

Using Network Analysis for Social Change

Breaking Through the Barriers of Unmet Need for Family Planning in Mali

Authors: Heather Buesseler, Irit Sinai, Susan Igras, Mariam Diakité, Rebecka Lundgren



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The research for this report was originally conducted under the *Terikunda Jekulu Project* in Mali with the support of the Cooperative for Assistance and Relief Everywhere (CARE), the Center for Development and Population Activities (CEDPA), and the Association of Support in the Development of Activities of Population. The project was relocated to Benin in the aftermath of political unrest in Mali in July 2012 and renamed *Tékponon Jikuagou*. The research and analysis featured in this report, while representative of the Mali context, nevertheless continue to inform *Tékponon Jikuagou's* research and intervention in Benin, which are led by the Institute for Reproductive Health at Georgetown University in partnership with CARE Benin and Plan International.

This assessment is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. AID-OAA-A-10_00066. The contents are the responsibility of the Project and do not necessarily reflect the views or policies of USAID or Georgetown University.

Tékponon Jikuagou Project
Institute for Reproductive Health
Georgetown University
4301 Connecticut Avenue, N.W., Suite 310
Washington, D.C. 20008 USA

irhinfo@georgetown.edu
www.irh.org/projects/tekponon_jikuagou/

ACKNOWLEDGEMENTS

The authors would like to acknowledge the contributions of Sarah Castle, as the lead researcher on the first phase of ethnographic research; Mamadou F Camara for leading the team of interviewers for the in-depth interviews and conducting preliminary analysis of the data; Begonia Fernandez and Thierno Faye for support with coding and analysis and Jennifer Keuler for overall program and research support and coordination, including editing and formatting of this report.

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EXECUTIVE SUMMARY

In Sub-Saharan Africa, despite the significant resources that have been allocated for family planning (FP) programs, unmet need for FP remains high, and sustained FP use remains elusive. In Mali, nearly twenty years of FP programming efforts have led to high levels of knowledge about various methods of FP, yet increases in unmet need have outpaced increases in contraceptive prevalence.

The way the reproductive health community has defined unmet need has led to an emphasis on supply side and service delivery issues. Less consideration has been given to the social contexts and relationships within which individuals and couples make reproductive health decisions, including important social influencers, such as family members, friends, and community leaders. The USAID-funded project, which loosely translates to “friends connecting friends through social networks,” was designed to assess the effectiveness of a set of social network interventions to address unmet need for FP and improve reproductive health outcomes in Mali.

In order to design the intervention package, the project first needed to understand the cultural context and social network dynamics, in particular power relations and gender norms as influences of family planning use. The first year of the project was dedicated to intensive formative research in two villages¹ in Mali, Bougouba in Mopti Region, and Koloni in Sikasso Region. This research was designed using a three-phase “ethnographic sandwich” approach:

1. **Ethnographic research:** Multi-faceted ethnographic research comprised of focus group discussions, in-depth interviews, social mapping, and network analysis via pile sorting. These results were used to provide the context and the appropriate terminology to use for the social network mapping census.
2. **Social network census:** Complete mapping of the two villages to elucidate the nature and extent of relationships among adults in the study population. It also generated data about respondents’ attitudes toward FP and child spacing and their perceptions of attitudes of the individuals in their networks.
3. **In-depth interviews:** Review of the data generated from the social network census, including maps, yielded many questions about the characteristics of network actors, what kinds of information flowed through the networks, and how that information was diffused. In-depth interviews were designed to fill in those gaps and provide a more complete understanding of network dynamics.

Individuals (or couples) make family planning choices, yet their attitudes are influenced by their social networks. Thus, it is necessary to understand all aspects of the environment in which people make family planning decisions. The “ethnographic sandwich” allowed us to explore individual attitudes, as well as network dynamics and social norms, in order to incorporate the relevant aspects into a comprehensive program design.

Results from the first phase of ethnographic research are reported fully elsewhere.² This report offers detailed account of the findings from the subsequent two phases of formative research. It also serves to

¹ Names of both villages have been changed to protect confidentiality.

² Castle, S. (2011) Using Network Analysis to Address Unmet Need in Mali: Women’s social networks, family planning use, and unmet need: formative research findings from Terikunda Jékulu. Washington, DC.: Georgetown University Institute for Reproductive Health for the U.S. Agency for International Development

fully contextualize and interpret the results from all three phases, as well as offer implications for program development not only for Terikunda Jékulu, but also for other demand-generation and/or social network programs that address unmet need for family planning in similar contexts.

PHASE 1: ETHNOGRAPHIC RESEARCH

The objective of the ethnographic research was to examine the spread of influence and family planning information through social networks in order to evaluate the role of social networks in facilitating or hindering family planning acquisition and use.

Bougouba village was found to have low contraceptive prevalence and low unmet need. Large, dense networks in this village reinforced negative messages and misinformation about FP. FP users in this community had small, open networks that enabled them to use secretly. Koloni village, on the other hand, had higher contraceptive prevalence and higher unmet need than Bougouba. Both FP users' and non-users' networks were small and dense. For users, their networks served to reinforce and sustain their use, and female marital kin helped some overcome spousal disapproval.

In general, low use and high unmet need in Bougouba can be explained by the intense circulation of rumors and misinformation fuelled, in part, by the existence of an active Islamic association which strongly disapproves of family planning for religious reasons. In Koloni, non-use seemed to be more related to a lack of information and, above all, access. In both settings, age hierarchies directed the flow of information and few couples had discussed FP. For some, female marital kin sometimes helped women overcome spousal disapproval by enabling users to hide their family planning use or to advocate to sons /husbands about its benefits.

In comparing the two villages, these findings suggest that social networks strengthen positive messages among FP users, but reinforce negative attitudes among those with unmet need. Network influences, whether facilitating or inhibiting, have an important impact on individual-level behaviors vis-à-vis family planning.

The results from Phase 1 informed the next phase of the “ethnographic sandwich”, by providing the context and the appropriate terminology to use for the social network mapping census. It also flagged areas of interest to explore further using quantitative methods.

PHASE 2: SOCIAL NETWORK CENSUS

In this phase of the formative research, we identified and interviewed all women of reproductive age, and all men married to women of reproductive age, in both Bougouba and Koloni. The interviews included questions about the respondent's background, followed by current and previous contraceptive use, as well as attitudes and behaviors related to the decisions of how many children to have, when to have another child, and whether or not to use contraception.

The crux of the interview was identifying the respondent's social network. The respondent was first asked to name up to three people who provided him/her material support (i.e., money loans, gifts of food or clothes); up to three people who provided him/her with practical support (i.e., child care, help with chores); up to three people who provided him/her with cognitive support (people they could learn from); and up to three people who provided him/her with emotional support. After these people were named, respondents were asked several questions about each of the individuals they named—their relationship

with them (i.e., relative, friend, community leader, etc.), whether the individual lived in the village or not, how close they were, and the perception of the respondent of the named individual's attitudes toward family planning. This resulted in a complete map of each village's social network of people of reproductive age and in particular network influences on family planning and unmet need.

These data were analyzed using the social network statistical analysis package, UCINET, to reveal the relative influence of each individual in the village. Scores were calculated to identify individuals who were influential (those who were named by more people), individuals who were connectors (those who connect segments of the network), and individuals who were isolated (those with few people in their networks and not well-connected). Illustrative maps of the village networks were also generated and are found in the main report.

Only 12% and 10% of women in the two villages (9% and 7% of men) were using a modern contraceptive method at the time of the survey. Surprisingly, few village residents were using a traditional method. We estimate unmet need for family planning to be about 30% of women and 34% of men, in both villages.

Not surprisingly, respondents in Koloni had more positive attitudes towards FP than respondents in Bougouba; yet men in both villages had more favorable attitudes than women towards FP. Women, more than men, in both villages cited access issues, such as cost or availability. Interestingly, more men than women were concerned with possible side effects or other negative health consequences of contraceptive methods. In both villages, with regards to self-efficacy to space births, about three quarters of men with unmet need, but only about half of women, thought that the timing of children was beyond their control (i.e., associated with the 'God's will' concept prevalent in Mali).

Turning to the social networks, the majority of individuals cited by women in their practical and emotional networks were female relatives (mothers, sisters, co-wives, and other female relatives), while a quarter of women in both villages cited a male relative in their material network. Men nominated mostly male relatives and male friends or colleagues to their networks. Very few people outside of a person's immediate social sphere – including health providers, religious or other leaders - were cited in any type of network.

Respondents were asked their perception of the attitudes of individuals they named in their networks toward contraceptive use, and their perceptions were compared to the nominated individual's stated beliefs. Results show no concordance between perceived and actual approval of family planning. For example, in both villages, although about one third of respondents who were cited as approving of family planning were in the top quartile of the family planning approval index we created (they approved), another third were in the bottom quartile (they disapproved). A similar analysis comparing FP attitudes between husbands and wives showed that men held more favorable attitudes towards contraceptive use than their wives realized.

Finally, the village network maps revealed dramatically different networks in each of the two villages. In Koloni, adults (both men and women) who used FP were more connected within their network than were people with no need or unmet need for FP. This makes sense, due to greater acceptance of FP in Koloni. On the other hand, in Bougouba, where negative attitudes about FP prevail, individuals with no need or unmet need for FP were more connected to networks than FP users were.

These findings suggest that communication and behavior change strategies designed to reach the tipping point for FP use may be more effective if they consider not only the ways in which community attitudes towards FP influence use but also how social networks, in particular the type and density of social connections, influence FP use.

PHASE 3: IN-DEPTH INTERVIEWS

In-person, semi-structured interviews were conducted with 12 men and 12 women in Bougouba and Koloni, respectively, for a combined total of 48 interviewees. Participants were drawn from a pool of social network mapping census respondents who had indicated their willingness to be contacted for this phase of the study. Interviews focused on: 1) the content, quality, and frequency of FP information shared between members of the community; 2) participants' understanding of their own need for FP based on their fertility intentions and desires; and 3) participants' reasons for not using FP.

Diffusion of FP Information varied by setting and by gender. In Bougouba, many social barriers prevented women and men from openly discussing their fertility, child spacing intentions, and FP use. Koloni residents, on the other hand, faced fewer barriers, indicating that they discussed such topics more openly, especially women. We also found that information was diffused differently between men and women. Men tended to discuss fertility, child spacing, and FP one-on-one with friends of their same generation or in small peer groups. They rarely had these discussions with family members or in formal group settings. Women, on the other hand, had such discussions most often with female family members and discussions were more likely to be intergenerational, including mothers, mothers-in-law, and sisters-in-law. Women were also more likely to discuss and debate ideas in formal group settings, like *tontine* meetings.

Women and men turned to trusted (influential) friends for advice and information, while family planning “expert resources” were not part of their social groups, which prevented correct FP information from circulating through networks. Respondents turned first to family and friends in close geographic proximity whose opinions mattered most to them, whether or not they had the best FP information. Thus, whatever FP attitudes and information individuals in respondents' inner circles held—positive or negative—were being diffused. Paradoxically, health agents were seen by respondents as trusted sources of FP information—including relais, traditional birth attendants, and other health care providers—but were not necessarily the people that respondents trusted most or sought out when they had questions.

Gender differences in social networks were also at play in terms of influential people. Men who were influential within networks tended to hold formal leadership positions, while influential women tended to hold informal leadership positions.

People with few social network connections are most at risk for experiencing unmet need. Participants defined as 'isolates' with unmet need did not confer as much as others with family and friends, and were less likely to seek information or advice from health providers. Because this group is less exposed to new information, they may lack the information they need to make any level of decision about family planning.

Respondents were overwhelmingly supportive of the concept of healthy timing and spacing of pregnancies, citing the health and well-being of women and children as primary advantages, but also had mixed reactions to FP use. Men voiced strong support for child spacing, as it enabled them to better care and provide for their families. Limiting births, however, was seen as distinctly separate from the concept of spacing births, and was not socially acceptable.

In both Bougouba and Koloni, nearly all respondents expressed a strong belief that children were a gift from God, and that their number and timing is predestined (although almost none associated these beliefs to religious teaching or religious leaders' opinion). At the same time, many stated it was not contradictory for couples to play a role in determining the timing of children, and consequently the number of children they will have.

Participants did not distinguish between modern and traditional methods when discussing FP, instead accorded all methods similar value. When discussing modern contraception, women had highly positive attitudes towards contraceptive methods, and generally recognized the link between FP use and successful birth spacing. Men were less informed about methods, and therefore expressed greater concerns about and resistance to their use. Often, they approved of modern FP in principle, but viewed it as something for others, such as wealthier or more educated people.

Misinformation about methods appeared to be minimal and method-specific, results that distinctly contrasted with the ethnographic research, which revealed intense circulation of rumors in Bougouba.

While many respondents indicated regular communication with their spouse about child spacing, talking about FP methods is less common. Prevailing gender norms may underlay the dynamics that influence couple communication and FP use. In general, women value FP communication more than men, but many are reluctant to raise the subject for fear of a negative reaction, because they believe their husbands' lack of communication signals disinterest or disapproval. For their part, men expressed little interest in communicating on FP. Although very few expressly opposed it, some doubted their wives' ability to understand FP-related topics and others simply assumed their wives agreed with their FP views and hence it did not require discussion. Both men and women unanimously believed men are the final decision-makers in regard to FP use, a consensus that makes conversation seem unnecessary for many couples.

Reactions to FP use in the public sphere create other social obstacles. Several participants pointed out that those using FP may be publicly criticized as unfaithful or otherwise lacking in character. They noted, however, that these attitudes were directed only towards women—men whose wives used FP were not criticized. Other participants stated that FP use is a personal choice that is not anyone else's concern.

Concerns about the cost of contraception and access to FP information and services were also cited as obstacles to FP use, but seemed less influential than gender and FP stigma-related challenges.

Misunderstanding about postpartum return to fertility may also affect a couple's decision to seek an FP method during at-risk moments in the reproductive life course. Many female participants knew that women were at risk of becoming pregnant while breastfeeding, even before the return of menses, but an important proportion of women simply believed that postpartum pregnancy risk was dependent on a woman's individual biology. Men had little or no knowledge about postpartum fertility. Hence, many were regularly experiencing periods of unmet need because they assumed that they were not at risk of pregnancy.

PROGRAMMATIC IMPLICATIONS

The three-phase “ethnographic sandwich” –ethnographic research, social network census, and in-depth interviews—yielded a nuanced understanding of the complex dynamics of social networks, FP information flow, social and communication barriers to FP uptake, and the nature and perception of individual FP need in the study communities. While the March 2012 coup d'état in Mali forced the project to relocate to Benin, the similarities between Mali and much of West Africa regarding the dynamics of unmet need, the social context and barriers to FP uptake and sustained use, and the history of FP programming, lead us to believe that the formative research conducted in Mali provides useful information to guide development of demand generation programs in other countries. Program implications in this section, therefore, are written for a broader context than Mali. In order to ground the discussion and recommendations, we use a

series of illustrations from our social network pilot in Benin to demonstrate how these findings can be applied to develop social network interventions to reduce unmet need. (The Mali findings were adjusted for Benin, based on additional formative research after the project relocated.)

Interventions that help women and men accurately identify their need for contraception while also aiming to reduce periods of unmet need over the reproductive life course will likely have greater long-term impact on achieving fertility desires. Research results clearly showed that unmet need is a dynamic concept. Changes in participants' need status from the time of the household survey to the time of the in-depth interviews illustrate in a tangible way that individuals cycle through different FP need statuses during the reproductive life course. At the same time, many participants had unrecognized need for FP – they perceived that they had met need or no need for a variety of reasons, but were in fact at risk of becoming pregnant – especially in the postpartum period. These participants also had a higher level of misinformation about FP. Thus, the need for accurate information and education that will enable woman and men to recognize their need for FP must be a first step in programs aiming to address unmet need. Programs should also consider taking a life-course perspective of unmet need by endeavoring to identify and reduce segments of time during which adults experience unmet need.

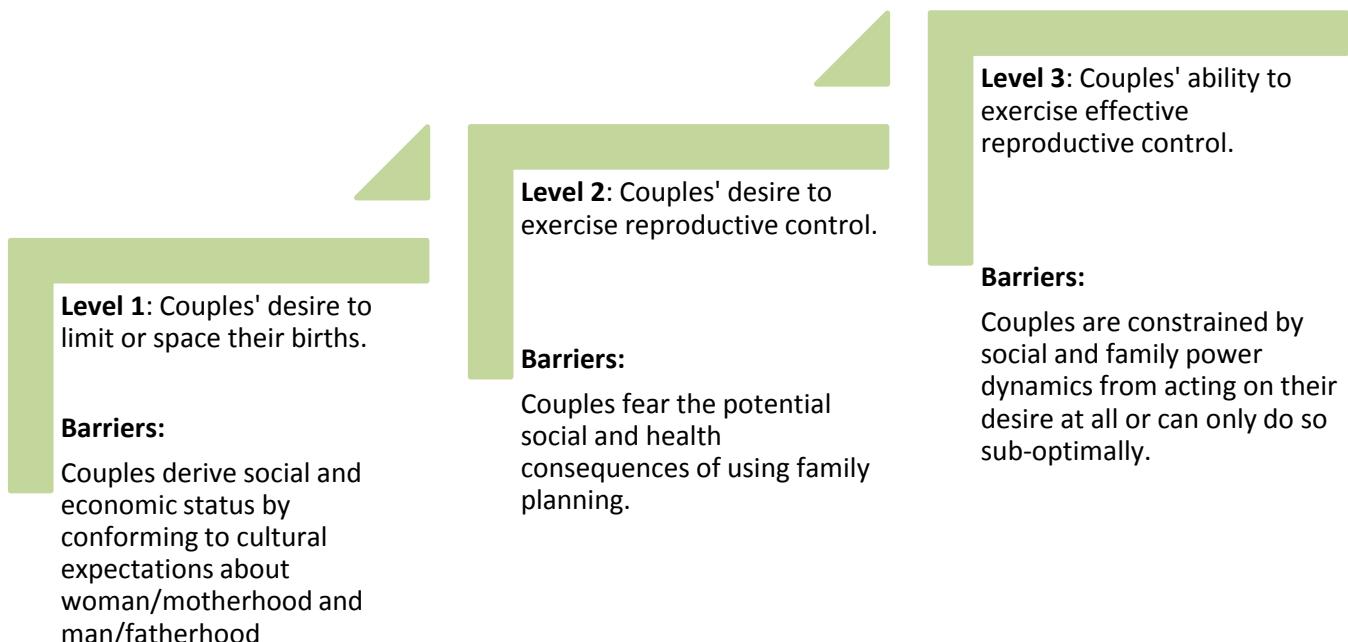
Mobilization through networks requires moving away from message-based approaches to reflective community dialogue, which may encourage more positive attitudes and more accurate information about FP, which will filter into social groups that are hostile to or uninformed about FP. Research revealed that social networks reinforce whatever messages are currently circulating; positive messages among FP users are strengthened through conversation with other users, but negative attitudes are reinforced among those with unmet need. It also revealed conflicting attitudes about FP that must be discussed publicly in order to clarify the true issues underlying reluctance to use FP. Reflective dialogue approaches create space for discussion and debate of such paradoxes.

Social network interventions need to create strategic linkages with FP services to ensure accurate information on contraception and service availability circulates within a community. The most trusted sources of FP information (trained health providers) were much less influential than social network members (close friends, family), who often had very little FP knowledge. Thus, it is important to encourage community-wide dialogue to spark critical examination of both positive and negative FP messages, as well as to create opportunities for expert sources of information to publically address rumors or myths and provide accurate FP information.

Programs need to address gender barriers by systematically integrating gender into the intervention design. As a result of deeply entrenched social norms, women lack both autonomy and self-efficacy to achieve their fertility desires. In fact, a woman's FP "needs" may be determined entirely by her husband because social norms dictate that a woman must abide by her husband's wishes. Such norms discourage couple communication about these issues, and may result in women feeling afraid to broach the topic with her husband. Integrated intervention approaches, materials, monitoring tools and indicators, and communication channels must be developed to address gender barriers within the context of this social reality.

A recent framework developed by the International Center for Research on Women (ICRW) clarifies types of barriers to demand for FP from a women's reproductive perspective. We have slightly modified the framework to focus on couples rather than women only, since decisions about FP use are often made in a couple context. This revised framework provides a novel understanding of gender barriers related to couples' reproductive control. It posits three interconnected levels of demand and explains the barriers at each level - desire to space or limit births, desire to do something about spacing or limiting, and ability to act on those desires. While research, including this study, shows that FP attitudes are influenced by social

networks, decisions about FP use are ultimately made as individuals (or couples). In designing programs to reduce unmet need for FP, this framework can be useful in structuring gender elements within a broader social network strategy. It may help to “sequence” program interventions, as discussed below, fully realizing that the barriers are operating not only at individual but also at community level.



At Level 1, the primary goal is to encourage shifts in social and gender norms to promote reproductive control as a *conscious* choice for couples. The role of ‘God’s will’ was a prominent theme in people’s contraceptive decision-making. While very few (less than 2%) of census participants felt their religious beliefs prohibited FP, over 70% stated “God’s will” as the reason they were not currently using FP. Couples in Mali also face strong pressure from families and societal norms to prove their fertility early in marriage because traditional ideas of manhood and womanhood are still tied to the ability to produce a large number of children. It seems these two ideas are distinct concepts, with the former expressing a fatalism that is characteristic of societies early in the transition from high to low fertility. The overwhelming deference to “God’s will” in childbearing indicates that reproductive decisions are not yet within the “calculus of conscious choice”³ for couples.

³ Coale, A.J. (1973). The demographic transition reconsidered. *International Population Conference, Liège*, Vol. 1:53-72. Liège: International Union for the Scientific Study of Population.

Some ways the social network intervention project in Benin, Tékponon Jikuagou addresses fatalism, gender and other social barriers to FP

- Support influential women and men to model attitudes and behaviors , such as communicating new ideas that value smaller, healthier families
- Focus reflective dialogue materials to increase awareness of conscious choices about healthy timing and spacing of pregnancies, while avoiding discussion of FP in the context of desired family size and limiting births, given that FP is acceptable in this context only for spacing
- Develop reflective dialogue questions that allow groups to explore conceptions and paradoxes of woman/motherhood and father/fatherhood to help women and men critically examine underlying attitudes towards fertility and childbearing

The primary goal at Level 2, where couples already desire to space births, but hesitate to exercise reproductive control, is to increase understanding and acceptance of contraceptive options. The primary obstacle at this level is fear of being stigmatized as a social deviant—someone who is unfaithful to their partner or does not desire children at all. This fear often causes FP users to be silent about their use, thereby reinforcing the perception that FP use is uncommon, and further entrenching discrimination and stigmatization, despite strong normative support for child spacing. In addition, a lack of knowledge about contraceptive methods and fears that use will lead to infertility, sterility, or menstrual changes, pose additional challenges to individuals' willingness to use FP.

Some ways the social network intervention project in Benin, Tékponon Jikuagou addresses FP stigma and myths

- Support influential community women and men to model (e.g., publicly communicate) the social acceptability and safety of FP use, to help people realize that approval of FP is widespread and reduce stigma of FP users
- Use reflective dialogue discussions within influential groups, combined with radio broadcasts of actual community dialogues by women and men, to create a safe space for sharing FP experiences and perceived benefits of FP use
- Create linkages between community health workers and health center staff and influential individuals and groups to open channels of communication between FP experts and those who influence diffusion of information and attitudes
 - Dispelling myths about FP methods
 - Raising awareness about FP methods, their availability, and tradeoffs

The primary goal at Level 3 is to create an enabling environment for women and couples to confidently and effectively make and act on their fertility decisions, and to optimize their use of FP methods. Our research

shows that gendered power relations prevent women from obtaining or using a method, even if motivated to do so. They are constrained by the decision-making authority of their husbands and by societal norms discouraging spousal communication about fertility preferences and FP. The resulting, often-incorrect, perception among women and men is that their partner desires more children or is against FP. Women are also constrained by age and family hierarchies that move some elements of FP decision-making to the family, rather than the couple level.

Some ways the social network intervention project in Benin, Tékponon Jikuagou addresses disabling environmental factors

- Encourage members of influential social groups who have engaged in reflective dialogues to reach out to family gatekeepers, especially husbands and in-laws, by asking members to share their group discussions with families and friends
- Model positive norms of women, men, and couples communicating about FP methods through social diffusion campaigns to encourage people to seek information and FP services. The 'Each One Invites Three' campaign engages satisfied FP users to invite non-using friends to seek information and services.

To conclude, social norms can be rigidly resistant to change. Since they are held in place by the reciprocal expectations of people's social networks, individual actions depend in large part on what others do (or think they should do). Due to the necessity of a coordinated shift, behavior is often delayed until most community members' *attitudes* have changed. Once that crucial tipping point is reached, however, new behaviors spread rapidly, and those who may still have negative attitudes toward the practice will begin to adopt it to avoid criticism from others. It seems reasonable to expect a similar transition would occur in the adoption of new attitudes towards fertility and FP. While one project alone will not affect widespread adoption of new attitudes and establishment of new norms at a societal level, we expect in areas where the social network interventions operate in Benin, attitudes will shift as interventions lead to reduced barriers at each of the three levels of the above framework. More time and partnerships are needed to reach a societal tipping point, but the project offers a potential roadmap to achieve this goal.

SYNTHÈSE

En Afrique subsaharienne, malgré les ressources considérables affectées aux programmes de planification familiale (PF), les besoins non satisfaits en PF demeurent élevés et son utilisation soutenue reste difficile à cerner. Au Mali, plus de vingt années d'efforts consacrés à l'établissement de programmes de PF ont amélioré le niveau de connaissance des diverses méthodes de PF. Cependant, les besoins non satisfaits ont connu une hausse supérieure à celle de la prévalence contraceptive.

La manière dont la communauté de la santé reproductive a défini les besoins non satisfaits a conduit à mettre l'accent sur les questions d'approvisionnement et de prestation de services. Une attention insuffisante a été accordée aux contextes sociaux et aux relations au sein desquels les couples et individus prennent des décisions liées à la santé reproductive, et qui incluent des sources d'influence sociale importantes, comme les membres de la famille, les amis et les responsables communautaires. Le projet Terikunda Jékulu, que l'on pourrait traduire par « le cercle des amis » financé par l'USAID, a été conçu pour évaluer l'efficacité d'un ensemble d'interventions sur les réseaux sociaux en vue de répondre aux besoins non satisfaits en PF et d'améliorer les résultats en matière de santé reproductive au Mali.

Afin de concevoir cet ensemble d'interventions, le projet nécessitait tout d'abord une compréhension du contexte culturel et de la dynamique des réseaux sociaux, en particulier des relations de pouvoir et des normes liées au genre, qui influencent le recours à la planification familiale. La première année du projet a été consacrée aux recherches formatives intensives dans deux villages⁴ du Mali, Bougouba dans la région de Mopti, et Koloni dans la région de Sikasso. Ces recherches ont été conçues grâce à une approche ethnographique en trois phases, dite « sandwich ethnographique » :

4. **La recherche ethnographique** : les recherches ethnographiques multidisciplinaires sont composées des groupes de discussions, des entretiens approfondis, de la cartographie sociale et de l'analyse de réseaux par la catégorisation des concepts. Ces résultats ont été utilisés pour fournir le contexte et la terminologie appropriée pour le recensement lié à la cartographie des réseaux sociaux.
5. **Le recensement des réseaux sociaux** : la cartographie complète des deux villages pour élucider la nature et l'étendue des relations entre les adultes de la population étudiée. Des données ont également été générées concernant l'attitude des personnes interrogées à l'égard de la PF et de l'espacement des naissances, ainsi que la manière dont ces personnes percevaient les attitudes des individus faisant partie de leur réseau.
6. **Les entretiens approfondis** : l'analyse des données générées par le recensement des réseaux sociaux, y compris les cartes, a soulevé de nombreuses questions sur les caractéristiques des acteurs des réseaux, le type d'informations qui circulaient au sein de ces réseaux et la manière dont ces informations étaient diffusées. Les entretiens approfondis ont été conçus pour combler les lacunes et fournir une compréhension plus complète de la dynamique des réseaux.

Les individus (ou les couples) font des choix de planification familiale, mais leurs attitudes sont influencées par leurs réseaux sociaux. Il est donc nécessaire de comprendre tous les aspects de l'environnement dans lequel ils prennent des décisions liées à la planification familiale. Le « sandwich ethnographique » nous a permis d'explorer les attitudes individuelles, ainsi que la dynamique des réseaux et les normes sociales, afin d'incorporer les aspects pertinents dans la conception d'un programme complet.

⁴ Les noms des deux villages ont été changés afin de protéger leur confidentialité.

Les résultats de la première phase de la recherche ethnographique sont présentés intégralement dans un autre document.⁵ Ce rapport présente un compte rendu détaillé des résultats issus des deuxièmes et troisièmes phases de la recherche formative. Il sert également à contextualiser et interpréter pleinement les résultats des trois phases de recherches, et fournit des implications pour le développement de programmes, non seulement pour Terikunda Jékulu, mais également pour d'autres programmes de création de demande et/ou de réseaux sociaux dont l'objectif est de répondre aux besoins non satisfaits en planification familiale dans des contextes similaires.

Première phase : la recherche ethnographique

L'objectif de la recherche ethnographique est d'examiner la portée de l'influence et la diffusion des informations de planification familiale par les réseaux sociaux afin d'évaluer le rôle joué par ces derniers pour faciliter ou entraver l'acquisition et le recours à la planification familiale.

On a observé dans le village de Bougouba une faible prévalence contraceptive et des besoins non satisfaits peu élevés. Des réseaux étendus et denses au sein de ce village ont renforcé les messages négatifs et les informations erronées sur la PF. Les utilisateurs de la PF dans cette communauté disposaient de petits réseaux ouverts leur permettant d'utiliser la PF en toute discréction. Le village de Koloni, d'autre part, était caractérisé par une prévalence contraceptive et des besoins non satisfaits plus élevés qu'à Bougouba. Les réseaux des utilisateurs de PF comme ceux des non-utilisateurs étaient petits et denses. Les réseaux des utilisateurs servaient à renforcer et à soutenir l'utilisation de la PF, et les femmes de la belle-famille pouvaient parfois aider à surmonter une désapprobation du mari.

En général, la faible utilisation et les besoins non satisfaits élevés en PF à Bougouba peuvent s'expliquer par une circulation intense de rumeurs et d'informations erronées, alimentées en partie par l'existence d'une association islamique active qui désapprouve fortement la planification familiale pour des raisons religieuses. À Koloni, la non-utilisation semble davantage être liée au manque d'informations, et par-dessus tout, au manque d'accès. Dans les deux cas, ce sont les hiérarchies d'âges qui dirigeaient les flux d'informations, et peu de couples avaient discuté de la PF. Dans certains cas, les femmes de la belle-famille ont parfois aidé leurs parentes à surmonter la désapprobation de leur mari en leur permettant de cacher leur utilisation de la planification familiale ou en faisant des commentaires sur ses avantages aux fils/maris.

En comparant les deux villages, ces résultats suggèrent que les réseaux sociaux renforcent les messages positifs parmi les utilisateurs de PF, mais renforcent également les attitudes négatives chez les personnes ayant des besoins non satisfaits en PF. L'influence des réseaux a un impact important sur les comportements individuels vis-à-vis de la planification familiale, que ce soit pour la favoriser ou le contraire.

Les résultats de la première phase ont apporté des renseignements utiles au « sandwich ethnographique » de la phase suivante, fournissant le contexte et la terminologie appropriée pour le recensement par cartographie des réseaux sociaux. Ils ont également permis d'identifier les zones d'intérêt à explorer davantage par des méthodes de recherche quantitatives.

⁵ Sarah Castle, « Using Network Analysis to Address Unmet Need in Mali : Women's Social Networks, Family Planning Use and Unmet Need : Formative Research Findings from Terikunda Jékulu », Institut pour la Santé reproductive, 2011, consulté le 21 janvier 2013, (<http://irh.org/resource-library/womens-social-networks-family-planning-use-and-unmet-need-formative-research-findings-from-terikunda-jekulu>).

Deuxième phase : le recensement des réseaux sociaux

Au cours de cette phase de la recherche formative, nous avons identifié et interrogé toutes les femmes en âge de procréer et tous les hommes mariés à des femmes en âge de procréer, dans les deux villages, Bougouba et Koloni. Les entretiens ont inclus des questions portant sur le milieu de la personne interrogée, son utilisation actuelle ou passée de contraceptifs, ainsi que sur les attitudes et comportements liés aux décisions portant sur le nombre d'enfants souhaité, le moment d'avoir un autre enfant et le choix de recourir ou non à la contraception.

L'objectif essentiel de l'entretien est d'identifier le réseau social des personnes interrogées. On leur a d'abord demandé chacune de nommer jusqu'à trois individus qui lui fournissent un soutien matériel (par ex., prêts d'argent, dons de nourriture ou de vêtements) ; jusqu'à trois individus lui fournissant une assistance pratique (par ex., garde des enfants, aide aux tâches ménagères) ; jusqu'à trois individus lui fournissant un soutien d'ordre cognitif (les personnes qui donnent des informations) ; et jusqu'à trois individus apportant un soutien émotionnel. Après avoir donné les noms de ces personnes, on leur a posé plusieurs questions à propos de chaque individu nommé. On demandait la relation qui les unit (par ex., parent, ami, responsable communautaire, etc.), et si les individus nommés habitaient dans le village. En plus on demandait et le degré d'affinité et la manière dont la personne interrogée perçoit les attitudes des individus nommés à l'égard de la planification familiale. Ceci a permis la création, pour chaque village, d'une carte complète du réseau social des femmes en âge de procréer et leur mari ; et en particulier, de l'influence du réseau sur la planification familiale et les besoins non satisfaits.

Ces données ont été analysées grâce au logiciel d'analyse statistique des réseaux sociaux, UCINET, pour révéler l'influence relative de chaque individu au sein du village. Les scores ont été calculés pour identifier les individus influents (ceux qui étaient nommés le plus souvent), les individus jouant le rôle de connecteurs (ceux qui reliaient les segments du réseau) et les individus isolés (ayant peu de relations dans leurs réseaux ou avec les autres). Des cartes illustrant les réseaux des villages ont également été générées. Elles figurent dans le rapport principal.

Seules 12% et 10% des femmes des deux villages (9% et 7% des hommes) utilisaient une méthode de contraception moderne au moment du sondage. Peu de résidents du village utilisaient une méthode traditionnelle. Nous estimons les besoins non satisfaits en planification familiale à environ 30% pour les femmes et 34% pour les hommes, dans les deux villages.

Il n'a pas été surprenant de constater que les personnes interrogées à Koloni faisaient preuve d'une attitude plus positive vis-à-vis de la PF que celles interrogées à Bougouba ; cependant, les hommes des deux villages avaient une attitude plus favorable que les femmes envers la PF. Dans les deux villages, les femmes, davantage que les hommes, ont mentionné des problèmes d'accès, tels que le coût ou la disponibilité. Il a été constaté que davantage d'hommes que de femmes s'inquiétaient par rapport aux effets secondaires possibles ou d'autres conséquences néfastes sur la santé liés à l'utilisation des méthodes contraceptives. Dans les deux villages, en ce qui concerne l'auto-efficacité en matière d'espacement des naissances ; environ trois quarts des hommes et environ la moitié des femmes ayant des besoins non satisfaits considéraient que le moment d'avoir des enfants échappait à leur contrôle (il était, par exemple, associé au concept de « volonté de dieu »).

S'agissant des réseaux sociaux, la majorité des personnes citées par les femmes dans leurs réseaux pratiques et émotionnels étaient des parentes (mères, sœurs, co-épouses et autres proches parentes), tandis qu'un quart des femmes des deux villages ont cité un parent de sexe masculin dans leur réseau de soutien matériel. Les hommes ont principalement nommé des proches, amis ou collègues de sexe masculin dans leurs réseaux. Les personnes extérieures au cercle social immédiat, dont les professionnels de la

santé, les responsables religieux ou autres dirigeants, n'ont été que très rarement citées dans les différents types de réseaux.

On a demandé aux personnes interrogées comment elles perçoivent les attitudes des individus nommés dans leurs réseaux vis-à-vis de l'utilisation de la contraception, et ses impressions ont été comparées aux opinions énoncées par les individus nommés. Les résultats n'indiquent aucune concordance entre l'approbation perçue ou réelle de la planification familiale. Par exemple, dans les deux villages, environ un tiers des personnes interrogées citées comme approuvant la planification familiale figurait dans le quartile supérieur de l'indice d'approbation de la planification familiale que nous avons créé (ils l'approuvaient). Un autre tiers figurait dans le quartile inférieur (ils la désapprouvaient). Une analyse similaire comparant les attitudes à l'égard de la PF entre les maris et les épouses a démontré que les hommes étaient davantage favorables à l'utilisation de la contraception que leurs épouses ne l'imaginaient.

Pour finir, les cartes des réseaux des villages ont révélé des réseaux complètement différents dans chacun des deux villages. À Koloni, les adultes (hommes et femmes) qui utilisaient la PF étaient davantage connectés à leur réseau que les personnes n'ayant aucun besoin ou des besoins non satisfaits en PF. Ceci est logique, si l'on considère que la PF est davantage approuvée à Koloni. D'autre part, à Bougouba, où les attitudes négatives envers la PF prévalent, les individus n'ayant aucun besoin ou des besoins non satisfaits en PF étaient davantage connectés à leurs réseaux que les utilisateurs de PF.

Ces résultats suggèrent que les stratégies de communication et de changement des comportements, conçues pour atteindre un tournant en matière d'utilisation de la PF, pourraient s'avérer plus efficaces. En effet, ce serait efficace si elles prenaient en compte la manière dont les attitudes de la communauté envers la PF influencent son utilisation ; également la manière dont les réseaux sociaux, en particulier le type et la densité des relations sociales, influencent le recours à la PF.

Troisième phase : les entretiens approfondis

Des entretiens individuels, semi-structurés, ont été menés avec 12 hommes et 12 femmes à Bougouba et à Koloni, respectivement, pour un total de 48 personnes interrogées. Les répondants provenaient du groupe interrogé au cours du recensement par cartographie des réseaux sociaux. Ils avaient indiqué au préalable leur volonté d'être contactés pour cette phase de l'étude. Les entretiens ont mis l'accent sur : 1) le contenu, la qualité et la fréquence des informations relatives à la PF partagées entre les membres de la communauté ; 2) la capacité des répondants à comprendre leurs propres besoins en PF, en se basant sur leurs désirs et intentions en matière de fécondité ; et 3) les raisons pour lesquelles les répondants utilisaient ou pas la PF.

La diffusion des informations relatives à la PF variait selon le milieu et le sexe. À Bougouda, de nombreux obstacles sociaux ont empêché les femmes et les hommes de discuter ouvertement de leur fécondité, de leur intention d'espacer les naissances et de l'utilisation de la PF. Les habitants de Koloni, d'autre part, se sont heurtés à moins d'obstacles, indiquant qu'ils ont abordé ces questions de manière plus ouverte, en particulier les femmes. Nous avons également découvert que les informations étaient diffusées différemment entre les hommes et les femmes. Les hommes avaient tendance à discuter de la fécondité, de l'espacement des naissances et de la PF en tête-à-tête avec des amis de la même génération ou en petits groupes de pairs. Ils discutaient rarement de ces sujets avec des membres de la famille ou dans un contexte formel de groupe. Les femmes, d'autre part, abordaient la plupart du temps ces sujets avec des femmes de la famille, et les discussions étaient plus intergénérationnelles et incluses les mères, les belles-mères et les belles-sœurs. Les femmes étaient plus susceptibles de discuter et de débattre dans un cadre de groupe formel, comme les réunions *tontines*.

Les femmes et les hommes se tournaient vers des ami(e)s (influent(e)s) pour obtenir des conseils et des informations lorsque les « ressources professionnelles » en planification familiale ne faisaient pas partie de leurs groupes sociaux, ce qui entravait la circulation d'informations correctes sur la PF au sein des réseaux. Les personnes interrogées se tournaient en priorité vers leur famille ou leurs amis géographiquement proches et dont les opinions comptaient le plus pour eux, qu'ils aient ou non les meilleures informations en matière de PF. Ainsi, toutes les attitudes et informations sur la PF quelles qu'elles soient —positives ou négatives — des individus appartenant aux cercles proches des personnes interrogées ont été diffusées. Paradoxalement, les agents de santé, dont les relais, accoucheuses traditionnelles et autres prestataires de santé, ont été perçus par les personnes interrogées comme des sources de confiance pour les renseignements liés à la PF. Mais ce n'était pas nécessairement vers ces derniers que les personnes se tournaient ni en qui elles avaient le plus confiance lorsqu'elles avaient des questions.

Les différences de genre dans les réseaux sociaux jouaient également un rôle en matière de personnes influentes. Les hommes influents au sein des réseaux avaient tendance à occuper une position de pouvoir formelle, tandis que les femmes influentes occupaient davantage une position de pouvoir informelle.

Les personnes ayant peu de relations sociales sont les plus à risque de connaître des besoins non satisfaits. Les répondants définis comme « isolés » et ayant des besoins non satisfaits ne discutaient pas autant que les autres avec leur famille ou leurs amis, et étaient moins susceptibles de rechercher des informations ou des conseils auprès des professionnels de santé. Ce groupe de répondants étant moins exposé aux informations nouvelles, ne disposent pas des informations nécessaires pour prendre des décisions relatives à la planification familiale.

Les personnes interrogées se sont montrées largement très favorables au concept de moment favorable et d'espacement des grossesses, citant la santé et le bien-être des femmes et des enfants comme les avantages principaux, avaient également des réactions mitigées face à l'utilisation de la PF. Les hommes ont vigoureusement appuyé l'espacement des naissances, puisque cela leur permettait de mieux s'occuper de leur famille et de subvenir à ses besoins. Le fait de limiter les naissances, cependant, a été perçu comme étant tout à fait distinct du concept de l'espacement des naissances, et n'était pas acceptable socialement.

Dans les deux villages de Bougouba et Koloni, presque toutes les personnes interrogées ont exprimé la profonde conviction que les enfants étaient un don de dieu, et que leur nombre et le moment de leur naissance étaient prédestinés (bien que quasiment personne n'ait associé ces croyances à l'enseignement religieux ou à l'opinion des responsables religieux). Dans le même temps, de nombreuses personnes ont déclaré qu'il n'était pas contradictoire pour les couples de contribuer à déterminer le moment des grossesses, et donc, le nombre d'enfants qu'ils auront.

Les répondants n'ont pas établi de distinction entre les méthodes modernes et traditionnelles lors des discussions sur la PF, et leur ont attribué une valeur égale. En discutant de la contraception moderne, les femmes avaient des attitudes très positives envers les méthodes de contraception, et ont généralement reconnu le lien entre l'utilisation de la PF et un espacement efficace des naissances. Les hommes étaient moins informés à propos des méthodes, ils ont donc exprimé davantage d'inquiétudes et de résistance face à leur utilisation. Ils approuvaient souvent la PF moderne en principe, mais ils la percevaient comme étant destinée aux autres, par exemple aux personnes plus riches ou plus éduquées.

Les informations erronées concernant les méthodes se sont avérées minimales et spécifiques à une méthode donnée : résultats distinctement opposés à ceux de la recherche ethnographique, qui révélait une circulation intense de rumeurs à Bougouba.

Bien que de nombreuses personnes interrogées aient indiqué une communication régulière avec leur époux(se) au sujet de l'espacement des naissances, il est moins commun de discuter des méthodes de PF. Les normes sexospécifiques en vigueur peuvent renforcer les dynamiques qui influencent la communication du couple et l'utilisation de la PF. En général, les femmes accordent davantage d'importance à la communication sur la PF que les hommes, mais nombre d'entre elles sont réticentes à aborder le sujet de peur d'une réaction négative. Elles croient en effet que le manque de communication de leur mari indique un désintérêt ou une désapprobation. Pour leur part, les hommes ont exprimé peu d'intérêt à communiquer à propos de la PF. Bien que très peu d'hommes s'y soient expressément opposés, certains doutaient de la capacité de leur femme à comprendre les sujets relatifs à la PF, et d'autres présumaient simplement que leur femme partageait leur opinion sur la PF et qu'il était donc inutile d'en discuter. Les hommes et les femmes ont estimé à l'unanimité que la décision finale concernant l'utilisation de la PF revient aux hommes, un consensus qui fait paraître une conversation inutile aux yeux de nombreux couples.

Les réactions à l'utilisation de la PF dans la sphère publique créent d'autres obstacles sociaux. Plusieurs répondants ont fait remarquer que les utilisateurs de la PF peuvent faire l'objet de critiques publiques selon lesquelles ils seraient infidèles ou manqueraient de caractère. Ils ont cependant constaté que ces attitudes étaient dirigées seulement envers les femmes : les hommes dont les épouses utilisent la PF n'étaient pas critiqués. D'autres répondants ont déclaré que l'utilisation de la PF constitue un choix personnel qui ne regarde personne d'autre.

Les préoccupations concernant le coût de la contraception et l'accès aux informations et services de PF ont également été citées comme des obstacles à l'utilisation de la PF. Celles-ci semblaient cependant moins déterminantes que les difficultés liées aux questions de genre ou à la stigmatisation associée à la PF.

Les méprises concernant le retour à la fertilité après une naissance peuvent également affecter la décision d'un couple à chercher une méthode au cours des moments à risque de la vie reproductive. De nombreuses répondantes savaient que les femmes allaitantes courraient un risque de grossesse, même avant le retour des règles, mais une proportion importante de femmes croyait simplement que le risque de grossesse post-partum dépendait de la biologie individuelle de chaque femme. Les hommes ne savaient rien ou peu de choses sur la fertilité après une naissance. C'est la raison pour laquelle nombre de femmes ne connaissaient pas réellement les périodes de besoins non satisfaits, car elles supposaient qu'elles n'étaient pas exposées à un risque de grossesse.

Les implications du programme

Le « sandwich ethnographique » est constitué de trois phases : recherche ethnographique, recensement du réseau social et entretiens approfondis. Il a permis une compréhension nuancée des dynamiques complexes des réseaux sociaux, des flux d'informations relatives à la PF, des obstacles sociaux et communicationnels à sa compréhension, et de la nature et de la perception des besoins individuels en PF dans les communautés étudiées. Le coup d'État de mars 2012 au Mali a forcé un déplacement du projet au Bénin. Il existe cependant des similarités entre le Mali et une grande partie de l'Afrique occidentale concernant les dynamiques des besoins non satisfaits, le contexte social et les obstacles à la compréhension et à une utilisation soutenue de la PF, ainsi que l'histoire des programmes de PF. Ceci nous amène à croire que les recherches formatives effectuées au Mali fournissent des informations utiles pour guider le développement des programmes sur la création de demande PF dans d'autres pays. Les implications du programme dans cette section sont donc conçues pour un contexte plus large que celui du Mali. Afin de donner les bases de la discussion et des recommandations, nous utilisons une série d'illustrations tirées de notre projet pilote sur les réseaux sociaux au Bénin. Celles-ci permettent de démontrer comment ces résultats peuvent être appliqués en vue de développer les interventions sur les réseaux sociaux pour

réduire les besoins non satisfaits. (Les résultats du Mali ont été ajustés pour le Bénin, en se basant sur des recherches formatives supplémentaires effectuées après le déplacement du projet.)

Les interventions aidant les femmes et les hommes à identifier avec précision leurs besoins en matière de contraception, tout en visant à réduire les périodes de besoins non satisfaits au cours de leur vie reproductive, auront probablement, à long terme, un impact considérable sur la réalisation des désirs de fécondité des femmes et des hommes. Les résultats des recherches ont clairement démontré que le besoins non satisfaits est un concept dynamique. Les changements dans le statut des besoins des répondants, du sondage des ménages et aux entretiens approfondis, illustrent de manière tangible que les individus alternent différents statuts de besoins en PF au cours de leur vie reproductive. Dans le même temps, de nombreux répondants avaient des besoins en PF non reconnus – ils percevaient qu'ils avaient des besoins satisfaits ou n'avaient aucun besoin pour diverses raisons, mais courraient en fait un risque de grossesse, en particulier lors de la période post-partum. Ces répondants avaient également un niveau plus élevé de fausses informations à propos de la PF. Par conséquent, la nécessité d'informations justes et d'un enseignement qui permettront aux femmes et aux hommes de reconnaître leurs besoins en PF doit être une première étape dans les programmes visant à répondre aux besoins non satisfaits. Les programmes devraient également envisager ceux-ci sous une perspective étendue tout au long d'une vie, en s'efforçant d'identifier et de réduire les moments au cours desquels les adultes ont des besoins non satisfaits.

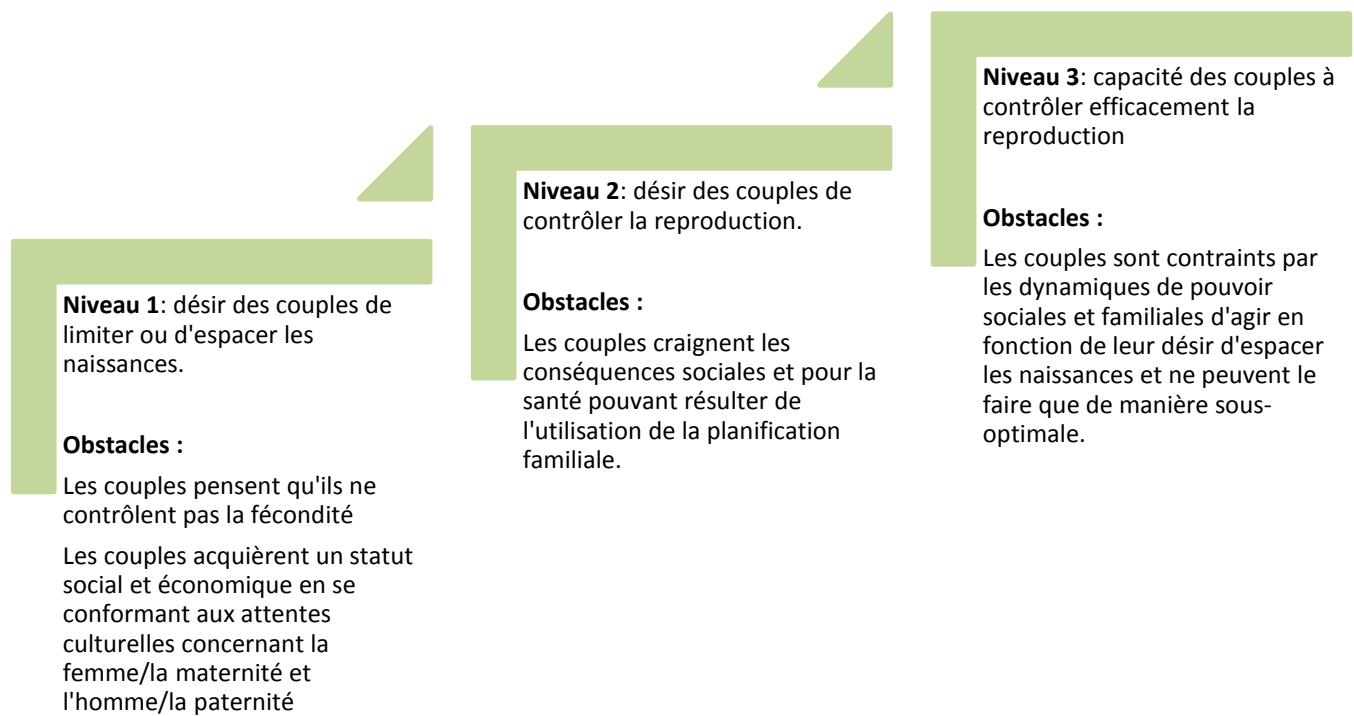
La mobilisation à travers des réseaux nécessite de s'éloigner des approches basées sur des messages pour aller vers un dialogue communautaire réfléchi. Celui-ci peut encourager des attitudes plus positives et des informations plus justes concernant la PF, qui filtreront dans les groupes sociaux hostiles ou mal informés à propos de cette dernière. Les recherches ont révélé que les réseaux sociaux renforcent tous les messages en circulation, sans distinction. Les messages positifs parmi les utilisateurs de PF sont renforcés par leurs conversations avec d'autres utilisateurs, mais, les attitudes négatives sont renforcées parmi les personnes ayant des besoins non satisfaits. Elles ont également révélé des attitudes contradictoires concernant la PF, qui doivent être abordées de manière publique pour clarifier les véritables problèmes sous-jacents à la réticence à utiliser la PF. Les approches de dialogue et réflexion créent un espace permettant de discuter et débattre de ces paradoxes.

Les interventions relatives aux réseaux sociaux doivent créer des liens stratégiques avec les services de PF pour garantir la circulation d'informations justes sur la contraception et la disponibilité des services au sein de la communauté. Les sources les plus fiables d'informations sur la PF (professionnels de santé formés) avaient beaucoup moins d'influence que les membres du réseau social (amis proches, famille) qui avaient souvent peu de connaissances à propos de la PF. Il est donc important d'encourager un dialogue à l'échelle de la communauté pour susciter un examen critique des messages positifs et négatifs sur la PF, et de créer des opportunités afin que les sources d'informations techniques puissent répondre publiquement aux rumeurs ou mythes et fournir des informations correctes sur la PF.

Les programmes doivent éliminer les obstacles liés au genre en intégrant systématiquement le genre dans la conception des interventions. En raison de normes sociales profondément enracinées, les femmes manquent à la fois d'autonomie et d'auto-efficacité pour réaliser leurs désirs de fécondité. En fait, il se peut que les « besoins » en PF d'une femme soient déterminés entièrement par son mari dont les normes sociales dictent qu'elle doit les respecter. De telles normes découragent la communication du couple à propos de ces questions, et peuvent conduire les femmes à avoir peur d'aborder le sujet avec leur mari. Des approches d'intervention, matériau, outils et indicateurs de suivi, et canaux de communication intégrés doivent être développés pour traiter les obstacles relatifs au sexe dans le contexte de cette réalité sociale.

Un cadre récent établi par le Centre international de recherche sur les femmes (CIRF) clarifie les différents types d'obstacles à la demande en PF du point de vue de la procréation féminine. Nous avons légèrement modifié ce cadre pour nous concentrer sur les couples plutôt que les femmes uniquement, puisque les

décisions concernant l'utilisation de la PF reviennent souvent au couple. Ce cadre révisé fournit une compréhension inédite des obstacles sexospécifiques liés à la contraception des couples. Il propose trois niveaux interconnectés de demande, et explique les obstacles de chaque niveau - désir d'espacer ou de limiter les naissances, désir de faire quelque chose pour espacer ou limiter les naissances et capacité d'agir en fonction de ces désirs. Tandis que les recherches, y compris cette étude, démontrent que les attitudes en matière de PF sont influencées par les réseaux sociaux, les décisions concernant l'utilisation de la PF sont finalement prises par les individus (ou les couples). En concevant des programmes pour répondre aux besoins non satisfaits en PF, ce cadre peut s'avérer utile en structurant les éléments de genre au sein d'une stratégie de réseau social plus vaste. Il peut être utile d'« échelonner » les interventions du programme, comme décrit ci-dessous, en réalisant pleinement que les obstacles agissent non seulement au niveau individuel, mais également au niveau de la communauté.



Adapté de :*Jennifer McCleary-Sills, Allison McGonagle et Anju Malhotra, « Women's Demand for Reproductive Control :Understanding and Addressing Gender Barriers,» International Center for Research on Women, 2012, consulté le 22 janvier 2014, www.icrw.org/publications/womens-demand-reproductive-control.*

Au niveau 1, le principal objectif est d'encourager l'évolution des normes sociales et sexospécifiques pour promouvoir la contraception comme un choix *conscient* pour les couples. Le rôle de la « volonté de dieu » constituait un thème important dans la prise de décision des personnes concernant la contraception. Tandis que seuls quelques rares répondants au recensement estimaient que leurs croyances religieuses leur interdisaient la PF (moins de 2%), plus de 70% des répondants ont cité « la volonté de dieu » comme la raison pour laquelle ils n'utilisaient pas la PF actuellement. Les couples au Mali subissent également une forte pression de la part des familles et des normes sociétales pour prouver leur fécondité tôt dans le mariage, à cause d'idées traditionnelles de virilité et de fémininité toujours associée à la capacité de donner naissance à un grand nombre d'enfants. Il semble que ces deux idées soient des concepts distincts, la première exprimant un fatalisme caractéristique des sociétés qui se trouvent au début du processus de transition d'une fécondité élevée à une fécondité faible. Le respect immense de la « volonté de dieu » en

matière de procréation indique que les décisions reproductives ne sont pas encore dans le « calcul d'un choix conscient »⁶ pour les couples.

Quelques composantes avec lesquels le projet d'intervention sur le réseau social au Bénin, Tékponon Jikuagou, traite le fatalisme, les sexospécificités et les autres obstacles sociaux à la PF

- Inciter les femmes et les hommes influents à montrer l'exemple dans leurs attitudes et comportements, en communiquant par exemple de nouvelles idées qui mettent en valeur des familles plus petites et en meilleure santé
- Axer les ressources de dialogue et de réflexion de manière à accroître l'encouragement des choix conscients concernant le moment favorable pour une grossesse et l'espacement des naissances, tout en évitant les discussions sur la PF dans le contexte de la taille désirée de la famille et de la limitation des naissances ; étant donné que la PF n'est acceptable dans ce contexte que pour l'espacement des naissances
- Développer des questions de dialogue réfléchi qui permettent aux groupes d'explorer les conceptions et paradoxes de la femme/maternité et du père/de la paternité pour permettre aux femmes et aux hommes d'examiner de manière critique les attitudes sous-jacentes à l'égard de la fécondité et de la procréation

L'objectif principal au niveau 2, où les couples désirent déjà espacer les naissances, mais hésitent à utiliser la contraception, est d'accroître la compréhension et l'acceptation des options de contraception. Le principal obstacle à ce niveau est la crainte d'être stigmatisé et perçu comme marginal — comme quelqu'un d'infidèle à son partenaire ou qui ne désire pas du tout d'enfant. Cette crainte entraîne souvent les utilisateurs de PF à passer sous silence son utilisation, renforçant ainsi la perception selon laquelle l'utilisation de la PF n'est pas courante, et consolidant davantage la discrimination et la stigmatisation, malgré un fort soutien normatif envers l'espacement des naissances. De plus, le manque de connaissance des méthodes contraceptives et les craintes liées aux effets secondaires; tels que la stérilité ou le changement du cycle menstruel, démotivent les personnes à utiliser la PF.

Quelques composantes avec lesquelles le projet d'intervention sur le réseau social au Bénin, Tékponon Jikuagou, traite la stigmatisation et les mythes liés à la PF

- Inciter les femmes et les hommes influents de la communauté à montrer (par ex., en communiquant de manière publique) l'acceptabilité sociale et la sûreté de l'utilisation de la PF, pour aider les personnes à réaliser que l'approbation de la PF est courante et réduire ainsi la stigmatisation des utilisateurs de PF

⁶ A.J. Coale, « La transition démographique reconsidérée » (document présenté lors de la Conférence internationale sur la population, Liège, belgique, 1973).

- Utiliser des discussions et dialogues réfléchis au sein de groupes influents, associés à des émissions de radio diffusant des dialogues réels entre des femmes et des hommes de la communauté, pour créer un espace sûr où partager les expériences de la PF et les avantages perçus de son utilisation
- Créer des liens entre les agents de santé communautaires, le personnel du centre de santé et les individus et groupes influents pour ouvrir des voies de communication entre les techniciens de PF et ceux qui influencent la diffusion des informations et des attitudes
- Dissiper les mythes sur les méthodes de PF
- Sensibiliser sur les méthodes de PF, leur disponibilité et leurs avantages et inconvénients

L'objectif principal au niveau 3 est de créer un environnement favorable pour que les femmes et les couples puissent prendre des décisions et des mesures sûres et efficaces concernant leur fécondité et optimiser leur utilisation des méthodes de PF. Nos recherches démontrent que les rapports de pouvoir entre les sexes empêchent les femmes d'obtenir ou d'utiliser une méthode, même lorsqu'elles en ont la motivation. Elles sont contraintes par le pouvoir de décision de leur mari et par les normes sociétales qui découragent la communication entre les époux à propos de leurs préférences en matière de fécondité et de PF. La perception, souvent fausse, qui en résulte parmi les femmes et les hommes est que leur partenaire désire davantage d'enfants ou est contre la PF. Les femmes subissent également les contraintes imposées par les hiérarchies d'âge et familiales qui déplacent certains éléments de la prise de décision en matière de PF au niveau de la famille, plutôt qu'au niveau du couple.

Quelques composantes avec lesquelles le projet d'intervention sur le réseau social au Bénin, Tékponon Jikuagou, traite les facteurs environnementaux défavorables

- Inciter les femmes et les hommes influents à montrer l'exemple dans leurs attitudes et comportements, en communiquant par exemple de nouvelles idées qui mettent en valeur des familles plus petites et en meilleure santé
- Encourager les membres des groupes sociaux influents ayant pris part aux dialogues de réflexion à aller vers les « gardiens » des familles, en particulier les maris et beaux-parents, en demandant aux membres de partager leurs discussions de groupe avec les familles et les amis
- Encourager des normes positives de femmes, d'hommes et de couples communiquant à propos des méthodes de PF par le biais de campagnes de diffusion sociale pour encourager les personnes à chercher des informations et des services de PF. La campagne « Chacun invite trois personnes » incite les utilisateurs de PF satisfaits à inviter des amis non utilisateurs à solliciter des informations et des services.

Pour conclure, les normes sociales peuvent causer une résistance rigide au changement. Puisqu'elles ne sont maintenues que par les attentes réciproques des réseaux sociaux des personnes, les actions individuelles dépendent en grande partie de ce que font les autres (ou de ce qu'ils pensent devoir faire). En raison de la nécessité d'une évolution coordonnée, les comportements ne changent que lorsque les *attitudes* de la plupart des membres de la communauté changent. Une fois que ce tournant critique est

franchi, cependant, les nouveaux comportements se répandent rapidement, et ceux qui ont encore des attitudes négatives à l'égard de cette pratique commenceront à l'adopter pour éviter les critiques des autres. Il semble raisonnable de s'attendre à ce qu'une transition similaire se produise dans le cas de l'adoption de nouvelles attitudes à l'égard de la fécondité et de la PF. Bien qu'un seul projet ne puisse affecter l'adoption généralisée de nouvelles attitudes et l'établissement de nouvelles normes au niveau sociétal, nous pensons que, dans les zones touchées par les interventions sur les réseaux sociaux au Bénin, les attitudes évolueront au fur et à mesure que les interventions réduiront les obstacles aux trois niveaux du cadre mentionné précédemment. Davantage de temps et de partenariats sont nécessaires pour parvenir à un tournant du point de vue sociétal, mais le projet peut constituer une feuille de route permettant d'atteindre cet objectif.

BACKGROUND

In Sub-Saharan Africa, despite the significant resources that have been allocated for family planning (FP) programs, unmet need for FP remains high, and sustained FP use remains elusive. Nearly twenty years of FP programming efforts in Mali have led to the majority of sexually active men and women knowing about various methods of FP, yet increases in unmet need (22.8% in 1996 to 31.2% in 2006) have outpaced increases in contraceptive prevalence (4.5% in 1996 to 6.9% in 2006) (DHS, 1996 & 2006). The way unmet need has been conceptualized by the reproductive health community has led to an emphasis on supply side issues, institutional strengthening, and provider capacity building. What demand-generation efforts have taken place have focused primarily on women and, in some cases, their partners, without taking into consideration the social networks in which reproductive health decisions are made. Little attention has been given to important social influences on women's health choices, such as family members (e.g., mother-in-law, sisters, uncles), friends, and community leaders. Literature on unmet need further underscores the importance of acknowledging social networks and cultural contexts when addressing unmet need, in particular power relations and gender norms as influences on reproductive health behavior (Gayen 2007, Bongaarts 1995, Greene & Biddlecom 2000).

A consortium led by Georgetown University's Institute for Reproductive Health (IRH), in collaboration with CARE International (CARE), the Centre for Development and Population Activities (CEDPA), and the Association de Soutien au Développement des Activités de Population (ASDAP) received a five-year award from the U.S. Agency for International Development (USAID) to improve reproductive health outcomes in Mali. *Project Terikunda Jékulu*, which translates to "friends connecting friends through social networks," was designed to assess the effectiveness of social network interventions to address unmet need for FP.

The first year of the project consisted of intensive formative research in two villages in Mali, Bougouba in Mopti Region, and Koloni in Sikasso Region. Both villages have a population of about 2,000 and are characterized by subsistence agriculture, high levels of illiteracy, and polygamous marriage. Most of Bougouba's inhabitants belong to the patrilineal Dogon ethnic group who live in extremely large, patrilocal, hierarchical households. Koloni is mostly comprised of the Minianka ethnic group which is patrilocal but matrilineal. Both Dogon men and unmarried women tend to undertake seasonal and long-term labor migration, often to areas as far away as Côte d'Ivoire or Gabon. Neither men nor women in Koloni regularly migrate but instead practice commercial cotton cultivation.

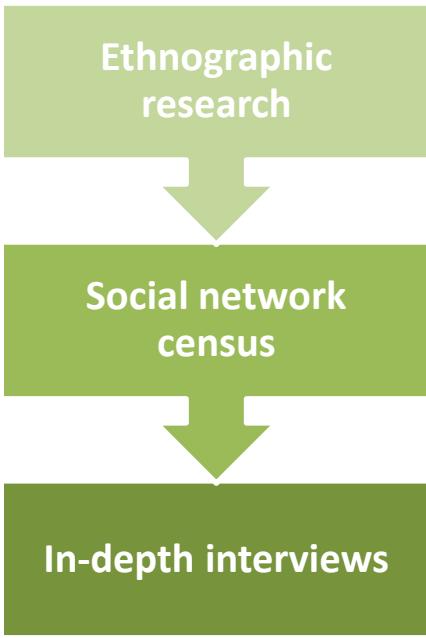
The results from the formative research were used to design the content of the social network intervention package and define measurable outcomes for the project.

METHODOLOGY

All study protocols and instruments were approved by the Georgetown University Institutional Review Board (USA), and by the National Committee of Ethics for Health and Life Sciences (Mali) before data collection began. Human subjects protocols were closely adhered to in the field. Participation was voluntary, and informed consent was obtained from each study participant prior to beginning the interview.

A. METHODOLOGICAL APPROACH

Intensive formative research was conducted during the first year of the project. This research was designed using the "ethnographic sandwich" approach, which involved three phases:



Ethnographic research: Multi-pronged ethnographic research comprised of focus group discussions, in-depth interviews, social mapping, and network analysis via pile sorting. These results were used to provide the context and the appropriate terminology to use for the social network mapping census.

Social network census: Complete mapping of the two villages to elucidate the nature of the relationships among adults in the study population. It also generated data about respondents' attitudes toward FP and child spacing and their perceptions of the attitudes of the individuals in their networks.

In-depth interviews: Review of the data generated from the social network census, including maps, generated many questions about the characteristics of network actors, what kinds of information flowed through the networks, and how that information was diffused. In-depth interviews were designed to fill in those gaps and provide a more complete understanding of network dynamics.

B. OUTCOME VARIABLE DEFINITION

Project Terikunda Jékulu ultimately aims to reduce unmet need for family planning. Various definitions exist of unmet need for FP. First, we outline our categories of unmet need; then we describe the differences between our definition and others used globally. Our categories of FP need (see Figure 1) are defined as follows:

Met need: Individuals using any FP method, modern or a traditional. We believe that any individual taking steps to prevent or delay a pregnancy, regardless of the method's actual efficacy, believes their FP need is being met.

No need: Individuals who wish to have another child now; women who are currently pregnant, menopausal, or not sexually active; and individuals who otherwise perceive that s/he has no need for FP for any reason (e.g., believes s/he is infertile, is postpartum amenorrheic and perceives no pregnancy risk).

Unmet need: Individuals who do not wish to become pregnant, who are sexually active, yet are not using any FP method. In other words, any individuals who do not fit the *met need* or *no need* categories.

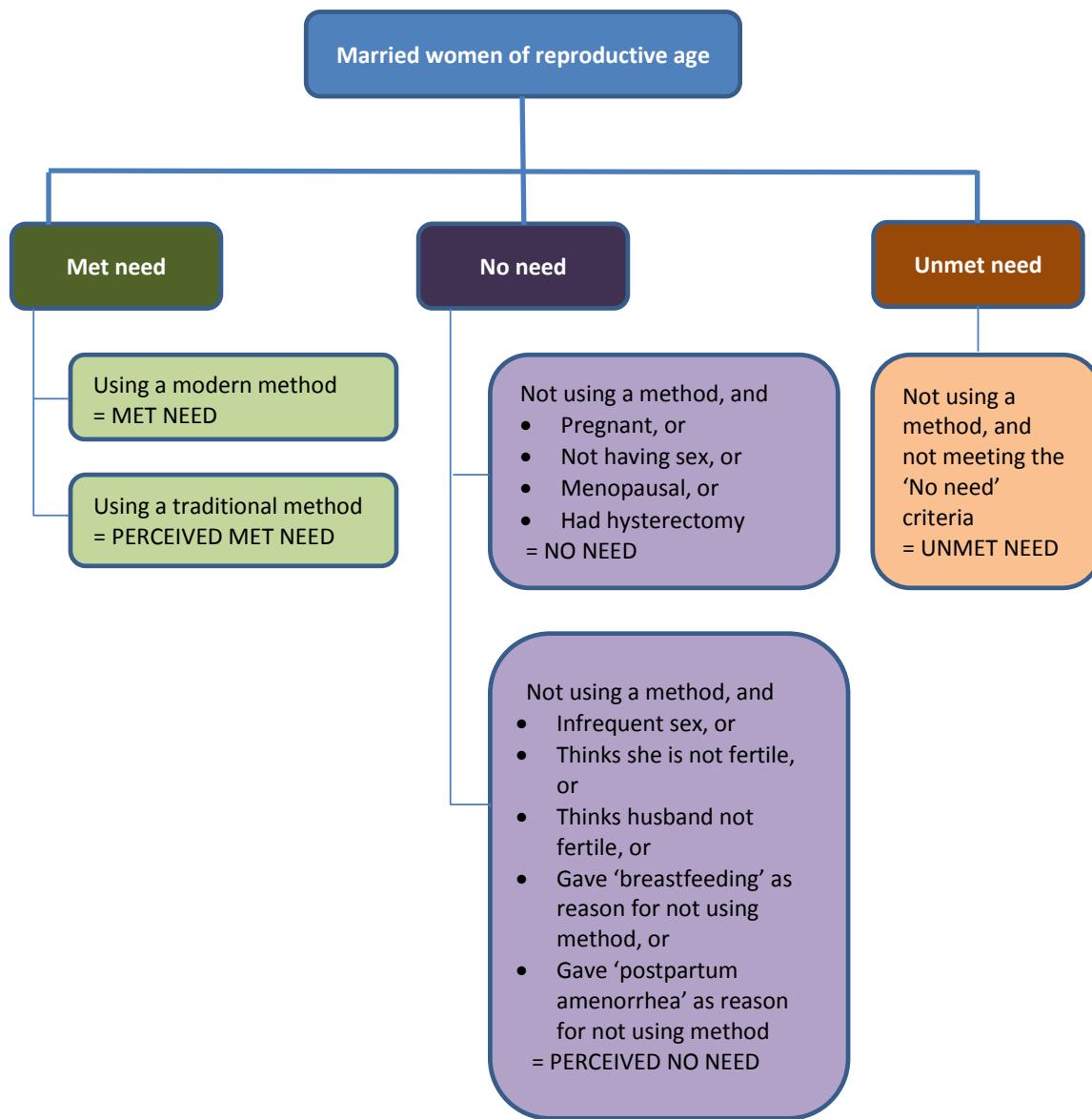
In our study, women were assigned only one FP need status (met need, no need, unmet need) based on their self-reported fertility desires, current FP use, or other conditions related to need status as outlined above. Due to the prevalence of polygamy in the study location, men could be assigned more than one FP need status. For example, a man could have met need with one wife and unmet need with another.

Our definition of unmet need for FP focuses on an individual's *perceived* need for FP. We believe that women's and men's own perception of their FP need is a more useful predictor of contraceptive use for program design and monitoring. This definition differs from the one recently revised by Bradley, et al. (2012) and subsequently adopted for use by USAID, UNICEF, and WHO. Their algorithm to determine need uses biologically based criteria to assess fecundity, incorporates intendedness of each pregnancy, and assesses the efficacy of the particular FP method, if one is being used. Whether or not it can be objectively substantiated, we believe an individual's *perceived* need for FP is the best predictor of his or her FP

behavior. For example, using the Bradley definition, a woman using traditional amulets to prevent pregnancy would be categorized as having unmet need, because amulets are not a modern method. However, in our definition, this woman is of the “contracepting mindset”—in other words, she believes she is doing something to avoid pregnancy. Thus, we consider her to have met need. In another example, Bradley, et al. would consider a woman who is not breastfeeding exclusively but still postpartum amenorrheic as having unmet need, since she is biologically susceptible to pregnancy. In contrast, our definition considers this woman as having no need if she believes it is impossible to become pregnant in this state.

Since *Project Terikunda Jékulu* addresses perceptions of and social norms around FP, we believe a definition based on perception of unmet need provides a better measure of the success of interventions designed to influence people’s attitudes and behaviors. While we are not necessarily arguing that one definition is better than the other, we believe our definition of unmet need has greater potential to measure FP need and guide strategies for our project interventions. We also note the differences for reasons of comparability—our rates of unmet need for FP should not be directly compared against rates generated by Demographic and Health Surveys (DHS) or other surveys that do not use our same algorithm to determine unmet need. A detailed explanation of the differences between these definitions will be outlined in a later paper.

Figure 1. Unmet Need Algorithm for married women of reproductive age



C. LIMITATIONS

The main limitation in this research was social desirability bias. In approaching the same villages several times at various stages of research, people were asked questions several times about the same topic. This could have increased the likelihood of giving socially desirable responses. Responses in the in-depth interviews sometimes suggested that participants may have been giving socially desirable responses to avoid further probing. Despite rigorous training, not all interviewers probed to the same degree. Nevertheless, the complexity and iterative design of the “ethnographic sandwich” allowed for an in-depth and nuanced understanding of unmet need in these communities that can be used to design effective intervention activities and communication materials.

PHASE I – ETHNOGRAPHIC RESEARCH

The first step of the “ethnographic sandwich” was multi-pronged ethnographic research. The objective of this phase was to look at the spread of influence and family planning information through social networks in order to evaluate the role of social networks in facilitating or hindering family planning acquisition and use. These results are reported elsewhere⁷, but are summarized here to provide context.

The following qualitative research activities were carried out in both villages:

Table 1. Ethnographic research activities

Activity	Description
Community checklist	Background information, mapping of village and list of community associations gathered from village chiefs and elders.
Focus Group Discussions	6 FGDs with married men and women of reproductive age on normative fertility attitudes and behaviors, FP use and social influence.
In-Depth Interviews with Men & Women	32 interviews with users, women with unmet need and men to ascertain material, practical, cognitive and emotional networks and their relationship to FP use.
In-Depth Interviews with Community/Religious Leaders & Health Providers	6 interviews with leaders and health providers to understand attitudes with regard to fertility, FP and unmet need, and assess role in social support of FP.
Social mapping	Group exercises with users and women with unmet need to map out locations where positive and negative FP information is transmitted as well as areas of FP provision.
Network analysis through pile sorting	Visualization and documentation of women’s social networks (size, composition and density) and the transmission of FP information through them.

Analysis revealed that in both villages, women using family planning perceived that it helped them avoid short birth intervals which were damaging to the health of both the mother and child. By contrast, men

⁷ Castle, S. (2011) Using Network Analysis to Address Unmet Need in Mali: Women’s social networks, family planning use, and unmet need: formative research findings from Terikunda Jékulu. Washington, DC.: Georgetown University Institute for Reproductive Health for the U.S. Agency for International Development..

placed greater emphasis on the economic benefits for the household. They thought spaced children were likely to be healthier and, unlike children born after short birth intervals, would not require regular and costly medical treatment. In Bougouba, which has low contraceptive prevalence and low unmet need, the large, dense networks of the women with unmet need served to reinforce negative messages, misinformation and rumors. These were repeated by like-minded network members who all knew each other. The FP users in Bougouba, on the other hand, had small, less dense networks which enabled them to use secretly as there were fewer people from which they needed to hide their use. Many women using family planning in this village had both modern and traditional health care providers in their networks and interacted with them socially. This was not the case for those with unmet need, nor for both groups of women in the village of Koloni, where contraceptive use was more open.

Women in Bougouba were less likely to discuss family planning with their husbands even if they suspected his attitude would be favorable. Contraception was simply not a topic that was discussed. If women did talk about it, they did so in the fields or in the bush where they were out of earshot. The pervasive view with regard to family planning in Bougouba was highly negative and had created a climate of suspicion whereby, if a woman's contraceptive use was divulged, she risked being denounced as immoral, being beaten or even divorced. As such, women told very few people of their use, usually only close friends but seldom relatives. Many used contraception having told no one about their decision to do so.

By contrast, in the village of Koloni (which has higher contraceptive prevalence and high unmet need) both users and non-users' networks were small and dense. For users, these served to catalyze and sustain their use, particularly as their networks frequently comprised their mothers-in-law and co-wives. These female marital kin sometimes helped them overcome spousal disapproval by enabling users to hide the fact that they were using family planning from their husbands. Alternatively, mothers-in-law sometimes acted as intermediaries on behalf of their daughters-in-laws to sensitize their sons as to the benefits of family planning. In Koloni, the non-users had networks of a similar size but did not include these key allies for open, or indeed, covert use. In general, unmet need in Bougouba can be explained by the intense circulation of rumors and misinformation fuelled, in part, by the existence of an active Islamic association which strongly disapproves of family planning for religious reasons. In Koloni, non-use seemed to be more related to a lack of information and, above all, access. Nevertheless, women in Koloni talked more openly about family planning and sometimes discussed it at saving clubs where the aim of their gathering and topics discussed could be 'disguised' from men.

Women in Bougouba who, when they were unmarried, had been on labour migration to Bamako or other 'higher prevalence' areas seemed to be more likely to use family planning than those who had never migrated for work. Not only had they heard family planning messages whilst away but were often actively encouraged to use contraception by their former employers. Method switching appeared to relate strongly to unfounded fears of side-effects which were discussed and reiterated the large, dense networks of those with unmet need. Mapping exercises in Bougouba showed both accurate and inaccurate information about family planning was transmitted in many public settings (wells, millet pounding areas etc.). The users took home the former and the non-users the latter from the same locations. It is hypothesized that women's social networks serve to sift conflicting information, appropriating that which the network is already inclined to believe. In this way, positive messages are reinforced among users and negative attitudes are reinforced among those with unmet need.

Overall, the ethnographic research revealed that similar kinds of social networks can play different roles in different contexts. In Koloni, large, dense networks reinforced negative messages and misinformation about FP. Users in this community had small, open networks that enabled them to use secretly. In Bougouba, users and non-users' networks were small and dense. For users, this served to catalyze and sustain their use, and female marital kin helped some overcome spousal disapproval. In comparing the two

villages, we learned that networks strengthen positive messages among FP users, but reinforce negative attitudes among those with unmet need. This impacts individual-level behavior change by engendering facilitating factors or barriers, respectively, in adopting innovations.

These results informed the next phase of the “ethnographic sandwich”, by providing the context and the appropriate terminology to use for the social network mapping census. It also flagged areas of interest to explore further using quantitative methods.

PHASE II – SOCIAL NETWORK CENSUS

The second phase in the “ethnographic sandwich” was to conduct a complete social network mapping census. In addition to demographic and socioeconomic characteristics of villagers, this census generated a list of adults of reproductive age in each village, all other villagers in their social network, and the nature of the relationships between these individuals. It also identified individuals with greater influence and more connections. Furthermore, the census collected data about respondents’ attitudes toward FP and child spacing and their perceptions of the attitudes of the individuals in their networks. All study instruments were developed in English, translated into French, and then verbally translated into the local languages at the time of the interview.

A. METHODOLOGY

SAMPLING

In order to identify and interview all married women of reproductive age in the village and all men married to women of reproductive age, we first created a complete list of all adult village residents (see Appendix A for forms used). Malian enumerators (both male and female), experienced in interviewing low-literacy populations and fluent in the local languages, updated existing village maps. They walked up and down every path in the village to ensure that no new structures were left out. They then visited each residential structure or compound in the village. They asked any adult who was present to name all adults (age 18+) living in the structure/compound, and collected information about gender, approximate age, and occupation of each individual. These details were necessary in order to later identify them on the list, as no addresses are available in these villages and many villagers share same names. This exercise resulted in a master list of all adult village residents, using the compound or structure code on the map for easy identification. Each adult on the list was given a unique code.

DATA COLLECTION

Once the adult village resident list was completed, we initiated the social network mapping census. The enumerators again visited all residential structures and compounds in the village and interviewed all married adults of reproductive age who agreed to participate. Interviews were individual and took place in a private place of the respondent’s choice by same-sex enumerators. The interview started with questions about the respondent’s background, followed by questions about current and previous use of FP, as well as attitudes and behaviors related to decisions about how many children to have, when to have another child, and whether or not to use FP. They were then asked to identify other villagers who influenced their lives in some way and were therefore members of their social network (see Appendix B for interview instrument).

We define social network in terms of four types of support—material, practical, cognitive and emotional (see Table 2). These categories were based on the social network analysis work of Madhavan et al. (2003)

in Mali, adapted to the current context from the previous phase of ethnographic research, which suggested that social interactions in the villages can be defined along these four axes.

Table 2. Four Types of Social Networks

Network Type	Definition
Material	Those who provide an individual with material support, such as money, loans, or gifts of food or clothes
Practical	Those who provide an individual with practical assistance, such as child care or help with household chores
Cognitive	Those who provide an individual with cognitive support and help them learn new things
Emotional	Those who provide an individual with emotional support, such as people they can talk to when they are upset or experiencing stress

Respondents were asked to name up to three people in each of the four categories. Women who did not spontaneously nominate their husband, mother, mother-in-law, or co-wives in response to these questions were probed about their relationship with these individuals. Men who did not spontaneously mention their wives, father, or any male relative were similarly probed.

After respondents named these individuals, the enumerator asked the respondent to identify each one of them on the complete adult village resident list (from the previous step). The respondent was asked several questions about each of these people—their relationship with the individual (i.e., relative, friend, community leader, etc.), whether the individual lived in the village or not, how close they felt to the individual, and the respondent's perception of the named individual's attitudes toward FP.

ANALYSIS

Data were analyzed using the social network program, UCINET (Borgatti, 2002). This resulted in a complete picture of the relationships between residents in each village and revealed the relative influence of each individual in the village. We used NetDraw (Borgatti, 2002) to create illustrative maps of the village networks.

Using UCINET, we were able to determine the influentials in the villages. These people were in the top quartile of the individuals that respondents nominated to any of their social network categories. Since they were nominated more often, influencers have a direct link to more villagers.

UCINET also enabled us to determine individuals who facilitate the flow of information in villages. These “connectors” have the shortest path to most villagers. A path is the number of individuals they go through to get to any other individual in the social network map. Though we look to connectors to facilitate the flow of information, they can also become bottlenecks.

We used SPSS (version 20) for all additional analyses of data collected in the census. To measure attitudes towards FP, an index was calculated based on responses to the following eight statements. The statements were as follows:

- It is good to have many children because they can help with household tasks (agree=1)
- Women who use FP are straying from the correct path or are immoral (agree=0)
- Women who use FP look better than women who do not use FP (agree=1)
- The FP methods provided by the health programs in this village are difficult to use (agree=0)
- Couples who practice FP and have fewer children are better able to provide for their family (agree = 1)
- Using FP is bad for a women's health (agree = 0)
- Only God can decide the number and timing of children a couple has (agree = 0)
- FP is something that people from outside our community want us to do for their benefit, not ours (agree = 0)

For positive statements, respondents were assigned "1" if they agreed, "0" if they disagreed (or didn't know). For negative statements, respondents were assigned "0" if they agreed (or didn't know), "1" if they disagreed. These scores were added for the final index. Dividing the total by the number of statements yielded an index ranging from 0 to 1, with 1 indicating approval of FP use.

B. RESULTS

VILLAGE PROFILE

Table 3 shows the number of adult men and women living in each village, the number who were eligible to participate in the mapping census (married women of reproductive age, and men married to women of reproductive age), the number interviewed, and the response rate. The two villages are of similar size, but the village population of Koloni comprises a higher proportion of women, while Bougouba has a higher proportion of men.

Table 3: Response rates among social network census participants

	Koloni			Bougouba		
	Women	Men	Total	Women	Men	Total
Adults in village	341	253	594	367	491	595
Eligible	225	167	392	251	177	428
Interviewed	217	149	366	208	152	360
Response rate	96.4%	89.2%	93.4%	82.9%	85.9%	84.1%

The information collected for the adult village resident list suggests that in both villages the mean age of adult men is one to two years higher than the mean age of adult women. Eligible participants in Bougouba are slightly older, with a mean age of 41 years, compared to a mean age of 36 years among participants in Koloni. About three-quarters of adults in both villages are married—more women are married than men due to polygamy. Almost 80% of men in both villages are farmers. Most women do not work for a living.

Table 4 summarizes characteristics of the men and women interviewed. Women in both villages have over three children, on average, men have over five. Education level is very low in both villages—while 13.2% of men in Bougouba have formal education, the proportion is significantly lower among men in Koloni and among women in both villages. The majority of the population in both villages is Muslim.

Table 4: Profile of eligible respondents in social network census

	Koloni		Bougouba	
	Women N=217	Men N=149	Women N=208	Men N=152
Age				
Mean	27.34**	39.47	30.89**	41.05
18-19	6.0%	0	3.4%	0
20-24	30.9%	4.7%	12.5%	2.0%
25-29	28.1%	16.1%	23.6%	5.9%
30-34	15.7%	24.8%	29.3%	18.4%
35-39	12.4%	14.8%	17.8%	23.0%
40-44	6.9%	10.7%	13.5%	17.8%
45-54	0	15.5%	0	23.0%
55+ (maximum 80)	0	13.5%	0	9.9%
Marriage				
In polygamous marriage	53.9%	36.9%	48.1%	31.6%
Number of children				
Mean	3.27**	4.97	3.82**	5.72
Education				
No formal education	94.5%	97.3%	93.8%*	86.8%
Religion				
Muslim	83.9%	89.9%	100%	98.7%
Animist	12.9%	8.7%	0	0
Christian	0.5%	1.4%	0	1.3%
No religion	2.8%	0	0	0

** & * denote significant levels at the $p<.01$ and $p<.05$ respectively. Significance levels compare women to men in each village.

FP USE, ATTITUDES, AND UNMET NEED

Current and ever FP use are uniformly low, with only 12% of women in both villages and even fewer men ever using a modern method (Table 5). Very few respondents reported currently using a traditional method (including periodic abstinence, withdrawal, and other traditional practices such as use of spider webs). Most current FP users use the pill or injectables. Nearly one-third of respondents in both villages have unmet need for FP.

Table 5: Family planning use

	Koloni		Bougouba	
	Women N=217	Men N=149	Women N=208	Men N=152
Current FP use¹				
Pill	7.8%	1.3%	3.8%	0.7%
Injection	3.2%	6.0%	4.3%	4.6%
Implant	0.5%	0	1.0%	0.7%
Condom	0	1.3%	0.5%	0.7%
SDM	0	0.7%	0	0
Traditional method	2.8%	6.7%	0.5%	0
Ever use of FP methods				
Pill	12.4%	6.0%	12.0%	4.6%
Injection	6.9%	7.4%	7.7%	13.2%
Implants	0.9%	0	1.0%	0.7%
IUD	0	0.7%	0	0
Condoms	0.5%	2.0%	0.5%	1.3%
Diaphragm/gel	0.5%	0	0	0
Periodic abstinence	0.5%	0	0.5%	2.0%
SDM	0	0.7%	0	0
LAM	0	0.7%	0	0
Need status²				
Met need				
Modern method	11.6%	9.4%	9.7%	6.6%
Traditional method	2.3%	6.7%	0.5%	2.0%
No need				
Pregnant	20.8%	26.8%	15.3%	26.3%
Desires another child in next year	17.1%	29.5%	16.8%	22.4%
Breastfeeding or in postpartum amenorrhea	16.7%	8.1%	20.4%	15.1%
Infertile/menopausal/hysterectomy/no sex	1.9%	10.7%	8.7%	2.6%
Unmet need	29.6%	34.9%	28.6%	34.2%

1. Men are listed if they have at least one wife who is using the method. If they have more than one wife in the same category, they are only counted once.
2. Men are listed if they have at least one wife in the category. Since some men have a different need for different wives, their figures sum to more than 100%.

As can be seen in Table 6, women with unmet need are the same age as women in the other categories, but men with unmet need appear to be slightly older. While there appear to be differences in parity between the groups, there is no consistent trend.

Table 6: Respondent profile by unmet need category

		Koloni			Bougouba		
		Met need	No need	Unmet need	Met need	No need	Unmet need
Women	Mean Age	N=30	N=122	N=64	N=20	N=120	N=56
	Marriage	27.6	27.0	27.6	30.4	30.7	29.7
	In monogamous marriage	12.0%	63.0%	25.0%	9.6%	59.6%	30.8%
	In polygamous marriage	15.5%	50.9%	33.6%	10.9%	63%	26.1%
Men	Mean number of children	4.1	2.6	4.1	4.2	3.6	3.6
	Mean Age	N=24	N=105	N=52	N=12	N=99	N=52
	Marriage	38.6	39.3	45.3	38.7	40.9	42.4
	In monogamous marriage	10.6%	75.5%	13.8%	8.2%	71.4%	20.4%
	In polygamous marriage	25.5%	61.8%	70.9%	8.3%	60.4%	66.7%
	Mean number of children	5.8	4.6	7.8	5.2	5.5	5.7

Attitudes toward FP varied, as can be seen in Table 7. In general, while respondents in Koloni have more positive attitudes toward FP than respondents in Bougouba, men in both villages have a more positive attitude than women. When men and women with unmet need were asked why they were not doing anything to avoid pregnancy, about three-quarters of men, but only about half of women in both villages said the timing of children is up to God. Fewer men than women in both villages cited access issues, including no access to FP, knowing of no contraceptive method, or perceiving that FP is expensive. Interestingly, more men than women in both villages perceived that contraceptive methods have side effects or other health consequences.

Table 7: Attitudes toward family planning use

	Koloni		Bougouba	
	Women N=217	Men N=149	Women N=208	Men N=152
Attitudes				
Mean attitude index	0.415**	0.557	0.353**	0.439
Having more children is good...(-)¹	62.7%	66.4%	62.5%**	74.0%
Women using FP are immoral (-)	18.4%**	36.9%	12.5%**	26.0%
Women using FP seem healthier (+)	53.5%**	77.2%	50.0%**	58.0%
Available methods are difficult to use (-)	43.3%	41.6%	21.2%**	23.3%
Couples with fewer children better off (+)	65.0%**	79.2%	43.3%**	52.7%
Using FP is bad for women's health (-)	23.5%**	27.5%	17.3%**	32.0%
Only God can decide number of children (-)	84.8%	90.6%	88.0%	90.75
FP external influence (-)	28.6%**	43.0%	15.9%**	31.3%
For respondents with unmet need, the reason they are not using anything ²	(N=64)	(N=52)	(N=56)	(N=52)
God's will³	45.3%	75.0%	57.1%	71.2%
Respondent opposed to FP	1.6%	5.8%	0	1.9%
Spouse opposed to FP	9.4%	0	5.4%	5.8%
Others opposed to FP	3.1%	0	0	0
Religious/moral issues³	0	1.9%	1.8%	0
FP is outsider influence⁴	1.6%	1.9%	0	0
Knows no method	14.1%	7.7%	3.6%	3.8%
Knows no source of method	25.0%	3.8%	10.7%	0
FP expensive	18.8%	1.9%	5.4%	0
No access to FP	9.4%	0	5.4%	7.7%
Health risk or side effects	7.8%	17.3%	10.7%	11.5%

** & * denote significant levels at the $p<.01$ and $p<.05$ respectively. Significance levels compare women to men in each village.

1. (+) if the statement is positive; (-) if the statement is negative; percentages are of those agreeing with the statement.

2. Respondents could list more than one, so totals may sum to more than 100%

VILLAGE NETWORK

Table 8 shows scores for “influence” and “connectivity” in both villages. A high influence score means that individuals named in peoples’ social networks were also nominated by many other respondents. For example, the maximum influence score in Bougouba was 9, which means the individual who was nominated the most in the village was nominated by nine people. We define individuals in the top 25% of influence scores as influential, because more people depend on them for more things.

A high connectivity score means that individuals named in peoples’ social networks had the shortest path to most villagers. We define individuals in the top 25% of connectivity scores as connectors, because they control the flow of information in a village.

Residents of Koloni appear to be more connected than residents of Bougouba, since the connectivity scores were much higher. They also appeared to have more influentials, since the highest influence score in Koloni was 19, as opposed to 9 in Bougouba.

Table 8: Network characteristics

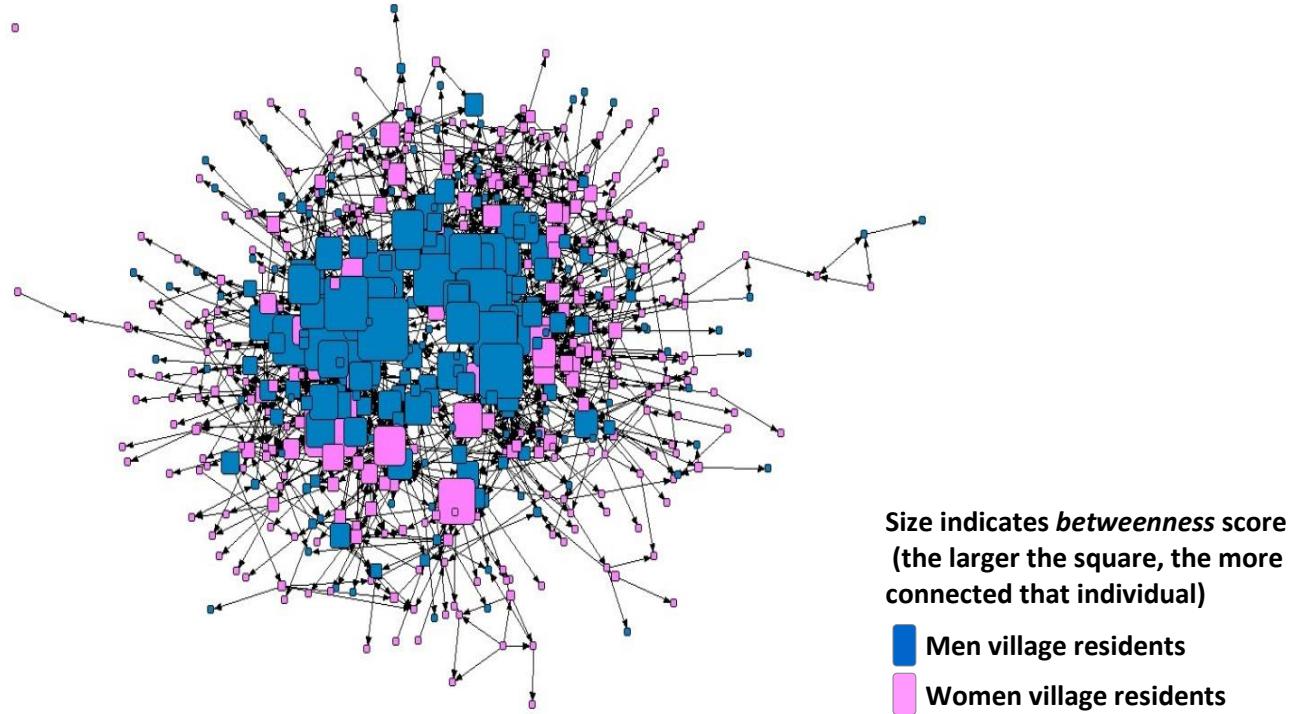
	Koloni		Bougouba	
	Influence scores	Connectivity scores	Influence scores	Connectivity scores
Mean	2.8	1573.6	1.9	314.4
Minimum	0	0	0	0
1st quartile	1	0	1	0
2nd quartile	2	128	1	0
3rd quartile	4	1,872	3	162.8
Maximum	19	16,577	9	4658
By gender (mean)				
Female	2.4	1,212.8	1.6	562.5
Male	4.2	4.113.7	2.4	673.7

In both villages, men were more connected and were nominated more often than women. In Koloni people who were currently FP users were nominated more often and were more connected than people with no need or unmet need; this was reversed in Bougouba, where people with met need were slightly less connected than people in the other two groups.

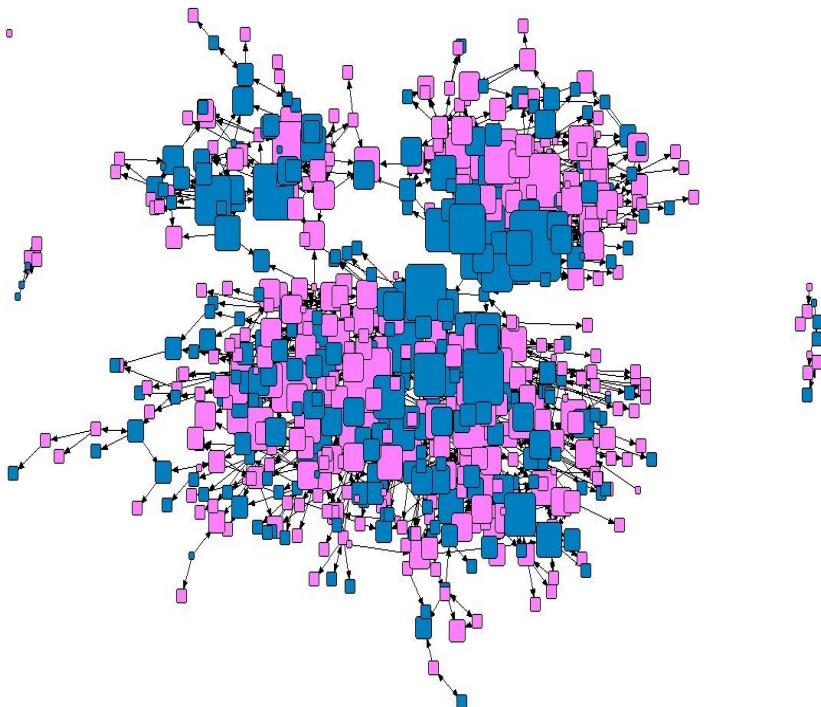
Figure 1 provides a visual representation of the full adult network for each village, including all adults who were interviewed, as well as all the people they nominated who reside in the village. The maps exclude people who were nominated who live outside the village. The difference in connectivity between the two networks is very visible. Whereas most individuals in Koloni are part of one large network, Bougouba consists of three distinct clusters.

Figure 1: Complete adult village network, by gender and connectivity score

Koloni



Bougouba



The relationships between participants and the persons they nominated are shown in Table 9. In both villages, about three-quarters of people nominated to the various networks (cognitive, emotional, material, and practical) lived in the same village. Participants claimed they felt close or very close to almost all the people they nominated. In general, women in both villages nominated more people than men.

Table 9: Relationship of nominated to nominating (respondents) by network type

	Koloni					Bougouba				
	Cognitive	Emotional	Material	Practical	Total	Cognitive	Emotional	Material	Practical	Total
Nominations by women¹	N=152 3.3%	N=144 2.1%	N=528 29.9%	N=265 2.6%	N=1089 15.9%	N=192 2.1%	N=74 0	N=481 32.8%	N=198 1.0%	N=945 17.4%
Husband	3.9%	3.5%	4.5%	17.4%	7.4%	0.5%	1.4%	0.6%	15.2%	3.7%
Co-wife	8.6%	18.8%	9.1%	2.6%	8.7%	12.5%	6.8%	10.6%	6.1%	9.7%
Mother	7.2%	5.6%	6.1%	10.2%	7.2%	10.9%	6.8%	3.7%	13.1%	7.4%
Mother in-law	11.8%	9.7%	4.5%	4.5%	6.2%	13.0%	8.1%	12.7%	7.1%	14.5%
Sister	28.9%	38.2%	16.0%	49.5%	28.9%	33.8%	37.8%	12.3%	47.4%	22.8%
Other female relative	15.1%	6.3%	4.4%	4.5%	6.6%	17.2%	23.0%	1.7%	2.5%	6.7%
Female friend/ colleague/neighbor	16.5%	9.8%	24.3%	7.1%	17.2%	9.3%	16.4%	24.8%	7.6%	17.4%
Male relative	1.3%	2.8%	1.3%	1.5%	1.6%	0.5%	0	0.6%	0	0.4%
Male friend	3.3%	0	0	0	0.5%	0	0	0.2%	0	0.1%
Leader or health provider (male or female)										
Nominations by men	N=147 3.4%	N=92 4.3%	N=279 3.6%	N=225 13.3%	N=743 6.6%	N=133 10.5%	N=77 7.8%	N=206 14.6%	N=210 20.0%	N=626 14.7%
Wife	4.8%	5.4%	2.2%	0.9%	2.7%	9.8%	7.8%	6.8%	0	5.3%
Mother	0	0	0	0	0	0	2.6%	0.5%	0	0.5%
Mother in-law	2.7%	1.1%	2.9%	4.0%	2.9%	6.1%	6.5%	4.9%	4.8%	5.3%
Other female relative	0.7%	0	0	0.4%	0.3%	0	0	0	0	0
Female friend/ colleague/neighbor	4.1%	3.3%	2.5%	0.4%	2.3%	6.8%	0	6.8%	1.0%	4.0%
Father	4.8%	2.2%	21.9%	1.3%	17.9%	13.5%	14.3%	25.7%	28.6%	22.7%
Brother	21.8%	21.7%	21.5%	49.8%	22.0%	28.5%	16.9%	23.8%	36.7%	28.3%
Male relative	53.1%	62.0%	45.2%	29.3%	44.0%	24.0%	41.6%	17.0%	9.0%	18.8%
Male friend/ colleague/neighbor	4.7%	0	0	0.4%	1.2%	0.8%	2.6%	0	0	0.5%
Leader or health provider (male or female)										

1. These are the genders of nominating respondents, not the people nominated.

While most nominations were people of the same gender, over half of women nominated men to their material network. The majority of women in both villages most often nominated female relatives to their networks (mothers, sisters, co-wives, and other female relatives). The one exception was the material network, where over half of women in both villages nominated either their husband or a male relative. Men

in both villages nominated mostly male relatives and male friends or colleagues to all networks. Very few health providers or religious or community leaders were nominated.

Also of interest are respondents' perceptions of attitudes toward FP among those they nominated compared to the stated beliefs of the nominated individuals themselves. Table 10 shows the percent of those who were nominated as approving or disapproving of FP (in other words, what the person who nominated them thought they believed) among those in the top quartile of the FP approval index, the bottom quartile of the FP approval index, and who have unmet need. Included in the analysis are only respondents who, in addition to being interviewed, were also nominated to one or more networks by at least one other respondent. Results show no concordance between respondents' perception of people's approval of FP and the nominated persons' actual stated beliefs. For example, about one-third of respondents in both villages who were nominated as approving of FP were in the top quartile of the FP approval index (they approve), but one-third were in the bottom quartile (they disapprove).

Table 10: Real¹ vs. perceived² attitudes toward FP by network status

% of those nominated as approving or disapproving of FP, who are in the top or bottom quartile of the FP approval index, or who have unmet need. ³	Koloni (N=339 nominated people, 581 nominations)			Bougouba (N=311 nominated people, 697 nominations)		
	Nominated respondents who are in highest quartile of FP approval index score	Nominated respondents who are lowest quartile of FP approval index score	Nominated respondents with unmet need	Nominated respondents who are in highest quartile of FP approval index score	Nominated respondents who are lowest quartile of FP approval index score	Nominated respondents with unmet need
Nominating person perceives that nominated person approves or disapproves of FP:						
Nominated as approving of FP	37.2%	32.4%	33.7%	34.9%	26.3%	30.1%
Nominated as disapproves of FP	31.2%	36.6%	32.1%	22.6%	35.5%	35.5%
Didn't know if nominated approves or not	32.1%	35.7%	34.4%	31.8%	28.9%	32.8%

1. Real attitudes are those expressed directly by the respondent

2. Perceived attitudes are those perceived by the nominating individual.

3. Since the vertical categories are not mutually exclusive (for example, a person with unmet need can also be in the bottom or top quartiles of the index), figures can sum to more than 100%; since people in the middle 50 percentile of the index are not included (unless they have unmet need), figures can some to less than 100%

Table 11 shows concordance between husbands and wives. In the top half of the table, we first see how many men believe that at least one of their wives approves of FP (in bold). We then gauge actual approval

of their wives by listing the percentage who agree with four statements used to calculate the FP attitude index. The top two statements are positive, and the bottom two statements are negative. If there is concordance between husbands and wives, agreement with the top two statements approach 100% and agreement with the bottom two statements approaches 0. In the bottom half of the table we look at the percent of women who believe that their husband approves of FP, and repeat the exercise with their husbands.

For example, 64.2% of men in Bougouba believe that at least one of their wives approves of family planning. When we look at these wives, we see that only 47.1% of them actually believe that couples who use FP are better equipped to take care of their families. This figure would have been higher if there was concordance. Overall, we see general concordance between husbands and wives, but it is not universal. In Koloni, for example, about one-quarter of women whose husbands perceive they approve of FP revealed they actually do not approve (in other words, they agree with two negative FP characteristics).

Table 11: Husband and wife agreement

	Koloni N=118 nominating men N=156 nominating women	Bougouba N=106 nominating men N=73 nominating women
% of men believing that at least one of their wives approves of FP		
Believe wife approve	66.1%	64.2%
Believe wife does not approve	25.1%	27.4%
Don't know	8.5%	8.5%
Of nominated wives, whose husbands say they approve of FP		
Positive attitude:		
% who believe that women who use FP look better than those who do not	64.1%	54.4%
% Believe that couples who use FP are better equipped to take care of their families	70.5%	47.1%
Negative attitude:		
% who believe that women using FP are immoral	24.4%	13.2%
% who believe that using FP is bad for women's health	25.6%	21.6%
% of women believing their husbands approve of FP		
Believe husband approves	42.9%	25.4%
Believe husband does not approve	8.3%	21.7%
Don't know	48.7%	52.9%
Of nominated husbands, whose wives say they approve of FP		
Positive attitude:		
% who believe that women who use FP look better than those who do not	86.6%	54.3%
% Believe that couples who use FP are better equipped to take care of their families	86.6%	57.1%
Negative attitude:		
% who believe that women using FP are immoral	32.8%	20.0%
% who believe that using FP is bad for women's health	29.9%	22.9%

NETWORK STATUS AND FAMILY PLANNING USE AND ATTITUDES

Figures 2 and 3 show FP use status of women and men, respectively, in the two villages. Size of nodes denotes connectivity—the larger the size, the higher the connectivity score. That is, individuals represented by larger symbols have a shorter path to more villagers. Men and women must be reviewed separately, because they were calculated differently. Women were assigned only one need status; therefore they are categorized as having no need, met need, or unmet need. Men, on the other hand, were sometimes assigned more than one need status for different wives. Therefore, for men, the figure shows those with unmet need with at least one wife and those with no need (had either no need or used FP with all their wives).

Figure 2: Women's FP use status by connectivity score

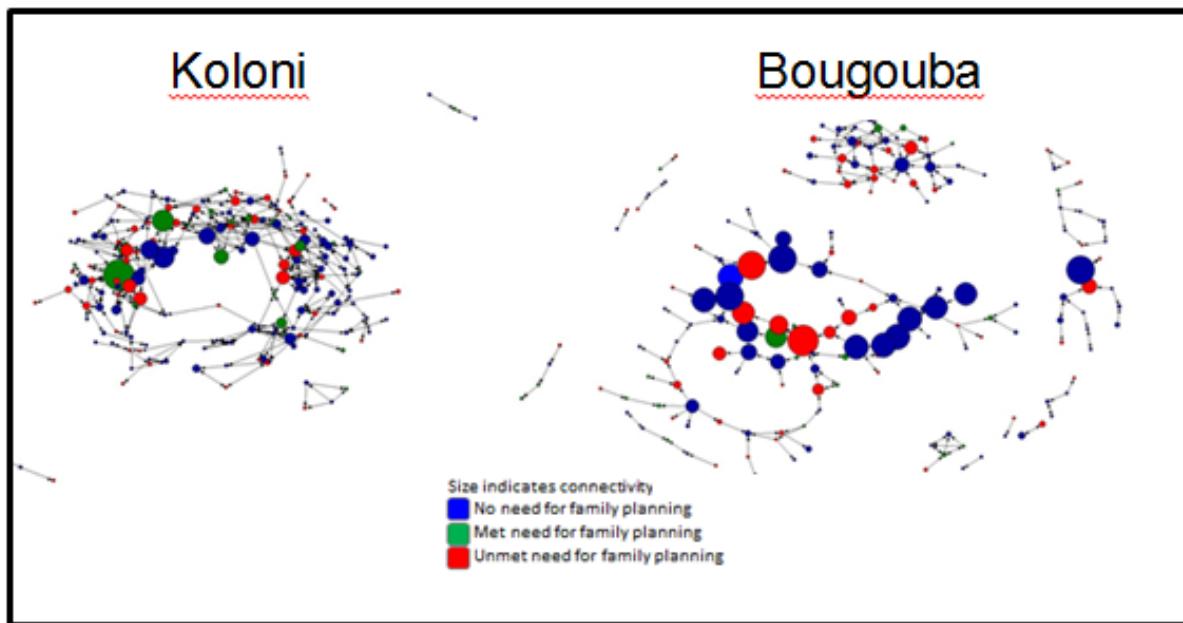
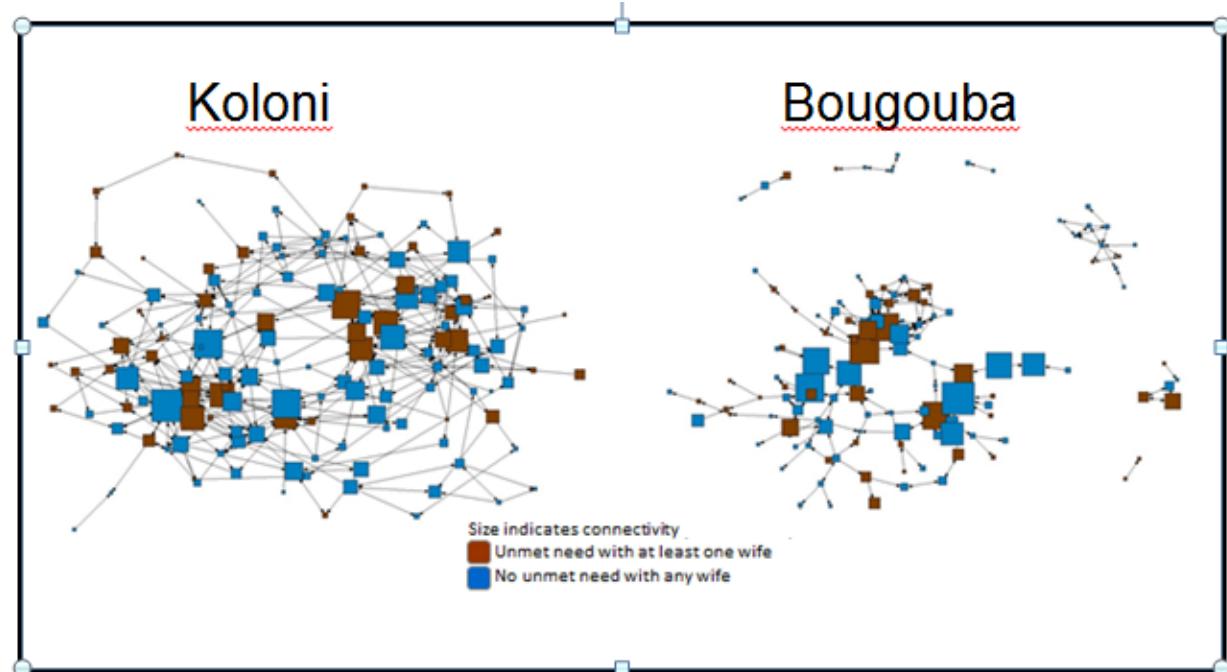


Figure 3: Men's unmet need status by connectivity score



For all men and for women in Koloni, there appears to be no visual correlation between having unmet need and being a connector (high connectivity score)—if anything, women and men with met need have the highest connectivity. However, in Bougouba the few women who use FP appear to be less connected than other women.

Table 12 shows the mean influence and mean connectivity scores by need status (men and women combined).

Table 12: Need status

	Koloni		Bougouba	
	Influence score (influential)	Connectivity score (connector)	Influence score (influential)	Connectivity score (connector)
No need	3.0	2,462.0	2.0	600.1
Met need	4.2	3,243.1	1.7	376.2
Unmet need	3.5	2,585.5	2.1	621.8

Different results emerge in the two villages. In Koloni, adults (both men and women) who use FP are more connected than people with no need or unmet need for FP. In Bougouba, people who use FP are the least connected.

C. SUMMARY

The findings from the social network census revealed the influence of social interactions on contraceptive use and how the type and density of social connections might be influencing use. But it also generated many questions. For example, are there common characteristics among influentials and/or connectors? What kinds of information flow through the networks? How is that information diffused? We therefore sought further explanations about people's perceptions of their need for FP and their reasons for not using methods, especially when they had unmet need. The next phase in the "ethnographic sandwich" was designed to elucidate these points.

PHASE III – IN-DEPTH INTERVIEWS

A series of in-depth interviews were designed to complete the "ethnographic sandwich". These interviews focused on the following topics:

- The content, quality, and frequency of FP information shared between members of the community;
- Participants' understanding of their own need for FP based on their fertility intentions and desires; and
- Participants' reasons for not using FP.

A. METHODOLOGY

SAMPLING

Participants were drawn from a pool of social network mapping census respondents who had indicated their willingness to be contacted for this phase of the study. Therefore all respondents were married women aged 18 to 44, and men married to a woman aged 18 to 44. They were purposively selected from this pool using criterion sampling (Miles & Huberman, 1994) based on FP need status (met need, no need, unmet need) and social network status, as determined from the social network analysis (Table 13).

Table 13.Social network status categories

Influentials	Those in the top 25% of influence scores from the social networking census. They can have direct influence on many people.
Connectors	Those in the top 25% of connectivity scores from the social networking census. They link two or more groups of individuals. They can control the flow of information in a village.
Influential-Connectors	Those who have characteristics of both influentials and connectors in the village social network.
Isolates	Individuals who are less connected or have smaller, more disparate social networks.

DATA COLLECTION

In-person, semi-structured interviews were conducted with 12 men and 12 women in each village, for a combined total of 48 participants in the two villages. Interview guides were developed for women and for men (see Appendix C). The topics and questions were developed in English, translated into French, and then verbally translated into the local languages at the time of the interview. Interviews were conducted by two teams of two female and two male interviewers. These interviewers had also conducted the social network mapping census, so they were familiar to village residents. Women interviewed female participants, and men interviewed male participants in private locations chosen by the participant. All interviews were audio recorded and later simultaneously translated and transcribed into French by the interviewers.

ANALYSIS

The analysis team was comprised of six Terikunda Jékulu staff—two Malian staff (male Project Director, female Monitoring & Evaluation Manager), three DC-based staff (one African male, Program Officer; two females of European descent with significant field experience throughout West Africa—Director of Programs and Program Officer for Research), and one female Peru-based consultant, formerly a Terikunda Jékulu Project Assistant. This collaborative, cross-cultural approach to analysis allowed for a rich exploration and full elucidation of the analysis themes.

Qualitative data analysis software (Atlas.ti 5.2) was used to facilitate analysis of transcripts and field summaries. First, descriptive codes were assigned to each transcript to identify similarities and differences among participants with particular attributes. Next, open and axial coding were carried out as an iterative process until theoretical saturation was reached (Corbin & Strauss, 2008) (see Appendix D for codebook). Once the 48 transcripts were coded, the analysis team conducted a disaggregated analysis of themes by different participant attributes, such as sex, social network status, or FP need status.

B. RESULTS

PARTICIPANT PROFILE

Table 14 shows participants by village and social network status (as determined based on the status identified during the census). Although we tried to identify a similar number in each group, this was not possible given the different proportion of people with various social network statuses in the different FP need categories.

Table 14: Participants by village and social network status

Social Network Status	Koloni	Bougouba	Total
Influential	4	2	6
Connector	5	7	12
Influential-connector	9	7	16
Isolates	6	8	14
TOTAL	24	24	48

Table 15 summarizes participants according to their social network status and FP need status, as identified from the census.

Table 15: Participants by social network status and FP need status

FP Need Status				
Social network status	Met need	Unmet need	No Need	Total
Influential	2	3	1	6
Connector	4	3	5	12
Influential-connector	5	6	5	16
Isolates	5	4	5	14

Table 16 shows participants according to their FP need status. The left column under both men and women shows the FP need status of participants as identified at the time the social network census (SNC) was conducted. When the in-depth interviews were conducted several months later, some participants FP need

status had changed. Thus, the right column under both men and women shows the FP need status of participants at the time of the in-depth interview (IDI). As described in the outcome variable definition early in this paper, in the polygamous, Malian context, men's FP need status is complex, because their need for FP can be different with each wife. For example, a man with two wives could have "no need" and "unmet need" at the same time; thus we added a fourth "need category" that applies only to men in this particular situation. We were only able to determine this for IDI participants; social network census data did not allow us to distinguish if men fell into more than one need category.

Table 16: Participants by FP need status

FP need status	Men		Women		Total	
	SNC	IDI	SNC	IDI	SNC	IDI
Met need (FP user)	8	3	8	6	16	9
Unmet need	8	8	8	6	16	14
No need (pregnant or wants child)	8	9	8	12	16	21
Unmet need & no need (men only, with multiple wives)	N/A	4	N/A	N/A	N/A	4

SOCIAL GROUP PARTICIPATION

Terikunda Jékulu seeks to diffuse information and catalyze social change via existing social platforms. As such, we sought to identify the types of groups in which individuals participate, as well as to determine whether participation differs by social network status or FP need status in order to inform our intervention development.

Common Social Groups	Almost all male and female respondents participate in some type of social group, regardless of their social network status or FP need status. Men and women most often cited participation in tontines (savings groups) and microcredit lending groups (organized by outside organizations), followed by agricultural collectives and religious study groups. It appears the local economy in the village drives the organization of certain social groups—the cotton growers association was mentioned frequently among respondents from Bougouba, for example, but not at all in Koloni.
Tontines Microcredit groups Agricultural collectives Religious groups	Participation in one type of group or another was not correlated with FP need status—in other words, men and women with unmet need, met need, and no need belonged to the same groups. Similarly, influencers and connectors participated in all types of groups, though they held leadership positions more frequently than isolates. This was true for mostly men, except for one woman—which has important implications for intervention design: it may be effective in this context to reach male influencers through leaders in official positions, but this may not be the case for female connectors.

a. Social groups for elders

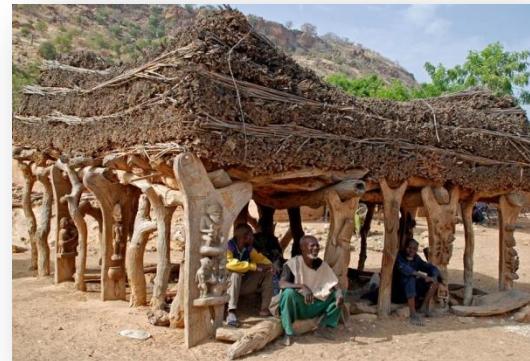
Since the ethnographic research revealed that age hierarchies direct the flow of information in social networks, especially around sensitive topics like FP, we specifically explored elders' participation in social groups. Due to their status and influence, we hypothesized that catalyzing discussions with elders about FP may accelerate changes in social norms throughout the community.

For the most part, social groups tend to include people of all ages. Besides informal gatherings of peers, respondents indicated that age-specific social groups are uncommon and groups do not exist whose members are uniquely older individuals. Participants noted that elder women in both villages participate in tontines, though it was unclear if there are tontines comprised exclusively of older women. Participants explained that older men in both villages gather frequently at the village chief's house or in front of the village store to discuss village activities.

b. Informal social gatherings

In addition to gathering information about formal social groups, we also sought to identify places and situations in which individuals socialize informally, so as to better understand social diffusion mechanisms. This has important implications for how topics discussed within the social groups through which TJ intends to intervene may be spread. It could also suggest other venues for intervention activities.

Results revealed that outside of organized social groups, respondents regularly spend time with their family members, peers, friends, and neighbors in various settings and contexts. In Bougouba, for example, men often have discussions under the toguna, a "men's only" outdoor gathering place characteristically found in Dogon villages. For others, formal social groups shape respondents' informal groups of friends and social gatherings outside group meetings, since many people form friendships with individuals in their tontines or agricultural collectives and meet with them outside of the formal group setting. Respondents also frequently mentioned other social gatherings where friends, family, or the entire village convene. They identified baptisms and weddings, in particular, as events where fertility and child spacing come up in conversation and it is acceptable to discuss.



Under the toguna in a Dogon village.
Photo credit: Dr. Vijay Pithadia

DIFFUSION OF INFORMATION

After identifying the social groups in which people commonly participate, we sought to identify how information flows through formal and informal networks of individuals.

Analysis by village revealed a distinct difference between Koloni and Bougouba. There were many social barriers in Bougouba that prevented people from openly discussing their fertility, child spacing intentions, and FP use. Koloni residents, on the other hand, discussed these topics much more openly, especially women. This corresponds with the network dynamics and flow found in the ethnographic research, which revealed that in the large, dense networks of Bougouba, strong community disapproval of FP use discouraged its discussion, whereas the small, dense networks of Koloni served to sustain and reinforce FP use and enabled key family member allies to help overcome disapproving spouses.

There were also differences between men and women in how fertility, child spacing, and FP information is diffused. This is important for intervention design, given that discussions on these topics typically happen

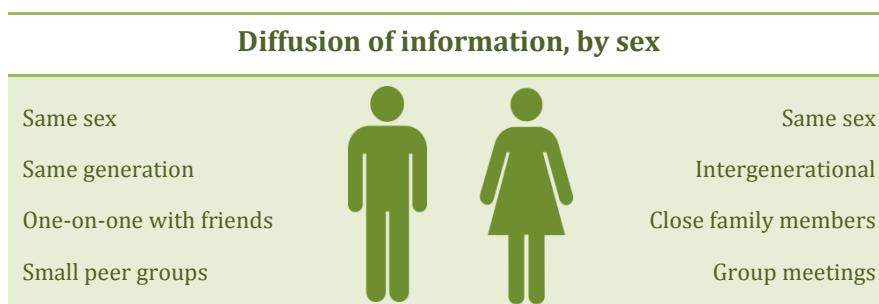
among the same sexes, and infrequently across sexes, unless between the married couple. Men tend to discuss fertility, child spacing, and FP one-on-one with friends of their same generation or in small peer groups. They rarely had these discussions with family members or in formal group settings.

Entre amis, il n'y a pas de tabou au moment de la causerie.

Between friends, there are no taboos in conversation.

-Man, 30 years, no need, isolate

Women, on the other hand, have these discussions most often with female family members and are more likely to be intergenerational, including mothers, mothers-in-law, and sisters-in-law. They are also more likely to discuss and debate ideas in formal group settings, for example, at tontine meetings.



a. Sparking the discussion

When people discuss fertility, child spacing, and FP, it arises spontaneously in conversation as opposed to being broached as a formal topic of discussion. Respondents described that conversing about their existing children can naturally spur discussions of fertility and child spacing. Some participants mentioned that a specific event or someone's personal experience can also spark the discussion, like a woman in the village giving birth to a child spaced closely after the last. Respondents value these kinds of real-life examples and use personal stories as a launching pad to talk about issues like child spacing and FP more broadly.

In general, most women and men said that anyone can bring up the subject of child spacing or FP. In some cases, especially among men, those who are older or who have more children are the ones that tend to bring up the topic.

b. Influential sources of information and attitudes

Those who are seen as trusted sources of FP information are not necessarily the people that respondents trust most or seek out when they have questions. Respondents frequently mentioned relais (community health workers) as experts in FP and traditional birth attendants (TBAs) as experts on pregnancy, childbirth, and less often on child spacing. Respondents also recognized health centers and providers as being experts in child spacing and FP, but cited them infrequently as sources of information in these domains. Most seemed to lack any personal connection with providers, due in part to long distances to health centers. Instead of actively seeking out health providers for FP information, respondents were passive recipients through the course of antenatal care or child vaccination visits.

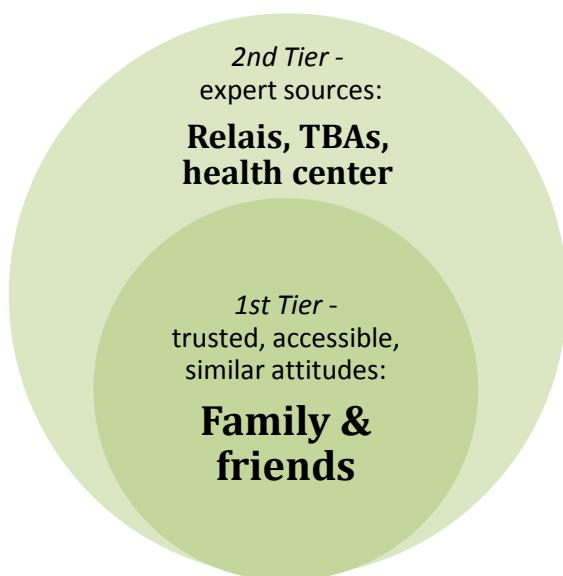
Interestingly, connectors (unlike those in other social network status groups) almost unanimously seek out a health provider for reasons of trust and expertise; however, they also simultaneously seek information from other sources, including mothers-in-law and TBAs. When people do receive FP information from health providers, it seems to get circulated back into the community.

C'est lorsque j'ai emmené mon enfant à Bougouba pour la vaccination que j'ai entendu les femmes parler des méthodes de planification, alors je suis venu à la maison pour parler à mon mari et mes belles sœurs. C'est aussi que j'ai commencé à faire l'injectable, de nos jours c'est la pilule que j'utilise.

I heard about family planning methods when I brought my child to Bougouba for a vaccination, so I came back home to talk to my husband and sisters-in-law. That's when I started using injectables, but these days I use the pill.
-Woman, 34 years, met need, connector

Therefore, a single interaction with a health provider has a multiplier effect—sparking more of these connections could be an effective program strategy to get expert information flowing through the community.

Radio may be one way to trigger more of these discussions, especially among men. Men in both villages cited radio as an important source of FP information. Some also mentioned that what they heard on the radio prompted them to seek additional information from health providers. This suggests unique potential for reaching a specific segment of the population with tailored educational and behavior change messages.



Despite the fact that relais, TBAs, and health providers are seen as experts in fertility and FP, most respondents prefer to first seek information from family members or friends, because they are trusted and geographically accessible. This was true for both FP users and non-users.

Lorsque je veux avoir des renseignements sur l'espacement des naissances...ce n'est ni à un agent de santé que je m'adresse ni à une accoucheuse traditionnelle. Je me rends à notre groupement... parce que c'est plus pratique et plus rassurant.

When I want information on birth spacing, I don't go to a health worker or a midwife. I go to our women's group... because it is more practical and more reassuring.
-Woman, 38 years, influencer, FP user

In addition to being a first choice for information, family members' opinions regarding fertility are also very important, especially among female respondents.

Souvent par cousinage d'autres me disent qu'il est temps que je tombe enceinte parce que mon dernier enfant a bientôt trois ans cette année.

Often people in my extended family tell me that it is time that try to get pregnant again because my youngest child will be three this year.
-Woman, 35 years, no need, isolate

Relatives who live within the closest geographic proximity and who are in more constant contact with respondents seem to have the greatest influence. The ethnographic research in the first phase of the formative research suggested that relatives who live outside of the village or migrants that travel frequently to and from Bamako may be useful sources of accurate information and role models for FP use. However, this phase of the research contradicts those findings. Additional research is recommended before designing interventions that engage returning migrants.

It is important to note that participants with unmet need did not confer as much with family and friends. This group seeks advice less often than FP users, and limited diffusion can lead this group to become isolated from information. Compounding this, results revealed that isolates were least likely to seek information or advice from health providers; only half of isolates said they would seek information from health providers. This underscores the importance of interventions that actively seek to reach isolates, as they are most at risk for experiencing unmet need.

In sum, we find that respondents turn first to family and friends within close geographic proximity whose opinions matter most to them, whether or not they have the best FP information. Those considered “experts” are disassociated from social groups, which prevents good quality FP information from circulating throughout the networks; instead, whatever attitudes and information individuals in respondents’ inner circles hold—good or bad—is diffused. In order to improve the quality of information flowing through the networks, it will be important for the project to connect *relais* and health center staff with influentials and connectors.

Overall, diffusion of ideas (sharing of views and attitudes) seems to occur in group settings, while advice-seeking happens more in one-on-one settings. In addition to group-focused debates, TJ should reach influential advice-givers (mothers and mothers-in-law for women and male friends for men).

c. Subject matters: What information and attitudes are diffused

Further to how and through whom information is diffused, we also sought what information and attitudes were being diffused through respondents’ social networks. Though “family planning” and “child spacing” are terms often used interchangeably among international health professionals, this study revealed that participants think about them as two distinct concepts—although support for healthy timing and spacing of pregnancies (child spacing) is widespread, peoples’ attitudes towards the means of achieving spacing (family planning) are mixed. We also found respondents’ attitudes towards child spacing and family planning are impacted by their beliefs about a couple’s agency in determining the number of timing of their children. Though many claim such matters are left to “God’s will”, these attitudes are not informed by religious teachings nor diffused by religious leaders. This suggests fatalism rather than religious devotion at work in shaping such beliefs, which are reinforced by and through network dynamics. Each of these themes is presented in more detail below.

d. Information and attitudes diffused about child spacing

Attitudes towards child spacing are very positive among respondents in both villages. Respondents are overwhelmingly supportive of healthy timing and spacing of pregnancies, citing the health and well-being of women and children as the primary advantages. Both women and men acknowledged that avoiding closely spaced births also helps a woman maintain her youth and beauty. In addition, participants recognized that since women are at the heart of the family, child spacing is of interest to the household at-large, and its benefits extend to the entire community.

Elles pensent que l’espacement des naissances est importante, ça permet de stabiliser la famille moins de problèmes et moins de maladies. Car quand un enfant est malade c'est toute la famille qui en endosse la conséquence encore moins si c'est plus d'un. Donc si l'on pratique les méthodes d'espacement des naissances ça fait moins de dépenses.

*Respondents with
unmet need seek out
FP information less
often than FP users.*

They think that spacing births is important, that it lets us balance the family with fewer problems and sicknesses. Because when a child is sick the whole family shoulders the consequences, and even more if it's more than one [child]. So if we practice methods of birth spacing that means fewer costs.
-Woman, 34 years, no need, influencer/connector

Some even went so far as to say that women who practice FP are more highly regarded than those who do not:

La femme qui pratique la PF pour espacer les naissances est beaucoup appréciée que celle qui porte toujours le bébé.

The woman who practices FP to space births is much more appreciated than the woman who is always carrying a baby.
-Man, 56 years, no need, connector

This does not mean that small families are preferred or the norm. In general, respondents prefer large families, in order to provide labor for household chores, compensate for anticipated child mortality, or take care of them in old age.

Given the high proportion of polygamous unions in our study locations, we wanted to explore the potential relationship between polygamy and fertility preferences. We wondered, for example, if men might take more wives because they wanted more children. But when asked directly, men did not indicate any conceptual link between polygamous relationships and their fertility preferences. In fact, they stated emphatically that their decision about the number of wives they take is not related to the number of children they desire. They also indicated that spacing and timing is related to each individual wife, not the overall family picture. This man illustrates:

Ma première femme à un enfant de moins de deux ans. Je souhaiterai que son enfant grandisse un peu. Quand à la deuxième je souhaiterai qu'elle ait un enfant cette année parce que son enfant a déjà grandi.

My first wife has one child less than two years old. I hope that her child gets a little older first. But I hope that my second wife has a child this year because her last child is already big.
-Man, 53 years, unmet need, influencer

Nevertheless, some mention that a woman can become tired and weak if she has too many children, so it is better to have multiple wives with smaller numbers of children per wife.

Certains disent que quand tu te maries avec deux femmes tu auras beaucoup d'enfants et que tu ne pourras pas assumer les dépenses. Donc, selon moi, lorsque tu as un certain nombre d'enfants tu dois arrêter la fécondité. Par exemple, quelqu'un peut prendre une femme, elle peut avoir 10 ou 11 enfants, et pense qu'une femme ne doit pas dépasser 3 ou 4 enfants. Donc avec deux femmes tu as 8 ou 9 grossesses, tes épouses tiennent mieux plus que celle qui a 10 ou 11 grossesses.

Some people say that when you marry two women you will have lots of children and that you won't be able to take on all the expenses. So in my opinion, when you have a certain number of children you should stop the fertility. For example, someone could take a wife, she could have 10 or 11 children, and think that a woman shouldn't have more than 3 or 4 children. So with two wives you have 8 or 9 pregnancies, your wives will be in better shape than the woman who has 10 or 11 kids.
-Man, 27 years, met need, connector

This reiterates previously stated benefits towards child spacing about women's health and well-being. Men also voiced strong support for child spacing, as it enables them to better care and provide for their families—well-spaced children mean fewer illnesses, fewer mouths to feed, and ultimately, fewer expenditures. In general, participants' responses suggest that decision-making around the timing of the next child and total family size is related to household economics. In the same way that respondents indicated it is good to space children to reduce expenditures, men in particular suggested that those with sufficient means can continue having children.

S'il y a un moyen [financier] c'est possible de... continuer à faire des relations sexuelles. Mais s'il n'y a pas d'autre moyen... tu te dis que si je fais des relations sexuelles pendant qu'elle allaite un enfant, ça crée des dépenses financières.

If you have the financial means, you can continue to have sex. But if there's no money, you tell yourself that if I have sex while she's breastfeeding a child, that creates financial expenditures.
-Man, 38 years, unmet need, influencer/connector

This suggests that many men perceive financial savings as the overriding benefit of child spacing. If this is not a concern, other stated benefits of child spacing (e.g., wife's well-being) may not be significant enough to encourage FP use. Given the preference for large families, particularly if they appear well cared for, a man with many children may be viewed as wealthy and be conferred greater social status. In short, men would have more children if they could afford it. It is important for social network projects to carefully address men's motivations for child spacing, especially since men are the primary decision-makers when it comes to FP use (discussed later in more depth).

e. Family size, timing pregnancies, and couple agency in the context of God's will

Although child spacing is viewed positively, limiting children is not at all socially acceptable and the use of FP for limiting children is expressly frowned upon. In both Bougouba and Koloni, there is a strong belief that children are a gift from God. Even the concept of ideal family size has the same connotation as limiting, since stating a preferred number of children would mean contradicting what God or fate may have in store. In fact, nearly all respondents believed the number of children one has and their timing is predestined by God. Some explained that even if pregnancies are not desired at the moment, they are willing to accept whatever God gives them ("Je reste derrière Dieu"). They simultaneously championed the advantages of spacing children two to three years while explaining that even if they were to determine an ideal family size or try to space their children, God's plan will always prevail.

Les gens disent que le nombre d'enfants que Dieu t'a prédestinée tu ne peux échapper à cela même en prenant des médicaments pour éviter une grossesse.

People say that you can't escape the number of children that God has predestined for you, even by taking medicines to avoid pregnancy.
-Woman, 36 years, no need, connector

A small number of people mentioned that this is the very reason they don't talk about ideal family size—if God has already determined the number of children they will have, there is no reason to discuss.

S'agissant du nombre d'enfant à avoir, là, sincèrement, on évite de soulever ou de parler de ce sujet car le nombre d'enfant à avoir relève

C'est Dieu qui décide.

Tout dépend de Dieu.

Ca dépend de la volonté de Dieu.

It's God who decides.

Everything depends on God.

It depends on God's will.

de la volonté de Dieu.

Regarding the number of children to have... there, truly, we avoid bringing it up or talking about it because the number of children to have depends on God's will.
-Man, 33 years, unmet need, influencer/connector

Although it is not acceptable to discuss ideal total family size, it is appropriate to reflect on the timing of the next child. Respondents indicated that the decision to have another child is often based on the development stage of a couple's youngest child—if their child is no longer breastfeeding and can walk on his/her own, then it is time to have another child. And although nearly all respondents believe in God's predestined plan, they also pronounced that couples have a role to play in the number and timing of pregnancies. In general, more women than men espoused the idea that couples can play a role in the number and timing of pregnancies; Koloni respondents had a slightly more favorable attitude in this regard than those from Bougouba.

Selon moi, le nombre d'enfants et l'espacement des naissances sont décidé à la fois par Dieu et les couples.

In my opinion, the number of children and birth spacing are decided by both God and couples at the same time.

*-Male, 33 years,
no need/unmet need, isolate*

*Si c'est pas Dieu, on ne peut pas avoir d'enfants.
Mais le nombre d'enfants depend de l'homme et la femme.*

Without God, we couldn't have children. But the number of children depends on the man and woman.

-Male, 41 years, unmet need, influencer/connector

All FP users ('met need') believed couples have a role in determining the number and timing of pregnancies. Only about half of participants with 'unmet need' or 'no need' felt this way—the other half believed children were a matter of God's will and felt couples have no choice in the matter.

At first, this may seem contradictory—how can people claim that fertility outcomes are in the hands of God, and yet couples can still have a hand in determining the number and timing of their children? Wouldn't this mean that couples are defying whatever religious teachings inform their views? It is important to note that despite the overwhelming number of references to "la volonté de Dieu", almost no one related this to religious teachings of any kind, except one person who mentioned that the Prophet Muhammed used child spacing. This may suggest that references to "God's will" may simply be common vernacular for fatalism, or resignation that "whatever will be will be". This could be understood given high infant and child mortality rates,

lack of knowledge and access to methods, and perceived community disapproval for using the methods that could achieve the space between children about which respondents professed such advantages. For those with unmet need, these barriers could feel insurmountable, contributing to an overall perceived lack of control, thereby engendering a default position of acceptance of "God's will". The below respondent with unmet need illustrates this well:

Je disais que j'ai envie d'utiliser la PF mais je ne sais pas comment je peux l'avoir. Donc, ça dépend de Dieu sinon moi je ne faire pas quelque chose.

I said that I wanted to use FP but I don't know how I can get it. So that depends on God, otherwise I can't do anything.
-Man, 41 years, unmet need, influencer/connector

Since many believe that couples can play a role in determining pregnancy timing, it is essential that FP projects aim to bolster peoples' sense of self-efficacy around child spacing—especially making the link

between contraceptive methods as the means to achieve child spacing and the advantages that ensue for the family. In promoting the couples' ability to determine the timing and spacing of the next child, however, care should be taken in designing intervention materials that focus on healthy timing and spacing and do not discuss ideal family size or encourage fewer children.

f. Information and attitudes diffused about family planning

As noted earlier, respondents viewed FP use as distinctly separate from the concept of child spacing. Despite strong support for child spacing, participants' attitudes towards the use of FP methods was mixed. In this section, we will explore their reasons.

Nous parlons de l'espacement des naissances et des méthodes de planification familiale; les gens disent que les grossesses rapprochées ne sont pas bonnes, donc en utilisant une méthode, nous pouvons éviter cela... D'autres personnes disent que les méthodes de planification ne sont pas bonnes...

**Concerns about
perceived side effects
should be addressed
but not
overemphasized.**

*We talk about birth spacing and about FP methods; people say that closely spaced pregnancies are not good and that by using a method, we can avoid that... Others say that planning methods are not good...
-Woman, 36 years old, no need, connector*

Respondents explained that discussions about FP methods among friends or within social groups often instigated a debate. When FP is discussed, more often than not, the discussions are about the idea of using FP, not about specific contraceptive methods. Relatively little factual information about FP methods, either accurate or inaccurate, is circulating in either village. Although some participants did say they discussed actual methods, this perhaps is not surprising given the low contraceptive prevalence (12%) found in the social network census.

Women had highly positive attitudes towards contraceptive methods, and generally recognized the link between the use of FP and achieving the desired space between births. They also tended to be more knowledgeable about contraceptive methods than men. All women could cite at least one modern method, and most could cite two to three methods, most frequently the pill, injectable, or implant, which corresponds to the most frequently used modern methods according to the social network census.

L'espacement naturel n'est pas éternelle alors toute femme qui ne souhaite pas tomber enceinte doit recourir à la PF. Maintenant la PF est un moyen d'éviter et d'espacer les naissances.

*Natural birth spacing doesn't work forever, so all women who don't want to get pregnant should use FP.
Now FP is a way to avoid (pregnancy) and space out births.
-Woman, 28 years, no need, connector*

Men, on the other hand, were less informed about methods, and, therefore, espoused greater fears about and resistance to their use. Only a few men made any mention about any method, whether modern or traditional. This is different than the social network census, where more women (14%) than men (8%) knew no FP method. One possible explanation is that men may consider FP to be an issue solely for women. And although some men approved of FP in principle, they often viewed it as something for "others", such as intellectuals or people that are wealthier than themselves. This rationale is somewhat contradictory, however, given men's attitudes that those with financial means can and should have more children (as opposed to using their wealth to purchase FP).

Les intellectuelles et les personnes riches ont plus d'avantages pour pratiquer la PF, les uns pour leur facilite de comprendre les choses modernes et les autres à cause des moyen qu'ils ont.

*Intellectuals and rich people have more advantages to practice FP, the former because they can understand modern things and the latter because of their means.
-Man, 42 years, met need, influential/connector*

When speaking about FP, respondents rarely distinguished between modern and traditional methods. When they mentioned traditional methods—such as *tafo* (belt) or periodic abstinence—they were usually mentioned in the same sentence as modern methods and accorded similar value. Many participants (especially in Koloni) use traditional methods and believe them to be equally or more effective than modern methods. The quote from a traditional FP user below illustrates this, as well as further exemplifies the earlier finding that isolates are more cut off from sound FP information and advice.

Je doute un peu de l'efficacité des injections, non seulement c'est périodique mais aussi elle peut être interrompue à tout moment. Par contre, ma méthode [traditionnelle] est garantie pendant une année. C'est un vieux qui me fournit une poudre contraceptive dont la date de péremption coïncide exactement à sa date de livraison, c'est-à-dire une année plus tard, le même mois et le même jour.

I somewhat doubt the efficacy of injectables: not only are they periodic but they can also be interrupted at any time. On the other hand, my [traditional] method is guaranteed for one year. A respected old man gives me a contraceptive powder for which the expiration date is exactly the same as the delivery date, just one year later, the same month and the same day.

-Man, 34 years, met need, isolate

Les questions relatives aux enfants et la planification familiale sont des nouvelles choses [pour moi].

Questions about children and family planning are new [to me].

-Man, 34 years, connector

Family planning programs often put great effort into addressing myths and rumors, believing they are among the primary reasons underlying unmet need; our data show that while program interventions should address a population's major concerns/perceived side effects, they should not be overemphasized. Our respondents rarely mentioned any myths or misinformation about FP. This correlates with the social network census, in which only a small proportion of respondents—8% of women and 17% of men—said that side effects were the reason they were not using a FP method. However, it distinctly contrasts the ethnographic research, which revealed intense circulation of rumors in Bougouba, in particular. The misinformation that did come up in the in-depth interviews centered around fertility—some believed that modern methods caused sterility or birth

defects. Others did not know a woman's fertile days or believed they could naturally space births for up to three years. Misinformation was also method-specific, e.g. the pill leads to twins or the injectable is ineffective because it is only used every two to three months. Although women were more knowledgeable about FP, both sexes held many misconceptions. Furthermore, myths and rumors do not appear to be circulated any more widely among respondents that espoused a belief in "God's will" than among those who do not.

The type and quality of FP information and attitudes circulated in respondents' social networks varies somewhat by FP need group. Among those with 'unmet need', all but two participants knew of at least one FP method. Although they were not necessarily against FP, those with unmet need did not see it as important or relevant for them. These respondents were more likely to be fatalistic about fertility.

FP attitudes, by FP need group

Unmet need	No need	Met need
<ul style="list-style-type: none"> • Neutral FP attitudes • Few myths • Low perceived couple efficacy (fatalistic) 	<ul style="list-style-type: none"> • Mixed FP attitudes • Some myths • Limited perceived couple efficacy 	<ul style="list-style-type: none"> • Positive FP attitudes • Few myths • High perceived couple efficacy

Those with 'no need' have more mixed attitudes towards FP. When asked to name FP methods, this group cited traditional methods more frequently than those with met need and unmet need and also had more misinformation about modern methods, including FP leading to sterility and children's health problems. Though they are generally open to contraceptive use, they only planned to begin using FP if it is easy, such as a health team coming to the village and offering methods at low cost.

Not surprisingly, those with 'met need' generally had positive attitudes, obviously because they are contraceptive users. Several FP users were very vocal about sharing the benefits of FP.

C'est moi qui amène ce sujet généralement, je leurs dis quand tu veux être à l'aise c'est d'utiliser une méthode de planification familiale jusqu'à ce que certains se moque de moi, mais maintenant ils ont tous compris, ils voient ça même dans leurs situations.

I'm the one who usually brings up the subject, and I tell them that if they want to be comfortable they should use family planning to the point where some of them make fun of me, but now they understand, they even see the truth of it in their own situations.

-Man, 27 years, met need, connector

Capitalizing on these "positive deviants" could help increase the flow of information and address entrenched negative attitudes in social networks, especially given that in-depth interview respondents' attitudes toward FP are usually the same as their families' attitudes. Consistent with findings from the ethnographic research, this was especially true when a participant's family has negative attitudes towards FP methods, as illustrated by the following participant:

Mon entourage a le même avis que moi... Lors de nos causeries, nous parlons des méthodes de planification familiale et de leurs méfaits sur une personne... que ça empêche une personne d'avoir les enfants...

My close friends and family have the same opinions as me... During our chats, we talk about family planning methods and their harmful side effects on women... and how that can prevent a person from having children...

-Woman, 21 years, no need, connector

Importantly, for most respondents, a belief in “God’s will” does not necessarily prohibit couples from using contraceptive methods. The following woman explains that it is not her belief in God’s will that prevents her from using FP, but rather, her fear of side effects.

C'est la volonté de Dieu, je tombe enceinte quand Dieu le veut. Je n'utilise pas parce que j'ai peur des effets secondaires et j'aimerai comprendre beaucoup de choses sur la planification familiale avant de l'utiliser.

It's God's will, I get pregnant when God wants me to. I don't use (FP) because I'm afraid of the side effects and I would like to understand a lot more about FP before I start using it.
-Woman, 25 years, unmet need, isolate

In order to bridge the divide between support for child spacing and support for contraceptive use, positive deviant stories may also help catalyze greater self- and couple-efficacy in FP use. For example, many believe that regardless of FP use, God’s predestined plan for the number and timing of children will always prevail. Some participants framed FP use as a way of “helping” God:

C'est vrai que c'est Dieu qui décide du nombre d'enfant, mais on peut aider Dieu en faisant en sorte d'avoir d'enfants qui sont à notre pouvoir.

It's true that it's God who decides the number of children you have, but we can help God by doing what is within our power.
-Woman, 22 years, met need, influencer/connector

Others justified their dual beliefs (in God’s will and FP use) by explaining that God wants to help people realize their goals/wishes.

C'est vrai que c'est Dieu qui donne les enfants, mais si le couple s'entend il peut décider du nombre et moment ensemble. C'est Dieu qui donne, mais si la personne cherche une solution, il t'aide sur cette voix.

It's true that it's God who gives children, but if the couple gets along they can decide the number and the moment [to have them] together. It's God who gives, but if the person looks for solution, He will help you reach it.
-Woman, 35 years, unmet need, influencer/connector

Only two people said they are not using a method because they believe God/religion prohibits their use. One used a traditional FP method and implied that while child spacing is acceptable, hormonal methods may not be:

Selon la religion musulmane, on n'accepte pas les méthodes car c'est contraire à la religion. Selon notre coutume, dès que la femme est mariée, sa fécondité est entre les mains de Dieu.

In the Muslim religion, we don't accept the [FP] methods because it's against our religion. In our tradition, when a woman is married, her fertility is in God's hands.
-Woman, 20 years, unmet need, influencer

g. Information and attitudes diffused by religious leaders

Knowing the vast majority of participants were Muslim, we wanted to better understand peoples’ connections to religious leaders in their communities, what FP information or attitudes these leaders disseminated, and how they are diffused in the community. Furthermore, due to the frequency with which respondents cited “God’s will,” we sought to explore how this concept is informed by religious leaders’ teachings. We found that participants in both Bougouba and Koloni knew very little about their religious

Perceived social acceptability of couple communication encourages married people to discuss fertility, child spacing, and FP **more often with their spouse.**

leaders' opinions on child spacing and FP. Among those who did, opinions varied widely—some said their religious leaders simultaneously believe in God's will and couples' ability to determine the timing and spacing of pregnancies, while others said their religious leaders only believe in God's will. One also noted that not all religious leaders support FP use:

Les leaders religieux n'ont pas tous les mêmes points de vue. D'autres sont pour la planification familiale, et d'autres les contraires.

Religious leaders don't all have the same points of view. Some are for family planning, and others oppose it.
-Woman, 34 years, met need, connector

We also asked about religious leaders' wives, supposing that while imams reach the men in their community, imams' wives may reach women. However, religious leaders' wives' don't seem to have much influence, either. Just one person mentioned that their imam's wife supports FP.

This lack of awareness about religious leaders' attitudes toward fertility, child spacing, and FP may suggest several things. First, leaders are not discussing these issues among their constituents. Furthermore, people are not asking their leaders for guidance in these domains, despite an apparently strong belief in "God's will". Finally, it reiterates findings from the social network census that very few religious leaders were nominated into peoples' social networks. Though many FP programs work through religious leaders to achieve behavior change, these findings suggest it may not be an effective strategy for the planned social network intervention.

COUPLE COMMUNICATION

In addition to understanding the flow of information through social networks, we also explored the communications exchanged between husbands and wives regarding fertility attitudes and FP decision-making. Interventions can be more effective if they are designed with an understanding of gender roles, power dynamics, and communication related to FP within the couple, as these issues often pose barriers to FP uptake.

Many respondents, regardless of their FP need status, communicate regularly with their spouse about child spacing—most often about the best time to have their next child. Regular communication about FP methods, however, is more varied. Women participants, particularly those in Koloni, reported discussing either fertility or FP with their husbands more frequently than male participants. Couple communication about FP was most frequent among FP users; participants with unmet need and no need communicated rarely with their partner on this topic.

a. Social norms related to couple communication

It appears that perceived social acceptability of couples discussions of fertility, child spacing, and FP encourages couples to communicate more frequently on these topics.

Cela [communication au sein du couple] peut se passer ici, je crois que parler de ces choses avec les femmes n'est plus un sujet tabou, parce qu'aujourd'hui on en parle partout, dans les radios, à la télé, et même les agents de santé ne cessent de parler de cela l'hors de leur animation au niveau des villages.

That [couple communication] can happen here. I think that talking about these things with wives isn't a taboo anymore because today they talk about it everywhere: on the radio, on TV, and also health workers don't stop talking about it during their presentations in the villages.
-Man, 33 years, no need/unmet need, isolate

On the other hand, those who do not perceive couple communication about these topics to be socially acceptable tend to communicate less frequently with their spouses.

C'est très rare ici chez nous que maris et femmes parlent de ces choses. Notre culture ne nous permet pas d'évoquer ces genres de choses avec nos femmes... Non c'est quelque chose que je n'aimerais pas faire.

It is very rare here that husbands and wives talk about these things. Our culture doesn't permit discussing these types of things with our wives... No, it's not something I would like to do.
-Man, 34 years, unmet need, connector

Young couples may also be discouraged from discussing fertility, child spacing, or FP with their partners due to the social expectation to have children soon after they are married. One young participant commented:

Nous n'avons pas parlé mais je pense que c'est parce que nous n'avons pas d'enfant.

We haven't talked, but I think that it's because we don't have children.
-Woman, 20 years, no need, connector

b. Gender norms related to couple communication

Other reasons participants cited about why couples do not discuss fertility, child spacing, and FP reveal many important gender dynamics that begin to provide an understanding of some of the root causes of unmet need in this context.

First, respondents (both women and men) who did not discuss fertility, child spacing, or FP with their spouse commonly believed it to be the responsibility of their partner to bring up the topic for discussion.

Je ne sais pas s'il veut attendre ou pas pour avoir un enfant, mais il ne m'a rien dit pour l'instant.

I don't know if he wants to wait or not for a child, but he hasn't said anything to me for now.
-Woman, 28 years, no need, connector

Je ne connais pas l'avis de ma femme. Je ne sais pas si elle a un besoin de PF... car elle ne m'en a jamais parlé.

I don't know my wife's opinion. I don't know if she needs FP... because she has never talked to me about it.
-Man, 24 years, unmet need, connector

Women tended to value couple communication more than men, claiming it helps create peace and stability in the household. All women who said they did not talk to their husband about child spacing or FP said communicating about these issues is something they would like to do. But women were reluctant to raise the topic because they believed their husbands' lack of communication around these issues signaled disinterest or because they feared how he would react:

Je n'ai pas dit à mon mari...je ne sais pas la réponse qu'il me donnera...c'est sa réaction que je crains. Je sais aussi qu'il est très islamiste.

I haven't said (anything) to my husband... I don't know what response he would give me. It's his reaction that I fear. I also know that he is very Islamic.
-Woman, 35 years, unmet need, influencer/connector

Men seemed less interested in communicating with their spouses about child spacing or FP. Among the men who said they did not discuss child spacing or FP with their wives, only a few said it is something they would like to do. Some were expressly opposed to the idea, claiming these are topics for women's chit-chat, or that these topics are simply not discussed.

Non je n'ai jamais parlé avec mes épouses du nombre d'enfants que je souhaiterai avoir et du moment auquel j'aimerai les avoir et d'ailleurs c'est quelque chose qui ne se dit pas.

No, I've never talked with my wives about the number of children that I would like to have and about when I would like to have them. Besides, that's something that isn't said.
-Man, 53 years, unmet need, influencer

Others believed their wives are not capable of understanding such topics:

J'aimerais en discuter avec elle un jour, mais je sais qu'elle ne va pas comprendre. Même quand je veux qu'elle fasse des injections je l'avise pas, j'amène un infirmier il fait l'injection et la donne des comprimés. Leurs défauts c'est toujours d'être analphabètes, sinon elle va penser qu'après l'injection elle ne pourra plus avoir d'enfants.

I would like to talk to her one day, but I know that she won't understand. Even when I want her to get shots I don't advise her to. I bring a nurse, he gives the injection and gives her pills. The problem is that she's still illiterate, so she would think that after the injection she couldn't have children.
-Man, 34 years, met need, isolate

But it seems the underlying issue as to why men feel it is not necessary to discuss these topics with their wives is because both men and women believe the husband is the final decision-maker when it comes to when and how many children to have. As such, men often assume their wives are in agreement with their fertility desires, or are not interested in their opinion, because their wives must accept their wishes anyway.

Il nous arrive de choisir le moment pour avoir un enfant mais le nombre d'enfants à avoir est du ressort de Dieu... Mes femmes n'ont pas d'autres choix en dehors de mes souhaits.

We can choose when we have a child, but the number of children is God's jurisdiction. My wives don't have a choice outside of my wishes.
-Man, 52 years, no need, influencer/connector

Indeed, statements from female respondents emphasized the inequitable power dynamics between married couples. Many women indicated they adjust their attitudes about fertility, child spacing, and FP to match those of their husband. In many cases, this means accepting their husband's fertility desires, even if they are contrary to their own:

Si lui il ne veut pas d'enfant cette année, alors j'accepterai. C'est mon mari, j'ai quitté mes parents pour lui, alors il est maintenant à la place de mes parents.

If he doesn't want a child this year, then I will accept that. He is my husband, and I left my parents for him, so he is now in the place of my parents.
-Woman, 35 years, no need, isolate

Further underscoring the power men have over their wives, women stated they need approval from their husbands before obtaining a method, suggesting that communication is a necessary precursor to FP use (unless they plan to use contraception in secret). Thus, it is not surprising that participants with unmet need and no need communicate rarely with their partner about FP. Sometimes, women who wanted to use FP were prevented from doing so due to their husband's preferences:

C'est mon mari qui ne veut pas le planning sinon je veux bien utiliser une méthode [de PF].

It's my husband who doesn't want FP, otherwise I would really like to use a [FP] method.
-Woman, 32 years, unmet need, influencer/connector

For women who had not communicated openly with their husbands about fertility or FP, they often adopt attitudes they assume their husbands hold. Thus, situations arise in which a woman may be afraid to bring up FP with her husband because she assumes he is against FP, even if, in reality, he is not. She assumes he believes that fertility outcomes rest in the hands of God, and so she believes that couples have no role in determining the number and timing of their children. Meanwhile, the husband may be waiting for his wife to broach the topic with him, and assumes that she hasn't said anything because she doesn't want to space or use FP.

A lack of communication and assumptions about a spouse's attitudes may be one reason for covert use of FP methods. Although only one woman in our sample used FP without her husband's knowledge, the initial phase of ethnographic research revealed a fair number of women who used FP covertly.

Mon mari ne sais pas que j'utilise des méthodes [de PF] pour espacer mes naissances. Quand j'achète mes pilules je les gardent très soigneusement, comme il n'a pas l'habitude de fouiller dans mes affaires, il ne saura pas si j'utilise ou pas de méthodes pour espacer mes naissances. Et ça ne me dérange pas du tout de demeurer ainsi...

My husband doesn't know that I use the [FP] methods to space out my births. When I buy my pills, I guard them very carefully. Since he doesn't usually search through my things, he won't know if I use a method or not to space my births. And it doesn't bother me at all to go on like that.
-Woman, 28 years, met need, influencer

Women in our sample who did talk about child spacing with their husband, revealed that communication does not necessarily mean it is a balanced exchange of opinions and ideas leading to a fair decision-making process. Often women would talk about "discussions" they had with their husbands, but their descriptions of these conversations reveal that they tend to be uni-directional communication from husband to wife about what fertility-related behaviors the couple would adopt.

Mon mari et moi avions les mêmes opinions à propos du désir de tomber enceinte. On a eu une conversation par rapport à ça, et il m'a fait comprendre qu'il n'a pas l'intention de limiter ni d'espacer ces naissances pour le moment. La dernière décision appartenait à mon mari...

My husband and I have the same opinions about the desire to get pregnant. We had a conversation about it and he let me know that he doesn't intend to limit or space births right now. The final decision comes from my husband.
-Woman, 25 years, no need, connector

In sum, programs must be careful in interpreting a woman's stated FP need status, as it may be more representative of her husband's fertility desires (presumed or articulated) than her own. The woman above, for example, was trying to get pregnant at her husband's wishes, and was therefore categorized as 'no need'. However, other statements in the interview suggested she did not necessarily want a child at the moment, which would have instead placed her in the 'unmet need' category. Currently, men's FP need status is rarely assessed (e.g., in national demographic and health surveys). But this research suggests that at least in this setting, it is critically important to take into account men's fertility desires and need status for FP, since women are oftentimes obligated to acquiesce to their husbands' preferences. Family planning programs also cannot assume that merely stimulating discussion about these topics is sufficient, given that men may simply dictate their fertility intentions to their wives.

Incorporating gender transformative activities into social network programming will foster more gender-equitable attitudes, encourage acceptance for couple communication about child spacing and FP, and promote greater equity in decision-making power in relationships.

<p><i>Ils traitent la personne de libertin. On dit qu'il n'est pas sur le bon chemin.</i></p> <p><i>They treat the person like a libertine. They say that she is not on a good path.</i></p> <p>-Man, 38 years, Doucoumbo, met need, connector</p>	<p><i>Ils diraient qu'elle faisait ça pour pouvoir s'amuser – c'est à dire, faire l'adultère.</i></p> <p><i>They say that she does it to have fun – in other words, to commit adultery.</i></p> <p>-Man, 34 years, Doucoumbo, unmet need, connector</p>	<p><i>Mon mari m'a donné son accord, puisque c'est lui qui a accepté que j'utilise la pilule. Mon mari et moi causons de ces choses-là...</i></p> <p><i>My husband gave me his approval, since he was the one who accepted that I use the pill. My husband and I talk about these kinds of things...</i></p> <p>-Woman, 34 years, Bougouba, met need, connector</p>
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STIGMA

Analysis revealed additional evidence of the critical role of gender norms as an underlying factor contributing to unmet need in these villages. Several participants commented that FP users are criticized behind their backs, for example, often when women are sitting around chatting. Respondents explained that a woman who uses FP may be thought of as unfaithful, as having generally poor character, or as someone who did not want children. This criticism was almost always directed toward women who use FP—men whose wives use FP are not criticized.

Although respondents suggested that implicit community stigma impacts FP uptake and sustained use, one couple said that public criticism did not deter them from using FP:

On a été victime de médisances, mais cela ne peut pas nous empêcher d'utiliser. Il faut être courageux c'est tout. Ça ne peut pas me faire changer d'avis.

We were victims of bad-mouthing, but that couldn't stop us from using FP. You have to be brave, that's all. That can't make me change my mind.

-Man, 27 years, met need, connector

More importantly, most participants believed that FP use is a personal choice that is not anyone else's concern; therefore, one should not be judged or blamed for using contraceptives. Physical assault or violence did not seem to be a concern for people in considering using FP—no participants said they had heard of anyone being physically victimized due to their decision to use FP. However, we did not specifically ask about intimate partner violence. Given the above comments about the stigma attached to women FP users, respondents' aforementioned fears in broaching the topic with their husband could be due to punishing her for her presumed infidelity.

OTHER BARRIERS TO FP UPTAKE AND USE

In addition to issues related to gender, financial barriers and poor access to FP information and services remain obstacles to FP use.

a. Financial barriers

Sometimes respondents wanted to use a more effective, modern method but could not because they did not have the means to purchase one, and so settled for traditional methods. When deciding among modern methods, some participants chose pills over injectables because they were less expensive. Other times, when the preferred method was perceived to be too expensive, respondents didn't use any method at all, as opposed to searching for a less costly alternative.

b. Information barriers

Lack of information about available methods could be one of the reasons respondents do not search out alternative methods when their preferred method is not available. As noted earlier, not much information about FP methods is circulating in either village. One woman noted that it is difficult to make a decision about FP use in the absence of adequate information:

Je n'ai pas assez d'information sur les méthodes de contraception. Vous savez que le manque d'information est un obstacle à nos désirs de faire une chose.

I don't have enough information about contraceptive methods. You know that the lack of information is an obstacle for our wishes to do something.
-Woman, 25 years, unmet need, isolate

FP DECISION-MAKING AND USE

Understanding how FP users decide whether to use a method and which method they choose is as important as understanding barriers to use, in order to ensure that programs meet their needs.

It seems respondents select their FP method based on a continuum of perceived efficacy. At one end, respondents did not see the utility of using a contraceptive method because they felt capable of achieving a two- to three-year space between births using periodic abstinence. At the other end of the continuum are long-acting hormonal method users, who are very satisfied with their method because it enables them to avoid unwanted pregnancies easily for long periods of time. Along the continuum, FP users weigh the immediate cost of a particular method with its perceived effectiveness. As mentioned earlier, some respondents preferred a more effective, hormonal method, but were forced to settle on a less effective, traditional method due to financial barriers. Respondents also weighed convenience and ease of use in selecting a contraceptive method. For example, they commented that the injectable does not require daily remembering or that implants are worry-free because they last for five years. One participant chose a traditional powder because it offered pregnancy protection for one year, as opposed to injectables, which are only effective for three months.

Respondents additionally selected methods with the fewest perceived side effects. A few mentioned they changed methods due to undesirable side effects, but no one stopped using a method altogether as a result of side effects. Still other respondents made their method choice based on what conforms to their religious beliefs. A select few specifically stated that they use traditional methods because hormonal methods are prohibited by Islam, as described by this man:

Mes femmes et moi, nous sommes tous d'accord sur l'abstinence... L'Islam même est d'accord sur ça... Les méthodes des blancs ne sont pas conformément avec la religion. « Quelles sont les qualités que vous n'aimez pas ? » Rien. Si c'est conformé à la religion, ça marche.

*My wives and I, we all agree on abstinence... Islam also agrees with that... White men's methods don't conform with our religion. [Interviewer: "What qualities don't you like?"] Nothing. If it went along with our religion, it would be okay.
-Man, 44 years, no need/unmet need, influencer/connector*

POSTPARTUM FERTILITY PERCEPTIONS AND BEHAVIORS

Globally, a combination of breastfeeding and postpartum abstinence has resulted in good birth spacing. But cultural norms in these areas are changing, and couples still struggle to access FP information and services. Postpartum women have specific information needs and systematically different barriers to FP uptake than others with unmet need for FP. Having a better understanding of the target population's fertility perceptions and normative sexual behaviors during the postpartum period can help projects tailor intervention materials.

Knowledge regarding pregnancy risk prior to the return of menses varies throughout the world. Though many women have a general idea that breastfeeding helps achieve spacing between pregnancies, knowledge of the specific criteria for LAM are inadequate. Women must meet three criteria to use LAM as a contraceptive method: 1) menstrual periods have not resumed, 2) infant is fully or nearly fully breastfed both day and night, and 3) her infant is less than six months of age.

In the social network census, 18.4% of women were either breastfeeding or postpartum amenorrheic, and 11.6% of men had at least one wife who was either breastfeeding or postpartum amenorrheic. The in-depth interviews showed that most female respondents know a woman is at risk of becoming pregnant while breastfeeding, even before the return of menses. Many learned this through direct experience or through the experiences of those close to them. This woman explains:

Je ne pense pas que le fait d'avoir un enfant à allaiter puisse être un moyen de prévenir l'avènement d'un autre durant la période d'allaitement...je l'ai appris par ma grande sœur qui en a été victime plus d'une fois.

*I don't think that having a child breastfeeding can be a method of preventing another pregnancy during that time. I learned that from my older sister, who was a victim of that thinking more than once.
-Woman, 18 years, met need, isolate*

Women who had not witnessed anyone become pregnant before her period returned doubted whether it was possible. Men also had less knowledge about women's postpartum pregnancy risk. One man said that he was taught in his Quranic studies that if menses are not present, it is impossible to become pregnant. Finally, several women and men said that postpartum fertility varies according to an individual woman's biology.

To further understand pregnancy risk in the postpartum period, we also explored customary postpartum sexual norms. Most participants said that according to traditional custom, a couple typically abstains for a

period of one to four months after a woman gives birth. Many men explained that a woman stays her mother-in-law during this period because it makes it easier to abstain.

Chez nous ici quand ta femme a accouché, elle déménage chez ta mère pendant quarante jours, sinon ce n'est pas facile de s'abstenir durant tout ce temps.

Here when your wife has given birth, she moves to her mother's house for 40 days. Otherwise, it would be difficult to abstain for all of that time.
-Man, 34 years, met need, isolate

However, in both villages participants mentioned that the practice of postpartum abstinence was changing. Some men and women noted that the months-long custom of postpartum abstinence has shortened over time, and that abstinence in general has become more of an individual decision for couples.

Autrefois il y avait la cohésion mais aujourd'hui c'est l'individualisme qui prend le devant. C'est la femme qui fait la cuisine pour toi il n'y a pas d'autre personne pour la remplacer ; elle ne peut pas aller séjourner dans sa famille paternelle. Maintenant, on s'abstient pendant 40 jours.

Before there was a general cohesion (to the rule), but today individualism is taking the lead. It's the woman who cooks for you and there's no one else to replace her... she can't go stay with her paternal family. So now we abstain for 40 days.
Man, 54 years, no need, influencer/connector

Varying knowledge about pregnancy risk in the postpartum period and changing sexual norms suggest that projects may be more effective in thinking of postpartum couples as having “unperceived need”—a FP need category that is distinctly different from “unmet need” or “no need”. Strategies that address “unperceived need” may require targeted interventions and tailored materials.

DISCUSSION & PROGRAMMATIC IMPLICATIONS

The three-phase “ethnographic sandwich”—ethnographic research, social network census, and in-depth interviews—yielded deep and nuanced understanding about the dynamics of social networks, flow of FP information, barriers to FP uptake, and the nature and perception of FP need in the intervention areas in Mali. In its entirety, it provided the evidence necessary to develop a culturally relevant social network intervention package for Terikunda Jékulu.

Unfortunately, in March 2012, civil unrest in Mali forced the project to relocate to Benin. Among the countries in West Africa, Benin was chosen due to USAID Mission interest in the project, presence of all consortium members in country, and certain sociocultural similarities regarding unmet need for FP. Given the similarities between the two countries and broad similarities throughout West Africa regarding the dynamics of unmet need, the social context of underlying barriers to FP uptake and sustained use, and history of FP programming, we believed this formative research conducted in Mali need not be abandoned nor replicated in its entirety in Benin.

Instead, we used these formative research results from Mali to design an initial intervention package for Benin. Additional rapid formative research was conducted in Benin through key informant interviews, focus group discussions, and participatory community mapping (the first activity in the intervention package) to confirm key concepts identified in the Mali formative research, as well as to provide enough local context to ensure the materials in the intervention package resonate with the intended target population.

The key concepts revealed through the Mali formative “ethnographic sandwich” research and its implications for program development are summarized here below.

A. THE EVOLVING NATURE OF UNMET NEED FOR FP

Both women’s and men’s FP need status is constantly evolving, as seen by the change in participants’ need status from the time of the household survey to the in-depth interview. This illustrates the dynamic nature of unmet need—individuals will cycle through different FP need statuses through the course of their reproductive years, and even during a one- or two-year period. Programs should consider adopting a life-course perspective of unmet need, which more holistically encompasses the FP needs of reproductive-age adults. Most FP projects assume “mission accomplished” when a person moves from having “unmet need” to having “met need”. Designing interventions that acknowledge the cyclical nature of unmet need is a new concept, and aiming to reduce total segments of time during which adults experience unmet need may be a more effective strategy. To measure this, Terikunda Jékulu’s baseline and endline surveys will employ a calendar to assess how many months within a calendar year a woman experiences unmet need.

Typically, global data only assess women’s unmet need status. But this research reveals the importance of assessing men’s FP need status, as well, given that their fertility preferences and attitudes toward contraceptive use ultimately dictate women’s FP need status.

PERCEPTION OF FP NEED

Interventions that distinguish between “recognized” and “unrecognized” need for FP may be more effective in reducing unmet need. This research categorized respondents according to their “recognized” or perceived need for FP. However, results showed that many people may have “unrecognized” need for FP—especially in the postpartum period (particularly before return to menses) and while breastfeeding, during which women and men typically do not fully understand pregnancy risk. We additionally found that people incorrectly assume they have no need for FP because they only have sex infrequently, a trend that is true globally⁸. In addition to ensuring that more accurate information about FP methods is circulated through social networks, Terikunda Jékulu has a unique opportunity to improve knowledge of pregnancy risk.

Enabling women and men to recognize their need for FP is a first step in enabling them to make a decision to use contraceptives. It may also improve the accuracy of information and positive attitudes circulating about FP. We found that respondents who perceived that they had no need for FP (whether they did or did not have an actual need) also had more misinformation about FP, including the misconception that FP can result in sterility and children’s health problems, or that it costs too much.

B. SOCIAL NETWORKS AND FP DISCUSSIONS

This research supports the literature, which suggests that the nature and composition of social networks affects diffusion of FP information. Similar to the results of the ethnographic research, in-depth interviews showed that in the closed networks of Bougouba, there were many social barriers that prevented people from openly discussing their fertility and FP intentions. Koloni residents, on the other hand, discussed fertility, child spacing, and FP much more openly, especially among women. This is also consistent with the social network maps, which show Koloni as one cohesive network, compared to Bougouba which consists of three distinct networks with gatekeepers connecting them, controlling the flow of information.

⁸ Barot, S. 2008. Making the case for a ‘contraceptive convenience’ agenda. *Guttmacher Policy Review*, (11)4, 11-16 .

This research revealed that networks strengthen positive messages among FP users, but reinforce negative attitudes among those with unmet need. This impacts individual-level behavior change by engendering facilitating factors or barriers for FP adoption. The key for social network projects, like Terikunda Jékulu, is to trigger the positive messages circulating among FP users to jump over to the networks of those with unmet need. One optimal strategy is to facilitate reflective community dialogue, especially among those with unmet need, to encourage a critical examination of their attitudes related to FP use and the underlying social context that gives rise to them. Project interventions can also build on the experiences of satisfied users to present a new model of positive attitudes and behaviors for those with unmet need to ponder and, hopefully, to adopt.

Another important finding related to social networks and FP discussions is that those who are seen as trusted sources of FP information (relais, health center personnel, and traditional birth attendants) have little actual influence on participants' information-seeking behaviors. Instead, participants turn first to those in their social networks for FP information. These influentials, however, may have little FP knowledge, as evidenced in the paucity of FP information circulating in either village. This results in women and men with a conceptual rather than practical knowledge of FP—while most were accepting of child spacing or FP as a concept, both women and men had very little information about actual contraceptive methods. In order to effect attitudinal changes and ensure sufficient information is available for couples to make decisions about FP use, programs should improve linkages between those seen as expert sources of information and influential individuals. This could be accomplished by having group leaders of existing social groups invite expert sources of FP information to group meetings to provide method-specific information, address prevalent rumors or myths about methods, and answer questions from group members.

C. OVERCOMING BARRIERS TO FP USE

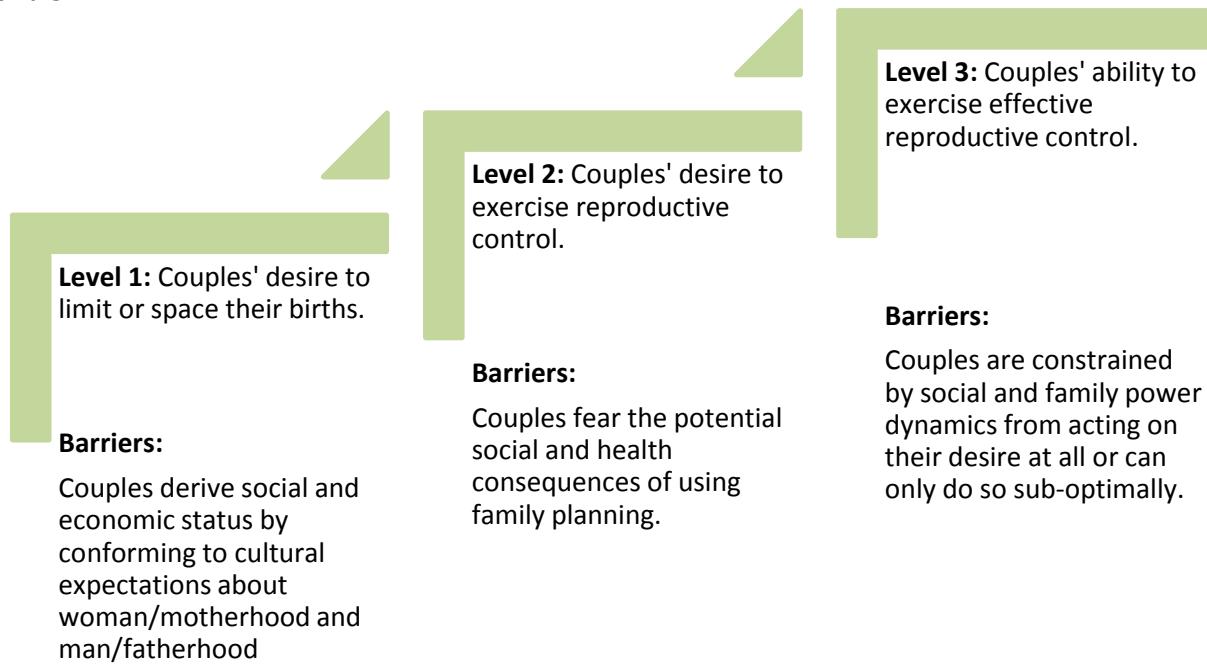
GENDER

Perhaps one of the most important findings of this research is the role of gender-based barriers to FP uptake. Especially in the final phase of the formative research, results revealed that women have little autonomy with regard to fertility preferences and FP decision-making. Women's FP "needs" may be determined entirely by her husband's wishes. Even if she wants to use FP or wishes to space her children, social norms dictate that she must abide by her husband's desires. Such social norms also discourage couples from communicating about issues related to fertility and FP—if the woman is expected to acquiesce to her husband's decisions, why is there any need to discuss their respective fertility preferences? Thus, men often assume their wives fertility desires are the same as their own, even if they haven't discussed, and women, afraid to broach the topic with their husbands, may adjust their attitudes to what they assume their husband's attitudes are, which may be different than the men's actual preferences.

Terikunda Jékulu, like many programs designed to address unmet need, was not envisioned as a gender project. But these results reveal that interventions must address gender barriers in order to effectively reduce unmet need. Gender must be systematically integrated into intervention design and communication materials, and specific, gender-related measures incorporated into the project results framework and monitoring indicators.

A new framework developed by the International Center for Research on Women (ICRW) provides a novel understanding of gender barriers related women's reproductive control.⁹ This framework posits three interconnected levels of demand and explains the barriers at each level. While the literature and our research show how people's FP attitudes are influenced by their social networks, decisions about FP use are ultimately made as individuals (or couples). In designing programs to reduce unmet need for FP, this framework can be useful in structuring the gender elements within a broader social network strategy. Though ICRW's framework is woman-centered, we have modified it slightly to focus on couples, since decisions about FP use are often made in this context.

Below is a summary of our findings at each of these levels, as well as suggestions for interventions that may address those barriers, as put forth in the ICRW framework. Generally, achieving one level of demand tends to be a precondition for reaching the next level. This may help to "sequence" program interventions and materials.



Level 1: Couples' desire to limit or space their births

Our evidence did not reveal a great deal about the cultural expectations regarding womanhood and motherhood, nor that men must prove their virility and manhood by fathering a large number of children—most likely because our research was not designed to answer these questions. But respondents' absolute opposition to using FP to limit childbearing could be interpreted as such. At this level, we also see that couples face strong social pressure to prove their fertility early in marriage, as evidenced by women and men's reluctance to discuss child spacing or FP use if they have not yet had any children.

In terms of understanding conscious choice about FP, our research provided a great deal of evidence regarding God's will and its role in people's contraceptive decision-making. Phase I ethnographic research found that the intense circulation of misinformation in Bougouba is due in part to an active Islamic association that strongly disapproves of family planning for religious reasons. We followed up on this in the

⁹ McCleary-Sills, J., McGonagle, A. & Malhotra, A. (2012) *Women's Demand for Reproductive Control: Understanding and Addressing Gender Barriers*. Washington, D.C.: International Center for Research on Women.

census and found that only about two percent of women (0% men) in Bougouba stated that religious or moral issues are the reason they are not using FP, and about two percent of men (0% women) in Koloni say this is the case. Findings from the in-depth interviews support this—in very few cases did participants expressly state that God or religion prohibits child spacing or FP use.

It seems somewhat contradictory, then, that “God’s will” was cited by a very high percentage of census respondents with unmet need as the reason they are not using contraception (Bougouba - 71% men, 57% women; Koloni - 75% men, 45% women). In-depth interview respondents also overwhelmingly agreed that the number and timing of one’s children is determined by God, though many—FP users in particular—simultaneously believed that couples can actively play a role in determining the number and timing of their pregnancies.

We believe that “God’s will” and religious opposition to contraceptive use are two distinct concepts. Despite the predominance of Islam throughout Mali and its general opposition to hormonal contraception, our research shows little evidence that religious doctrine about FP use is circulated through the social networks. “God’s will”, on the other hand, tends to be a fatalistic concept, quite characteristic of societies early in the transition from high to low fertility. Similar to the preconditions for reaching demand at Level 1, A.J. Coale stated that one of the preconditions for the fertility transition is that “reproductive decisions must be within the calculus of conscious choice”¹⁰.

¹⁰ Coale, A.J. (1973). The demographic transition reconsidered. *International Population Conference, Liège, Vol. 1:53-72.* Liège: International Union for the Scientific Study of Population.

In Demographic and Health Surveys (DHS), women are asked the following question: "If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?" Countries early in the fertility transition historically have high mean ideal numbers, but also high proportions that provide nonnumeric responses (e.g., "up to God"). Nonnumeric responses have been interpreted according to Coale: that women who answer "up to God" to a question about ideal number of children have not yet reached the first stage of the fertility transition, which includes an awareness of family size and the possibility of influencing it.¹¹ Van de Walle calls this

Program Recommendations – Level 1

The primary goal at Level 1 is to change social and gender norms so as to promote reproductive control as a conscious choice for couples.

Promote conscious choices about childbearing to overcome couples' strong tendencies toward fatalism.

Strategies

- Model aspirational attitudes and behaviors about valuing smaller families and a preference for women and men who raise smaller, healthier, more successful families
 - Model attitudes in story lines, images, activities
 - Avoid direct discussions about total desired family size, given strong social opposition to limiting childbearing
- Develop reflective dialogues questions that explore conceptions of woman/motherhood and man/fatherhood to help respondents critically examine their underlying attitudes towards fertility and childbearing.
- Feature newly marrieds discussing and making conscious choices about healthy timing and spacing of children to change social perception that such discussions suggest they want to limit total number of children.

Intervention ideas appropriate for Level 1

- Interpersonal communication programs, e.g., social network approaches like Terikunda Jékulu
- Mass media campaigns
- Male & family involvement initiatives

¹¹ McCarthy, J. & Oni, G. (1987). Desired family size and its determinants among urban Nigerian women: a two-stage analysis. *Demography* 24(2):279-90.

“numeracy about children”—a clear notion of what family size ought to be and to individuals’ awareness of where they stand with respect to the norm.¹² He explains, “Fertility decline is not very far away when people start conceptualizing their family size”.

But how can programs such as Terikunda Jékulu encourage numeracy about children when discussing family size is perceived as akin to limiting, a strict taboo? Van de Walle does concede that effective spacing does not require numeracy about children and could reduce family size—and our respondents strongly support child spacing. But sub-Saharan Africa already exhibits long birth intervals, when compared to other regions of the world, including Latin America and Asia/North Africa, and total fertility rate and unmet need for FP remain high.¹³ Bongaarts and Casterline explain that both rapid socioeconomic change and strong family planning programs, including ones that promote ideational change and the diffusion of ideas (like Terikunda Jékulu), can bring about changes in fertility preferences. ¹⁴

Level 2: Couples’ desire to exercise reproductive control

The barriers at this level are most frequently characteristic of societies with low contraceptive prevalence, which is the case in Mali and many countries where FP programs are implemented. Our research shows that the primary reason that people are not able to move from their desire to space births to actually using contraceptive methods is due largely to fear of social stigma and disapproval of FP use. The fear of being stigmatized as an adulteress or as someone who does not desire children discourages women from discussing FP with their husbands and social networks, thereby impeding FP use, even if support for child spacing exists.

In addition to the gender dynamics at work in generating this stigma, we can also apply theories about stigma mechanisms developed for other health domains (HIV/AIDS, abortion, mental health) to explain how it operates in this context. Figure 4 describes why contraceptive method use is stigmatized despite strong support for and recognized benefits of child spacing. This figure is adapted from a model about abortion-related stigma¹⁵, since research on sexuality and stigma related to the practice of contraception is still nascent.

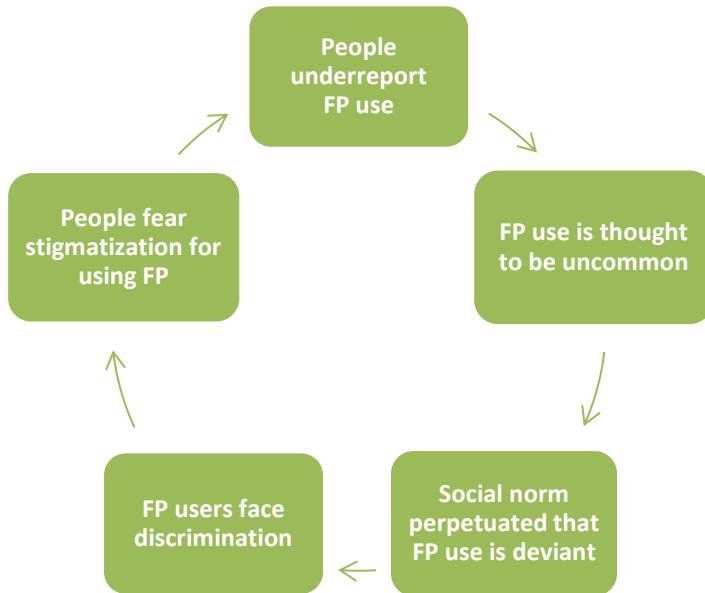
¹² Van de Walle, E. (1992). Fertility transition, conscious choice, and numeracy. *Demography*, 29(4): 487-502.

¹³ Bongaarts, J. & Casterline, J. (2012). Fertility transition: Is sub-Saharan Africa different? *Population and Development Review*, 38(supplement): 153-168.

¹⁴ Ibid.

¹⁵ Kumar, A., Hessini, L. & Mitchelle, E. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, 11(6): 625-39.

Figure 4: Social construction of deviance related to contraceptive use despite strong support for healthy timing and spacing of pregnancies



At the top of this self-perpetuating cycle, people are reluctant to disclose contraceptive use because FP users are viewed as deviant from the norm (deviance only pertains to women, in the case of Mali). If people underreport FP use, it leads to a perception that FP use is uncommon, regardless of actual contraceptive prevalence. Thus the social expectation is that people do not use FP, leading to the establishment of a social norm that FP use is deviant. Moral anxiety in the form of guilt and shame become attached to contraceptive use, due to its relationship with sexuality—a traditionally taboo subject in Malian society.

Since the behavior (FP use) is perpetuated as deviant, FP users then face discrimination (explicit or tacit) because they have violated the moral taboos of society. They are seen as a danger to the foundation of society—in this case, what it means to be a woman or a man. One of the underlying reasons for strong cultural opposition to contraceptive use is often the challenge to existing gender constructs—it confounds expectations of women as mothers (e.g., women who used FP were berated because they were thought to want to remain childless) (ICRW). Thus, FP users are described as moral deviants—sinful, sexually promiscuous, and irresponsible, according to our research.

Finally, we arrive at the fifth box, where people are afraid to use FP due to the threat of being stigmatized. Even if they support child spacing and want to avail themselves of its advantages, individuals who do not want to become pregnant right now do not make the leap to using a method out of fear of stigmatization. We are then left with those with unmet need, or those who may bravely decide to use a method anyway, but do so quietly. Then we come full circle to the first box, where silence and fear of social exclusion keep women from speaking out either about their own contraceptive use or in support of other FP users.

In addition to fear of social stigma, our research revealed several other elements relevant to couples' ability to exercise reproductive control (Level 2). Our research showed that lack of knowledge about contraceptive methods was also a barrier to couples' ability to use FP. Related to this, respondents expressed fear of side effects, namely infertility and other health consequences, also posed a barrier,

although findings from the census and the in-depth interviews were slightly different. In-depth interviews showed fear of side effects played little role in people not using FP, while the census showed a low, but persistent fear (8 to 17%) among those with unmet need. The fear of infertility, especially, is related to concepts of woman/motherhood and man/fatherhood presented in Level 1.

Program Recommendations - Level 2

The primary goal at Level 2 is to increase the understanding and acceptance of contraceptive options.

Strategies

- Model acceptance for FP use—especially among influential individuals—to help people realize approval for FP is more widespread than they realize.
- Model positive attitudes toward FP use to reduce stigma.
 - Create a safe social space for FP users to share positive experiences.
 - Model improved family outcomes (healthier, improved finances) for both female and male FP users. Market this as definition of a “good man” or a “good woman”.
- Connect community health workers and health center staff with influentials, connectors, and existing social groups to create a conduit between recognized subject matter experts and those who play a central role in information/attitude diffusion. This will:
 - Dispel negative myths about FP methods.
 - Raise awareness about available FP methods, and increase understanding about the tradeoffs between the multiple method choices in order to make an appropriate choice for one’s needs.

This is especially important for men, who are less informed about methods and espouse greater fears about and resistance to their use!

- Ensure availability of a range of methods at various price points, including fertility awareness-based methods, to address financial barriers to FP use.

Intervention ideas appropriate for Level 2

- Interpersonal communication programs, e.g., social network approaches like Terikunda Jékulu
- Mass media campaigns
- Male involvement initiatives
- Social marketing
- Supply-side interventions, e.g., community-based delivery, provider training

Although social network projects to address unmet need for FP, like Terikunda Jekulu, intervene primarily on the demand side, they also need to ensure availability of contraceptive methods and that people know

where and how to access them. Availability of FP methods may contribute to respondents' fatalistic attitudes ("God's will"), considering respondents' reported lack of access to contraceptives. What is the motivation for people to think more consciously about ideal family size if contraceptive methods are not widely available or affordable? One might draw parallels to HIV testing and treatment availability—before antiretroviral treatment was made widely available and affordable in low- and middle-income countries, testing prevalence was low. Why get tested for an almost certainly fatal disease if there was nothing to treat it?

Program Recommendations – Level 3

The primary goal at Level 3 is to create and enabling environment for women and couples to confidently and effectively make and implement fertility decisions and optimize their use of FP methods.

Strategies

- Encourage support for FP use from family gatekeepers—especially husbands and in-laws.
- Modeling positive norms of couple communication about FP methods
 - Encourage men and women to explore real versus perceived differences in opinion about fertility preferences and FP method use.
- Social network referral approaches, such as Each One Invites Three (EOI3)⁶.

Intervention ideas appropriate for Level 3

- Male involvement initiatives
- Social marketing
- Vouchers and referral programs
- Supply-side interventions, e.g., community-based or mobile FP services

Though there were a myriad of social and economic factors at work, it wasn't until access to treatment improved that testing behaviors also improved. Similarly, without access to FP methods, it is not possible to attain one's fertility ideals. This underscores the importance of demand-generation projects, like Terikunda Jékulu, linking to FP services or advocating for their improvement. If attitudes and social norms begin to shift and methods are discovered to be unavailable, it could create a backlash, and attitudes could slide back or become more negative than before. In addition, if the project boosts demand but methods are not available, the project could have the unintended effect of increasing unmet need.

Level 3: Couples' ability to exercise effective reproductive control

At level 3, according to this framework, gendered power relations prevent a woman from effectively obtaining or using a method, even if she is motivated to do so. Our research shows that in Mali, women are constrained by the decision-making authority of their husbands if and when they want to use FP. In order to gain approval from their husbands, women must discuss contraceptive use with them, which is not an established social norm. Lack of spousal communication can cause women to overestimate their husbands' desire for more children or their opposition to FP, which creates barriers to using a specific method.

WHAT PROGRAMS CAN EXPECT TO ACHIEVE

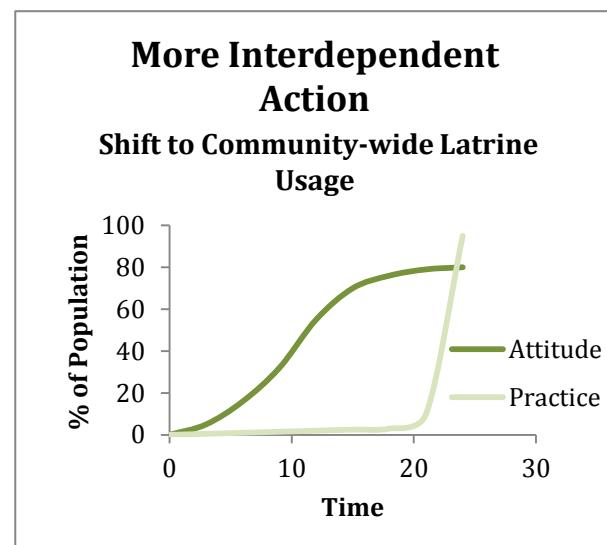
Social norms can be rigidly resistant to change. Since they are held in place by the reciprocal expectations of people's social networks, individual actions depend in large part on what others do (or think they should do). In their explanation of measuring social norms, Mackie and Moneti use a graph to show the interdependent nature of changing attitudes and practices over time¹⁶. They explain that due to the necessity of a coordinated shift, the behavior of adopting latrine usage would be delayed until most community members' attitudes have changed. At that point, the new behavior would spread rapidly. Furthermore, after the new behavioral norm with its associated sanctions has been established, those who may still have negative attitudes toward the practice may nevertheless adopt it to avoid criticism from others.

Given the dynamics of social norms surrounding FP use in Mali learned through this research, it seems reasonable to expect a similar transition would occur in the adoption of this innovation. The attitude arc will increase as interventions move stepwise to remove barriers at each of the three levels of the framework of women's demand for reproductive control. Given the time required for attitude shifts to occur, as per the graph above, a single project may not witness widespread adoption of FP or major reductions in unmet need during its short intervention period. In fact, it is likely that until Level 3 barriers are removed, intervention areas could experience increases in unmet need.

As barriers related to conscious choice about FP (Level 1) and social stigma and other factors contributing to couples' desire to exercise reproductive control (Level 2) are removed, people's sense of self-efficacy about reproductive control may increase. This means people who previously fell into the "no need" category may move into the "unmet need" category (e.g., a woman who used to believe her fertility was in the hands of God because she presumed her husband was against contraceptive use). But barriers related to the enabling environment (Level 3) may still exist that prevent her from using a method and transitioning to "met need" status. This does not mean Terikunda Jékulu, or other community mobilization projects, are not successful—it may simply mean more time is needed for intervention communities to reach the tipping point where a large enough segment of the population has adopted new attitudes and established new social norms for the resulting practices to take hold and spread.

Measures that assess this transition of social norms will be key to understanding if and in what ways demand-generation/social norms projects are having the intended effect. If a project is only assessed based on changes in the desired behaviors (e.g., rate of unmet need, contraceptive prevalence rate), it may be judged too quickly as unsuccessful. Similarly, if only individual attitudes are taken into account, its effects could be overestimated.

Mackie and Motneti suggest exploring the dimensions below for measuring changes in social norms over time. To measure these things, it is necessary to identify the individual's reference network (everyone who



¹⁶ Gerry Mackie and Freancesca Moneti, 2012. What are social norms? How are they measured? Working Paper, UNICEF-UCSD Center on Global Justice.

matters to an individual in a certain situation), which is exactly the methodology we used in the household census. The items in red are of most importance for identifying the presence of a social norm.

What the Self believes about...

	Self	Others – 1st Order	Others – 2nd Order
Empirical	What I do <i>Normally measured to determine prevalence</i>	What others do <i>Sometimes measured and important for measuring social norms</i>	What others think I do <i>Normally not measured and not deemed to be of priority</i>
Normative	What I think I should do <i>Often measured, to determine attitudes</i>	What I think others should do <i>Rarely measured and not of top priority</i>	What others think I should do <i>Rarely measured and of top priority to measure a social norm</i>

Mackie and Moneti also suggest that monitoring changes in social norms may be best accomplished by asking fewer questions at shorter intervals. They also state the importance of investigating the counterfactuals—the perceived consequences of what would happen if one were not to comply with the social norm.

For Terikunda Jékulu and similar projects, measuring changes in social norms may be best accomplished by identifying the key normative attitudes and related behaviors and the counterfactuals at each of the three levels of reproductive demand, and implementing small, rapid assessments (e.g., using LQAS or other methodology) periodically at several points over the project intervention, instead of or in addition to a traditional baseline/endline survey. If this is not possible, currently planned evaluation methodologies (baseline/endline survey and cohort interviews) should be designed to include the empirical and normative questions suggested above.

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APPENDICES

APPENDIX A: VILLAGE RESIDENT LIST FORM

APPENDIX B: HOUSEHOLD CENSUS INTERVIEW GUIDE

APPENDIX C: IN-DEPTH INTERVIEW GUIDE

APPENDIX D: CODEBOOK USED FOR IN-DEPTH INTERVIEW ANALYSIS

Terikunda Jékulu
Network mapping census
Complete listing of village adults

Structure code (from map)

--	--	--

enumerator code

--	--	--

Identifying information about the structure: _____

Enumerator instructions:

As you enter the residence, introduce yourself to any adult present, and read the following:

“We are conducting a research study in this village, and in one other village in Mali, to find out how information about certain topics is passed along between people, and how people communicate with each other. The research is done by researchers from Georgetown University in the United States, in partnership with CARE/ASDAP. The first step of this research is to make a list of all adults living in this village. I will ask you for the name, gender, approximate age, and occupation of all adults who live in this compound. May I proceed?”

1. What is the name of the head of household? _____
2. As we go around the compound, please tell me the names of all married adults who usually live here. We can go house by house, so we do not forget anyone. First, tell me the names of all married women, who are between the ages of 18 and 44. Then tell me the names of all the men who are married to women from that age group. For each person you name, please tell me their age and their occupation.

#	Name	M/F	Age	Occupation
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

#	Name	M/F	Age	Occupation
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40				

Continuation page

Terikunda Jékulu
Network mapping census
Women form

Client code

Interviewer code

Today's date _____ / _____ / _____
Day Month Year

Consent script:

You are invited to participate in a research study. As you know, we created a complete list of all adults living in this village. We are now going to use this list to find out how information about certain topics is passed along between people, and how people communicate with each other. The study is being done because there are many couples who say they do not want to have any more children, or who do not want to have another child right now, yet are not doing anything to avoid pregnancy. Results of this study will help design programs to make it easier for women and men who wish to avoid pregnancy. The research is done by researchers from Georgetown University in the United States, in partnership with CARE/ASDAP.

You are being asked to take part in this study because you are either a married woman age 18-44, or you are a man who is married to a woman who is age 18-44. We will interview all men and women in these age groups who agree to participate in the study, in this village, and in one other village in Mali.

If you decide to participate in this study, you will take part in one interview, lasting about 20 minutes. We will find a private place for the interview. It can be in your home, or at any other place you prefer where no one can hear us. We can do the interview now, or we can do it later, at a time and place that you prefer.

During the interview, I will first ask you for some background information about yourself, then I will ask you about your ideas related to how many children to have, when to have another child, and whether to use family planning. In the next part of the interview, I will ask you several questions about different people that you talk to about certain things. You will identify up to 17 people. I have with me the list of all the adults living in this village, and a map of the village. I will ask you to identify on the list each of the people you name. I will then ask you a few questions about each of them, such as how you know them and how important their opinions are to you.

Because the information we are collecting is sensitive, and it may be embarrassing for you if anyone finds out your answers, or which people you name, we are going to make sure that no one finds out the information you provide. This means that the people you name will not know that you named them. If they live in this village, we will also interview them for the study, but we will not tell them that you named them or what you said about them, and we will not tell you later if they also named you or not. I will have a laptop with me during the interview. The information that I enter onto the laptop will not include your name or address, or any of the names you mention, only the codes from the list. I will keep the laptop with me at all times and in the evening I will take the laptop with me out of the village. The laptop will be stored in a locked file cabinet, in a locked office, that only myself and the research team will have access to. The computers and data files will be encrypted and password protected. After the study is completed the list will be destroyed, and there will be nothing to connect the information you provided and the names you mentioned to you.

If you agree to participate in this study, there will be no direct benefit to you. However, information that we gather will help us and others develop programs that will improve the lives of couples in your community and other communities.

Your participation in this study is entirely voluntary at all times. You may choose not to participate at all or to stop the interview at any point. If talking about certain topics makes you uncomfortable, you do not need to respond to these questions. If you decide not to participate at all, or to answer only some questions, or to stop the interview early, there will be no effect on your relationship with the researcher, with CARE/ASDAP, or any other negative consequences. If you wish, I can give you the phone number for the researchers and of the IRB office at Georgetown University, so that you can ask them about the research and about your rights as a participant.

May I interview you?

Let's start with some questions about you

No.	Questions and filters	Coding categories	Skip
1	How old were you on your last birthday?	Age <input type="text"/> <input type="text"/>	
2	Have you ever attended school?	Yes 1 No 2 → 4	
3	How many years have you attended school?	Years at school..... <input type="text"/> <input type="text"/>	
4	What is your husband's name?		
5	How many co-wives do you have?	Number of co-wives..... <input type="text"/> <input type="text"/> Don't know..... 98 → If 00, go to Q.7	
6	Are you the first, second, . . . , wife? If Q.5 is 'I don't know': Do you know your rank? If 'Yes': Are you the first, second, . . . , wife?	Rank <input type="text"/> <input type="text"/> Don't know..... 98	
7	How many children have you given birth to, who are alive?	Number of living children..... <input type="text"/> <input type="text"/>	
8	What is your religion?	Muslim 1 Catholic..... 2 Other Christian 3 Animist..... 4 Other _____ 9 (specify)	

Now I would like to talk about family planning – the ways or methods that a couple can use to delay or avoid a pregnancy

No.	Questions and filters	Coding categories	Skip
9	Are you pregnant, or think you might be pregnant?	Yes 1 → 15 No 2	

No.	Questions and filters	Coding categories	Skip
10	Would you like to have (a/another) child at any time in the future, or would you prefer to never have any (more) children?	As god wills it.....1 Have (a/another) child.....2 No more/none.....3 Undecided/don't know.....8	15
11	Would you like to become pregnant within the next year?	Yes1 No2 Says she can't get pregnant.....3 If God wills it4 Don't know.....8	15
12	Are you currently doing something or using any method to delay or avoid getting pregnant?	Yes1 No2	14
13	Which method are you using? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill..... C IUD D InjectablesE ImplantsF CondomG Diaphragm/foam/jelly..... H Standard Days Method/CycleBeadsI Lactational Amenorrhea Method J Periodic abstinenceK Withdrawal..... L Herbal preparations (drink)..... M Herbal preparations (douche) N Spider web O Beads/amulets.....P Other _____ X (specify)	All to 15

No.	Questions and filters	Coding categories	Skip
14	<p>You have said that you do not want to become pregnant in the next year, but you are not using any method to avoid pregnancy.</p> <p>Could you tell me why you are not using a method?</p> <p>Any other reason?</p> <p>CIRCLE ALL MENTIONED</p>	<p>God's will/up to God..... AA</p> <p>PERCIVED RISK OF PREGNANCY Not having sex..... BA Infrequent sex..... BB Menopausal/hysterectomy BC Husband not fertile BD Thinks she is sub-fecund or infecund..... BE Postpartum amenorrheic..... BF Breastfeeding BG</p> <p>OPPOSITION TO/DISAPPROVAL OF USE Respondent opposed CA Husband opposed CB Husband will divorce her/withhold support/ send her back to family CC Husband will punish/hit/insult/yell at her CD Husband will get another wife CE Husband won't discuss it..... CF Others opposed/fear of criticism/fear of Losing status in family CG Others will think she is a bad wife CH Religious prohibition CI Believes it is immoral..... CJ Outsiders bring methods that harm us CK Want more children before using FP..... CL</p> <p>LACK OF KNOWLEDGE Knows no Method..... DA Don't know where to obtain methods DB Don't know cost/thinks very expensive DC</p> <p>LACK OF ACCESS Don't have money to buy methods..... EA No time to go to health center EB No way to get to health center EC Afraid someone will find out she got method ED</p> <p>METHOD-RELATED REASONS Health concerns FA Fear of side effects..... FB Results in having twins..... FC Fear of sterility..... FD Inconvenient to use FE Interferes with body's normal processes..... FF Method desired not available FG</p> <p>Other _____ X (specify)</p> <p>Don't know..... Z</p>	
15	Have you ever done or used any method to delay or avoid getting pregnant?	Yes 1 No 2	17

No.	Questions and filters	Coding categories	Skip
16	Which method have you used in the past? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill..... C IUD D InjectablesE ImplantsF CondomG Diaphragm/foam/jelly..... H Standard Days Method/CycleBeadsI Lactational Amenorrhea MethodJ Periodic abstinenceK Withdrawal..... L Herbal preparations (drink)..... M Herbal preparations (douche) N Spider webO Beads/amulets.....P Other _____ X (specify)	
17	<p>I am going to read you statements about the use of family planning. Please tell me if you agree or disagree with each statement</p> <p>(a) It is good to have many children because they can help with household tasks</p> <p>(b) Women who use family planning are straying from the correct path or are immoral</p> <p>(c) Women who use family planning look better than women who do not use family planning.</p> <p>(d) The family planning methods provided by the health programs in this village are difficult to use</p> <p>(e) Couples who practice family planning and have fewer children are better able to provide for their family</p> <p>(f) Using family planning is bad for a women's health</p> <p>(g) Only god can decide the number and timing of children a couple has.</p> <p>(h) Family planning is something that people from outside our community want us to do for their benefit, not ours</p>	Agree Disagree Don't know/Depends 1 2 8 1 2 8	

Instructions and questions for completing network grid

1. Read "Now we are going to talk about the people in your network – people who you interact with, people you receive support from, people you consider to be part of your world. I will ask you about four different types of networks. People you mention can live in this village or elsewhere. You can name the same person more than once."
2. Ask the following questions. Write the names they provide in the name column.
 - (a) Think of the people who provide you material assistance. For example, someone who loans you money, someone who buys things for you in the market, or someone who gives you food or clothes. Please tell me the names of three people that you go to for this type of support.
 - (b) Think of the people who provide you practical assistance. For example, they help you take care of your children, or they can help with household chores, or they can help you with trading or agriculture. Please tell me the names of three people that you go to for this type of support.
 - (c) Think of the people that you can learn from, either because they give you advice or instructions, or because you see what they do and try to do the same. Please tell me the names of three such people.
 - (d) Think of the people who give you emotional support. For example, you can talk to them when you are sad, or when you have an argument with your husband or his mother, or when your children misbehave. Please tell me the names of three people who give you emotional support most often.
3. Go through all the names in the list (up to 12 names). For each person do the following:
 - (i) Find the person in the map/chart/list and write the code in column (b).
 - (ii) Ask: "What is your relationship with (name of person)? You can mention more than one relationship. For example, a person can be your aunt, and can also be your health provider." Write the relationships. Relationships can be family relationship (such as mother, husband, sister, co-wife, etc.) or friend, or it can be a different type of relationship, such as shop-keeper, co-worker, health worker, teacher of the respondent's children, member of her *grin* or *tontine*, etc. It can also be the *marabout* or religious leader.
 - (iii) Ask: "Does (name of person) live in this village, or elsewhere?" If 'elsewhere', ask "In what town does (name of person) live?"
 - (iv) Ask: "How close would you say you are to (name of person)? Very close, close, or not close?" Write the response.
 - (v) ASK: "Does this person influence your decisions planning your family, how many children to have and when to have them?"
 - (vi) Ask: "Would you say that (name of person) approves of people spacing their births and using a family planning method to do so?"
 - (vii) Ask: "Would you say that (name of person) would approve of a woman using a family planning method without her husband's knowledge?"

If a person is mentioned in more than one network, you do not need to complete the information a second time. Instead write the respondent number from the first network the person is mentioned in the code space. For example, if the respondent's sister is the third person mentioned in Material support, and the second person mentioned in Practical support, then in the line item corresponding to the second person in Practical support write M3 in the code column, and ignore the rest of the line.

4. If the respondent's husband was not mentioned in any of the networks, ask "Does your husband provide you with any of these types of support? If she responds positively, complete the Husband line, otherwise leave it blank. Repeat this for the respondent's mother, mother-in-law, and co-wives.

Coding for questions in network grid

Column (a): Name of nominated person

Column (b): Code of nominated person from household listing

Column (c): Relationship(s) of nominated person to the respondent

Husband-101

Wife-201

Son-102

Daughter-202

Brother-103

Sister-203

Father-104

Mother-204

Nephew-105

Niece-205

Male Cousin-106

Female Cousin-206

Daughter of the husband/wife -207

Son of the husband/wife -107

Grandfather-108

Grandmother-208

Father in law-109

Mother in law-209

Daughter in law-210

Son in law-110

Uncle maternal/paternal -111

Aunt maternal/paternal-211

Servant-213

Female friend-214

Male friend-114

Male neighbor-115

Female neighbor-215

Religious leader-116

Male provider-117

Female provider-217

Male Colleague-118

Female Colleague-218

Male village teacher-119

Female village teacher-219

Male Muslim religious leader /trad. therapist/healer-120

Female Muslim religious leader /trad. therapist/healer -220

Cowife-221

Brother in law -122

Sister in law-222

Other-999

Column (d): place of residence:

1. This village
2. Another village in Mali
3. Bamako
4. Another city in Mali
5. Gabon
6. DRC
7. CAR
8. Other (specify)

Column (e): Closeness

1. Very close
2. Close
3. Not close

Column (f): influence

1. Yes
2. No
8. I don't know

Column (g): Approves FP

1. Yes
2. No
8. I don't know

Column (h): FP acceptable

1. Yes
2. No
8. I don't know

Column (i): Approves secret use

1. Yes
2. No
8. I don't know

Network N		Name (a)	Code (b)	Relationship (c)			Residence (d)	Closeness (e)	Influence (f)	Approves FP (g)	FP acceptable (h)	Approves secret use (i)
Material	M1											
	M2											
	M3											
Practical	P1											
	P2											
	P3											
Cognitive	C1											
	C2											
	C3											
Emotional	E1											
	E2											
	E3											
Husband												
Mother												
Mother in law												
Co-wife 1												
Co-wife 2												

Ask:

"After this phase of the study is complete, including analysis of the data, we will come back to the village to conduct longer interviews with some women and men. We will choose participants for the interviews based on the picture we get about communication and how information is shared in the village. We will look at different characteristics of village residents, and how they responded to each questions, to try and get a big variety of participants. Only 12 men and 12 women in this village will be interviewed"

Will you be willing to participate in these future interviews? Can we add your name to the list of people that we will draw participants from?

Yes / No (circle one)

Terikunda Jékulu
Network mapping census
Men form

Client code

Interviewer code

Today's date _____ / _____ / _____
Day Month Year

Consent script:

You are invited to participate in a research study. As you know, we created a complete list of all adults living in this village. We are now going to use this list to find out how information about certain topics is passed along between people, and how people communicate with each other. The study is being done because there are many couples who say they do not want to have any more children, or who do not want to have another child right now, yet are not doing anything to avoid pregnancy. Results of this study will help design programs to make it easier for women and men who wish to avoid pregnancy. The research is done by researchers from Georgetown University in the United States, in partnership with CARE/ASDAP.

You are being asked to take part in this study because you are either a married woman age 18-44, or you are a man who is married to a woman who is age 18-44. We will interview all men and women in these age groups who agree to participate in the study, in this village, and in one other village in Mali.

If you decide to participate in this study, you will take part in one interview, lasting about 20 minutes. We will find a private place for the interview. It can be in your home, or at any other place you prefer where no one can hear us. We can do the interview now, or we can do it later, at a time and place that you prefer.

During the interview, I will first ask you for some background information about yourself, then I will ask you about your ideas related to how many children to have, when to have another child, and whether to use family planning. In the next part of the interview, I will ask you several questions about different people that you talk to about certain things. You will identify up to 17 people. I have with me the list of all the adults living in this village, and a map of the village. I will ask you to identify on the list each of the people you name. I will then ask you a few questions about each of them, such as how you know them and how important their opinions are to you.

Because the information we are collecting is sensitive, and it may be embarrassing for you if anyone finds out your answers, or which people you name, we are going to make sure that no one finds out the information you provide. This means that the people you name will not know that you named them. If they live in this village, we will also interview them for the study, but we will not tell them that you named them or what you said about them, and we will not tell you later if they also named you or not. I will have a laptop with me during the interview. The information that I enter onto the laptop will not include your name or address, or any of the names you mention, only the codes from the list. I will keep the laptop with me at all times and in the evening I will take the laptop with me out of the village. The laptop will be stored in a locked file cabinet, in a locked office, that only myself and the research team will have access to. The computers and data files will be encrypted and password protected. After the study is completed the list will be destroyed, and there will be nothing to connect the information you provided and the names you mentioned to you.

If you agree to participate in this study, there will be no direct benefit to you. However, information that we gather will help us and others develop programs that will improve the lives of couples in your community and other communities.

Your participation in this study is entirely voluntary at all times. You may choose not to participate at all or to stop the interview at any point. If talking about certain topics makes you uncomfortable, you do not need to respond to these questions. If you decide not to participate at all, or to answer only some questions, or to stop the interview early, there will be no effect on your relationship with the researcher, with CARE/ASDAP, or any other negative consequences. If you wish, I can give you the phone number for the researchers and of the IRB office at Georgetown University, so that you can ask them about the research and about your rights as a participant.

May I interview you?

Let's start with some questions about you

No.	Questions and filters	Coding categories	Skip
1	How old were you on your last birthday?	Age <input type="text"/> <input type="text"/>	
2	Have you ever attended school?	Yes 1 No 2 → 5	
3	How many years have you attended school?	Years at school..... <input type="text"/> <input type="text"/>	
5	How many wives do you have?	Number of wives..... <input type="text"/> <input type="text"/>	
4	What are the names of your wives?	1. _____ 2. _____ 3. _____ 4. _____	
7	How many children do you have?	Number of living children..... <input type="text"/> <input type="text"/>	
8	What is your religion?	Muslim 1 Catholic 2 Other Christian 3 Animist 4 Other _____ 9 (specify)	

Now I would like to talk about family planning – the ways or methods that a couple can use to delay or avoid a pregnancy. I will ask you some questions about your senior wife, then about your other wives.

No.	Questions and filters	Coding categories	Skip
9a	Is your (senior) wife pregnant, or thinks she is pregnant	Yes 1 → 9b No 2 Don't know 8	If one wife go to 15

No.	Questions and filters	Coding categories	Skip
10a	Would you like your (senior) wife to have (a/another) child at any time in the future, or would you prefer that she never has any (more) children?	As god wills it.....1 Have (a/another) child.....2 No more/none.....3 Undecided/don't know.....8	9b <i>If one wife go to 15</i>
11a	Would you like your (senior) wife to become pregnant within the next year?	Yes1 No2 Says she can't get pregnant.....3 If God wills it4 Don't know.....8	9b <i>If one wife go to 15</i>
12a	Are you or your (senior) wife currently doing something or using any method to delay or avoid getting pregnant?	Yes1 No2	14a
13a	Which method are you or your (senior) wife using? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill.....C IUDD InjectablesE ImplantsF CondomG Diaphragm/foam/jelly.....H Standard Days Method/CycleBeadsI Lactational Amenorrhea MethodJ Periodic abstinenceK Withdrawal.....L Herbal preparations (drink).....M Herbal preparations (douche)N Spider webO Beads/amulets.....P Other _____X (specify)	All to 9b <i>If one wife go to 15</i>

No.	Questions and filters	Coding categories	Skip
14a	<p>You have said that you do not want your (senior) wife to become pregnant in the next year, but you are not using any method to avoid pregnancy.</p> <p>Can you tell me why you are not using a method?</p> <p>Any other reason?</p> <p>CIRCLE ALL MENTIONED</p>	<p>God's will/up to God..... AA PERCIVED RISK OF PREGNANCY OF WIFE Not having sex..... BA Infrequent sex..... BB Menopausal/hysterectomy BC Wife not fertile BD Thinks she is sub-fecund or infecund..... BE Postpartum amenorrheic..... BF Breastfeeding BG</p> <p>OPPOSITION TO/DISAPPROVAL OF USE Respondent opposed CA Wife opposed CB Wife won't discuss it CF Others opposed/fear of criticism/fear of Losing status in family CG Religious prohibition CI Believes it is immoral..... CJ Outsiders bring methods that harm us CK Want more children before using FP..... CL</p> <p>LACK OF KNOWLEDGE Knows no Method..... DA Don't know where to obtain methods DB Don't know cost/thinks very expensive DC</p> <p>LACK OF ACCESS Don't have money to buy methods..... EA No time to go to health center EB No way to get to health center EC Afraid someone will find out he/she got method..... ED</p> <p>METHOD-RELATED REASONS Health concerns FA Fear of side effects..... FB Results in having twins..... FC Fear of sterility..... FD Inconvenient to use FE Interferes with body's normal processes..... FF Method desired not available FG</p> <p>Other _____ X (specify)</p> <p>Don't know..... Z</p>	<i>If one wife, go to 15.</i>
9b	Is your second wife pregnant, or things she is pregnant	<p>Yes 1</p> <p>No 2</p> <p>Don't know..... 8</p>	<p>→ 9c</p> <p><i>If two wives go to 15</i></p>

No.	Questions and filters	Coding categories	Skip
10b	Would you like your second wife to have (a/another) child at any time in the future, or would you prefer that she never has any (more) children?	As god wills it.....1 Have (a/another) child.....2 No more/none.....3 Undecided/don't know.....8	9c <i>If two wives go to 15</i>
11b	Would you like your second wife to become pregnant within the next year?	Yes1 No2 Says she can't get pregnant.....3 If God wills it4 Don't know.....8	9c <i>If two wives go to 15</i>
12b	Are you or your second wife currently doing something or using any method to delay or avoid getting pregnant?	Yes1 No2	14b
13b	Which method are you or your second wife using? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill.....C IUDD InjectablesE ImplantsF CondomG Diaphragm/foam/jelly.....H Standard Days Method/CycleBeadsI Lactational Amenorrhea MethodJ Periodic abstinenceK Withdrawal.....L Herbal preparations (drink).....M Herbal preparations (douche)N Spider webO Beads/amulets.....P Other _____X (specify)	All to 9c <i>If two wives go to 15</i>

No.	Questions and filters	Coding categories	Skip
14b	<p>You have said that you do not want your second wife to become pregnant in the next year, but you are not using any method to avoid pregnancy.</p> <p>Can you tell me why you are not using a method?</p> <p>Any other reason?</p> <p>CIRCLE ALL MENTIONED</p>	<p>God's will/up to God..... AA</p> <p>PERCIVED RISK OF PREGNANCY OF WIFE Not having sex..... BA Infrequent sex..... BB Menopausal/hysterectomy BC Wife not fertile BD Thinks she is sub-fecund or infecund..... BE Postpartum amenorrheic..... BF Breastfeeding BG</p> <p>OPPOSITION TO/DISAPPROVAL OF USE Respondent opposed CA Wife opposed CB Wife won't discuss it CF Others opposed/fear of criticism/fear of Losing status in family CG Religious prohibition CI Believes it is immoral..... CJ Outsiders bring methods that harm us CK Want more children before using FP..... CL</p> <p>LACK OF KNOWLEDGE Knows no Method..... DA Don't know where to obtain methods DB Don't know cost/thinks very expensive DC</p> <p>LACK OF ACCESS Don't have money to buy methods..... EA No time to go to health center EB No way to get to health center EC Afraid someone will find out he/she got method..... ED</p> <p>METHOD-RELATED REASONS Health concerns FA Fear of side effects..... FB Results in having twins..... FC Fear of sterility..... FD Inconvenient to use FE Interferes with body's normal processes..... FF Method desired not available FG</p> <p>Other _____ X (specify)</p> <p>Don't know..... Z</p>	<i>If two wives, go to 15.</i>
9c	Is your third wife pregnant, or things she is pregnant	<p>Yes 1</p> <p>No 2</p> <p>Don't know..... 8</p>	<p>→ 9d</p> <p><i>If three wives go to 15</i></p>

No.	Questions and filters	Coding categories	Skip
10c	Would you like your third wife to have (a/another) child at any time in the future, or would you prefer that she never has any (more) children?	As god wills it.....1 Have (a/another) child.....2 No more/none.....3 Undecided/don't know.....8	9d <i>If three wives go to 15</i>
11c	Would you like your third wife to become pregnant within the next year?	Yes1 No2 Says she can't get pregnant.....3 If God wills it4 Don't know.....8	9d <i>If three wives go to 15</i>
12c	Are you or your third wife currently doing something or using any method to delay or avoid getting pregnant?	Yes1 No2	14c
13c	Which method are you or your third wife using? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill.....C IUDD InjectablesE ImplantsF CondomG Diaphragm/foam/jelly.....H Standard Days Method/CycleBeadsI Lactational Amenorrhea MethodJ Periodic abstinenceK Withdrawal.....L Herbal preparations (drink).....M Herbal preparations (douche)N Spider webO Beads/amulets.....P Other _____X (specify)	All to 9d <i>If three wives go to 15</i>

No.	Questions and filters	Coding categories	Skip
14c	<p>You have said that you do not want your third wife to become pregnant in the next year, but you are not using any method to avoid pregnancy.</p> <p>Can you tell me why you are not using a method?</p> <p>Any other reason?</p> <p>CIRCLE ALL MENTIONED</p>	<p>God's will/up to God..... AA</p> <p>PERCIVED RISK OF PREGNANCY OF WIFE Not having sex..... BA Infrequent sex..... BB Menopausal/hysterectomy BC Wife not fertile BD Thinks she is sub-fecund or infecund..... BE Postpartum amenorrheic..... BF Breastfeeding BG</p> <p>OPPOSITION TO/DISAPPROVAL OF USE Respondent opposed CA Wife opposed CB Wife won't discuss it CF Others opposed/fear of criticism/fear of Losing status in family CG Religious prohibition CI Believes it is immoral..... CJ Outsiders bring methods that harm us CK Want more children before using FP..... CL</p> <p>LACK OF KNOWLEDGE Knows no Method..... DA Don't know where to obtain methods DB Don't know cost/thinks very expensive DC</p> <p>LACK OF ACCESS Don't have money to buy methods..... EA No time to go to health center EB No way to get to health center EC Afraid someone will find out he/she got method..... ED</p> <p>METHOD-RELATED REASONS Health concerns FA Fear of side effects..... FB Results in having twins..... FC Fear of sterility..... FD Inconvenient to use FE Interferes with body's normal processes..... FF Method desired not available FG</p> <p>Other _____ X (specify)</p> <p>Don't know..... Z</p>	If three wives, go to 15.
9d	Is your fourth wife pregnant, or things she is pregnant	<p>Yes 1</p> <p>No 2</p> <p>Don't know..... 8</p>	→15

No.	Questions and filters	Coding categories	Skip
10d	Would you like your fourth wife to have (a/another) child at any time in the future, or would you prefer that she never has any (more) children?	As god wills it.....1 Have (a/another) child.....2 No more/none.....3 Undecided/don't know.....8	15
11d	Would you like your fourth wife to become pregnant within the next year?	Yes1 No2 Says she can't get pregnant.....3 If God wills it4 Don't know.....8	15
12d	Are you or your fourth wife currently doing something or using any method to delay or avoid getting pregnant?	Yes1 No2	14d
13d	Which method are you or your fourth wife using? CIRCLE ALL MENTIONED	Female sterilizationA Male sterilization.....B Pill..... C IUD D InjectablesE ImplantsF CondomG Diaphragm/foam/jelly..... H Standard Days Method/CycleBeadsI Lactational Amenorrhea Method J Periodic abstinenceK Withdrawal..... L Herbal preparations (drink)..... M Herbal preparations (douche) N Spider web O Beads/amulets.....P Other _____ X (specify)	All to 15

No.	Questions and filters	Coding categories	Skip
14d	<p>You have said that you do not want your fourth wife to become pregnant in the next year, but you are not using any method to avoid pregnancy.</p> <p>Can you tell me why you are not using a method?</p> <p>Any other reason?</p> <p>CIRCLE ALL MENTIONED</p>	<p>God's will/up to God AA</p> <p>PERCIVED RISK OF PREGNANCY OF WIFE Not having sex BA Infrequent sex BB Menopausal/hysterectomy BC Wife not fertile BD Thinks she is sub-fecund or infecund BE Postpartum amenorrheic BF Breastfeeding BG</p> <p>OPPOSITION TO/DISAPPROVAL OF USE Respondent opposed CA Wife opposed CB Wife won't discuss it CF Others opposed/fear of criticism/fear of losing status in family CG Religious prohibition CI Believes it is immoral CJ Outsiders bring methods that harm us CK Want more children before using FP CL</p> <p>LACK OF KNOWLEDGE Knows no Method DA Don't know where to obtain methods DB Don't know cost/thinks very expensive DC</p> <p>LACK OF ACCESS Don't have money to buy methods EA No time to go to health center EB No way to get to health center EC Afraid someone will find out he/she got method ED</p> <p>METHOD-RELATED REASONS Health concerns FA Fear of side effects FB Results in having twins FC Fear of sterility FD Inconvenient to use FE Interferes with body's normal processes FF Method desired not available FG</p> <p>Other _____ X (specify)</p> <p>Don't know Z</p>	
15	Have you ever done or used any method to delay or avoid getting pregnant?	<p>Yes 1</p> <p>No 2</p>	17

No.	Questions and filters	Coding categories	Skip																								
16	<p>Which method have you used in the past? CIRCLE ALL MENTIONED</p>	<p>Female sterilizationA Male sterilization.....B Pill..... C IUD D InjectablesE ImplantsF CondomG Diaphragm/foam/jelly..... H Standard Days Method/CycleBeadsI Lactational Amenorrhea MethodJ Periodic abstinenceK Withdrawal.....L Herbal preparations (drink)..... M Herbal preparations (douche) N Spider webO Beads/amulets.....P</p> <p>Other _____ X (specify)</p>																									
17	<p>I am going to read you statements about the use of family planning. Please tell me if you agree or disagree with each statement</p> <p>(a) It is good to have many children because they can help with household tasks</p> <p>(b) Women who use family planning are straying from the correct path or are immoral</p> <p>(c) Women who use family planning look better than women who do not use family planning.</p> <p>(d) The family planning methods provided by the health programs in this village are difficult to use</p> <p>(e) Couples who practice family planning and have fewer children are better able to provide for their family</p> <p>(f) Using family planning is bad for a women's health</p> <p>(g) Only god can decide the number and timing of children a couple has.</p> <p>(h) Family planning is something that people from outside our community want us to do for their benefit, not ours</p>	<p>Agree Disagree Don't know/Depends</p> <table> <tr> <td>1</td><td>2</td><td>8</td></tr> </table>	1	2	8	1	2	8	1	2	8	1	2	8	1	2	8	1	2	8	1	2	8	1	2	8	
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Instructions and questions for completing network grid

1. Read "Now we are going to talk about the people in your network – people who you interact with, people you receive support from, people you consider to be part of your world. I will ask you about four different types of networks. People you mention can live in this village or elsewhere. You can name the same person more than once."
2. Ask the following questions. Write the names they provide in the name column.
 - (a) Think of the people who provide you material assistance. For example, someone who loans you money, someone who buys things for you in the market, or someone who gives you food or clothes. Please tell me the names of three people that you go to for this type of support.
 - (b) Think of the people who provide you practical assistance. For example, they help you take care of your children, or they can help with household chores, or they can help you with trading or agriculture. Please tell me the names of three people that you go to for this type of support.
 - (c) Think of the people that you can learn from, either because they give you advice or instructions, or because you see what they do and try to do the same. Please tell me the names of three such people.
 - (d) Think of the people who give you emotional support. For example, you can talk to them when you are sad, or when you have an argument with your husband or his mother, or when your children misbehave. Please tell me the names of three people who give you emotional support most often.
3. Go through all the names in the list (up to 12 names). For each person do the following:
 - (i) Find the person in the map/chart/list and write the code in column (b).
 - (ii) Ask: "What is your relationship with (name of person)? You can mention more than one relationship. For example, a person can be your aunt, and can also be your health provider." Write the relationships. Relationships can be family relationship (such as mother, husband, sister, co-wife, etc.) or friend, or it can be a different type of relationship, such as shop-keeper, co-worker, health worker, teacher of the respondent's children, member of her *grin* or *tontine*, etc. It can also be the *marabout* or religious leader.
 - (iii) Ask: "Does (name of person) live in this village, or elsewhere?" If 'elsewhere', ask "In what town does (name of person) live?"
 - (iv) Ask: "How close would you say you are to (name of person)? Very close, close, or not close?" Write the response.
 - (v) ASK: "Does this person influence your decisions planning your family, how many children to have and when to have them?"
 - (vi) Ask: "Would you say that (name of person) approves of people spacing their births and using a family planning method to do so?"
 - (vii) Ask: "Would you say that (name of person) would approve of a woman using a family planning method without her husband's knowledge?"
- If a person is mentioned in more than one network, you do not need to complete the information a second time. Instead write the respondent number from the first network the person is mentioned in the code space. For example, if the respondent's sister is the third person mentioned in Material support, and the second person mentioned in Practical support, then in the line item corresponding to the second person in Practical support write M3 in the code column, and ignore the rest of the line.
4. If none of the respondent's wives were not mentioned in any of the networks, ask "Do any of your wives provide you with any of these types of support? If he responds positively, complete one or both of the Wife lines, otherwise leave them blank.
5. If the respondent's father was not mentioned in any of the networks, ask "Does your father provide you with any of these types of support? If he responds positively, complete the Father line, otherwise leave it blank.

6. If no other male relative was mentioned in any of the networks, ask "Does any of your male relatives provide you with any of these types of support? If he responds positively, complete one or both of the Male relative lines, otherwise leave them blank.

Coding for questions in network grid

Column (a): Name of nominated person

Column (b): Code of nominated person from household listing

Column (c): Relationship(s) of nominated person to the respondent

Husband-101

Wife-201

Son-102

Daughter-202

Brother-103

Sister-203

Father-104

Mother-204

Nephew-105

Niece-205

Male Cousin-106

Female Cousin-206

Daughter of the husband/wife -207

Son of the husband/wife -107

Grandfather-108

Grandmother-208

Father in law-109

Mother in law-209

Daughter in law-210

Son in law-110

Uncle maternal/paternal -111

Aunt maternal/paternal-211

Servant-213

Female friend-214

Male friend-114

Male neighbor-115

Female neighbor-215

Religious leader-116

Male provider-117

Female provider-217

Male Colleague-118

Female Colleague-218

Male village teacher-119

Female village teacher-219

Male Muslim religious leader /trad. therapist/healer-120

Female Muslim religious leader /trad. therapist/healer -220

Cowife-221

Brother in law -122

Sister in law-222

Other-999

Column (d): place of residence:

1. This village
2. Another village in Mali
3. Bamako
4. Another city in Mali
5. Gabon
6. DRC
7. CAR
8. Other (specify)

Column (e): Closeness

1. Very close
2. Close
3. Not close

Column (f): influence

1. Yes
2. No
8. I don't know

Column (g): Approves FP

1. Yes
2. No
8. I don't know

Column (h): FP acceptable

1. Yes
2. No
8. I don't know

Column (i): Approves secret use

1. Yes
2. No
8. I don't know

Network		Name (a)	Code (b)	Relationship (c)			Residence (d)	Closeness (e)	Influence (f)	Approves FP (g)	FP acceptable (h)	Approves secret use (i)
Material	M1											
	M2											
	M3											
Practical	P1											
	P2											
	P3											
Cognitive	C1											
	C2											
	C3											
Emotional	E1											
	E2											
	E3											
Wife 1												
Wife 2												
Father												
Male relative 1												
Male relative 2												

Ask:

"After this phase of the study is complete, including analysis of the data, we will come back to the village to conduct longer interviews with some women and men. We will choose participants for the interviews based on the picture we get about communication and how information is shared in the village. We will look at different characteristics of village residents, and how they responded to each questions, to try and get a big variety of participants. Only 12 men and 12 women in this village will be interviewed"

Will you be willing to participate in these future interviews? Can we add your name to the list of people that we will draw participants from?

Yes / No (circle one)

GUIDE DES ENTRETIENS APPROFONDIS Auprès des FEMMES IN DEPTH INVERVIEW GUIDE/ WOMEN

<p>OBJECTIFS DES ENTRETIENS</p> <ol style="list-style-type: none"> 1. Examiner la manière dont les participants voient leur rôle au sein de leur réseau social. 2. Comprendre de quelle manière les gens entendent parler d'innovations par le biais de leurs réseaux sociaux (apprentissage social) et de quelle manière d'autres personnes influencent leur comportement (influence sociale). 3. Déterminer de quelle manière les informations sur la planification familiale circulent à travers leurs réseaux, ainsi que le type d'informations que l'on y trouve. 4. Comprendre de quelle manière les participants considèrent leurs besoins non satisfaits, et les raisons pour lesquelles ils ont recours ou non à la planification familiale. 	
<p>INTRODUCTION</p> <p>Merci d'avoir accepté de participer à cette entrevue. Si vous vous souvenez, il y avait quelques chercheurs qui ont mené des entrevues avec les ménages de ce village, il y a 3 mois. Aujourd'hui, nous sommes venus pour faire la suite de cette entrevue. Je suis ici pour vous parler de vos décisions sur votre famille et votre santé, et les gens qui influencent votre vie. Je suis particulièrement intéressé à apprendre comment vous prenez les décisions importantes sur le moment d'avoir des enfants et le nombre d'enfants à avoir. Je vais vous demander de me parler des gens dont les opinions comptent pour vous, des gens dont vous suivez les exemples, la façon dont vous apprenez de nouvelles choses, et comment d'autres personnes influencent votre croyance et votre comportement.</p> <p>Pourrions-nous commencer? Premièrement, j'aimerais vous parler de vous et votre rôle au sein de votre communauté, et les caractéristiques générales de votre communauté. Commençons à parler de votre communauté et du village, dans leur ensemble.</p>	<p>INTRODUCTION</p> <p>A be kalo saba bo bi, an djè gnogon dow nana gnikali la aw fé yan; olassa, bi an na kun yé ka o gnikaliw tow sékè sékè. gnikigaliw bé boli I ka akilina taa ka debaya ani kènèya kow kan ani mogow minou be I ka kè walé siraw do I koro. Kèrè kérè né ya là, né ée fè ka don, e bé akilina taa tiogo jumèn là I ka dé soro wati kan ani I ka de akè sorota kan. Ne Be fè I ka kibaru diya mogow kan, mogo minuw akilana ka bo I bolo ni be olou ka walé yonkon kè, I be kunafoni soro tiogoti ko kuraw kan.Tiogodi mogo wèrèw be se ka yèlèma do e ka akilinala ani I ka ko kè ta la.</p> <p>Yali né bé ée ka bara daminè wa? An bé a daminè i yèrè la, e jon yé ani e jo yoro yé mun yé aw ka siguida la, siguida yèrè kow be tiogodi. I bi se ka do fo yé aw ka siguida kan wa ani a mogow ka.</p>

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En gras et souligné: directions pour les interviewers et les questions à sauter

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(DEMANDEZ A TOUTES LES FEMMES) <i>Thème1</i> Informations sur la communauté, les groupes sociaux et les réseaux communautaires		
N°	QUESTIONS	
1	<p>Quand nous regardons la manière dont chacun est connecté dans la communauté, nous remarquons que (choisir selon la respondent):</p> <ul style="list-style-type: none"> <input type="radio"/> Vous êtes bien connectées <input type="radio"/> Vous connectez des groupes de personnes <input type="radio"/> Vous n'êtes pas trop connectées comme certains membres de la communauté <p>Etes-vous d'accord? Pourquoi ou pourquoi pas ?D'après vous, pourquoi c'est comme ca ?</p>	<p>An ka Kolosi yé a yira ko mogow ni gnogon tiè,choisir</p> <ul style="list-style-type: none"> ○ E don né do kosobè, i lamèn do ○ E bè diama kulu tiaman ni gnogotiè ○ E ni mogo tiaman té gnogon don <p>E son na o lakolosi ma wa? Tiogodi ? E Bolo mun de be o kè ?</p>
2	<p>Est-ce que les personnes viennent vous voir pour obtenir des conseils sur des questions relatives à la santé ou à la famille ?</p> <p>Qui vient vous voir pour chercher ces conseils ?</p> <p>Quel genre de renseignements leur donnez-vous ?</p> <p>A quel point vous sentez-vous prête à fournir des conseils aux gens sur les questions que nous sommes en train d'aborder ?</p> <p>Pouvez-vous me dire des raisons qui font que vous soyez plus à l'aise (pour donner des conseils) avec une personne en particulier mais pas à avec une autre ?</p>	<p>Yali mogow bi na ladilikan yini e fè kènèya ko ani debaya kow ka wa?</p> <p>O mogo nounou yé djon de yé?</p> <p>I bé kunafoni sougouya djoumè dé di ou ma ?</p> <p>E dalé bè I joyoro la ka sé hakè jumèn ma walasa ka se kan ni ladilikan sugu di mogow ma?</p> <p>Yali mogo do ladili ka nogo I ma ka tèmè do kan wa? Mou de bé o kè?</p>
3	<p>Vous considérez-vous comme un modèle à suivre – par exemple, estimez-vous que vos actes ou vos paroles ont une influence sur ce que d'autres personnes font ?</p> <p>Pourquoi dites -vous cela? <i>Pour quelle raison estimez-vous que vous avez une influence (ou que vous n'avez aucune influence) sur d'autres personnes ?</i></p> <p>Veuillez me donner des exemples de la manière dont vous avez influencé quelqu'un d'autre.</p>	<p>E bolo, mogow be se ka I ka tabolo la déki wa? Missali la, yali e ka fô taa ani I ka kè walé bé sé ka yèlè ma do mogo wèrè ka ko kè taa là Wa?</p> <p>Mouna?<i>Mou dé ba to mogwo bé e ka waléya la déki (walima out a la deki?)</i></p> <p>I be sé ka missali do foyé I ka waléya do kan mou yé yèlèma do mogo wèrè ka waléya là, wa?</p>

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4	<p>Appartenez-vous à des groupes sociaux tels que les <i>tontines</i> / les associations de micro-crédit, les <i>grins</i>, les groupes sportifs ou religieux ou à d'autres groupes ? Lesquels ?</p> <p><u>Si la réponse est OUI, poursuivez en demandant :</u> dites-moi-en plus à propos des groupes que vous avez cités.</p> <p><u>Si la réponse est NON, poursuivez en demandant :</u> selon vous, comment cela se fait-il ?</p>	<p>Yali e be jèkulu do là wa? I bé jèkulu djoumè ni djoumè la?</p> <p>OUI: I bé sé ko jèkulu wala wala né yé wa (dinè, pari, grins, etc.)</p> <p>NON : togodi I té djèkulu la ? Mouyo kè ?</p>
5	<p>Existe-t-il des groupes informels de personnes, autre que les membres de votre famille, avec qui vous passez du temps(<i>comme personnes de votre génération, l'étudereligieuse,groupes de cultivateurs etc.</i>)?</p> <p>Dites-moi plus.</p>	<p>Ka bo I ka sogono mogow la, e ni mogow wèrè bé yoko daladjè baroda là wa? (i na fô filan maw, kalanso, bara kègnoko)</p> <p>I bé sé ka o fèssè fèssè né yé wa?</p>
6	<p>Parlez vous des choses, par exemple comme le nombre d'enfants que vous souhaitez avoir dans ces groupes ? A quel moment en avoir ?Comment éviter les grossesses ?</p> <p>Comment ces questions sont-elles soulevées ? Qui évoque les sujets relatifs à la fécondité et à la planification familiale ?</p>	<p>O baro kè daw là, yala aw da bé sé bangué ko kuma ma wa? I na fô dén sorota hakè, a waati ani bangué Kolosi kè tiogo.</p> <p>Baro bé na o kuma nounou kan togodi? Djon dé bé na ni dén ko ani bangué kolossi kuma yé ?</p>
7	<p>Connaissez-vous des groupes ou associations hors du village qui font des actions pour ce village (associations du village) ?</p> <p>Avez-vous des liens avec eux ? Avez-vous des amis ou des parents dans ces groupes ?</p>	<p>Yala I bé djèkulu don minuw be na dèmè do aw ma yan ka bo dugu wèrè wa?</p> <p>Djè be e ni o djèkuluw ni yonko tchiè wa ?Yala e téri wali I somogo do bé o jèkulu do la wa?</p>
8	<p>A quel genre de groupes officiels les femmes et les hommes plus âgés (comme les grands-pères et les grands-mères) appartiennent-ils , habituellement?</p> <p>Comment se regroupent-ils pour fréquenter d'autres gens ?Donc,appartiennent-ils à d'éventuels groupes informels ?</p>	<p>Moussokoroba walima tchiè koroba Ton kulu soukou djoumè de la kodoné do (Association, coopérative, etc)?</p> <p>Ou ka la djè bé kè togodi walassa ou ni mogo wèrè wali djèkulu wèrè bé sé ka yonko la soro ? Ma korow djèkulu dow be yé wa i na fo (Pari, ton, grin, etc) ?</p>

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(DEMANDEZ A TOUTES LES FEMMES) Thème 2 : <i>Connaissances et attitudes à l'égard des méthodes de planification familiale</i>		
9	<p>Si vous vouliez en savoir plus sur l'espacement des naissances ou l'utilisation de la planification familiale, iriez-vous voir une accoucheuse traditionnelle ou un relais (agent de santé communautaire) ?</p> <p>Pourquoi ou pourquoi pas ?</p>	<p>N'i makobé kunafoni na bangué kolosi ani a fèrèw matarafalikan, yala i bésé timinè muso dé ma wa wala kènèya tiguilamogow ?</p> <p>Muna ?</p>
10	<p>Dans certains endroits, beaucoup de gens disent que si une femme allaite, ou si elle n'a pas encore vu ses règles après avoir eu son bébé, elle ne peut pas tomber enceinte. Qu'en pensez-vous ?</p> <p>A quel point est-ce que vous croyez que cela est efficace pour éviter la grossesse ?</p> <p>Où/comment l'avez-vous appris ?</p> <p>Est-ce que c'est dans l'habitude des gens de s'abstenir des relations sexuelles après l'accouchement ? <i>Pour combien de temps ?</i></p>	<p>Siguida dow la, mogow ba fô, kô muso té sé ka kono soro ka dén to a china walama kasoro a maa ka lada yé a ka bangué kofè. E hakilina ta yé mungné o kan?</p> <p>Togo jumèn na e dalé do o kè walé la ko bé sé ka kono bali?</p> <p>Hé yé o kunafoni mè mini, togodi?</p> <p>Yala, bangué kofè, a ka tian mogow ka u yèrè minè glan là wa? Fo wagati jumèn ?</p>
11	<p>Certaines personnes pensent que la planification familiale est imposée à la communauté par des gens de « l'extérieur ». Êtes-vous d'accord ou non avec cela ? <i>Pourquoi ?</i></p> <p>Qu'en pensent les autres membres de votre communauté ?</p>	<p>A be mogo dow gnèna ko bangué kolosi yé faradjè ka ko wajibi yalen dé yé an kan, e sonna o kuma ma wa? Muna?</p> <p>Aw ka siguida la mogo mirinayé mouyé o kuma kan?</p>
>>>Parlons à présent de votre famille et d'autres personnes qui sont proches de vous ou qui sont importantes dans votre vie		<p>>>>Sisan, an bé na kuma I ka débaya ka ani I masuru mogow minuw joyoro ka bo I ka jignè la tikè la.</p>

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<u>(DEMANDEZ A TOUTES LES FEMMES)</u>		
<u>Thème 3:</u> <i>Influence exercée par la famille et par les gens qui sont proches des femmes sur la taille de la famille et l'utilisation de la planification familiale (entourage)</i>		
N°	QUESTIONS	
12	<p>Pour commencer, pourriez-vous m'en dire un petit peu sur votre ménage ?</p> <p>Avec qui habitez-vous ? (<i>Sondez sur sa mère, son mari, ses coépouses</i>)</p> <p>Est-ce que vous avez un parent qui habite hors de votre ménage ? Hors de votre concession ? Hors du village ? <i>Qui ?</i></p>	<p>I bé sé ka do fô gné i ka dénbayakan wa?</p> <p>E ni jon ni jon ni dé bé bo dou kélen konon? (Tiè, bâ, sinamuso)</p> <p>Yala e so mogo do sigulen bé fan wèrè wa? A bé sé ka kè so wèrè walima dugu wèrè? O tigui yé djon yé?</p>
13	<p>Est-ce qu'il y a quelqu'un dans votre famille ou votre village qui influence vos décisions sur le moment pour avoir des enfants et combien en avoir ?<i>Qui ?</i> (Demandez plus de précisions sur : la belle mère, le mari, les co-épouses).</p> <p>Une de ces personnes est-elle en désaccord avec le moment que vous avez choisi pour avoir des enfants ou avec le nombre d'enfants que vous avez eu ? <i>Dites-m'en plus.</i></p> <p>Où habitent-elles ?<i>Ici dans le village ou ailleurs ?</i></p> <p>Parmi les personnes que vous avez citées, quelles sont celles dont les opinions ont le plus d'importance à vos yeux ? <i>Dites-m'en plus.</i>(Demandez plus de précisions sur : les anciens par rapport aux jeunes, les leaders religieux, hommes par rapport aux femmes, le statut social.)</p> <p>En regardant votre vie jusqu'à présent, diriez-vous que les conseils des personnes qui ont influencé vos décisions sur le fait d'avoir des enfants ont changé, ou bien sont-ils restés les mêmes au fil des ans ?</p>	<p>Aw ka du kono walima aw ka dugu kono, yala mogo bé mi bé hakilinaw do i koro i ka den soro waati ani dén sorota hakè kan wa? (buramuso, tchiè, sinamuso, etc.)</p> <p>O Mogow la, yala do bé ye n'o ma jè ni e ka den soro waati yé wa, walima i yé dén hakè mi soro? I bé sé ka o gnèfô yé ?</p> <p>O tigui bé bo mi? Yan dugula wa walama dugu wèrè?</p> <p>O mogow be la i be jon ni djon de ka kumakan lamen kosobè ?</p> <p>I bé sé ko gnèfô yé wa? (a tigui djo yoro,etc)</p> <p style="text-align: right;">← - -</p> <p>Ni yé i miri i ka mogoyakan ka bo kunu na ka sé bi ma, yala mogominu kun bé waléya do I koro bangué ko kan, o lou hakilina yèlèmanabangué kokan wa ? walima hakilina kélé dé bé ou fè alisa ?</p>

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14	<p>Que pensent les personnes qui sont proches de vous à propos sur le fait <u>d'attendre</u> avant d'avoir le prochain enfant et de ne pas avoir les enfants l'un après l'autre (<u>l'espacement des naissances</u>) ?</p> <p>Que pensent-elles de celles qui <u>prennent des mesures</u> pour éviter la grossesse, par exemple, l'<u>utilisation d'une méthode de planification familiale</u>?</p> <p><i>Comment savez-vous que c'est ce qu'ils pensent ? (Demandez plus de précisions sur les indices non verbaux. (par exemple, si on roule les yeux, reste silencieux, etc)</i></p> <p><i>Êtes-vous d'accord ou non avec elles ?</i></p>	<p>E masuruna mogo ka hakina ta yé mouyé furan tchiè bilalina denw ni gnogon tchiè kan ?</p> <p>Ou miri nayé mouyé mogow minou bé bangué kolossi fèrè tiguè, kan? Missalila, i ba fo ka fourakissè ni taa?</p> <p>E bé mogow hakili na ta don tiogodi?(mi bè fô ani mi bé yira ka soro a ma fô, kè walé, etc.)</p> <p>E ni ou bè hakili na ta yé kélé wa?</p>
15	<p>Si les gens savaient ou découvraient que quelqu'un utilisait une méthode de planification familiale, est-ce qu'ils la tiendraient à l'écart ou bien est-ce qu'ils la culpabiliseraient ?</p> <p><i>Que diraient-ils à son sujet ? Que feraient-ils ? Comment ?</i></p> <p>Connaissez-vous personnellement quelqu'un qui a été critiqué ou qui a subit les brimades parce qu'il utilisait une méthode de planification familiale ?</p> <p><i>De quelle manière ont-ils été traités négativement ? Qu'en pensez-vous ?</i></p>	<p>Ni siguida la mogow bora a kalama ko do bé ka bangué kolosi fèrè matarafa, u bé a tigui minè tiogodi ? ou bê ou ma bô a tiguita walima ou bé a tigui dialaki dé?</p> <p>Ou bé mun dé fô a tigui ma ? ou bé mou dé kè ? Tiogodi ?</p> <p>I bé mogo don kérèn kérèn neya la mi délila ka lagosi bangué kolossi matarafali la wa?</p> <p>A lagosira tiogodi? E hakilina ta yé mu yé o kèwalé kan?</p>
16	<p>Dans certains endroits, les coépouses rivalisent entre elles pour obtenir l'approbation de leur mari et famille. Dans quelle mesure est-ce que cette rivalité entre coépouses affecte les décisions d'une femme à avoir des enfants et à recourir à la planification familiale ?</p> <p><i>Si l'une des épouses utilise la planification familiale, de quelle manière cela pourrait-il avoir un effet sur les autres coépouses ?</i></p>	<p>Sinaya ni musow ka dén ko bë sira kélen na wa? Wala muso ka mandia sirilen bë den soro la wa,?</p> <p>Ni muso kélé be ka bangué kolosi fèrè tiguè, o be se ka mu de lassé muso tow ma?</p>

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(DEMANDEZ À TOUTES LES FEMMES) Thème 4: <i>Coûts et bienfaits associés aux enfants et à l'utilisation de la planification familiale</i>		
17	<p>Beaucoup de gens disent que le nombre d' enfants et l'espacement des naissances sont décidés par Dieu. D'autres croient que les couples doivent choisir le moment et nombre d' enfants qu' ils vont avoir. Qu'en pensez-vous ?</p> <p>Qu'est-ce que les leaders religieux et leurs femmes en pensent ?</p> <p>Pourquoi dites-vous cela ?</p>	<p>Mogo dow ba fo ko dén hakè sorota ani a wati be bo allah de là, dow fènè kow tchiè ni muso bé sé ka ben dén sorota hakè ani a soro wati kan? E hakili na ta yé mouyé o folé nunu kan ?</p> <p>Dinè yémogow ni ou musow miriya yé mouyé o kan?</p> <p>E be o fô mou dé fè?</p>
18	<p>Quel est le code moral approprié par rapport à la fécondité (le fait d'avoir des enfants) ? <i>Comment les gens devraient-ils agir ? Comment les gens devraient-ils y réfléchir ?</i></p> <p>Quels sont les éléments spirituels ayant une influence sur la fécondité des gens ? <i>Comment sont-ils différents des éléments non-spirituels ?</i></p>	<p>Aw ka lada bé mou yamaruya wala ka mun fo banguéko nasira kan? Mogow kan ka walé kè tiogodi? Ou kan ka miri tiogodi?</p> <p>Dinè walama ladalako jumenw béké minu be hakili na do mogow koro baguékola ? Furantiè jumèn de be o hakilinaw ni hakilina wèrè tiè ?</p>
NB : ALLEZ A LA : <i>-Section 1 (page 8), si la femme <u>veut</u> tomber enceinte cette année -Section 2 (page 10), si la femme <u>ne veut pas</u> tomber enceinte cette année</i>		← → Formatted: Line spacing: single

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<p style="text-align: center;"><u>Thème 5:</u> Désirs de fécondité</p>			
<p>Section 1 : Femmes qui souhaitent tomber enceinte</p>			
	19a	<p>Quand nous avons parlé la fois dernière, vous avez dit que vous voulez tomber enceinte cette année. Est-ce toujours le cas? <u>Si elle dit qu'elle ne veut pas tomber enceinte cette année, ALLEZ A LA SECTION2.</u></p>	
2	20a	<p>Est-ce que vous savez ce que votre mari pense à propos? Comment le savez-vous?</p> <p><i>Vous arrive-t-il de parler de ça ou bien est-ce quelque chose de tacite ? Qu'est-ce qui déclenche la conversation ?</i></p> <p>Si votre mari ne veut pas un autre enfant maintenant, pourquoi pensez-vous que vos opinions sont différentes ? <i>Comment vous sentez vous à ce sujet? Comment gérez-vous ce désaccord?</i></p> <p>Dans certains villages, les maris et les femmes pensent que c'est bon de se parler de ces choses. Est-ce possible ici ?</p> <p><i>Que pensez-vous de cette idée ? Aimeriez-vous le faire ? Qu'est-ce qui se produirait dans ce cas-ci ?</i></p>	<p>An ka gnikali témènew na i yé a jira kafo ki bé fè ka guarsikè soro gnina san kono i be o hakilinaka halibiwa ?</p> <p>Yala i be i tiè hakilina ta don o ko kan wa? E yé o don tiogodi?</p> <p>E ni tiè bé kuma o ko kan wa walima o kuma nunu bé té fô, i bé don kèwalé dé la wa? mudé be se ka na no kuma nason yé?</p> <p>Ni e tiè t'a fè ka den soro gnninan, e hakilila kun jumèn dé bé aw mirina bo gnogoma? O ko nasogna be e bila mi? E bé o hakili fognoko kônlatèmè tiogodi?</p> <p>Dugudow la mogow miri yé ko a kagni furugnogomaw ka djè ka kuma ni fin masinaw kan? Yali o be se ka kè aw fé gnan wa?</p> <p>E hakili na ta yé mu yé o miriya kan? A kadi e yé ko kè wa ? O kèli bé se kana ni sabaou jumèn dé yé?</p>
	21a	<p>Et les autres personnes dans votre vie? Pensent-elles que vous devez attendre pour tomber enceinte aussi ou est-ce qu'elles veulent que vous tombiez enceinte?</p> <p><i>Quelle est l'importance de leur avis pour vous? Pourquoi dites-vous cela?</i></p>	<p>I masuruna mogow tow du? O lu fana hakilila i kakan ka waati makono sani ka garizike were soro wa, walima ou bé fè I ka garisikè soro sisan?</p> <p>Fana jumen be olou ka hakilina e bolo? I yo fo muna?</p>
	22a	<p>Dans le passé, avez-vous utilisé des méthodes pour éviter une grossesse ?</p> <p><u>SI NON, TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA</u></p> <p><u>SI OUI</u>, lesquelles ?</p> <p>Pourquoi avez-vous utilisé cette méthode</p> <p><i>Quelle satisfaction avez-vous eu ? Quelles sont les qualités de cette méthode que vous avez particulièrement appréciées ?</i></p>	<p>Wati tèmè lew na, é delila ka bangué kolosi fèrè do matarafa wa?</p> <p><u>NON, TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA :</u></p> <p>OUI : Fèrè jumèn ?Muna, I yé o fèrè folé dé matarafa?</p> <p><i>I yé nimisi wasa jumèn de soro a la? Mun dé diara I yé kossobè ni férèni la?</i></p>

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Bold & underlined: Directions for interviewers and skip patterns

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	<u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA</u>	<u>TERMINÉ L'ENTRETIEN ET REMERCIEZ-LA</u>
	<i>Section 2 : si la femme ne veut pas tomber enceinte</i>	
19b	Quand nous avons parlé la dernière fois, vous avez dit que vous ne vouliez pas tomber enceinte cette année. Est-ce toujours le cas? (Si elle dit qu'elle voudrait tomber enceinte, allez à la Section 1)	An ka gnikali temenew na i ye a djira kafo ki t'a fè ka garisiguè soro gnnan san kono i be o hakilinaka halibiwa ?
20b	Est-ce que vous savez ce que votre mari pense à propos de cela? Comment est-ce que vous le savez? <i>Vous arrive-t-il de parler de ça ou bien est-ce quelque chose de tacite ? Qu'est-ce qui déclenche la conversation ?</i>	Yali i bé i tchiè hakilina ta don o ko kanwa? E ye o don tiogodi? E ni tchiè be kuma o ko kan wa walima o kow nunu te fo? Mun dé bé na no kuma nason yé?
21b	Est-ce que votre mari veut attendre ou veut-il avoir un autre enfant maintenant? Si votre mari veut un autre enfant maintenant, pourquoi pensez-vous que vos opinions sont différentes? <i>Comment vous sentez vous à ce sujet? Comment gérez-vous ce désaccord?</i>	E tchiè be fè ka djo doni gnnan ka dén wèrè soro wa walima a be fè ka dén soro sisan dé? Ni e tiè bé fè ka dén soro gnnè , e hakilila kun jumèn dé bé aw mirina bo gnogoma ? O ko nasogna bé e bila mi? E be o fognoko kòn latèmè tiogodi?
22b	Dans certains villages, les maris et les femmes pensent que c'est bon de se parler de ces choses. Est-ce possible ici ? <i>Que pensez-vous de cette idée ? Aimeriez-vous le faire ? Qu'est-ce quil se produirait dans ce cas-ci ?</i>	Dugudow la mogow miri yé ko a kagni furugnogomaw ka jè ka kuma ni fin masinaw kan? Yala o bé sé ka kè aw fé yan wa? E hakili na ta yé mun yé o miriya kan? A kadi e yé ko kè wa ? O bé se kana sababou jumèn dé yé?
23b	Et les autres personnes dans votre vie- qu'en pensent-elles? Pensent-elles que vous devez attendre pour tomber enceinte aussi? <i>Quelle est l'importance de leur avis,pour vous? Pourquoi dites-vous cela?</i>	I masuruna mogow tow du? O lu fana hakilila i kakan ka waati makono sani ka garisiguè wèrè soro wa? joyoro jumen be o lu ka hakilina e bolo? I yo fo muna?

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24b	<p>Est-ce que vous (ou votre mari) faites quelque chose pour éviter les grossesses en ce moment? <u>Si OUI, allez au Thème 6 (page 12).</u></p> <p><u>SI NON, demandez :</u> Pouvez-vous me dire pourquoi vous n'utilisez pas une méthode de PF, alors que vous dites que vous aimeriez éviter la grossesse?*</p> <p><u>Si elle repond « à cause de l'allaitement », demandez-lui :</u> Pouvez-vous m'en dire plus ?</p> <p>Pourquoi est-ce que vous ne pouvez pas utiliser une méthode de PF pendant l'allaitement ? Qu'est-ce que les femmes qui allaitent peuvent faire pour éviter la grossesse ?</p> <p>Connaissez-vous des femmes qui sont tombées enceinte au moment où elles allaient ? <u>PASSEZ À Q 25b (page 11)</u></p> <p><u>Si elle reponde « parce qu'elle s'abstient (des relations sexuelles), demandez -lui :</u></p> <p>Votre mari, respecte-t-il votre décision de s'abstenir ou parfois avez-vous des relations sexuelles ?</p> <p>Combien de temps continuez-vous à vous s'abstenir ? <u>PASSEZ À Q25b (page 11)(quelle modalité de réponse ?)</u></p> <p><u>Si elle ne repond aucune reponse, demandez lui:</u> Pouvez-vous m'en dire plus ?</p> <p><i>Demandez plus de précisions sur les préoccupations par rapport à une méthode en particulier, opposition du mari, la religion, l'impossibilité d'accéder à telle ou telle méthode, l'opinion de la société, le fait de penser qu'il n'y a pas de risque de tomber enceinte <u>ALLEZÀ Q25b (page 11)</u></i></p> <p><u>* SI ELLE EVOQUE QUELQUE PART QUE C'EST LA VOLONTE DE DIEU, DEMANDEZ PLUS DE PRECISIONS :</u> Pouvez-vous m'en dire plus à ce sujet ? Qu'entendez-vous par volonté de Dieu.</p>	<p>Ni waati ni là, yala e ni tiè dolakélé be ka bangué kolosi fère matarafa wa? OUI : Allez au thème 6</p> <p>SI NON: E te fè ka garizikè soro sisane muna e du te ka fèrè tiguè ka garisikè bali?</p> <p>Allaitement: I be sé ko fèsè fèsè gné wa?</p> <p>Muna I te sé ka bangué kolosi fère matarafa ka dén to I sin na? Dén be muso mi sin na, o bé sé kayèrè tangan kono ma tiogodi?</p> <p>E be mogodon walima e deli la ka mogo yé mi yé gariziguè soro kan dén to a sin na wa? <u>Q25b (page 11)</u></p> <p>Abstinence: Ni e ko, ki be I yèrè minè glan na, yala e tiè bë son o ma kumabè wa?</p> <p>E bi yèrè minè fo waati jumèn? <u>Q25b (page 11)</u></p> <p>Pas de réponse: I be sé ka do fo yé ni kan?</p> <p><i>I tié ka baguékolosi fère matarafa baliya kun ée yé, fère nunuw kololo, mogow gnè sirangnè, dinè, a sorotogo guélèya, mogow be min fo, E yèrè hakilila i téssé ka garizikè soro wa ?</i> <u>(Q25b (page 11))</u></p> <p>*DIEU:I be sé ko fèsè fèsè ne yé wa? N'i ko, ka be dia allah de</p>
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		yé, e be fè ka mun de kélé fo o là?
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<p>25b</p> <p><u>DEMANDEZ SEULEMENT AUX FEMMES QUI N'UTILISENT AUCUNE METHODE DE PF (SI UNE FEMME UTILISE UNE METHODE, ALLEZ AU THEME 6)</u></p> <p>Avez-vous déjà utilisé (dans le passé) une méthode ? Si oui, lesquelles ? <i>Pourquoi avez-vous arrêté d'utiliser ces méthodes ?</i></p> <p>Diriez-vous que vous avez « besoin » d'utiliser une méthode de planification familiale?</p> <p>Pourriez vous m'expliquer plus en détail les raisons pour lesquelles vous avez « besoin » ou non de recourir à la planification familiale?</p> <p>Et votre mari, diriez-vous qu'il a « besoin » de la planification familiale? <i>Dites-m' en plus...</i></p> <p>Certaines personnes disent que puisque vous ne souhaitez pas tomber enceinte et que vous n'utilisez pas de méthode efficace pour empêcher les grossesses, c'est que vous avez « besoin » de recourir à la planification familiale. Êtes-vous d'accord ou non avec cela ? Dites-m' en plus...</p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA</u></p>	<p><u>AUX FEMMES NON UTILISATRICES</u></p> <p>Yala e delila ka bangué kolosi fèrè do matarafa wa? Fèrè jumèn? <i>Muna I yo fèrè kèli dabila?</i></p> <p>Bangué kolosi fèrè mako b'ye wa?</p> <p>I bé sé ka fésè fésè yé kun jumèn na e bolo I mako bé bangué kolosi fèrè là walima kun jumèn na e bolo I mago té a là?</p> <p>E tiè du, alé mako be a la wa? I be sé ko yèfo yé ka gnan?</p> <p>Mogow dow ba fo ko, ni té fè ka gariziguè soro, wa I te ka fèrè tiguè walasa ka gariziguè bali fènè. Ko ba yira ka fo ki mago bè ka bangué Kolosi fèrè do matarafa. E son na o kuma ma wa? I bé sé ka ka o miriya wala wala doni?</p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA</u></p>
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DEMANDEZ SEULEMENT A LA FEMME QUI : <u>NE VEUT PAS UNE GROSSESSE ET UTILISE UNE METHODE DE PF</u> <u>(TRADITIONNELLE, MODERNE, EFFICACE, INEFFICACE)</u>		
<u>THEME 6: Utilisation Actuelle et Satisfaction</u>		
26	<p>Qu'est-ce que vous faites/utilisez ? <i>Dites m'en plus.</i></p> <p><u>Si c'est l'allaitement, demandez les questions suivantes</u></p> <p>Est-ce que vous pensez que ce que vous faites est efficace pour éviter la grossesse ? Pourquoi ?</p> <p>Où/comment l'avez-vous appris ?</p> <p>Est-ce que vous continuez à avoir des relations sexuelles avec votre mari ?</p>	<p>E bé ka bangué kolosi fèrè jumèn de matarafa? I be sé ko gnèfo?</p> <p>Allaitement.</p> <p>E mira la sin di yé fèrè gnuman yé mi bé sé ka gariziguè soroli bali wa? Muna ?</p> <p>E yé ni kibaru mèn min, I y a mèn tiogodi ?</p> <p>Yala glan be ka tèmè I ni tiè tiè wa?</p>
27	Qu'est-ce qui vous a motivé à l'origine à commencer à utiliser la planification familiale ?	Sababu jumènw de yi bila bangué kolosi fèrè matarafali la ?
28	Comment avez-vous entendu parler de votre méthode? <i>Ou avez-vous obtenu des renseignements sur cette méthode ?</i>	I yé kunafoni soro tiogodi i ka bangué kolosi fère ni kan ? I yé o kunafoni soro min ?
29	<p>Qui a choisi la méthode que vous utilisez actuellement ? (<i>Sondez pour voir qui : elle, son mari, sa belle-mère, son prestataire, ou quelqu'un d'autre ?</i>)</p> <p>A votre avis, Qui devrait prendre la décision – l'homme, la femme, ou quelqu'un d'autre ?</p>	<p>jon dé gné e ka fèrè kè ta ni sukandi? (i yèrè wa, i tiè, buramuso kènèya tiguala mogow, mogo wèrè?)</p> <p>E hakilila, a tu ka kan jon dé ka sukandi ? Tiè wa, muso wa, yala mogo wèrè ?</p>
30	Avez-vous entendu parler d'autres moyens pour empêcher les grossesses ? Parlez-moi de ces autres méthodes que vous connaissez .	Yala, i yé bangué kolosi fèrèw wèrè komèwa? I be se ka kuman gné o fèrew kan wa ?
31	<p>Pourquoi avez-vous choisi d'utiliser la méthode que vous utilisez actuellement plutôt que les autres méthodes que vous avez citées ?</p> <p>Est-ce que vous avez discuter des différents méthodes avec votre mari avant de choisir cette méthode ?</p>	<p>Muna i yé I ka fèrè ni sukandi ka bo i ka fèrè kolen tow la?</p> <p>Yala, i ni tiè kuma na fèrè nunu kan folo sani i ka ni sukandi wa?</p>

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32	<p>Que pensez-vous de la méthode que vous utilisez actuellement ?</p> <p>Quelles sont les caractéristiques de cette méthode que vous aimez particulièrement (par rapport à d'autres méthodes) ?</p> <p>Quelles sont les qualités que vous n'aimez pas ?</p> <p>En comparant les différentes qualités de la méthode utilisée, quelle importance accordez-vous à certaines qualités qui font que la méthode soit efficace pour empêcher les grossesses ?</p> <p>A quel point êtes-vous satisfaites de la méthode que vous utilisez actuellement ? Pourquoi ?</p>	<p>E ka hakilina yé mun yé I ka fèrè surandi len kan?</p> <p>Kèrè kèrè né ya la, mun dé bé i ka fèrè ni la ni o kadi I yé?</p> <p>Mun dé bé a la mi man di e yé?</p> <p>Ni yé fèrè ni nafa bè ladjè, a nafama yoro jumènw de ka bo e bolo, no dé bé a to fèrè ni bé sé ka gariziguè bali?</p> <p>E yé nimisiwasa sugu jumèn dé soro i ka fèrè kèlen ni la ? Tiogodi?</p>
33	<p>Selon vous, a quel point ces méthodes sont-elles efficaces pour empêcher les grossesses ?</p> <p>Pourquoi pensez-vous cela ?</p>	<p>E bolo, fèrè ni kagni ka sé hakè jumèn ma walassa ka sé ka gariziguè bali?</p> <p>I bè o fo mun dé fè ?</p>
34	<p>Est-ce que votre mari sait que vous utilisez cette méthode pour prévenir une grossesse ?</p> <p>Si NON, demandez: Pourquoi pas? Comment faites-vous pour le dissimuler? Comment cela vous affecte le fait que vous devez utiliser en secret ? Dites-m'en plus.</p> <p>Si OUI, demandez: Est-ce qu'il est satisfait avec cette méthode? Dites m'en plus sur son opinion.</p> <p>Comment connaissez-vous son opinion sur la méthode?</p>	<p>Yala I tiè bé a kalama ko I be ka bagué kolosi fèrè matarafa wa?</p> <p>NON: Muna a te a kalama? E dun be i dogo tiogodi? Dogoli ni be mundé da e kan? I bé sé ka o fèsè fèsè ne yé wa?.</p> <p>OUI: I tiè nimisi wasalé do bangué kolosi fèrè ni ko la wa? I bé sé ka a hakilinata fogné wa?</p> <p>E béa akilina ta don tiogodi fèrè ni kan?</p>
35	<p>Qui d'autre dans votre vie sait que vous faites cela pour prévenir une grossesse ? (<i>Demandez-lui de spécifier : belle-mère, coépouses, belle-sœur, mère, père</i>)</p> <p>Si c'est le cas (ou s'ils arrivent à l'apprendre), quelle serait leur opinion ?</p> <p>Est-ce que leur opinion vous importe ? Pourquoi / pourquoi pas? <i>Sondez pour des leaders religieux et la communauté.</i></p>	<p>E don baga jumènw dé b'a kalama ka fo ko i bé ka bangué kolosi fèrè matarafa ? (<i>buramuso, sinamuso, nimogomuso, kansinamuso, i ba, i fa</i>)</p> <p>O tiguiwmirina ta yé mun yé bangué kolosi kan?</p> <p>O tiguiw hakilina be e bolo tiogodi ? Muna? (<i>mogobaw: Dinè gnèmogo, dugutogui ,musokuntogui, etc</i>)</p>
36	<p>Avez-vous personnellement déjà été victime de médisances, d'insultes ou subi des conséquences préjudiciables parce que vous utilisez la planification familiale ? Pouvez-vous en expliquer plus?</p>	<p>Yala bangué kolosi fèrè matarafali délila ka lagosi lasé i ma wa ? i be sé ko gnèfo gné ka gné wa ?</p>

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37	<p>Avez-vous utilisé d'autres méthodes, auparavant ? Si oui, lesquelles ?</p> <p>Que pensez-vous de ces méthodes ?</p> <p>Quelles sont les caractéristiques de cette méthode que vous avez vraiment aimées ? Quelles sont les caractéristiques que vous n'avez pas aimées? Est-ce que vous étiez satisfait de la méthode ?</p> <p>Pourquoi avez-vous interrompu ce que vous faisiez pour éviter les grossesses ?</p> <p>Recommanderiez-vous ces méthodes à d'autres personnes ? Lesquelles ? <i>À qui ?</i></p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LA</u></p> <p><u>Dites à la fin de chaque entretien :</u> Merci beaucoup de nous avoir consacré un peu de votre temps. Nous vous en sommes extrêmement reconnaissants.</p> <p>Y a-t-il des questions que vous aimeriez me poser ?</p>	<p>E dili la ka bangué kolosi fèrè wèrè matarafa Wa? jumèn ni jumèn ?</p> <p>E miri na yé mun yé o fèrèw kan? Mun ni mun dé diara i yé o fèrè kan ? mun ma dia i yé o fèrè la ? Yala i yé nimisi wasa soro o fèrè la wa ?</p> <p>Muna e yé o fèrè matarafa li dabila?</p> <p>Yala e be son ka fèrè nunuw ko fo I ka mogo do yéna walasa ou ka matarafa wa? E be fèrè kélé jumèn dé fo u yé?</p> <p><u>FIN ET REMERCIEMENT.</u></p> <p>Gninikali bé I fènè fè wa?</p>
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GUIDE DES ENTRETIENS APPROFONDIS Auprès des HOMMES

IN DEPTH INVERVIEW GUIDE/ MEN

<p>OBJECTIFS DES ENTRETIENS</p> <ol style="list-style-type: none"> 1. Examiner la manière dont les participants voient leur rôle au sein de leur réseau social. 2. Comprendre de quelle manière les gens entendent parler d'innovations par le biais de leur réseau social (apprentissage social) et de quelle manière d'autres personnes influencent leur comportement (influence sociale). 3. Déterminer de quelle manière les informations sur la planification familiale circulent à travers leurs réseaux, ainsi que le type d'informations que l'on y trouve. 4. Comprendre de quelle manière les participants considèrent leurs besoins non satisfaits, et les raisons pour lesquelles ils ont recours ou non à la planification familiale. 	
<p>INTRODUCTION</p> <p>Merci d'avoir accepté de participer à cette entrevue. Si vous vous souvenez, quelques chercheurs ont mené des entrevues avec les ménages de ce village, il y a 3 mois. Aujourd'hui, nous sommes venus pour faire la suite de cette entrevue. Je suis ici pour vous parler de vos décisions sur votre famille et votre santé, et les gens qui influencent votre vie. Je suis particulièrement intéressé à apprendre comment vous prenez les décisions importantes sur le moment d'avoir des enfants et le nombre d'enfants à avoir. Je vais vous demander de me parler des gens dont les opinions comptent pour vous, des gens dont vous suivez les exemples, la façon dont vous apprenez de nouvelles choses, et comment d'autres personnes influencent votre croyance et votre comportement.</p> <p>Pourrions-nous commencer? Premièrement, j'aimerais vous parler de votre rôle au sein de votre communauté, et les caractéristiques générales de votre communauté. Commençons à parler de votre communauté et du village, dans leur ensemble.</p>	<p>INTRODUCTION</p> <p>A be kalo saba bo bi, an jè gnogon dow nana gnikali la aw fé ya; olasa, bi an na kun yé ka o gnikali to sékè sékè. gnikali bé boli I ka hakilina taa ka débaya ani kénèya kow kan ani mogow minun be I ka tabolo do I koro. Kèrè kèrè né ya là, né bé fè ka don, e bé hakilina taa tiogo jumèn I ka dén soro waati kan ani I ka dén sorota hakè kan.</p> <p>Ne Be fè I ka kibaru diya mogow kan, mogo minuw hakilina ka bo I bolo ni be o lu ka walé gnongo kè, I be kunafoni soro tiogodi ko kuraw kan. Tiogodi mogo wèrèw be se ka yèlèma do e ka hakilinala ani I ka ko kè ta la.</p> <p>Yala né bé sé ka bara daminè wa? An bé a daminè i yèrè la, e jo yoro yé mun yé aw ka siguida la, siguida yèrè kow be tiogodi. I bi se ka do fo yé aw ka siguida kan wa ani a mogow ka.</p>

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>>> Change of subject

<u>DEMANDEZ A TOUS LES HOMMES</u> Thème1 <i>Informations sur la communauté, les groupes sociaux et les réseaux communautaires</i>		
N°	QUESTIONS	
1	<p>Quand nous regardons la manière dont chacun est connecté dans la communauté, nous remarquons que (choisir selon le répondant):</p> <ul style="list-style-type: none"> • Vous êtes bien connectés • Vous connectez des groupes de personnes • Vous n'êtes pas trop connectés comme certains membres de la communauté <p>Etes-vous d'accord? Pourquoi ou pourquoi pas ?D'après vous, pourquoi c'est comme ça ?</p>	<p>An ka Kolosi yé a yira ko mogow ka gnongan don na,choisir :</p> <ul style="list-style-type: none"> • E don né do kosobè, i lamèn ne do wa ? • E be diama kulu tiaman ni gnogotiè wa? • E ni mogo tiaman té gnogon don <p>E so na o kolosi ma wa? Tiogodi ? E Bolo mun de be o kè ?</p>
2	<p>Est-ce que les personnes viennent vous voir pour obtenir des conseils sur des questions relatives à la santé ou à la famille ?</p> <p>Qui vient vous voir pour chercher ces conseils ?</p> <p>Quel genre de renseignements leur donnez-vous ?</p> <p>A quel point vous sentez-vous prêt à fournir des conseils aux gens sur les questions que nous sommes en train d'aborder ?</p> <p>Pouvez-vous penser à quelque chose qui vous mettrait plus à l'aise pour donner des conseils à une personne et non à une autre ?</p>	<p>Yala mogow bi na ladilikan gnini e fè kènèya ko ani dénbaya kow ka wa?</p> <p>O mogo nunuw yé jon yé?</p> <p>I bé kunafoni suguya jumèn dé di u ma ?</p> <p>Hakè jumèn na e dalé bé i yèrè la kibé sé ka mogow bila sira ni ko nunuw kan?</p> <p>Yala I bé sé ka kun dô fô néyé mi besé ka to mogo do ladili bé nogoya I ma ka tèmè do kan?</p>
3	<p>Vous considérez-vous comme un modèle à suivre – par exemple, estimez-vous que vos actes ou vos paroles ont une influence sur ce que d'autres personnes font ?</p> <p><i>Pourquoi dites-vous cela? Pour quelle raison estimez-vous que vous avez une influence (ou que vous n'avez aucune influence) sur d'autres personnes ?</i></p> <p>Veuillez me donner des exemples de la manière dont vous avez influencé quelqu'un d'autre.</p>	<p>E bolo, mogow be sé ka I ka tabolo la déki wa? Misali la, e ka fô taa ani I ka kè walé bé sé ka yèlè ma do mogo wèrè ka ko kè taa là Wa?</p> <p>Muna? <i>Mun dé ba to mogow bé e ka waléya la déki (walama ou tè a la deki)?</i></p> <p>I be sé ka misali do foyé I ka waléya do kan mun yé yèlèma do mogo wèrè ka tabolo là, wa?</p>

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4	<p>Appartenez-vous à des groupes sociaux tels que les <i>tontines</i> / les associations de micro-crédit, les <i>grins</i>, les groupes sportifs ou religieux ou à d'autres groupes ? Lesquels ?</p> <p><u>Si la réponse est OUI, poursuivez en demandant :</u> dites-m'en plus à propos des groupes que vous avez cités.</p> <p><u>Si la réponse est NON, poursuivez en demandant :</u> selon vous, comment cela se fait-il ?</p>	<p>Yala e be jèkulu do là wa? I bé jèkulu jumèn ni jumèn la?</p> <p>OUI: I bé sé ka dô fô ne yé o jèkuluw kan wa(dinè, pari, grins, etc.)</p> <p>NON : tiogodi I tè jèkulu chi la ? Mun yo kè ?</p>
5	<p>Existe-t-il des groupes informels de personnes, autre que les membres de votre famille, avec qui vous passez du temps(<i>comme personnes de votre génération, l'étudereligieuse,groupes de cultivateurs,etc.</i>)?</p> <p>Dites-m'en plus.</p>	<p>Ka bo I ka sogenon mogow la, e ni mogow wèrè bé gnongan daladjè baroda là wa? (<i>i na fô filan maw, kalanso, bara kègnoko</i>)</p> <p>I bé sé ka o fèsè fèsè né yé wa?</p>
6	<p>Dans ces groupes, parlez vous des choses, par exemple comme le nombre d'enfants que vous souhaitez avoir? A quel moment en avoir ?Comment éviter les grossesses ?</p> <p>Comment ces questions sont-elles soulevées ? Qui évoque les sujets relatifs à la fécondité et à la planification familiale ?</p>	<p>O baro kè daw là, yala aw da bé sé bangué ko kuma ma wa? I na fô dén sorota hakè, a waati ani bangué Kolosi kè togow.</p> <p>Baro bé na o kuma nunuw kan tiogodi? jon dé bé na ni déni ko ani bangué kolosi kuma yé ?</p>
7	<p>Connaissez-vous des groupes ou associations hors du village qui font des actions pour ce village (associations du village) ?</p> <p>Avez-vous des liens avec eux ? Avez-vous des amis ou des parents dans ces groupes ?</p>	<p>Yala I bé jèkulu don bo dugu wèrè la ninuw be na dèmè do aw ma yan ka wa?</p> <p>jè be e ni o jèkuluw ni yonko tiè wa ?Yala e téri wali I somogo do bé o jèkulu do la wa?</p>
8	<p>À quel genre de groupes les femmes et les hommes âgés (comme les grands-pères et les grands-mères) appartiennent-ils, habituellement?</p> <p>Comment se regroupent-ils pour fréquenter d'autres gens ? Déviennent-ils des groupes informels par la suite ?</p>	<p>musokoroba walama tiè koroba Ton kulu soukou jumèn de la kodoné do yan (Association, coopérative, etc)?</p> <p>Ou bé gnogon la djè tiogodi ?Yala o gnogon la jèbè sé ka kè sababou yé ou ka jekulu dôw sigui sé kan wa (<i>i na fo : Pari, ton, grin, etc</i>) ?</p>

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<u>DEMANDEZ A TOUS LES HOMMES</u> Thème 2 : <i>Connaissances et attitudes à l'égard des méthodes de planification familiale</i>		
9	<p>Si vous voudriez en savoir plus sur l'espacement des naissances ou l'utilisation d'une méthode de planification familiale, iriez-vous voir une accoucheuse traditionnelle ou un relais (agent de santé communautaire)?</p> <p>Pourquoi ou pourquoi pas ?</p>	<p>N'i makobé kunafoni na bangué kolosi ani a fèrèw matarafalikan, yala i béssé timinè musso dé ma wa wala kènèya tigilamogow ?</p> <p>Muna ?</p>
10	<p>Dans certains endroits, beaucoup de gens disent que si une femme allaite, ou si elle n'a pas encore vu ses règles après avoir eu son bébé, elle ne peut pas tomber enceinte. Qu'en pensez-vous ?</p> <p>A quel point est-ce que vous croyez que cela est efficace pour éviter la grossesse ?</p> <p>Où/comment l'avez-vous appris?</p> <p>Est-ce que c'est dans l'habitude des gens de s'abstenir des relations sexuelles après l'accouchement ? <i>Pour combien de temps ?</i></p>	<p>Siguida dow la, mogow ba fô, kô muso té sé ka kono soro ka déni a sin na walama kasoro a maa ka lada yé bangué kofè. E hakilina ta yé moyé o kan?</p> <p>Tiogo jumèn na e dalé do o kè walé la ko bé sé ka kono bali?</p> <p>Hé yé o kunafoni mè mini, tiogodi?</p> <p>Yala, bangué kofè, a ka tchia mogow ka ou yèrè minè glan là wa? <i>Fo wagati jumèn ?</i></p>
11	<p>Certaines personnes pensent que la planification familiale est imposée à la communauté par des gens de « l'extérieur ». Êtes-vous d'accord ou non avec cela ? <i>Pourquoi ?</i></p> <p>Qu'en pensent les autres membres de votre communauté ?</p>	<p>A be mogo dow yèna ko bangué kolosi yé farajè ka ko wajibi yalé dé yé an kan, e sonna o kuma ma wa? <i>Muna?</i></p> <p>Aw ka siguida la mogo mirinayé mun yé o kuma kan?</p>
>>>Parlons à présent de votre famille et d'autres personnes qui sont prochesde vous ou qui sont importantes dans votre vie		>>> Sisan, a bé na kuma I ka dénbaya ka ani I masuruna gnan mogo niuw joyoro ka bo I ka adamadén ya la.

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<u>DEMANDEZ A TOUS LES HOMMES</u>		
<i>Thème 3 :</i> <i>Influence exercée par la famille et par les gens qui sont proches des hommes sur la taille de la famille et l'utilisation de la planification familiale (entourage)</i>		
N°	QUESTIONS	
12	<p>Pour commencer, pourriez-vous me parler de votre ménage ?</p> <p>Avec qui habitez-vous ? (<i>Sondez sur sa mère, l'épouse (ou les épouses), les frères et sœurs, les beaux-parents</i>)</p> <p>Est-ce que vous avez un parent qui habite hors de votre ménage ? Hors de votre concession ? Hors du village ? <i>Qui</i> ?</p>	<p>I bé sé ka do fô gné i ka dénbayakan wa?</p> <p>E ni jon ni jon dé bé bo du kélé konon? (<i>Tiè, bâ, sinamuso</i>)</p> <p>Yala e sô mogo do siguilé bé fan wèrè wa? A béssé ka kè sôwèrè walama dougou wèrè yé? <i>O tigui yé djon yé?</i></p>
13	<p>Est-ce qu'il y a quelqu'un dans votre famille ou votre village qui influence vos décisions sur le moment pour avoir des enfants et combien en avoir ?<i>Qui</i> ? (<i>Demandez plus de précisions sur : la mère, l'épouse (ou les épouses), les beaux-parents, leaders religieux et/ou ses femmes, le Chef.</i>)</p> <p>Y'a-t-il quelqu'un parmi ceux la qui n'était pas d'accord du moment que vous avez choisi pour avoir des enfants ou du nombre d'enfants que vous avez eu ? <i>Dites-m'en plus.</i></p> <p>Où habitent ces personnes? <i>Ici dans le village ou ailleurs</i> ?</p> <p>Parmi les personnes que vous avez citées, quelles sont celles dont les opinions ont le plus d'importance à vos yeux ?</p> <p><i>Dites-m'en plus.</i> (<i>Demandez plus de précisions sur : les anciens par rapport aux jeunes, les leaders religieux, hommes par rapport aux femmes, le statut social.</i>)</p> <p>En regardant votre vie jusqu'à présent, diriez-vous que les conseils des personnes qui ont influencé vos décisions sur le fait d'avoir des enfants ont changé, ou bien sont-ils restés les mêmes au fil des ans ?</p>	<p>Aw ka du konon walama aw ka dugu konon, yala mogo bé yé mi bé hakilinaw do i koro i ka dén soro waati ani dén sorota hakè kan wa? (<i>buramuso, tiè, sinamuso, etc.</i>)</p> <p>O Mogow la, yala do bé n'o madjè ni e ka dén soro waati yé wa, walama i yé dén hakè mi soro? <i>I bé sé ka o gnèfô yé?</i></p> <p>O tigui bé bo mi? <i>Yan dugula wa walama dugu wèrè?</i></p> <p>O mogow bè la i be jon ni jon de ka kumakan lamèn kosobè ?</p> <p><i>I bé sé ko gnèfô yé wa? (a tigui djo yoro,etc)</i></p> <p>Ni yé i miri i ka mogoyakan ka bo kunu na ka sé bi ma, yala mogoninuw kun bé i ladi bangué ko kan, yala olu ka ladili kanw yèlèmana wa walama ladili kan kéléni dé bé u fè alisa ?</p>

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14	<p>Que pensent les personnes qui vous sont proches et les autres membres de votre communauté sur le fait <u>d'attendre</u> pour avoir le prochain enfant et de ne pas les avoir proches l'un del'autre (<u>l'espacement des naissances</u>) ?</p> <p>Que pensent-ils du fait d'éviter de tomber enceinte comme, l'<u>utilisation d'une méthode de planification familiale</u>?</p> <p><i>Comment savez-vous que c'est ce qu'ils pensent ? Prenez une attention à la communication non verbal, ou aux messages indirectes ou attitudes (par exemple, si on roule les yeux, reste silencieux, etc)</i></p> <p><i>Êtes-vous d'accord ou non avec eux ?</i></p>	<p>E masuruna mogo ani aw ka sigui da la mogow hakilina yé mun yé furan tiè bilala denw ni gnogon tiè ?</p> <p>u miri nayé mun yé bangué kolosi férè matarafali, kan?</p>
15	<p>Si les gens savaient ou découvraient que quelqu'un utilisait une méthode de planification familiale, est-ce qu'ils la tiendraient à l'écart ou bien est-ce qu'ils la feront se sentir coupable ?</p> <p><i>Que diraient-ils à son sujet ? Que feraient-ils ? Comment ?</i></p> <p>Connaissez-vous personnellement quelqu'un qui a été critiqué ou qui a subit les brimades parce qu'il utilisait une méthode de planification familiale ?</p> <p><i>De quelle manière ont-ils été traités négativement ? Qu'en pensez-vous ?</i></p>	<p>Ni siguida la mogow bora a kalama ko do bé ka bangué kolosi férè matarafa, u bé atigui minè tiogodi ? u bè u ma bô a tiguila walama u bé a tigui dialaki dé?</p> <p>u bé mun dé fô a tigui ma ? u bé mun dé kè ? Tiogodi ?</p> <p>I bé mogo don krinkrin neya la mi délila ka lagosi bangué kolosi matarafali la wa?</p> <p>A lagosira tiogodi? E hakilina ta yé moyé o kewalé kan?</p>
16	<p>A votre avis, est-ce que le désir d'un homme concernant le nombre d'enfants à avoir et le moment de l'avoir diffère selon qu'il a une ou plusieurs femmes? Comment (Pouvez-vous m'expliquer)?</p>	<p>E hakilila, yala dan fara bè tiè muso kélé tigui ani tiè muso tiama tigui chè, u ka layini na dén sorota hakè ani dén soro watí kan wa ? Tiogodi ? I bé sé ko gnèfô yé wa ?</p>
17	<p>Dans certains endroits, les coépouses rivalisent entre elles pour obtenir l'approbation de leur mari et famille. Dans quelle mesure est-ce que cette rivalité entre coépouses affecte les décisions d'une femme à avoir des enfants et à recourir à la planification familiale ?</p> <p><i>Si l'une des épouses utilise la planification familiale, de quelle manière cela pourrait-il avoir un effet sur les autres coépouses ?</i></p>	<p>Sinaya ni musow ka dén ko bè sira kélen na wa? Wala muso ka mandia sirilen bè den soro la wa,?</p> <p>Ni muso kélé be ka bangué kolosi férè tiguè, o be se ka mun dé lasé muso tow ma?</p>
>>>À présent, j'aimerais vous parler du fait d'avoir des enfants et des bienfaits que cela apporte.		<p>>>>Sisan gnikali benasé dén soro ani a nafaw ma..</p> <p>.</p>

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<u>DEMANDEZ A TOUS LES HOMMES</u>		
<i>Thème 4 :</i> <i>Coûts et bienfaits associés aux enfants et à l'utilisation de la planification familiale</i>		
18	<p>Beaucoup de gens disent que le nombre d'enfants et l'espacement des naissances sont décidés par Dieu. D'autres croient que les couples doivent choisir le moment et le nombre d'enfants qu'ils veulent avoir. Qu'en pensez-vous ?</p> <p>Qu'est-ce que les leaders religieux et leurs femmes en pensent ?</p> <p>Pourquoi dites-vous cela ?</p>	<p>Mogo dow ba fo ko dén hakè sorota ani a waati be bo allah de là, dow fènè ba fô ko tiè ni muso bé sé ka bè dén sorota hakè ani a soro waati kan? E hakili na ta yé mouyé o folé nunuw kan ?</p> <p>Dinè yémogow ni ou musow miriya yé mouyé o kan?</p> <p>E be o fô mou dé fè?</p>
19	<p>Quel est le code moral approprié par rapport à la fécondité (le fait d'avoir des enfants) ? <i>Comment les gens devraient-ils se comporter ? Comment les gens devraient-ils y réfléchir ?</i></p> <p>Quels sont les éléments spirituels qui ont une influence sur la fécondité des gens ? <i>Comment sont-ils différents des éléments non-spirituels ?</i></p>	<p>Aw ka lada bé mou yamaruya wala ka mun fo banguéko nasira kan? <i>Mogow ka tabolow kan ka kè tiogodi? u kan miriya dun?</i></p> <p>Dinè walama ladalako jumenw bényé ninuw be hakili na do mogow koro baguékola ?<i>Furantiè jumèn de be o hakilinaw ni hakilina wèrètiè?</i></p>
20	<p>Est-ce qu'il y a des avantages à recourir à la planification familiale ? SI OUI: Quels sont les avantages? <i>Qu'est-ce que les hommes gagnent-ils à utiliser la planification familiale ? Que perdent-ils ?</i> SI NON : pourquoi ?</p> <p>Qu'en est-il des femmes ? <i>Dites-moi plus.</i></p> <p>Cela peut-il être différent selon la situation de l'homme? Comment ? <i>Selon vous, qu'est-ce qui pourrait faire la différence ?</i> (<i>Demandez plus de précisions sur : l'âge, les revenus, l'épouse, l'éducation, la relation avec les coépouses / les beaux-parents, etc.</i>)</p> <p>Existe-t-il une différence entre le fait d'utiliser une méthode de planification familiale pour l'espacement des naissances, et l'utilisation d'une méthode de planification familiale pour arrêter d'avoir des bébés ? <i>Quelle est la différence ? Pouvez-vous m'en dire plus ?</i></p>	<p><i>Yala nafa be Bangué kolosi la wa ? OUI: A nafa yé mouyé? A nafa yé mouyé tièw ka? A be mun dé tignè tiè u yé? NON: Muna?</i></p> <p>Musow dun? I besé ka o yèfô né yé doni wa?</p> <p>E hakili la, yala dafara Tièw ka soro walama ou ka togoya ni gnonkontiè be se ka to bangué kolosi nafa walama a kololo be sé doma ka tèmè do kan wa? Tiogodi? <i>Danfara bé sé ka bô mi? (Chi, soro, muso ka wale, kalan, tiè kêtogo musow ani buranw fanfè, etc.)</i></p> <p>Ka bangué kolosi fèrè tiguè ka fourantiè do dénw ni gnogotiè ani ka bangué kolosi fèrètiguè ka bangué ladjô; yala danfara bé o lou ni gnogotiè wa? <i>Danfara be sé ka kè mun yé? I bésé ka o wala wala wa?</i></p>

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<u>DEMANDEZ A TOUS LES HOMMES</u> THEME 5: Désirs de fécondité		
21	<p>Je vois donc que vous êtes mariés à XX épouses. Pouvez-vous m'en dire un petit peu plus sur les circonstances de chacune de vos mariages et les raisons pour lesquelles vous avez décidé de prendre une autre épouse ?(Le sondage ne concerne que les polygames.)</p> <p>Comment vos pensées sur le nombre d'enfants à avoir affectent vos décisions sur le mariage ? <i>Sondage sur le nombre d'épouses, leurs âges, instance entre les mariages (intervalle de temps entre les mariages)</i></p>	<p>Né yè bé a la kafo ko muso XX bé I bolo, I be sé ki ka furu kélé kéléna bë do togo gnèfô ne yé wa. Ani kou mi ya to I yé muso wèrè furu?</p> <p>Nassoro é ka lagnini yé ka dén hakè dô soro, Tiogodi, o bé sé ka hakilina dima i ka muso furu ko la? (muso hakè, u chi, wakati ni gnogotière)</p>
22	<p>Avez-vous réfléchi sur lenombre d'enfants que vous aimeriez idéalement avoir ? Dites-m'en plus à ce sujet. <i>Combien d'enfants avez-vous ? Quel âge a l'aîné(e) ? Quel âge a le(la) cadet(te) ?</i></p> <p><u>SI L'HOMME RÉPOND « C'EST LA VOLONTÉ DE DIEU », poursuivez en demandant :</u> Pouvez-vous m'en dire un peu plus à ce propos ?</p>	<p>Yala é déli la ka miri a kadi yé I ka dén hakè mi soro kan wa? <i>Dén joli bé i bolo ? Dén fôlô chi be san jolila, dén laban dun ?</i></p> <p><u>VOLONTE DE DIEU :</u> i bésé ka o gnèfô né yé ka gnan wa ?</p>
23	<p>En tant que père, que voyez-vous comme étant vos responsabilités ?</p> <p><i>Demandez plus de précisions sur le soutien économique, l'amour, le réconfort, le soutien pratique (nourrir le bébé, faire sa toilette, aider la femme durant les travaux ménagers)</i></p>	<p>E hakili la é ka faya djoyoro yé jumèn yé ? <i>musaka bô, tobotoli, djikiya, dêmè bara fanfè</i></p>
24	<p>Aimeriez-vous que votre épouse (n'importe laquelle) tombe enceinte cette année ? J'aimerais en savoir un peu plus sur ce que vous pensez à ce sujet. <i>Laquelle ou lesquelles de vos épouses ?</i></p> <p><i>Demandez plus de précisions sur les caractéristiques des différentes épouses qui engendreraient des souhaits différents de grossesse (par exemple, différences d'âge)</i></p>	<p>A kadi é yé I muso (muso dola kélé) ka garizikè soro gniñè san kono wa? I bésé ka I hakili na taawala wala né yé wa? <i>A kadi é yé a ka kè i muso jumèn dé yé?</i></p> <p><i>Dafara jumèn de be se ka kè musow ni gnokotière no be se ka to I ba gnini ka garizikè soro dô fè ka témè dô kan</i></p>
25	<p>Que pensent votre épouse (vos épouses) à ce propos ? Est-elle (sont-elles toutes) d'accord avec vos désirs ?</p> <p>Comment gérez-vous les désaccords ?</p> <p><i>Demandez plus de précisions sur les désaccords entre coépouses</i> <i>Demandez plus de précisions sur les désaccords entre l'épouse et la personne</i></p>	<p>E muso (musow) mirina yé mun yé o kan? A (Ou) bé son é diyagnè ko bè ma wa?</p> <p>Aw bé aw ka fognogo kôn la témè tiogodi?</p> <p><i>I bésé ka i musow ka fognogo kôn gnèfô ka gnan wa</i> <i>I bésé ka i yèrè ni muso (musow)ka fognogo kôn gnèfô ka gnan</i></p>

Clé: Questions Normales à poser

En *italique*: Questions suggérées au cas où il n'y aurait pas de réponse à la question posée.

En gras et souligné: directions pour les interviewers et les questions à sauter

>>>Changement de sujet

Legend Normal: Question to ask

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Bold & underlined: Directions for interviewers and skip patterns

>>> Change of subject

	<u>interrogée</u>	
26	<p>Avez-vous parlé avec votre épouse/vos épouses du nombre d'enfants que vous souhaiteriez avoir et le moment auquel vous aimeriez les avoir ou bien est-ce quelque chose qui ne se dit pas? <u>SI OUI</u> : Qu'est-ce qui déclenche la conversation ?</p> <p><u>SI NON</u> : Est-ce quelque chose que vous aimeriez faire ?</p> <p>Dans certains villages, maris et femmes pensent qu'il est bon de se parler de ces choses. Cela peut-il se passer ici ? <i>Que pensez-vous de cette idée ?</i></p>	<p>E ni muso (musow) deli la ka kuma aw ka dén sorota hakè a ni a soro watì kan wa ? SI OUI : Mun dé bésé ka na no kuma nason yé?</p> <p>SI NON : A kadi yé ni kumaw ka tèmè i ni muso(w) tiè wa ?</p> <p>Dugudow la mogow miri yé ko a kagni furugnogomaw ka djè ka kuma ni fin masinaw kan? Yala o be se ka kè aw fé gnan wa? <i>E hakili na ta yé mun yé o miriya kan?</i></p>
27	<p>Diriez-vous que VOUS avez un « besoin » d'utiliser une méthode de planification familiale?</p> <p>Pourriez vous m'expliquer plus en détail les raisons pour lesquelles vous avez ou non un « besoin » d'utiliser la planification familiale?</p> <p>Selon vous, que diraient les prestataires?</p> <p>Et votre épouse(s), diriez-vous qu'elle a un « besoin » de planification familiale? <i>Dites-m'en plus...</i></p> <p><u>S'IL VEUT QUE TOUTES SES FEMMES TOMBENT ENCEINTES CETTE ANNEE, TERMINEZ L'ENTREVUE ET LE REMERCIEZ.</u></p>	<p>E bolo, I mago be bangué kolosi fèrè matarafali là wa?</p> <p>I bé sé ka fèsè fèsè né yé kun jumèn na e bolo I mago bé bangué kolosi fèrè là walama kun jumèn na e bolo I mago té a là?</p> <p>Hé hakili la kènèya tigui la mogow bé mun de fô? ?</p> <p>E tiè dun, alé mago be a la wa? <i>I be sé ko yèfo yé ka gnan?</i></p> <p><u>VEUT QUE TOUTES SES FEMMES TOMBENT ENCEINTES, TERMINEZ L'ENTREVUE ET LE REMERCIEZ</u></p>
28	<p>Vous avez dit que vous ne vouliez pas que <u>nom de l'épouse (des épouses)</u> tombe(nt) enceinte(s) cette année. Pourquoi avez-vous dit cela ?</p>	<p>Muna I té fè I muso <u>karisa (ni karsa)</u> ka garizikè soro gniñè?</p>
29	<p>Faites-vous quelque chose pour qu'elle(s) évite(nt) de tomber enceinte?</p> <p><u>S'il FAIT quelque chose ou qu'il UTILISE une méthode (traditionnelle, moderne, efficace ou inefficace) avec son épouse (avec une ou plusieurs de ses épouses), PASSEZ AU SIXIÈME THEME (page 10)</u></p> <p><u>Si la réponse est NE FAIT RIEN ou N'UTILISE RIEN avec son épouse (avec aucune épouse), PASSEZ AU SEPTIÈME THEME (page 14)</u></p>	<p>Yala aw bé ka fèrè dô tiguè walasa ka garizikè bali wa?</p>

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>>> Change of subject

DEMANDEZ SEULEMENT SI L'homme A RECOURS À LA PF / FAIT QUELQUE CHOSE avec AU MOINS UNE épouse
(la méthode peut être traditionnelle, moderne, efficace ou inefficace)

THEME 6:Utilisation Actuelle et Satisfaction

30	<p>Que faites-vous pour éviter la grossesse ? <i>Dites m'en plus.</i></p> <p><u>Si c'est l'allaitement, demandez les questions suivantes</u></p> <p>Est-ce que vous pensez que ce que vous faites est efficace pour éviter la grossesse ? Pourquoi ?</p> <p>Où/comment avez-vous appris cela ?</p> <p>Est-ce que vous continuez à avoir des relations sexuelles avec votre épouse(s) ?</p> <p><u>S'il utilise des méthodes différentes avec des épouses différentes, DEMANDEZ :</u></p> <p>Pourquoi vous utilisez des méthodes différentes avec vos différentes épouses. <i>Sondez sur les effets secondaires, l'âge de femme.</i></p>	<p>Hé bé ka bangué kolosi fèrè jumèn de matarafa? <i>I be sé ko gnèfo?</i></p> <p>Allaitement.</p> <p>E mira la sin di yé fèrè gnuma yé mi bé sé ka garizikè soroli bali wa? Muna ?</p> <p>E yé ni kibarou mè mi, I ya mè tiogodit?</p> <p>Yala glan be ka tèmè I ni muso tiè wa?</p> <p>Utilise différentes méthodes:</p> <p>Muna é té ka fèrè kélé tiguè né ni musow bè yé? <i>Fèrè kololo, muso chii.</i></p>
31	Comment avez-vous entendu parler de votre méthode(s)? <i>Où avez-vous obtenu des renseignements sur cette méthode ?Demandez plus de précisions sur les épouses, les amis, les pairs, les prestataires, les anciens</i>	I yé i ka bangué kolosi fèrè (w) kibaru mèn tiogodi ? <i>I yé o kunafoni soro min?</i> (<i>I muso, I teriw, kènèya tiguila mogow, makôrow</i>)
32	Qu'est-ce qui vous a motivé à l'origine à commencer à utiliser la planification familiale avec votre épouse ou vos épouses ? <i>Sondez sur les différentes raisons et motivations</i>	Mun dé yé e bila bangué kolosi fèrè matarafali la ?
33	<p>Qui a choisi la méthode(s) que vous utilisez actuellement ? (<i>Sondez pour voir qui : lui, son épouse ou ses épouses, sa mère, son prestataire, ou quelqu'un d'autre ?</i>)</p> <p>A votre avis, qui devrait prendre la décision – l'homme, la femme, les deux, ou quelqu'un d'autre ?</p>	<p>jon dé gné e ka fèrè kè ta ni surandi? (<i>i yèrè wa, i muso(w)I bâ, kènèya tiguila mogo, mogo wèrè?</i>)</p> <p>E hakilila, a tou ka kan jon dé kun ka a surandi ? Tiè, muso, mogo wèrè?</p>
34	Avez-vous entendu parler d'autres moyens pour empêcher les grossesses ? Parlez-moi des autres méthodes que vous connaissez.	Yala, i yé bangué kolosi fèrèw wèrè komè wa? I bé sé ka kuman gné o fèrew kan wa ?
35	Pourquoi avez-vous choisi d'utiliser les méthodes que vous utilisez actuellement plutôt que les autres méthodes que vous avez citées ?	Muna i yé I ka fèrè ni dé sukandi ka bo fèrè tow la?

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>>> Change of subject

36	<p>Pourquoi utilisez-vous actuellement cette méthode en particulier avec (<u>nom de l'épouse</u>) ? Avez-vous parlé d'autres méthodes ou en avez-vous essayé avec (<u>nom de l'épouse</u>) avant de choisir celle que vous utilisez actuellement ?</p> <p>Et qu'en est-il avec vos autres épouses ? (Uniquement pour les polygames)</p>	<p>Muna e ni <u>karsa</u> bé ka ni fèrè ni dé tiguè? Gnani aw ka ni fèrè ni matarafa, yala aw kumara fèrè wèrèw kan wa? Yala aw déllila ka fèrè wèrè matarafa wa?</p> <p>I muso tow dun?</p>
37	<p>Que pensez-vous de la méthode que vous utilisez maintenant ?</p> <p>Quelles sont les caractéristiques de cette méthode que vous aimez particulièrement (par rapport à d'autres méthodes) ?</p> <p>Quelles sont les qualités que vous n'aimez pas ?</p> <p>En comparant les différentes qualités de la méthode utilisée, quelle importance accordez-vous que la méthode soit efficace pour empêcher les grossesses ?</p> <p>A quel point êtes-vous satisfait de la méthode que vous utilisez actuellement ? Pourquoi ?</p> <p>Selon vous, votre(vos) épouse(s) est-elle(sont-elles) satisfaite(s) des méthodes qu'elle(s) utilise(nt) actuellement ? Pourquoi dites-vous cela ?</p> <p><i>Demandez plus de précisions sur les niveaux de satisfaction pour chacune des méthodes citées, ainsi que les motifs de satisfaction</i></p> <p><u>SI L'HOMME UTILISE DIFFÉRENTES MÉTHODES AVEC DIFFÉRENTES ÉPOUSES, demandez plus de précisions sur</u> la méthode qu'il utilise actuellement, comparez les méthodes entre elles / soulignez les différences de chaque méthode. (satisfaction, l'importance de l'efficacité, les caractéristiques qu'il aime/n'aime pas)</p>	<p>E ka hakilina yé mun yé I ka fèrè sukandi lé kan? kèrèn kèrèn né ya la, mun dé bé i ka fèrè ni la ni o kadi I yé (ni o té fèrè tow la)?</p> <p>Mun dé bé a la mi man di e yé?</p> <p>Ni yé fèrè ni nafabè taa kalajè, a gnan ka sé ka garisikè bali , nafa bé é bolo tiogodi?</p> <p>E yé nimisi wassa sugu jumèn dé soro i ka fèrè kèle ni la ? Muna?</p> <p>E hakili é muso(w) nimisi wasa lé do aw ka fèrè kète ta la wa? Mun dé bé o yira e la ?</p> <p><i>Nimisi wasa.</i></p> <p><u>UTILISATION DE DIFFERENTES METHODS AVEC DIFFERENTES FEMMES</u></p>
38	<p>Selon vous, à quel point ces méthodes sont-elles efficaces pour empêcher les grossesses ? Pourquoi pensez-vous cela ?</p>	<p>E bolo, fèrè ni kagni garizikè balila ka sé hakè jumèn ma? I bè o fo mun dé fè ?</p>

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>>> Change of subject

39	<p><u>POSEZ LA QUESTION SUIVANTE UNIQUEMENT SI L'HOMME A PLUSIEURS ÉPOUSES :</u> Vos épouses savent-elles toutes que vous utilisez actuellement une méthode de planification familiale ou que vous êtes en train de faire quelque chose pour éviter que l'une de vos épouses ne tombe enceinte ? <u>Si OUI</u> Dites m'en plus.</p> <p><u>Si la réponse est NON, poursuivez en demandant :</u> pourquoi ne savent-elles pas ?</p>	<p><u>POUR LES POLYGAMES:</u> Yala I musow bè a kalama ki ni Karisa bé ka bangué kolosi fèrè matarafa wa? <u>SI OUI:</u> I bèsé ka o gnè fô né yé wa?</p> <p><u>SI NON:</u> Muna?</p>
40	<p>Y a-t-il d'autres gens dans votre vie qui savent que vous faites ça pour prévenir une grossesse? (<i>Demandez-lui de spécifier : belle-mère, coépouses, belle-sœur, mère, père</i>) Si c'est le cas (ou s'ils arrivent à l'apprendre), quelle serait leur opinion ? Leur opinion importe-t-elle, pour vous ? Pourquoi / pourquoi pas? <i>Sondez pour les leaders religieux et communautaires.</i></p>	<p>E don baga dow ba kalama ko i bé ka bangué kolosi fèrè matarafa ? (<i>buranmuso, nimogomuso, i ba, i fa</i>) O tiguiw mirina ta yé mun yé a ko kan? (Mimuw té a kalama, nou ya dôn, i mirina bé kè mun yé ?) O tiguiwka hakilina be e bolo tiogodi ? Muna? (<i>mogobaw: Dinè gnèmogo, dugutogui,muso kuntogui, etc</i>)</p>
41	<p>Vous-même ou votre(vos) épouse(s), avez-vous ou ont-elles déjà été victime(s) de commérage, d'insultes ou subi des conséquences négatives parce que vous avez eu recours à la planification familiale ? <i>Pouvez-vous en expliquer plus?</i> <i>Demandez plus de précisions au cas où l'une des épouses a été victime de médisances, mais une autre ne l'a pas été.</i></p> <p><u>SI L'HOMME A SEULEMENT UNE ESPOUSE, TERMINEZ L'ENTRETIEN ET REMERCIEZ-LE</u> <i>Merci beaucoup de nous avoir consacré un peu de votre temps. Nous vous en sommes extrêmement reconnaissants.</i></p> <p><i>Y a-t-il des questions que vous aimeriez me poser ?</i></p>	<p>Yala bangué kolosi fèrè matarafali délila ka lagosi lasé i yèrè walama i muso(w) ma wa ? i be sé ko gnèfо gné ka gna wa ?</p> <p><u>POUR LES MONOGAME ET LES HOMMES UTILISATEURS AVEC TOUTES LEURS FEMMES TERMINER L'ENTRETIEN:</u></p>
42	<p><u>Posez les questions suivantes SI l'homme a également D'AUTRES épouses qu'il NE SOUHAITE PAS mettre enceintes, et NE FAIT RIEN / N'UTILISE AUCUNE MÉTHODE DE PF avec elles</u></p> <p>Je constate qu'actuellement vous n'utilisez rien ou vous ne faites rien avec (nom de l'épouse ou des épouses) pour éviter la grossesse. Pourquoi cela ? Pourquoi utilisez-vous ou faites-vous actuellement quelque chose avec (épouse X) mais pas avec (épouse Y) ? <i>Demandez plus de précisions sur la réticence de l'épouse, les effets secondaires, la pression de la part des pairs ou de la famille, la crainte des rumeurs ou de</i></p>	<p><u>L'HOMME A D'AUTRES FEMMES NON UTILISATRICES</u></p> <p>Muna é ni X té ka bangué kolosi fèrè foyi tiguè ? Muna é dou ni Y dé bé ka bangué kolosi fèrè matarafa ; i ni X té ka matarafa? <i>Muso dé ban né do, kololo, mogow be mi fô, lagosi sirangnè, etc</i></p>

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>>> Change of subject

	<i>commérages</i>	
43	<p>Avez-vous déjà fait ou utilisé quelque chose par le passé (avec ces épouses pour éviter les grossesses) ?</p> <p><u>Si la réponse est OUI, poursuivez en demandant :</u> qu'avez-vous fait précisément / avez-vous utilisé quelque chose ?</p> <p><u>ALLEZ À LA PROCHAINE QUESTION (Q44)</u></p> <p><u>Si la réponse est NON, poursuivez en demandant :</u> pourquoi pas ? Pouvez-vous m'en dire plus ? (<i>Demandez plus de précisions sur les préoccupations par rapport à une méthode en particulier, la réticence de l'épouse, les effets secondaires, la pression de la part des pairs ou de la famille, la crainte des rumeurs ou des commérages, la religion, l'accès aux services de planification familiale, l'opinion des autres, l'opinion de la société, ou le fait de penser qu'il n'y a pas de risque de tomber enceinte.</i>)</p> <p>* S'IL EVOQUE LA VOLONTE DE DIEU, DEMANDEZ PLUS DE PRÉCISIONS : Pouvez-vous m'en dire plus ? Que voulez-vous dire par « volonté de Dieu » ?</p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LE</u></p> <p><i>Merci beaucoup de nous avoir consacré un peu de votre temps. Nous vous en sommes extrêmement reconnaissants.</i></p> <p><u>Y a-t-il des questions que vous aimeriez me poser ?</u></p>	<p>E ni X (walama Y) tun délila ka fèrè dô matarafa walasa ka gariziguè bali wa ?</p> <p>SI OUI: aw tun bè fèrè jumèn dé matarafa?</p> <p><u>ALLEZ A LA(Q44)</u></p> <p>SI NON: Muna? I béssé ka o wala?</p> <p><i>Siran gnè ka ta fèrè do kan, amandi I muso yé, fèrè nunuw kololo, mogow gnè sirangnè, dinè, a sorotogo guèlèya, mogow be mi fo, I hakilila I muso(w) se ka gariziguè soro</i></p> <p>*DIEU: I be sé ko fèsè fèsè ne yé wa? Ne ko, ka be ja allah de yé, e be fè ka mun de kélé fo o là?</p> <p><u>TERMINER L'ENTRETIEN ET REMERCIEZ-LE</u></p>
44	<p>Étiez-vous satisfait de cette méthode ? <i>Qu'avez-vous apprécié de cette méthode ? Que n'avez-vous pas apprécié ?</i></p> <p>Pourquoi avez-vous choisi cette méthode plutôt qu'autre chose ?</p> <p>A quel point elle a marché pour éviter la grossesse ?</p>	<p>Yala é tun be ka nimisi wasa soro e fèrè tiguè ta ni na wa? <i>Mun de jara i yé fèrè ni na ? Mun ma dia i yé a la?</i></p> <p>Muna I yé ni fèrèw dé sukandi ka bô fèrè tow la?</p> <p>E dara la ka sé hakè jumèn ma, ko fèrè ni sera ka konobara bali ?</p>
45	<p>Pourquoi avez-vous interrompu ce que vous faisiez pour éviter les grossesses ?</p> <p><u>Si la femme a arrêté parce qu'elle est tombée enceinte, poursuivez en demandant :</u> Pourquoi n'avez-vous pas recommencé après qu'elle ait eu son bébé ?</p>	<p>Muna I yé a jô?</p> <p><u>Femme tombée enceinte:</u> <i>jiguini kôfè, muna aw ma séki bangué kolosi fèrè ni ma?</i></p>
46	<p>Utiliserez-vous à nouveau l'une de ces méthodes ? <i>Pourquoi ou pourquoi pas ?</i></p> <p><u>TERMINER L'ENTRETIEN ET REMERCIEZ-LE</u></p> <p><i>Merci beaucoup de nous avoir consacré un peu de votre temps. Nous vous en sommes extrêmement reconnaissants.</i></p> <p><u>Y a-t-il des questions que vous aimeriez me poser ?</u></p>	<p>Yala é bé son ka ni fèrè fôlé nunuw dolakélé matarafa tuguni wa?</p> <p><u>TERMINER L'ENTRETIEN ET REMERCIEZ-LE</u></p>

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>>> Change of subject

	<p>L'homme N'UTILISE RIEN / NE FAIT RIEN avec aucune de ses épouses</p> <p><u>Theme 7: Besoin non-satisfait</u></p>
47	<p>Comment se fait-il que vous n'utilisez rien avec votre épouse ou vos épouses, alors que vous ne souhaitez pas qu'elle(s) tombe(nt) enceinte(s) ?</p> <p>S'il ilrépond que son épouse est entrain d'allaiter, demandez- lui : Pouvez-vous m'en dire plus ?</p> <p>Pourquoi ne pouvez-vous pas utiliser une méthode de planification familiale pendant l'allaitement ? Qu'est-ce que les femmes qui allaitent peuvent faire pour éviter la grossesse ?</p> <p>Connaissez-vous des femmes qui sont tombées enceinte pendant l'allaitement ?</p> <p>S'il répond « parce qu'ils s'abstiennent (des relations sexuelles), demandez -lui : Pensez-vous qu'il est facile ou difficile de respecter la période d'abstinence ?</p> <p>Pendant combien de temps allez-vous vous abstenir ?</p> <p>S'il ne donne aucune réponse, demandez lui: Pouvez-vous m'en dire plus ?</p> <p><i>Demandez plus de précisions sur leurs raisons de n' utiliser aucune méthode, y compris : les préoccupations par rapport à une méthode en particulier, la réticence de l'épouse, les effets secondaires, la pression de la part des pairs ou de la famille, la crainte des rumeurs ou de commérages, la religion, l'accès aux services de planification familiale, l'opinion des autres, l'opinion de la société, le fait de penser qu'il n'y a pas de risque de tomber enceinte</i></p> <p>* S'IL EVOQUE QUELQUE PART QUE C'EST LA VOLONTE DE</p>

Clé: Questions Normales à poser

En *italique*: Questions suggérées au cas où il n'y aurait pas de réponse à la question posée.

En gras et souligné: directions pour les interviewers et les questions à sauter

>>>Changement de sujet

Legend Normal: Question to ask

Italics: Suggested probes to ask if original question does not elicit response.

Bold & underlined: Directions for interviewers and skip patterns

>>> Change of subject

	DIEU, DEMANDEZ PLUS DE PRECISIONS : Pouvez-vous m'en dire plus à ce sujet ? Qu'est-ce que vous voulez dire par « volonté de Dieu » ?	
48	<p>Avez-vous déjà utilisé (par le passé) une méthode ? Si oui, lesquelles ? <i>Pourquoi avez-vous arrêté d'utiliser ces méthodes ?</i></p> <p><u>Si par le passé il n'a eu recours qu'à l'allaitement au sein, demandez plus de précisions :</u></p> <ul style="list-style-type: none"> • Pourquoi pensez-vous que les femmes qui allaitent ne courrent pas le risque de tomber enceintes ? • Connaissez-vous une femme qui est tombée enceinte alors qu'elle allaitait ? • Qu'est-ce que les femmes qui allaitent peuvent faire d'autre pour éviter de tomber enceinte ? <p>Diriez-vous que vous avez un « besoin » d'utiliser une méthode de planification familiale?</p> <p>Pourriez-vous m'expliquer plus en détail les raisons pour lesquelles vous avez « besoin » ou non de recourir à la planification familiale?</p> <p>Et votre épouse(s), diriez-vous qu'elle a un « besoin » de planning familial? <i>Dites-m'en plus...</i></p> <p>Certaines personnes disent que puisque vous ne souhaitez pas que votre femme(s) tombe enceinte et que vous n'utilisez pas de méthode efficace pour empêcher les grossesses, c'est que vous avez « besoin » de recourir à la planification familiale. Êtes-vous d'accord ou non avec cela ? Dites-m'en plus...</p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LE</u></p>	<p>Yala e delila ka bangué kolosi fèrè do matarafa wa? Fèrè jumèn? <i>Muna I yo fèrè kèli dabila?</i></p> <p><u>Allaitements:</u></p> <ul style="list-style-type: none"> • Mou bé a yira é la ko chiin di béssé ka muso tangan kono ma? • E be mogodon walama e deli la ka mogo yé mi yé gariziguè soro kan dén to a sin na wa? • Déni bé muso ninuw sin na, o lu bé sé ka fèrè wèrè jumèn dé tike walasa ka kono bali? <p>E bolo, I mago be bangué kolosi fèrè là wa?</p> <p>I bé sé ka fèsè fésè yé kun jumèn na e bolo I mago bé bangué kolosi fèrè là walama kun jumèn na e bolo I mago té a là?</p> <p>E muso(w) dun, alé mago be a la wa? <i>I be sé ko yèfo yé ka gnan?</i></p> <p>Mogow dow ba fo ko, ni té fè ka gariziguè soro, wa i te ka fèrè tiguè walasa ka gariziguè bali fana. Ko ba yira ka fo ki mago bè ka bangué Kolosi fèrè do matarafa. E son na o kuma ma wa? I bé sé ka o miriya wala wala doni?</p> <p><u>TERMINEZ L'ENTRETIEN ET REMERCIEZ-LE</u></p>

Clé: Questions Normales à poser

En *italique*: Questions suggérées au cas où il n'y aurait pas de réponse à la question posée.

En gras et souligné: directions pour les interviewers et les questions à sauter

>>>Changement de sujet

Legend Normal: Question to ask

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>>> Change of subject

Table of Codes (TJ In-Depth Interviews)

Family	Code	Brief Definition	Full Definition
Social Networks & Places	Social Role	Participant's perception of their social role in the community (SN & role model status)	Whether and reasons why participant agrees/disagrees with SN status (influencer, connector, isolate) and participant's perception of how well known they are in the community, whether they influence others or not, whether they see themselves as a role model for others.
	Soc.Groups_Elders	Social groups for elders	Groups or gathering places mentioned specifically for older men or older women. Also code when people say they don't know any specific groups for older men and women.
	Soc.Groups_Formal	Formal social groups and gathering places	Member or knowledge of formal social groups in village and where those social groups gather. Examples: tontines, microcredit associations, religious association/group, agricultural cooperatives.
	Soc.Groups_Informal	Informal social groups and gathering places	Member or knowledge of informal social groups in village and where those social groups gather. Examples: peer groups, groups of friends, grins, family.
Social Influence	Co-wife_Influence	Influence between co-wives	Instances and ways in which co-wives influence one another.
	Influenced.by	People who influence participant and the advice that participant receives	People the participant says influences them, the issues about which they influence participant, and the advice the participant receives about FP/CS/fertility. (References to exchanges of advice or reciprocal advice should go under code "info_exchange")
	Indiv.they.influence	Individuals participant influences and the advice the participant gives	People the participant thinks he/she influences, the issues about which they believe they influence them, and the advice the participant gives to others. References to reciprocal advice should go under code "info_exchange"
	Media	Media influences	Media sources, especially radio, that influence participant or are a source of information about FP/CS/fertility. (Does not include griots – griots should be coded as a person under "Influenced.by")
	Advice_Prep	Preparedness to give advice	What makes participant feel comfortable/prepared/knowledgeable giving advice on xxx subject to xxx person (IDI guide Q#2)
	Info_Exchange	Reciprocal information exchange	Bi-directional exchange of advice/information between participant and others (as opposed to instances where information flows uni-directionally).
Family Structure	Household	Household composition	The family members that make up participant's household.
	Relatives_Outside	Relatives outside village	Participant's relatives who live outside village and/or travel back and forth.
	Polygamy	Polygamous unions	Circumstances of a man's first marriage and decision to take a second wife. (IDI guide Q#21)

Table of Codes (TJ In-Depth Interviews)

Religious beliefs	Gods.Will_CS/FP	God's will and CS/FP/fertility	Discussions about God's will in relation to fertility, childspacing, and/or FP use and/or methods
	God's.Will_Pro-CS/FP	God's will in favor of childspacing and FP	Discussions about God's will in support of childspacing or FP use.
	CS/FP.Att_Relig.Leaders	Religious leaders' attitudes toward childspacing/FP	Participant's perception of religious leaders' attitudes towards childspacing/FP. Also code if participant says they don't know religious leaders' attitudes.
	Fertility.Att_Relig.leaders	Religious leaders' attitudes towards fertility	Participant's perception of religious leaders' attitudes towards fertility. Also code if participant says they don't know religious leaders' attitudes.
Partner/spouse relationship	Couple_Communic	Couple communication	Couples' discussions (or lack thereof) about fertility, childspacing, or FP. Also includes who initiates the discussion, motivation to discuss or how topic is brought up, and what is discussed. Code with "Secret_Use" if participant mentions hiding FP use from their husband.
	Decision_Couple	Decision-making power	References to decision-making power in a couple-context. Code with "FP_Choice" if who chose method is mentioned.
Communication	Communic_Norms	Perceived couple communication norms	Participant's perception of community norms re couple communication. Also code if participant does not know community norms. (IDI guide Q# 26,)
	Couple_Communic	Couple communication	Couples' discussions (or lack thereof) about fertility, childspacing, or FP. Also includes who initiates the discussion, motivation to discuss or how topic is brought up, and what is discussed. Code with "Secret_Use" if participant mentions hiding FP use from their husband.
	Discussions_Fam	Fertility, childspacing/FP discussions w/ family	Participant's discussions (or lack thereof) about fertility, childspacing/FP with member(s) of family. Also includes who initiates discussion, motivation to discuss or how topic is brought up, and what is discussed. Discussions with partner/spouse should be coded as "Couple_Communic"
	Discussions_Social.Network	Fertility, childspacing/FP discussion in formal or informal groups	Participant's discussions (or lack thereof) about fertility, childspacing/FP in the formal or informal group(s) in which they participate. Also includes who initiates discussion, motivation to discuss or how topic is brought up, and what is discussed.
	Info_Exchange	Reciprocal information exchange	Bi-directional exchange of advice/information between participant and others (as opposed to instances where information flows uni-directionally).

Table of Codes (TJ In-Depth Interviews)

Fertility Norms & Attitudes	Fertility.Att_Self	Participant's fertility preferences	Participant's stated fertility attitudes/preferences (number of children he/she would like to have).
	Fertility.Att_Partner	Partner's fertility preferences	Participant's perception of partner's fertility attitudes/preferences (number of children partner would like to have). Also code if they don't know partner's attitudes. Code with "Couple_Communic" only if participant mentions how they know what their partner thinks (talked about it, didn't talk about it).
	Fertility.Att_Community	Fertility attitudes and preferences of participant's community and social network	Participant's perception of their social networks' (family, friends or people who are close to participant) fertility attitudes and their perception of the community norms regarding fertility/number of children. Also code if they don't know community norms or social network's fertility attitudes.
	Fertility.Att_Relig.leaders	Religious leaders attitudes towards fertility	Participant's perception of religious leaders' attitudes towards fertility. Also code if participant says they don't know religious leaders' attitudes.
	Postpartum_Fertility	Postpartum return to fertility	Understanding of postpartum return of menses and risk of pregnancy, including breastfeeding/LAM as a form of FP.
	Postpartum_Sex.Norms	Postpartum sexual norms	Participant or community's beliefs and practices re postpartum abstinence.
Childspacing and FP norms and attitudes	CS/FP.Att_Self	Individual attitudes towards childspacing/FP	Participant's stated attitudes towards childspacing/FP. Excludes method preferences, which should be coded to FP.Choice.
	CS/FP.Att_Partner	Partner's attitude toward childspacing/FP	Participant's perception of their partner's attitude toward childspacing/FP. Also code if participant does not know partner's attitudes. Code with "Couple_Communic" if participant mentions how they know what their partner thinks (talked about it, didn't talk about it).
	CS/FP.Att_Community	Childspacing/FP attitudes of participant's community and social network	Participant's perception of their community's and social networks' attitudes towards childspacing/FP. Also code if participant does not know social network or community attitudes towards FP.
	CS/FP.Att_Relig.Leaders	Religious leaders' attitudes toward childspacing/FP	Participant's perception of religious leaders' attitudes towards childspacing/FP. Also code if participant says they don't know religious leaders attitudes.
	CS/FP_Adv.W	CS/FP advantages for women, children, family	Stated advantages of childspacing or FP for women, children, or family in general.
	CS/FP_Adv.M	CS/FP advantages for men only	Stated advantages of childspacing or FP specifically for men.
	Closely-Spaced_Disadv	Disadvantages of closely-spaced births	Consequences of too closely-spaced births.
	FP_Imposed	FP imposed by outsiders	Participant's perception about whether FP is imposed by outsiders/others
	Stigma	Stigma re FP use	Experiences of stigma, shaming, physical violence, either perceived or actual, associated with FP use. Can be for self or others.

Table of Codes (TJ In-Depth Interviews)

Unmet need for FP	FP.Need_Self	Perceived need for FP	Participant's perception about whether he/she needs FP.
	FP.Need_Partner	Partner's need for FP	Participant's perception of her/his partner's need for FP. Also code if participant does not know whether partner needs FP.
FP Information	FP_Knowledge	Knowledge of methods of FP	Knowledge of any FP method (hormonal, natural, traditional). Excludes postpartum breastfeeding.
	FP_Misinfo	Misinformation about FP	Misinformation or rumors about FP methods and/or perceived side effects.
	FP.Info_Source	Preferred or past source of FP info	The place/person the participant would most likely go to for FP info or the place/person where the participant has heard about/obtained FP info in the past. Also code if they say they would not seek out additional info.
FP Use	FP_Motiv	Motivation to use FP	Reasons for using/starting to use a FP method.
	FP.Use_Past	Previous FP use	References FP method used in the past. Include references to satisfaction with method, perceived efficacy, and reasons for discontinuation.
	FP_Choice&Satis	Choice of FP method, satisfaction with method and perceived efficacy	FP method currently using (hormonal, natural, traditional), who chose the method, why it was chosen, and perceived advantages of this specific method (methods include periodic abstinence). Include satisfaction with current method and perceived efficacy.
	Secret_Use	Secret FP use	Mentions clandestine FP use, how they hide it, who helped her obtain/use. Code with "Couple_Comm" if participant mentions hiding FP use from her husband.
	FP_Obstacles	Obstacles to FP use	When a participant wants to use a method but cannot, or is experiencing difficulties consistently using a method. May include any of the following reasons: social (community does not approve), inter-personal (husband does not allow), financial (can't afford), infrastructural (no transportation to clinic), others.
	FP_Side.Effects	Side effects of FP	Actual side effects of FP as experienced by user or partner.
Quotations	Good_Quotes	Quotes to use in materials	Good quotes with pro-FP/childspacing messages, quotes that could be used in communication materials. Also include parables, songs, or sayings. Attach a memo about why you think it is a good quote or how it might be used.
	Case_Scenario	Case scenarios for discussion guides	Situations or scenarios that might be good fodder for reflective discussion guides. Attach a memo about what the situation illustrates or how it might be used.
Assessment of Need Status	FP.Need_Assessment	Assessment of participant's need for FP by the analysis team.	Assessment of participant's need for FP. Participant either has no need, unmet need or is family planning user. Code at the beginning of transcript, along with memo explaining what the participant's need status is and why. Make sure code and memo are attached to same quotation.