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**DEGREES OF INSTITUTIONALIZATION: FAMILY PLANNING POLICIES  
AND PROGRAMS IN SENEGAL, 1980–2005**

by

**Yazmine Michelle Watts**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Philosophy  
Department of Political Science  
Advisor: J. Kevin Corder, Ph.D.**

**Western Michigan University  
Kalamazoo, Michigan  
June 2009**

## DEGREES OF INSTITUTIONALIZATION: FAMILY PLANNING POLICIES AND PROGRAMS IN SENEGAL, 1980–2005

Yazmine Michelle Watts, Ph.D.

Western Michigan University, 2009

Senegal's population growth rate of 2.7% is greater than double that of the world average of 1.16%. The Government of Senegal acknowledges the population problem and has made efforts to address this issue. For over the past two decades the United States Agency for International Development (USAID) has served as the predominant donor in Senegal's health sector and has been a strong supporter of Senegal's family planning program. The evolution of family planning in Senegal cannot be understood without considering the roles of culture, religion, decentralization and funding in the institutionalization process. This research addresses important questions concerning factors that contribute to the institutionalization of family planning policies and programs in Senegal and it also examines how Senegal has progressed in the institutionalization of its family planning policies and programs from 1980–2005.

This project draws its analytical framework on theoretical approaches within historical institutionalism including path dependency, layering, conversion and policy drift. This research uses several methodological tools to address the research questions. Historical analysis of policy, program and evaluation documents, statistical reports, family planning studies, family planning related variables for the period 1980–2005, in addition to the use of interview, questionnaire and other data collected during field

research in Senegal, are employed. Three categories of independent variables are used to measure the institutionalization of family planning including culture/religion, decentralization, and donor support. In order to determine degrees of institutionalization of family planning in Senegal, three categories of measurement are used including legitimacy, knowledge and capacity-building.

Results of this study reveal that social norms block the institutionalization of family planning in Senegal, the negative effects of decentralization were not observed, and it also confirms that high reliance upon donor aid leads to lower levels of institutionalization of family planning. Finally, the results also indicate that progress since 1997 has waned and the Government of Senegal in conjunction with USAID needs to continue to develop innovative family planning strategies that accommodate cultural and social norms.

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Yazmine Michelle Watts



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## CHAPTER I

### BACKGROUND AND INTRODUCTION

#### Family Planning in Africa and Senegal

Since the 1960s the population in sub-Saharan Africa has more than doubled and many Africans continue to practice the tradition of having large numbers of children. While it is a cultural norm throughout sub-Saharan Africa to have big families, many sub-Saharan African countries are unable to provide adequate basic necessities such as health care, food, education and jobs for their growing populations. Countries in Africa are among the poorest in the world and rely heavily upon donor assistance in sectors such as health which includes family planning. Over the past two decades, the United States Agency for International Development (USAID) has been a major donor in the health sector in many poor African countries. From 1980 to the present, USAID has served as the predominant donor in Senegal's health sector (Wickstrom, Diagne and Smith 2006, 14).

While some progress has been made towards controlling the population growth problem with the introduction of family planning programs in Senegal by USAID during the 1980s, the actual use of family planning has increased slowly and remains low. Several factors contribute to the lack of use of family planning in Africa, mainly early age at marriage, the social desire to have many children widely practiced in Islamic countries, cultural norms and other factors in addition to limited access to education and resources. Over the past decade, family planning has increased among women in Africa, notably for

married women. Unfortunately West Africa lags behind most other regions in Africa (Gribble 2008, 1) as shown in Table 1.1 below.

Table 1.1

Contraceptive Prevalence by Region of Africa

REGIONS	Contraceptive Prevalence
Northern Africa	60%
Southern Africa	58%
Eastern Africa	26%
Middle Africa	19%
Western Africa	13%

**Notes:** Estimates are based on the most current data available between 1998 and 2007. These percentages refer to women who are married or in a union.

**Northern Africa:** Algeria, Egypt, Libya, Morocco, Sudan, Tunisia.

**Western Africa:** Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo.

**Eastern Africa:** Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Somalia, Tanzania, Uganda, Zambia, Zimbabwe.

**Middle Africa:** Angola, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Gabon, Sao Tome and Principe

**Southern Africa:** Botswana, Lesotho, Namibia, South Africa, Swaziland.

**Source:** Clifton, Kaneda, and Ashford 2008.

The average number of births per woman in West Africa remains high at 5.7. Gribble (2008) maintains that

given the young age structure of West Africa, the number of women of reproductive age is expected to increase from 69 million in 2008 to 83 million in 2015. The combination of high fertility and a growing number of women of reproductive age sets the stage for continued rapid population growth and challenges to meeting the different needs of these people (Gribble 2008, 1).

Senegal, like many other African nations, is struggling to provide education, housing, jobs and health care, while trying to compete in the global economy (Goliber 1997, 2).

The continued use and expansion of family planning is essential in Senegal.

### Statement of the Problem

Senegal's population growth rate of 2.7% is greater than double that for the world average of 1.16%. According to the Central Intelligence Agency World Factbook, Senegal's population growth rate is ranked 22 out of 234 countries (Central Intelligence Agency 2009). By the year 2050 Senegal's population is projected to double in size with an estimated population of over 25 million (United Nations Department of Economic and Social Affairs 2007). Like other African nations, the cultural norm of the large family is encouraged in Senegal. Senegalese women would ideally like to have about six children. Based upon the government's inability to cover health services without donor assistance, investment in family planning is essential in order to control the population and to improve the overall health of mothers and children.

### *Population Growth Problem*

A majority of countries in sub-Saharan Africa have taken measures and "adopted policies that acknowledge the important role that demographic trends play in their quest to modernize, but these policies are carried out differently among the region's diverse cultures" (Goliber 1997, 2). In its *5<sup>th</sup> Plan (1977-1981)* the Government of Senegal recognized the intensity of its population problem and was concerned with prospects for socio-economic development because a large percentage of the population was under the young age of 15. The Ministry of Health advocated for the adoption of a population policy directed toward the protection of mothers and children. It was agreed that a family planning program would be used for the purpose of spacing births and educating and informing the people (Republic of Senegal, Ministry of Planning and Cooperation 1977).

Tomaro (1980) argues that these measures did not constitute a fully integrated health and population program, but indicated that the government was aware of the nature of its population problem and was taking steps to deal with it. Despite its best efforts, the government realized that no matter what was done, the country's population would double within 30 years.

### *Cultural Beliefs and the Population Problem*

Although the Senegalese government is aware of the need to control its population, controlling the population as a strategy to limit births and reduce growth rates is a very sensitive issue in Senegal due to social norms and cultural beliefs. Islam is the religion of 94% of the people in Senegal. Among certain sects of Muslims, limiting births is considered contrary to the laws of the Koran. "Children are riches measured by their social value and longevity, not their economic benefit or cost" (Tomaro 1980, 6). Outside of the capital region of Dakar, there is more resistance to policies perceived as anti-natal. Even in the Dakar region, there is some resistance to endorsing family planning. Many political leaders and program managers have been reluctant and have remained cautious in advocating family planning programs that could be viewed as an assault on Islam. Also, there is a small, but vocal segment of the community that questions donor interest in providing assistance for family planning, but not massive economic aid. This group is not convinced that Senegal has a population problem (Wilson 1998).

### *USAID: The Donor Providing Birth Control*

In a country where there is some receptiveness to the subject of limiting or preventing births, USAID is often identified as the donor that is providing birth control. Since 1980, USAID/Senegal has been supporting the Government of Senegal in its efforts to provide family planning services. Donor support for population activities in Senegal is largely supported by USAID. Although there are other donors that contribute to population activities in Senegal, USAID is the only donor agency that has sponsored programs that deliver direct family planning services. In general, donors other than USAID have supported population activities such as research and technical assistance projects, but have not supported family planning service delivery projects, nor provided contraceptives or the education needed to those who need it most.

### *The Problem of Foreign Donor Supported Institutionalization*

This research is important because it examines a common problem in foreign aid. The relationship between USAID and Senegal in the area of family planning is a complicated one. On the one hand, Senegal needs family planning services and it is beneficial for USAID to provide the country with both resources and leadership. Yet, it is also important for Senegal to take charge and play an active role in the development and expansion of its family planning policies and programs.

Currently Senegal is facing a problem with policy and program institutionalization. Full policy and program institutionalization would require the Government of Senegal to be solely in charge of its family planning policies and programs which also entails covering all of the costs in addition to running the infrastructure. USAID continues to follow a

family planning strategy based upon its project goals, but it is difficult to ascertain how much the Government of Senegal wants to follow this course. A huge question of concern is: whose program is it? How do you get the Government of Senegal to run the family planning program and want to do it without help? Policy institutionalization is a common problem in foreign aid and has been an issue with the military in Iraq and also with environmental policy in many developing countries. For example, forestry policy in Senegal has historically been dictated by foreigners. Larson and Ribot (2007) maintain that Europeans have dictated environmental policies in the developing world dating back to the colonial period. They also maintain that while policy changes have continued to occur, environmental policies remain unfairly biased against local rural communities (Larson and Ribot 2007).

In Senegal, it can be argued that the active involvement of USAID in the funding and development of family planning projects has triggered some crucial change. Although steps have been made to improve it, family planning in Senegal is by no means fully institutionalized. Senegal has not achieved full institutionalization of its policies and programs for a variety of reasons that will be discussed in later chapters of this dissertation. Senegal is a post-colonial country that will have to rely on major donor aid for many more years to come. The fact that Senegal continues to receive a large amount of foreign aid from USAID makes it difficult to assess the degree of autonomy that Senegal has in its family planning policies and programs. I will attempt to overcome part of this challenge by conducting a thorough analysis of the developments over a 25-year period.

### *The Benefits of Family Planning Programs and Services*

There are a variety of benefits associated with the use of family planning programs and services. The use of family planning can help to avoid unintended pregnancies, which can also decrease the number of maternal deaths. "Using contraception helps avoid unsafe abortions to end unintended pregnancies. It also enables women to limit births to their healthiest childbearing years and to avoid giving birth more times than is good for their health" (Upadhyay and Robey 1999, 1). Family planning is also beneficial because people who plan their childbirths put less financial stress on the government because they rely less on free or subsidized government services and/or programs. For example, with more careful childbirth planning, families do not have to rely on many government programs in order to feed and care for their large families. Lastly, with family planning, unemployment levels in Senegal will decrease over time. As the rate of population growth decreases, there will be a better ratio of the number of jobs available to the actual population size.

To date, Senegal's economy remains weak and is not growing fast enough to provide jobs due to its population growth. For example, in 1980, Senegal had a population of 5,639,785. By the year 2000, the population nearly doubled to 9,784,325 (USAID 2004b, 5). As of July 2009, Senegal's population is estimated at 13,711,597 (Central Intelligence Agency 2009). By 2030, the population is projected at 18,583,728 and by 2050, 24,577,651 (USAID 2004b, 5). The fertility rate remains high at 4.95 children born per woman (Central Intelligence Agency 2009). Policies and programs that support the long-term, continued use of family planning are essential in order to help Senegal reduce its population growth rate, which will allow this country to grow economically.

### Justification of Senegal as a Case Study

Senegal serves as an ideal country for a case study of family planning for a variety of reasons. Senegal has one of the highest levels of unmet need for family planning in the world. Several research studies on family planning in sub-Saharan Africa argue that West Africa has some of the highest levels of unmet need for family planning in the world.

According to the Demographic and Health Survey (DHS),

a woman has an unmet need for contraception if she is fecund, sexually active, not using any contraception methods, and does not want a child for at least two years (“spacers”) or wants no more children (“limiters”) ... Yet family planning programs are currently low on most national agendas and there is no concerted effort to address the expressed need for family planning (Policy Project 2005, 1).

Table 1.2 below demonstrates that Senegal has the highest unmet need of all countries in West Africa.

Table 1.2

#### Unmet Need for Family Planning Services by Country (West Africa)

Countries	Percentages of Unmet Need
Benin	27%
Burkina Faso	29%
Cameroon	20%
Côte d'Ivoire	28%
Ghana	34%
Guinea	24%
Mali	29%
Niger	17%
Nigeria	17%
<b>Senegal</b>	<b>35%</b>
Togo	32%

Source: Policy Project 2005, 2



Senegal also serves as an ideal case study due to the fact that USAID has longevity as a major donor agency in family planning and has been involved since the very early stages, which allows one to trace the history of the role of the donor agency from the beginning of family planning programs and services in Senegal in 1980 until more recently.

### Research Questions

This research will help us understand the long-term results of how funding and guidance from a major outside donor agency affects family planning policies and programs in Senegal, with the potential to infer that similar results can and/or may have occurred in other African countries that receive major funding from USAID. From a policy perspective, this research could have implications regarding how donor agencies can support recipient governments in taking an active role in somewhat costly and analytically demanding, yet nevertheless terribly important development policies. How does a government come to recognize the value of a program and to develop the capacity to implement it when the initiative has historically come from the outside? The most pertinent question of concern for the future of family planning policies and programs in Senegal is the following: Has the continued involvement of USAID in family planning policies and programs facilitated institutionalization in Senegal? Equally important, what has been the extent of institutionalization of family planning policies and programs in Senegal?

This research will address several important questions:

- 1) *What forces have contributed to determining the shape of the institutional/organizational arrangements for family planning in Senegal?*
- 2) *How far has institutionalization progressed from 1980–2005 in family planning policies and programs in Senegal? How have use, knowledge and capacity-building in family planning increased over time?*

3) *What factors contribute to the degree of institutionalization of family planning policies and programs in Senegal?*

Theoretical Framework: Historical Institutionalism

Historical institutionalism is an ideal theoretical framework for evaluating family planning policies and programs in Senegal.<sup>1</sup> Based on a review of the literature, Senegal's history of family planning is unique in the fact that USAID has served as the major donor agency for family planning from 1980 to the present. The historical framework for this research consists of understanding how family planning has progressed in Senegal over a 25 year period of time (1980–2005). Beyond the simple notion that “institutions matter too,” the perspective taken for this research is path dependent<sup>2</sup> in many ways, emphasizing the role of existing institutions in shaping historical choices and outcomes in family planning in Senegal. The analysis will focus on several key domains and their impact on policy outcomes. These areas include religion and culture, decentralization and government and donor funding and resources. These areas will be discussed in Chapters IV, V and VI.

In Senegal, it can be argued that although new institutions have been added, the core institutional structure revolves around policies and programs that were set in the past. USAID has historically been the source of the majority of money, information and ideas in the field of family planning in Senegal—all provided with a distinctive U.S. accent (Levine 2007). We can only understand contemporary family planning policy choices in Senegal as responses to or products of policy choices that were made in the

---

<sup>1</sup> See Chapter II for a detailed discussion of historical institutionalism and public policy studies.

<sup>2</sup> This term is defined and discussed in Chapter II.

past. Past policy choices in Senegal have privileged some actors, shaped some norms, and directed resources towards particular family planning activities.

There are three major players that have a stake in family planning in Senegal. These include USAID, the Government of Senegal and Senegalese religious leaders. First, USAID began its first official family planning program in Senegal in 1981.<sup>3</sup> Since 1980, USAID's focus areas have been in Dakar and 21 districts in four regions throughout Senegal (Kaolack, Louga, Thies and Ziguinchor). USAID has been the major donor agency providing for family planning services, programs, training, technical assistance and social marketing in Senegal. The next major player in family planning in Senegal is the government. The Senegalese government relies mainly upon USAID for family planning funding in major areas which include service training, staff supervision, contraceptives, contraceptive management, and technical expertise among other areas. Lastly, Senegalese religious leaders (also known as *marabouts*) also have a stake in family planning. Historically, some have been opposed to family planning in Senegal. As previously mentioned, Senegal is a predominately Muslim country. Population interpreted as a strategy to limit births and reduce growth rates is still a very touchy issue in Senegal. Religious leaders have argued that limiting births is contrary to the precepts of the Koran. USAID, the Government of Senegal, and Senegalese religious leaders are all key players that have had an impact on the evolution of family planning in Senegal. In subsequent chapters of the dissertation, the role of these major actors over the 25-year period of study will be discussed using historical institutionalism as a theoretical framework for analysis.

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<sup>3</sup> Prior to 1981, USAID authorized Senegal's first Family Planning Project in urban areas in Dakar, Thies, and Casamance, and in rural areas in Kaolack. This project was a part of the larger Sine Saloum Rural Health Care Project.

## Data and Methodology

### *Data Sources*

The sources of data for this research are diverse. Policy, program and evaluation documents, statistical reports, family planning studies, family planning related variables for the period 1980–2005, interview, questionnaire and other data collected during field research in Senegal, in addition to the appropriate literature on historical institutionalism and public policy, are the major sources of data. The sources of the data are multiple and include the USAID Development Experience Clearinghouse, the USAID library in Senegal, the Senegalese Ministry of Health, the Senegal Demographic and Health Survey (DHS) for the years 1986, 1992/1993, 1997 and 2005, the World Development Indicators (WDI) database, online World Health Organization (WHO) data and the Population Reference Bureau.

### *Data Collection*

Data for this dissertation were collected during six months of field research in Dakar, Senegal under a Fulbright fellowship in 2004 and on a subsequent field research trip in summer of 2006 and during a more recent follow-up interview with USAID leadership in Senegal during 2009. In addition to data collected in Senegal, relevant family planning documents were ordered from the USAID Development Experience Clearinghouse. Available data on family planning for the period of study were retrieved from Macro International, which houses the Senegal DHS data, the WDI database and

online data from the WHO and the Population Reference Bureau. All other relevant data were collected via library and online resources.

### *Methodology*

The methodology for this research includes an in-depth historical analysis of family planning policies and programs in Senegal from 1980–2005 in addition to the analysis of family planning related variables for the period of study. The institutionalization of family planning serves as the dependent variable and the research design specifies three categories of independent variables that influence the institutionalization<sup>4</sup> of family planning; these categories include religion/cultural bias, decentralization and donor support. In order to determine where Senegal stands in terms of the institutionalization<sup>4</sup> process, three categories of measurement were created. The three categories include *legitimacy*, *knowledge* and *capacity-building*, which are defined in Chapter IV. For each of the categories, relevant and available variables for the period of study were chosen. For *legitimacy* data concerning the contraceptive prevalence rate, contraceptive usage and issues concerning attitudes and acceptance about family planning are utilized. For *knowledge*, variables are used in order to determine if Senegalese people have sufficient and accurate information about family planning methods such as knowledge about modern methods of contraception. For *capacity-building*, variables concerning government expenditures on health and family planning are utilized in addition to variables pertaining to donor aid.

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<sup>4</sup> This term is defined and operationalized in Chapter IV.

Throughout the empirical Chapters IV, V and VI, various methodological approaches are taken in order to answer the research questions. Chapter IV uses available data for the period of study from all four Senegal DHS's 1986, 1992/1993, 1997 and 2005, data collected during field research in Senegal and other family planning related research in order to analyze the influence of culture and religion in the institutionalization of family planning in Senegal. Variables that indicate trends about marriage, social norms, Islam and religious leaders and polygamy over the period of study are examined.

Chapter V analyzes the impact of decentralization in the institutionalization of family planning using available regional data (Central, North East, South and West regions) for the period of study from three of four of the Senegal DHS's 1992/1993, 1997 and 2005. These years are chosen in order to analyze pre-decentralization, decentralization implementation and post-decentralization trends. In addition to these data, family planning related research on decentralization in Africa, archival data collected in Senegal during field research and information collected during interviews with USAID/Senegal officials are utilized in order to analyze the impact of decentralization in the institutionalization of family planning in Senegal.

Chapter VI is the final empirical chapter which uses available government health expenditure and donor aid data using a cross-country approach. Data for Senegal, Guinea and Mauritania from the WDI database, the WHO, research studies on health expenditures and family planning in Africa and interview data obtained from USAID leadership in Senegal are utilized in order to analyze the impact of government contributions and donor aid in the institutionalization of family planning in Senegal.

### Significance of the Research

As previously mentioned in this chapter, this research is significant as it addresses a common problem in foreign aid: donor supported institutionalization. Many developing countries are unable to successfully operate family planning programs on their own. The Senegalese government must have the capacity and capabilities required to operate a self-sustaining family planning program. This requires a significant financial commitment to family planning objectives. Since Senegal's commitment to spending on health from 1995–2005 as a percentage of the central government expenditure was only 3% (UNICEF 2009), it is clear that this expenditure is not sufficient to run a self-sustaining family planning program.

In addition to addressing the problem of foreign donor supported institutionalization, this research will be beneficial to several audiences. Rutherford (1997) conducted research on the role of social policy and civil society in sub-Saharan Africa and Latin America. In his study, similar to my research, he focuses on the role of institutions in the social policy reform process. Drawing on his contributions to the public policy literature, my work on family planning policy in Senegal makes similar contributions. Major actors involved in the policy process can gain knowledge about family planning strengths and weaknesses and use this information to see what type of institutional capacity is needed to accommodate the process (Rutherford 1997, 6). This research will also be useful for development agencies involved in the social reform process. Development agencies have the opportunity to gain clear insight based upon the outcomes of their own current program activities (Rutherford 1997, 6). Members of society and international donors will also find this research of use as they can use the knowledge gained in order to make

policy suggestions for other countries which can ultimately have an impact on decisions made by policymakers in those countries (Rutherford 1997, 6). This research can be used to assess the legitimacy of those involved in the policy process (Rutherford 1997, 53); examples of actors in Senegal include USAID, the Government of Senegal and religious leaders. As previously argued, unmet need for family planning in Senegal is high; therefore this research is beneficial in helping to determine which members of society lack coverage and the reasons for this gap (Rutherford 1997, 53). This research can also shed light on how differing capacities and responsibilities of the state and civil society can impact users and non-users of the services in question (Rutherford 1997, 53). Since this research addresses a large question, it will also be useful to scholars who are concerned with the process of institutionalization.

Freifeld (2003) conducted important research on family planning, analyzing policy outcomes in 34 Muslim countries, including Senegal. He maintains that “one of the key determinants of whether the extent of the population growth will exceed national resource capacities is centered in whether or not states actively promote family planning” (Freifeld 2003, 6); this is key in the case of Senegal. Like Freifeld’s research, my research on family planning in Senegal contributes to the literature on family planning and population policy formulation in a state that is experiencing one of the most poignant cases of this problem.

Next, “the particular form of family planning policy represents the priorities of the actors within the state, especially in an environment where resources are scarce” (Freifeld 2003, 6). Senegal is a good example of a country that has limited resources to contribute to the health sector. In Senegal, other areas within the integrated health sector



such as infant mortality and malaria have taken precedence over family planning during certain periods of time.

Lastly, this study contributes to the political science literature on the state as an autonomous actor at the policymaking level as it demonstrates, for example, how Senegal (a Muslim state) with traditional customs and societal norms responds to family planning policy in unique ways, resulting in a meaningful comparative framework for analyzing other Muslim state policymaking with respect to family planning policy and other social policy areas (Freifeld 2003, 6).

### Overview of Dissertation Chapters

Chapter II focuses on the relevant literature on historical institutionalism and public policy that is drawn upon as a theoretical framework for the empirical chapters of the dissertation. Chapter III gives a brief overview of family planning in Africa in addition to a review of the major family planning policies and programs in Senegal from 1980–2005.

Chapters IV, V and VI are the empirical chapters of the dissertation. Chapter IV examines social and cultural norms and finds that the concept of the large family is a practice that has endured and is unlikely to change. The major finding is that social norms block the institutionalization of family planning. Chapter V investigates the impact of decentralization in the institutionalization of family planning using regional data. The primary finding in this chapter argues that the expected negative effects of decentralization are not observed. Chapter VI uses cross-country data to investigate the role of government contributions and donor aid in the institutionalization of family planning,

finding that Senegal has not made significant financial contributions in comparison to its neighboring country, Guinea. The primary finding in this chapter is that a high dependence upon donor aid leads to lower levels of institutionalization of family planning programs and services.

Chapter VII serves as a discussion and conclusion where I provide an overview of the research findings, an overall assessment of where Senegal stands in the institutionalization process in terms of legitimacy, knowledge and capacity-building, what the future holds for family planning in Senegal, policy implications for donors and policymakers, the broader implications of the study, suggestions for future research and problems faced for future research. The results of this dissertation lead me to the conclusion that after over two decades of work on family planning, USAID and the Government of Senegal need to find more effective ways to address social and cultural norms in order for usage of family planning to increase significantly and become a societal norm.

## CHAPTER II

### HISTORICAL INSTITUTIONALISM AND PUBLIC POLICY ANALYSIS IN POLITICAL SCIENCE

#### Historical Institutionalism and Public Policy

Historical institutionalism is a theoretical approach that is often used to analyze the evolution of policy outcomes over long periods of time. It examines the role of various factors, notably institutions (both formal and informal) and their role in shaping and reforming public policy. Historical institutionalism is useful in explaining public policy outcomes because it considers how institutions shape political strategies and influence political outcomes (Steinmo, Thelen and Longstreth, 1992) in addition to considering the importance of time in the policymaking process. Tracing the history of policy outcomes over extended periods of time is useful in demonstrating the link among the causal factors impacting policy choices, policy reforms and policy shifts. Path dependency and change as a process of layering, conversion and policy drift are central concepts in historical institutional analysis that have proven to be powerful tools for explaining public policy developments and outcomes.

Scholars of historical institutionalism have addressed policy problems by taking a variety of approaches. All of the approaches taken by scholars of historical institutionalism will not be discussed, yet two distinct approaches that will serve as a basis of discussion for later chapters of this dissertation will serve as the focal points. While path

dependency can serve to explain many family planning outcomes in Senegal, layering, conversion and policy drift are distinct mechanisms that can also explain several elements of institutional change. A review of these concepts along with the ways in which various scholars have applied them in their research will serve as a point of discussion for the next section.

### Path Dependency

Path dependency theory began in the field of technological development and economics and over the past two decades has spread to political science, becoming a widely used concept in historical institutional analysis. It is important to note that there are various models of path dependency. The most popular model for political scientists is the idea that politics “involves some elements of chance (agency, choice), but once a path is taken it becomes ‘locked in,’ as all the relevant actors adjust their strategies to accommodate the prevailing pattern” (Thelen 1999, 385). There are several key explanatory terms that have been used in path dependency models in the study of political development, institutional change and public policy analysis. These terms include positive feedback and/or increasing returns (these terms are interchangeable), timing and sequence, critical junctures and developmental pathways. An analysis of how historical institutional scholars have applied these critical elements in policy analysis follows.

#### *Policy Feedback Effects: Positive Feedback and Increasing Returns*

The concepts of positive feedback and/or increasing returns demonstrate how early policy choices create conditions favorable to further development along an existing

path that dictates the direction and character of future policy trajectories (Pierson 1993, 2000). As previously stated the concepts of positive feedback and increasing returns are interchangeable; economists commonly use the term increasing returns while political scientists use positive feedback. Historical institutionalists such as Pierson, Thelen, North and Skocpol, among others, agree that political developments, processes and outcomes are subject to positive feedback or increasing returns. The list of historical institutionalists who have applied the concept of positive feedback in their research is long, including Ikenberry, Krasner and Hall. For the purposes of this chapter, the works most relevant to family planning policy in Senegal serve as the points of discussion.

Pierson is widely cited and has made significant contributions to the path dependency literature. Pierson (2000) argues that many social scientists use the term *path dependency* very loosely without careful elaboration of the concept. To create more clarity and to use the term in a more narrow sense for political analysis, he conceptualizes path dependency as a social process subject to “increasing returns ... which could also be described as self-reinforcing or positive feedback processes” (Pierson 2000, 251). Pierson maintains that the concept captures two major elements that are central to path dependency. First, they give direction to how the costs of switching from one alternative to another will increase over time in certain social conditions. Next, they also draw attention to timing and sequence, “distinguishing formative moments or conjunctures from the periods that reinforce divergent paths” (Pierson 2000, 251).

Pierson (1993) argues that Skocpol “more than any scholar has been at the center of efforts to use historical institutional analysis to understand the dynamics of policy feedback” (Pierson 1993, 599). Throughout her work Skocpol (1992, 1999) demonstrates

why many of the organizations founded in the nineteenth century still exist today. Pierson (2000, 258) cites Skocpol's (1999) research arguing that her work on voluntary associations in the United States provides concrete "evidence of the organizational persistence that can result from positive feedback." Skocpol's work demonstrates positive feedback as she is able to demonstrate how major changes in social groups and their interests proved to be successful in setting the policy path and key policy outcomes in their favor. She cites veterans as a prime example of a social group that was able to successfully organize and demand improved benefits (Skocpol 1992, 59).

While Skocpol argues in several seminal works that positive feedback helped a diversity of organizations throughout history set the path for future policy outcomes in their favor, Pierson (1994) argues in his influential work on the welfare state in the United States and Britain that routine structures can also serve as an obstacle to major policy shifts. For example, well-established public policies can often create complex patterns of dependence which lock in several groups and interests while constraining governments who wish to enact drastic changes. Despite much struggle, Pierson argues that radical retrenchment did not occur in either nation because welfare agendas were historically restricted by policy feedbacks.

Citing the work of Pierson, Skocpol and several other prominent historical institutionalists, Hacker (1998) also takes a path dependency approach, explaining the differences in public health insurance reform in the United States, Britain and Canada. He makes a parallel argument to Pierson (1994), maintaining that the United States was unable to make radical changes in public health insurance due to constitutional fragmentation and structural impediments to third party movements in the United States.

Overall, due to policy feedbacks, the United States was not able to create the structure or platform needed that would allow for a more comprehensive program in the future. Instead, the government had to respond to the needs of the private system that was already in place.

Another influential path dependency argument emerges from the work of North (1990). While his work most closely complements that of Pierson, his work is different due to the fact that he applies the concept of increasing returns in order to examine the differences in economic performance across societies. More specifically using England and Spain as examples he maintains that the development of Parliament in England set it on a divergent path from that of Spain. North maintains that “with increasing returns, institutions matter and shape the long-run path of economies” (North 1990, 95). In both Spain and England, differing institutions developed according to the foundations that were in place. In accord with Pierson (2000), North argues that “although the specific short-run paths are unforeseeable, the overall direction in the long run is both more predictable and more difficult to reverse” (North 1990, 104).

Summing up, while positive feedback and/or increasing returns arguments have much merit and validity, scholars such as Thelen have challenged increasing returns arguments. While Thelen agrees with the increasing returns arguments put forth by Pierson, Skocpol, North and others, she asserts that increasing returns is only a promising starting point for conducting research on institutional change that needs to go much further (Thelen 2003, 231). She argues that layering and conversion processes<sup>1</sup> can serve as additional complements to the increasing returns argument. The concept of increasing

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<sup>1</sup> These concepts will be explored in the section “Change as a Process of Layering, Conversion and Policy Drift” of this chapter.

returns is an important justification for another key element of path dependency: timing and sequencing.

### *Timing and Sequencing*

Most path dependency scholars agree that timing and sequencing (the specific order of events) are important factors in determining policy outcomes. Pierson (2005) argues that history and timing play an important role in examining long-term sources of policy change. He argues that analyses need to incorporate “substantial stretches of time” (Pierson 2004, 45). In addition to considering time, Pierson argues that sequencing is important. Pierson and Skocpol (2002), Thelen (2003), Weir (1992) and Hacker (1998) argue that the order of events can make a big difference in the historical process. The same set of events can have different outcomes depending on their sequencing (Pierson 2004, 18). Both Thelen and Pierson agree that events occurring earlier in a sequence will have a much greater impact than those occurring later in the process (Thelen 2003, Pierson 2004).

Applying his theoretical argument, in several studies on public policy Pierson demonstrates why policy choices at one point in time affect choices at subsequent points in time. Considering the importance of time, Pierson (1994) seeks to explain how the welfare state successfully survived Reaganomics in the United States and Thatcherism in Britain. For the welfare state, the timing and sequencing of events along with other path dependent self-reinforcing processes throughout history has made it difficult to restructure or change established institutions. In a similar approach to Pierson’s, Skocpol (1992) takes a path dependency approach to show how timing was essential in understanding the



political and institutional changes that occurred around 1900. Both Pierson and Skocpol maintain that welfare state development is not a smooth or evolutionary process, yet developments in the welfare state are a result of the political constructs of the time. For example, the welfare state catered to the needs of Union veterans in the nineteenth century and in the early twentieth century to the needs of middle class women. Historically, welfare provisions were changed and negotiated to fit the institutional arrangements and the goals of the institutional actors of the time. Mothers' pensions were successful during the 1910s and 1920s due in a large part to the fact that no agency or government coalition had a large stake in them one way or the other. If women had tried to set the path for the public policy debate during another time period in history, the outcome of their success could have been completely different.

While Pierson and Skocpol consider the importance of timing and sequence in their studies of the welfare state, Hacker (1998), citing the work of Pierson, Thelen and others, argues that timing and sequencing are essential in public health reform. He maintains:

the timing and sequence of policies can be extremely important in determining eventual political outcomes. By pushing policy development down a particular historical path, a policy passed at time  $T_1$  may significantly constrain the range of possible options at time  $T_2$  (Hacker 1998, 77).

In his research, Hacker concludes that extreme reform in the United States is unlikely to develop into a European style national system of health insurance due to path dependency. He argues, like Pierson, Skocpol and Thelen, that historical institutionalists should focus on the sequence of policy change. Hacker asserts that the emergence of national health insurance should not be seen as a one-time event, as Skocpol (1992) maintains in her argument about evolutionary welfare state developments, yet should be

considered as a long-term historical process whose sequence determines eventual outcomes (Hacker 1998, 127).

Like other historical institutionalists, Weir (1992) makes a complementary argument in maintaining that decisions made at one point in time establish policy boundaries which then limit the options available to future policymakers. This argument is most similar to the one put forth by Pierson (1994). Much like Hacker (1998), who argues that the United States will never be able to adopt a European style system of national health insurance, Weir examines why the United States does not have a full employment policy similar to those in many Western European countries. She considers the development of policy as a sequential process in which new initiatives create boundaries that restrict the shape of future innovation (Weir 1992, 5).

Pierson, Thelen, Skocpol, Hacker and Weir agree that timing and sequencing are essential to path dependency arguments. While these elements are important, specific events that occur throughout time can have enduring impacts. The next section explores how distinct events that occur throughout history can also change the policy path.

### *Critical Junctures*

Critical junctures are rare events that take place when the concurrence of various activities opens a window of opportunity for change (Kingdon 1995). Critical junctures are vital because during these times the options for policy change are relatively flexible. During critical junctures specific choices are made which can send countries along diverse and broad developmental paths (Thelen 1999, 387) which can have long-term impacts that may be difficult to change. Pierson maintains that “junctures are ‘critical’ because

they place institutional arrangements on paths or trajectories, which are then very difficult to alter” (Pierson 2004, 135). He also asserts that large enduring consequences can result from relatively small or contingent critical events, in contrast to other mainstream arguments in political science that have traditionally attributed large outcomes to large causes (Pierson 2000, 251).

Other scholars, such as Mahoney and Berins Collier and Collier, have also used the concept of critical junctures in their work. Mahoney’s explanation of the connection between critical junctures and the path dependency process is akin to Pierson’s, that once a particular path is taken it becomes increasingly difficult to return to the starting point where several options were still available (Mahoney 2001, 113). Critical junctures are also an important element in Berins Collier and Collier’s (1991) study of political development in several Latin American countries. They maintain like Pierson and Mahoney that critical junctures are periods of notable change, yet change can vary among different countries, producing distinct legacies (Berins Collier and Collier 1991). Although Thelen (2003, 2004) agrees that the concept of critical junctures is a useful analytic tool, she challenges mainstream arguments of critical junctures asserting that explanations that rely too heavily on critical junctures often underestimate what she terms “incremental” changes that happen during periods of non-crisis.

The concept of critical junctures is valuable as it can help us to understand why countries follow particular development and policy paths. In conjunction with other elements such as positive feedback and timing and sequencing, it can prove to be powerful in explaining public policy outcomes. A final concept within path dependency, which allows for more flexibility, is the next topic of consideration.

*Developmental Pathways*

The concept of developmental pathways “suggests that institutions continue to evolve in response to changing environmental conditions and ongoing political maneuvering but in ways that are constrained by past trajectories” (Thelen 1999, 387). Developmental pathways are evolutionary and it can be argued that this concept can be placed somewhere in between path dependency and layering, conversion and policy drift. In the developmental pathways view, change can occur, yet without changing the major core principles. Thelen (2003) maintains that developmental pathways allow for what she terms functional transformation, where the same institution can serve a different purpose from its original intention. Like Thelen, North (1990) argues that once created institutions may be changed. North (1990) takes both a more deterministic path dependency approach with his increasing returns argument analogous to Pierson, yet he also takes a developmental pathways approach, which is parallel to Thelen, arguing that the process of institutional change is often incremental, involving a variety of evolutionary processes (North 1990).

In sum although North makes some arguments for the use of developmental pathways to explain differences in economic performance across societies, Thelen offers the strongest argument for the use of developmental pathways. Her research focuses on evolutionary changes that impact institutional change. Thelen argues that institutional change requires a variety of processes to take place among the rule-makers and the rule-takers in society. A discussion of three explanatory concepts, which are considerably different from path dependency arguments to explain institutional change and policy change are the focus of the next section.

### Change as a Process of Layering, Conversion and Policy Drift

A strand of historical institutionalists have examined institutional change, policy reforms and policy outcomes by considering various factors that have overlapping effects. The terms that explain this process have been coined layering, conversion and policy drift by scholars such as Thelen, Schickler and Hacker. These scholars have focused their research on the ways in which institutions change over time vs. using the concept of path dependency and the increasing returns arguments put forth by scholars such as Pierson, North and Mahoney. So, in addition to path dependency approaches, examining public policy using layering, conversion and policy drift is a useful explanatory tool. Next, an analysis of how historical institutionalists have applied these analytic frameworks in their research will be considered.

#### *Layering*

According to Thelen, layering refers to the “grafting of new elements” onto the existing institutional structure. This grafting can change the path of an institution’s development (Thelen 2004, 35). Thelen was not the first historical institutionalist scholar to coin the term layering, as Schickler (2001) argues that layering plays a key role in congressional reform and innovation. He maintains that congressional reform and innovation have never followed one single path and asserts that “many different coalitions promoting a wide range of collective interests drive processes of change” (Schickler 2001, 4). Like several other historical institutionalists, Schickler believes that the historical development of Congress is often subject to institutional changes that are simply layered on top of older ones.

As previously argued, although Thelen agrees with the applicability of path dependency arguments in the study of institutional and policy change, she argues that other explanatory elements such as layering can be used to explain change and political outcomes. Thelen (2003, 2004) cites the work of Schickler (2001) and extends upon his original argument about the role of layering in congressional reform. Thelen's argument, while analogous to Schickler's, makes a further contribution by showing how with the use of layering, powerful actors can effectively transform old institutions to serve new purposes (Thelen 2004). Using Germany, Britain, Japan and the United States as case studies, Thelen shows how each country developed different sets of institutions that guided the training and skill formation of workers from the late 1800s throughout most of the twentieth century. Historically, each country developed its own institutional structure that helped to guide further developments in the training systems over the years. Most of the systems proved to be highly resistant to change, but were not resistant to critical junctures such as war and depression. In her study, as previously argued; Thelen supports the idea of incremental change. For example, the institutions that she considered did not experience intense transformations, yet they changed incrementally as new elements were layered onto existing institutions. Overall, like Schickler, Thelen also maintains that institutional change is a path dependent process, yet layering can also be used to understand institutional outcomes. Thelen (2003, 2004) is unique from other historical institutionalist scholars because she combines path dependency arguments along with layering, conversion and policy drift.

### *Conversion*

Conversion occurs when new actors (those not originally involved in the design of the institutional system), find an opportunity to take over an institution and redirect or modify its goals (Thelen 2003, 228). Thelen is a leading scholar within the historical institutionalist strand to develop and advance the concept of conversion. For example, Thelen (2004) demonstrates how the German vocational training system was transformed when unions were able to gain a powerful role within the system. She does argue that increasing returns can serve as a viable explanation for part of the evolution of German vocational training, yet asserts that increasing returns explanations “are mostly designed to capture the logic of institutional reproduction, not institutional change” (293). Overall she maintains that institutional change should be captured in terms of layering and conversion and not solely in terms of path dependent increasing returns and lock in arguments (Thelen 2003, 231).

Thelen (2003) cites several examples of how conversion has been utilized in institutional evolution. Although Weir does not specifically use the term *conversion* in her work, Thelen argues that Weir (1992) provides a good example of how conversion can be effectively used. Thelen (1999, 396) argues that Weir’s work exemplifies how the War on Poverty and the Civil Rights Movement, two disconnected policy courses, had a substantial impact on the development of employment policy in the United States, “turning it in a direction that policy makers did not originally intend.” More specifically, Weir (1992) demonstrates how during the 1960s traditional American social assistance programs were converted into programs that also addressed an important issue of the time, racial equality.

While both Thelen and Weir have made significant contributions to the study of institutional change, Hacker (2004) agrees strongly with Thelen (2003) when he asserts “that there is not one single pattern of institutional change, whether it be the ‘big bangs’ of sudden transformation or the ‘silent revolutions’ of incremental adjustment” (Hacker 2004, 244). His argument revolves around the claim that institutional change is often politically difficult and therefore proponents of change must use multiple strategies in order to achieve their goals; these discrete strategies include layering, conversion and policy drift. Hacker’s overall argument can be summed up in the following quote:

actors who wish to change popular and embedded institutions in political environments that militate against authoritative reform may find it prudent not to attack such institutions directly. Instead, they may seek to shift those institutions’ ground-level operation, prevent their adaptation to shifting external circumstances, or build new institutions on top of them (Hacker 2004, 244).

A third element, policy drift, which Hacker (2004) introduces in order to supplement the concepts of layering and conversion will serve as the next point of discourse.

### *Policy Drift*

Hacker (2004), citing Thelen (2003) and several works by Pierson, extends upon Thelen’s argument by adding another strategy of change that he labels policy drift. Hacker shows how each strategy (layering, conversion and policy drift) is applicable to various political conditions. For example, he refers to changes that have occurred within the world of private benefits as an example of “drift”—incremental “changes in the operation or effect of policies that occur without significant changes in those policies’



structure” (Hacker 2004, 246). Esping-Andersen<sup>2</sup> and other historical institutionalists often view drift as an apolitical process (Hacker 2004, 246), yet from Hacker’s point of view, the inaction of policymakers to make policy changes during crucial times is a deliberate form of political behavior that can lead to institutional transformation within the context of certain economic and social conditions.

Throughout his work, Hacker also goes on to demonstrate, like Thelen, how layering and conversion are applicable in various political settings. Hacker’s work makes a similar contribution to that of Thelen and Schickler, allowing one to understand how actors (both elites and non elites) can work around institutional barriers using various strategies to impact policy changes in their favor.

Overall, several scholars have successfully used the concepts of layering, conversion and policy drift as an analytic framework for policy studies. Many historical institutionalists have used the concept of path dependency in policy analysis, yet authors such as Schickler, Thelen and Hacker, among others, have used layering, conversion and policy drift to explain how institutions transform over time (Schickler 2001, Thelen 2004 and Hacker 2004). Consistent with the work of Thelen, it can be argued that path dependency, layering, conversion and policy drift are all useful theoretical concepts that can be combined to create a middle range theory in order to explain institutional change and policy change in Senegal. A combination of these concepts will serve as analytic tools to explain the historical evolution of family planning policies, programs and services in Senegal from 1980–2005.

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<sup>2</sup> See Gøsta Esping-Andersen. 1990. *The three worlds of welfare capitalism*. Princeton: Princeton University Press.

### Path Dependency, Layering, Conversion and Policy Drift for the Analysis of Family Planning in Senegal

The empirical chapters of this dissertation (Chapters IV, V and VI) rely on concepts from the historical institutionalist approach in order to explore the impact of cultural and social norms, decentralization and the persistence of donor aid in the institutionalization of family planning in Senegal. What follows is an overview of how these concepts can be used to analyze the evolution of family planning in Senegal.

#### *Positive Feedback: The Link Between Cultural and Social Norms and Family Planning in Senegal*

Path dependency is an ideal theoretical approach for analyzing how cultural and social norms have impacted family planning outcomes in Senegal. Senegalese people have strong cultural heritages and established social norms that shape their feelings about family planning. The work of North (1990) and Pierson (2000) complements this argument as they maintain that social and cultural behavioral continuities are an important feature of society. Culture is transmitted from one generation to the next via teaching, imitation, knowledge and other behavioral factors; these informal constraints are important sources of continuity for long-term societal change (North 1990, 37). In society it is natural that information will be culturally processed and as an informal constraint, plays an important role in the way institutions evolve and consequently is a source of path dependence (North 1990, 44). Cultural traits such as taboos, customs and traditions are by far enduring and most cultural changes are slow.

In a similar argument, Pierson (2000) asserts that institutions and policies encourage individuals and organizations to invest their time and energy in specialized skills, in-

depth relationships with others, and to develop particular political and social identities. Since social actors make commitments based upon existing institutions and policies, their cost of exiting from the established arrangements rises significantly (Pierson 2000, 259). Since the concept of the large family is a traditional cultural and social norm in Senegal, it is quite difficult for members of society to deviate from this institutional norm. Deviating from this norm is especially challenging for women because having many children is a status symbol in Senegalese society.

Path dependent analyses do not suggest that a particular path is permanently locked in, yet by examining self-reinforcing processes we can understand why certain organizational and institutional practices are persistent in society, such as the tradition of the large family in Senegal. Pierson argues that the social landscape can change, which has occurred to a certain extent in Senegal, but he argues that change will be bounded until something destroys or wears down the components of reproduction that generate continuity (Pierson 2000a, 265). Based on Senegalese cultural and social norms, it will be quite difficult to change the thinking of Senegalese people, since having many children has long been a standard norm. The concept of positive feedback is useful in analyzing public policy and social and cultural norms because the specific characteristics of the concept provide a key to making sense of how to consider the role of traditional societal norms in combination with change. In terms of family planning, in agreeing with North (1990), the process of institutional change for family planning in Senegal is incremental, yet characterized by path dependency.

*Layering, Conversion and Policy Drift: Analyzing Decentralization of Family Planning in Senegal*

In 1996, the Government of Senegal passed legislation known as the Decentralization Code which outlined a process of decentralization for nine sectors in Senegal, including health. Decentralization went into effect as of January 1997 and the authority to manage health, population, and social affairs was transferred to semi-autonomous local government units. With the process of decentralization, Senegal was also divided into administrative regions, with each having some political and financial autonomy. The process of decentralization in Senegal has not been smooth and has faced many challenges. In order to understand the impact of decentralization in the institutionalization of family planning in Senegal, concepts such as layering, conversion and policy drift can be used as analytic tools.

When considering a new process such as decentralization, it is essential to build upon existing institutions within society by slowly adding new elements or what can also be referred to as the process of layering. Old institutions cannot immediately be ignored and new institutions should follow an incremental implementation process building upon the existing cultural, social and economic conditions within society. Ouedraogo (2003) maintains that the decentralization process in francophone West Africa most commonly entails layering new local initiatives on top of existing ones. Based upon this evidence it can be argued that the concept of layering can be used to explain how incremental change has occurred for family planning in Senegal with new program initiatives being implemented and how local leaders have supported new initiatives while also considering traditional customs and social norms.

With the implementation of decentralization, several local leaders who were not originally involved in the health sector were given the opportunity to take on a role of leadership within their communities. Local leaders have a very powerful position within society and many members of the Senegalese community (especially those in more rural areas) rely upon them for guidance and education about a variety of issues including family planning. Conversion can be used to explain how and why some regions have been more successful than others in institutionalizing family planning.<sup>3</sup> Depending upon the region in Senegal, some communities gained several new leaders who were highly committed to family planning initiatives, while leaders in other regions may have had other health objectives and goals.

Lastly, drift can also be used to analyze the role of decentralization in family planning policies and outcomes in Senegal. Since the implementation of decentralization in 1997, incremental change has occurred in Senegal, yet significant change has not occurred in the overall policy structure. Most local officials are not involved in the health planning process. Although a majority of local leaders cite health as a top priority in their communities, they exercise almost no role in planning for health (Wilson 2000, 3).

Wilson sums up the very limited role of local leaders in health policy process:

Health technicians and elected leaders generally agree that a critical part of the role of the elected leaders should be to set the health policy and determine the health priorities of the community; however, they are not yet performing this function (Wilson 2000, 3).

Overall, policy drift can be used to explain the lack of significant change in the policy structure since the implementation of decentralization in 1997.

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<sup>3</sup> Chapter IV will examine the impact of decentralization in the institutionalization of family planning in Senegal considering regional family planning data. The regions include Central, North East, South and West.

*Developmental Pathways: An Approach to Understanding Government of Senegal and USAID Contributions to Health*

Family planning has continued to evolve in Senegal despite the challenges it has faced; some evolutionary changes can be explained using the concept of developmental pathways. Despite some setbacks with decentralization of the health sector, USAID along with the Ministry of Health in Senegal are making efforts to do more training with local leaders, encouraging them to prioritize their health budgets to include family planning initiatives and programs. While decentralization shifted focus away from family planning to a more integrated health system (Wickstrom et al. 2006), through developmental pathways political, social and financial institutions have continued to evolve. For example, with proper education and resources, over time leaders will gain knowledge and learn to properly plan budgets necessary to fully integrate family planning into the health sector. Many local leaders in Senegal have been eager to help, yet due to a lack of information about how to create an appropriate budget for family planning, have been unable to make family planning a priority. While the overall structure of decentralization may remain unchanged, authorities should be able to continue to implement changes that will allow the system to continuously evolve and transform in order to meet the family planning needs of society.

### Conclusion

This chapter has provided a justification for the use of historical institutionalism and concepts such as path dependency and layering, conversion and policy drift for the study of family planning in Senegal. It has also provided an overview of the relevant

work of other historical institutionalists in their studies of public policy using many of these concepts.

Chapter III will provide a historical overview of family planning in Africa and Senegal.

## CHAPTER III

### FAMILY PLANNING IN AFRICA AND SENEGAL

#### An Analysis of Population Dynamics and Implications for Socio-Economic Development in Africa

Several decades ago population growth was not an issue in Africa. Infant mortality, chronic disease, malnutrition and limited access to proper health care resources were common. Therefore many families chose to have large numbers of children in order to assure long-term family survival. Prior to the 1980s, high fertility was a necessity rather than being the problem that it is today. Yet, in the past 25 years or so African nations have experienced notable changes in their societies and economies. On a positive note while death from disease and poor nutrition has decreased significantly, birth rates continued to increase in many countries up until the twenty-first century.

Addressing the issue of rapid population growth is of concern because overpopulation makes it difficult for African countries to achieve basic development goals. When population growth outpaces economic development and progress, this becomes a serious obstacle for countries that are already struggling. There are several problems that can result from high fertility rates and excessive population growth, some of which include the inability to maintain and/or improve essential services such as health, education and training, lack of jobs and sufficient housing, in addition to a high dependence upon government subsidized programs to support those in poverty. In order to control the



population and to continue to make progress towards development goals, countries in Africa must support family planning initiatives.

*The Need for Family Planning in Africa*

Family planning is necessary in Africa for a variety of reasons. First it can be argued that it is essential due to the fact that “contraceptive prevalence is far lower than that of any other region in the world” (Caldwell and Caldwell 2002, 76) which has historically limited its advancement of socio-economic development. Next, unmet need for family planning in Africa remains high as many women continue to bear the consequences of unintended fertility and births (Rosen and Conly 1998; Casterline and Sinding 2000; Policy Project 2005). Third, family planning will contribute to an increased level of health for mothers and children as the use of family planning will improve child spacing, decrease infant mortality and reduce the number of abortions (Rosen and Conly 1998). Dr. Elhadji Mbow, Maternal and Child Health /Family Planning Specialist at USAID in Senegal, made the exact argument as Rosen and Conly about the benefits of family planning in a 2009 interview.<sup>1</sup>

An Analysis of Population Dynamics and Implications for  
Socio-Economic Development in Senegal

The rapid growth of population slows per capita growth and increases the inequality among the social classes. Increases in the labor force without increasing job opportunities reduces the return on the scarce factor of production, land and capital. “As the ratio of dependents to workers goes up, total savings go down and investments dwindle”

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<sup>1</sup> Dr. Elhadji Mbow, telephone interview with Yazmine Watts, March 27, 2009.

(Tomaro 1980, 3). Without investment in family planning policies, programs and services, Senegal will be unable to provide the resources needed to reduce poverty and improve living standards for its people.

### *The Need for Family Planning in Senegal*

The reasons for advocating for the use of family planning in Senegal mirror those previously stated as an overall justification for the use of family planning in Africa. In Senegal as in many other African nations, contraceptive prevalence is low, unmet need is high and family planning is needed to improve the health of mothers and children. In comparison to other African nations, the unmet need for family planning in Senegal is particularly high at 35% (one of the highest levels of unmet need in the world) as previously argued in Chapter I. Overall, Senegal will bear several consequences if members of society do not practice family planning. With the continued use and expansion of family planning services, Senegal can improve the overall “health of mothers and their children and families, provide couples with ways and means to decide the size and spacing of their families, and to contribute to the overall social and economic development effort” (Policy Project 2005, 9).

### *The Structure of Family Planning Services in Senegal*

Family planning services in Senegal are integrated within Senegal’s decentralized health system. The infrastructure of the service sector is divided between the public sector and the private sector. A majority of family planning services are offered through the public sector which relies heavily on the government for its financing. The private

sector is made of up private clinics, dispensaries and pharmacies based primarily in the capital, Dakar.

The health system in Senegal has a pyramid structure. At the base of the pyramid are the health centers, health posts and health huts. Health huts are most commonly located in remote villages and are designed to serve the local people with basic health information and services. In the middle of the pyramid are 10 regional hospitals. At the top of the pyramid there are seven national hospitals that provide more specialized care and services. 7 of the 17 hospitals in Senegal are based in the Dakar region while some regions such as Fatick and Kolda have no hospitals at all. The population growth rate in Senegal has made it difficult to ensure national service coverage through the existing health facilities, especially in poor rural areas. Costs for family planning services in Senegal are minimal with most service providers offering contraceptives free of charge. Although contraceptives are free, patients must pay for their own examination costs, which varies among facilities (Wilson 1998, CRLP 1999, Wickstrom et al. 2006).

#### *The Role of the Government in Family Planning in Senegal*

The Government of Senegal has played a key role in the evolution of family planning in Senegal. Several government ministries have participated in the process; notable ministries include the Ministry of Health, the Ministry of Public Health and Social Action and the Ministry of Education among others. A critical juncture occurred in 1980, as the Government of Senegal began taking on serious efforts towards implementing family planning when it became legal and when Abdou Diouf was elected President. Throughout his presidency, Diouf signed several decrees in support of family planning.

In 1997, he was also the first political leader to publicly address issues concerning family planning (Wilson 1998, 12). The Ministry of Health has also actively supported family planning efforts in Senegal over the years. Unfortunately the Government of Senegal has faced challenges with its family planning program. In the 1980s government leadership for family planning was divided and over a 19-year period the program changed departments 11 times (Wickstrom et al. 2006, 13). The section “Major Family Planning Policy, Program and Service Outcomes in Senegal: 1980–2005” later in this chapter will provide an overview of the government’s adoption of several key family planning policies, programs and services from 1980–2005.

### *The Role of USAID in Family Planning in Senegal*

Chapter I argued that USAID is often identified as the donor that is providing birth control in Senegal. USAID began family planning efforts in Senegal as early as 1978 and continues to work towards institutionalizing family planning. USAID heavily subsidizes Senegal’s family planning program providing support in the most essential aspects of family planning which include policy, training, technical support, service delivery and social marketing. USAID has also supported Senegal throughout the decentralization process by helping “to develop innovative ways to empower local communities to plan and finance health services” (Wickstrom et al. 2006, 15). Based upon USAID’s extensive involvement, a crucial question of concern is: Will Senegal be able to continue to make significant progress towards achieving institutionalization of its family planning policies, programs and services anytime in the near future? The section “Major Family Planning

Policy, Program and Service Outcomes in Senegal: 1980–2005” later in this chapter will discuss several of the major USAID projects from 1980–2005.

*The Cultural Context and the Role of Religious Leaders in Family Planning in Senegal*

As previously mentioned in Chapter I, family planning in Senegal cannot be understood without considering the cultural and religious context. In Senegal it has been a traditional social norm to have many children and it is quite difficult to change this legacy. Having a large family is encouraged and is deeply respected within society. Religious leaders are also highly respected within Senegalese society and many people rely upon them for guidance. Gaining the support of religious leaders is vital to the success of family planning policies, programs and services in Senegal. While many religious leaders support family planning efforts, others oppose it, arguing that Islam prohibits the practice of family planning. Religious leaders have supported some components of family planning, but not all components. This section only provides a very brief overview of the role of culture and religious leaders in family planning in Senegal. Chapter IV provides a historical overview of culture and religion in addition to an analysis of the role of culture, religion and social norms in the institutionalization of family planning in Senegal.

**Major Family Planning Policy, Program and  
Service Outcomes in Senegal: 1980–2005**

USAID authorized its first family planning project in Senegal in 1978 as part of the Sine Saloum Health Project. In 1980, family planning became legal in Senegal and progress towards implementing family planning began. One cannot analyze the history of family planning outcomes in Senegal without considering the social and cultural context.

Senegal has historically been strongly Islamic and socially conservative. Therefore, support for family planning has tended to be somewhat silent (Wilson 1998, vi). The Government of Senegal has increased its funding for health in general, although USAID provides the vast majority of funding for family planning. The government along with the assistance of USAID has made continued improvements towards the institutionalization of family planning. Yet, Senegal still faces many constraints to family planning policies, programs and services, some of which include the lack of infrastructure, equipment, and trained personnel; lack of funding, lack of knowledge about family planning services in addition to some health providers and religious leaders' attitudes towards limiting the birth rate. Since the 1990s, the government has made notable strides towards institutionalizing family planning, including the adoption of a decentralization program in the health sector in 1996. The literature review that follows will give an overview of the major developments within family planning policies, programs and services in Senegal from 1980–2005.

#### *Early Beginnings: Family Planning Initiatives in Senegal*

In its *Fifth Four-Year Plan for Economic and Social Development (1977–1981)*, the Senegalese government acknowledged the seriousness of the population problem and high rate of growth at 2.7%. A major issue of concern with the population was the overall implication for socio-economic development since a large portion of the population was less than 15 years of age (Republic of Senegal, Ministry of Planning and Cooperation 1977, 17–20). In the plan, the Ministry of Health also advocated for the adoption of a population policy designed to protect mothers and their children and proposed a family

planning program for the purposes of spacing births and educating the people. The Ministry also encouraged the establishment of more Maternal and Child Health (MCH) centers and extended health coverage for those living in rural areas (Republic of Senegal, Ministry of Planning and Cooperation 1977, 250). By 1980, the government was well aware of its population problem and was making incremental steps to address the problem, yet no comprehensive strategy was developed. Due to the lack of a comprehensive strategy along with the lack of financial resources, there was a high probability that Senegal as many other poor African nations would become a ward of the donor community (Tomaro 1980, 4).

Throughout the late 1970s and beginning in 1980, the Senegalese government continued to address the population problem slowly but surely. The Commission Nationale de la Population (CONAPOPOP) was established in October 1979 by decree of the President of Senegal, Abdou Diouf. CONAPOPOP reported directly to the Minister of Planning and Cooperation. Members of CONAPOPOP were diverse including traditional, political, governmental and non-governmental representatives. CONAPOPOP held its first official meeting in May 1980, considering the effects of rapid population growth on critical areas such as education, public health, migration, employment and per capita income. Although members of CONAPOPOP made sincere efforts to address the population problem, by 1980 no consensus on defining the problem was reached and no action program was defined or approved (Tomaro et al. 1981, 32).

A significant sign on the part of the Senegalese government toward liberalizing laws concerning family planning came on December 24, 1980, when the 1920 French law prohibiting the distribution and use of contraceptives was revoked. This was a critical

juncture that legalized family planning in Senegal. However, the vote to change the old law was not unanimous. Several deputies argued that contraceptive methods were “immoral and not appropriate in Islamic and developing countries” (Tomaro et al. 1981, 34). This development was one of the major incentives that donor agencies were given to work on family planning in Senegal.

Another critical juncture occurred in 1980 when the Senegalese Association for Family Well-Being (ASBEF), a local large NGO, was reorganized and reactivated, opening the first model family planning clinic. ASBEF was originally established in 1974 and is the local affiliate of International Planned Parenthood. Throughout the 1970s it played a key role in lobbying to change the 1920 Senegalese law that prohibited contraception (Wilson 1998, 15; Wickstrom et al. 2006, 5). During 1980 and 1981, the organization carried out two important activities: a training course on family planning for midwives and the President of ASBEF personally visited influential religious leaders throughout Senegal discussing the importance of family planning. As a result, many religious leaders expressed their support for child spacing activities, but were highly opposed to abortion and sterilization services (Tomaro et al. 1981, 35).

By 1980, the use of contraception was permitted in Senegal and the President at the time, Abdou Diouf, a Muslim, was supportive of Senegal’s need to encourage family planning. During a 1980 visit to Senegal by Douglas Bennett, a former USAID administrator, President Diouf was proactive in his efforts to address the population problem and raised the subject of family planning. He was supportive of actions that would encourage the country to achieve a reduced rate of population growth. Tomaro et al. 1981 (36) argue that during this time the government’s position moved from restrictive to



permissive. Notable changes included the permission to sell contraceptives, the practice of family planning in private clinics in addition to encouraging members of society to discuss issues around family planning.

Despite President Diouf's encouragement of family planning, other members of Senegalese society did not agree with his efforts to reduce the population growth rate. For example, the provincial governors of Diourbel stated that there was no population problem in their region and that their areas were actually under-populated and required more hands to be productively developed. The government sub-commission responsible for developing policies for the *Sixth Plan (1981–1985)* (which will be discussed later in the literature review) also denied the existence of a population problem and the need to develop policies that would advocate spacing births and reducing rates of growth. The commission recognized some of the demographic realities in Senegal (i.e., the 2.7% national growth rate), yet argued that it was more realistic to search for an economic solution to the demographic problems rather than turning to family planning and/or other population policies (Tomaro et al. 1981, 36).

In addition to resistance of family planning policies by the government sub-commission for the *Sixth Plan*, members of Senegalese society also had fears about adopting and promoting family planning and/or a population program. Due to the strong history of colonialism in Senegal, many felt that restricting the population would represent a return to colonial and racist practices. Those who favored a return to the strong, extended family and other pastoral ways did not identify a role for family planning (Tomaro et al. 1981, 36–38).

Some members of the Government of Senegal and other various segments within Senegalese society were aware of the need to control the population. However, population policy interpreted as a strategy to limit births and reduce growth rates was and still is a very sensitive issue in Senegal. Among certain sects of Muslims, limiting births is considered contrary to the words of the Koran. While the Koran does not explicitly prohibit the practice of modern contraception, many devout Muslims feel that limiting births is contrary to Islam (Tomaro 1980, 5–6; Tomaro et al. 1981, 38). The role of Islam and religion in family planning will be further addressed in Chapter IV.

Anti-Modernists are another group opposed to policies aimed at limiting or spacing births. Tomaro (1980) sums up their view in the following quote:

This group is particularly sensitive to the racial implications of birth planning policies and blames urbanization, modern western culture and the white man for the ills of juvenile delinquency, drugs and prostitution. The Anti-Modernists ... favor a return to the old ways, predominantly rural in nature, in which the white man and his "enslaving" culture have no part (Tomaro 1980, 6).

By 1981, the Government of Senegal appeared to be moving closer to formulating and advocating for a comprehensive population policy designed to limit births. However, the proposals and programs at the time reflected the government's overall sensitivity to the issue. During the early stages of family planning it can be argued that the government made an effort to steer a middle course to try to accommodate the needs and fears of both urban and rural constituents.

In the midst of trying to advocate for a reduction of the population, by 1981, Senegal, like many other African nations at the time was suffering from financial constraints. *The Sixth Four-Year Plan for Social and Economic Development (1981–1985)* showed a significant decrease in the combined budget for health and social welfare in

Senegal. Since 1969 the overall percentage of the national budget dedicated to health steadily declined. In 1969/70 9.2% of the national budget was dedicated to health, by 1975/76 it had dropped to 7.1% and by 1980/81 it reached a low at 5.8%. The continued reduction of the percentage of the national budget dedicated to health was a sign of the difficulty Senegal faced in meeting its health needs and its high dependency upon donor aid in the health sector. Keita 1988 (139) argues "that dependency often allowed external parties the freedom to experiment on the Senegalese system and its recipients."

In 1981, USAID began its first official mission in Senegal with the *Senegal Family Health Project (1981–1985)*. The Senegal family health project was a \$1.7 million project that was formalized by the government into the existing government health services with USAID backing (USAID 1982b, 3; USAID 1984, 1). The project was carried out through the collaboration between the Secretary of State for Human Promotion, the Ministry of Health, the Ministry of Social Development and USAID. Representing the Government of Senegal, the Secretary of State for Human Promotion carried the overall responsibility for the project's implementation. A National Family Planning Unit, made up of personnel from the Secretary of State for Human Promotion and the Ministry of Health was also established and assumed its program responsibilities effective January 1982 (USAID 1982a, 1).

The goal of the *Senegal Family Health Project* was to improve the quality of life and health of Senegalese women by reducing the rate of unwanted fertility. The goals of the program were achieved through the development of a family planning administrative structure responsible for directing the national family planning program, the establishment of information, education and communication programs and the provision and

supervision of strategically placed family planning service delivery centers in major regions throughout Senegal which included Dakar, Thies, Fatick, Kaolack, Ziguinchor, and Kolda (USAID 1985a, 2). In forming its approach to promoting the concept of family planning, the project did consider the differing cultural and religious viewpoints within Senegalese society. By 1982, the national family planning campaign had the sanction of both Islamic and Christian leaders (USAID 1984, 2), yet the problem of differing viewpoints regarding child spacing and the problem of unwanted fertility remained an ongoing debate.

As for funding, according to USAID project reports, the project had early problems in financing as its projected activities required a budget of \$6,000,000 CFA (Senegalese Francs) whereas only \$3,500,000 CFA was available from the Government of Senegal. All service delivery sites were fully equipped by February 1984. The project had staffing at both the national and regional levels, yet the regional staff was not directly affiliated under the direction or the budget of the project in regards to salary since these members performed other duties assigned by their specific ministries (USAID 1984, 3). Throughout the region, there were a total of 19 centers offering family planning services by February 1984. Clients attending the clinics were expected to pay a small fee of 25–50 CFA (which is about 10 cents U.S.).

Despite the construction of several clinics throughout the region, there were several problems with the *Senegal Family Health Project*. The regional chief medical officers stated that they did not have an adequate budget to meet the expenses of hiring night guards for family planning centers since the project was not considered a permanent part of the health delivery services. Unfortunately many centers were stocked with expensive equipment and supplies that could not be properly safeguarded. Another problem in-

volved the role of trained midwives in family planning. Midwives were not sure if they were expected to be solely involved in family planning outreach services or if they were expected to continue their work as midwives at the MCH centers. The regional medical chief officers also indicated that they had no budget for small expendable supplies such as cotton balls and antiseptics (USAID 1984, 4).

On a positive note, during 1983 and 1984 USAID staff members offered six weeks of onsite training to midwives and program promoters. For example, 30 social workers were able to undergo training in Thies while 19 midwives underwent training in family planning outreach and contraceptive methods in Dakar. Throughout 1984 there were also several additional training sessions offered to physicians, midwives and others involved in family planning. There was also a National Family Planning Policy Conference held in February 1984 where participation and expressions of views by doctors were given. Doctors' views indicated that professional resistance to family planning was gradually declining (USAID 1984, 4-5).

A final important development in the project included the creation of a management information system. Service cards were used in several other African countries during 1983. In Senegal, during 1984 a detailed consultation/service card, a patient appointment card and a medication stock card were developed and printed following a conference held that trained national and regional medical staff in information management (USAID 1984, 6).

Overall, USAID's first official project had both positive and negative elements. The major obstacles included lack of motivation by the staff due to salary issues, insufficient funding by the Government of Senegal, insufficient training for those involved in

family planning and the loss of many good trained personnel. On the positive side, during a 1984 site visit made by USAID to ASBEF, viewpoints and valuable clinic information was gained. At the time, ASBEF was offering family planning services at two sites in Dakar. It was noted that some 650 clients were seen each month, and 87% of them were using contraceptives. The ratio of old to new clients was 50/50 and most users indicated that they had heard of the services through a friend, who was already enrolled. Unfortunately it was noted that there was poor privacy for clients during the interview process and that in general contraceptive care was not begun at the initial visit and required several subsequent visits. ASBEF did not charge clients any service fees so the inability to pay was not a concern for users (USAID 1984, 7-9).

By 1985 USAID and the Government of Senegal were dealing with some of the major issues of the project. After evaluation, it was apparent from the monthly reports received back from the regions and the lack of reports in some regions, that the management information system that was implemented in 1984 was not correctly being followed. Supervision visits to field family centers revealed that in 50% of cases staff had classified client charts by chronological number instead of by month or next appointment and therefore could not determine how many clients had dropped out of the program. By March 1985, a team of 6 USAID consultants were in Senegal preparing a project paper for the next project. The director of USAID/Dakar informed the project advisors in January 1985 that there would be no extension of the current contract which expired on June 30, 1985 and that the new project was to immediately follow (USAID 1985a, 3). When the *Senegal Family Health Project* ended in 1985, about \$2.1 million had been spent (USAID 1987, 1).

In conclusion, it can be argued that the early 1980s were important in the development of family planning in Senegal. 1980 was a year of critical junctures where the government recognized the seriousness of the population problem, NGOs such as ASBEF were committed to family planning initiatives, family planning became legal, and USAID began its first official project in Senegal. Shortly after USAID ended its first project, the first Senegal DHS was completed in 1986. The results of the first DHS showed some progress towards family planning goals, yet it was also clear that there was much more work that needed to be done in order to control the high fertility and population growth rates. A historical analysis of DHS data from 1986–2005 will serve as major points of discussion in Chapters IV and V. The next section of discussion will focus on family planning developments after Senegal's first DHS.

#### *Family Planning Outcomes After Senegal's DHS 1: 1986–1991*

Several key developments occurred after the completion of Senegal's first DHS including the start of USAID's second mission, the *Senegal Family Health and Population Project (1985–1992)* (this actually started slightly before the first DHS was completed), the adoption of a National Population Policy in 1988, the launch of the National Family Planning Program in 1990 and the Ministry of Health and Social Development's order to eliminate the requirement for laboratory testing prior to prescribing birth controls pills or inserting intrauterine devices (IUD's) in 1991. A discussion of USAID's second mission project is what follows.

The goal of the *Senegal Family Health and Population Project (1985–1992)* was similar to that of the first mission, "to improve the health of Senegalese women and their

children and to help achieve population growth rates compatible with Senegal's capacity to provide basic health and social services for its people" (Bair 1985, 7). The 7-year project had a budget of \$27.4 million of which \$20 million was to be provided by USAID and \$7.4 million by the Government of Senegal (USAID 1985b, 1). The purposes of this project were to improve the capacity of the public and private sector by providing safe and effective contraception to 15% of married women of reproductive age, to provide comprehensive support to MCH services, for example through the detection and treatment of sexually transmitted diseases and infertility, improve the demographic database so that more effective development planning could occur and increase awareness of policymakers, planners and all other members of Senegalese society about the impact of rapid population growth on development (Bair 1985, 7-8).

The overall goals for the project aimed to have all health personnel and other appropriate organizations and groups in the private and public sectors appropriately trained in order to deliver family planning services in both an integrated and non-integrated fashion. Family planning services were scheduled to be available in service sites in all 10 regions of Senegal. Community based programs were to be ongoing in selected urban and rural areas and commercial retail of contraceptives was to be initiated. It was anticipated that family planning services would be available in all Government of Senegal health centers and in about 25% of the dispensaries by the end of the project (Bair 1985, 7-8).

Throughout the project information, education and communication programs concerning the impact of rapid population growth on development, the importance of child spacing as a health measure and the use and availability of contraception were to be



developed, tested and modified. This program was aimed at significantly increasing commitment to family planning and increasing awareness of contraceptive practices and availability throughout Senegalese society (Bair 1985, 7–8).

By 1985 there was still a significant training gap for those involved in family planning in Senegal. Training was vital as the success of this project depended highly on the quality of the training programs. There were broad types of training programs available for those involved in family planning. Long- and short-term training was held in the United States for professionals such as nurses and development planners. Training was also carried out in Senegal for those such as supervisors and services providers of government and non-government family health. The project plan included well over a thousand person months of pre-service and in-service training conducted at Senegalese training institutes with the ultimate goal of becoming principally self-sustaining by the end of the project (Bair 1985, 35).

In order to assess the success of this second mission project, the plan called for three main evaluations during the life of the project. The first evaluation was scheduled to be carried out at the end of year two by the Government of Senegal and USAID personnel, a second evaluation was to be carried out in year four with local project team leaders along with external assistance, and lastly, a final evaluation during the sixth year was scheduled to be carried out with more external assistance. The final evaluation was critical since it was supposed to address performance issues in addition to making some initial analyses about the project's impact on birth spacing and in reducing the percentage of high risk mothers exposed to undesired or high risk pregnancies. It was also to address broad issues such as the degree of institutionalization achieved (the topic of this

dissertation), project sustainability and needs for future assistance (Bair 1985, 86). The evaluations were to be based upon surveys, reports, interviews and site visits which included:

an initial and fifth year contraceptive prevalence/reproductive health survey, the 1987 census, service statistics of client use and contraceptive flow, quarterly progress reports on government and non-government actions, interviews with government personnel, community leaders and trainees, operations and bio-medical research reports, internal evaluation reports of sub-sector activities, and visits to clinic and project sites (Bair 1985, 86).

Despite all of the ambitious project goals, according to a USAID audit, efforts to assist family planning in Senegal got off to a slow start with the second USAID mission project. USAID/Senegal officials reported that the first project did not fully achieve its objectives and the second project experienced setbacks during the first two years due to procurement delays and problems with the technical assistance team. On a positive note, by mid-1987 most of the family planning efforts were gaining some headway. Yet a major obstacle was the fact that project progress could not be adequately measured because sufficient information was not being collected. An additional obstacle was the weak control over the distribution of project commodities. Despite these set-backs, controls over local currency accounts were found to be sufficient (USAID 1987, i).

A final evaluation of the *Senegal Family Health and Population Project* contained many findings. Despite the constraints and problems during implementation, the family planning environment in Senegal changed dramatically with the implementation of USAID's second project. Knowledge and practice of family planning grew significantly, many new family planning services were introduced into clinics throughout the country, many health workers and managers were trained in clinical services, communications and family planning management, effective information dissemination, education and communication

activities occurred, and several other important programs were created. The project also helped to increase the awareness of Government of Senegal planners and policymakers of the significance of demographic factors in development planning. As a result of these activities and achievements, a National Population Policy was adopted in April 1988, Francophone Africa's first population policy (Hardee et al. 1998) and the President of Senegal also signed a National Family Planning Policy into effect in March 1990.

One notable success of the second mission that should be mentioned is the increase in access to modern family planning methods that occurred. For example, an evaluation of the project revealed that:

the number of active contraceptive acceptors increased from 7,500 in 1985 to 29,890 in 1990 at public sector clinics, an average annual increase of 28 percent; the number of active contraceptive acceptors in the private sector has increased from 1,000 in 1985 to 9,111 in 1990, an average annual increase of 44 percent; combined public and private sector clients increased from 8,500 to 39,000 between 1985 and 1990 (Devres 1991, xxiv).

Of course, there were also problems with the project. Many argued that the project was overdesigned and underfunded. Others maintained that the goals were too optimistic and unrealistic to be achieved within the given timeframe. Many also felt that the project was too ambitious and more time was necessary considering the cultural and policy position of Senegal at the time the project was first designed. Other issues included too many project components and activities to be managed and carried out successfully, an insufficient level of financial resources provided by USAID and the Government of Senegal to support all of the activities of the project, and also inadequate training and technical assistance needed to develop a sufficient number of highly qualified local management and technical staff with the ability to sustain diverse project components (Devres 1991, xxv).

There were also unforeseen changes in the project's overall environment. Economic deterioration in Senegal and an International Monetary Fund (IMF) structural adjustment program reduced the government's ability to meet its financial obligations to the project. Frequent personnel changes in the project also reduced the number of key people with long-term knowledge of the project. The Government of Senegal's organization also changed several times during the duration of the project and in the short run weakened its authority and structure to coordinate important components of the project (Devres 1991, xxv). Other issues included weak project management and supervision and insufficient and inaccurate population service statistics. Population statistics were found to be inadequate and inaccurate while clinical data were found to be inconsistent and unsupported. A lack of timely and accurate operational information and data was one of the major constraints that hindered improvements to project management (Devres 1991, xxvi).

Despite some of the problems associated with the project, steps were being taken and encouragement was given towards institutionalizing family planning policies, programs and services throughout Senegal. Improved project management in the future would help balance USAID's need to control project funds and to assure that project goals and purposes would be achieved. At the same time, improving project management would allow the Government of Senegal and other members of Senegalese society to learn how to take over, manage, and financially support a sustainable family planning program. These initiatives would bring Senegal closer to institutionalizing family planning policies, programs and services.

*Post-DHS 2 Family Planning Outcomes: 1992–1996*

Senegal completed its second DHS in 1992. Some progress was made since the first DHS was completed in 1986. For example the modern contraceptive prevalence rate for married women increased from 2.4% to 4.8% while the total fertility rate decreased from 6.6 to 6.0 by 1992. Several other important developments occurred following the second DHS which include (1) USAID's *Senegal Child Survival/Family Planning Project (1992–1997)*, (2) Senegal's attendance at the International Conference on Population and Development (ICPD) in Cairo, Egypt, and (3) the decentralization of the health sector, which transferred health, population and social affairs to local government units.

USAID's 5-year, \$27 million *Senegal Child Survival/Family Planning Project* was designed to continue with its effort through a set of activities aimed at reducing the fertility rate in Senegal. The project was especially designed to increase the use and knowledge of modern contraceptives in Senegal. The project had three major components: (1) increasing the demand for contraceptives and MCH services, (2) increasing access to MCH/Family Planning services, and (3) improving the quality of MCH/Family Planning services. Under the first component health care workers were provided with training in family planning methods. Under the second component, clinics were provided with the equipment and commodities to provide family planning services. Under the third component, the quality of MCH/Family Planning services were improved by training health care workers and supervisors in areas such as counseling skills and better intake procedures (USAID 1992, 2).

Like previous projects, this project had some notable successes according to evaluation reports. For example, between 1992 and 1996, knowledge of two or more modern

methods of contraceptives among women of reproductive age increased from 57% to 70%. Among men there was a significant increase from 32% to 50%. Surprisingly, knowledge in rural areas was estimated at 58.4%, higher than the overall national average of 54%. The final year of the project, 1997, proved to be an intense year of family planning activity with significant results. National couples years of protection increased by 23% in one year alone, moving from 166,000 in 1996 to 206, 777 in 1997 (USAID 1998b, 10–11). This major increase in contraceptive use was “mainly due to the opening of additional regional referral centers, expanding services to rural posts, and a greatly increased number of condom retail sales sites” (USAID 1998b, 10).

By 1997, 13 of the 14 originally planned regional family planning referral centers were functioning. Rural posts made notable progress with 80% (up from 60%) being fully equipped and staffed to provide family planning services in the targeted regions. During 1997, the USAID mission supported 7 NGOs working in the health sector in five regions. Notable accomplishments included the NGOs securing 27 health huts, a mobile team, two referral centers, and delivery services in two different workplaces (USAID 1998b, 10).

Despite all of the positive successes and efforts, USAID did have shortcomings in their project strategy. According to a final country report, “USAID’s strategic direction and plans, along with implementing personnel, changed frequently and rapidly, resulting in confusing and conflicting messages in direction and guidance” (USAID 1999b, 30). For example, a local Senegalese NGO that had been funded by USAID for 10 years requested technical assistance in order to address family planning program issues within their center. USAID responded to their request by sending technical assistance through the Family Planning Service Expansion and Technical Support Project (SEATS).

Unfortunately SEATS had a short stay while assisting the NGO and was asked by USAID/Senegal to leave when less than 9 months of technical assistance had been provided. Unfortunately it was obvious that many program objectives could not be met despite efforts (USAID 1999b, 30).

The final project report also maintains that “inconsistency in resource allocation (i.e. funding not following performance) was another problem” (USAID 1999b, 30). Coordination with other cooperating agencies also lacked clear focus (USAID 1999b, 30). On a final note, the key issue of sustainability of family planning activities was addressed during the last quarter of 1997. By 1997, health facilities were charging a standardized fee for services and condoms with the authority to keep a portion of the funds for use in support of health committees’ social mobilization activities in the community. This was a major step towards institutionalizing family planning services in Senegal. This approach was highly effective because it allowed full participation of the communities who were willing to invest in their health services. With the profits earned, many communities were also able to pay health workers’ salaries and other expenses in addition to resupplying their drugs (USAID 1998b, 10). During the period 1992–1997, it can be argued that USAID made some progress towards the project goals while remaining focused on maternal child health, family planning and reproductive health, while keeping the Government of Senegal’s interest in mind on these areas as well.

Another key development in family planning after Senegal’s second DHS was Senegal’s attendance and participation in the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994. The ICPD is very important to the discussion of family planning in Africa and Senegal. Before this conference, the concept

of reproductive health was unheard of in many African countries such as Senegal. The ICPD set specific goals for reducing maternal and child mortality and called for universal access to family planning and other reproductive health services. Several sub-Saharan African countries created their reproductive health and family planning policies and programs based on the definition of reproductive health that was stated in the ICPD Plan of Action. In 1997, in response to the ICPD, the Government of Senegal drafted a Program of Priority Actions and Investments in Population, 1997–2001. This development will be discussed in the next section of this chapter.

In 1996, two notable events occurred in Senegal. First, the Government of Senegal adopted a Family Planning Declaration, establishing the first national norms and standards for family planning. The adoption of this declaration showed the government's initiative to incorporate recommendations from the ICPD held in 1994. The Family Planning Declaration pledged to provide contraceptive services to help couples and individuals in spacing births and preventing early, late, and unwanted pregnancies, to provide services to prevent sexually transmitted diseases, infertility and sterility and to provide Information, Education, and Communication (IEC) services, including family life education (CRLP 2001, 5–6). Second, the Government of Senegal also passed legislation outlining a process of decentralization for nine sectors in Senegal, including health. One major goal of decentralization was to spread access to health care services throughout the country. Prior to decentralization health services were highly concentrated in urban areas such as Dakar. Decentralization has proven to have both opportunities and challenges for the development and implementation of family planning programs.



First, as for the positive aspects, decentralization allows individuals and groups that have never had an opportunity to express their needs and interests to participate in a program that will aid in the country's overall development process. On the other hand, problems can arise with decentralization because many locally elected leaders lack sufficient planning skills and technical understanding of the importance of family planning and reproductive health in general (Wilson 1998; CRLP 2001; Wickstrom et al. 2006). Another major challenge for decentralization in Senegal is having a consistent interpretation of the texts on decentralization. Locally elected leaders' interpretation of their roles in the process varies throughout Senegal. Some local leaders want to participate in the planning, while others prefer to abdicate their responsibilities to government health officials. Another problem with decentralization has been with the distribution of funds. Throughout the process, many councils in Senegal reported that they did not receive funds from the state, while some councils received funds for an entire health district. Also since a large portion of the Ministry of Health's budget was put to the discretion of local leaders, many chose to spend it in other non-related sectors outside of health (Wilson 2000, 1–4). Despite some of the challenges with decentralization, Senegal continued to make efforts towards family planning after its third DHS was completed. The modern contraceptive prevalence rate for married women increased significantly from 4.8% in 1992 to 8.1% by 1997 while the total fertility rate declined slightly from 6.0 to 5.7. Key developments following the third DHS and the implementation of decentralization is the next topic of discourse.

*Post-DHS 3 and Post-Decentralization Family Planning Outcomes: 1997–2004*

In March 1997, the Government of Senegal responded to some of the recommendations of the 1994 ICPD, establishing a National Reproductive Health Program (1997–2001). The program's goals included the promotion of reproductive health by reducing maternal and infant morbidity and mortality, in addition to improving overall welfare. Specific program objectives were diverse, those relating to the provision of family planning included:

providing quality prenatal care to 80% of pregnant women; increasing assisted childbirth to 80%; ensuring that 50% of women who give birth have quality postnatal care; increasing contraceptive prevalence to 20% with a mean annual progression of 3%; reducing the rate of spontaneous and induced abortion by 50%; and reducing the incidence of early or unwanted pregnancy in young women and adolescents aged 10 to 24 years by 25% (CRLP 1999, 159).

A September 1997 evaluation of USAID health programs in family planning revealed that progress had been made in implementing health care objectives, yet despite the implementation of decentralization in January 1997, community participation in promoting the use of family planning services and support of preventive services was weak (Partnerships for Health Reform 1997). Many local government officials refused to release their 1997 budget allocations making it difficult to assess how much money local communities were dedicating to family planning efforts (USAID 1998b).

By 1998 it was clear that family planning was increasingly becoming a component of a more integrated health initiative. The Ministry of Health issued the Plan National de Developpement Socio-Sanitaire (National Socio-Medical Plan for Development) (1998–2007) which dissolved the 1990 National Family Planning Program. Responsibilities for the National Family Planning Program were moved to a new division of reproductive

health that was housed within the Department of Primary Health Care. Wickstrom et al. (2006) argue that “this integration reduced the status and advocacy for family planning within the Ministry of Health, decreasing its national visibility overall” (14).

By the year 2000 it was apparent that the government was making more efforts to increase awareness and knowledge of family planning. One initiative was made by the Ministry of Education, which developed several new teaching schools centered on family planning. The Government of Senegal also produced a promotional leaflet on family planning that was given to over 125 religious leaders in six health care districts that discussed safe motherhood and family planning. Also, in cooperation with the Ministry of Education, a local NGO by the name of Groupe pour l’Etude et l’Enseignement de la Population (Group for the Study and Teaching of Population, or GEEP) created the TV film “FAKASTALU” whose theme dealt with the consequences of early pregnancy in a school based environment. The efforts of the Ministry of Education along with the TV film helped to make the political and socio-cultural environment more favorable for promoting family planning among young people in Senegal (MSH 2000).

Social marketing is key in educating people and in promoting new types of contraceptive methods available in Senegal. In 2002, the Agency for the Development of Social Marketing (ADEMAS), a local NGO devoted to social marketing in Senegal, launched a marketing campaign for an oral contraceptive called Securil. Data indicate that at the time of the product launch only 3.3% of Senegalese women used Securil and there were no other cheaper oral contraceptives available through the private sector (Wickstrom et al. 2006, 19). Unfortunately the launch for the pill created media backlash, resulting in a requirement for generic advertising. Mentions of brand names in mass media are prohib-

ited in Senegal. The USAID/ Senegal Annual Report 2005 states that although ADEMAs has had many successes in social marketing, it has not been successful in terms of family planning and has not been able to make a significant impact in Senegal's family planning program.

In 2004, USAID began the *Projet de Réduction de la Mortalité de la Morbidité Maternelle* (Project for the Reduction of Maternal Mortality and Morbidity, or PREMOMA). Recently, PREMOMA has made significant contributions to the efforts of the government and local NGO's in improving maternal health, reducing maternal mortality and increasing awareness of family planning. PREMOMA's activities are based on the following strategies: improving the skills of healthcare agents, increasing the availability and quality of maternal health services, increasing the availability and quality of contraceptives, and improving knowledge and acceptance of and demand for reproductive health services. These strategies are employed at 432 service delivery points in 25 health districts throughout Senegal. Maternal health and family planning activities are employed in 22 districts and family planning activities solely in 3 districts in the Dakar region (MSH 2006, 1).

#### *DHS 4: Family Planning Outcomes in 2005 and Beyond*

The fourth and most recent Senegal DHS indicated slight improvements from DHS 3 in 1997. The modern contraceptive prevalence rate for married women increased from 8.1% to 10.3% while the total fertility rate decreased from 5.7 to 5.3. It can be argued that these changes were not significant given a period of about 8 years. Throughout 2005, PREMOMA continued its family planning efforts, implementing a contraceptive supply

system that reduces the occurrence of stock-outs in order to accelerate progress for couples whose contraception is financed by USAID. Policymakers and opinion leaders in Senegal have also remained involved in efforts towards achieving institutionalization of family planning. In 2005, reproductive health content and skills were introduced into the Ecoles de Formation d'Instituteurs (Schools for the Training of Teachers) and by lawmakers in the National Assembly who played an active role in advocating for the adoption of a law regarding reproductive health. In the Kaolack district, there was also collaboration between public and private sectors in health by regularly sharing periodic reports and by expanding training sessions and refresher training sessions for private personnel (MSH 2006b).

In 2005, the government of Senegal was to take responsibility for integrating contraceptive distribution with the distribution of essential drugs. However, donors such as USAID “continued to provide technical assistance to prepare the annual contraceptive procurement tables, receive and process contraceptives procured by donors, and provide assistance for nationwide distribution” (Wickstrom et al. 2006, 18). In 2005, repositioning family planning, an innovative approach to reaching national and millennium development goals was actively being used. This is why it was the subject of the regional Repositioning Family Planning conference held in Accra, Ghana in February 2005 (MSH 2005). During conference, the Senegalese government “committed to an action plan that would transfer management and financing of contraceptives to the government within the medium term” (Wickstrom et al. 2006, 18). However, given the extensive long-term involvement by USAID in contraceptive procurement and distribution since 1980, “there

were some concerns about the sustainability of the system and about contraceptive security over time (Wickstrom et al. 2006, 18).

### Conclusions

In sum, despite many efforts to improve family planning in Senegal, a fully institutionalized program has not been achieved. There were many successes in the earlier stages of family planning, yet in the past decade or so the rate of progress has been much slower as evidenced by the DHS data over the period of study. It can be argued that family planning was strongest and made the most progress between 1992 and 1997 (after the completion of second DHS) while progress between 1997 and 2005 waned due to a variety of factors.

Chapters IV, V and VI of this dissertation will provide an analysis of DHS, government health expenditure and donor aid data over the period of study along with other archival and interview data in order to assess where Senegal stands in the institutionalization of family planning.

## CHAPTER IV

### ANALYZING THE ROLE OF CULTURE, RELIGION AND SOCIAL NORMS IN THE INSTITUTIONALIZATION OF FAMILY PLANNING IN SENEGAL

#### Introduction and Chapter Overview

As previously argued in earlier chapters, family planning in Senegal cannot be analyzed without considering cultural and social norms. The traditional practice of having large numbers of children and opposition by religious leaders are factors that have historically influenced the choices of Senegalese people to use or not use methods of family planning. Historical institutionalism is a useful theoretical approach that can help to explain how social, cultural and religious factors have impacted the institutionalization of family planning in Senegal. More specifically, path dependency can be used to explain how cultural heritage, social norms and religion continue to dictate how people feel about family planning. Since Senegalese people have such strong cultural heritages and established societal norms, it is unlikely that they will diverge from what they have been accustomed to.

This chapter uses available data for the period of study from all four Senegal Demographic and Health Surveys (DHS) 1986, 1992/1993, 1997 and 2005, data collected during field research in Senegal and other family planning related research in order to analyze the role of culture and religion in the institutionalization of family planning in Senegal. The chapter begins with an overview of four contributing factors which include

marriage, social norms, Islam and religious leaders and polygamy. Next three categories of measurement which include legitimacy, knowledge and capacity-building are introduced and defined. These categories serve as the basis of measuring where Senegal stands in the institutionalization process. The analysis section of the chapter begins with four major hypotheses, one for each of the four contributing factors. Relevant variables for each factor are presented in tables created using DHS data. The chapter concludes with a summary of the findings. The primary finding in this chapter argues that social and cultural norms collide with policy and program objectives and block the institutionalization of family planning.

#### Historical Overview of Culture and Religion in Senegal: Marriage, Social Norms, Islam and Religious Leaders, and Polygamy

There are several key factors that play an important role in the evolution of culture and religion in Senegal. In order to understand why Senegal has faced obstacles in institutionalizing family planning one must examine the role of marriage, social norms, Islam and religious leaders, and polygamy. What follows is a brief overview of the influence of these institutions within Senegalese society.

##### *Marriage*

Marriage in Senegal is a highly respected institution. Marriage traditions are derived from Islam, Christianity, Western and local traditions. In Senegal, even before the spread of Islam, marriage served as the sole institution that condoned sexual relations and procreation; this tradition still holds true. A majority of Senegalese women are taught how to cook and clean and other necessary household chores at a very young age; skills



needed for a married woman rather than those needed for a young girl to succeed in school. Thus, starting from a young age girls look forward to being married and being a good wife to their husbands. Marriage in Senegal offers a woman social status and the opportunity to have many children which is highly respected in society. It can be argued that a woman's success in Senegal is often based upon marriage and the number of children she has.

Remaining a single woman is looked down upon in Senegalese society and women are encouraged to get married at a very young age even when situations may not be most ideal. Data from the most recent Senegal DHS in 2005 indicate that the median age at first marriage for all women is 18.5 years and 17.1 years for rural women. Single women are expected to remain virgins until married and due to the social stigma and other cultural norms, single women's access to family planning is questionable. Although single women are expected to remain virgins until married, many do not (Wickstrom et al. 2006, 10). Data from the 2005 Senegal DHS indicate that the median age at first sexual intercourse for women 20–49 is 18.7 years. The data also show that rural women start having sex at an even younger age than urban women with a mean of 17.3 years of age.

Wickstrom et al. (2006) maintain that “fewer than one-third of young men and women report using contraception at their sexual debut, and access to family planning services for unmarried adolescents is problematic” (10). Based upon this evidence it can be argued that single women face more barriers to using family planning than married women. In sum, since marriage is so highly respected and remaining single is not the societal norm, it is expected that married women will have easier access to family planning and be more likely to use family planning than single women.

### *Social Norms*

Levels of education for members of Senegalese society are extremely low, more notably for women. The adult literacy rate (those over the age of 15 who can read and write) for the total population is a little over 39% (Central Intelligence Agency 2009, World Bank 2008). Literacy rates for females are a lot lower than that of males. The adult male literacy rate is 51.1% while that of females is only 29.2% (Central Intelligence Agency 2009). The most up-to-date statistics for Senegalese youth literacy rates are not much stronger than those of the adult rates; the male youth literacy rate (ages 15–24) for the period 2000–2006 is 59% while the rate for female youth during the same period is 41% (UNICEF 2009). In general, many members of Senegalese society rely upon religious leaders as their sole source of education and information and it is common cultural practice to have strong spiritual beliefs and to leave one's overall destiny in life, including the number of children one has in the hands of God.

Despite their exposure to Western influences, many Senegalese people continue to hold onto their indigenous roots; one notable tradition includes the practice of having large families. Wickstrom et al. (2006) argue that culturally the small-family norm has not taken hold in Senegal. Throughout Senegal, especially in rural areas, children are a necessary economic resource in the extended family system. Children help out their families in farming and agriculture and take care of their parents in old age. Also, having many children is seen as a status of wealth and social prestige for women; therefore many women choose not to use modern methods of contraception in order to increase their chances of giving birth to a large number of children. It is also important to note that there is a large incentive for Senegalese wives to have more children as they will inherit

more, especially those with more male children; therefore competition among wives is a common practice in order to give their husbands the greatest number of children (Wickstrom et al. 2006, 9).

### *Islam and Religious Leaders*

Islam has historically served as a strong political and social force in Senegalese society, having a major impact on how members of society make important decisions including the choice to use or not use methods of family planning. Islam has a long history in Senegal and can be traced back to the eighteenth century when the British and French fought for control over West Africa. The rivalry between France and Britain coincided with the Islamic revival in Senegal. In 1776, a group of Tukolor marabouts (also known as spiritual leaders) led a successful revolution and established a theocratic oligarchy. The leaders of the movement sent missionaries throughout Senegal and developed relationships with other resurgent Islamic movements throughout West Africa (Gellar 1995, 5).

Throughout the mid-nineteenth century Tukolor clerics led several holy wars and established Muslim states in the region. Al Haj Umar Tall was one of the most famous Muslim warriors. In the 1820s he was initiated into the Tijaniya brotherhood and eventually acquired a large Muslim following which eventually extended into Senegal. Tall's Islamic reform movement made a lasting impact on Senegalese Islamic history.

Despite French colonial rule, Islam continued to make progress in Senegal. By the turn of the century less than half of Senegal's population was Muslim (Gellar 1995, 111); today 94% of the Senegalese population is Muslim (Central Intelligence Agency 2009). Since Senegal gained its independence from France in 1960, Islam has been one of the most

preeminent forces in Senegalese society. Muslim brotherhoods have played a significant role in spreading Islam and most Senegalese Muslims identify themselves with one of four brotherhoods: the Tijaniya, the Muridiya, the Layenne, or the Qadiriya (Callaway and Creevey 1994; Piga 2003). Each brotherhood practices slight differences in Islamic rituals and codes of conduct (Gellar 1995, 111). The Qadiriya is the smallest and oldest brotherhood, the Muridiya is the most organized and influential brotherhood, the Tijaniya brotherhood is largest in membership and most Senegalese identify with it (Gellar 1995, 111–12) and the Layenne is a very small brotherhood with little political strength that is active in the Cap Vert region and influential among young people (Piga 2003, 43). To date, the Tijaniya and the Muridiya serve as the two strongest Islamic brotherhoods in Senegal.

Islamic leaders within the major brotherhoods have traditionally played a strong role in educating members of Senegalese society in addition to promoting a strong moral pedagogy. As Piga (2003) notes, social norms and behaviors of Muslims within the community are strict and Muslims must conform to certain acceptable values which are endorsed by religious leaders. Many Senegalese people faithfully follow the teachings of religious leaders and/or spiritual marabouts making it very difficult for any initiatives contrary to the word of the religious leaders to be accepted. According to a report from the Advance Africa Project, many religious leaders in Senegal feel that family planning is not a high priority area of concern and therefore does not even make it a point of discussion among Muslim followers (Ouedraogo 2004).

Despite a lack of sufficient resources for its growing population, population policy interpreted as a strategy to limit births and reduce growth rates is a very sensitive issue in Senegal. Piga (2003) argues that the Islamist ethos is highly opposed to Western-style

modernity and continues to criticize the West for imposing modern practices upon Senegalese people. Many religious leaders oppose family planning for reasons such as it questions God's will, the use of family planning does not support the creation of large families and leaders are also opposed to Westerners meddling in the affairs of Muslims (Bowen 2004, 149). "Among certain sects of Muslims ..., limiting births is considered contrary to the precepts of the Koran. Children are riches measured by their social value and longevity, not their economic benefit or cost" (Tomaro 1980, 6). Outside of the capital region of Dakar (notably in rural regions), there is stronger resistance to policies perceived as anti-natal. Even in the Dakar region, there is some resistance to endorsing family planning and both political leaders and program managers are very cautious and apprehensive about undertaking any new measures that might be considered controversial and an assault on Islam (Wilson 1998, vi).

### *Polygamy*

Senegal has the highest rate of polygamy in West Africa. The practice of polygamy is permitted by Islam and remains widespread; according to the most recent Senegal DHS, 40% of women in Senegal are married to polygamous husbands. Senegalese men are allowed to marry up to four wives according to Islamic law. Polygamy is significantly higher in rural areas of Senegal and often a man may inherit the widow of his brother(s) and the number of wives he has may be as high as six or seven. Polygamy has not decreased significantly over the past 20+ years and is a contributing factor to the high fertility rate in Senegal (Wickstrom et al. 2006, 9). For example, Senegalese DHS data support the argument that women living in polygamous marriages have more children

than those in monogamous marriages. This argument will be further discussed in the analysis section of this chapter.

It can be argued that marriage, the role of Islam, polygamy and other cultural beliefs and practices have had a long and enduring impact on family planning practices in Senegal. Both men and women in Senegal have traditionally refused to use family planning with the belief that having a large family is necessary for societal acceptance and the use of contraception could prevent this; in addition many also feel that contraception should be avoided because Islam opposes it. Many religious leaders have interpreted the Koran in different ways although Islam does not explicitly condemn family planning.<sup>1</sup> The role of culture and religion in the institutionalization of family planning in Senegal will be analyzed using data from a variety of sources such as research studies on religion and Islam in Senegal, research, program, policy and evaluation studies and reports on family planning in Senegal, a questionnaire, an interview with a USAID official and all of the Senegal Demographic and Health Surveys (DHS) which include 1986, 1992/1993, 1997, and 2005, in addition to data from the World Development Indicators Database (WDI).

### Measuring Institutionalization

In order to determine where Senegal stands in terms of the institutionalization process, three categories of measurement are used. These categories include legitimacy (as a measure of use, attitudes and acceptance), knowledge and capacity-building. Legitimacy is perhaps the most central concept in institutional research. Legitimacy can be defined as the acceptance of policies and programs by members in Senegalese society.

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<sup>1</sup> A detailed interpretation and discussion of the Koran and family planning goes beyond the scope of this research and will therefore not be discussed.

Do the people of Senegal support the government in its family planning policies and programs? Do members of Senegalese society discuss family planning with their spouse?

One valuable measure of legitimacy is use. A vital question of concern is: do members of Senegalese society utilize family planning services and, if so, to what extent? Several empirical questions will be used in order to measure legitimacy, focusing specifically on usage, attitudes and acceptance of family planning. Some questions include: *what is the contraceptive prevalence rate, what percentage of women have ever used contraception and what percentage of women intend to use contraception in the future, and what percentage of couples approve of family planning?*

A second category of measurement is knowledge. Knowledge is defined as the extent to which the Senegalese population has correct information and/or knowledge about how family planning works and the consequences of more and less rapid population growth. An important question of concern is does a high level of knowledge about family planning lead to high levels of usage? Some empirical questions that will measure knowledge include *what percentage of women have knowledge of modern and traditional methods of family planning and what percentage of women have heard about family planning on the radio?*

A final measurement of institutionalization is capacity-building. Does Senegal have the capacity to manage a family planning program at the executive level, meaning the capacity of the Senegalese government to make decisions about policies and programs over the short and long term and also at the implementation level, meaning the capacity of trained service providers to effectively manage family planning programs by utilizing the necessary skills and resources required for continued success? Empirical

questions that will measure capacity-building include *how much money has the government of Senegal contributed to health expenditures and has the percentage of donor aid increased significantly over the period of study?* Capacity-building is not addressed in this chapter and will be addressed in Chapter VI

### Analyzing the Role of Culture, Religion and Social Norms

Based upon the research conducted, four hypotheses are implied about the impact of culture and religion in the institutionalization of family planning, one for each of the four factors: marriage, social norms, Islam and religious leaders, and polygamy. Given the historical traditions and culture in Senegal, it is expected that married women are more likely to use and have access to family planning than single women, having a positive impact on the institutionalization of family planning. It is also expected that family planning use will not increase significantly over the period of study due to the fact that Senegalese people prefer large families and many couples are opposed to using family planning for religious and other personal reasons. These factors will hinder and/or have a negative impact on the institutionalization of family planning. Lastly, it is expected that polygamous couples will have more children than monogamous couples therefore having a negative impact on the institutionalization of family planning. It can be argued that Senegalese cultural norms and biases have not changed significantly over the years and have therefore become locked in as common practice. Relevant actors in family planning such as USAID, the Government of Senegal and religious leaders can only adjust their strategies in order to accommodate the prevailing cultural customs and norms.

*Hypothesis 1: Marriage has a positive impact on the institutionalization of family planning.*



Hypothesis 2: *Cultural norms and biases have a negative impact on the institutionalization of family planning.*

Hypothesis 3: *Islam and religious practices have a negative impact on the institutionalization of family planning.*

Hypothesis 4: *Polygamy has a negative impact on the institutionalization of family planning.*

### *Contraceptive Prevalence for Married Women*

The contraceptive prevalence rate in Senegal has been historically low and this has served as a major obstacle in institutionalizing family planning in Senegal. Table 4.1 gives the contraceptive prevalence rate for married women ages 15–49 over a 20-year time span. The years of available data include 1986, 1993, 1997, 1999, 2000, 2005 and 2006. These data are essential in the analysis of family planning in Senegal because they can be used as one measure of legitimacy.

Table 4.1

Contraceptive Prevalence (% of Married Women Ages 15–49)

Year	%
2006	12.0
2005	11.8
2000	10.5
1999	10.5
1997	12.9
1993	7.4
1986	11.3

Contraceptive prevalence (% of women ages 15–49):

Contraceptive prevalence rate is the percentage of married women who are practicing, or whose sexual partners are practicing, any form of contraception.

Source: The World Bank, World Development Indicators Database 2008 and UNICEF 2009.

Wickstrom et al. (2006) argue that an annual increase of 1–2 percentage points in the contraceptive prevalence rate is an indicator of a strong family planning program. Between 1986 and 2006, there has only been an increase of 0.7% from 11.3% in 1986 to 12.0% in 2006. USAID began its family planning programs in Senegal between 1978 and 1980, and the results of the 1986 Senegal DHS reflect the efforts of USAID after about six to eight years of on the ground work. 1997 was a critical juncture and during this year Senegal had the highest percentage of contraceptive prevalence over the period of study at 12.9%. As previously argued in Chapter III, following the 1994 ICPD conference and the establishment of the National Reproductive Health Program, the Government of Senegal was very active in promoting family planning objectives and in trying to implement the recommendations given at the conference. The post-ICPD period was a critical juncture, opening up a window of opportunity where significant progress and improvement could be made in family planning. Yet despite the dedication to family planning during this juncture, by 1999 the contraceptive prevalence dropped to 10.5%. In interviews with the current and former USAID Maternal and Child Health/Family Planning Specialist in Senegal, several reasons were identified as major constraints to increasing contraceptive prevalence some of which include insufficient resources in both quantity and quality in reproductive health and finance, the weak public engagement of decision-makers, cultural aspects such as certain interpretations of Islam, the influence of pronatalists in Senegalese society, and the weak decision-making power of women to address questions concerning their own health.<sup>2</sup> Overall, usage levels have been

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<sup>2</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009. Dr. Elisabeth Benga-De, correspondence with Yazmine Watts, Summer 2004.

traditionally low, so it can be argued that legitimacy is low indicating that acceptance of family planning may not be very high among members of Senegalese society.

### *Marriage and Ever Use of Contraception*

It was hypothesized that marriage would have a positive impact on the institutionalization of family planning. Therefore it is expected that married women will be more likely to try a method of contraception in comparison to unmarried women. It is important to mention that many women in Senegal have never used contraception despite the widespread efforts of USAID to promote the use of family planning. Table 4.2 gives an overview of the percentage of women both married and unmarried who have ever used a method of contraception between 1986 and 2005.

Table 4.2

### Percentages of Women Who Ever Used Contraception

	All			Currently married		
	Contraceptive method			Contraceptive method		
	Any method	Any modern method	Number	Any method	Any modern method	Number
<b>Senegal 2005</b>	21.8	19.9	14602	28.6	26.0	9866
<b>Senegal 1997</b>	21.8	14.8	8593	26.7	17.3	5851
<b>Senegal 1992/93</b>	15.4	10.2	6310	17.0	10.7	4450
<b>Senegal 1986</b>	32.5	6.2	4415	37.9	5.7	3365

Ever use of contraception:

Percentage of all women and of currently married women who have ever used any contraceptive method.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

Ironically in 1986, 37.9% of married women and 32.5% of all women tried using some form of contraception, indicating that USAID was doing an excellent job in educat-

ing Senegalese people about contraception during their second official mission, the *Senegal Family Health and Population Project*, yet the methods of ever use for modern contraceptive methods were significantly lower at 5.7% for married women and 6.2% for all women. These results indicate that at the time, USAID still needed to make more efforts to educate and encourage women to use modern methods of contraception. As previously argued in Chapter III, results from an evaluation of the second mission revealed that the project was too ambitious and more time was necessary considering the cultural and policy position of Senegal at the time the project was first designed.

Despite obstacles, between 1986 and 2005 there was a steady and significant increase in the percentage of all women and married women who tried modern methods of contraception indicating that USAID was continuing to make progress with its mission to educate women about modern contraception. USAID continued to carry out projects increasing its funding significantly over time. For example, its first mission had a budget of \$1.7 million while its second mission had a budget of \$27.4 million. Between 1986 and 2005, married women had the largest increase in ever use of modern methods of contraception as hypothesized with an overall increase of 20.3%. Between 1997 and 2005, both all women and married women had significant increases in ever use of modern methods of contraception, yet married women yielded stronger results. Married women had an overall increase of 8.7% in ever use while women overall had an increase of 5.1%.

Although there are notable increases in ever use, unfortunately continuation rates are low as the contraception prevalence rate is currently at 12.0% for all married women of reproductive age. As expected, the data support the argument that married women are more likely to use contraception and therefore have higher percentages of usage than un-

married women. An important question of concern is: are sexually active unmarried women trying contraception? As previously argued, although sex is taboo for unmarried women, many still do have sex.

*Contraceptive Use Among Unmarried Sexually Active Women*

In Senegal it is expected that sex will only occur between married couples, yet unmarried women do have sex although not openly. It is interesting to note that ever use of contraception for sexually active unmarried women is very high, indicating that unmarried women are taking precautions to prevent pregnancy out of wedlock and to prevent sexually transmitted diseases. Table 4.3 presents data about sexually active unmarried women who have ever used a method of contraception from 1992/1993 to 2005.

Table 4.3

Percentages of Ever Use of Contraception Among Unmarried Sexually Active Women

	Contraceptive method		Number
	Any method	Any modern method	
<b>Senegal 2005</b>	73.9	73.9	50
<b>Senegal 1997</b>	67.1	61.8	143
<b>Senegal 1992/93</b>	58.6	53.5	99

Ever use of contraception:

Percentage of sexually active unmarried women who have ever used any contraceptive method.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler.

<http://www.measuredhs.com>.

The most recent 2005 DHS data indicate a rate of 73.9% for ever use of both any method and any modern method of contraception by sexually active unmarried women.

Ever use of contraception for sexually active unmarried women can be expected to be

high since a pregnant unmarried woman is not socially acceptable in Senegalese society. This is considered a serious disgrace to the woman's family. In the case of unmarried women social norms have increased the likelihood of a woman using contraception in order to prevent pregnancy and being subject to non acceptance among members of Senegalese society.

*Marriage: Discussion and Attitudes About Family Planning*

As previously mentioned, one of the major goals of this dissertation is to measure where Senegal stands in the institutionalization process and legitimacy is one of the major categories of measurement. Tables 4.4 and 4.5 present data about discussion of family planning among couples and couples' attitudes about family planning. Based upon the fact that culturally many Senegalese people are educated by religious leaders and family planning is not a high priority topic among several key local leaders<sup>3</sup>, it is of interest to see how important this topic is among couples and how couples feel about family planning. Positive feedback would indicate that couples' discussion and attitudes about family planning would continue to follow the same direction.

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<sup>3</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009.

Table 4.4

## Percentages of Discussion of Family Planning With Spouse

	Discussed family planning with partner				Total %	Number
	Never	Once or twice	More often	Missing		
<b>Senegal 2005</b>	58.3	22.6	18.0	1.1	100.0	9238
<b>Senegal 1992/93</b>	70.7	14.2	15.0	0.1	100.0	3326
<b>Senegal 1986</b>	79.1	12.3	8.5	0.2	100.0	3070

Discussion of family planning with husband:

Percent distribution of currently married non-sterilized women knowing a contraceptive method by the number of times they discussed family planning with their husbands in the year preceding the survey.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

Table 4.5

## Percentages of Attitude of Couples Toward Family Planning

	Attitude of couples towards family planning		
	Both Approve	Both disapprove	Number
<b>Senegal 2005</b>	23.0	25.6	9238
<b>Senegal 1997</b>	28.6	8.6	5024
<b>Senegal 1992/93</b>	25.9	15.8	3326
<b>Senegal 1986</b>	17.0	24.1	3070

Not all response categories are included.

Attitudes of couples toward family planning:

Percent distribution of currently married non-sterilized women who know a contraceptive method by approval of family planning.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler.

<http://www.measuredhs.com>.

In 1986, the percentage of women who never discussed family planning was very high at 79.1%. This figure indicates that for the most part couples did not discuss family planning; therefore the likelihood of using family planning would be very low. This can be expected as USAID was in the very early phases of its second mission in Senegal and the Government of Senegal was still cautious when discussing issues related to family

planning as many felt that family planning was contrary to the teachings of Islam. By 2005, this percentage was better, yet 58.3% of couples never discussed family planning. The percentages of couples who discussed family planning three times or more is also very low ranging from 8.5% in 1986 to a high of 18% in 2005. These findings indicate that family planning is not of high priority and/or interest among married couples. Since social norms have not changed since 1986, it was expected that discussion about family planning would be subject to positive feedback, but the data indicate otherwise.

Examining couples' attitudes towards family planning is a good indicator of legitimacy as it shows if members of society approve of using family planning. It is also expected that couples' attitudes towards family planning will be subject to positive feedback. The data indicate that approval has generally been low among couples. Approval rates were highest in 1997 at 28.6% as a result of the government's strong commitment to following the recommendations of the ICPD and with the implementation of the National Reproductive Health Program, yet, dropped to 23% by 2005. Disapproval rates both increased and decreased over the period of study. Disapproval rates were at a high in 2005 at 25.6% which is very close to the rate reported in 1986 at 24.1% essentially showing no progress over 19 years. Although there was some improvement over the period of study, the overall finding supports positive feedback. Approval for family planning ultimately declined over the period of study confirming that Senegalese people are generally opposed to family planning. Based on the results between 1997 and 2005, progress in family planning was weakened and it is clear that USAID needs to do a better job in addressing social norms. Wickstrom et al. (2006) argue that the absence of sustained behavior change communications is often cited as an obstacle to family planning efforts. Cultural



norms and past ways of thinking dictate the direction of how Senegalese people will continue to feel about family planning in the future. This will be quite difficult for USAID and the Government of Senegal to change.

It is clear that marriage plays a significant role in the institutionalization of family planning in Senegal. It was hypothesized that marriage would have a positive impact on the institutionalization of family planning in Senegal. Unfortunately the contraceptive prevalence rate has remained low among married women, only reaching 12% according to the most recent data, indicating that social norms may create a plateau in the contraceptive prevalence rate. Married women have made significant progress in their efforts to try methods of contraception as Table 4.2 indicates, but unfortunately low continuation rates continue to impact the prospects for widespread and significant progress.

Discussion of family planning among married couples was weak as cultural and religious biases would suggest. The lack of discussion about family planning among couples is a negative indicator of institutionalization vs. a positive indicator. Data on married couples' attitudes towards family planning showed fairly low approval rates. The disapproval rate made a surprising increase between 1997 and 2005 when it increased from 8.6% to 25.6%, indicating that no progress was made in this area. Progress decreased despite extensive spending by USAID and social marketing programs introduced by the Government of Senegal and local NGOs aimed towards educating people about family planning and making the political and socio-cultural environment more favorable for promoting family planning.

It can be argued that overall marriage has somewhat of a positive impact in the institutionalization of family planning, but social norms and religious factors play an

important role in married couples' decisions to talk about family planning and in their overall attitudes about approving or disapproving of family planning. While discussion about family planning improved moderately over the period of study, attitudes about family planning is a social norm subject to positive feedback.

### *Social Norms*

According to DHS data from 1986 to 2005, many women would ideally like to have about six children. This number has not changed significantly over about 20 years as the mean ideal number of children in Senegal remains high at 5.4 for all women according to the most recent data. Many women do not choose to use family planning and many do not want to limit their birth spacing until they have well over six children because cultural traditions encourage large families. In Table 4.6 data were extracted from the Senegal DHS indicating the mean ideal number of children for all women by the number of living children for women with four, five or six or more children.

A review of the data reveals that the mean ideal number of children for Senegalese women is higher than the actual mean number of children. The mean ideal number of children has decreased slightly since 1986, but overall Senegalese women still want six or more children. In 1997, the mean ideal number of children for all women who already had six or more children was 5.9. By 2005, this figure increased to 6.3, supporting the path dependent trend, that women are not in support of having smaller families and ideally want six or more children. The overall actual mean number of children increased slightly for all women from 5.3 in 1997 to 5.4 by 2005 indicating that no progress was made.

Despite USAID efforts, this social norm has remained constant and has clearly served as a barrier to institutionalizing family planning.

Table 4.6

Ideal and Actual Number of Children for All Women With Four or More Children

	Total and mean			
	Living children + current pregnancy			Total
	4	5	6+	
<b>Senegal 2005</b>	5.9	6.1	6.3	5.4
<b>Senegal 1997</b>	5.7	6.0	5.9	5.3
<b>Senegal 1992/93</b>	6.5	6.7	6.5	5.9
<b>Senegal 1986</b>	7.3	7.2	6.8	6.8

Ideal and actual number of children (mean):

Mean ideal number of children for all women, according to number of living children, 4, 5 and 6 or more children.

Number of respondents and response percentages unavailable.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler.

<http://www.measuredhs.com>.

Table 4.7 presents data on the percentage of married women who want no more children by the number of living children. These data were selected in order to see if women had a desire to stop giving birth after having a certain number of children. The total fertility rate is 4.95 children born per woman (Central Intelligence Agency 2009) so based on this average; it is of interest to see if women who have more than four children have a high desire to stop giving birth.

Table 4.7

## Desire to Stop Childbearing by Number of Children

	Number of Living children							Total
	0	1	2	3	4	5	6+	
<b>Senegal 2005</b>	0.4	1.7	4.4	11.7	21.9	36.7	62.2	21.0
<b>Senegal 1997</b>	0.8	1.0	5.0	9.1	19.6	33.3	61.2	23.0
<b>Senegal 1992/93</b>	1.2	1.4	4.0	9.0	16.6	28.3	52.7	20.4
<b>Senegal 1986</b>	1.9	2.2	4.2	10.9	18.7	31.0	61.6	19.0

Desire to stop childbearing:

Percentage of currently married women who want no more children by number of living children.

Number of respondents and response percentages unavailable.

*Note:* Women who have been sterilized or whose spouses are sterilized are considered to want no more children. Number of living children includes current pregnancy.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

An analysis of the data indicates that as the number of children a woman has increases, her desire to stop giving birth increases, which is good. Yet, a crucial question of concern is to what extent? The percentage of women with four children who wanted no more children did not change significantly between 1986 and 2005 only rising from 18.7% in 1986 to 21.9% in 2005, a mere 3.2% change over 19 years. It is not until women have six or more children that a high percentage of women desire to stop childbearing. This percentage has remained fairly consistent between 61% and 62% over the period 1986–2005 with the exception of 1992/1993 where the percentage was 52.7%. An examination of the overall totals indicates that the desire of women to stop childbearing by the number of living children is relatively low, only reaching a high of 23% in 1997, then dropping to 21% by 2005. These findings support the Senegalese social norm of the large family despite USAID's extensive efforts to education women about contraception over the past two decades.

It is clear that USAID has made extensive efforts over the past two decades to inform women about the importance of using contraception. In Table 4.8 data were extracted from the Senegal DHS indicating the percentage of married women's future intention to use contraception according to the number of living children for women with three and four or more children. These data are important as they also shed light on one of the key measurements of institutionalization in this dissertation, legitimacy.

Table 4.8

## Percentages of Future Use of Contraception by Number of Living Children

	Living children + current pregnancy				Total	
	3		4+		Total women	
	Currently married nonusers		Currently married nonusers		Currently married nonusers	
	Does not intend	Number	Does not intend	Number	Does not intend	Number
<b>Senegal 2005</b>	65.2	1234	66.9	3435	65.8	8700
<b>Senegal 1997</b>	49.7	700	52.7	2338	52.8	5094
<b>Senegal 1992/93</b>	61.9	598	60.9	1966	62.3	4117
<b>Senegal 1986</b>	76.0	479	73.8	1179	76.6	2981

Future use of contraception:

Percent distribution of currently married women who are not currently using a contraceptive method by intention to use in the future, according to number of living children, 3 and 4 or more children.

Not all response categories are included.

Note: Living children includes current pregnancy.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

In examining the overall data, generally Senegalese women do not have high levels of future intention to use family planning. Women with three and four or more children were used for analysis purposes in order to determine if having a significant number of children had an impact on a woman's choice to use contraception to prevent future births. Senegal DHS data show that between 1986 and 1997 notable progress was made among women's future intention to use contraception, yet there was a big change

between 1997 and 2005. Between 1997 and 2005, the percentage of all women who did not have the intention of using contraception in the future increased from 52.8% to 65.8%; this is a significant change in the percentage of women choosing not to use contraception indicating a low level of legitimacy. These percentages were even higher for women who had three or four or more children. For example, for women with three children, the percentage of women who did not intend to use contraception in the future increased by 15.5% between 1997 and 2005. For women with four or more children this increase was also significant with an overall increase of 14.2%. These increases support the fact that even after having four or more children, women generally want to have even more, supporting the historical trend of the large family. Overall, women with four or more children had the highest percentage for future non usage at 66.9% in 2005. Based on this evidence it is clear that USAID still needs to do a lot of work in this domain if progress is to be made with the next DHS scheduled for 2010.

The overall findings indicate that social norms are a strong barrier to the institutionalization of family planning therefore supporting the original hypothesis that cultural norms and biases have a negative impact on the institutionalization of family planning. As the data in Table 4.6 strongly indicate, Senegalese women on average desire to have about six children. This desire has not changed to any significant degree since 1986. Other data such as the desire to stop childbearing which is presented in Table 4.7 also support the original hypothesis as evidence indicating that women show no significant desire to stop childbearing until they have six or more children. Lastly, women's future intention to use contraception as presented in Table 4.8 is very low. Notably the intention of non users increased significantly between 1997 and 2005. Results indicate that over

65% of married women with three and four or more children do not intend to use contraception in the future. This is also a major obstacle to the institutionalization of family planning that will be difficult to reverse.

Contraceptive use in Senegal is low because women want to conceive large numbers of children. The presence of USAID in Senegal over two decades and their efforts to educate women about contraception have not changed the fact that women would ideally like to have six children. Despite this obstacle, USAID and the Government of Senegal have more recently changed how they have confronted this problem since the Repositioning Family Planning conference was held in Accra, Ghana in February 2005. Dr. Elhadji Mbow of USAID Senegal maintains that the new family planning repositioning strategy is focused upon the problem of unmet need and the catastrophic consequences on health and development. The focus is no longer placed on controlling fertility as was the case in the past.

So, our response developed in a bilateral agreement with Senegal and is founded upon family planning as a reduction of maternal and infant mortality and objective in prioritizing the reduction of unmet need. It is no longer the strategy to reduce the number of children in each family but to encourage couples to respect birth spacing ideally 36 months between each birth regardless of how many children they desire. In comparison to other strategies this is culturally easier to accept.<sup>4</sup>

Dr. Mbow also maintains that USAID Dakar prefers to put an emphasis on maternal and child health rather than telling women to limit births because this is a better strategy that will naturally limit births. To date USAID is currently working in conjunction with the Futures Group International on the RAPID program which is an electronic simulation that predicts the impact of family planning on various domains in areas such as the number of

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<sup>4</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009. Quotation translated from French to English by Yazmine Watts.

deaths prevented and the amount of money saved. The technical aspects of the program began in 2008 and USAID hopes to present it to the Senegalese Ministry of Health in summer 2009.<sup>5</sup>

Despite the new repositioning strategy, Dr. Mbow argues that policy leaders, development partners and community leaders do not pay enough attention to family planning in spite of its positive impact on the good of individuals and collectively. He maintains that to date the new family planning repositioning strategy has not received the dedicated attention of political decision-makers and community leaders nor has it received the required resources and the political and strategic support necessary for implementation.<sup>6</sup> So overall based on an analysis of the data and evidence collected it is expected that the next DHS scheduled for 2010 will not reveal significant decreases in the desired number of children or significant increases in the contraceptive prevalence rate.

### *Islam and Religion*

According to several studies it has been argued that religious factors have served as an obstacle to family planning in Senegal (Tomaro 1980, Tomaro et al. 1981, Wilson 1998, Piga 2003, Bowen 2004, Wickstrom et al. 2006). Many religious leaders in Senegal have argued that family planning is contrary to Islam. In order to test the validity of these arguments, DHS data on the reasons for not using contraception were analyzed. Table 4.9 presents data on reasons for not using contraception for married women, while Table 4.10 presents data on reasons for not using contraception for married men only. These data

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<sup>5</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009.

<sup>6</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009.



were selected in order to see if a high percentage of respondents cited Islam or religion as a reason for non usage of family planning.

Table 4.9  
Percentages of Women's Reasons for Not Using Contraception

	Main reason not to use a method				Number
	Wants more children	Respondent opposed	Spouse opposed	Religious prohibition	
<b>Senegal 2005</b>	14.3	21.9	9.1	10.6	5726
<b>Senegal 1997</b>	31.1	3.0	3.2	10.9	2687
<b>Senegal 1992/93</b>	40.5	3.2	2.2	10.6	2566

Reason for not using contraception:

Percent distribution of currently married women who are not using a contraceptive method and who do not intend to use in the future by main reason for not intending to use.

Not all response categories are included.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

The data in Table 4.9 indicate that many respondents were opposed to contraception, yet religious opposition was not the main reason for non usage. This evidence disproves the hypothesis that Islam and religious practices have a negative impact on the institutionalization of family planning. Between 1992 and 2005, the percentage of married women citing religious prohibition as a reason for not using contraception was consistent at about 10.6% rising only minutely to a high of 10.9% in 1997.

In 1992/1993 the main reason for not using contraception was women's desire to have more children; this was fairly high at 40.5%. The percentage of women indicating that the reason for not using contraception was because they wanted more children dropped to 31.1% in 1997 and there was a dramatic drop to 14.3% by 2005. On the other hand, it is interesting that respondent opposition as a reason for not using contraception has continued to increase over the years.

In 1992/1993, 3.2% of women cited personal opposition as a reason for not using contraception and by 2005 this percentage increased dramatically rising to 21.9%. This indicates that over the years, women's opposition to using contraception has continued to increase despite the efforts of USAID to promote the use of contraception. Women have also cited spousal opposition as a reason for non usage of contraception. The percentage of women citing spousal opposition has also increased over the years rising from 2.2% in 1992/1993 to 9.1% in 2005. In sum, it can be argued that respondent opposition and spousal opposition were subject to positive feedback. Data about married men's reasons for not using contraception follow.

Table 4.10

## Percentages of Men's Reasons for Not Using Contraception

	Main reason not to use a method				Number
	Wants more children	Respondent opposed	Spouse opposed	Religious prohibition	
<b>Senegal 1997</b>	23.8	11.9	0.1	24.9	1760
<b>Senegal 1992/93</b>	28.4	6.0	–	24.1	630

Reason for not using contraception (men):

Percent distribution of currently married men who are not using a contraceptive method and who do not intend to use in the future by main reason for not intending to use.

Not all response categories are included.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

Although data are only available for 1992/1993 and 1997 in Table 4.10, it is noteworthy to mention that a significantly higher percentage of men cited religious opposition as a reason for not using contraception in comparison to women. This can be expected since a majority of the religious, political and community leaders in Senegal are males. In 1992/1993 24.1% of men cited religious opposition as a reason for non usage and this

percentage increased slightly in 1997 to 24.9%. So it can be argued that in general men are more likely to cite religious opposition as a reason for not using contraception than women. Also, another main reason for not choosing contraception is because men want their wives to have more children. Again this social norm continues to serve as a barrier to the institutionalization of family planning.

Given the debate surrounding the impact of religion and Islam on family planning in Senegal it is important to mention a study conducted by Roudi-Fahimi (2004). Roudi-Fahimi's study on Islam and family planning focused on countries or territories with populations of 50% or more Muslims. Senegal was one of the countries that had 90% or more Muslims. In data presented on government views on the current fertility level and on policy access to contraception, the Government of Senegal's view was that the fertility level was too high and the government directly supported full access to contraception. These actions contribute to progress towards the institutionalization of family planning. Roudi-Fahimi argues that Islam should not be a barrier to family planning and governments should provide "financial and political support for culturally sensitive reproductive health programs that meet the needs of Muslim couples" (Roudi-Fahimi 2004, 8). In Senegal, there has been some opposition, yet the government is well aware of the problem and is working in conjunction with USAID to support, promote and expand family planning initiatives. Based on the evidence collected it is apparent that Senegal has provided more political vs. financial support for family planning initiatives. An analysis of government expenditures on health care over the period of study will be provided in Chapter VI.

As previously stated, one of the categories used in this dissertation to measure the institutionalization of family planning in Senegal is knowledge. USAID has committed a huge amount of funding towards education and family planning outreach over the past two decades. For example, as previously stated in Chapter III, USAID's 5-year, \$27 million *Senegal Child Survival/Family Planning Project* was especially designed to increase the use and knowledge of modern contraceptives in Senegal. This dissertation has also argued that many Muslim members of Senegalese society are educated by religious leaders. Based on this argument it will be interesting to see if knowledge about contraception varies by religious affiliation. Tables 4.11 and 4.12 present knowledge of modern and traditional methods of family planning by religious affiliation for the years 1986 and 2005.<sup>7</sup>

Table 4.11

## Percentages of Knowledge of Any Method of Contraception (1986)

Religion	Knows no method	Knows only traditional	Knows modern method	Total
Muslim	10.32	20.83	68.86	100.00
Christian	8.85	10.94	80.21	100.00
Other	0.00	28.57	71.43	100.00
Total	10.24	20.41	69.35	100.00

Source: Senegal DHS 1986.

<sup>7</sup> DHS data were unavailable for 1992/1993 and 1997.

Table 4.12

## Percentages of Knowledge of Any Method of Contraception (2005)

Religion	Knows no method	Knows only traditional	Knows modern method	Total
Muslim	8.69	0.62	90.43	100.00
Christian	2.92	0.56	96.53	100.00
Animist	0.00	0.00	100.00	100.00
No Religion	0.00	0.00	100.00	100.00
Total	8.43	0.62	90.71	100.00

Source: Senegal DHS 2005.

Based upon the data, it is clear that Senegalese people are very knowledgeable about modern methods of contraception. In 1986, Christians' knowledge of modern methods of contraception was 80.21%. Muslims had a lower rate of knowledge of modern methods of contraception at 68.86%. Very few Christians or Muslims knew no method of contraception with Christians at 8.85% and Muslims at 10.32%. More Muslims than Christians knew only about traditional methods of contraception with Muslims at 20.83% and Christians at 10.94%. Overall, Christians were slightly more knowledgeable about modern methods of contraception while Muslims were slightly more knowledgeable of traditional methods of contraception.

These results indicate that USAID was doing an excellent job in spreading knowledge about contraception after the completion of its first mission and during the early stages of its second mission. Since Christians were more knowledgeable about modern methods of contraception than Muslims, it can be argued that it is likely that influential Muslim leaders may not have been as active as Christian leaders in educating Senegalese people who relied upon them for information about modern methods of contraception.

This can be attributed to a lack of interest in family planning by religious leaders and/or leaders not promoting family planning because they feel it is contrary to Islam.

By 2005 there is a notable increase in knowledge about modern methods of contraception by both Muslims and Christians. There is a 21.83% increase in knowledge of modern methods of contraception among Muslims between 1986 and 2005 indicating strong evidence of positive feedback. Early efforts made by USAID to devote significant time and resources to knowledge had a favorable outcome. Christians also saw an increase in knowledge of modern methods of contraception between 1986 and 2005 with an overall increase of 16.32%. So as for knowledge, it is clear that both Muslims and Christians are very knowledgeable about modern methods of family planning; unfortunately these figures are not nearly as high for contraceptive prevalence and/or usage. As previously mentioned, USAID and the Government of Senegal have changed their family planning strategy as they realize that knowledge of contraception will not reduce the population growth rate as the DHS data indicate.

It was hypothesized that Islam and religious practices would have a negative impact on the institutionalization of family planning. Data from Tables 4.9 and 4.10 present major reasons for non usage of contraception among married women and men. It was expected that religious opposition would be very high. Religious prohibition was fairly consistent among women over the period of study, while data indicated that religious prohibition was a stronger reason for non usage among Senegalese men. Although the percentages for religious prohibition are not very high, it may be the case that many respondents did not want to specifically site religious prohibition as a reason for non usage. Respondent opposition among married women increased significantly between

1992/1993 and 2005 from 3.2% to 21.9%. Respondent opposition increased for men between 1992/1993 and 1997 from 6.0% to 11.9%. It is difficult to ascertain the exact reasons for respondent opposition when no specific reason was indicated. It is highly possible that many men and women are opposed for religious reasons, but chose to respond as generally opposed vs. choosing religious opposition as a questionnaire response. It may also be the case that previous studies have exaggerated the impact of religious opposition to family planning in Senegal.<sup>8</sup>

Overall, available data in Tables 4.11 and 4.12 indicate that both Muslims and Christians are fairly knowledgeable of modern methods of contraception. The difference between Christian and Muslim knowledge of modern methods of contraception was 11.35% in 1986, with Christians being somewhat more knowledgeable. Yet, by 2005 this gap was narrowed and Muslim knowledge increased to 90.43% while Christian knowledge increased to 96.53% making the difference in knowledge among Muslim and Christians 6.1%. So it can be concluded that religion does not have a negative impact on knowledge about modern methods of contraception, but it does have somewhat of a negative impact on reasons for non usage of contraception. So while Senegalese people are highly knowledgeable of contraception, most still choose not to use it due to the social norm of having a large number of children. USAID and the Government of Senegal will need to continue to address this obstacle as they work toward implementing new family planning goals and strategies.

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<sup>8</sup> Other studies who have argued that religious opposition is a major reason for non usage of family planning in Senegal include Tomaro 1980, Tomaro et al. 1981, Bowen 2004, and Wickstrom et al. 2006.

### *Polygamy*

As previously mentioned, polygamy has been a long tradition in Senegal. Polygamy is permitted by Islam and Senegal has the highest percentage of polygamy in West Africa. Senegalese men can have up to four wives and men normally have children with each of their wives. Since the social norm is to have many children and having many children gives women social prestige within society, wives in polygamous unions often compete against each other to give their husband the highest number of children. Given these circumstances, the likelihood of women in polygamous unions using family planning is quite low (Wickstrom et al. 2006, 10).

Table 4.13 presents the percentage of married women in polygamous and monogamous unions with the mean number of children born in each union type. These data were chosen for two major reasons. The first was to see whether the rate of polygamy has increased or decreased significantly over the period of study. Second, these data were chosen to determine if women in polygamous unions have more children than those in monogamous unions.

The data indicate that polygamy has decreased somewhat over the period of study, but not to a significant degree. The percentage of married women in polygamous unions was 46.5% in 1986 and by 2005 only decreased by 6.5% to a rate of 40%. Monogamous unions have increased, yet also at a slow rate. In 1986 the percentage of married women in monogamous unions was 53.5% and this rate only increased to 60% by 2005.



Table 4.13

Percentages of Married Women in Polygamous and Monogamous Unions  
With Mean Number of Children Ever Born, 1986–2005

	<b>% of Married women in polygamous unions</b>	<b>Mean number of children born in polygamous unions</b>	<b>% of Married women in monogamous unions</b>	<b>Mean number of children born in monogamous unions</b>
<b>Senegal 2005</b>	40.0%	4.61	60.0%	3.13
<b>Senegal 1997</b>	46.0%	4.91	54.0%	3.63
<b>Senegal 1992/93</b>	47.3%	5.04	52.7%	3.86
<b>Senegal 1986</b>	46.5%	4.64	53.5%	3.48

Source: Senegal DHS 1986, 1992/93, 1997, and 2005.

Based on the data, the mean number of children who were born in polygamous unions is greater than the mean number of children who were born in monogamous unions over the period of study. Polygamous unions produced 1.16 more children than monogamous unions in 1986 and by 2005 polygamous unions produced 1.48 more children than monogamous unions. Therefore the number of children born in polygamous relationships is subject to positive feedback. Overall, it can be argued that despite the mean number of children decreasing slightly in both polygamous and monogamous unions over the period of study, women living in polygamous unions have more children than those living in monogamous unions. The practice of polygamy in Senegal is a long and enduring social norm and institution that is unlikely to change, therefore polygamous unions will continue to produce more children than monogamous ones.

Based upon the evidence presented, Senegalese people are knowledgeable about family planning. Yet an important question of concern is: where are they most likely to

get their knowledge about family planning? Although Senegal is becoming more and more urbanized, a large percentage of the population resides in rural areas. People in rural areas are more likely to use the radio as their source of news and education. These people often do not have access to television, educational centers and other resources readily available in urban areas. Tables 4.14 and 4.15 present data on whether Senegalese people have heard a family planning message on the radio by union type, polygamous or monogamous for the years 1992/1993 and 1997.<sup>9</sup>

Table 4.14

Percentages Who Heard Family Planning Message on the Radio  
by Type of Union (1992/1993)

	No	Yes	Total
<b>Monogamous</b>	80.19	19.81	100.00
<b>Polygamous</b>	81.37	18.63	100.00
<b>Total</b>	80.75	19.25	100.00

Source: Senegal DHS 1992/1993.

Table 4.15

Percentages Who Heard Family Planning Message on the Radio by Type of Union (1997)

	No	Yes	Total
<b>Monogamous</b>	75.63	24.37	100.00
<b>Polygamous</b>	75.00	25.00	100.00
<b>Total</b>	75.34	24.66	100.00

Source: Senegal DHS 1997.

<sup>9</sup> DHS data were unavailable for 1986 and 2005.

In 1992/1993 most Senegalese people whether in monogamous or polygamous union had not heard a message about family planning on the radio. This is quite surprising given that many people in Senegal especially those who live in rural areas use the radio as their major source of news and information. It may be that USAID did not support the funding of radio ads to a large extent during this period of time or that the Government of Senegal played a role in limiting the promotion of family planning via the radio. It is important to note that some forms of social marketing in Senegal are banned as argued in Chapter III; mentioning brand names of products in the mass media is prohibited.

By 1997, the percentage of Senegalese people who heard about family planning through a message on the radio increased slightly from the period 1992/1993. As in 1992/1993, the percentages of monogamous and polygamous couples who heard about family planning via a message on the radio were very close. The increase for polygamous couples was slightly higher than that of monogamous couples in 1997. The percentage of polygamous couples who heard about family planning via the radio increased by 6.37% between 1992/1993 and 1997. The percentage of monogamous couples who heard about family planning via the radio increased by 4.56% for the same period of time. As of 1997, 75.34% of all couples, both polygamous and monogamous had not heard a message about family planning on the radio. As previously stated, social marketing by USAID and the Government of Senegal may have been weak during this time in addition to the fact that some forms of social marketing are not allowed in Senegal. Since many forms of social marketing for family planning in Senegal have been banned for more than two decades, in agreeing with Weir (1992), this policy decision will limit the options to those publicly promoting family planning in the future.

It was hypothesized that polygamy would have a negative impact on the institutionalization of family planning. Evidence supports the fact that polygamy is a strong contributing factor to the high fertility rate which is clearly a major barrier in institutionalizing family planning. As previously mentioned, women in polygamous unions are often in competition with other co-wives to produce more children for their husbands. If this trend continues, efforts at institutionalizing family planning will be negatively impacted. In an effort to measure knowledge, data were analyzed to determine whether being in a polygamous union or monogamous union had an impact on knowledge about family planning. It was determined that Senegalese people living in both types of unions had not heard about family planning on the radio to any significant degree. This is most likely due to the fact that radio messages were not largely used as a method of disseminating information about family planning between 1992 and 1997.

### Summary of Key Findings

Overall, the results of the data affirm some of the original hypotheses while refuting some others. It was hypothesized that marriage would have a positive impact on the institutionalization of family planning. The evidence did not strongly support this hypothesis, but there is some evidence that supports the positive influence of marriage. For example, married women have made progress through their attempts at trying methods of contraception yet continuation rates have remained very weak. Discussion about family planning was poor among married couples in addition to low family planning approval rates. Religious and cultural factors likely have a strong influence in married couples' decision-making and attitudes about family planning.

There is strong evidence to support the fact that social norms are a major barrier to the institutionalization of family planning in Senegal. Senegalese people have continued the tradition of having large families. Women ideally want six or more children and have no desire to stop childbearing until this ideal number is reached. Although many women have tried a method of contraception at some point in time, their future intention to use family planning is low.

As for religion, DHS data indicated that religious opposition is one of the reasons cited by Senegalese people for non usage of family planning. Senegalese men were more likely to cite religious opposition than Senegalese women. There was also an increasing level of individual opposition and it is likely that many people are opposed for religious reasons but did not choose to indicate religious opposition as their response to the DHS questionnaire for a variety of reasons. Regarding knowledge, both Muslims and Christians were highly knowledgeable of modern methods of family planning at rates above 90%, but unfortunately high levels of knowledge did not equate to high levels of usage.

The last factor that was analyzed was polygamy. It was found that polygamous couples had more children than monogamous couples over the period of study. Between 1986 and 2005, the mean number of children born in polygamous unions continued to exceed the mean number of children born in monogamous unions. By 2005, the mean number of children born in polygamous unions was 1.48 more children than the mean number of children born in monogamous unions. When examining the knowledge of polygamous couples vs. monogamous couples, it was found that both had similar levels of knowledge about family planning via radio messages. Unfortunately for both types of unions, most people had not heard about family planning via a message on the radio.

This chapter has discussed the impact of culture and religion in the institutionalization of family planning in Senegal. It uses Senegal DHS data, research and data collected during field research in Senegal and other related family planning research. Two categories of measurement which include legitimacy and knowledge were used to measure where Senegal stands in the institutionalization of family planning. As for legitimacy, use has been historically low due to social norms. Attitudes and acceptance of family planning have also been low among married Senegalese couples. While legitimacy levels did not prove to be very high, knowledge-wise it is clear that members of Senegalese society are informed, yet social norms such as the concept of having many children continue to serve as a barrier to the institutionalization of family planning.

In sum, it can be argued that social norms are the strongest obstacle in the institutionalization of family planning in Senegal. Many social norms in Senegal have been subject to path dependency and positive feedback. Some social conditions will be difficult to change (i.e., the large family) since Senegalese cultural traditions have not changed to any significant degree since 1986. Senegal has the highest rate of polygamy in West Africa and it is likely that the competition among wives in polygamous unions to provide their husbands with the largest number of children, especially sons, will also hinder efforts at institutionalizing family planning. It can be argued that marriage and religion have both negative and positive impacts on the institutionalization of family planning.

Another general conclusion that can be derived from an analysis of the data and historical developments in family planning in Senegal is the fact that 1997 was a critical juncture for family planning in Senegal. During this year significant progress was made in several areas such as a significant increase in the contraceptive prevalence rate, a sub-

stantial increase in the percentage of women intending to use contraception in the future and the highest level of approval among married couples for family planning. Unfortunately the period 1997 to 2005 has been a period in which progress has lagged. As of 2005, 65.2% of women did not intend to use contraception in the future and 21.9% of respondents were opposed to family planning vs. 3% who were opposed in 1997. If Senegal is to continue to make progress towards institutionalizing family planning, USAID and the Government of Senegal will need to continue to find ways to accommodate cultural and social norms into their overall family planning strategy.

Chapter V will analyze the impact of the decentralization of the health sector (which includes family planning) in the institutionalization of family planning in Senegal.

## CHAPTER V

### THE IMPACT OF DECENTRALIZATION IN THE INSTITUTIONALIZATION OF FAMILY PLANNING IN SENEGAL

#### Introduction and Chapter Overview

This chapter uses available regional data for the period of study from Senegal Demographic and Health Surveys (DHS), family planning related research on decentralization in Africa, archival data collected in Senegal during field research and information collected during interviews with USAID leadership in Senegal to analyze the impact of decentralization in institutionalization of family planning in Senegal. The chapter begins with an overview of the decentralization process in Senegal. The analysis section of the chapter begins with the hypothesis that decentralization will have a negative impact on the institutionalization of family planning in Senegal. Regional family planning data are presented during the pre-decentralization, decentralization implementation and post-decentralization periods. The chapter concludes with a summary of the findings. The primary finding is that the expected negative effects of decentralization were not observed.

#### Historical Overview of the Decentralization Process in Senegal

Over the past two decades, Senegal's health system has moved from a highly centralized program to a decentralized program. As part of the process, the Ministry of Health in Senegal has transferred planning and administrative responsibility to district



health officers who report directly to the central ministry (République du Sénégal, Ministère de l'Intérieur 1996, 2001). In 1996, the Government of Senegal decided to further the decentralization process by undertaking devolution, where authority within the health sector was transferred to semi-autonomous local government units. Responsibility for nine sectors, including health, was given to 372 local elected councils (10 regional, 48 municipal and 320 rural community councils). The operational budget established in 1996 required the central ministries to contribute money to a fund that was controlled by local councils (République du Sénégal, Secrétariat Général du Gouvernement 1997). The Ministry of Health was the largest contributor to the municipal and rural community councils, contributing nearly 90% of the budget (Wilson 2000, 1). The overall funding was provided in the form of a grant which had some line items included within the budget that were established by the ministries. Elected leaders were expected to follow the budget allocations within the first few years. Unfortunately many local leaders chose to use the money as they saw fit (Wilson 2000, 1). Wickstrom et al. (2006) argue that one major result of decentralization was that there were more than 800 elected health committees throughout Senegal and many of them did not have family planning high on their priority list.

The official decentralization process began in January 1997 with the implementation of the 1996 Decentralization Code where more than 14,000 local officials were elected to local government units (Wickstrom et al. 2006, 12). Early on there were several obstacles with the decentralization process. According to a study conducted by Wilson (2000) with local leaders in Senegal, many local leaders did not have a clear understanding of their roles. She maintains that 79% admitted that they did not have

sound knowledge of the laws and regulations pertaining to decentralization. Results from Wilson's study and a Government of Senegal technical report on decentralization and local governance argue that elected leaders were not involved in the health planning process within their communities which posed major problems (Wilson 2000, 2–3, République du Sénégal, Présidence 2001). Varying attitudes about family planning among local leaders also posed problems. While the results of Wilson's study indicated that 80% of local leaders were in favor of family planning in order to space births, 45% were opposed to the use of contraception in order to limit births (Wilson 2000, 2–3). Dr. Elhadji Mbow, USAID Senegal Maternal and Child Health/Family Planning Specialist, makes an argument similar to Wilson (2000), arguing that currently many local leaders are not trained and educated on the benefits of family planning. He also maintains that another problem is the fact that local leaders often use money for other purposes besides family planning. Overall he asserts that the work of local collectives remains weak. He argues that

With the support of the Ministry of Health we are looking for a better framework for planning, taking into account the question of health and notably reproductive health. ... We are doing a lot more training now with local leaders. We are encouraging leaders to prioritize their health budget to include family planning initiatives and programs.<sup>1</sup>

Ouedraogo (2003) argues that early on, the attitudes of local people towards decentralization were problematic, as many had attitudes of passive resistance to a new authority whose legitimacy was not recognized (101). In addition to these problems, some leaders and local people felt that family planning was not acceptable to Islam. Lastly, funding was also a major constraint. The grants received by local councils were small and not sufficient to maintain entire health posts (Wilson 2000, 3).

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<sup>1</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009. Quotation translated from French to English by Yazmine Watts.

In order to address problems with funding, a Sector-Wide Approach (SWAp) was implemented in 1997 and ended in 2005. Under this program a national strategy was created along with a budgeting process that included all donor contributions. The World Bank completed an evaluation in 2005, giving the program unsatisfactory ratings in nearly all of the most crucial areas including institutional capacity-building, resource flow, training and technical aspects. The final results also yielded poor health indicators. The World Bank felt that these unsatisfactory results were detrimental and would prevent Senegal from achieving the Millennium Development Goals (World Bank 2005, Wickstrom et al. 2006, 13).

So overall, it can be argued that implementing decentralization was a way to address dissatisfaction with the old centralized health approach, yet implementation has been problematic (Wilson 2000, Ouedraogo 2003, World Bank 2005, Wickstrom et al. 2006). Ouedraogo (2003) maintains that decentralization in Senegal will remain unsettled for several key reasons. His main argument is that local populations need to gain ownership of decentralized institutions if success is to be achieved. For example, he asserts that grassroots organizations identify more “with local level indigenous institutions than with those created during decentralization processes” (Ouedraogo 2003, 101). Another issue is the fact that the state often decentralizes functions in areas where it has not been able to achieve success on its own. Ouedraogo argues that progress with decentralization can only be achieved if those who are promoting decentralization consider local existing institutions and build upon them considering economic, social and cultural contexts. The promoters of decentralization and local governance must consider customary and indigenous institutions when creating laws and policies and when implementing change.

### Analyzing the Role of Decentralization With Regard to Family Planning

Based upon an analysis of the literature and data on decentralization in Senegal a hypothesis is implied about the impact of decentralization in the institutionalization of family planning. Given that other studies have argued that decentralization has weakened the focus on family planning (Wickstrom et al. 2006), local people are skeptical of new institutions created under decentralization (Ouedraogo 2003), confusion has surrounded the decentralization process (Wilson 2000), along with the fact that progress in Senegal towards achieving family planning goals has declined since 1997, it is hypothesized that decentralization will have a negative impact on the institutionalization of family planning.

The process of decentralization in Senegal has been implemented within the existing institutional structure. Therefore the concept of layering can be used as an analytic tool to explain how new initiatives have been implemented into the existing structure. The impact of decentralization varies across the four major regions in Senegal. New local leaders involved in the process have taken differing approaches in determining health priorities and health sector financing; therefore the concept of conversion can be used to explain why some regions have been more successful than others in institutionalizing family planning. Policy drift can also be used to analyze the impact of decentralization in the institutionalization of family planning in Senegal. Since the implementation of decentralization in 1997, incremental change has continued to occur yet the overall policy structure has remained intact. Some incremental changes have benefited family planning goals while others have hindered family planning progress.

*Knowledge of Contraceptive Methods by Region*

As previously argued in Chapter IV, knowledge about contraceptive methods in Senegal is high, indicating that USAID and the Government of Senegal have been successful in educating Senegalese people about contraception. In Table 5.1 regional data are presented on knowledge of contraceptive methods for the pre-decentralization period, during the implementation of decentralization and post-decentralization. By examining regional data on knowledge, one can determine if contraceptive knowledge increased or decreased during the post-decentralization period across regions.

The data indicate that decentralization did not have a negative impact on knowledge of contraception by region. The regional total average indicates that between the decentralization and post-decentralization periods there was a 10.6% increase in knowledge of modern methods of contraception and a 7.7% increase in knowledge of any method of contraception which includes methods such as periodic and long-term abstinence, natural family planning methods, traditional and/or folk methods. A higher increase in knowledge of modern methods of contraception also indicates that local leaders may have been more active in educating people about modern methods of contraception than previous studies have argued. For example, Wickstrom et al. (2006) argue that family planning was not a high priority among many local elected health committees, yet based on the results it is clear that local leaders were making progress towards educating people about contraception. Therefore it can be argued that many new local leaders were successful at conversion with their new roles as family planning educators. While knowledge of any method of contraception also increased, knowledge of modern methods increased most significantly.

Table 5.1

## Percentages of Knowledge of Contraceptive Methods by Region

	Knowledge of contraception		
	Knows any method	Knows modern method	Number of Respondents
<b>Region: Central</b>			
Post-Decentralization	92.6	91.3	3497
Decentralization Implementation	85.1	81.7	2197
Pre-Decentralization	73.3	69.4	1744
<b>Region: North East</b>			
Post-Decentralization	87.5	85.9	1774
Decentralization Implementation	73.6	65.5	1039
Pre-Decentralization	59.6	52.4	806
<b>Region: South</b>			
Post-Decentralization	98.4	97.6	1304
Decentralization Implementation	83.9	77.0	751
Pre-Decentralization	70.9	59.6	530
<b>Region: West</b>			
Post-Decentralization	97.7	97.1	3290
Decentralization Implementation	96.0	95.1	1863
Pre-Decentralization	88.4	86.5	1370
<b>Total: Total</b>			
Post-Decentralization	94.1	93.1	9866
Decentralization Implementation	86.4	82.5	5851
Pre-Decentralization	75.2	70.4	4450

Knowledge of contraceptive methods by background characteristics:

Percentage of currently married women who know at least one contraceptive method and at least one modern contraceptive method by region.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

The South region made the most progress in both knowledge about any method of contraception and knowledge of modern methods of contraception. Knowledge of any method of contraception increased by 14.5% between the decentralization implementa-

tion and post-decentralization periods, while knowledge of modern methods of contraception increased by 20.6%. This can be attributed in part to the fact that USAID was strengthening the capacities of regional and district health authorities with their decentralization efforts throughout 1996 and 1997 in select regions. Ziguinchor, located in the South region, was one of the prime target areas (PHR 1997, ix). Between the pre-decentralization and post-decentralization periods, knowledge of modern methods of contraception increased by 38% in the South region.

Based upon the evidence it can be argued that conversion was strong in the South region. Despite the fact that some religious leaders may have been opposed to family planning and faced obstacles in implementing new policies within the existing structure, new local leaders made a significant impact on contraceptive knowledge levels. As previously argued this may not have been expected based upon the findings in previous studies on decentralization in Senegal.

### *Current Use of Contraception by Region*

Previous chapters of this dissertation have argued that contraceptive use in Senegal has been traditionally low despite USAID's efforts over the past two decades. Accessibility to services has been an ongoing issue throughout the history of family planning in Senegal. Young unmarried women and adolescents are often denied family planning services and married women often require the written consent of their husbands (MSPAS 1995, Naré and N'Diaye 1996). A 1998 study by the Ministry of Health and the Population Council in Senegal maintains that during the period 1994 to 1998, family planning services for men and adolescents were available in only 6 out of 10 service delivery

points. While the costs of services were found to be affordable, services were offered during limited hours, 9:00 a.m. to 2:00 p.m. (Ministère de la Santé and the Population Council 1998, v). A report produced by the Ministry of Health and Prevention in Senegal on family planning services in Kaolack, a major city located in the Central region, argues that by 2002 only 25.9% of women aged 15 to 24 could name a point of service where they felt comfortable, compared with 43% of men. The report also maintains that only 2.9% of women in the region were using a method for twelve months (Ministry of Health and Prevention Senegal 2002, 26). Based on the fact that these studies occurred during the implementation of decentralization, it will be of interest to see if these factors negatively impacted contraceptive use across various regions. Table 5.2 presents data for current use of contraception by region during the pre-decentralization, decentralization implementation and post-decentralization periods. While contraceptive use has been traditionally low in Senegal, it is expected that some regions will have higher usage levels than others.

In the pre-decentralization, decentralization and post-decentralization periods, use of modern methods of contraception continued to increase. The most significant increases can be seen between pre-decentralization and decentralization implementation. These successes can be credited in a large part to USAID's *Senegal Child Survival/Family Planning Project (1992–1997)*. As previously argued in Chapter III, the project was especially designed to increase the use and knowledge of modern contraceptives in Senegal. Based on this evidence USAID was very successful in achieving this goal.



Table 5.2  
Percentages of Current Use of Contraception by Region

	Contraceptive method		
	Any method	Any modern method	Number of Respondents
<b>Region: Central</b>			
Post-Decentralization	5.9	4.9	3497
Decentralization Implementation	5.6	3.9	2197
Pre-Decentralization	3.4	2.2	1744
<b>Region: North East</b>			
Post-Decentralization	6.7	6.1	1774
Decentralization Implementation	11.1	5.1	1039
Pre-Decentralization	5.6	3.2	806
<b>Region: South</b>			
Post-Decentralization	14.6	12.0	1304
Decentralization Implementation	18.6	4.1	751
Pre-Decentralization	5.5	1.7	530
<b>Region: West</b>			
Post-Decentralization	19.8	17.7	3290
Decentralization Implementation	20.4	16.4	1863
Pre-Decentralization	14.5	10.1	1370
<b>Total: Total</b>			
Post-Decentralization	11.8	10.3	9866
Decentralization Implementation	12.9	8.1	5851
Pre-Decentralization	7.5	4.8	4450

Current use of contraception by region:

Percent distribution of currently married women by contraceptive method currently used by region.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

The decentralization implementation and post-decentralization periods can be characterized as periods of drift. While there were increases in modern methods of contraceptive use between the two periods, they were more incremental. There was an

exception, however—for example, between decentralization implementation and post-decentralization, modern methods of contraceptive use increased by 7.9% in the South, a substantial increase in comparison to the other regions whose increases ranged from 1% to 2.2%. Based on this evidence, it can be argued that health centers were doing a good job in providing access to modern methods of contraception at a reasonable cost as previously argued. It is also possible that local elected officials in the South region dedicated a larger portion of their health budget to family planning efforts, although no specific budget data are available. In addition, a final report of the PREMOMA project which began in 2004 argues that Ziguinchor and Bignona, cities located in the South region, were both very successful in service delivery performance between 2003 and 2006 (MSH 2006b).

Incremental change also occurred during the decentralization implementation and post-decentralization periods in use of any method of contraception. Unfortunately, these incremental changes showed decreases in use with the exception of the Central region. These findings indicate that although the use of modern methods also increased in the Central region between the decentralization implementation and post-decentralization periods, people were continuing to use other methods of contraception such as natural family planning methods. The fixed days method (MJF), also known as the cycle beads method, was introduced with the 2004 PREMOMA project (MSH 2006a). It is likely that this method was most popular in the Central region.

Despite decreases in any method of contraception throughout the region, the decentralization structure has remained the same. The North East Region had the biggest decrease in usage of any method at 4.4% while the South region also had a significant decrease at 4%. This indicates that modern methods of contraception were becoming

more and more popular over time. So it can be argued that decentralization had a modest negative impact on use of any method of contraception and a positive impact on use of any modern method of contraception.

*Regional Percentages of Women Who Have Heard About Family Planning  
by Radio and Television*

As previously argued in Chapter IV, a large percentage of the rural population relies upon the radio as a major source of information. Television is more popular in urban areas. Based upon these facts it is of interest to see how well USAID and the Government of Senegal did in terms of relaying information about family planning during the pre-decentralization, decentralization implementation and post-decentralization periods. Table 5.3 provides regional data on whether Senegalese people have heard about family planning on the radio and television.

Results indicate that significant progress was made in disseminating information about family planning via the radio and television during the decentralization implementation and post-decentralization periods. In the pre-decentralization period it is clear that the percentage of women who had heard about family planning via the radio and television was quite low across all regions. This also supports the findings in Chapter IV where over 80% of both monogamous and polygamous couples had not heard about family planning via the radio in 1992/1993.

Table 5.3

## Percentages Who Heard Family Planning on Radio and Television by Region

	Heard family planning on radio or TV					Total percentage and number	
	Radio & television	Radio only	Television only	Neither	Missing	Total	Number
<b>Region: Central</b>							
Post-Decentralization	20.8	24.6	2.7	51.9	0.1	100.0	4813
Decentralization Implementation	8.7	12.9	3.6	74.8	0.1	100.0	2931
Pre-Decentralization	3.4	13.5	2.0	81.0	0.1	100.0	2280
<b>Region: North East</b>							
Post-Decentralization	22.7	18.8	3.6	54.9	0.0	100.0	2340
Decentralization Implementation	7.5	8.6	2.6	81.2	0.0	100.0	1359
Pre-Decentralization	4.4	10.8	2.1	82.7	0.0	100.0	1012
<b>Region: South</b>							
Post-Decentralization	20.9	27.5	3.3	48.2	0.1	100.0	1609
Decentralization Implementation	5.3	15.3	1.5	77.9	0.0	100.0	1029
Pre-Decentralization	4.5	12.1	1.0	82.4	0.0	100.0	692
<b>Region: West</b>							
Post-Decentralization	34.6	11.3	11.1	42.8	0.3	100.0	5839
Decentralization Implementation	20.1	10.4	9.1	60.4	0.0	100.0	3274
Pre-Decentralization	14.1	10.1	5.2	70.6	0.0	100.0	2326
<b>Total: Total women</b>							
Post-Decentralization	26.6	18.6	6.3	48.3	0.1	100.0	14602
Decentralization Implementation	12.5	11.5	5.3	70.7	0.0	100.0	8593
Pre-Decentralization	7.6	11.7	3.1	77.6	0.0	100.0	6310

Heard family planning on radio and television:

Percent distribution of all women by whether they have heard a radio or television message about family planning in the last few months prior to interview by region.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>

Between the decentralization implementation and post-decentralization periods, the percentage of couples who heard about family planning via radio and television increased significantly. The total percentage of women who heard about family planning via the radio and television across all four regions increased by 14.1% between the decentralization implementation and post-decentralization periods. Overall, information was more likely to be relayed via the radio vs. the television. Information about family planning via the television was most popular in the West region and this can be expected as this is where the capital, Dakar, is located and the most urban region. Yet, while the percentage of women who had heard about family planning via television reached 11.1% in the post-decentralization period in the West region, USAID and the Government of Senegal did not rely highly upon the television to educate people about family planning. Overall in the post-decentralization period, 48.3% of women had not heard about family planning via the radio or television. Decentralization did not have a negative impact on whether women heard a message about family planning on the radio or television.

#### *Attitudes of Couples Toward Family Planning by Region*

Chapter IV presented data on attitudes of couples toward family planning as one measure of legitimacy. Based upon the evidence it was argued that legitimacy levels were low since approval of family planning continued to decline between 1997 and 2005. Table 5.4 presents regional data on attitudes of couples toward family planning. While it has already been established that approval declined in the post-decentralization period, it is important to see which regions had the highest percentages of disapproval.

Table 5.4

## Percentages of Attitudes of Couples Toward Family Planning by Region

	Attitude of couples towards family planning		Total		Number
	Both Approve	Both Disapprove	Spouse Approves	Respondent Approves	
Region: Central					
Post-Decentralization	14.4	32.5	16.4	42.5	3219
Decentralization Implementation	21.1	10.9	21.9	68.8	1864
Pre-Decentralization	17.2	21.4	19.2	58.6	1276
Region: North East					
Post-Decentralization	14.5	23.8	16.2	39.5	1546
Decentralization Implementation	18.1	5.5	19.9	62.9	762
Pre-Decentralization	21.4	20.1	23.5	57.4	477
Region: South					
Post-Decentralization	25.7	18.4	26.9	56.1	1278
Decentralization Implementation	22.2	13.9	23.7	65.4	626
Pre-Decentralization	23.1	10.5	26.0	64.1	373
Region: West					
Post-Decentralization	34.6	22.5	38.3	59.8	3195
Decentralization Implementation	43.3	5.7	46.0	82.3	1773
Pre-Decentralization	37.7	9.8	39.6	79.0	1200
Total: Total					
Post-Decentralization	23.0	25.6	25.4	49.9	9238
Decentralization Implementation	28.6	8.6	30.3	72.2	5024
Pre-Decentralization	25.9	15.8	27.9	66.4	3326

Attitudes of couples toward family planning:

Percent distribution of currently married non-sterilized women who know a contraceptive method by approval of family planning and by their perception of their husband's approval by region.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>

Overall, there was some progress made in couples' approval of family planning between the pre-decentralization and decentralization implementation periods, yet disapproval rates for family planning soared following the implementation of decentralization. Disapproval rates were highest among couples in the Central region with an increase in disapproval of 21.6% between the decentralization implementation and post-decentralization periods. The overall disapproval increased by 17% among couples in the four regions between the decentralization and post-decentralization periods. Based upon these results it can be argued that couples did not approve of the strong efforts of USAID and the Government of Senegal during the decentralization implementation and post-decentralization periods to expand and improve family planning programs. Therefore it can be argued that decentralization had a negative impact on couples' approval of family planning. As previously argued in Chapter IV, couples' attitudes toward family planning have been subject to positive feedback.

#### *Desire to Limit Childbearing by Region*

This dissertation has argued that cultural and social norms in Senegal encourage women to have many children. Data were presented in Chapter IV about women's desire to limit childbearing. It was concluded that not until women have six or more children does a high percentage of women desire to stop childbearing. Table 5.5 presents regional data on women's desire to stop childbearing for women with 4, 5 or 6 or more children during the pre-decentralization, decentralization implementation and post-decentralization periods.

Table 5.5

## Percentages of Desire to Limit Childbearing by Region

	Living children			Total
	4	5	6+	
Region: Central				
Post-Decentralization	19.2	30.1	60.2	20.2
Decentralization Implementation	15.1	33.7	58.5	20.6
Pre-Decentralization	15.0	25.0	48.5	18.2
Region: North East				
Post-Decentralization	19.3	29.3	55.5	17.8
Decentralization Implementation	18.5	36.0	50.8	18.2
Pre-Decentralization	14.9	33.3	51.5	18.7
Region: South				
Post-Decentralization	17.9	29.9	58.1	17.3
Decentralization Implementation	17.7	31.6	51.1	18.3
Pre-Decentralization	14.8	24.3	42.7	16.4
Region: West				
Post-Decentralization	29.3	51.4	69.8	25.1
Decentralization Implementation	28.7	32.1	70.2	30.4
Pre-Decentralization	20.7	32.2	60.6	25.6
Total: Total				
Post-Decentralization	21.9	36.7	62.2	21.0
Decentralization Implementation	19.6	33.3	61.2	23.0
Pre-Decentralization	16.6	28.3	52.7	20.4

Desire to limit (stop) childbearing:

Percentage of currently married women who want no more children by number of living children by region.

*Note:* Women who have been sterilized or whose spouses are sterilized, are considered to want no more children. Number of living children includes current pregnancy.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler.

<http://www.measuredhs.com>.

Incremental change has occurred in women's desire to limit the number of children they have, but significant progress has not occurred during the implementation of decentralization and in the post-decentralization periods. For example, during the post-



decentralization period, 55.5% of women in North East region with 6+ children did not want to have any more children; these percentages were higher among women in other regions. Women in the West region with 6+ children had the highest desire to stop childbearing at 69.8%. These results can be expected due to the fact that the North East is a fairly rural area where many people practice traditional beliefs. Islam is very influential in the Northeast city of Matam as Islam was brought to Senegal by the Toucouleur people who reside in this area. Dakar is the most urban city in Senegal, located in the West region where women are more liberal and the tendency is to have a smaller number of children due to the increasing costs of living.<sup>2</sup> In a 2009 interview, a senior USAID official in Senegal speculated that a recently initiated communications campaign may further reduce the desired number of children nationwide. These outcomes will be measured as part of the next DHS scheduled for 2010.<sup>3</sup>

So overall it can be argued that decentralization had a modest positive impact on women's desire to stop childbearing. In every region, between the decentralization implementation and post-decentralization periods, the percentage of women with four or more children who desired to limit childbearing increased. This indicates that progress towards educating women about the risks and dangers of having multiple children by using techniques such as child spacing is evident. Gains were smaller during the post-decentralization period in comparison to the pre-decentralization period, yet progress is still evident in each region. While the direction is positive, progress has slowed. It is expected that social and cultural norms will continue to hinder progress in this domain. Since disapproval for family planning increased in all four regions over the period of study, USAID and the

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<sup>2</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009.

<sup>3</sup> Dr. Elhadji Mbow, correspondence with Yazmine Watts, March 27, 2009.

Government of Senegal have a more difficult task at hand in encouraging women to limit the number of births.

*Need for Family Planning Services by Region*

As previously argued in Chapter I, unmet need for family planning in Senegal is the highest among countries in West Africa at 35% (Policy Project 2005, 2). The Senegal DHS uses three categories to measure need for family planning: unmet need, demand and percentage of demand satisfied. Women with an unmet need for family planning are “women of reproductive age who prefer to avoid or postpone childbearing, but are not using any method of contraception” (Maki 2007, 1). Family planning demand is the percentage of married women who desire to limit and space their births and therefore demand contraceptive information and services. The percentage of satisfied demand is the percentage of married women “who are fecund and are currently using modern contraceptive methods to stop or postpone the next pregnancy” (USAID 2008, 13). Addressing the problem of unmet need is one of the two major current areas of focus for USAID’s new family planning repositioning strategy. A 1995 analysis of family planning services in Senegal gives several reasons to which the increased unmet need and demand for services can be attributed to. One key problem was the fact that 40% of the service delivery points were health posts and 47% of the health posts were located in Dakar. There were also major problems with accessibility to services. For example, results of the study found that only 18% of service delivery points opened on time, over 53% opened one hour later than their posted hours. Many service delivery points had age restrictions while more than 50% required that clients have a minimum number of children before being given any method of

contraception. Lastly, price disparities among service delivery points, was another problem that needed to be addressed in order to make costs more universal (MSPAS 1995, 1–68). These are just some of the problems noted among several others. Table 5.6 presents

Table 5.6

## Percentages of Need for Family Planning Services by Region

	Need for family planning			Number
	Unmet need - total	Demand - total	% demand satisfied	
Region: Central				
Post-Decentralization	34.0	40.0	14.8	3497
Decentralization Implementation	37.1	42.7	13.1	2197
Pre-Decentralization	27.9	31.4	11.0	1744
Region: North East				
Post-Decentralization	29.1	35.8	18.7	1774
Decentralization Implementation	32.0	43.1	25.7	1039
Pre-Decentralization	30.8	36.4	15.4	806
Region: South				
Post-Decentralization	26.3	40.8	35.7	1304
Decentralization Implementation	26.6	45.2	41.1	751
Pre-Decentralization	24.5	30.0	18.2	530
Region: West				
Post-Decentralization	32.4	52.2	37.9	3290
Decentralization Implementation	37.1	57.4	35.5	1863
Pre-Decentralization	31.9	46.4	31.3	1370
Total: Total				
Post-Decentralization	31.6	43.4	27.2	9866
Decentralization Implementation	34.8	47.8	27.1	5851
Pre-Decentralization	29.3	36.7	20.4	4450

Need for family planning services:

Percentage of currently married women with total unmet need for family planning, total demand for family planning services and percentage of satisfied demand by region.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>.

regional data on need for family planning services by region for the pre-decentralization, decentralization implementation and post-decentralization periods.

During the pre-decentralization and decentralization implementation periods, unmet need for family planning services continued to increase across all regions. The total average increase was 5.5% for unmet need. The results indicate that during the pre-decentralization period and during the early phases of decentralization, services were insufficient to meet the needs of the population under the health system that was in place. Prior to 1997 the health sector was centralized yet, with the implementation of decentralization, new service delivery points and other structures and policies were created, grafting new elements onto the existing structure. Many leaders took on new roles and family planning services changed in many aspects including locations where services were offered, types of services offered and costs among other aspects. After the implementation of decentralization, progress in unmet need was made through the post-decentralization period, as the percentage of unmet need continued to decrease in all regions. The West region made the most progress where unmet need decreased by 4.7%.

Layering, conversion and drift can be used to explain how unmet need was addressed during the pre-decentralization, decentralization implementation and post-decentralization periods. It has been argued that between the pre-decentralization and decentralization implementation periods, unmet need increased, yet after the implementation of decentralization unmet need began to decrease. Between the decentralization implementation period and through the post-decentralization period, USAID and the Government of Senegal continued to add new components to the decentralization system making it more efficient and accessible. The data confirm that they were successful in these efforts.

Conversion can also be used to explain the unmet need trend. As previously argued, several new leaders took on roles with the implementation of decentralization. It is also apparent that local leadership was dedicated to addressing unmet need, especially in the West region. Despite early issues with decentralization, the structure remained unchanged and incremental change continued to occur. For example, in the South region unmet need for family planning declined slightly with decentralization, only increasing by 0.3% between the decentralization implementation and post-decentralization periods.

While progress for unmet need was made between the decentralization implementation and post-decentralization periods, progress in demand was not. The percentage of demand decreased between the decentralization implementation and post-decentralization periods, indicating that fewer women were seeking access to family planning services. Demand for family planning decreased most notably in the North East region by 7.8%. The large decrease in demand could indicate that people in this region were not continuing to receive information about the benefits of family planning. Leadership in the North East could have also changed between the decentralization implementation and post-decentralization periods, as this was quite common. New leaders may have been more conservative and/or opposed to family planning and therefore did not encourage it or dedicate sufficient funds to family planning initiatives. In all four regions, demand was highest during decentralization implementation period, yet unfortunately declined post-decentralization. These results indicate that efforts in promoting family planning may have been strong following the implementation of decentralization yet waned in the post-decentralization period. Overall, it can be argued that demand was negatively impacted as a result of decentralization.

The percentage of satisfied demand was lowest in all four regions in the pre-decentralization period. By the implementation of decentralization, the percentage of satisfied demand increased in all regions, most notably in the South region where the increase was 22.9% between the pre-decentralization and decentralization implementation periods. Between the decentralization implementation and post-decentralization periods, results were mixed across regions. The percentage of satisfied demand improved in the Central and West regions, while declining in the North East and South regions. The total percentage of satisfied demand for all four regions nearly stayed the same between the decentralization implementation and post-decentralization periods only increasing by a mere 0.1%. It can therefore be argued that decentralization had a modest positive impact on the percentage of satisfied demand.

Overall it can be argued that decentralization had a modest negative impact on need for family planning services. While it positively impacted unmet need, it negatively impacted demand. The total unmet need for all regions decreased by 3.2% between the decentralization implementation and post-decentralization periods, while total regional demand for family planning decreased by 4.4%. While USAID and the Government of Senegal may have been making strong efforts to address unmet need in the post-decentralization period, it is evident that education and outreach initiatives were weaker during this time and that local leaders were not doing a good job in continuing to educate people about the benefits of family planning that would encourage more women to seek information and services. Figures for the percentage of satisfied demand increased in some regions while decreasing in others. By the post-decentralization period, the total percentage of satisfied demand for all four regions only reached 27.2% indicating that there is still

significant work that needs to be done in this area. More funding and services will be required in all four regions in order to adequately address the percentage of satisfied demand.

*Mean Ideal Number of Children by Region*

One of the main obstacles to institutionalizing family planning in Senegal is the fact that women would ideally like to have six children. This argument was made based upon data presented in Chapter IV. Table 5.7 presents the ideal number of children by region during the pre-decentralization, decentralization implementation and post-decentralization periods. These data are useful in determining if the mean ideal number of children varies across regions in addition to seeing if decentralization had a negative impact on the mean ideal number of children.

Based upon the data the mean ideal number of children was well over 6 during the pre-decentralization period in three of the four regions with the exception of the West region where the mean was 5 children. By the decentralization implementation period, the mean ideal number of children decreased in all regions with the most notable results in the Central region, where the mean ideal number of children decreased from 6.4 to 5.6 between the pre-decentralization and decentralization implementation periods. Results for the mean ideal number of children varied among regions between the decentralization implementation and post-decentralization periods. The total results for all regions reveal that the mean ideal number of children increased slightly from 5.3 to 5.4 between the decentralization implementation and post-decentralization periods. These results reveal that there was no progress made in reducing the mean ideal number of children in the post-decentralization period. The social norm of women wanting to have many children

Table 5.7

## Mean Ideal Number of Children by Region

	<b>Total</b>
	<b>All women</b>
<b>Region: Central</b>	
Post-Decentralization	6.0
Decentralization Implementation	5.6
Pre-Decentralization	6.4
<b>Region: North East</b>	
Post-Decentralization	5.7
Decentralization Implementation	5.7
Pre-Decentralization	6.4
<b>Region: South</b>	
Post-Decentralization	6.0
Decentralization Implementation	6.1
Pre-Decentralization	6.7
<b>Region: West</b>	
Post-Decentralization	4.7
Decentralization Implementation	4.6
Pre-Decentralization	5.0
<b>Total: Total women</b>	
Post-Decentralization	5.4
Decentralization Implementation	5.3
Pre-Decentralization	5.9

Mean ideal number of children by background characteristics:  
Mean ideal number of children for all women by region.  
Number of respondents and response percentages unavailable.  
Source: Macro International Inc, 2009. MEASURE DHS STAtcompiler.  
<http://www.measuredhs.com>.

continued to endure. It can therefore be argued that decentralization had a modest negative impact on the mean ideal number of children. These results support the findings in



Chapter IV as decentralization conspired to reinforce social and cultural norms about the ideal number of children.

#### *Wanted Fertility Rates by Region*

It has been argued throughout this dissertation that women in Senegal want to ideally have about six children. Table 5.8 presents regional data on the wanted total fertility rate and the total fertility rate during the pre-decentralization, decentralization implementation and post-decentralization periods. The use of this data will help to investigate whether there is a disparity among the wanted total fertility rate and the actual total fertility rate.

During the pre-decentralization period wanted fertility rates were well over 5 children across the regions with the exception of the West region whose rate was 4.3 children. By the decentralization implementation period some progress occurred, but the North East and South regions remained stagnant at 5.3 and 5.9, respectively. Between the pre-decentralization and decentralization implementation periods, slight regional progress was made as the wanted total fertility rate was decreased in two out of the four regions, West and Central. Both the North East and South region made no progress. The total wanted fertility rate for all of the regions showed progress between the pre-decentralization and decentralization implementation periods with a 0.5% decrease. Progress between the decentralization implementation and post-decentralization periods was slight. The South region had a 0.6% decrease between the two periods in the wanted total fertility rate, while the Central region had a 0.4% increase in the wanted total fertility rate. The North East region remained stagnant at 5.3 between the pre-decentralization and post-decentral-

ization periods, while the West region had a very slight decrease of 0.1% between the two periods.

Table 5.8  
Wanted Fertility Rates by Region

	Wanted fertility rates	
	Wanted total fertility rate	Total fertility rate
<b>Region: Central</b>		
Post-Decentralization	5.4	6.1
Decentralization Implementation	5.0	6.2
Pre-Decentralization	5.6	6.3
<b>Region: North East</b>		
Post-Decentralization	5.3	5.7
Decentralization Implementation	5.3	6.2
Pre-Decentralization	5.3	6.5
<b>Region: South</b>		
Post-Decentralization	5.3	5.9
Decentralization Implementation	5.9	6.5
Pre-Decentralization	5.9	6.5
<b>Region: West</b>		
Post-Decentralization	3.3	4.2
Decentralization Implementation	3.4	4.7
Pre-Decentralization	4.3	5.5
<b>Total: Total</b>		
Post-Decentralization	4.5	5.3
Decentralization Implementation	4.6	5.7
Pre-Decentralization	5.1	6.0

Wanted fertility rates:

Total wanted fertility rates and total fertility rates for the three years preceding the survey by region.

*Note:* Rates are based on births to women 15–49 in the period 1–36 months preceding the survey.

Number of respondents and response percentages unavailable.

Source: Macro International Inc, 2009. MEASURE DHS STATcompiler. <http://www.measuredhs.com>

Unfortunately the results indicate that the total fertility rate has been historically higher than the wanted fertility rate. The data indicate that there is an acute problem that needs to be addressed. Women have been unable to control their fertility rate. Some factors that limit progress may include a lack of knowledge about family planning, disapproval of the use of family planning and social norms. The total fertility rate continued to decrease between the decentralization implementation and post-decentralization periods, indicating that decentralization did not have a negative impact in this domain, yet the total fertility rate during the post-decentralization period remains high at 5.3 and has only decreased by 0.7% since the pre-decentralization period. These results complement the findings on the mean ideal number of children in Table 5.7. Rapid progress was made prior to decentralization, yet slower progress after decentralization. The results found in Table 5.7 on mean ideal number of children along with results from Table 5.8 on wanted fertility rates could reflect diminishing marginal returns of investment in family planning and/or stronger local expressions of cultural norms.

### Summary of Key Findings

The findings in this chapter indicate that the expected negative effects of decentralization in the institutionalization of family planning were not observed. There has been progress made following decentralization, most notably in knowledge of modern methods of contraception. This might explain why the actual fertility rate in most regions is moving closer to the desired fertility rate. This indicates that local leaders throughout the regions were successful in the conversion process taking on new roles and in redirecting health priorities towards family planning. Decentralization had a positive impact on

use of modern methods of contraception across all four regions. These findings are a result of USAID's strong commitment to increasing knowledge and use of contraception.

Over the pre-decentralization and post-decentralization periods, the percentage of women who heard about family planning via the radio or television continued to increase although it was clear that radio and television were not resources that were widely used by USAID and the Government of Senegal to disseminate information about family planning. The attitude of couples toward family planning was negatively impacted as a result of decentralization. In agreeing with Ouedrago (2003), many Senegalese people may be resistant to the new institutions that have been created and are therefore in opposition. Religious factors can be accounted for part of the opposition, yet, as argued in Chapter IV, religion did not have as negative of an impact in the institutionalization of family planning in Senegal as originally hypothesized.

It was also found that decentralization had a modest positive impact on the desire of women to limit childbearing. Social and cultural norms have also been an obstacle to changing women's desire to have large numbers of children. As for need for family planning services, the results indicated that decentralization had an overall modest negative impact on unmet need, demand and the percentage of satisfied demand. The mean ideal number of children slightly increased from 5.3 to 5.4 between the decentralization implementation and post-decentralization periods; therefore it can be concluded that decentralization had a modest negative impact in this domain. Lastly, the total fertility rate continued to decrease over the period of study indicating that decentralization did not have a negative impact on fertility. As previously argued in Chapter IV, if Senegal is to continue to make progress towards institutionalizing family planning in the post-decentralization

period, USAID and the Government of Senegal will need to continue to find innovative ways to accommodate cultural and social norms into their overall family planning strategy.

Chapter VI will analyze the impact of the government contributions and donor agency funding in the institutionalization of family planning in Senegal.

## CHAPTER VI

### THE ROLE OF GOVERNMENT CONTRIBUTIONS AND DONOR AGENCY FUNDING IN THE INSTITUTIONALIZATION OF FAMILY PLANNING IN SENEGAL

#### Introduction and Chapter Overview

This chapter uses available government health expenditure and donor aid data for Senegal, Guinea and Mauritania obtained from the World Development Indicators (WDI) database, the World Health Organization (WHO), research studies on health expenditures and family planning in Africa and interview data obtained from USAID leadership in Senegal in order to analyze the impact of government contributions and donor aid in the institutionalization of family planning in Senegal for the period of study 1980–2005.<sup>1</sup> Previous studies have argued that based upon the increasing costs of financing health programs in developing countries, government data on health expenditures is a necessary component for policymakers and others involved in the process (Conly et al. 1995; Peters, Kandola, Elmendorf, and Chellaraj 1999). Peters et al. (1999) maintain that “in much of Africa, information that would be critical to policymakers, health system managers and consumers of health services is often not available, despite an increasing emphasis on data collection in many countries”(2). They also assert that the limited information that is available is rarely used (Peters et al. 1999, 2). Government health expenditure data over the period of study are also limited for Senegal and in order to examine how Senegal

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<sup>1</sup> Specific data on family planning expenditures for the countries of study are only available for the early 1990s.

compares to other countries in West Africa, health expenditure data from two neighboring countries with similar cultures and infrastructures to Senegal, Guinea and Mauritania, are presented.

The chapter begins with an overview of health funding trends in Africa and Senegal. The analysis section of the chapter argues insufficient government financial contributions to health and family planning leads to lower levels of institutionalization of family planning programs and services. Kates and Lief (2007) argue that donors provide almost all external health funding to low income countries, yet despite increases in donor funding for health, “a significant funding gap remains, much of which will need to be filled by donors” (1). Based upon this argument, a hypothesis is made about donor contributions to family planning which argues that a strong dependence upon USAID and other donor agencies for health funding leads to lower levels of institutionalization of family planning programs and services. As argued in Chapter I, foreign donor supported policy institutionalization is a common problem in developing countries. For example, Larson and Ribot (2007) argue that forestry policy in developing countries such as Honduras and Senegal have been defined by foreigners and the rural poor are disadvantaged and are not involved in the policymaking process. They also assert that, unfortunately, the playing field has been historically unfair and maintain that forestry policy needs to consider the interests of the poor. Since forestry policy, like many of the family planning policies and initiatives in Senegal, has historically come from the outside, the likelihood of the Government of Senegal fully owning family planning is less likely.

In analyzing Senegalese and other West African government contributions to health in addition to considering donor aid contributions, this chapter will measure

capacity-building, one of three categories used in this research to determine where Senegal stands in the institutionalization process. As argued in Chapter IV, one empirical question that can measure capacity-building is *how much money has the government of Senegal contributed to health expenditures and has it increased significantly over the period of study?* The chapter concludes with a summary of the findings. The primary finding in this chapter is that the persistence of funding from USAID and other donors eliminates the incentive for Senegal to take ownership or develop its own capacity.

#### Historical Overview of Family Planning Funding Trends in Africa and Senegal

Donor funding for family planning in sub-Saharan Africa has continued to grow over the past two decades. Between 1993 and 1994 alone, donor spending on family planning increased by 52% (FHI 2002, 6). “The proportion of total family planning expenditure made up by donor contributions is far higher in sub-Saharan Africa than in any other developing region” (FHI 2002, 7). In sub-Saharan Africa excluding South Africa, donor contribution to family planning is more than 70% (FHI 2002, 8).

It is very difficult to determine how much money African governments spend on family planning initiatives. As previously argued in Chapter V, family planning in Senegal has been integrated within the health sector along with decentralization and most local leaders do not report specific family planning expenditures. Including family planning within the overall health care budget has also been the trend in many other African countries. Another obstacle in gathering information about government spending on family planning is the fact that “government spending is often not available at the central level” and data must be directly collected from health facilities (FHI 2002, 8). Based on the availability



of government health expenditure data in sub-Saharan Africa despite its limitations, sub-Saharan African governments' spending on family planning is below average, they rely heavily upon donor aid and the likelihood of them being able to provide the resources necessary for the growing population without significant outside assistance is low (Conly et al. 1995; Peters et al. 1999; FHI 2002).

### Analyzing the Level of Government Contributions to Health

While it can be argued that government financial contributions to health are not adequate, health sector institutions have continued to evolve in response to the existing conditions. The concept of developmental pathways can be used to explain how the Government of Senegal along with USAID has responded to one of the major needs of new local leaders. For example, the Government of Senegal along with USAID is currently making efforts at improving health budgets by teaching local leaders how to incorporate family planning into their overall budgets. With the initial implementation of decentralization many local leaders were given large amounts of funding that were supposed to be dedicated to all aspects of health, yet many did not know how to divide up the funds among the various health sector priorities. This initiative is a way to increase the Government of Senegal's capacity even with the presence of USAID funding. This educational strategy is also a way to address the family planning problem without relying heavily on USAID funding, which is a step in the right direction for Senegal.

*Family Planning Expenditures in Senegal, Guinea and Mauritania During the Early 1990s*

As previously argued, data available on government contributions to family planning are limited. Conly et al. (1995) conducted a study on family planning expenditures in 79 countries during the early 1990s in order to assess the magnitude of annual spending on family planning by country and region in addition to identifying patterns of financing, "including the share of expenditures borne by governments, external donors and consumers" (Conly et al. 1995, 5). In Table 6.1 data are presented on family planning expenditures during the early 1990s for Senegal, Guinea and Mauritania.

Table 6.1

Family Planning Expenditures by Country and Source of Financing

Countries	Gov. \$	%	World Bank \$	%	Donors \$	%	Consumers \$	%	TOTAL \$
Senegal	0.2	2.3	3.0	34.5	5.2	59.8	0.3	3.4	8.7
Guinea	1.0	32.3	0.0	0.0	2.0	64.5	0.1	3.2	3.1
Mauritania	<0.1	NA	1.4	73.7	0.5	26.3	NA	NA	1.9

Family planning expenditures in Senegal, Guinea and Mauritania in the early 1990s in millions of dollars and source of financing.

NA= Not available

Source: Conly, Chaya and Helsing 1995, 11.

The data indicate that Senegal received the highest amount of donor aid and World Bank funds in comparison to Guinea and Mauritania with \$5.2 million from donors and \$3 million from the World Bank, totaling 94.3% of family planning expenditures during the early 1990s. The Senegalese government contributed 2.3% to family planning expenditures, while the Guinean government contributed a significantly higher percentage of funds to family planning expenditures at 32.3%. Mauritania received only 26.3% of

family planning expenditures from donors and relied heavily upon funding from the World Bank. These findings indicate that Senegal, like its neighboring countries, relied heavily on donor aid and World Bank assistance, yet in comparison to Guinea the government did not contribute a significant amount of its own funds to family planning expenditures. Although Guinea did not spend as much as Senegal on family planning expenditures, it is clear that the government made more efforts to contribute to family planning and received less outside assistance than Senegal, receiving no assistance from the World Bank.

The implications regarding World Bank support are important for a variety of reasons. Since the 1980s, through policy-based lending, the World Bank has dictated key policies to borrowing countries. Countries who receive funding in the form of loans from the World Bank have certain conditionalities attached to the loan that often refocus “the national economic priorities and development strategies of borrowing countries” (Edigheji and Amuwo 2008, 15). Borrowing countries are also required to contribute matching funds to those received from the World Bank. This strategy is powerful because it forces borrowing governments to spend money on programs dictated by the World Bank (Edigheji and Amuwo 2008, 17). Edigheji and Amuwo (2008) argue that “in the process, the ability of borrowing countries to adopt individual, independent or autonomous path to development is severely constrained” (17). Based upon these facts, countries who receive significant funding from the World Bank have policies that are largely dictated by the World Bank. Since Senegal and Mauritania received large amounts of World Bank funding for family planning during the 1990s, it can be argued that many of the policy choices were determined by the World Bank rather than being created by the respective governments. Family planning expenditures in Guinea were not supported by the World

Bank during the 1990s which could also indicate that Guinea was more autonomous in creating its own family planning strategies. Based upon the evidence, these circumstances make it quite difficult for Senegal and Mauritania in addition to other countries receiving large amounts of funding from the World Bank to create their own policy strategies.

*Family Planning Costs per User in Senegal, Guinea and Mauritania  
During the Early 1990s*

An analysis of how much users spend on family planning is a good indicator of efficiency. Conly et al. (1995) maintain that analyzing per user costs is useful for making cross-national comparisons of programs with countries that have similar costs structures. "The level of resources spent per user may also be a reflection of the quality of services," yet expenditure per user does not capture coverage and levels of access provided by family planning programs (Conly et al. 1995, 19). Table 6.2 provides data on family planning costs per user during the early 1990s for Senegal, Guinea and Mauritania.

Table 6.2

Family Planning Costs per User by Country

Countries	Family Planning Costs per User
Senegal	\$61.52
Guinea	\$45.39
Mauritania	\$99.64

Family planning costs per user in Senegal, Guinea and Mauritania in the early 1990s in U.S. dollars.  
Source: Conly, Chaya and Helsing 1995, 17.

During the early 1990s, Mauritania had the highest cost per user for family planning services. Senegal was second and Guinea had the lowest family planning cost per

user. In comparison to other African nations, Senegal's cost per user was still relatively high. Conly et al. (1995) maintain that per user costs were highest in sub-Saharan Africa with an average of \$29.12. Senegal's per user costs for family planning more than doubled this figure, which can indicate that spending was inefficient and/or costly in relative terms. Since contraceptive prevalence rates in Senegal remained low during the early 1990s, it was clear that high investments were required by the Senegalese government and the remaining costs were spread to the small percentage of family planning users. Based upon data presented in Chapter V, in 1992/1993, 7.5% of married women used any method of contraception, while 4.8% used any modern method of contraception. During the early 1990s data support the fact that family planning services were expensive for the average Senegalese citizen. This may have been an obstacle to usage prior to the implementation of decentralization where user fees became significantly lower.

*Per Capita Family Planning Expenditures and Source of Financing in Senegal, Guinea and Mauritania During the Early 1990s*

In comparison to other regions of the world, per capita family planning expenditures in sub-Saharan have been traditionally low. "The proportion of government expenditures on family planning and health serves as a barometer of the importance a government places on family planning and health issues" (USAID 1999b, 9). Analyzing government spending trends is also a good indicator for assessing future sustainability (USAID 1999b, 9); unfortunately specific family planning expenditures data are not available for periods beyond the 1990s. Table 6.3 presents data on per capita family planning expenditures by source of financing for Senegal, Guinea and Mauritania during the early 1990s.

Table 6.3

## Per Capita Family Planning Expenditures by Country and Source of Financing

Countries	Total	Government	World Bank	Donors	Consumers
Senegal	\$1.09	\$0.02	\$0.38	\$0.66	\$0.03
Guinea	\$0.49	\$0.16	\$0.00	\$0.32	\$0.02
Mauritania	\$0.85	\$0.00	\$0.63	\$0.23	\$0.00

Per capita family planning expenditures in Senegal, Guinea and Mauritania in the early 1990s in U.S. dollars.  
Source: Conly, Chaya and Helsing 1995, 21.

During the early 1990s, per capita spending on family planning in sub-Saharan Africa averaged \$0.54. Senegal was doing well at this time spending more than \$1.09, more than both Guinea and Mauritania and double the average for sub-Saharan Africa. Yet in comparison to neighboring Guinea, government contributions were low as was evidenced in overall family planning expenditures in Table 6.1. The Senegalese per capita expenditure was \$0.02 while that of Guinea was \$0.16. The Mauritania government did not make any contributions and relied heavily upon the World Bank.

Overall despite a high level of per capita spending on family planning, donors heavily contributed to per capita spending in Senegal at \$0.66 in comparison to Guinea at \$0.32 and Mauritania at \$0.23. During the early 1990s it was apparent that USAID was making a concerted effort in per capita spending in Senegal. As previously argued in Chapter III, USAID spent \$1.7 million under its first mission, the *Senegal Family Health Project (1981–1985)*, yet spent \$20 million under its second mission, the *Senegal Family Health and Population Project (1985–1992)*. After the first mission was completed in 1985, USAID perceived the first mission as partially successful, yet as argued in Chapter III, due to issues such as insufficient funding by the Government of Senegal and a lack of

appropriately trained personnel, more funding was needed if significant progress was to be achieved. So in order to address the failures of the first mission and in order to achieve higher levels of success, USAID invested an increased level of funding in order to achieve its family planning goals in Senegal.

*General Government Expenditures on Health for Senegal, Guinea and Mauritania During the 1990s and 2000s*

As previously argued, government expenditures on family planning and health are important indicators of a government's commitment to family planning. It is unfortunate that family planning expenditures data are not available for the entire period of study; therefore data on general government expenditures on health will be utilized to assess the trend in government health expenditures. Table 6.4 provides data on general government health

Table 6.4

Percentage of General Government Expenditures on Health by Country

Countries	Year									
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Senegal	36.8	34.7	36.0	37.1	37.2	38.0	39.4	38.5	40.3	36.1
Guinea	13.9	14.6	12.8	13.5	14.0	21.7	18.4	16.5	13.2	14.0
Mauritania	65.8	66.2	65.5	72.6	71.2	64.5	72.6	68.9	63.9	62.6

General government expenditures on health for Senegal, Guinea and Mauritania during the 1990s and 2000s. Source: Peters et al. 1999 and the World Health Organization 2009, Senegal, Guinea and Mauritania National Expenditure on Health.

General government expenditure on health (GGHE): "is the sum of outlays by government entities to purchase health-care services and goods. It comprises the outlays on health by all levels of government, social-security agencies, and direct expenditure by parastatals and public firms. Expenditures on health include final consumption, subsidies to producers, and transfers to households (chiefly reimbursements for medical and pharmaceutical bills). It includes both recurrent and investment expenditures (including capital transfers) made during the year. Besides domestic funds it also includes external resources (mainly as grants passing through the government or loans channeled through the national budget)."

(<http://www.who.int/whosis/indicators/2007NationalHealthAccounts2/en/index.html>)

Government health expenditure: Health spending from the government (local and central) budgets, as well as social insurance funds. External assistance, including donations from international NGOS, is not included as part of the government expenditure (Peters et. al, Annex 2, 36).

expenditures in Senegal, Guinea and Mauritania for all available years during the period of this study, 1980–2005. Data are unavailable during the 1980s and only partially available during the 1990s.

An analysis of the data indicates that Mauritania had the highest percentage of general government expenditure dedicated to health, followed by Senegal and Guinea. Senegalese government expenditures did not increase significantly over the period of study. As argued in Chapter V, Senegal went through important structural and funding changes with the implementation of decentralization in 1997. These changes may help explain why expenditures on health were lowest in 1997. Between 1999 and 2002, the percentage increased slowly, yet by 2003 contributions waned. Contributions increased in 2004, yet by 2005 government health expenditures reached a nearly all-time low, third to the years 1997 and 1998 at 36.1%. This figure indicates that the government had financial constraints and/or may not have been as committed to contributing to health as it was in previous years. These lower contributions may help explain why progress in some areas of family planning slowed by 2005. While percentages for government health expenditures were higher in Mauritania than in Senegal over the period of study, Mauritania also reached an all-time low in 2005. These results may indicate that these countries are more recently relying upon more donor aid in the health sector.

#### Analyzing the Role of Donor Contributions

As previously argued throughout the dissertation, USAID is the predominant donor in Senegal's health sector. When posed the question: "Does USAID have plans to end support for Senegal's reproductive health care sector within the next 10 years?",



former USAID Senegal Technical Assistance in AIDS and Child Survivor Advisor, Bradley Barker, maintained that USAID had no intention to do so.

USAID receives its funds from Congress and these funds are “earmarked” for particular purposes. I’m not aware of any intention of Congress to suspend funding for “reproductive health.” Unless Congress ceases to fund this activity or unless AID decides to close USAID/Senegal, I doubt it.

Mr. Barker also maintained that the next USAID strategy would run through 2014 in addition to stating that USAID strategies are always done in 8-year increments.<sup>2</sup>

Kates and Lief (2007) argue that “tracking donor funding for health is important for assessing their priorities and the availability of funding over time” (1). Since donors have played such a strong role in financially backing Senegal’s health sector, a hypothesis is made about donor contributions to family planning, arguing that a strong dependence upon donor aid for health funding leads to lower levels of institutionalization of family planning services and programs in Senegal. Specific data on donor contributions to family planning in Senegal, Mauritania and Guinea are not available; therefore three variables on general aid where significant data are available are chosen in order to assess the significance of external assistance. This is a challenge and makes it difficult to assess how much aid is being dedicated to family planning initiatives.

*Official Development Assistance (ODA) in Senegal, Guinea and Mauritania Between 1986 and 2005*

Official development assistance (ODA) is commonly a major source of external financing for developing countries. ODA funds are often used to support programs such as education, rural development, agriculture and health. ODA helps countries make

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<sup>2</sup> Bradley Barker, correspondence with Yazmine Watts, Summer 2004.

progress towards achieving basic development goals. Table 6.5 presents data on ODA funds to Senegal, Guinea and Mauritania during the periods of the four Senegal DHS studies. These data are important as they will allow one to see if ODA funds are increasing or decreasing in three West African countries.

Table 6.5

## ODA in Millions by Country

Countries	Year				
	1986	1992	1993	1997	2005
Senegal	576	662	493	423	686
Guinea	168	447	407	381	199
Mauritania	229	200	325	238	183

Official development assistance (ODA) for Senegal, Guinea and Mauritania between 1986 and 2005.

Source: World Bank. 2007. World development indicators (WDI) database.

Official development assistance (ODA): "Net official development assistance (ODA) consists of disbursements of loans made on concessional terms (net of repayments of principal) and grants by official agencies of the members of the Development Assistance Committee (DAC), by multilateral institutions, and by non-DAC countries to promote economic development and welfare in countries and territories in the DAC list of ODA recipients. It includes loans with a grant element of at least 25 percent (calculated at a rate of discount of 10 percent). Data are in current U.S. dollars" (World Bank, 2007).

ODA funds in Senegal have been much higher than those of their neighboring countries of Guinea and Mauritania. ODA assistance in Senegal has not been consistent over the period of study, both increasing and decreasing. By 1997, with the implementation of decentralization, ODA funds were lowest at a time when Senegal needed much help. Yet by 2005, ODA increased significantly, reaching a high in Senegal at \$686 million while ODA in both Guinea and Mauritania declined significantly. These results indicate that Senegal in comparison to other West African nations has more resources available to work towards achieving development goals which is positive. Yet they also

indicate that their reliance upon ODA is much higher than that of neighboring countries. Senegal seems to be the exceptional case in comparison to other countries. Donors have a keen interest in Senegal which is a unique country due to the fact that while it is predominantly Muslim, it is also both a stable democratic and secular country. Senegal has also traditionally served as a role model for other African nations in policymaking areas such as HIV/AIDS.

*Aid Per Capita in Senegal, Guinea and Mauritania Between 1986 and 2005*

Analyzing aid per capita is another way to gage the amount of aid a country receives from external resources. Aid per capita includes ODA and all other official aid. Table 6.6 provides data on aid per capita for Senegal, Guinea and Mauritania between 1986 and 2005.

Table 6.6

**Aid Per Capita in Millions by Country**

<b>Countries</b>	<b>Year</b>				
	<b>1986</b>	<b>1992</b>	<b>1993</b>	<b>1997</b>	<b>2005</b>
Senegal	82.2	79.3	57.4	44.3	57.1
Guinea	32.0	68.0	60.0	49.0	22.0
Mauritania	130.0	97.0	154.0	101.0	68.0

Aid per capita in millions of dollars for Senegal, Guinea and Mauritania between 1986 and 2005.

Source: World Bank. 2007. World development indicators (WDI) database.

Aid per capita: "Aid per capita includes both official development assistance (ODA) and official aid, and is calculated by dividing total aid by the midyear population estimate" (World Bank 2007).

Data indicate that aid per capita was highest in Mauritania during the period of study. Aid per capita declined in Senegal between 1986 and 1997 and then rose again by 2005. Aid per capita in Guinea reached a high in 1992 at \$60 million, yet by 2005 aid per capita dropped to \$22 million. Overall the results indicate that the donor commitment to official development assistance and official aid is declining. Since developing countries depend highly upon outside donor assistance in efforts to meet development goals, which includes controlling the fertility rate, drops in external aid pose a serious problem. So it can be argued that while donors continue to contribute millions of dollars in aid, these resources are not sufficient to meet the needs of poor countries. According to a fact sheet produced by the United Nations Development Program (UNDP), in Senegal “annual disbursements for 1998–2002 fell short of commitments by an average of 45%, in a country that relied on aid for one-third of public spending on health” (UNDP 2005). These facts raise a serious question about whether Senegal will be able to find ways to achieve its family planning goals without significant outside donor assistance.

*Aid as a Percentage of the Gross National Income (GNI) in Senegal, Guinea and Mauritania Between 1986 and 2005*

Aid as a percentage of the Gross National Income (GNI) is important for analyzing the significance of aid in a country's GNI. Historically, while the population in Africa has continued to grow, wealth in Africa has decreased. Therefore external assistance is needed to help the overall GNI. Table 6.7 presents data on aid as a percentage of the GNI in Senegal, Guinea and Mauritania between 1986 and 2005.

Table 6.7

## Aid as a Percentage of the GNI by Country

Countries	Year				
	1986	1992	1993	1997	2005
Senegal	14.3	11.3	9.0	9.2	7.9
Guinea	10.0	14.0	13.0	10.0	6.0
Mauritania	27.0	14.0	27.0	17.0	11.0

Aid as % of the Gross National Income (GNI) for Senegal, Guinea and Mauritania between 1986 and 2005.

Source: World Bank. 2007. World development indicators (WDI) database.

Aid as % of the Gross National Income (GNI): "Aid includes both official development assistance (ODA) and official aid. Ratios are computed using values in U.S. dollars converted at official exchange rates" (World Bank, 2007).

GNI: "GNI (formerly GNP) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. Data are in current U.S. dollars" (World Bank, 2007).

As the results above indicate, aid as a percentage of GNI has continued to decrease over time in all three countries. Aid as a percentage of the GNI is highest in Mauritania at 11%. Aid as a percentage of the GNI is much lower than expected and has steadily declined in Senegal. As of 2005 it was a mere 7.9%. Aid as a percentage of the GNI is lowest in Guinea and has also steadily declined. These findings indicate that donors are contributing a lot less than the original hypothesis expected which argued that high donor aid will limit government contributions to family planning. Unfortunately, as aid has gone down, government contributions and overall capacity have not increased enough to fill the existing gap.

### Summary of Key Findings

The findings in this chapter indicate that donor support for family planning was substantial during the early 1990s, comprising 58.9% of the family planning expenditure in Senegal while the Government of Senegal contributed a mere 2.3%. Guinea, a neighboring country to Senegal, had a much stronger contribution at 32.3%. This evidence supported the fact that donor reliance was high in Senegal and government contributions were low. While family planning costs per user were highest in Mauritania in the early 1990s, Senegal's cost per user was also high, with a figure more than double the average for sub-Saharan Africa. High costs per user may have also been an obstacle to usage for Senegalese people in the pre-decentralization period. It was also found that per capita family planning expenditures in Senegal were low in comparison to Guinea. Overall despite having the highest level of per capita spending on family planning at \$1.09, donors heavily contributed to per capita spending in Senegal at \$0.66 in comparison to Guinea at \$0.32 and Mauritania at \$0.23. The percentage of general government expenditures dedicated to health in Senegal was low by 2005 at 36.1% indicating the government was suffering from budgetary constraints and/or commitment levels to health declined. Overall, based upon the data that were available, the original hypothesis was confirmed that insufficient government contributions lead to lower levels of institutionalization of family planning policies and programs.

An analysis of the data on ODA and donor aid provided results that are more difficult to interpret. It was hypothesized that a strong dependence upon USAID and donor agencies for funding leads to lower levels of institutionalization of family planning policies and programs in Senegal. While ODA has both declined and increased over the

period of study, it is difficult to assess the impact on family planning since specific data on donor contributions to family planning for all three countries is unavailable. It can be argued that donor aid is not sufficient to meet the development needs of many poor countries. ODA and aid per capita increased between 1997 and 2005 in Senegal, yet ODA and aid per capita decreased significantly in Guinea and Mauritania. While Senegal may have been in a somewhat of a better financial position by 2005 than their neighboring countries, funding may still be insufficient. Despite some evolution throughout the period of study, based upon the evidence, institutionalization of family planning will be difficult to achieve solely by the Senegalese government. If donors do not continue to increase the amount of aid given and the Government of Senegal does not make significantly higher contributions, family planning in Senegal may lack sufficient progress. This was evidenced based upon the data presented in Chapters IV and V, where it was concluded that family planning progress waned between 1997 and 2005. As previously argued, although USAID has no intention of ending support for development initiatives anytime soon, the Government of Senegal needs to make a strong financial commitment to health and seek alternative sources of financing as donors cannot always contribute the amount of funds needed to make substantial progress.

## CHAPTER VII

### DISCUSSION AND CONCLUSION

#### Overview of Research Findings

This study revealed several important findings about the institutionalization of family planning in Senegal. Historical institutionalism was used as a theoretical framework to analyze family planning outcomes. In Chapter IV, path dependency and more particularly the concept of positive feedback was most compelling for explaining the impact of social and cultural norms in the institutionalization of family planning. It was found that due to strong cultural heritages and established norms, Senegalese people do not deviate from their traditional customs.

In Chapter V, the concepts of layering, conversion and policy drift were also useful for explaining the impact of decentralization in the institutionalization of family planning. These concepts helped to explain how new initiatives were implemented into the existing structure, how local leaders were able to take on new roles, and how incremental change occurred while the overall policy structure remained the same.

Lastly, in Chapter VI developmental pathways helped to explain how the Government of Senegal and USAID responded to the changing conditions and needs of local leaders. Since many leaders were not familiar with budgeting, the Government of Senegal along with USAID has recently begun to educate local leaders on how to plan for family planning programs and services within their overall health budgets. Overall it can be



argued that path dependency and layering, conversion and policy drift were the most pertinent concepts for analyzing family planning in Senegal. The following section will provide an overview of the major research findings.

In Chapter IV, an analysis was done in order to measure the impact of cultural norms and religion in the institutionalization of family planning. The chapter made a strong case for why successful implementation of fully institutionalized family planning programs and services is not possible in Senegal. The results revealed that social norms serve as a barrier to the institutionalization of family planning in Senegal. Some strong social norms include the tradition of the large family that has endured in Senegal and the fact that women would ideally like to have about six children. These cultural challenges are common across most of Africa and the Middle East in addition to other developing countries. In the developing world, it is economically rational to have six or more children so that children can assist the family financially by helping out on the farm and by other income generating means in addition to supporting their parents in old age.

Based upon a review of previous studies on decentralization, it was hypothesized in Chapter V that decentralization would have a negative impact on the institutionalization of family planning. The results revealed that arguments made in previous studies may have exaggerated the negative impact of decentralization. The expected negative effects of decentralization were not observed. The most progress was made in educating people about family planning, as knowledge of contraceptive methods increased significantly following the implementation of decentralization.

The results of Chapter VI confirm the original hypothesis that a strong dependence upon donor aid for health funding leads to lower levels of institutionalization of family

planning services and programs. Results also indicate that donor aid has decreased over the period of study and may not be sufficient to meet all of Senegal's development goals. These results were not expected. Overall it can be argued that while Senegal has made some progress towards family planning goals, full institutionalization of family planning policies and programs has not been achieved. This research is important as it revealed many of the barriers to institutionalization which include strong cultural and social norms and insufficient financial resources.

**Assessing Degrees of Institutionalization in Family Planning:  
Where Does Senegal Stand in the Institutionalization Process  
(Legitimacy, Knowledge and Capacity-Building)?**

For the purposes of this research, three categories of measurement were established in order to assess degrees of institutionalization of family planning policies and programs in Senegal. Chapter IV measured legitimacy by posing questions about family planning usage and attitudes about family planning. Based upon the evidence it can be argued that legitimacy levels were weak in Senegal as of 2005. After 1997, disapproval of family planning among married couples continued to increase.

In Chapter V, regional data were used in order to analyze married couples' attitudes toward family planning. Disapproval increased across all regions and between 1997 and 2005; disapproval increased most notably by 21.6% in the Central region. Two other regions also had double digit increases in disapproval between 1997 and 2005. The North East had an increase in disapproval by 18.3% while the West region had an increase of 16.8%. As for usage, while there have been some gains in the use of modern methods of contraception, usage levels remain low. In 1986, the contraceptive prevalence rate for

married women aged 15–49 was 11.3% and as of 2005 was 11.8%. So despite having high levels of knowledge about contraception, usage levels have not increased to a significant degree.

A next category of measurement is knowledge. By far, knowledge levels about methods of family planning in Senegal are high. In Chapters IV and V data were presented on knowledge about contraceptive methods. Results in Chapter IV revealed that by 2005, the percentage of Muslims who were knowledgeable about modern methods of contraception was well over 90% while knowledge among Christians was over 96%. Regional data about knowledge of contraceptive methods were presented in Chapter V. The results confirmed those found in Chapter IV. By 2005, total knowledge of any method of contraception for all four regions was 94.1% while total knowledge of any modern method of contraception was 93.1%.

Chapter VI used data on family planning expenditures and donor aid in order to assess Senegal's capacity-building. It was found that during the early 1990s Senegal's family planning expenditures were low and insufficient. Family planning cost per user was also high, which can be a factor that contributed to low usage levels in 1990s. The Government of Senegal's per capita family planning expenditure was also low in comparison to neighboring countries. The percentage of general government spending on health was also found to be weak in comparison to Mauritania. Overall, donor aid in Senegal decreased over the period of study indicating that Senegal may need to make a stronger financial commitment to health and/or find alternative resources to achieve family planning objectives.

### The Future of Family Planning in Senegal

Despite the general finding that progress in family planning has slowed since 1997 in Senegal, USAID and the Government of Senegal, along with local leaders, are continuing to find creative ways to promote family planning. Yet financing in the health sector will continue to serve as a major issue of concern. If fertility levels do not decline significantly in the near future, Senegal will be faced with a growing gap between needs and financial resources. Although progress has been made towards decreasing unmet need, significant future funding will be needed in order to help resolve this problem. In a report addressing major family planning issues in Senegal, Janowitz, Measham and West (1999) argue that “even if donor and government funding is projected optimistically, countries will be faced with a large and growing gap between needs and resources” (1). Although it was confirmed in an interview with USAID leadership that USAID has no intention of ending support to family planning in Senegal, finding sufficient funding to cover health costs is becoming more difficult and donors cannot carry the entire burden. Bradley Barker, former USAID/Senegal Technical Assistance in AIDS and Child Survivor Advisor, maintained that USAID’s \$15 million annual contribution is “significant” yet relative to the economy of Senegal, a pittance<sup>1</sup>. This claim supports the fact that Senegal, like many other sub-Saharan African nations, needs to continue to find other sources of revenue to support family planning objectives.

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<sup>1</sup> Bradley Barker, correspondence with Yazmine Watts, Summer 2004.

### Policy Implications for Donors and Policymakers

The findings of this research will be of interest to donors and those involved in the policymaking process. Senegal is only one of many Muslim countries in sub-Saharan Africa. Based upon the fact that contraceptive prevalence did not increase significantly over two decades, as is the case in other African nations, it will be of importance for those involved in the policymaking process to carefully consider social and cultural norms in their family planning strategies. This should be a major priority.

As previously argued, after two decades of working towards controlling the fertility rate, USAID and the Government of Senegal have more recently changed their family planning strategy to one that is more culturally acceptable. Other countries may find success in encouraging couples to practice birth spacing for the safety of mothers and children rather than simply telling people to limit the number of children they have.

A valuable lesson learned by donors and policymakers in Senegal is access to family planning and high levels of knowledge does not equate to high family planning usage levels and will not reduce the population growth rate if women want six or more children. Therefore it will be of interest to see if significant changes are achieved when the 2010 DHS results are released. Other countries can use Senegal's new family planning repositioning strategy for guidance and they can also see how successful the strategy has been based upon 2010 DHS results.

Also lessons may be learned from the decentralization process in Senegal. Ouedraogo (2003) argues that "since the 1980s, decentralization has become a key development theme in Francophone West Africa" (1). Other countries like Senegal may be dissatisfied with centralized approaches to health. With the exception of Senegal,

decentralization is a relatively new phenomenon in Francophone West Africa so there is much to be learned from the successes and failures of Senegal's decentralization program. By studying the Senegal case, other West African policymakers can better understand how to tailor their specific family planning programs while considering the impact on existing local institutions. Since local leaders play an important role in society, policymakers need to put a great emphasis on including them in all aspects of the decentralization process.

There were several lessons learned from the Senegalese case that can be of use to other countries. First, local leaders need extensive training on the importance of family planning; otherwise, many will have no incentive to promote and support it as was the case with some local leaders in Senegal. Many local Senegalese leaders did not bother to include family planning in their overall health budgets. Also, in order to run a more efficient program, elected leaders should be involved in the health planning process (Wilson 2000). Another lesson learned from the Senegalese case is the idea that there should be more emphasis on involving members of civil society. Citizens must be informed in addition to feeling comfortable expressing their health needs to their local leaders. Without the support of the local people, progress will be hindered.

#### **Broader Implications: The Problem of Foreign Donor Supported Institutionalization**

As previously mentioned in Chapter I, Senegal is facing a problem with policy and program institutionalization. Senegal does not currently have the necessary resources to run a family planning program on its own. Relying heavily on donor aid makes it difficult to see how committed the government is to achieving family planning goals.

Assessing the degree of Senegal's autonomy is also difficult to determine since many African governments are in need of funding and may follow the path led by donors vs. creating their own. This argument was put forth in Chapter VI in terms of the consequences of receiving aid from the World Bank.

During an interview, a senior USAID official maintained that policy ownership is a necessary component to a successful family planning program. He maintained that USAID works in tandem with the Government of Senegal to help them achieve family planning objectives:

I believe that policy "ownership" is absolutely necessary. This is why we don't get out ahead of the Government of Senegal decision makers. This makes it all happen a lot slower than it might need to happen from our point of view but nonetheless it is clear to me that if the decision makers and implementers don't end up "owning" the policy choice, it will never be implemented.<sup>2</sup>

Based upon Mr. Barker's argument, policy choices in Senegal are made with the guidance of USAID and USAID does not dictate the policy path. Yet Levine (2007) argues that "USAID has played a dominant role among donors as the source of money, information and ideas about family planning in the developing world" (8). A vital question of concern is: how susceptible is Senegal to donor pressure? Does the government agree with USAID on strategies just to get the funding? How much say do they actually have in the family planning strategy? While the Government of Senegal works with USAID towards family planning goals, many of the ideas and strategies about controlling the fertility rate have come from the outside. One will only be able to assess the level of commitment to family planning by the Government of Senegal if USAID ceases to fund the family planning

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<sup>2</sup> Bradley Barker, correspondence with Yazmine Watts, Summer 2004.

program as it has done in other African countries after decades of support. However, this is unlikely to occur anytime in the near future because the problem is so acute in Senegal.

### Suggestions for Future Research

The research conducted used data for the four Senegal DHS studies: 1986, 1992/1993, 1997 and 2005. Based upon the work of USAID in conjunction with the Government of Senegal it will be of interest to see if the new family planning repositioning strategy improves family planning outcomes and, if so, to what extent. The new strategy of reducing the number of children using birth spacing for the purposes of reducing maternal and infant mortality is more appealing to Senegalese people. A future study adding the results of the next 2010 DHS is an option for a future project. Since this project was a single case study of Senegal, a future cross-country study with other Muslim West African nations can be useful for those involved in the policymaking process throughout West Africa. A study which interviews several local leaders involved in family planning will be of use in order to see how leaders feel about family planning in addition to finding out how much money they are dedicating within their health budgets to family planning initiatives. A study that includes government family planning expenditures over the past decade would also be useful since as, to date, specific family planning expenditures data are only available from Conly, Chaya and Helsing's (1995) study.



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