

# Baseline Household Survey Report

## Tékponon Jikuagou Project

### Addressing Unmet Need for Family Planning through Social Networks in Benin

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## I. BACKGROUND

In Sub-Saharan Africa, significant resources have been allocated to family planning (FP) programs for activities ranging from improving services to advocating for policy change, from conducting media campaigns to organizing peer education sessions, and from strengthening contraceptive supply chains to pioneering contraceptive technologies. Yet, unmet need for FP – that is, the number of women and men who do not want a pregnancy but are sexually active, yet not using an effective means of preventing pregnancy – remains high, and sustained FP use remains elusive. Interpretation of unmet need has led to an emphasis on “supply side” issues, and significant resources have been devoted to institutional strengthening and provider capacity building. Nearly twenty years of FP programming efforts in Benin, for example, have led to the majority of sexually active men and women knowing about the various methods of FP, yet unmet need has increased from 21% in 1996 to 32.6% in 2006 (DHS, 2012), and contraceptive prevalence has only risen from 3% in 1996 to 7% in 2006. Evidently, unmet need does not represent demand for FP methods nor does providing an influx of programming necessarily translate into adoption and sustained use of family planning. What prevents men and women who supposedly have an “unmet need for FP” from using a method?

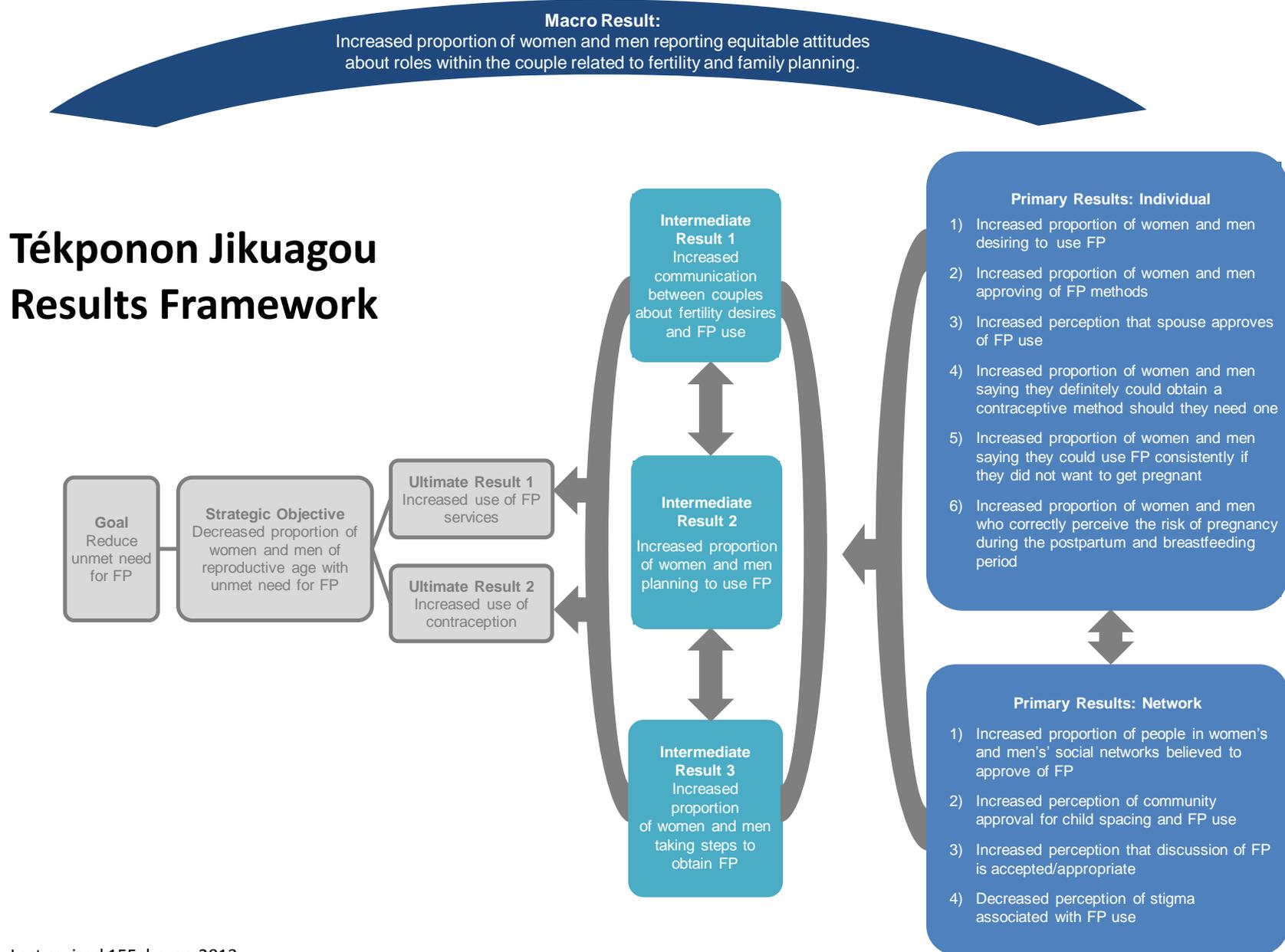
Many efforts to reduce unmet need have focused primarily on women and, in some cases, their partners, without taking into consideration the social networks in which reproductive health decisions are made. Recently in Benin, increasing attention has been given to the influence of men on women’s FP use. Research indicates, for example, that partner disapproval (real or perceived) contributes to women’s inability to use FP successfully and that improved couple communication increases FP use (Tapsoba et al., 1994; Terefe & Larson, 1993). Less attention, however, has been given to other important social influences on women’s health choices, such as opinions of family members (e.g., mother in law), friends, and community leaders. Literature on unmet need further underscores the necessity of acknowledging social networks and cultural contexts when addressing unmet need, in particular power relations and gender norms as influencers of reproductive health behavior (Gayen 2007, Bongaarts 1995, Greene & Biddlecom 2000).

Social network analysis theorizes that once a FP method has been adopted by a group within a community, social interaction can accelerate the pace of diffusion by providing opportunities for social comparison, support and influence – not only for adopting a method but also for continuation or switching to another method. While ecologic models have become accepted practice in public health, only recently have public health practitioners begun to use social network analysis as both an analytic tool and a theoretical paradigm to pose and answer important ecological questions (Luke & Harris, 2007).

Increased understanding of social networks can improve efforts to mobilize communities around FP, and more effectively support changes in FP related attitudes, beliefs, desires, intentions and behaviors. This is particularly relevant because for many, the decision to initiate or use FP is not made during a single counseling session, nor is it a once-and-for-all commitment. Women and men may discontinue FP use or switch among methods repeatedly even during a single year. Presence of a social system that supports the use of FP methods that meet couples’ changing fertility intentions over the life course can help women and men fulfill their reproductive intentions.

Ultimately, Tékponon Jikuagou aims to reduce unmet need for FP. Figure 1 shows the results framework that is the theoretical underpinning for the project, and what it aims to achieve.

Figure 1. Tékponon Jikuagou Results Framework



With the ultimate goal of reducing unmet need for FP, the project is implementing programs designed to influence individuals and their networks, to not only improve access for FP, but to also increase couples' empowerment to use FP, and ensure an enabling environment. The project aims to do so, using a social network approach. Key features of this approach are:

1. Identification of individuals, groups or organizations influential in spreading information, attitudes and ideas;
2. Specification of who influences whom during the diffusion process;
3. Identification of channels of communication and influence (e.g. village meetings, community radio); and
4. Utilization of these networks to spread innovations.

## **DEFINITIONS OF FAMILY PLANNING NEED**

As the ultimate goal of the Tékponon Jikuagou project is to reduce unmet need for FP, it is important to have a clear definition of the unmet need concept. Various definitions exist of unmet need for FP. Our definition differs from commonly used variations, in that it focuses on perceptions of the individual, as follows:

**MET NEED:** Individuals using any FP method, modern or 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 who believe that this protects them from pregnancy (correctly or erroneously); and individuals who otherwise perceive that they have no need for FP for any reason.

**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. 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, as she will not be responsive to supply-side FP programs. Rather, she may benefit from

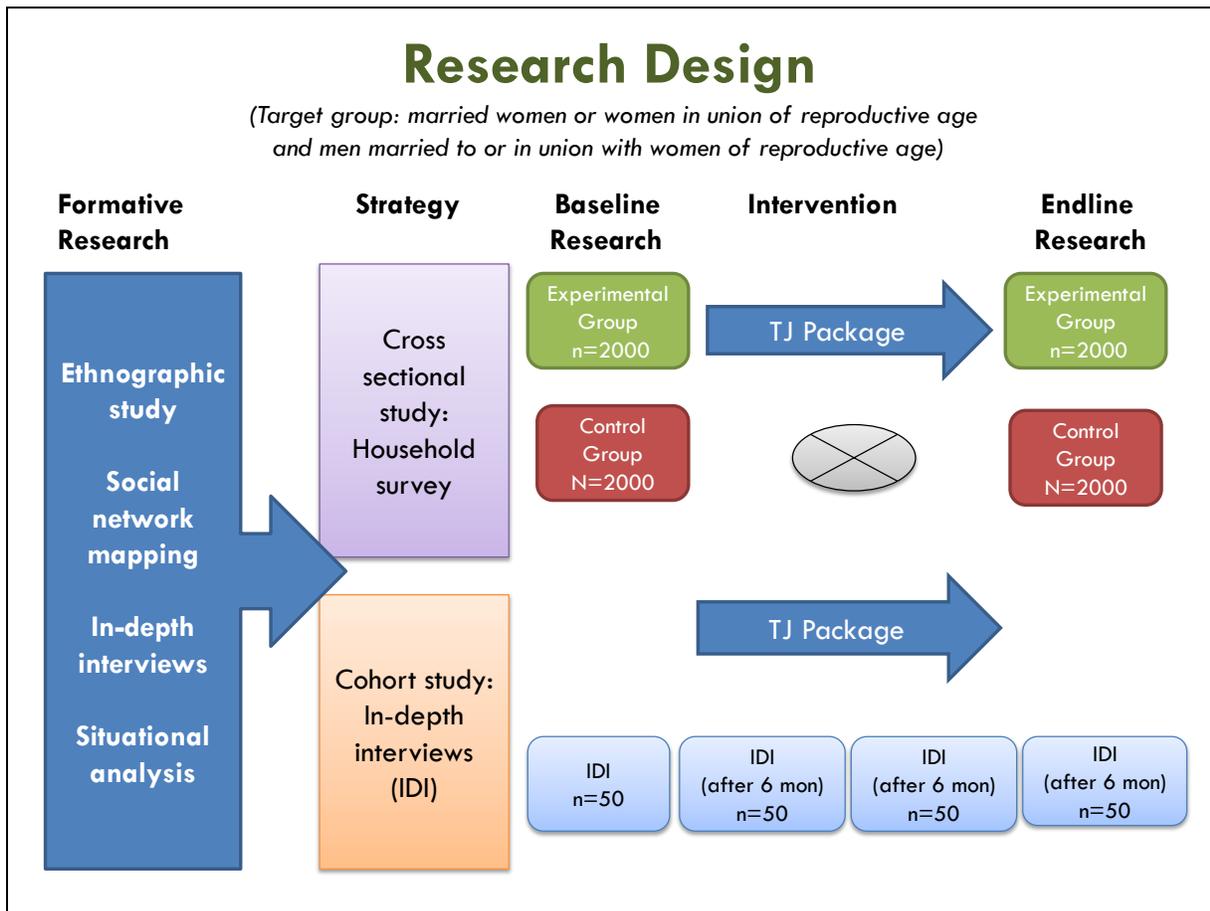
educational programs about the efficacy of various methods. In another example, Bradley, et al. would consider a woman who is not breastfeeding exclusively but still postpartum amenorrheic as having unmet need, since she is biologically susceptible to pregnancy. In contrast, our definition considers this woman as having no need if she believes it is impossible to become pregnant in this state, as she will not take advantage of FP programs and services.

Since Project Tékponon Jikuagou 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. In addition, the traditional definition of unmet need is a static measure. We posit that need-status can change over time, and therefore measure unmet need monthly (retrospectively), for a full year.

## **II. BASELINE SURVEY OBJECTIVES, DESIGN AND IMPLEMENTATION**

The research agenda is multi-faceted; Figure 2 represents a schematic diagram of the research design during the pilot phase to allow the reader to understand how the household survey baseline is part of a larger study design. The effectiveness of the Tékponon Jikuagou package of social network interventions will be evaluated using a quasi-experimental design. In addition to the household survey, an embedded study will determine the cost of offering the full package, important information for scale-up. Discussed earlier, another element of the Tékponon Jikuagou research agenda is to enhance understanding of unmet need by using social network analysis and qualitative techniques to explore the dynamic nature of unmet need from the perspective of women and men rather than service delivery organizations. To this end, a group of women and men, selected on the basis of unmet need status for FP, will be followed during the pilot phase and interviewed every six months.

**Figure 2. Tékponon Jikuagou Research Design**



*\*Note that throughout this report, we use the term “married” to refer to individuals who are married or in union (co-habiting).*

The main objective of the baseline household survey was to collect data on study respondents’ attitudes and behaviors related to fertility, child spacing and FP, to identify their FP need status, and to learn about their social networks. Results will help refine the design and implementation of the Tékponon Jikuagou interventions to reduce unmet need, and will ultimately be compared to similarly designed endline survey, to evaluate the interventions.

The household survey was conducted in all six communes in the department of Couffo which were selected by IRH and partners as the location of the Tékponon Jikuagou pilot project (hereafter referred to as intervention areas) and three control communes in the department of Plateau—Pobé, Adja-Ouère, and Sakété—where the project will not be piloted (hereafter referred to as control areas). Couffo was selected as the intervention zone due to ongoing activities of our in-country partners in these areas, as well as the interest of local policy makers.

The department of Plateau was chosen as the control zone based on certain criteria, including the unmet need rate, the contraceptive prevalence rate (CPR), and the population. In fact, comparisons of data for these criteria indicated that Plateau was more similar to Couffo than other potential departments like Mono or Colline. Conversely, there are some differences in socio-demographic

characteristics (ethnicity, polygamy, etc.) between the two departments. These differences will be controlled for during statistical analysis of the combined baseline and endline results, through an analysis of the project intervention based on two approaches. The first approach will examine the gross effect of the Tékponon Jikuagou package on beneficiaries, and the shift in their situation from before to after the intervention. A second, complementary approach, will examine the net effect by comparing differences between peer groups that most resemble each other in the intervention and control zones. Multivariate analysis techniques such as ordinary least squares (OLS) will be used to put together homogenous peer groups (beneficiaries and non-beneficiaries) based on their socio-demographic and cultural characteristics, and matched according to variables that appear to have affected intervention results.

The availability of FP services was also considered in choosing a control zone; the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA) is present in all three control communes in Plateau, as in the intervention communes in Couffo, which ensures free distribution of contraceptive methods in both zones.

The baseline study was completed before the intervention activities began.

## **SAMPLING**

A representative sample of households in the intervention and control areas was obtained through a two-stage stratified cluster sample of households. In the first stage, a sample of forty-five villages/districts was drawn with probability proportional to size among the ninety villages/neighborhoods targeted by the Tékponon Jikuagou Project (intervention area) and among the one hundred thirty-nine communes of Adja-Ouèrè, Pobè and Sakété (control area); the total sample size was the population recorded in 2002. Within each of these clusters, a sample of households was then selected at random. One married woman of reproductive age, and the man married to that woman were interviewed, in each selected household, if they agreed to participate in the study.

Tables 1 and 2 provide information on the number and distribution of respondents in both the intervention and control zones. Researchers selected 2,732 households in the 90 villages/neighborhoods for the sample. Among these households, 2,592 men and women agreed to participate in the study, yielding a response rate of 94.9%. Within surveyed households, 2,184 eligible women were selected, of which 2,160 were successfully interviewed for an response rate of 98.9%. Of the 2,175 eligible men identified, 2,160 were successfully interviewed, a 99.3% response rate. Table 2 shows the distribution of respondents in the study areas. For a complete list of villages that participated in the survey, please see Appendix A.

**Table 1 : Households, Women and Men Selected and Surveyed, and Response Rate**

Distribution by number and (%) of households and respondents by sex

Households and respondents by sex	Intervention	Control	Total
<b>Households</b>			
Households selected	1332	1400	2732
Households surveyed	1251	1341	2592
Household response rate (%) <sup>1</sup>	<b>93.9</b>	<b>95.8</b>	<b>94.9</b>
<b>Women</b>			
Women selected	1082	1102	2184
Women interviewed	1080	1080	2160
Women respondents response rate (%) <sup>2</sup>	<b>99.8</b>	<b>98.0</b>	<b>98.9</b>
<b>Men</b>			
Men selected	1080	1095	2175
Men interviewed	1080	1080	2160
Men respondents response rate (%) <sup>2</sup>	<b>100.0</b>	<b>98.6</b>	<b>99.3</b>

<sup>1</sup> Households surveyed/Households selected<sup>2</sup> Respondents surveyed/Respondents selected

## SURVEY INSTRUMENTS

All study protocols and instruments were approved by the Georgetown University Institutional Review Board (USA), and by the Institut des Sciences Biomédicales Appliqués (Benin) before data collection began. Protocols for conducting research with human subjects were closely followed in the field, to ensure respondents' rights and their safety. Participation was voluntary, and informed consent was obtained from each study participant prior to the interview.

Research instruments were written in French and orally translated to the local languages at the time of data collection by interviewers fluent in these languages and in French. Interviewers training included exhaustive translation and back-translation exercises, to ensure that verbal translation was done as accurately as possible. The full men's and women's questionnaires and consent forms are attached in Appendix B.

## QUESTIONNAIRES

Baseline questionnaires were developed in consultation with field-based project staff and partners, and with the local research organization CRAD. Questionnaires included several components:

- A series of questions on respondents' background characteristics, fertility, contraceptive history, and attitudes and behaviors toward fertility, contraception, and desired family size
- A social network grid intended to gather information about respondents' material networks (those who provide material assistance such as money, food, or clothes) and practical networks (those who provide practical assistance such as child care or help with chores)
- A calendar (women's questionnaire only) to provide detailed information about women's evolving FP need status during the twelve months immediately preceding the study

During the first phase of development, eight interviewers (four women and four men) were selected to pre-test the study tools. Along with CRAD's trainers and lead researcher for the study, they attended a brief orientation on the survey instruments led by IRH Benin's Coordinator for Research, Monitoring and Evaluation. Following the orientation, interviewers were dispatched to the Fiyegnon neighborhood, which has a large population of Popo, Xwla and Adja ethnic groups, to test the tools with members of those ethnic groups in their native language. Feedback from the pre-test allowed the research team to revise the tool before the full training of all seventy interviewers on February 4-7, 2013.

During this training, interviewers were introduced to the study issues, objectives and methodology for data collection. The training manual was read aloud to ensure that all interviewers received the same level of training and information about efficient and correct implementation of the study. Particular attention was given to proper completion of the different tools, including the coded list of participants, consent forms and men's and women's questionnaires. Practical exercises on how to fill out the calendar portion of the women's questionnaire helped interviewers understand how to complete the form, which provides information on women's contraceptive use during the twelve months preceding the interview. Other exercises on how to fill out the social network grid facilitated better comprehension of the tool's purpose and the method for completing it. In addition, interviewers participated in an informational session on family planning methods and a session on ethical research practices for working with human subjects, which focused on the importance of confidentiality during data collection.

Key concepts and phrases in the survey tools were translated into Adja and Yoruba in small groups during the training, and subsequently validated in a plenary session. This was done so that interviewers could provide standardized verbal translations of the French questionnaires to respondents in local languages. Simulated interviews between interviewers provided practical experience in administering the questionnaire before teams of one man and one woman each were sent to four neighborhoods in Cotonou's sixth arrondissement—Gbedjromede 1, Ayidjedo 1, Ayidjedo 2 and Ayidjedo3—to conduct a second pre-test of the tool. Following the pre-test, a final meeting was held to discuss and resolve challenges encountered and a final group of 60 interviewers were selected from the group of 70 who participated in the pre-test, based on their performance and quality of data they collected.

#### CONSENT FORMS

All respondents who agreed to participate in the study were consented before they were interviewed. Since we expected a high proportion of respondents to be illiterate, they were consented in front of a witness, such as a village resident, teacher or visiting relative who was fluent and literate in French, to ensure that all aspects of the informed consent were understood by the participants. A script was written in French, which was orally translated to the local language in front of the respondent and the witness. Both the research participant and the witness signed a written consent document, and a card was given to participants with information about who to contact in case of questions about their rights as research participants. To ensure confidentiality, the witness did not observe the interview itself.

#### DATA COLLECTION AND DATA ENTRY

After households were randomly selected, interviewers visited each selected household to determine participant eligibility: women of childbearing age (18-44) and men married to women of

childbearing age. If eligible participants resided in the household, interviewers described the study to them, and asked them to participate. If more than one eligible woman resided in the household, interviewers randomly selected one to interview. If this woman did not consent to participate, the interviewer moved to the next wife. After completing the interview with the wife, or if no wives consented to participate, the interviewer asked the husband to participate. Since we were interested in husband-wife dyads and concordance/discordance of responses, if one or the other spouse was not available at the time, the interviewer returned to the household up to two times in an attempt to interview the corresponding spouse. If only one spouse agreed to participate, that spouse was still interviewed.

During community survey interviews, wives and husbands at each household were interviewed independently of each other and responses were kept confidential from each other. The need for this was explained to respondents during the informed consent procedures. Male interviewers interviewed male respondents, and female interviewers interviewed female respondents.

Data collection efforts were closely supervised. Four supervision teams were used, two each in the control and intervention areas, to coordinate data collection and address any challenges encountered in the field. Supervisors observed the data collection teams, ensured correct implementation of the survey methodology, and identified any incorrectly completed questionnaires. In some cases, interviewers returned to select households to collect missing data on incomplete forms.

Completed questionnaires were transported by field supervisors to CRAD's office in Calavi for data entry. All research instruments were kept in a secured, centralized location to ensure data were not lost or compromised, and to protect participants' confidentiality. Data were entered using CS Pro 5.0; data assistants entered data from several questionnaires and addressed difficulties with certain data in the template before commencing data entry from all surveys. This process was repeated a second time to ensure there were no remaining technical difficulties. Two teams of six data assistants worked simultaneously to input data, the first group entering data in the morning and the second group re-entering the same data in the afternoon. This method minimized the risk of errors due to fatigue or attention loss. Both sets of data were edited and validated, after which they were cleaned to ensure internal coherence of responses. Results tables were created using SPSS.

### **III. RESULTS**

#### **BACKGROUND CHARACTERISTICS**

Table 2 presents the demographic profile of study participation in the intervention and control areas. The mean age of women was about 30, and of men about 38, in both study areas. With the exception of age, results suggest significant differences between the intervention and control areas. Polygamy was much more prevalent in the intervention areas (45% of women) than in the control (27%). Respondents in the control area had significantly fewer children than in the intervention area. Over 90% of respondents in the intervention area were Adja; in the control area two thirds were Yoruba, and about a quarter were Fon. Given different ethnicities, it is not surprising that there was a significant difference in religion between the intervention and control area.

**Table 2 : Socio-Demographic Characteristics of Baseline Participants (% women and men)**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
<b>Age</b>				
Mean	29,7	38,0	29,7	37,8
18-19	2,9	0,6**	3,4	0,0
20-24	19,5	5,1	20,8	5,0
25-29	28,9	17,6	27,2	15,1
30-34	20,8	18,5	21,7	20,7
35-39	16,9	17,1	15,5	19,9
40-44	10,9	15,3	11,4	15,9
45-54	0,0	16,4	0,0	17,4
55 et +	0,0	9,4	0,0	5,9
<b>Marriage status</b>				
Polygamous	45,0**	41,9**	37,1	31,7
Monogamous	55,0	58,1	62,9	68,3
<b>Number of children</b>				
Mean	3,4	5,7**	3,2*	4,6
<b>Level of education</b>				
None	76,4	43,1**	74,3	53,5
Primary	16,7	34,6	18,9	29,7
Secondary 1	6,3	13,7	6,1	9,0
Secondary 2	0,6	5,7	0,6	5,3
Post-secondary	0,1	2,9	0,1	2,5
<b>Religion</b>				
Catholic	8,7**	7,6**	16,9	20,1
Protestant	8,9	1,7	9,3	9,7
Other Christian	31,8	26,0	49,7	41,2
Traditional/Voodoo	42,3	55,7	4,8	7,4
Muslim	0,3	0,5	15,6	16,3
Animist/None	8,1	8,4	3,6	4,7
Other	0,0	0,1	0,0	0,6
<b>Ethnicity</b>				
Adja (or related)	90,7**	91,0**	1,7	4,3
Fon (or related)	8,9	8,6	24,8	23,1
Yoruba (or related)	0,1	0,2	67,9	72,1
Other	0,3	0,2	5,6	0,6

\*\* & \* denote significance level at the  $p < .01$  et  $p < .05$ , respectively

## NETWORK CHARACTERISTICS

Respondents were asked to identify people who provide them with material assistance (for example, someone who loans them money, purchases goods for them in the market, or gives them food or clothes). They were also asked to list people who provide them with practical assistance (for example, they help care for their children, assist with household chores, or help with trading or agriculture). For each person named, they were asked what is their relationship with that person (for example: sister, mother in law, male or female friend, religious leader). They were then asked where the person lives (in the village or elsewhere), whether they have spoken to that person about birth spacing or contraception in the three months preceding the survey, and if, as far as they knew, the person approves of FP use. Table 3 shows the results of this section of the interview, for women.

<b>Table 3 : Network Characteristics of Baseline Participants (# women and men)</b>	Intervention n=1080 women	Control n=1080 women
Total number of network members	3284**	3840
Material network	2539	2442
Practical network	1502	2080
Mean number of members per respondent <sup>1</sup>		
Total	3.11 (1-18)	3.11(1-18)
Material network	2.43 (1-13)	2.27(1-13)
Practical network	1.58 (1-13)	2.00(1-13)
% of members who provide both types of support	23.1	17.8
% of members who are same gender as respondent	45.6**	53.1
Relationship		
% own family	38.4**	34.0
% spouse family	49.5	44.4
% not kin	12.1	21.6
Husband was listed in one or both networks	86.6	86.6
Residence		
% part of the household	39.8	39.1
% in the village	34.2	35.9
% outside of the village	26.0	25.0

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively.

1. While the list of network members was supposed to be open ended, the questionnaire had 13 spaces for each network, and it seems that data collection stopped there. However, since no more than 4 respondents in each network listed 13 members, this does not significantly influence the results.

Mean network size was about three members, for women in both control and intervention areas. In both areas about 39% of network members lived in the same household, and an additional third lived in the same village as the respondent. There were significant differences in network composition between the intervention and control areas. Specifically, in the control area 22% of network members were not family members, compared to only 12% in the intervention. A greater percentage of network members were women in the control area as compared to the intervention area. About half of network members belonged to the spouse's family and a little over one third to the woman's family. Almost 90% of women's networks included men.

## **FAMILY PLANNING USE**

Table 4 shows the percent of women who had ever used a FP method, and the percent who were using a method at the time of the survey, by method. There were significant differences in FP use between the intervention and control areas. While in the intervention area half of women had never used a method, almost three quarters of respondents in the control areas were in this category. While the proportion of those who were currently not using a method (and were not pregnant) was similar (18.9% and 17.1% for intervention and control areas respectively), the percentages of those using a traditional (ineffective) method was significantly higher in the intervention areas (13.8%), then in the control (6.6%). However, the difference in current FP can be attributed to the large proportion of women in the intervention areas who were relying on traditional (ineffective) FP

method. Use of modern method was a little higher in the control areas, with the exception of condoms and the Standard Days Method.

<b>Table 4 : Current and Past Family Planning Use (% women)</b>	Ever used		Currently using	
	Intervention n=1080	Control n=1080	Intervention n=1080	Control n=1080
<b>Method</b>	49,5**	26,4	30,1	27,5
Female sterilization	0,3	0,3	0,3	0,6
Male sterilization	0,0	0,0	0,0	0,1
Pill	4,4	4,1	1,2	1,9
IUD	0,1	0,4	0,2	0,5
Injectables	2,6*	4,3	0,8**	2,7
Implants	3,5	4,4	2,9*	5,0
Condoms	4,2**	1,9	3,1	1,9
Diaphragm / Foam / Jelly	0,0	0,1	0,0	0,1
Standard Days Method © / CycleBeadds	7,9**	1,8	4,9**	2,0
Lactational Amenorrhea Method	0,0**	0,6	0,4**	3,4
Periodic abstinence	11,2	9,6	7,8	8,7
Other traditional methods	24,7**	4,6	13,8**	6,6
<b>Never used a method</b>	50,5	73,6**		
<b>Not currently using a method and not pregnant</b>			18,9	17,1
<b>Currently pregnant</b>			51,0*	55,4

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively.

Contraceptive prevalence of men (27.2%) is about the same as women (27.2%) in the control areas. However, in the intervention areas, significantly more men (47.4%) than women (30.1%) were using a FP method at the time of the survey, suggesting that men have multiple “FP need” statuses, because one wife may be using a method, while another may not.

#### REASONS FOR NON-USE

Women who were not pregnant, did not wish to become pregnant, yet were not using a FP method, were asked why. Table 5 shows the results. The most commonly given reasons had to do with perceptions of fecundity. About a third of women thought that they could not become pregnant because they had infrequent or no sex. Obviously, a woman cannot become pregnant if she has no sex. However, it is likely that these women have sex infrequently, and do not realize that they can become pregnant if they have sex even only once a month. These women thought that they had no need for FP, when in fact they did. Similarly, about 20% of women did not use a method because they were breastfeeding or still in postpartum amenorrhea, not realizing that women can, and do, become pregnant during that time. These women, too, perceived that they had no need for FP, when in fact they did. These women would benefit from programs designed to educate women about the risk of pregnancy at different times in the menstrual cycle, in various life stages.

**Table 5 : Reasons for Non-Use (% women)**

	Intervention n=1080	Control n=1080
<b>Fertility-related reasons</b>		
Infrequent/not having sex	35,2	33,5
Cannot become pregnant	4,0	3,7
Not menstruated since last birth	8,8**	3,2
Breastfeeding	11,4	12,7
Wants more children before using FP	2,0**	7,9
Up to God/fatalistic	2,3**	15,4
<b>Opposition to use</b>		
Respondent opposed	3,7	6,5
Husband opposed	5,4	5,2
Others opposed	0,0*	1,2
Religious prohibition	1,7**	6,0
<b>Lack of knowledge</b>		
Knows no method	28,1**	13,4
Knows no source	5,7	5,0
<b>Method-related</b>		
Side effects/health concerns (self)	10,2**	18,1
Health concerns (child)	1,1	0,5
Lack of access/too far	0,6	0,5
Costs too much	1,7*	0,2
Preferred method not available	0,0	0,7
No method available	0,0	0,5

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively.

About 10% of women in the intervention areas, and 20% of women in the control were not using a method because of real or perceived opposition to FP use by themselves, their husband, or others in the community. These women would benefit from programs designed to create an environment that is more enabling and supportive of FP use.

On the other hand, about 45% of women in the intervention areas, and 37% of women in the control, were not using a method because they did not know of a method, did not know of a place to get a method, were afraid of side effects, or for other method-related reasons. These women would benefit from increased access to high quality services which offer a wide range of family planning methods.

#### UTILIZATION OF FAMILY PLANNING SERVICES

Respondents were asked whether in the 12 months preceding the survey they had visited a health facility or talked to a community health worker to obtain information about a method, and if in the past 12 months they had visited a health facility to obtain a FP method. If they responded in the affirmative to the latter, they were asked if their husbands accompanied them. Table 6 shows the results.

**Table 6: Use of FP Services**

	Intervention n=1080	Control n=1080
In the past 12 months, have you asked a health worker or <i>relais</i> for information about methods to delay or avoid pregnancy?	9,6	12,9*
In the past 12 months, have you visited a health facility to obtain a method to delay or avoid pregnancy?	6,4	10,6**
When you visited the health center to obtain a method to delay or avoid pregnancy, did your husband go with you?	3,4	3,7

## FAMILY PLANNING NEED

### MET NEED, UNMET NEED, AND NO NEED (REAL OR PERCEIVED)

The questionnaires allowed us to calculate need status (per the definition described in the background section), for the 12 months preceding the survey. For each month we asked if the woman was pregnant (=no need). If not, we asked if she desired a pregnancy at that time (no need). If not, we asked if she was using a method (=met need), and if so which. We then asked about the woman's perception of her pregnancy risk, and why she was not using a method. Table 7 shows the results.

**Tableau 7: Need Status (%)**

	Current Month	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11
<u>Intervention</u>												
Unmet need	11.1	10.5	10.7	10.4	10.5	10.1	10.1	9.8	10.1	9.5	9.8	9.3
No need perceived	23.6	22.7	22.3	21.3	19.4	18.4	18.7	18.0	17.3	16.2	16.3	16.6
No need	32.8	35.5	35.6	37.9	39.7	42.0	42.3	43.7	44.4	45.4	44.5	45.0
Met need perceived	18.6	17.6	17.8	17.4	17.6	16.8	16.5	16.5	16.2	16.7	17.3	17.1
Met need	13.9	13.8	13.5	13.1	12.9	12.7	12.4	12.0	11.9	12.2	12.0	12.0
<u>Control</u>												
Unmet need	14.1	15.4	14.4	14.2	14.4	14.1	15.0	15.5	15.3	15.6	15.9	16.4
No need perceived	25.6	25.4	25.7	25.1	24.6	23.7	22.8	22.1	22.5	21.6	20.8	20.5
No need	30.5	32.2	33.9	35.7	36.7	39.2	40.2	40.8	40.9	42.0	43.0	43.2
Met need perceived	11.3	10.3	10.2	9.5	9.3	9.0	8.7	8.3	8.3	8.0	8.0	7.9
Met need	18.6	16.8	15.8	15.5	15.0	14.1	13.3	13.2	13.0	12.8	12.3	12.0

Several results stand out. First, unmet need in the current month is higher in the control than the intervention area. This includes perceived unmet need (11.1% and 14.1% in intervention and control respectively) and perceived no need (23.6% and 25.6%). [Note that most of the women with perceived no need *are* at risk of unintended pregnancy; only some truly have no need.] However, more women in the intervention area are using a traditional method, and therefore have perceived met need.

Second, in both intervention and control areas, the percentage of women with all types of need for family planning (unmet and met need, perceived and real) appear to have increased over time, except for no need (women who are pregnant or desire more children – more detailed analysis suggests that the trends hold for both). This suggests recall issues. Women recall that they wanted more children several months ago, than they do now. Perhaps it is a way for them to justify unwanted pregnancies to themselves. As for pregnancies, it is possible that women who are currently pregnant do not yet know it, or do not wish to report it.

#### PERCEPTION OF POST-PARTUM PREGNANCY RISK

When asked if in their opinion women who are breastfeeding could become pregnant, only 73% of women in the intervention area (70% in control) replied affirmatively. Similarly, only 62% and 55% of women in intervention and control areas respectively, said that women can become pregnant before their menses return postpartum. This corresponds well with the figures presented above, where so many respondents believed that they could not become pregnant (and therefore were not using a FP method) because they were breastfeeding or in the postpartum period.

#### ACCESS TO FAMILY PLANNING SERVICES AND SELF-EFFICACY

Respondents were read a series of questions about their ability to obtain FP services, and were asked if they agree or disagree with each statement. Table 8 shows the results. More women than men said they had the information they needed to use a FP method if they chose to do so, in both intervention and control areas. However, more men than women said they knew where to obtain a method, could go to that place without difficulty, and had the money to purchase a method. With the exception of having the means buy a method, men and women in the control areas had greater access to services than those in the intervention area, and these differences are statistically significant.

**Table 8 : Self-Efficacy in Obtaining FP Services (% who agreed with the statement)**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
I have the information I need to make a decision about whether to use family planning, if I wanted to delay or avoid pregnancy	52,0*	43,9**	56,9	50,9
I know where to obtain a method to delay or avoid pregnancy	52,9*	54,8**	57,8	61,7
I am able to reach this place without too much difficulty	49,3	51,5*	51,2	55,9
If I wanted to obtain a method, I have the means to purchase one	53,7	55,4*	49,7	50,5*

\* and \*\* denote significance level at the  $p<0.05$  and  $p<0.01$  respectively, comparing intervention to control.

In a separate question, respondents were asked if they felt confident that they could use a method correctly all the time. More than 70% of respondents, both men and women, in both intervention and control areas, responded in the affirmative.

## ATTITUDES TOWARD FAMILY PLANNING

Respondents were asked many questions about their opinions about child spacing and FP use, as well as their perception of attitudes of their network members, and of the community. Results are presented in this section.

### PERCEIVED ADVANTAGE AND DISADVANTAGES OF FAMILY PLANNING

Table 9 shows the percentage of respondents who strongly agreed, or agreed, with a series of statements about FP and child spacing. Some statements were stated in the positive (approve) and others in the negative (disapprove). Attitudes in the intervention area were significantly more positive than in the control area. Also, in the intervention area women generally had more positive attitudes toward child spacing and FP use than men; in the control area gender differences were mixed.

Table 9: Perceived Advantages and Disadvantages of FP (% who agreed with the statement)	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
<b>Positive Statements</b>				
Couples who use family planning have more time to do revenue-generating activities	86,9**	85,1**	68,2	69,8
Couples who practice family planning and have fewer children are better able to provide for their family	88,6**	83,1**	74,5	72,1
Using family planning is good for a woman's health	66,1**	61,3**	50,6	51,9
Child spacing is good for children's health	93,5*	96,1*	95,9	94,3
<b>Negative Statements</b>				
It is good to have many children so they can provide for you when you are older	30,6*	29,4	25,8	27,4
The family planning methods available in this village have many negative side effects	33,2	48,9**	35,6	30,7
Family planning methods are difficult to obtain because they are not available, they cost too much, or because services are too far	33,2	39,5	32,2	40,0

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively, comparing intervention to control.

### THE EFFECT OF RELIGION

Followers of traditional religions use modern FP methods less than other religious denominations (10.7% in the intervention and 5.8% in the control areas). While numbers in some religious categories are too small for significance calculations, there appear to be no substantial differences in modern FP use between Catholics, Protestants, other Christian denominations, and Muslims. A detailed breakdown of FP use by religious categories is available in Appendix C. Religious categories in this baseline survey are identical to those used in the DHS.

About two thirds of women in both intervention and control areas responded 'strongly agree' or 'agree' to the statement "*Only God can decide the number of children a couple will have, or the time to have them*" (64% and 65% in intervention and control respectively). Fewer men agreed with this statement, especially in the intervention area, where only 45% of men agreed.

In the intervention area, only 2% of women provided this reason for not using a FP method, and 2% said they did not use a method because of their religion. This proportion was significantly higher among women in the control area, where 15% said that child spacing is up to God and 6% said they did not use a method because of their religion.

#### PERCEIVED FAMILY AND ENTOURAGE APPROVAL

Since the project utilizes social network theory, it is also important to examine respondents' perceptions of support for family planning from their spouse, other family members, network members and the community at large. Table 10 presents the percentage of respondents who responded 'strongly agree' or 'agree' to statements regarding whether they feel comfortable discussing FP with members of their social network. Responses were consistently more positive in the intervention area than in the control, and this difference was statistically significant. Men in both intervention and control areas would feel more comfortable discussing FP than woman.

**Table 10: Perception of Community Support for FP Use**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
If you use a FP method, would you feel comfortable telling your...				
• Mother-in-law	48,1**	56,9	26,0	55,2
• Aunt	53,3**	59,7**	39,6	49,4
• Members of your tontine or other social group in which you participate	45,3	58,4**	42,8	45,6
• Someone older than you	43,1**	61,6**	34,1	46,9
• A man/woman other than your spouse	18,0	33,7*	16,6	29,5
If you wanted to use a FP method....				
• Birth family would support decision to use a method to delay or avoid pregnancy	69,5**	67,9	61,5	66,6
• Family-in-law would support decision to use a method to delay or avoid pregnancy	52,0**		38,5	
• Entourage would support decision to use a method to delay or avoid pregnancy	61,2**	64,7	51,1	64,9

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively

Thirty-two percent of women in the intervention area, and 21% in the control, believed that their husband approved of FP use (this difference was statistically significant). As for their network, we calculated the percent of each woman's network members whom she believed were supportive of FP use. This percent was low in both the intervention and the control areas (16% and 14% respectively).

#### STIGMA

Several statements were read to respondents to gauge their perception of stigma against FP in their community. Table 11 shows the proportion of respondents who responded 'strongly approve' or 'approve' to these statements. Results show that more men than women stigmatize FP use, in both intervention and control areas, but these results are not consistent across all statements. Results shown in Table 12 confirm that more women than men expect to be stigmatized by their spouse and the community if they use FP. Interestingly, men expect that a man would beat his wife if he

finds out that she uses FP methods, much more than women expect that their own husbands would beat them if they start using a method.

**Table 11: Perception of Stigma Related to FP Use (% who agree with the statement)**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
<b>FP Use is Stigmatized</b>				
Women who use family planning have multiple sexual partners	7,9	17,0	7,0	16,4
Men whose wives use family planning lack authority	9,8	17,5	12,2	14,9
It is shameful to be associated with a woman who is known to use family planning	14,3	13,4	15,2	12,5
<b>FP Use is not Stigmatized</b>				
In this village, it is acceptable to discuss family planning in public	64,0	78,5**	63,3	71,3
It is appropriate for a husband and wife to talk about child spacing and methods to delay or avoid pregnancy	89,7**	89,7**	82,2	81,6
You should defend someone if they are being teased or criticized for using family planning	88,0**	74,6	75,7	73,3

\* and \*\* denote significance level at the  $p<0.05$  and  $p<0.01$  respectively

**Table 12: Perception of Stigma in the Community (% who responded 'yes')**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
From what you have seen in this community, if you used family planning and people found out, do you think you would be teased or criticized?	26,6	10,6**	24,7	6,9
From what you have seen in this community, if you used family planning and people found out, do you think you would be excluded by member of the community?	8,2**	2,6	2,0	1,5
From what you have seen in this community, if you used family planning and your husband found out, do you think he would beat you?	5,1**	26,9**	11,3	20,9

\* and \*\* denote significance level at the  $p<0.05$  and  $p<0.01$  respectively

## COUPLE COMMUNICATION

Husbands are instrumental in women's ability to use a FP method, thus couple communication about desired family size and FP use is important. This is the focus of this section.

## PERCEPTIONS OF COUPLE COMMUNICATION

Respondents were read a series of questions about their perceptions regarding ideal couple communication, and about who should make decisions in the household, especially with respect to child spacing and FP use. Table 13 shows the results. For ease of review, we present the results in categories, but the distinction between categories is not clear cut. For example, the statement “C’est la responsabilité de la femme d’aborder le sujet de la planification familiale pour en discuter avec son mari », could be listed in either the *wife decides* or *couple decides* group.

More than twice as many women in the intervention area than in the control believe that a man should side with his wife in family disputes. With that exception, there are no real differences between female and male respondents with respect to their perceptions of gender norms related to the home. While differences between intervention and control are statistically significant, they are not large.

As for decision making within the couple regarding child spacing and FP use, results are mixed. For example, about 78% of women in the intervention areas thought that it is the wife’s responsibility to decide on using a FP method because she is the one who would get pregnant, but some 83% of them thought that it is the men’s responsibility to make that decision because he will have to support them. Despite such contradictions, it is evident that more women than men, in both intervention and control areas, think women, or couples, should make FP decisions, while more men think it is their responsibility.

**Table 13 : Gender Norms and Couple Communication (% who agree with the statement)**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
<b>Gender Roles in the Household</b>				
A woman's role is to maintain harmony in the home	97,9	99,0**	98,8	96,8
In the home, a man must have the final word in decision-making	96,7*	96,9	94,6	95,6
A woman must always obey her husband	95,9**	95,2**	93,1	91,9
In family disputes, a man should be on his wife's side	73,1**	32,1**	63,6	59,7
<b>Gender Norms Related to Child Spacing and FP</b>				
<b>Couple decides</b>				
It's a woman's responsibility to bring up the topic of family planning for discussion with her husband	89,3**	78,0	78,5	77,9
It is the responsibility of both the woman and her husband to avoid pregnancy	99,4**	99,4	97,8	98,6
If a couple does not want to get pregnant and the wife is not using contraceptives, her husband should do so	93,9	90,6**	93,1	79,5
A couple should decide together how many children they want and when to have them	97,3	95,5	98,2	95,6
A woman and her husband should decide together what type of contraceptive to use	96,8	94,1**	95,3	96,8
<b>Woman decides</b>				
The woman can decide to use contraceptives because she is the one who will get pregnant	77,9*	55,4	74,0	53,5
It is the woman who should decide how many children to have, since she is the one who has to care for them	53,7**	39,8*	38,5	35,6
The woman can decide what type of contraceptive to use because she is the one who will use it	76,4	58,2	76,3	60,2
<b>Man decides</b>				
The husband should decide how many children to have, since he is the one who has to support them	83,3	90,5	73,4**	83,9**
It is man's responsibility to make sure his wife will not get pregnant if the couple do not want a child at this time	93,6	92,4	85,4**	86,1**
The man should be the one to decide what type of contraceptive to use	63,4	80,3	53,3**	66,2**

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively

#### COUPLE COMMUNICATION REGARDING FAMILY SIZE, CHILD SPACING, AND FAMILY PLANNING USE

Table 14 presents responses to questions about actual communication between the couple, as it relates to desired family size and FP use, from the women's perspective. It is clear that there is more communication within couples in the intervention area than in the control, but that communication rates are quite low in the intervention areas, where less than a third of women have discussed these issues with their husbands in the year preceding the survey.

**Table 14: Couple Communication (% women)**

	Intervention n=1080	Control n=1080
Know how many children their husband would like to have	29.3**	16.6
Know how often their husband would like to have children	43.1**	14.4
Are comfortable talking with their partner about the use of FP methods	57.5**	47.9
Believe their husband definitely approves, or might approve, of using a method to delay or avoid getting pregnant	61.2**	52.2
Have discussed their opinion about having children with their husband in the past 12 months	28.1*	24.3
Have discussed which method they would like to use to delay or avoid pregnancy with their husband in the past 12 months	18.6	18.2

These findings are consistent with the results related to women's efficacy to use FP without her husbands' knowledge or approval, which are shown in Table 15. While about 40% of women in both intervention and control areas believed that they must secure their husband's approval before they can obtain FP services at their local facility, almost three quarters of men believe so. About half of women in the intervention area thought that they could use a method consistently without their husbands' knowledge, and this proportion is significantly higher in the control.

**Table 15: Attitudes towards PF (% women who responded 'yes')**

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
In your opinion, at the village clinic, is it necessary for the health worker to get approval from a woman's husband before giving her a family planning method?	46,5**	71,7	39,3	70,3
I feel certain that I would be able to correctly use FP to delay or avoid a pregnancy, even if my husband disagreed	49,4**	46,4**	62,9	64,0

\* and \*\* denote significance level at the  $p < 0.05$  and  $p < 0.01$  respectively

## FAMILY PLANNING TALK IN THE COMMUNITY

In the context of a program to utilize social networks to increase the prevalence of FP use, it is important to note where women and men in the community are already talking, or getting information, about child spacing and FP. The Tékponon Jikuagou intervention is designed to increase the diffusion of FP information through these channels. This is shown in Table 16. Radio is clearly a good source of information about FP and other topics relevant to the study, especially for men. While only a quarter of women, and about 10% of men, attended social or religious group meetings, issues of relevance were discussed in some of them. Therefore this is another venue that can be successfully utilized to spread messages that may lead to behavior change.

**Table 16: Sources of Information or Communication about FP  
(%, intervention zone, during the three months before interview)**

	Intervention	
	Women n=1080	Women n=1080
Attended a meeting of a social group, such as a tontine, micro-credit association, or agricultural cooperative... ...where the following subjects were discussed:		
(a) Child spacing	26,8	14,5
(b) Family planning	10,3	8,6
(c) Couple communication	8,0	8,0
(d) Characteristics of an ideal man or woman	12,2	6,9
(e) Decision-making within the couple	7,6	6,1
(e) Decision-making within the couple	7,4	6,3
Visited by a <i>relais</i> or other health worker...	14,7	5,9
...and discussed FP methods	9,7	5,0
Heard radio programming on:		
(a) Child spacing	43,6	63,0
(b) Family planning	42,0	63,0
(c) Couple communication	34,4	50,0
(d) Characteristics of an ideal man or woman	27,1	39,1
(e) Decision-making within the couple	26,6	42,7
Heard village or religious leaders discuss:		
(a) Child spacing	12,3	11,2
(b) Family planning	10,8	11,2
(c) Couple communication	15,6	11,0
(d) Characteristics of an ideal man or woman	11,8	9,6
(e) Decision-making within the couple	10,7	9,2
Participated in a religious group or activity... ...where the following subjects were discussed:	21,3	8,1
(a) Child spacing	8,3	3,9
(b) Family planning	6,3	2,5
(c) Couple communication	15,0	3,6
(d) Characteristics of an ideal man or woman	11,6	2,5
(e) Decision-making within the couple	10,3	2,8
Asked a friend or family member about his/her experiences with FP	14,0	13,3
Shared your own knowledge or positive experiences with FP with a friend or family member	10,0	17,2

## STUDY LIMITATIONS

The study was well designed and implemented, but has several limitations. First, the definition of unmet need (perceived or real), is not as clean as it could be. Specifically, the questionnaire included having no sex and having infrequent sex as one category, when women explain why they are not using a method, despite not wishing to become pregnant. The first (having no sex) is real no need, while the second (infrequent sex) is perceived no need.

The intervention and control zones were selected based on unmet need and contraceptive prevalence rates (DHS 2011-2012), as these were critical variables of interest for the intervention. However, it is important to note the significant differences in these variables were noted between these two zones in this baseline survey. Different ethnicities, religions, and other demographic and

cultural differences resulted in significant differences in behavioral and social norms, including the outcomes Tékponon Jikuagou aims to influence. This will be controlled for in the final analysis, when we compare endline results to these baseline findings to evaluate the intervention. Multivariate analysis will be employed to control for underlying differences between the intervention and the control areas.

## CONCLUSIONS

The study was designed to provide a complete picture of the population living in the intervention and in the control areas before intervention activities begin. This information will be useful to fine-tune the Tékponon Jikuagou package of social network interventions. In addition to background demographic characteristics, we learned about respondents' FP need status through a comprehensive calendar that allowed us to calculate changes in need over a 12 month period. A complete map of ego-centric networks (the network of the individuals interviewed) was developed for each respondent, and the information gathered shows the state of social and individual norms relating to gender equality, family size, child spacing, and FP use.

There are important gender and other social and relational factors at play in communities where the TJ project will be operating, and many unspoken contradictions between beliefs and behaviors that, if clarified could open doors to family planning efforts. While overall support exists for child spacing, FP users may experience stigma if they are known publicly to be using FP. While availability of FP services may be an issue, social factors also influence desires and actions to seek contraception. For example, 69% of women think about using a family planning method, but only 11% of women discussed FP with their partner in the last 12 months and only 10 % took any action in the last month to obtain information or services, alone or with their partner. A significant proportion of women in the baseline, such as those using traditional methods, are at risk of pregnancy even while they think they are protected. Many are unaware when pregnancy can occur at particular moments in the reproductive life cycle, such as during the post-partum period, a critical lack of knowledge that is also leading to unrecognized unmet need. We expect that a set of social network interventions will help break down social barriers by engaging communities. In particular, supporting influential women's and men's groups as well as their leaders to reflect on these social realities and the paradoxes that exist can break social silences, allowing women and men to hear each other's views, and consequently allowing new ideas to diffuse through influential community networks. These results also suggest the importance of interventions to improve understanding of pregnancy risks among women and men at different moments in the reproductive life phase.

While there were minimal differences in levels of unmet need and contraceptive prevalence, we found that the intervention and control areas were quite different in other ways, including basic demographic characteristics, such as ethnicity, religion, prevalence of polygamy, and mean number of children. Network characteristics were also different. Networks were significantly larger, with a higher percentage of same gender members in the control areas than in the control. It is not surprising, therefore, that individual and community norms and behaviors also differed when comparing intervention and control areas.

In general, there was more FP use in the intervention areas than in the control, but the effect was due mostly to the large proportion of traditional method users. Modern method use was a little higher in the control. As a result, unmet need in the intervention areas appeared to be lower,

because the significant proportion of women who were using traditional ineffective methods perceived that their FP needs were met.

While significantly more women in the control areas asked a provider for services in the year preceding the study, the women in the intervention areas felt significantly more enabled to obtain services. In general, attitudes toward FP were more positive than in the control, though there was significant stigma associated with FP use in all areas. Couple communication around the issues related to this project was significantly better in the intervention areas than in the control.

When the endline survey results are available, these significant differences between intervention and control areas will have to be controlled for in multivariate analysis to evaluate the success of the interventions at endline. While perceived unmet need in both intervention and control areas appears to be relatively low, a significant proportion of women believe that they have no physical need for FP (while in fact they do), or that their FP needs are met (when in fact they don't) – both areas that may be positively influenced by the interventions.

## APPENDIX A: LIST OF VILLAGES SURVEYED FOR BASELINE EVALUATION

### INTERVENTION ZONE (COUFFO)

COMMUNE	ARRONDISSEMENT	VILLAGE
APLAHOUE	DEKPO	DEKPO
		LAGBAVE
	KISSAMEY	GBAKONOU
		HEDJINNAWA
		HOUETAN
		TOUVOU
	APLAHOUE	AFLANTAN
		APLAHOUE
		DJIKPAME
		LOKOGBA
DJAKOTOMEY	BETOUMEY	BOTA
		ZOHOUDJI
	KOKOHOUE	KANSOUHOUE
		KOKOHOUE
	KPOBA	KPOBA
SOKOUHOUE	SOKOUSOHOUE	
DJAKOTOMEY I	DJAKOTOMEY CENTRE	
	AGBEDRANFO	
DOGBO	LOKOGOHOUE	HOUNSA
		LOKOGOHOUE
		TOULEHOUDJI
	TOTA	DEKANDJI
		FONCOME II

		HOUEDJAMEY TOTA
KLOUEKANME	KLOUEKANME CENTRE	TROTROYUYU AGBODOHOUIN
	HONDJIN	HONDJIN AKPAHOUE/CENTRE
	TCHIKPE	SOKPAME AKOUEGBADJA
	DJOTTO	DJOTTO YENAWA AKIME
TOVIKLIN	TOVIKLIN CENTRE	DAVI DJIGANGNONHOU TOVIKLIN I
	DOKO	KLEME
	MISSINKO	MISSINKO
LALO	LALO	LALO CENTRE KOUTIME GOULOKO
	LOKOGBA	YOBOHOUE
	ADOUKANDJI	ADOUKANDJI
	ZALLI	KOWOME
	GNIZOUNME	GNIZOUNME

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**CONTROL ZONE (PLATEAU)**

<b>COMMUNE</b>	<b>ARRONDISSEMENT</b>	<b>VILLAGE</b>
ADJA-OUERE	IKPINLE	IKPINLE
		ITA BOLARINWA
	KPOULOU	HOUEDAME
	MASSE	MASSE
		MOWOBANI
		TEFI OKE IGBALA
		OKO DJEGUEDE
	TATONNOUKON	DJIDAGBA
		LOGOU
		OLOHOUNGBODJE
OUIGNAN GBADODO		
TATONNOUKON		
ADJA-OUERE	DOGBO	
	IGBA	
	OBEKE-OUERE	
	OKE-ODAN	
POBE	AHOYEYE	AHOYEYE
		BANIGBE
		ISSALE-IBERE
	IGANA	EGUELOU
		IGANA
	ISSABA	ABBA
		ONIGBOLO
	TOWE	IBATE

		IGBO OCHO TOWE
	POBE	ADJAGOUNLE IDOGAN ISSALIN AFFIN I OKE ATA OKE OLA POBE NORD
SAKETE	AGUIDI	AKPECHI ILAKO IDI ORO KOBEDJO
	ITA-DJEBOU	ADJEGOUNLE
	TAKON	ADJAHOUN KOLLE ITA KO HOUEGBO
	YOKO	GBAGLA YOVOGBEDJI YOKO ARAROMI ET KADJOLA
	SAKETE I	MORO ODANREGOUN
	SAKETE II	WAHI

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## **APPENDIX B: WOMEN'S AND MEN'S SURVEY QUESTIONNAIRES**

## APPENDIX C : CURRENT CONTRACEPTIVE PREVALENCE BY RELIGIOUS AFFILIATION

Women (%)	Intervention				Control			
	No use	Traditional	Modern	Sample size (n)	No use	Traditional	Modern	Sample size (n)
Catholic	60.6	21.3	18.1	94	68.3	12.0	19.7	183
Protestant	47.9	17.7	34.3	96	67.0	11.0	22.0	100
Other Christian	71.1	15.5	13.4	343	68.9	12.3	18.8	537
Traditional/Voodoo	67.6	21.7	10.7	457	82.7	11.5	5.8	52
Muslim	33.3	66.7	0.0	3	72.2	7.7	20.1	169
Animist/none	82.8	11.5	5.7	87	76.9	10.3	12.8	39