	24.1
Fourth	78.7	16.2	5.1	21.3
Richest	77.6	17.6	4.8	22.4
Overall	73.2	20.2	6.6	24.1
<p>*Unmet need for birth-spacing includes pregnant women whose pregnancies did not occur at the desired time and fertile women who are not pregnant and do not use FP methods and who want to wait at least two years before their next birth.</p> <p>Unmet need for birth limitation are for women whose pregnancies were not desired and fertile women who are not pregnant and do not use FP methods and who do not want any more children.</p> <p>Women who became pregnant even though they were using an FP method are excluded from these statistics.</p>				

CHAPTER 6: FAMILY PLANNING

In African countries, the high rate of population growth is a major obstacle to development efforts. Persistent imbalance between high population growth and insufficient economic growth contributes to the deterioration of living conditions. With some of the world's highest fertility rates, sub-Saharan African countries experience a great variety of situations. Since the 1970's, thanks to the collection of demographic data, knowledge of fertility trends has improved considerably. In addition to disparities between regions and countries, there are also differences between the level of fertility in urban and rural milieus within the same country. Unlike rural areas, the urban environment is mostly characterized by a lower level of fertility. Beyond this dichotomy, certain characteristics of the population have a much greater impact than others.

One of the reasons behind the recent drop in fertility observed in developing countries is the use of contraception. The past few decades have seen a rapid and considerable increase in the use of contraception in nearly all countries with the exception of some West African countries.

Moreover, given the known impact of FP on the reduction in maternal and child mortality, the world community continues to pledge its support to the expansion and development of FP programs in areas characterized by high rates of unintended pregnancy and significant maternal and child mortality. The Bill & Melinda Gates Foundation (BMGF) is part of this effort and aims at reducing maternal and child mortality as well as unwanted pregnancies across developing countries, by improving access to quality voluntary FP services.

During the baseline survey, information on contraceptive methods was collected to assess the level of knowledge and opinions on FP, as well as current levels and potential changes that have occurred over the past few years in terms of contraception. The survey addresses the following issues:

- Knowledge
- Past and current use of contraception
- Awareness of the fertile period
- Sources of contraceptive supply
- Knowledge of side effects and other problems of the current method
- Sources of information on contraception
- Opinions and attitudes vis-à-vis contraception.

Contraceptive methods were divided into two categories: modern methods—which are proven to be effective through evidence based research—and traditional methods. Modern methods include female sterilization, male sterilization, oral contraceptives (the pill), the intra-uterine device (IUD), contraceptive injection, implants, male condoms, female condoms, the Lactational Amenorrhea Method (LAM) and emergency contraceptives. Traditional methods include the rhythm, withdrawal, charms, and roots. These traditional practices do not have an evidence base that has determined their effectiveness.

Awareness of Contraceptive Methods

The collection of information on the awareness of methods was a two-stage process. First, female interviewers noted the method(s) spontaneously cited by the interviewee after which, if the interviewee failed to cite all methods featured in the questionnaire, the interviewer gave a brief description of the methods not cited and recorded whether or not the interviewee was aware of them. A woman is deemed aware of the contraceptive method, without any further clarification, if she cites it spontaneously or claims she knows it once it has been described by the interviewer.

The results presented in the next table show that almost all women (97% to 98%) in all sites are aware of at least one contraceptive method. The same percentage is observed for modern methods, which are better known than traditional methods, with levels of awareness ranging from 61% in Mbao to 73% in Guédiawaye. In the majority of cases and in all sites, modern methods were cited spontaneously, while in many cases traditional methods had to be described before they were recognized. The level of awareness of modern methods varies, however, depending on the method. The pill and male condoms (over 90% of women) are best known. It is in Pikine that male condoms were most frequently cited spontaneously (37%). Most of the time, the method had to be described before it was recognized by women (97% after description compared with 35% spontaneous declaration in Guédiawaye; and 96% and 35% in Mbour, 96% and 32% in Mbao, and 94% and 28% in Dakar.

In terms of awareness, contraceptive injection comes third with 85% (Dakar) to 91% (Mbao and Mbour). In all six cities, contraceptive injection was spontaneously cited far more often. Implants are not far behind with 75% (Dakar) to 81% (Guédiawaye) of women. The awareness levels of IUD and female sterilization are fairly close: 71% each in Guédiawaye, respectively, 67% and 68% in Dakar, 69% and 64% in Pikine, 70% and 66% in Mbao, 66% and 77% in Mbour, and finally 64% and 74% in Kaolack. In all sites, approximately one in two and six out of ten women, respectively, claimed they were aware of LAM and the female condom. Emergency contraceptives and male sterilization are the least familiar methods.

As with women, the level of contraceptive awareness is widespread for men (see table 19); it is even generally higher for men. This is notably the case in Dakar for male sterilization, the pill, and condoms; and in Guédiawaye, Pikine and Mbao for male sterilization and condoms.

Table 19. Distribution (%) of Women Based on Their Knowledge of Contraceptive Methods, by Site

Contraceptive method	Dakar		Guédiawaye		Pikine		Mbao		Mbour		Kaolack	
	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge
Any method	97.1	85.1	98.2	88.6	98.2	85.7	98.5	83.9	98.2	88.9	96.9	87.1
Any modern method	97.0	85.0	98.0	88.4	98.2	85.5	98.4	83.7	98.2	88.9	96.9	87.0
Any traditional method	68.7	13.9	72.8	18.8	62.8	11.4	61.4	11.0	63.6	12.2	63.3	10.7
Female sterilization	68.3	3.6	71.2	4.5	64.2	2.4	66.1	3.1	76.8	4.2	74.1	4.8
Male sterilization	16.3	0.6	25.6	2.3	13.4	0.5	15.4	0.8	13.8	1.2	14.0	1.3
Implants	75.3	47.7	80.9	50.1	77.7	50.8	75.2	48.3	76.8	49.5	80.4	56.3
IUD	66.7	39.0	71.0	40.0	69.2	37.7	69.5	37.8	65.9	33.2	64.0	33.7
Injectables	84.5	62.4	87.9	67.8	89.1	69.6	90.9	68.5	91.2	77.3	89.0	72.3
Pills	91.3	76.2	94.2	79.4	92.7	79.0	94.1	78.3	94.5	82.9	91.5	78.8
Emergency contraception	25.7	2.9	31.0	5.3	19.5	1.5	17.9	0.5	16.3	2.3	14.2	2.2
Male condom	94.3	28.3	96.9	34.6	96.1	36.8	96.2	32.4	96.0	34.9	94.6	30.7
Female condom	62.6	13.4	66.5	16.2	58.0	14.9	56.2	12.5	66.0	17.9	57.4	12.7
Foam/gel	18.6	2.6	24.9	2.8	18.6	2.2	15.5	1.8	15.4	2.6	15.7	3.4
LAM	44.7	4.4	56.8	8.9	47.4	5.4	54.1	6.6	49.8	6.0	45.8	4.4
Number of women	1704	1704	1246	1246	1105	1105	1154	1154	2036	2036	2369	2369

Table 20. Distribution (%) of Men Based on Their Knowledge of Contraceptive Methods, by Site

Contraceptive method	Dakar		Guédiawaye		Pikine		Mbao	
	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge	Spontaneous knowledge or after insisting	Spontaneous knowledge
Any method	99.2	88.8	98.9	86.6	99.1	89.0	97.8	86.0
Any modern method	99.2	88.0	98.9	85.7	99.2	86.8	97.8	84.2
Any traditional method	85.1	29.0	82.7	40.1	80.1	30.1	74.8	29.2
Female sterilization	48.7	5.5	52.3	13.2	48.4	10.8	51.8	11.0
Male sterilization	22.2	2.2	29.3	8.0	28.4	4.7	33.2	7.7
Implants	48.0	20.5	52.3	19.9	44.0	16.2	44.9	16.8
IUD	52.8	22.5	51.3	16.4	49.0	15.7	49.3	13.2
Injectables	80.2	35.3	71.8	26.7	78.0	37.0	72.1	33.7
Pills	92.5	63.7	86.0	52.0	87.7	56.8	84.2	46.6
Emergency contraception	21.6	1.9	26.0	7.8	14.2	1.4	14.0	2.2
Male condom	98.9	70.2	98.9	80.5	98.9	77.3	97.1	75.4
Female condom	80.0	27.0	69.4	30.4	73.5	33.8	65.7	29.0
Rhythm	47.2	9.7	47.5	14.3	40.4	20.9	41.5	17.2
Withdrawal	29.4	4.4	40.8	9.0	39.4	4.9	57.1	12.2
Number of men	745	745	509	509	517	517	499	499

Use of Contraception at Any Given Time

The next table indicates, for each site, the percentage of women who used a contraceptive method at any point in their life, by economic quintile. Regardless of the site, more than 30% of women all marital statuses combined and more than 40% of women in union have used a modern method of contraception. Guédiawaye is where the percentage of modern contraceptive method users at any time is highest (37% of women all marital statuses combined and 58% of women in union). In this city, the most commonly used method is the pill (21% of all women all marital statuses combined and 37% of women in union), followed by injection (18% and 29%, respectively) and, in decreasing order, male condoms (12% and 15%), LAM (4% and 7%), IUD (3% and 5%), implants (3% and 4%), emergency contraception (1.3% and 1.1%), female sterilization (0.2% to 0.3%), and female condoms (0.2% and 0%). The use of modern methods, all methods combined, is more widespread among the poorest (42%) and richest women (43%) than in intermediate categories (32% to 35%). The use of the pill barely varies between the first and fourth quintiles (19%-20%) and is highest among the richest (28%). However, the usage rate of contraceptive injections, which is much higher for women from the poorest households (24%), decreases with the welfare quintile (17% and 19% in the second and third quintiles, and 15% in the last quintile). Male condoms were used in particular in the poorest category (18%) and, to a lesser extent, in the last two quintiles (14%). LAM mostly relates to the last two quintiles (6%).

Dakar has the second highest number of contraceptive users at any time with 37% of all women and 54% of women in union. Like in Guédiawaye, the most commonly used method is the pill (19% of all women all marital statuses combined and 32% of women in union), followed by injection (14% and 23%, respectively) and, in decreasing order, male condoms (13% and 16%), implants (4% and 6%), IUD (3% and 6%), and LAM (2% and 4%). Emergency contraception (2.1% and 1.9%), female sterilization (0.4% to 0.7%), and female condoms (0.1%) were marginally used. The use of all modern contraceptive methods combined was highest among women in the second (42%) and fourth quintiles (43%). The lowest usage rate of the pill (10%) is observed in the poorest women and hardly varies between the second and fifth quintiles, although it peaks in the middle class. The use of male condoms decreases with the welfare quintile between the second and fifth quintiles.

Pikine and Mbour have equivalent levels of modern contraceptive usage, all methods combined, at any time (35% of all women all marital statuses combined and 53% of women in union). Here too, the main methods used by all women are the pill (23% in Pikine and 20% in Mbour), contraceptive injection (17% and 21%), male condoms (8% and 8%), LAM (3% and 2%), implants (2.4% and 1.4%), and IUD (2.4% and 1.8%). Emergency contraception (0.1% and 0.7%), female sterilization (0.2% to 0.2%), and female condoms were used only marginally. As with the other sites, women in union use these methods far more often than all women all marital statuses combined, but this is even more prevalent in Pikine than in Mbour. In Pikine, the percentage of pill and implant users generally increases with the economic welfare quintile. The same applies to male condoms, with a much lower usage level in the first two quintiles than in the next quintiles. In Mbour, for these three most commonly used methods, the levels are much lower for women from the poorest category. The levels observed in Kaolack are lower for modern contraceptive methods, all methods combined: 31% of all women and 48% of women in union, but the levels vary in a similar manner to Mbour.

Mbao has the lowest overall levels of modern contraceptive usage methods, all methods combined, at any given time: 30% of all women all marital statuses combined and 47% of women in union. The usage level of the pill is limited in the first quintile (10% compared with more than 18% in other

quintiles). Usage of the injectable and male condoms is practically as high among the poorest women as it is among the richest. The injectable is used mostly by women from the fourth quintile and, to a lesser extent, those in the third quintile.

Table 21. Distribution (%) of Women Who Used a Contraceptive Method at a Given Time Based on the Economic Well-Being Index, by Site

Sites	Method													Total number	
	Any method	Any modern method	Modern method										Any traditional method		
			Female sterilization	Implants	IUD	Inject-ables	Pills	Emergency contraception	Male condom	Female condom	LAM	Other modern method			
Dakar															
Poorest	59.5	30.7	0.1	4.3	0.3	15.2	10.4	0.1	14.1	0.0	1.7	0.0	49.1	360	
Second	72.1	42.2	0.3	6.2	3.7	16.7	18.3	1.7	18.3	0.0	1.0	2.1	60.5	359	
Average	69.4	34.8	0.6	5.4	2.3	13.2	24.4	2.0	11.1	0.1	3.1	0.7	60.7	332	
Fourth	78.1	42.9	0.4	2.5	5.7	13.9	20.5	6.2	14.0	0.0	2.0	2.7	69.2	313	
Richest	73.3	32.5	0.5	3.2	5.0	12.4	21.2	1.1	8.4	0.3	2.5	0.8	69.2	340	
Total	70.3	36.5	0.4	4.4	3.3	14.3	18.8	2.1	13.2	0.1	2.0	1.2	61.5	1704	
Total married women	79.7	53.7	0.7	5.9	5.8	23.0	32.1	1.9	15.9	0.1	3.5	2.0	68.7	835	
Guédiawaye															
Poorest	68.7	41.7	0.0	5.0	2.3	24.1	18.7	1.6	18.2	0.0	2.1	0.1	56.5	221	
Second	71.2	33.6	0.6	1.2	1.5	17.3	20.1	0.3	7.7	0.3	3.0	2.4	65.1	277	
Average	68.6	31.7	0.0	3.0	2.4	19.0	18.4	1.4	8.2	0.0	2.1	0.6	60.7	246	
Fourth	79.2	35.3	0.0	2.5	6.7	15.0	20.1	1.5	14.1	0.4	6.4	6.3	70.7	261	
Richest	78.3	42.9	0.2	1.8	2.5	14.5	27.8	2.0	13.9	0.0	5.6	1.5	67.6	241	
Total	73.3	36.8	0.2	2.6	3.1	17.8	21.0	1.3	12.2	0.2	3.9	2.3	64.4	1246	
Total married women	85.6	57.9	0.3	3.7	5.2	29.1	36.7	1.1	15.4	0.0	7.0	4.1	73.6	646	
Pikine															
Poorest	56.0	26.1	0.0	1.5	1.7	16.9	13.0	0.0	5.8	0.0	3.0	0.0	48.6	210	
Second	62.3	34.8	0.8	1.5	1.6	17.1	23.4	0.0	5.9	0.0	2.6	1.3	49.0	206	
Average	61.2	30.5	0.0	1.7	0.3	16.2	19.6	0.0	9.6	0.0	4.4	1.1	49.9	225	
Fourth	68.5	39.5	0.2	3.7	5.1	19.3	26.1	0.0	9.9	0.0	2.7	1.6	56.7	224	
Richest	73.5	40.5	0.0	3.2	3.4	15.2	32.7	0.5	9.3	0.0	1.7	2.9	65.8	240	
Total	64.6	34.5	0.2	2.4	2.4	16.9	23.2	0.1	8.2	0.0	2.9	1.4	54.4	1105	
Total married women	76.3	52.8	0.3	3.7	4.1	27.2	37.2	0.0	10.5	0.0	4.9	2.5	61.4	646	
Mbao															

Poorest	53.4	24.3	0.4	2.6	1.2	14.8	10.1	0.0	6.4	0.7	2.7	0.3	46.3	207
Second	68.1	28.7	0.0	2.2	1.3	12.4	18.4	0.0	3.8	0.0	3.6	0.0	60.7	217
Average	62.4	30.1	0.3	2.6	1.9	16.2	22.3	0.6	4.0	0.0	1.2	0.6	48.6	232
Fourth	67.1	34.4	0.9	3.0	0.8	17.6	26.3	0.4	4.6	1.9	4.4	0.8	61.8	223
Richest	71.6	32.0	0.3	1.2	3.0	15.5	20.9	0.5	5.8	0.0	2.5	0.9	62.9	275
Total	65.0	30.1	0.4	2.3	1.7	15.4	19.8	0.3	4.9	0.5	2.8	0.6	56.4	1154
Total married women	73.8	46.9	0.5	3.3	3.0	24.2	31.5	0.4	6.7	0.8	4.9	0.9	61.4	672
Mbour														
Poorest	58.8	27.1	0.0	0.8	1.0	15.9	15.3	0.3	6.1	0.0	1.8	0.0	49.2	339
Second	62.1	38.6	0.0	1.5	1.9	25.6	20.4	0.5	7.0	0.3	2.3	0.2	46.5	392
Average	65.7	33.7	0.8	0.9	0.9	18.4	19.0	0.0	8.9	0.2	1.8	0.8	54.0	413
Fourth	69.2	39.3	0.0	1.9	1.2	23.8	23.4	1.7	9.9	0.2	2.1	1.6	58.7	422
Richest	68.3	34.1	0.0	1.9	3.6	19.9	20.2	0.9	9.5	0.1	2.3	0.7	59.5	470
Total	65.2	34.8	0.2	1.4	1.8	20.8	19.8	0.7	8.4	0.2	2.1	0.7	54.0	2036
Total married women	75.8	53.0	0.3	2.0	2.7	32.7	31.1	0.6	10.8	0.3	3.2	1.2	58.3	1187
Kaolack														
Poorest	56.6	30.6	0.3	2.6	1.9	19.3	12.1	0.0	6.6	0.0	1.2	0.8	42.7	414
Second	62.6	33.4	0.3	3.2	2.9	16.8	20.2	0.0	8.6	0.3	1.5	1.2	49.7	446
Average	63.2	30.2	0.2	3.2	1.5	16.2	16.0	0.5	7.0	0.0	0.6	0.6	53.8	460
Fourth	63.5	32.0	0.2	3.5	2.3	18.7	16.2	0.0	8.2	0.0	1.4	1.5	54.7	519
Richest	67.9	30.5	1.0	4.1	2.1	14.3	17.4	1.1	9.2	0.0	1.3	1.5	62.7	530
Total	63.0	31.3	0.4	3.4	2.1	17.0	16.5	0.3	8.0	0.1	1.2	1.1	53.3	2369
Total married women	72.1	48.3	0.6	5.7	3.4	27.4	27.3	0.5	10.4	0.1	2.0	1.5	57.1	1332

Current Use of Contraceptive Methods

Current use of contraception is a key indicator making it possible to assess the success of FP programs. Male/female interviewers asked men and women who claimed to have knowledge of a given contraceptive method whether they were currently using this method. The next table indicates, for each site, contraceptive prevalence, i.e., the proportion of women who were using a contraceptive method at the time of the survey. Prevalence is presented according to quintile.

Regardless of the site, more than 13% of women in all marital statuses combined and more than 20% of women in union are currently using a modern or traditional contraceptive method. For modern methods, the minimum prevalence rates observed are between 12% and 20%. Guédiawaye is again where the percentage of current users of modern contraceptive methods is highest (19% of women all marital statuses combined and 32% of women in union). In this city, the most commonly used methods are, in decreasing order, the pill (7.2% of all women, and 12.2% of women in union), contraceptive injection (6% and 12%), male condoms (3.1% and 3.9%), implants (1.3% and 1.6%) and IUD (0.7% and 1.3%). Prevalence rates of other specific modern methods are well below 1%. The prevalence rate of the pill is highest in the last quintile, which corresponds with the women from the richest households (14%); it is also higher in the first two quintiles (6% to 7%) than in the next two (4.0% to 4.8%). Contraceptive injection is more commonly used in the middle class (10%); its prevalence rate is 8.1% in the second quintile, and 6.2% in the first quintile as compared to 5.5% in the last quintile. The lowest prevalence rates of male condoms are found in the poorest and richest categories, while the highest is observed in the fourth quintile (7.6%). IUD and contraceptive injection seem to mostly concern the poorest women.

Dakar ranks second in terms of prevalence of modern contraceptive methods, all methods combined, with 17.5% of all women and 25.1% of women in union. Like in Guédiawaye, the most commonly used methods are, in decreasing order, the pill (4.7% of all women, and 8.4% of women in union), contraceptive injection (4.7% and 7.3%), male condoms (4.0% and 3.2%), implants (2.2% and 2.8%) and the IUD (1.0% and 1.7%). The prevalence rates of other specific modern methods were not significant. Unlike the pill for which prevalence fluctuates from one quintile to the next (3.4% and 3.2% in the two poorest quintiles, 8.2% in the middle quintile, and 4.0% in the last), contraceptive injection generally tends to decrease with the economic welfare quintile (6.0% in the first; 5.1% in the second; and 3.8% in the last). The highest prevalence rate of male condoms is observed for women from the second quintile (7.1%); it amounts to 5.2% in the fourth and 4.9% in the poorest category; it is lowest in the third and last quintiles (1.4% and 1.5%).

The prevalence rate of modern contraceptive methods, all methods combined, for the Mbour site is 16.2% for all women and 25.8% for women in union. Once again, two methods predominate: the pill with 8.5% of all women and 9.5% of women in union, and contraceptive injection, with 6.8% and 11.0%, respectively. These two methods are mostly used by women in the second and fourth quintiles. The prevalence rate of male condoms (1.7% of all women and 2.0% of women in union) is lowest for the poorest women (0.8%). Implants and IUD are used by, 0.9% and 0.7% of all women and 1.4% and 1.1% of women in a union. The prevalence rates of other specific modern methods are less than 1%.

The prevalence rate of modern contraceptive methods, all methods combined, in Pikine, is 15.8% for all women and 25.7% for women in union. The corresponding percentages for all methods are 16.9% and 27.5%. Once again, two methods predominate: contraceptive injection with 7% of all women and 11% of women in union, and the pill, with 7% and 11%, respectively. The use of the pill increases with

the welfare quintile, while contraceptive injection is primarily used by the poorest women (8%) and, to a lesser extent, the women from the fourth quintile (7%). The contraceptive prevalence rate for IUD is 0.9% for all women and 1.6% for those in union, and 0.6% and 1.0%, respectively for implants. The prevalence rates of other specific modern methods are less than 1%.

The prevalence rate of modern contraceptive methods, all methods combined, in Mbao is lower than in the above mentioned sites: 12.2% for all women and 20.1% for women in union. Once again, the two largely predominant methods are contraceptive injection (4.4% of all women and 6.9% of women in union) and the pill (5.0% and 8.5%, respectively). The use contraceptive injection decreases with the quintile, the highest level being observed in the first two quintiles (5.7% to 5.9%) and the lowest in the last quintile (3.3%). Conversely, the pill seems to be used by women in the last two quintiles.

Finally, Kaolack has the lowest level of prevalence for modern contraceptive methods, all methods combined: 12.6% for all women and 20.6% for women in union. Contraceptive injection is used by 5.5% of all women and 9.3% of women in union; the corresponding rates for the pill are 3.8% and 6.6%. In all likelihood, implants, used by 1.3% of all women, are primarily used by women in the middle quintile. Male condoms are less frequently used in the upper classes (last two quintiles).

Table 22. Distribution (%) of Women Who Used a Contraceptive Method at a Given Time Based on the Economic Well-Being Index, by Site

Sites	Any method	Any modern method	Modern method										Any traditional method	Total number
			Female sterilization	Implants	IUD	Injectables	Pills	Emergency contraception	Male condom	Female condom	LAM	Other modern method		
Dakar														
Poorest	59.5	30.7	0.1	4.3	0.3	15.2	10.4	0.1	14.1	0.0	1.7	0.0	49.1	360
Second	72.1	42.2	0.3	6.2	3.7	16.7	18.3	1.7	18.3	0.0	1.0	2.1	60.5	359
Average	69.4	34.8	0.6	5.4	2.3	13.2	24.4	2.0	11.1	0.1	3.1	0.7	60.7	332
Fourth	78.1	42.9	0.4	2.5	5.7	13.9	20.5	6.2	14.0	0.0	2.0	2.7	69.2	313
Richest	73.3	32.5	0.5	3.2	5.0	12.4	21.2	1.1	8.4	0.3	2.5	0.8	69.2	340
Total	70.3	36.5	0.4	4.4	3.3	14.3	18.8	2.1	13.2	0.1	2.0	1.2	61.5	1704
Total married women	79.7	53.7	0.7	5.9	5.8	23.0	32.1	1.9	15.9	0.1	3.5	2.0	68.7	835
Guédiawaye														
Poorest	68.7	41.7	0.0	5.0	2.3	24.1	18.7	1.6	18.2	0.0	2.1	0.1	56.5	221
Second	71.2	33.6	0.6	1.2	1.5	17.3	20.1	0.3	7.7	0.3	3.0	2.4	65.1	277
Average	68.6	31.7	0.0	3.0	2.4	19.0	18.4	1.4	8.2	0.0	2.1	0.6	60.7	246
Fourth	79.2	35.3	0.0	2.5	6.7	15.0	20.1	1.5	14.1	0.4	6.4	6.3	70.7	261
Richest	78.3	42.9	0.2	1.8	2.5	14.5	27.8	2.0	13.9	0.0	5.6	1.5	67.6	241
Total	73.3	36.8	0.2	2.6	3.1	17.8	21.0	1.3	12.2	0.2	3.9	2.3	64.4	1246
Total married women	85.6	57.9	0.3	3.7	5.2	29.1	36.7	1.1	15.4	0.0	7.0	4.1	73.6	646
Pikine														
Poorest	56.0	26.1	0.0	1.5	1.7	16.9	13.0	0.0	5.8	0.0	3.0	0.0	48.6	210
Second	62.3	34.8	0.8	1.5	1.6	17.1	23.4	0.0	5.9	0.0	2.6	1.3	49.0	206
Average	61.2	30.5	0.0	1.7	0.3	16.2	19.6	0.0	9.6	0.0	4.4	1.1	49.9	225
Fourth	68.5	39.5	0.2	3.7	5.1	19.3	26.1	0.0	9.9	0.0	2.7	1.6	56.7	224
Richest	73.5	40.5	0.0	3.2	3.4	15.2	32.7	0.5	9.3	0.0	1.7	2.9	65.8	240
Total	64.6	34.5	0.2	2.4	2.4	16.9	23.2	0.1	8.2	0.0	2.9	1.4	54.4	1105

Sites	Any method	Any modern method	Modern method										Any traditional method	Total number
			Female sterilization	Implants	IUD	Injectables	Pills	Emergency contraception	Male condom	Female condom	LAM	Other modern method		
Total married women	76.3	52.8	0.3	3.7	4.1	27.2	37.2	0.0	10.5	0.0	4.9	2.5	61.4	646
Mbao														
Poorest	53.4	24.3	0.4	2.6	1.2	14.8	10.1	0.0	6.4	0.7	2.7	0.3	46.3	207
Second	68.1	28.7	0.0	2.2	1.3	12.4	18.4	0.0	3.8	0.0	3.6	0.0	60.7	217
Average	62.4	30.1	0.3	2.6	1.9	16.2	22.3	0.6	4.0	0.0	1.2	0.6	48.6	232
Fourth	67.1	34.4	0.9	3.0	0.8	17.6	26.3	0.4	4.6	1.9	4.4	0.8	61.8	223
Richest	71.6	32.0	0.3	1.2	3.0	15.5	20.9	0.5	5.8	0.0	2.5	0.9	62.9	275
Total	65.0	30.1	0.4	2.3	1.7	15.4	19.8	0.3	4.9	0.5	2.8	0.6	56.4	1154
Total married women	73.8	46.9	0.5	3.3	3.0	24.2	31.5	0.4	6.7	0.8	4.9	0.9	61.4	672
Mbour														
Poorest	58.8	27.1	0.0	0.8	1.0	15.9	15.3	0.3	6.1	0.0	1.8	0.0	49.2	339
Second	62.1	38.6	0.0	1.5	1.9	25.6	20.4	0.5	7.0	0.3	2.3	0.2	46.5	392
Average	65.7	33.7	0.8	0.9	0.9	18.4	19.0	0.0	8.9	0.2	1.8	0.8	54.0	413
Fourth	69.2	39.3	0.0	1.9	1.2	23.8	23.4	1.7	9.9	0.2	2.1	1.6	58.7	422
Richest	68.3	34.1	0.0	1.9	3.6	19.9	20.2	0.9	9.5	0.1	2.3	0.7	59.5	470
Total	65.2	34.8	0.2	1.4	1.8	20.8	19.8	0.7	8.4	0.2	2.1	0.7	54.0	2036
Total married women	75.8	53.0	0.3	2.0	2.7	32.7	31.1	0.6	10.8	0.3	3.2	1.2	58.3	1187
Kaolack														
Poorest	56.6	30.6	0.3	2.6	1.9	19.3	12.1	0.0	6.6	0.0	1.2	0.8	42.7	414
Second	62.6	33.4	0.3	3.2	2.9	16.8	20.2	0.0	8.6	0.3	1.5	1.2	49.7	446
Average	63.2	30.2	0.2	3.2	1.5	16.2	16.0	0.5	7.0	0.0	0.6	0.6	53.8	460
Fourth	63.5	32.0	0.2	3.5	2.3	18.7	16.2	0.0	8.2	0.0	1.4	1.5	54.7	519
Richest	67.9	30.5	1.0	4.1	2.1	14.3	17.4	1.1	9.2	0.0	1.3	1.5	62.7	530
Total	63.0	31.3	0.4	3.4	2.1	17.0	16.5	0.3	8.0	0.1	1.2	1.1	53.3	2369

Sites	Any method	Any modern method	Modern method										Any traditional method	Total number
			Female sterilization	Implants	IUD	Injectables	Pills	Emergency contraception	Male condom	Female condom	LAM	Other modern method		
Total married women	72.1	48.3	0.6	5.7	3.4	27.4	27.3	0.5	10.4	0.1	2.0	1.5	57.1	1332

Awareness of the Fertile Period

The results of the previous section showed that the current use of traditional contraceptive methods, which include periodic abstinence, was not insignificant. However, the efficiency of this method is based on good knowledge of the fertile period during the menstrual cycle. To measure how aware women were of the fertile period, they were asked whether they believed that, during the cycle, there was a period during which they were more likely to get pregnant and, if so, what time during the month this occurred. The responses to this question are presented in the following table. Because of the many nuances of the responses to this question, women were grouped into three major categories:

- Those who are aware of the fertile period, i.e., the women whose response was "middle of the cycle"
- Those whose awareness of the period is dubious, i.e., the women whose response was "just before menstruation starts," "just after menstruation ends." While these responses are too vague to be deemed to correspond with the ovulation period, depending on women's idea of "just after the end" and "just before the start," they may correspond with the fertile period.
- Those who are not aware of the period, i.e., the women whose response was "during menstruation," "no specific period," "do not know," or any other response.

Twenty-seven percent to 40% of women are not at all aware that there is a fertile period in women's menstrual cycle. It is in Mbour (40%), Pikine (37%), and Kaolack and Mbao (36%) that the percentages of women are highest, and in Guédiawaye (27%) and Dakar (30%) that they are lowest. According to the abovementioned typology, 20% to 31% of women are well aware of the ovulation period: 31% in Dakar, 28% in Guédiawaye, and 27% in Pikine; in other sites, percentages range from 20% to 22%. Conversely, those who in all likelihood are not aware of the fertile period amount to 44% of women in Mbour; 39%-40% in Pikine, Mbao, and Kaolack; 34% in Dakar; and 29% in Guédiawaye. In all sites, more than one in three women has a dubious grasp of the menstrual cycle period during which a woman is more likely to get pregnant. The percentage of men whose response was "the middle of the cycle" is, respectively, 24%, 30%, 14%, and 22% in Dakar, Guédiawaye, Pikine, and Mbao. Unlike the other two sites, this level is lower than that of women in Dakar and Pikine. Twenty-nine percent to 35% of men are not aware of the high pregnancy risk period during women's menstrual cycle.

Table 23. Distribution (%) of Women and Men Based on Their Knowledge of the Fertility Period, by Site

Women						
Fertility period	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Right before the menstrual cycle	5.7	9.4	3.8	7.3	6.2	7.0
During the menstrual cycle	0.6	1.0	1.7	1.3	1.2	0.9
Right after the menstrual cycle	29.2	32.5	29.6	34.0	28.4	30.3
Between the menstrual cycles	30.7	28.4	27.1	19.8	21.6	21.9
Other	3.2	1.9	0.6	1.3	2.8	3.5
No specific period	3.0	5.4	8.1	5.2	6.1	5.5
Doesn't know	27.4	21.2	29.0	31.1	33.6	30.7
Not determined	0.2	0.2	0.0	0.1	0.1	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Number of women	1704	1246	1105	1154	2036	2369
Men						
Fertility period	Dakar	Guédiawaye	Pikine	Mbao		
Right before the menstrual cycle	10.6	9.3	7.8	2.8		
During the menstrual cycle	4.0	6.8	10.5	1.6		
Right after the menstrual cycle	35.9	29.4	42.9	44.3		
Between the menstrual cycles	24.2	29.5	13.6	22.1		
Other	2.7	0.3	0.4	0.2		
No specific period	3.2	6.6	3.6	2.8		
Doesn't know	18.5	18.0	20.8	25.7		
Not determined	0.8	0.2	0.4	0.5		
Total	100.0	100.0	100.0	100.0		
Number of men	745	509	517	499		

Source of Supply of Modern Contraceptive Methods

To assess the contribution of the public and private medical sectors to the distribution or sale of the different modern contraception methods, female users were asked where they procured their current method. The results are presented in the next table. Pharmacies were separated from the private sector in light of their potential impact on access to contraceptives. It should also be noted, as already mentioned, that the major modern contraceptive methods used in the different sites are, in decreasing order, the pill, injectable, male condoms, and implants.

In all sites, to obtain modern contraceptive methods, 64% to 78% of women contact the public health sector, the main service provider in this domain. There are relatively more women in Kaolack (71%), Pikine (74%), and Mbao (78%) who use this source than in other sites (64% to 66%). The private sector, with the exception of pharmacies, contributes more to the supply of contraceptives in Pikine (16%) and, to a lesser extent, Mbour (11%) than in other sites (9% in Mbao, 7% in Kaolack, 6% in Guédiawaye, and 5% in Dakar). Conversely, it is in Guédiawaye (22% of women users), Dakar (21%), and Mbour (20%) that pharmacies contribute most; the corresponding percentages in other sites range from 9% to 10%. Potential sources such as workplace clinics, youth centers, nongovernmental organizations (NGOs), and volunteers/peer educators essentially were cited by users in Kaolack (11%) and Dakar (8%); the percentage of women who used these sources is around 3% to 4% in Mbao, Guédiawaye, and Mbour, and about zero in Pikine.

Table 24. Distribution (%) of Female Users Based on the Source of Procurement of Their Current Modern Method, by Type of Facility and by City

Source	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Public sector	64.7	65.9	74.2	78.2	64.2	70.7
Private sector*	5.2	6.4	15.7	8.8	10.5	6.8
Pharmacy	20.9	21.7	9.6	8.6	20.1	9.9
Other**	8.0	3.5	0.5	2.9	3.7	11.4
Doesn't know	0.0	0.0	0.0	0.0	0.0	0.3
Not determined	1.1	2.5	0.0	1.5	1.6	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Number of women	292	240	173	139	329	298
* Formal and informal sectors (not including pharmacies)						
** Including clinic in the workplace, center for youths, NGO, volunteers/peer educators, etc.						

Informed Choice of a Contraceptive Method

As part of the provision of services in health facilities, FP service providers are supposed to provide their customers with comprehensive services by giving them as much relevant information as possible, in particular on the different contraceptive methods available and their constraints, as well as on the methods' side effects and possible contraindications. The purpose of this information is to help women make an informed choice and raise their awareness of how to make the best use of these methods and how to manage their potential downside. The information provided also helps address and combat prejudices on contraceptive methods.

According to the results of the survey, in all sites with the exception of Dakar (46%), more than 50% of the women who are currently using a modern method have been informed of the side effects or potential problems associated with these methods. In Mbour, this percentage reaches 64%. Women have rarely received information on the methods for which these issues are insignificant (emergency contraception, male condom, spermicides, natural methods, LAM, and others). Mbour and Pikine stand out on this issue, with high percentages of informed women for emergency contraception and LAM, respectively, and for the male condom.

For the other methods, the percentage of informed women generally exceeds 60% but varies depending on the method and the site. In Dakar, women were most aware of IUD (76%) and implants (73%). In total, 69% of contraceptive injection users and 61% of sterilization and pill users have been informed of the side effects or potential problems associated with these methods. For Guédiawaye, implants top the list (84%), followed by sterilization (78%), injectables (69%), the pill (66%), and IUD (60%). In Pikine, the level of information varies little according to the method (60% to 66%), with the exception of sterilization, with only 24% of informed users. In Mbao, like in Dakar, IUD (81%) and implant users (82%) were most frequently informed, followed by pill (74%) and contraceptive injection users (62%). It is also in this site that sterilization users have been least informed (28%). An almost identical pattern is observed in Mbour (89%, 85%, 78%, 77%, and 33%, respectively, for IUD, implants, the pill, contraceptive injection, and sterilization, and in Kaolack where the corresponding figures for the users of these methods are, respectively, 83%, 80%, 69%, 70%, 73%, and 55%).

Table 25. Distribution (%) of Women Currently Using a Modern Method Who Are Informed of Its Side Effects or Potential Problems, by Method and by Site

Method	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Sterilization	61.0	77.7	23.9	28.3	32.9	55.2
Implants	73.0	83.9	67.0	81.8	84.9	79.6
IUD	75.9	59.5	63.2	81.0	89.1	83.3
Injectables	69.0	69.1	60.3	61.5	76.5	73.3
Pills	60.7	65.6	63.3	74.4	77.6	70.0
Emergency contraception	0.0	17.0	0.0	0.0	51.5	0.0
Male condom	5.1	0.0	66.3	0.0	3.2	0.0

Method	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Spermicide	0.0	0.0	0.0	0.0	0.0	0.0
Natural method	7.3	0.9	0.0	7.0	9.0	7.9
LAM	0.0	0.0	0.0	0.0	51.4	0.0
Other	0.0	0.0	0.0	0.0	32.1	0.0
Total	46.4	52.6	56.6	57.3	63.6	59.2
Number of women	292	240	173	139	329	298

Information on Contraceptive Methods

To assess to what extent women and men have access to information on FP and how they were informed, they were asked whether they heard any FP messages on the radio or television in the three months preceding the survey.

According to the next table, during the three months prior to the survey, television was the number one channel through which women heard or saw a message on FP, all sites combined. More than one in three women heard a FP message via the television. Guédiawaye (51% of women) was the number one site in this respect, followed by Dakar (41%) and Pikine (40%). Other sites follow with percentages of 32% to 36%. Radio came in second with 24% of those surveyed in Pikine, 22% in Guédiawaye and Mbour, 20% in Kaolack, 18% in Dakar and 15% in Mboa reporting to have heard a FP message via radio. Magazines and newspapers were least cited as a source of information, with the highest scores in Guédiawaye (7%) and Dakar (5%). Similarly, it should be noted that, in all other sites with the exception of Guédiawaye (43%), more than 50% of women had no access to information on FP via the media in the three months prior to the survey.

Television is also the number one channel through which men have obtained information on FP (more than two in three men in Guédiawaye and Mbao, nearly six in ten in Pikine, and nearly one in two in Dakar). The radio was cited by more than one in three men (51% in Guédiawaye, 44% in Mbao, 40% in Pikine, and 33% in Dakar). It is in Guédiawaye that newspapers and magazines (22% of men, compared with 12% to 15% in the other three sites) were the predominant source of information for men. Finally, many more men than women heard or saw an FP message on the radio, television, or in newspapers and magazines. Consequently, a smaller percentage of men had no information on FP through the media in the three months prior to the survey.

Table 26. Distribution (%) of Women and Men Who Have Seen or Heard an FP Message over the Past Three Years, by Media Outlet and by Site

Women						
Media outlet	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Radio	18.0	21.6	24.0	14.7	21.7	20.4
TV	41.3	50.7	39.7	36.0	33.6	32.4
Magazines/newspapers	4.8	7.2	3.9	2.3	3.4	1.9
None	52.3	43.0	54.1	57.0	58.5	59.5
Number of women	1704	1246	1105	1154	2036	2369
Men						
Media outlet	Dakar	Guédiawaye	Pikine	Mbao		

Radio	32.8	51.0	40.3	43.9		
TV	48.9	67.4	56.8	67.3		
Magazines/newspapers	11.9	22.3	14.7	13.4		
None	42.2	25.9	35.6	23.3		
Number of men	745	509	517	499		

Beliefs, Myths and Misperceptions in Terms of Contraception

Certain beliefs, myths and misperceptions likely to deter women and men from using contraceptive methods are widespread. During the survey, all the women and men aware of at least one contraceptive method were asked whether they totally agreed, agreed, disagreed, or strongly disagreed with some of these beliefs. The next table presents, for each site, the percentage of women who claimed they agreed or totally agreed with these assertions.

High percentages of women claimed they subscribed to these inaccurate assertions. Nearly seven in ten women (67%) and more than six in ten (61%) in Mbao, believe that people who use contraceptives ultimately have health problems and that contraceptives are hazardous to health. According to more than four in ten women (42%), contraceptives can damage the uterus, while 40% believe that getting a contraceptive injection makes women permanently sterile. Twenty-six percent to 27% of them agree or totally agree with each of the following assertions: "Contraceptives reduce sexual desire," "Contraceptives can cause cancer," and "Contraceptives can give you deformed babies." In Guédiawaye, 57% of the women believe that people who use contraceptives ultimately have health problems and 51% that contraceptives are hazardous to health. According to 40% of women, contraceptives can damage the uterus, and 31% believe that getting a contraceptive injection makes women permanently sterile. The response rates to the other three assertions are equivalent to those observed in Mbao. Similar results were found in the other sites. Mbour and Kaolack are generally where these beliefs are least widespread. However, the percentage of women who claimed that getting a contraceptive injection makes women permanently sterile, that people who use contraceptives ultimately have health problems, and that contraceptives are hazardous to health, is slightly higher than in Dakar.

Table 27. Distribution (%) of Women Agreeing or Completely Agreeing with the Following Arguments Regarding the Use of FP among Those Who Know FP Methods

Arguments against FP	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Contraceptive injections can make women sterile forever	30.2	31.0	33.0	40.0	28.2	32.0
Contraceptive users end up having health problems	52.4	57.1	58.5	67.3	49.6	57.5
Contraceptives may harm the uterus	31.0	40.3	39.1	42.2	26.5	32.1
Contraceptives may decrease sexual desire.	23.5	24.5	21.5	26.4	15.4	19.8
Contraceptives may cause cancer	21.8	25.7	21.9	26.3	15.4	15.7
Contraceptives may result in malformation for newborns	19.7	25.4	21.8	27.3	15.4	15.5

Arguments against FP	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Contraceptives may harm people's health	42.5	50.8	48.1	61.1	34.2	44.4
Number of women	1655	1224	1085	1136	1998	2296

The next table presents, for each site, the percentage of men who claimed they agreed or totally agreed with certain assertions.

The proportion of men in Dakar who agree with these assertions is higher than that of women. Almost six in ten men in Dakar believe that people who use contraceptives ultimately have health problems; 53% and 52%, respectively, agree that contraceptives can damage the uterus and that contraceptives are hazardous to health. Forty-five percent of men believe that contraceptives reduce sexual desire and one in three believes that getting a contraceptive injection makes women permanently sterile. The same applies to the statements associated with the use of male condoms: using a condom reduces women's sexual pleasure (52%) and using a condom reduces men's sexual pleasure (54%). In Guédiawaye, men's most common misconceptions are: "people who use contraceptives ultimately have health problems" (51%); "contraceptives can damage the uterus" (51%); "contraceptives reduce sexual desire" (47%); and "contraceptives are hazardous to health" (44%). For the arguments associated with the use of male condoms, the assertions are shared by 40% to 45% of men. The situation in Pikine is similar to that in Guédiawaye. With the exception of the assertion "getting a contraceptive injection makes women permanently sterile," the proportion of men in Mbao who share these ideas on contraception is relatively lower than the proportion of women.

Table 28. Distribution (%) of Men Agreeing or Completely Agreeing with the Following Arguments Regarding the Use of FP among Those Who Know FP Methods

Arguments against FP	Dakar	Guédiawaye	Pikine	Mbao
Contraceptive injections can make women sterile forever	33.4	27.1	38.6	30.8
Contraceptive users end up having health problems	59.5	50.7	51.8	40.1
Contraceptives may harm the uterus	53.2	50.5	48.2	33.8
Contraceptives may decrease sexual desire	45.3	46.9	42.0	35.3
Contraceptives may cause cancer	29.3	26.1	31.2	25.1
Contraceptives may cause malformation in newborns	25.4	22.4	34.8	21.7
Contraceptives may harm people's health	51.9	44.3	47.2	33.4
Do you think that using a condom decreases female pleasure?	51.8	39.6	39.7	16.1
Do you think that using a condom decreases male pleasure?	53.8	44.5	41.6	17.6
Do you think that using a condom is a sign of infidelity?	41.5	40.5	35.3	22.9
Number of men knowing about FP*	737	503	511	485

Future Use of Contraception

Women who were not using contraception at the time of the survey were asked whether they intended

to use a method in the future. The next table gives the breakdown of women and men aware of at least one FP method but who did not use a contraceptive method at the time of the survey, according to their intention to use in the future.

This table reveals that a significant percentage of women and men who were not using a contraceptive method at the time of the survey do not know whether or not they will use a contraceptive method in the future: 13% (Kaolack) to 22% (Guédiawaye) of women and 13% (Pikine) to 25% (Mbao) of men. The percentage of women who intend to use a contraceptive method in the next 12 months (potential need for contraception) is fairly similar for all sites: 11% in Kaolack and Mbao; 13% in Dakar, Guédiawaye, and Mbour; and 17% in Pikine. However, the corresponding percentage of men varies dramatically from one site to another: 11% in Mbao, 16% in Dakar, 17% in Pikine, and 23% in Guédiawaye. For those who do not intend to use a contraceptive method in the next 12 months, results show that the proportion of women in Kaolack (75%) and Mbour and Mbao (72%) in this case is relatively higher. The corresponding percentages for the other sites are 64% to 67%. For men, Pikine (68%) and Dakar (67%) have the highest percentages of men who do not intend to use a contraceptive method in the next 12 months. The lowest percentage is found in Guédiawaye (53%). Generally speaking, the intention to use a contraceptive method in the next 12 months is more clear-cut for men than women, particularly in Guédiawaye.

Table 29. Distribution (%) of Women and Men Currently Not Using FP Methods Who Know at Least One Method Based on Their Intent to Use a Method in the Future

Sites	Planning on using an FP method over the next 12 months		Not planning on using an FP method over the next 12 months		Doesn't know		Not determined		Number	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Dakar	13.3	15.9	67.4	66.8	18.2	16.6	1.1	0.7	1323	479
Guédiawaye	12.7	22.7	63.6	52.5	22.3	23.3	1.4	1.5	956	342
Pikine	16.6	17.2	66.3	68.4	16.3	12.5	0.9	1.9	898	383
Mbao	11.2	11.1	71.7	62.5	15.9	25.4	1.3	1.0	979	341
Mbour	12.7		71.6		15.1		0.6		1637	
Kaolack	11.1		74.8		12.7		1.3		1967	

Reasons for Not Using Contraception

During the survey, the women aware of at least one FP method but who were not using any contraceptive method at the time of the interview were asked for the main reasons why they are not currently using a method. The results are presented in the next table. These reasons were classified into five relatively similar categories.

The results show that, in all sites, the most cited reason is the absence of sexual intercourse or low sexual intercourse frequency (56%-57% in Dakar and Guédiawaye; 49%-50% in Mbour, Mbao, Pikine, and Kaolack).

In addition to this reason, the most cited reason in Dakar is the desire to get pregnant (9%), followed by the interviewee's objection to the use of contraception (9%), the desire to have as many children as

possible (6%), being pregnant (6%), fear of side effects (6%), fear of health problems (5%), the husband's objection (4%), breastfeeding (4%), and religious considerations (4%). Other reasons only score 3% or less.

The results are fairly similar in Guédiawaye: desire to get pregnant (9%), interviewee's objection to the use of contraception (9%), fear of side effects (9%), desire to have as many children as possible (7%), being pregnant (5%), fear of health problems (5%), husband's objection (5%), breastfeeding (3%), and religious considerations (3%).

Equivalent results are observed in the other sites:

Pikine: desire to get pregnant (10%), interviewee's objection to the use of contraception (10%), fear of side effects (10%), desire to have as many children as possible (8%), being pregnant (4%), fear of health problems (4%), husband's objection (5%), breastfeeding (5%), and religious considerations (1%).

Mbao: desire to get pregnant (13%), interviewee's objection to the use of contraception (10%), fear of side effects (10%), desire to have as many children as possible (8%), absent partner/husband (6%), being pregnant (4%), fear of health problems (5%), husband's objection (5%), breastfeeding (4%), and religious considerations (4%).

Mbour: desire to get pregnant (11%), interviewee's objection to the use of contraception (9%), fear of side effects (14%), desire to have as many children as possible (7%), absent partner/husband (6%), being pregnant (6%), fear of health problems (5%), husband's objection (4%), breastfeeding (4%), and religious considerations (3%).

Kaolack: desire to get pregnant (11%), interviewee's objection to the use of contraception (9%), fear of side effects (12%), absent partner/husband (7%), desire to have as many children as possible (6%), being pregnant (5%), fear of health problems (4%), husband's objection (4%), and breastfeeding (4%).

Table 30. Distribution (%) of Women Based on Their Reasons for Not Using FP Methods among Those Who Know at Least One Method

Reasons for not using FP	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Reasons related to fertility						
Infrequent sexual relations/no sexual relations	56.2	56.7	50.0	49.2	48.6	48.8
Absent partner or husband	5.6	9.2	10.5	6.4	6.0	7.0
Menopause/hysterectomy	1.9	0.9	1.2	2.2	1.2	2.0
Already pregnant	5.6	4.9	4.2	3.9	5.8	4.6
Breastfeeding	4.0	3.2	4.8	4.4	4.4	4.4
Cannot have children	0.2	1.2	0.4	0.1	0.1	0.3
Wishes to have as many children as possible	6.2	6.9	7.6	7.5	7.1	6.2
Would like to become pregnant	9.4	9.4	9.9	12.6	10.5	10.6
Post-partum amenorrhea	0.9	1.6	3.1	2.7	2.7	2.5
Opposition to FP use						

Reasons for not using FP	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
The interviewee is opposed to FP use	8.7	9.0	9.5	10.2	9.1	8.6
The partner is opposed to FP use	4.3	5.0	5.2	4.6	4.4	3.7
Other people are opposed to FP use	0.9	0.3	0.4	0.9	0.5	0.2
Religion is against it	3.6	3.1	1.3	4.2	2.5	2.3
Lack of knowledge						
Does not know how to use the method	1.3	0.5	0.9	1.0	1.3	1.3
Does not know the sources of procurement	1.3	0.6	0.9	1.0	1.3	1.5
Reasons related to the FP method						
Health issues	5.0	5.2	3.9	5.3	4.5	4.2
Fear of side-effects	5.6	8.5	10.1	9.8	13.5	12.1
Lack of access/too far	0.0	0.7	0.0	0.4	0.0	0.1
Too expensive	0.3	0.1	0.2	0.5	0.2	0.2
Not convenient	0.2	0.0	0.7	0.4	1.5	1.1
Does not like existing methods	1.6	0.6	1.5	1.7	0.6	1.5
Bad experiences with existing methods	0.4	0.2	0.6	0.6	0.3	0.5
Religious reasons						
"It is God's will"	2.0	1.9	2.2	1.4	1.9	1.6
Other people are opposed to FP use	10.8	12.6	18.9	21.7	19.1	16.2
Doesn't know	0.5	0.8	0.7	0.4	0.7	0.7
*Among women who know of at least one method (spontaneously or after receiving some explanation)						

Ability to Procure and Use a Contraceptive Method

The purpose of this section is to assess to what extent women can access contraceptive methods and decide to use them independently without being influenced by others opinion and would use the method while knowing of potential side effects associated with its use. The next table presents, for each of the sites, the percentage of women who expressed their ability to procure and use a contraceptive method in different situations.

In all six sites, approximately 80% or more women claimed they could access a place which offers/sells contraceptive products if they decided to use them, obtain an FP method if they decided to use one, and use an FP method even if none of their friends/relatives used them. However, a significantly lower proportion of women would go against their partner's will (30% to 40%) and, more importantly, would use them if they were aware of the adverse effects associated with them.

Women's points of view vary however from one site to another. In Dakar, 83% of women could use contraception even if none of their friends or relatives used it; 78% and 79%, respectively, could access a place which provides FP services, and could obtain a method if they decided to use one. Two in three

women would use contraception even if a religious leader was opposed to this use, while the objection of the husband/partner (36% only would go against their partner's will) and awareness of side effects (10% would use one even if there are adverse effects) would strongly discourage women from using a contraceptive method. Similar results are observed in the other sites. However, the highest percentages of women who could use contraception even if their partners were opposed to it are found in Guédiawaye and Pikine (39%). It is also in Pikine that the lowest proportion of women (55%) who would go against the opinion of religious leaders by using contraception is recorded. Finally, the negative opinion of religious leaders and the adverse effects associated with a method would have the least impact on women's propensity to use contraception in Mbour (77% and 23%, respectively) and Kaolack (72% and 19%).

Table 31. Distribution (%) of Women Agreeing or Agreeing Completely with the Following Arguments Regarding Use of and Access to Contraception, by Site*

Sites	Could have access to a location offering or selling FP products if they decided to use them	Could obtain an FP method if they decided to use one	Could use an FP method even if partner did not approve	Could use an FP method even if none of their friends or close relatives were using one	Could use an FP method even if a religious leader was opposed to them using it	Could still use an FP method even after knowing undesirable side effects of that method
Dakar	78.1	78.5	36.4	82.9	65.9	9.8
Guédiawaye	84.7	83.9	38.3	80.3	63.1	14.2
Pikine	79.8	77.8	38.7	80.0	54.8	13.5
Mbao	82.4	82.0	29.0	86.6	65.6	12.9
Mbour	83.9	85.1	32.1	83.7	76.9	23.2
Kaolack	84.8	83.6	30.7	83.2	71.8	19.2

Opinions and Perceptions of the Quality of Contraception Services

Women's assessment of the quality of FP services is a good indicator whether or not she feels the health center is meeting her FP needs and whether or not she will continue to use the method of choice. The next table represents the percentages of women who feel that FP service providers in their community do not treat customers well, the percentages of women who do not like the way they are treated in the FP services in their community, and the percentages of women who feel that FP service providers/product vendors make women uncomfortable when they come to purchase contraceptive products.

In Dakar, nearly one in four women believe that the FP service providers of their community do not treat customers well; a similar proportion feel that women do not like the way they are treated in FP services. Twenty-seven percent of them claim that FP service providers/product vendors make women feel uncomfortable when they come to procure contraceptives. The situation seems less favorable in Guédiawaye: 28%, 28%, and 28%, respectively. The same applies to Pikine. Mbour and above all Kaolack seem to be the cities where women are least dissatisfied with their FP service providers.

Table 32. Distribution (%) of Women Knowing FP Who Agree or Completely Agree with the Following Arguments Regarding the Perceptions on FP Service Quality

Sites	FP providers do not treat clients well	Women do not like the way they are treated in FP services	FP providers make women uncomfortable when they try to obtain contraceptive products
Dakar	24.2	24.7	26.6
Guédiawaye	27.5	28.1	27.8
Pikine	26.3	26.0	26.0
Mbao	22.0	20.9	21.6
Mbour	17.8	17.2	15.9
Kaolack	15.6	15.7	15.6

CHAPTER 7: MATERNAL AND CHILD HEALTH

In Senegal, maternal and child health has always been a priority for public authorities. Reducing maternal and child mortality is a priority strategic focus in the Poverty Reduction Strategy document. Furthermore, the primary objective of the National Health Development Program is to reduce the burden of maternal, infant, and child morbidity and mortality. This chapter presents a few results relating to the place of delivery, assisted childbirth and advice and information on FP received during the last visit to a health facility for various types of treatment (maternal and child health care, treatments for sexually transmitted infections (STIs)/HIV).

Place of Delivery

The next table presents the breakdown of 15-49 year-old women who have had a live birth since 2009, according to the place of delivery. In all sites, the vast majority of women (more than three in four) gave birth in a public health facility. It is in Guédiawaye (91%) that the highest percentage of women who gave birth in this type of facility is found, followed by Mbao (87%), Dakar (86%), Pikine, and Mbour (82%); the lowest proportion is found in Kaolack (76%). The lowest proportion of women who gave birth in a private health facility is observed in Guédiawaye, and Mbao at 7% each. Mbour (10%) and Dakar (11%) are at similar levels, with a peak in Kaolack (17%). Home birth cases are generally fairly rare, particularly in Guédiawaye (1.5%) and Dakar (2.3%). The highest percentages of home births are recorded in Kaolack (4.8%) and Mbour (5.3%).

Table 33. Distribution (%) of Women Who Gave Birth to a Child since 2009 Based on the Location of Child-Delivery

Location of child-delivery	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Public sector	85.7	90.8	81.9	86.9	81.5	76.4
Private sector	10.6	7.4	13.0	7.1	9.8	17.2
At home	2.3	1.5	3.8	4.7	5.3	4.8
Other	0.1	0.1	1.4	0.0	2.2	0.1
Not determined	1.3	0.3	0.0	1.4	1.1	1.5
Number of women	362	270	339	325	604	634

Assisted Childbirth

The level of a health workers qualification largely determines the quality of the delivery. The next table shows the percentage of women who have had a live birth since 2009, according to the type of personnel who assisted them in the birth of the latest child and according to the economic welfare index, for each city. The question (Who assisted you in the birth of your latest child?) had multiple responses as several people could intervene simultaneously.

In all cities and in most cases, women were assisted during childbirth by at least one midwife (over 80% regardless of the economic welfare index). Nurses and head nurses (HNs) were involved to a much lesser extent, which varied depending on the welfare index and the site, followed by, in decreasing order, physicians, matrons, other health professionals, relatives, or friends. It should be pointed out that, due to the limited number of women in some sites, certain disparities must be interpreted with caution.

In Dakar, the percentage of women who were assisted by a physician generally increases with the quintile: 2% for the poorest women, 11% to 13% in the next quintiles, and 37% in the richest quintile. The highest percentages of women assisted by a midwife are found in the two richest quintiles (92%), while the lowest is observed in the first quintile (84%). Nurses and HNs were less often involved in the richer categories (last two quintiles). Other health professionals and other people are rarely involved in assisted childbirth.

Guédiawaye has similar results in terms of assistance by a physician, the difference being that the percentage of women concerned is higher in the poorest quintile (5%) than in the next two quintiles. The percentage of women who were assisted by a midwife is similar in the first four quintiles (91% to 96%); it is at its lowest in the last quintile (83%). The poorest women were those most assisted by a nurse or HN (34%); conversely, the richest women were least concerned (16%).

The pattern in Pikine is comparable with that of Guédiawaye. Assistance by a physician essentially concerns the richest category; this category is, however, least concerned by the assistance of a midwife.

As in Dakar, the percentage of women assisted by a physician in Mbao increases with the level of welfare. Negligible for the poorest women, this percentage reaches 10% among the richest. The lowest percentages of women assisted by midwives are observed in the poorest categories (77%); in these categories, women were more often assisted by other health professionals (8%), matrons (14%), or were not assisted at all.

In Mbour, the proportion of women from the last quintile assisted by a physician during childbirth (7%) is relatively higher than that of women from the first two quintiles (less than 2%). The percentage of women who were assisted by a midwife increases from the first to the fourth quintile but remains lower in the richest quintile (86%) than in the previous two. Nurse or HN assistance seems far less frequent for the richest women (10%). Matrons (19%) were much more often involved for the women from the middle quintile. It appears that traditional birth attendants and relatives or friends are still playing a significant role in the lower and middle classes.

Finally, in Kaolack, the richest category is most concerned by the assistance of a physician and least concerned by midwives. Matrons were more involved in the second (20%) and third (16%) quintiles.

Table 34. Distribution (%) of Women Who Gave Birth to a Child since 2009 Based on the Type of Birth Attendants and the Economic Well-Being Index

Economic well-being index by site	Health professionals				Other staff			None	Number of women who gave births since 2009
	Physicians	Midwives	Nurses /head-nurses	Other health professionals	Matrones	Traditional birth attendants	Other parent/ close relative		
Dakar									
Poorest	2.3	83.5	27.0	2.2	1.7	5.3	1.2	5.7	91
Second	12.5	91.4	34.1	1.9	8.6	0.0	0.0	0.0	85
Average	11.2	88.3	25.4	5.2	14.8	0.0	1.6	0.0	83
Fourth	12.6	92.0	22.7	3.3	12.9	0.0	0.0	0.0	50
Richest	36.6	92.3	22.2	4.5	5.6	0.0	1.3	0.0	53

Economic well-being index by site	Health professionals				Other staff			None	Number of women who gave births since 2009
	Physicians	Midwives	Nurses /head-nurses	Other health professionals	Matrones	Traditional birth attendants	Other parent/ close relative		
Guédiawaye									
Poorest	4.9	93.1	34.4	6.3	2.5	2.2	0.0	1.2	76
Second	1.3	96.3	17.3	5.2	6.6	0.0	3.6	0.7	62
Average	3.6	91.0	19.4	8.2	20.3	0.0	3.5	0.0	53
Fourth	5.0	92.2	24.1	10.9	10.1	0.0	3.5	0.0	46
Richest	7.8	83.4	15.7	10.4	16.9	0.0	3.0	4.4	34
Pikine									
Poorest	8.3	85.9	16.4	1.5	14.9	0.6	3.4	0.7	84
Second	6.9	90.6	23.8	1.6	16.7	0.0	4.5	0.7	68
Average	13.0	80.2	8.0	1.9	20.5	0.0	2.1	0.0	65
Fourth	7.6	88.3	18.5	0.0	17.5	0.0	8.6	0.0	67
Richest	17.4	74.4	18.0	0.0	16.3	0.0	0.0	6.7	56
Mbao									
Poorest	0.8	77.4	13.6	8.0	14.4	0.0	6.4	1.8	73
Second	1.6	88.0	22.9	0.8	11.7	0.0	1.9	0.0	79
Average	5.6	81.2	10.2	5.1	26.1	0.0	1.2	0.0	52
Fourth	8.3	92.9	20.4	5.7	19.6	1.5	0.0	0.0	60
Richest	9.4	86.5	16.7	7.1	29.1	0.0	0.0	0.0	60
Mbour									
Poorest	1.7	82.4	23.1	2.3	8.0	2.7	6.0	0.0	130
Second	0.7	85.4	24.4	2.1	15.2	2.1	2.1	0.7	146
Average	4.1	93.3	18.5	2.4	18.6	0.0	2.7	0.0	115
Fourth	4.5	93.4	23.3	2.2	8.9	0.0	0.0	0.0	123
Richest	6.9	85.8	10.4	3.7	8.0	0.0	0.8	0.0	89
Kaolack									
Poorest	5.2	90.4	19.5	2.3	9.1	0.0	1.6	1.0	146
Second	3.8	89.0	15.7	0.0	19.7	0.7	1.4	0.0	125
Average	5.9	89.5	18.1	1.8	16.0	0.0	0.5	1.7	128
Fourth	4.9	89.4	14.7	3.6	6.3	0.0	2.2	0.0	124
Richest	9.9	86.0	22.5	4.4	9.2	0.0	2.3	1.1	112

Integration of Family Planning Services into Maternal and Child Health Services and STI/HIV Services

The efficiency of antenatal care depends not only on the type of examination performed during consultations but also on the services provided and advice given to women. Thus, women were asked whether, during their visits for various health treatments, they had been given advice or information on FP or if they had received a contraceptive method. The following four tables present the different results obtained on these subjects.

In all sites, more than three in four women received no advice or information on FP on the occasion of their last visit to a health facility for maternal health care purposes. The lowest percentages of women concerned are found in Dakar (74%) and Guédiawaye (75%), while the highest is observed in Kaolack (84%). Dakar and Guédiawaye (25%) have the highest percentages of women who were given advice or information on FP on the occasion of these visits, while the lowest percentages is observed in Mbour and Kaolack (16%); this percentage reaches 21% in Mbao and 23% in Pikine.

On the occasion of these visits, more than one in five women received a contraceptive method, with significant variations from one site to the next. While 39% received a method in Mbour and 37% in each Mbao and Kaolack, this figure drops to 22% in Pikine, 25% in Dakar, and 33% in Guédiawaye. In Kaolack, 17% of women (compared with 9% in each Dakar and Mbao) were merely given a prescription. Prescriptions were rarely issued, if at all, in the other sites (7% in Mbour, 4% in Guédiawaye, and less than 1% in Pikine). Customer referral was more frequent in Mbao (22%) and, to a lesser extent, Dakar (19%). This practice concerned approximately 11% to 12% of women in Mbour and Kaolack, compared with 9% in Guédiawaye and 5% in Pikine. There is a relatively high proportion of women who received no method, no prescription, and no referral, notably in Pikine (73%) and even Guédiawaye (53%). They represent 47% of the customers in Dakar, 43% in Mbour; the lowest percentages are recorded in Kaolack and Mbao (32% each).

Table 35. Distribution (%) of Women Who Received Counseling or Some Information on FP during Their Last Visit in Maternal Health Services

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
% of women receiving counseling or information						
Yes	25.0	24.6	22.6	20.5	15.9	15.7
No	74.1	75.2	76.4	79.5	81.9	83.5
Not determined	0.9	0.2	1.0	0.0	2.3	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	394	264	254	298	524	533
Services received						
Received a method	25.2	33.2	21.6	37.0	39.0	37.0
Received a prescription	8.6	4.4	0.4	8.5	6.6	16.9
Was referred	19.1	9.4	4.7	22.1	10.7	11.6
No method, no prescription, no referral	47.1	53.0	73.3	32.3	43.1	31.7
Not determined	0.0	0.0	0.0	0.0	0.6	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	99	65	57	61	83	84

The next table presents the breakdown of women who were given advice or information on FP before or after the birth of their youngest child in a health facility. Regardless of the site, the vast majority of women (six in ten or more) who have given birth in a health facility since 2009 received no information or advice on FP before or after the birth. This situation seems particularly worrying in Kaolack (80%) and Mbao (74%). In other sites, the situation is only marginally better: 72% in Pikine, 70% in each Dakar and Mbour, and 60% in Guédiawaye. On very rare occasions, information or advice on FP was

given to women before delivery (9% in Guédiawaye, 4% in Mbao, and less than 3% in other sites). Some effort was made after the birth, for example in Guédiawaye (26%) and Mbour (22%). Percentages in the other sites range from 12% to 16%.

Table 36. Distribution (%) of Women Who Received Counseling or Some Information about FP during Their Last Child Delivery in a Health Facility since 2009

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
% of women who received counseling/information and moment when those were provided						
Before delivery	1.7	9.1	2.5	3.7	2.8	2.7
After delivery	14.6	26.0	15.4	19.2	21.5	11.7
Both before and after delivery	4.1	3.1	3.9	3.0	5.4	3.2
None	69.7	60.2	71.9	74.1	69.5	80.1
Doesn't remember	9.2	1.4	5.4	0.0	0.4	1.1
Not determined	0.7	0.3	0.9	0.0	0.5	1.2
Number of women delivering a child in a health facility since 2009	354	266	327	310	571	604

The next table presents the breakdown of women who were given advice or information on FP and the breakdown of women by type of FP service received, on the occasion of a visit to a health facility for child care purposes. Regardless of the site, more than 90% of women received no advice or information on FP. The site that most benefited from this type of service is Guédiawaye (10%) and, more rarely, Pikine (7%); in other cities, the corresponding percentage is 5% or less.

The percentage of women who were given a contraceptive varies dramatically from site to site. While 30%, 24% and 25% were respectively given a method in Pikine, and in Mbour and Guédiawaye, only 13% received one in Kaolack and even less in Dakar and Mbao (5%). Very few prescriptions are issued in two sites (5% in Pikine and in Mbao) and probably none in the other sites. Customer referral occurs mainly in Kaolack (37% of women), less often in Mbour and Dakar (17% and 20%), and is almost non-existent in Mbao and Pikine. The norm tends to be that women receive no method, no prescription, and no referral: 51% in Kaolack, 56% in Pikine, 59% and 60% in Mbour and Guédiawaye, 76% in Dakar, and 90% in Mbao.

Table 37. Distribution (%) of Women Who Received Counseling or Some Information on FP during Their Last Visit in Child Care Services, by Site

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
% of women receiving counseling/information						
Yes	5.3	9.5	7.4	3.6	3.2	3.1
No	94.7	89.9	92.6	96.2	96.3	96.8
Not determined	0.0	0.7	0.0	0.2	0.5	0.1
Total	100.0	100.0	100.0	100.0	100.0	100
Number of women	397	303	359	305	465	470
Services provided						
Received a method	4.6	25.1	30.1	5.1	24.2	12.6

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Received a prescription	0.0	0.0	5.2	5.1	0.0	0.0
Was referred	19.7	7.9	0.8	0.0	17.0	36.9
No method, no prescription, no referral	75.7	59.5	56.3	89.9	58.9	50.5
Not determined	0.0	7.5	7.6	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	21	29	27	11	15	15

Finally, the next table presents the breakdown of women who were given advice or information on FP and the breakdown of women by type of FP service received, on the occasion of their last visit to a health facility for STI/HIV treatment. Here too, regardless of the site, more than 80% of women received no advice or information on FP during their visit. The percentage of women who were given a contraceptive is generally very low. The percentages in Dakar and Guédiawaye are 2% and 3%, respectively. The proportions are even lower for the other sites. Prescriptions were only issued in Pikine (3%). Once again, the norm tends to be that women receive no method, no prescription, and no referral: 92% in Mbour, 82% in Guédiawaye, 64% in Kaolack, 62% in Pikine, 53% in Dakar, and 36% in Mbao.

Table 38. Distribution (%) of Women Who Received Counseling or Some Information on FP during Their Last Visit in STI/HIV Services, by Site

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
% of women who received counseling/information						
Yes	5.0	19.0	10.3	1.9	4.5	3.7
No	95.0	81.0	89.4	97.8	95.0	94.7
Not determined	0.0	0.0	0.3	0.4	0.5	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	273	238	234	171	313	429
Services received						
Condom	6.4	6.4	10.8	0.0	0.0	16.0
Method	2.1	2.6	0.0	0.0	0.0	0.0
Prescription	0.0	0.0	3.0	0.0	0.0	0.0
Referral	38.6	4.3	15.0	42.8	7.9	19.9
No method, no prescription, no referral	52.9	82.4	61.9	35.8	92.1	64.1
Does not know	0.0	4.4	0.0	21.4	0.0	0.0
Not determined	0.0	0.0	9.3	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	14	45	24	3	14	16

CHAPTER 8: COMMUNICATION

This chapter tackles the results of the discussion on FP and the decision-making process within the household, access to the different types of media, and sources of information on FP.

Communication between Partners and the Decision-Making Process within the Household

More than 50% of women in a union have already discussed the subject of FP with their husband/partner (from 50% in Kaolack to 59% in Mbour). Twenty-eight percent to 40% of women who have discussed this issue with their husband/partner have not discussed it at all in the past six months. The highest proportion of women in this case is found in Kaolack (40%) and Pikine (38%); Mbour, Guédiawaye, and Dakar are on a par (28%-29%) while this percentage is 33% in Mbao. In cities other than Guédiawaye (21%) and Mbour (15%), 9% to 13% of women have discussed it with their partner more than twice in the past six months. Twenty-two percent to 28% of women have discussed it often or regularly.

In the majority of cases, it is the woman who initiates the discussion: 67% in Mbour; 65% in Dakar, Guédiawaye, and Kaolack; 57% in Mbao; and 52% Pikine. Their partners initiated the discussion far less often (18% to 23%, depending on the site).

In all sites, more than two in three women claimed they needed the consent of their partner or family before they could use FP. The highest proportions of women in this case are found in the Kaolack (82%), Mbao (79%), and Mbour sites (77%).

The choice of method is essentially made by the woman alone or is a joint decision by the woman and the partner. Thus, in Dakar, 47% and 39% of women, respectively, claimed that they made the decision themselves or that it was a joint decision with their partners. The corresponding percentages are 50% and 41% in Guédiawaye, 58% and 25% in Pikine, 38% and 43% Mbao, 56% and 33% in Mbour, and 50% and 33% in Kaolack.

In the majority of cases, the discussion with the husband or partner on the number of children women would like to have does not take place within the couple. The absence of communication on this issue is particularly frequent in Mbao and Mbour (76% of women) but also in Kaolack (74%). This concerns fewer couples in Pikine (67%), Dakar (62%), and Guédiawaye (60%).

Among the women in union who discuss the number of children they would like with their partners, a significant percentage has not discussed this subject with their partners in the past six months. Forty percent of women in Pikine are in this situation, compared with 32% to 33% of those in Kaolack, Guédiawaye, and Dakar, and 28% of those in Mbao and Mbour. Twenty-three percent of women in Pikine have regular discussions on the subject, compared with 26% in Dakar; 28% to 30% in Kaolack, Guédiawaye, and Mbour; and 47% in Mbao.

Table 39. Distribution (%) of Women Regarding Discussions of FP, Fertility, and Decision-Making, by Site

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Has already discussed FP with her partner (among married women)						
Yes	54.9	57.7	55.5	52.1	59.1	50.3

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
No	44.5	42.3	44.1	47.7	40.9	49.5
Not determined	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	835	646	643	672	1187	1332
Frequency of FP-related discussions with the partner over the past six months (among married women who have already discussed FP)						
Has not discussed	27.8	28.8	37.8	32.6	29.0	39.9
Once or twice	31.7	28.0	29.8	30.1	34.2	26.3
More than twice	13.0	20.9	10.7	10.9	14.7	9.3
Often/regularly	27.5	22.3	21.5	26.4	21.8	24.3
Not determined	0.0	0.0	0.3	0.0	0.3	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	459	373	358	350	701	670
Who initiates FP discussion (among those who discuss topic with partner)						
The woman herself	64.7	64.9	52.2	56.9	67.3	64.5
The partner	18.2	22.7	23.3	21.3	17.7	22.0
Either one	17.1	12.4	24.3	21.6	14.8	13.2
Not determined	0.1	0.0	0.2	0.2	0.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	459	373	358	350	701	670
Need consent from the partner or from the family before using FP						
Yes	68.4	67.0	74.1	79.0	77.1	82.0
No	27.8	29.2	22.4	17.6	20.2	15.5
Doesn't know	3.8	3.4	3.3	3.2	2.5	2.4
Not determined	0.1	0.4	0.3	0.2	0.2	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1704	1246	1105	1154	2036	2369
Who decides on the type of methods (among current users)						
The woman mostly	46.5	49.8	58.3	37.5	56.1	50.2
The partner mostly	8.8	8.2	8.3	11.5	6.9	9.9
Joint decision	38.5	41.1	24.8	43.1	33.0	33.0
Other	6.2	0.9	8.6	7.7	4.0	7.0
Not determined	0.0	0.0	0.0	0.3	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	332	268	187	157	362	330
Discussed the number of desired children with partner (among married women)						

	Dakar	Guédiawaye	Pikine	Mbao	Mbour	Kaolack
Yes	37.2	40.5	32.8	23.7	24.5	26.3
No	62.4	59.5	66.8	76.1	75.5	73.6
Not determined	0.4	0.0	0.4	0.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	835	646	646	672	1187	1332
Frequency of discussions with partner regarding the desired number of children over the past six months (among married women discussing topic with partner)						
No discussion over the past six months	33.0	33.1	39.6	27.8	28.0	31.6
Once or twice	18.1	23.7	19.9	12.9	30.1	28.3
More than twice	22.1	14.0	16.5	10.4	11.7	10.1
Often/regularly	26.3	28.9	22.9	46.5	30.0	28.4
Not determined	0.2	0.4	1.1	1.9	0.2	1.2
Other	0.4	0.0	0.0	0.5	0.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	311.0	262.0	212.0	159.0	291.0	350.0

The next table provides similar information on men in union. Less than half of these men have discussed the issue of FP with their partner, except in Mbao where this percentage reaches 55%. Dakar (42%) and Guédiawaye (43%) have the lowest percentages. Among those who discussed the subject, in 43% of cases in Dakar and 30% to 33% of cases in other sites, men initiate the discussion themselves. The initiative came from women far less frequently in Guédiawaye (19%) and Dakar (22%). Women however played an important role in Mbao (35%) and above all in Pikine (40%). However, the vast majority of men claimed they found it easy to start discussing FP with their partners (73% in Dakar, 78% in Guédiawaye, more than 90% in Pikine and Mbao). Most men (more than 62% in all sites) claimed they did not discuss with their partners the number of children they would like to have with them. Nearly four in ten men in Mbao, and less than one in four in the other sites, have done so in the past six months. In addition, the proportion of men who have often or regularly discussed the number of children they would like to have with their partner in the past six months is relatively higher than that of women, in particular in Guédiawaye (51%) and Pikine (52%). This was far less frequent in Mbao (27%) and Dakar (29%).

Table 40. Distribution (%) of Men Regarding the Discussions on FP, Fertility, and Decision-Making, by Site

	Dakar	Guédiawaye	Pikine	Mbao
Has already discussed FP with partner (among married men)				
Yes	42.4	43.4	48.2	55.1
No	57.4	56.6	50.3	44.9
Not determined	0.3	0.0	1.5	0.0
Total	100.0	100.0	100.0	100.0
Number of men	269	193	203	199.0

	Dakar	Guédiawaye	Pikine	Mbao
Who initiates FP discussion (among those discussing topic with partner)				
The man himself	42.9	30.2	32.9	31.2
The partner	22.4	19.0	40.3	34.6
Either one	34.2	50.9	26.8	34.3
ND	0.5	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0
Number of men	154	109	102	90
How difficult is it to initiate an FP discussion?				
Very difficult	19.2	20.5	4.4	1.8
Somewhat difficult	7.7	1.6	3.8	1.7
Easy	72.6	77.9	91.8	96.5
Not determined	0.5	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0
Number of men	154	109	102	90
Has discussed the number of desired children with partner (among married men)				
Yes	37.9	36.6	21.7	23.4
No	62.1	63.4	78.3	76.6
Total	100.0	100.0	100.0	100.0
Number of men	269	193	203	199
Frequency of discussions with partner regarding the desired number of children over the past six months (among married discussing topic with partner)				
Has not discussed over the past six months	23.6	19.4	17.1	39.8
Once or twice	33.2	19.8	18.0	20.3
More than twice	13.0	10.2	7.2	12.9
Often/regularly	29.4	50.6	51.6	27.1
Not determined	0.9	0.0	6.1	0.0
Total	100.0	100.0	100.0	100.0
Number of men	102	71	44	47

Access to the Media

The next two tables indicate for each site, for women and men, the percentages of respondents who have access to certain media or communication supports, according to the economic welfare quintile.

In Dakar, 37% and 31% of women, respectively, read newspapers and magazines. Nearly seven in ten women (68%) listen to the radio at least once a week, and 97% watch television at least once a week. Cell phones are widespread (84% overall). Two in ten women have access to the Internet via a computer, and less than 3% via a mobile phone.

The level of access to these different media and communication tools increases with the level of economic welfare.

Figures in Guédiawaye are comparable with those in Dakar, and trends are similar in terms of the economic welfare quintile. However, the proportion of women listening to the radio and with access to mobile phones is much higher here, but lower for access to the Internet via a computer.

Access to newspapers and magazines is far more limited in the Pikine site (24% and 15%, respectively), as is access to mobile phones and the Internet via a computer. In Mbao, access to magazines (22%) is more limited than in the Guédiawaye and Dakar sites; this is the site where women listen least to the radio (65%) and also the site with the most women owning their own mobile phone (90%). It should be pointed out that the level of access to media and communication tools does not necessarily increase with the economic welfare quintile.

The situation in Mbour and Kaolack is similar, but with the lowest levels of access to newspapers and magazines.

Table 41. Distribution (%) of Women Based on Their Access to Different Media Outlets and on the Economic Well-Being Index, by Site

Sites	Reads newspapers	Reads magazines	Listens to the radio at least once a week	Watches TV at least once a week	Has access to a mobile phone	Has her own cell phone	Can access the internet via her mobile phone	Can access the internet via a computer	Number of women
Dakar									
Poorest	11.1	8.9	58.8	93.0	73.9	84.6	0.3	9.4	360
Second	36.1	36.3	60.0	99.1	79.5	83.6	1.2	23.2	359
Average	34.9	30.1	70.4	95.1	84.8	90.6	2.9	21.3	332
Fourth	52.2	38.6	75.2	98.3	91.5	77.8	5.1	32.4	313
Richest	56.1	42.3	78.1	99.4	91.1	81.6	5.0	40.6	340
Overall	37.5	30.9	68.2	97.0	83.9	84.5	2.8	26.4	1704
Guédiawaye									
Poorest	21.0	20.4	67.5	93.6	63.4	86.5	1.7	8.2	221
Second	29.2	29.3	72.6	99.5	77.2	92.4	2.1	13.1	277
Average	37.1	32.2	78.1	98.6	74.6	85.2	4.6	13.0	246
Fourth	46.9	39.5	77.2	99.5	87.5	87.1	6.5	28.6	261
Richest	56.8	54.4	78.2	100.0	85.7	78.4	15.2	36.7	241
Overall	38.4	35.3	74.8	98.4	78.0	86.6	6.0	20.7	1246
Pikine									
Poorest	12.5	8.6	66.8	89.5	59.8	82.5	0.3	5.8	210
Second	20.0	11.3	68.5	94.6	66.2	88.9	0.4	11.7	206
Average	23.8	18.4	72.2	97.8	72.9	91.1	1.8	11.6	225
Fourth	29.7	19.8	73.8	96.6	76.8	91.0	3.9	13.9	224
Richest	32.9	16.9	69.2	99.1	76.8	84.6	0.9	17.6	240
Overall	24.1	15.2	70.1	95.7	70.8	87.2	1.5	12.5	1105
Mbao									
Poorest	10.5	11.2	47.9	81.2	42.0	90.8	0.0	3.2	207
Second	21.5	16.2	60.2	96.7	65.5	88.4	2.0	14.2	217
Average	18.5	20.0	72.3	98.4	73.5	85.4	2.7	14.0	232
Fourth	34.5	31.2	73.3	98.2	75.1	94.9	0.8	15.7	223
Richest	33.7	28.4	68.2	96.5	78.9	87.9	3.4	27.8	275
Overall	24.4	21.9	64.9	94.5	67.9	89.6	1.9	16.8	1154
Mbour									

Sites	Reads news-papers	Reads magazines	Listens to the radio at least once a week	Watches TV at least once a week	Has access to a mobile phone	Has her own cell phone	Can access the internet via her mobile phone	Can access the internet via a computer	Number of women
Poorest	6.3	3.0	67.1	71.0	50.2	85.2	0.1	2.7	339
Second	15.0	10.7	68.3	92.5	65.4	94.9	1.8	4.4	392
Average	16.8	17.6	74.7	98.5	67.5	89.4	2.1	10.3	413
Fourth	26.2	18.3	68.2	97.4	72.7	87.1	2.8	13.8	422
Richest	45.6	34.0	72.6	98.5	81.9	83.7	2.5	28.8	470
Overall	23.3	17.8	70.4	92.5	68.6	88.3	1.9	13.9	2036
Kaolack									
Poorest	7.4	10.5	71.4	81.5	53.7	80.1	0.3	6.2	414
Second	11.1	12.9	75.1	94.1	69.3	88.6	0.2	7.9	446
Average	15.6	15.8	78.3	98.4	71.5	91.9	1.3	13.0	460
Fourth	19.6	17.9	77.6	98.2	74.1	87.9	2.0	17.1	519
Richest	31.3	32.1	77.8	97.9	78.3	82.9	2.2	30.2	530
Overall	17.7	18.4	76.2	94.5	70.1	85.8	1.2	16.6	2369

Sixty-eight percent (68%) and 33% of men in the Dakar site read newspapers and magazines respectively. Approximately 97% watch television at least once a week, and 89% listen to the radio at least once a week. Mobile phones are practically universally accessible (93% overall). Nearly five in ten men (46%) have access to the Internet via a computer, and approximately 10% via a mobile phone.

The correlation between the level of access to these different media and the level of economic welfare is not as clear-cut as it is for women.

In Guédiawaye, 59% and 27% of men, respectively, read newspapers and magazines. Ninety-one percent of them listen to the radio, and 99% watch television at least once a week. The level of access to the Internet via a computer (37%) is lower than in Dakar.

Pikine and Mbao are less privileged than the previous two sites in terms of access to newspapers and magazines, listening to the radio, and above all access to the Internet via a computer. The positive correlation between the level of access to the different media and communication tools is extremely apparent in Pikine, but less so in Mbao.

Table 42. Distribution (%) of Men Based on Their Access to Various Media Outlets and on the Economic Well-Being Index, by Site

Sites	Reads newspapers	Reads magazines	Listens to the radio	Watches TV	Can access a mobile phone	Has his own mobile phone	Can access the internet via a mobile phone	Can access the internet via a computer	Number of men
Dakar									
Poorest	49.0	21.5	87.2	92.4	96.4	92.7	2.0	19.1	162
Second	53.7	26.5	87.5	97.3	97.2	94.2	6.2	35.5	151
Average	81.3	37.0	88.8	98.9	96.4	92.9	14.0	56.8	124
Fourth	79.6	38.9	94.5	96.5	91.3	87.9	9.2	57.8	161
Richest	78.7	40.1	88.6	98.6	98.5	96.6	18.3	66.2	148
Overall	67.8	32.5	89.4	96.6	95.9	92.8	9.6	46.4	745

Sites	Reads newspapers	Reads magazines	Listens to the radio	Watches TV	Can access a mobile phone	Has his own mobile phone	Can access the internet via a mobile phone	Can access the internet via a computer	Number of men
Guédiawaye									
Poorest	46.3	16.0	87.2	98.2	92.7	80.7	4.7	20.9	134
Second	37.0	12.6	93.2	100.0	92.5	91.0	8.9	12.5	75
Average	58.2	21.4	91.7	98.2	93.8	84.2	14.0	34.2	80
Fourth	69.9	46.7	93.2	99.7	97.7	92.7	32.8	60.9	97
Richest	76.0	36.8	89.6	98.2	91.3	86.3	24.9	54.3	123
Overall	58.5	27.2	90.5	98.8	93.5	86.4	17.0	37.4	509
Pikine									
Poorest	28.7	7.5	91.0	94.9	87.1	81.0	9.6	11.1	130
Second	35.8	7.6	95.0	98.5	90.8	87.2	17.0	15.5	87
Average	56.2	20.8	87.6	97.4	95.2	84.1	24.2	33.0	96
Fourth	65.8	29.9	93.4	99.1	95.5	90.9	24.3	37.2	130
Richest	60.1	20.1	99.3	99.3	98.5	91.8	34.5	74.5	75
Overall	48.9	17.4	92.8	97.7	93.0	86.7	20.8	31.6	517
Mbao									
Poorest	33.71	14.27	84.41	91.58	91.58	79.33	5.462	14.23	97
Second	35.86	10.07	88.86	96.09	99.19	89.08	6.028	19.38	97
Average	40.4	13.58	95.37	98.75	95.07	77.48	7.565	28.89	116
Fourth	48.18	15.19	96.81	100	100	86.95	10.96	27.2	94
Richest	64.52	16.56	85.96	99.42	99.24	84.9	19.16	51.32	95
Overall	44.3	13.9	90.5	97.2	96.9	83.3	9.7	28.1	499

Sources of Information on Family Planning

All women and men with knowledge of any contraceptive method were asked via which sources they had heard or seen information on FP in the 12 months preceding the survey. The results are presented in the next two tables according to the sources cited, respectively for women and for men and according to the economic welfare quintile.

According to next table, there are two predominant sources of information for women: relatives or friends and the television. In the city of Dakar, the two major sources are the television (58% of women) and relatives or friends (49%), followed by public health facilities and radio with 22% each, and private health facilities with 7%. All other unspecified methods represent 18%. Overall, 8% of women have not received any information on FP in the past 12 months. The women least frequently informed by public health facilities are those from the first and last quintiles. For television, the percentage of women increases with the welfare quintile up until the fourth; it is lower in the richest group (62%) than in the previous one (68%). Relatives or friends were more involved in the first two quintiles (52% and 57%, respectively, in the first and second quintile).

In Guédiawaye, 44% and 63% of women, respectively, have received information from relatives or friends and television. Other significant sources of information on FP are public health facilities (26%) and radio (23%). Private health facilities account for 12%, the highest percentage of all sites. Nearly 5%

used newspapers and magazines as a source. Overall, 6% of women have not received any information on FP in the past 12 months. All other unspecified methods represent 18%. The women least frequently informed by public health facilities are those from the first (primarily) and second quintiles. For television, the percentage of women increases with the welfare quintile. Relatives or friends were much more involved in the first two quintiles (49% to 50% compared with 38% to 42% in the other quintile).

Similar results are observed in Pikine. Sixty percent and 52% of women, respectively, have received information from relatives or friends and the television. Public health facilities are next with 26%, followed by the radio with 22%. Private health facilities contribute 7% and newspapers and magazines less than 2%. Overall, 6% of women have not received any information on FP in the past 12 months. No clear pattern by welfare quintile has been highlighted. However, the radio concerns the poorest category more so than the richest. The first quintile is the least concerned by the television. The results are very similar in the other three sites, even though the level of access to information is lower in Kaolack, in particular via private health facilities and the television.

Table 43. Distribution (%) of Women Based on Their Source of FP Information over the Past 12 Months among Those Who Knew about Contraception and on the Economic Well-Being Index, by Site

Sites	Sources										Has not received FP information over the past 12 months	Number of women
	Public facility	Private facility	Pharmacy	Faith-based facility	Community-based sources		Media sources			Other sources		
					NGO/CBO	Parents/friends	TV	Radio	Newspapers/magazines/posters			
Dakar												
Poorest	13.9	6.3	1.5	0.1	0.7	52.2	41.9	19.3	1.2	11.9	13.4	360
Second	26.9	7.1	1.6	1.6	2.4	57.1	57.7	23.4	1.4	19.2	4.8	359
Average	26.4	8.8	0.1	0.3	2.4	48.0	62.3	23.1	3.6	14.6	4.5	332
Fourth	24.2	5.3	0.3	0.0	0.1	41.7	67.8	22.7	4.3	20.6	6.0	313
Richest	18.6	8.2	2.9	0.3	2.5	46.2	61.7	22.7	3.1	22.8	11.0	340
Overall	21.9	7.1	1.3	0.5	1.6	49.3	57.9	22.2	2.6	17.7	8.0	1704
Guédiawaye												
Poorest	37.6	14.5	2.4	0.0	0.5	50.3	52.2	17.6	3.6	11.7	8.9	221
Second	28.0	8.9	0.5	0.2	1.4	49.2	56.0	23.9	6.2	12.7	7.7	277
Average	25.4	12.3	0.0	0.0	4.6	41.6	68.9	26.0	4.1	13.6	4.5	246
Fourth	18.2	7.7	0.8	0.6	2.3	38.3	63.6	18.3	2.3	27.6	5.3	261
Richest	22.1	15.3	1.6	0.5	1.7	40.9	73.3	29.2	6.1	21.6	3.2	241
Overall	26.0	11.6	1.0	0.3	2.1	44.0	62.8	23.1	4.5	17.5	5.9	1246
Pikine												
Poorest	29.4	7.1	0.0	0.0	0.0	62.3	44.1	26.6	0.3	4.8	7.2	210
Second	25.3	8.0	0.0	0.8	1.4	62.0	53.1	20.1	2.2	5.4	6.7	206
Average	27.4	5.5	0.0	0.0	1.3	65.4	53.0	22.5	0.8	8.4	4.4	225
Fourth	22.4	8.3	0.0	0.0	0.5	56.1	52.1	21.6	1.2	10.7	7.7	224
Richest	25.3	7.3	0.0	0.0	1.8	56.1	55.8	17.4	1.9	11.9	4.2	240
Overall	25.9	7.2	0.0	0.1	1.0	60.3	51.8	21.6	1.3	8.4	6.0	1105
Mbao												
Poorest	28.4	7.9	0.9	0.3	0.8	59.2	45.8	8.2	0.7	5.1	8.2	207

Sites	Sources									Has not received FP information over the past 12 months	Number of women	
	Public facility	Private facility	Pharmacy	Faith-based facility	Community-based sources		Media sources					Other sources
					NGO/CBO	Parents/friends	TV	Radio	Newspapers/magazines/posters			
Second	31.0	5.3	1.5	0.0	0.3	62.8	57.6	14.3	2.3	9.4	6.3	217
Average	30.3	10.1	0.2	0.4	0.3	52.2	52.7	16.0	1.7	7.7	9.4	232
Fourth	25.4	7.0	1.2	0.0	1.8	57.8	61.2	14.7	1.2	12.1	8.2	223
Richest	31.0	8.7	1.9	0.2	0.2	58.0	64.0	14.6	3.7	14.2	3.3	275
Overall	29.3	7.9	1.2	0.2	0.7	57.9	56.7	13.7	2.0	10.0	6.9	1154
Mbour												
Poorest	23.8	2.2	1.3	0.0	1.4	66.0	26.4	17.0	0.4	9.6	7.1	339
Second	29.9	6.9	0.4	0.0	1.0	64.6	44.3	17.9	1.5	12.5	6.4	392
Average	24.1	3.4	1.4	0.0	1.7	60.8	52.9	17.0	1.9	11.5	11.2	413
Fourth	26.9	2.6	0.8	0.0	2.0	58.5	50.8	17.1	0.6	12.3	6.9	422
Richest	28.1	6.5	0.8	0.0	2.8	55.4	50.4	18.4	3.0	19.1	7.9	470
Overall	26.7	4.4	0.9	0.0	1.8	60.7	45.8	17.5	1.6	13.3	7.9	2036
Kaolack												
Poorest	23.5	2.2	0.0	0.0	1.4	61.9	32.5	21.5	1.0	12.3	6.4	414
Second	24.2	2.7	0.5	0.0	1.6	58.4	45.2	22.5	1.3	10.4	7.5	446
Average	24.7	2.9	0.3	0.0	1.6	59.4	46.8	18.8	0.3	13.0	8.9	460
Fourth	22.1	3.9	0.0	0.0	1.4	52.8	44.4	16.4	1.0	14.6	10.7	519
Richest	22.4	3.5	0.4	0.0	1.8	54.2	50.2	21.2	1.5	18.4	7.9	530
Overall	23.3	3.1	0.2	0.0	1.6	57.0	44.2	20.0	1.1	13.9	8.4	2369

For men (see the next table), three sources of information played a key role: the television, relatives or friends, and the radio. In Dakar, these three sources concern, respectively, 57%, 45%, and 36%. This is followed by newspapers and magazines (10%), public health facilities (9%), pharmacies (8%), and private health facilities (5%). All other unspecified methods account for 20%. Overall, 18% of men have not received any information on FP in the past 12 months. The men least frequently informed by health facilities and newspapers and magazines are those from the poorest category.

As in Dakar, three sources of information stand out in Guédiawaye: the television, relatives or friends, and the radio, with, respectively, 78%, 38%, and 55%. This is followed by public health facilities (20%), pharmacies (17%), newspapers and magazines (13%), and private health facilities (8%). All other unspecified methods account for 24%. Overall, 9% of men have not received any information on FP in the past 12 months. In Guédiawaye, the men least frequently informed by relatives or friends are those from the richest category. Out of all sites, Guédiawaye is where public health facilities, pharmacies, and private health facilities contributed most.

In Pikine, the percentages observed for the television, radio, and relatives or friends are, respectively, 70%, 53%, and 49%. This is followed by newspapers and magazines (8%), private health facilities (7%), public health facilities (6%) and pharmacies (3%). All other unspecified methods amount to 15%, while 8% of men have not received any information on FP in the past 12 months. In Pikine, the men least frequently informed by health facilities, pharmacies, and relatives or friends are those from the richest category.

Finally, in Mbao, the percentages observed for the television, radio, and relatives or friends are, respectively, 82%, 53%, and 23%. This is followed by newspapers and magazines (7%), public health facilities (5%), and private health facilities (3%). All other unspecified methods amount to 12%, while 3% of men (the lowest level of all sites) have not received any information on FP in the past 12 months.

Table 44. Distribution (%) of Men Based on Their Source of FP Information over the Past 12 Months among Those Who Knew about Contraception and on the Economic Well-Being Index, by Site

	Source of FP information									Has not received FP information over the past 12 months	Number of men
	Public facility	Private facility	Pharmacy	NGO/CBO	Parents/Friends	TV	Radio	Papers/magazines/posters	Other sources		
Dakar											
Poorest	1.7	1.3	4.1	0.5	46.6	57.1	36.7	5.4	15.6	19.6	157
Second	9.9	6.0	5.1	1.3	44.2	52.2	36.0	11.7	9.9	23.3	151
Average	6.2	2.2	1.0	2.3	47.7	58.8	40.4	9.8	31.0	12.7	124
Fourth	15.0	9.9	15.5	0.9	44.3	60.8	41.4	7.9	23.1	18.4	161
Richest	10.4	3.9	11.7	2.3	42.8	56.2	23.7	17.0	22.9	17.0	147
Overall	8.8	4.8	7.8	1.4	45.1	57.0	35.6	10.3	20.1	18.4	739
Guédiawaye											
Poorest	24.5	15.2	19.8	0.9	44.0	81.4	57.6	8.3	11.7	7.5	132
Second	9.5	1.4	9.3	0.4	36.5	66.0	57.7	15.6	9.0	16.9	75
Average	26.2	4.0	18.7	3.8	33.4	72.9	50.8	19.2	24.8	10.5	80
Fourth	27.1	3.4	34.2	3.1	50.3	79.6	54.4	21.3	41.3	5.3	97
Richest	10.3	9.1	1.5	2.5	25.2	82.1	54.3	4.1	33.4	6.8	120
Overall	19.7	7.7	16.5	2.1	37.9	77.6	55.1	12.6	24.2	8.8	504
Pikine											
Poorest	4.6	5.9	0.6	0.0	35.0	58.9	45.6	4.3	5.1	15.8	126
Second	9.9	7.1	5.1	0.9	54.4	76.1	56.8	9.1	11.7	8.2	87
Average	9.1	7.5	3.8	2.5	60.9	69.5	56.6	10.0	15.0	6.6	95
Fourth	2.4	8.0	4.1	0.7	46.7	73.7	55.3	6.2	21.3	4.3	130
Richest	9.1	5.3	1.9	5.5	53.0	73.3	55.5	12.5	22.9	4.1	75
Overall	6.4	6.9	3.0	1.6	48.7	69.6	53.4	7.9	14.7	8.2	513
Mbao											
Poorest	4.3	3.5	1.1	3.3	24.0	82.0	58.9	4.4	8.6	3.6	95
Second	9.0	2.5	0.0	0.0	22.2	78.5	58.4	10.6	8.5	5.7	97
Average	3.8	2.1	1.2	0.0	27.5	82.3	57.9	3.8	8.9	1.8	111

	Source of FP information										Has not received FP information over the past 12 months	Number of men
	Public facility	Private facility	Pharmacy	NGO/CBO	Parents/Friends	TV	Radio	Papers/magazines/posters	Other sources			
Fourth	1.3	4.3	0.0	1.1	22.0	81.3	44.2	7.4	7.7	2.2	91	
Richest	5.4	5.1	2.2	1.9	19.5	84.8	41.7	6.6	24.8	3.9	94	
Overall	4.8	3.4	0.9	1.2	23.2	81.8	52.5	6.5	11.6	3.4	488	

CHAPTER 9: SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Women and men's knowledge of at least one modern FP method is high in all cities but varies dramatically depending on the type of method. The most well-known methods among women in all cities include oral contraceptive pills, contraceptive injections, and implants. The best-known methods among men are male condoms and the pill. The percentage of women who are currently using a modern contraceptive method varies somewhat depending on the city but remains low overall. Guédiawaye has the highest proportion with 32.1%, while Mbao has the lowest with only 20.1%, and Dakar is marked by extreme differences between the poorest and richest classes.

Fertility is relatively high in all cities but varies somewhat depending on the location: women in Dakar give birth to about three children on average, while women in Pikine give birth to more than four children in their lifetime. In each city, 19% to 25% of women would have preferred to delay the timing of their last birth. A strong proportion of women interviewed on their desire and favorite time to have a child claimed they wanted to wait at least two years from the time of the survey or until they get married. Unmet need for FP is greater in Mbao, with 27.6%, and Dakar with 26%. In all cities, the unmet need spacing is greater than those for limitation.

Over 20% of women in Dakar and over 30% of women in Pikine entered into a marriage when they were 17 or younger. This increases the likelihood that they will start having children at a young age, and will act as a barrier to girls finishing their education. In Senegal, compared to men, a high percentage of women have had no education whatsoever.

In all cities, the majority of women purchase contraceptives from the public sector (from 64.2% in Mbour to 78.2% in Mbao). Pharmacies are, to a lesser extent, a source of supply of contraceptive methods.

Myths and misconceptions on the effects of FP on health are relatively widespread. For example, more than half of the women in all cities believe that people who use contraceptive methods will ultimately have health problems. Men also largely subscribed to this belief.

The survey identified several priority areas for project interventions with a view to increasing the use of contraceptive methods:

Intensification of interventions according to the use of contraceptive methods in urban areas:

The results of the survey on contraceptive prevalence according to the cities indicate that particular emphasis should be placed on supply and demand interventions in Mbao and in the disadvantaged populations of the city of Dakar. Interventions must be strengthened in these cities by allocating additional resources while maintaining a significant focus in Guédiawaye and in Pikine.

FP communication (birth spacing): The relatively high fertility, and the fact that unmet need for spacing is greater than those for limitation in all cities, indicate that initiatives should focus its communication on birth spacing and make it easier for women to access the methods which help respond to these specific needs. In addition, interventions should raise women's awareness of the different FP options available to them and provide accurate easily understandable messages.

Introduction of topics on early marriages in FP communication: Early marriage—which affects from one fifth to one third of women, in an environment where the level of education is often very low—limits women's control of their own fertility. In terms of FP information and awareness, the projects should introduce messages on the link between early marriage and maternal and child health, while explaining the benefits of using FP in this specific and sensitive context.

Role of pharmacies in the supply of FP methods: According to the results of the baseline survey, the private sector (medical and pharmaceutical sectors combined) is the second major supplier of FP products, with a predominance of the pharmaceutical sector (20%). Out of all those who procured their products from pharmacies, very few (3%) claimed they were given advice, information or assistance with the product. As the laws and regulations of Senegal prohibit pharmacists from providing FP services (except in case of emergency), the challenge will be to improve legislative and regulatory RH policy framework so as to enable pharmacists to offer products and services directly to the public. Pharmacists are trusted service providers and are well located within communities to provide this service. Pharmacists create networks with customers as well as their relatives and friends, gradually passing on reliable, pertinent, and adapted information on sensitive and very personal issues. Providing these services at the community level through pharmacies, is part of a larger strategy of improving access to FP products and services and repositioning FP in the country. Furthermore, a greater involvement of private pharmacists in the supply of FP products and services would be a strategic move and open a secondary source of contraceptives.

Overcoming myths and misperceptions of FP: The baseline demonstrated that rumors and myths about contraceptives persist. This incorrect information continues to impact practically one in every two women and men. Messages, designed to dispel these myths and provide accurate information to populations, should be formulated and demand stimulated at the community level as well as among service providers.

Public endorsement of FP by religious leaders: Although very few people mentioned religion as a reason for not using FP (1% to 4%), Islam remains a major influence on Senegalese social and cultural environment, especially in when discussing health and FP. The fact that the most influential religious leaders have yet to express their opinion on FP opens the door to all possible interpretations, in accordance with the individuals' religious beliefs. The projects would only benefit if the religious leaders endorsed FP and issued public messages in favor of FP. To achieve this, partnerships with religious figures should be a key approach to the demand creation process.