

Tékponon Jikuagou: Addressing Unmet Need for Family Planning through Social Networks in Benin

AID-OAA-A-10-00066

Annual Progress Report

October 2012 – September 2013



USAID
FROM THE AMERICAN PEOPLE



TÉKPONON JIKUAGOU
INSTITUTE FOR REPRODUCTIVE HEALTH GEORGETOWN UNIVERSITY
CARE INTERNATIONAL
PLAN INTERNATIONAL

OVERVIEW

The five-year Project Tékponon Jikuagou (TJ), led by Georgetown University's Institute for Reproductive Health (GU/IRH) in collaboration with CARE-International and Plan-International, was launched in September 2010 to test new ways to address unmet need for family planning (FP). The project was initially located in Mali but the March 2012 coup d'état ended project operations before fieldwork began. Consequently, the TJ project relocated to Benin in September 2012, and began a Benin-based partnership with CARE and Plan. One year later, with support from USAID, the MOH and other FP stakeholder groups, the TJ Project is firmly established. As a country beginning FP revitalization efforts, there is much anticipation in Benin how a social-network based approach to addressing FP-related social barriers will influence unmet need and FP uptake. The TJ interventions package (see graphic) aims to create a social environment that allows women, men, and couples to exercise their desire to space or limit births by maximizing use of social networks to diffuse information and ideas. Influential and connected social groups and opinion leaders, identified by communities, catalyze discussions related to planning births and using modern FP options, supported by an enabling environment created by radio and better linkages with FP services. Rigorous monitoring and evaluation will allow us to test the effectiveness of the TJ package in changing attitudes, self-efficacy, couple communication, and to evaluate whether such interventions lead to changes in network dynamics, e.g. more positive FP information flows and related shifts in gender-equitable attitudes and ideation. Related research will lead to new ways to think about and define women and men's unmet need for FP.

Much has been accomplished in 12 months of operation in Benin, and the detailed report that follows attests to such progress. A new team of technical support, management, and field staff have been oriented. Formative research has led to Benin-specific adjustments in network strategies and reflective dialogue materials, which had initially been developed for the Malian context. Household survey research has established a baseline against which to measure the effectiveness of the TJ interventions package. A first round of in-depth interviews with a cohort of women and men has established a baseline to monitor changes in unmet need and social network status over time. Two project advisory groups – the national-level Technical Advisory Group (TAG) and the zonal-level TJ Pilot Committee – have been established and are providing technical and political support for the project. Community social mapping, the base activity to identify a small number of influential social groups and opinion leaders who will act as core social-network diffusers, has been conducted in 64 of 90 villages to be reached during the pilot period. As of April 2013, TJ field staff began supporting the first round of influential groups in using reflective dialogue materials. Field observations indicate that groups are actively engaged in reflective dialogues and monitoring data show that significant diffusion is occurring beyond the immediate groups.

The TJ package is still being rolled out, though. Work is underway to field-test two package components, one that engages influential individuals at village level, the other that uses local radiobroadcasts to engage a wider audience in reflections on unmet need for FP. Active creation of network linkages (nonexistent in most places) between FP providers and influential social groups is also underway. The complete package should be operational by January 2014, and in support of this innovation, discussions with USAID-Washington have opened the possibility of a much-needed sixth year of project funding to allow sufficient time in Benin to pilot, evaluate, and expand the TJ package to new areas.

TJ is monitoring closely how different interventions in the TJ package are working. Observational and monitoring data have already revealed that some adjustments are needed. For example, there are fewer men's groups engaged in TJ activities than women's groups, yet TJ's premise is that women *and* men need to be engaged to effect significant network and social change. Looking forward, as a project preparing for a scale-up phase in 2015, we are constantly challenged with making as simple as possible the TJ interventions package to ensure its scalability.

INTERVENTION COMPONENTS

1 ENGAGE COMMUNITIES IN SOCIAL MAPPING



2 SUPPORT INFLUENTIAL GROUPS IN REFLECTIVE DIALOGUE



3 ENCOURAGE INFLUENTIAL INDIVIDUALS TO ACT



4 USE RADIO TO CREATE AN ENABLING ENVIRONMENT



5 LINK FP PROVIDERS WITH INFLUENTIAL GROUPS



ACCOMPLISHMENTS –OCTOBER 2012 THROUGH SEPTEMBER 2013

	Objectives	Planned Activities	Accomplished
Project Launch	Introduce the TJ Project to FP stakeholders and local communities in the intervention districts	Launch of the Project in Couffo (immediately following the national launch in Cotonou in September 2012)	The official launch of the TJ Project took place outdoors on October 18, 2012 in Djakotomey municipality in Couffo, with full participation from the Secretary General of the Ministry of Health, the Directors of the MCH Division (DSME) and the FP Division, staff from the DDS (Departmental Directorate of Health), district and municipal doctors, the Director of the USAID Health Section and his team, UNICEF, UNFPA, ROBS, PISAF/URC, the Mayor and his team, the village leaders, community leaders and many others. In addition to speeches by the Ministry of Health, USAID and the Mayor of Djakotomey, the ceremony was enlivened by three local groups for community and cultural events who sang messages about FP.
		Introduce the TJ Project at the department level	Three organized visits took place from October 2012 to February 2013 after the launch of the project. The Mono-Couffo health department Director and two area coordinators were visited. These visits made it possible to share the TJ concept and to request their involvement in the implementation of this project in a department where contraceptive prevalence is 4.9%.
		Introduce the TJ Project in round one villages where TJ interventions will be launched	Immediately prior to the start of the December 2012 social and community mapping activities, TJ field agents introduced the project to local authorities. Sixty-four villages were covered by September 2013, representing 71% of the 90 total villages contemplated by Plan and Care for TJ's pilot activities. Both organizations plan to step up this introduction process over the coming months to reach all 90 villages by the end of January 2014.
		Create the Comité de Pilotage (Steering Committee) to engage local leaders at health zone level and hold two (2) meetings	<p>On March 13, 2013 at the Plan-Benin premises in Azové, the first Meeting was held to implement the committee structure, chaired by a mayor of Klouékanmè municipality. In addition, the chief of the DSME/Mono-Couffo was designated as the focal point of the TJ Project at the Mono-Couffo Departmental Directorate of Health. From this point onwards, the committee will hold quarterly meetings to better support and properly take ownership of TJ pilot activities.</p> <p>This meeting was an opportunity to share the TJ concept with different people and especially to mobilize local authorities towards greater involvement. The workshop was attended by the representative of the mayors of the two health zones- Aplahoue, Djakotomey, Dogbo (ADD) and Klouékanme, Tokviklin, Lalo (KTL), the Area Health Coordinators and a representative of the Departmental Health Directorate, midwives from both zones, a women's representative (ADD and KTL) and the TJ agents.</p>

			<p>The second meeting scheduled for July could not take place, as the Director of the Mono-Couffo health department and local authorities were unavailable. It was held instead on 10 September, with all members present, including the mayors of Koulekamé and Djakotomey. The crux of the meeting was to review and clarify proposed responsibilities of the committee: the Mayor of Koulékamé was confirmed as committee Chairman. He called a meeting in early October to further clarify the roles and responsibilities of each member in order to re-launch the Committee.</p> <p>Furthermore, to create synergies with the TAG, the Focal Point in Lokossa was appointed to represent the committee at the TAG meeting held September 17, 2013.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Partner Relations</p>	<p>Hold Partner Advisory Group (PAG) meetings</p>	<ul style="list-style-type: none"> • Hold monthly Benin PAG meetings • Hold monthly Benin – USA PAG meetings until April 2013. After April hold PAG meetings bi-monthly. • Hold monthly USA PAG meetings (as of June 2013) 	<p>Coordination of TJ by the Local PAG</p> <p>Three-quarters (14) of the planned 18 meetings were held. This 22% gap against what was planned was due to the numerous field visits with TJ USA staff. Instead of face-to-face meetings, email and telephone exchanges took place with Plan and CARE colleagues; these meetings have facilitated:</p> <ul style="list-style-type: none"> • Regular times to review the completion of activities • Creation of a team spirit • Propose possible solutions to problems • Keep the entire TJ Team up-to-date <p>Coordination and support by the International PAG</p> <p>Six Benin-USA PAG meetings took place, with others missed due to travel by PAG-USA members and/or field agents during the period from November 2012 to March 2013. In reality, missed meetings were replaced with on-site technical and management support visits to ensure successful installation of the project and start-up of field activities in a new context. The PAG enjoyed regular monitoring and support, well- organized project coordination (particularly since TJ partnerships and ways of working together had to be re-established in Benin), and speed in decision-making to facilitate implementation.</p> <p>Annual project meeting</p> <p>From September 25-28, 2013 the International PAG was held in Bohicon, with staff from Benin and the USA. Members of TJ's 'external' team were also present, including representatives from the TAG, Steering Committee, and USAID.</p> <p>During the three days, the team discussed activities carried out and challenges, discussed the outcome of the project's baseline survey and its implications for project activities and</p>

			<p>strategies, refined the activities planned for FY 2014 and continued to discuss preparations to scale the TJ Package after its pilot phase. This meeting also marked the first project-wide learning and reflection meeting, to be held every six months, in which staff reflect upon and analyze what is working within TJ and implementation lessons learned, as well as to reflect on social changes being observed at village level due to TJ.</p> <p>Key outcomes of this meeting: The team made decisions on content for the radio strategy and for influential leaders, the two missing elements of the TJ package which will be added as of January 2014. Important decisions were made about the way forward in implementation for FY2014, including identifying and refining the full “package” and preparing a work plan containing the steps we must achieve to be ready for FY 2015 scale up phase. The team also refined strategies to improve supply and to establish a link between the community and health workers. Improving the efficiency of the TAG and the Steering Committee was on the agenda, to prepare them for scaling up. The meeting was extremely useful for IRH, Plan, and CARE staff from the HQ and Benin to get to know each other and further establish productive relationships with all partners. (See meeting agenda and several presentations to inform program decision making in Appendix B.)</p> <p>Other coordination meetings Additional meetings – onsite and distance- took place between Plan and Care to facilitate field operations relating to: harmonization of intervention implementation and budgeting, developing TJ reflective dialogue materials, deepening staff understanding of gender issues within TJ, preparing for community social mapping, determining coaching strategies for catalyts needing additional support, and conducting a rapid assessment of FP services in areas reached by the project.</p>
	<p>Conduct joint field visits with the Ministry of Health, IRH, CARE and Plan to learn first-hand of TJ field activities.</p>	<p>Complete two (2) joint field visits (TJ and the Ministry of Health)</p>	<p>Given that the actual start of activities only took place in April 2013, and taking into account travel by TJ personnel and holiday periods, it was only in September that TJ staff made a field visit with the Ministry of Health. This visit took place from September 8 to 11, 2013 in Couffo, specifically in Dogbo and Klouekamé with staff from the central MOH, CARE, Plan, and IRH.</p> <p>Findings:</p> <ul style="list-style-type: none"> • The Mayor of Dogbo is very involved in TJ activities and especially sensitization the community on birth spacing, hosting a monthly radio show on this topic. As an influential person, he is modeling open communication on sensitive issues. The Mayor of Klouékamé is the Chairman of the Steering Committee, and he says he finds TJ is trying to improve the new FP user numbers. • Discussions with health personnel involved in FP indicated they have noticed a

		<p>change in number of people seeking FP since TJ activities have started.</p> <ul style="list-style-type: none"> The field visit allowed direct observation of TJ groups in action using the reflective dialogue materials and the groups' intense involvement in discussions, indicating that the materials were working in catalyzing discussions on social factors influencing unmet need for FP.
	Complete twelve (12) field supervision visits (CARE and Plan)	The 12 planned supervision visits were carried out, making it possible to reinforce regularly skills of staff and volunteers in the field, assure quality of data collection, and harmonize approaches taken by CARE and Plan in their respective implementation areas.
Hold monthly project coordination committee meetings	Hold monthly coordination meetings (by the Program Committee and the Monitoring, Learning and Evaluation Committee).	<p>These two structures operate to ensure clear communication about project activities and accomplishments, share experiences, coordinate joint activities and to troubleshoot challenges or delays that may arise. See PAG section, above, for updates on the Program Committee (essentially the PAG). See Monitoring section, below, for updates on the M&E Working Group. In addition, other inter-partner meetings were held, noted below, to ensure coordination and joint planning around specific events.</p> <p>CARE/PLAN Joint Implementation Meetings CARE and PLAN conducted all planned monthly joint implementation meetings. Held monthly, these meetings bring together six facilitators (6 in the ADD health zone and 6 in the KTL health zone), led by the two area coordinators and the two Plan and CARE national supervisors. Issues discussed usual related to implementing field activities and solutions for bottlenecks.</p> <p>Plan/CARE/IRH Telephone Meetings Several phone meetings were held during the period for improving coordination of activities between the partners. These are organized according to need; one discussion took place on July 22, concerning the budget, several planning meetings were held in preparation for the International PAG meeting in September, other meetings focused on sessions on the International Conference on FP to be held in Addis Ababa.</p>
Consolidate Benin TAG membership and TAG contributions to TJ.	Hold first Benin TAG meeting hosted by MOH	The Technical Advisory Committee (TAG) was instituted by Decree No. 0424 of September 2012 by the Health Minister. One of the TJ project 'pillars' in terms of supporting innovation to address unmet need in Benin, the TAG currently includes 20 members with Deputy Chief of Staff of the MOH as chairman. This committee, located within the cabinet of the Minister of Health, allows for greater ownership of TJ's aims, and contributes to Recommendation (8) of the 2011 Ouagadougou conference, <i>"Addressing the institutional anchoring of family planning to aim for high-level commitment."</i>

After several attempts to meet the schedule of a majority of members, the first TAG meeting was held on January 15, 2013 in the conference room of the MOH. USAID and UNFPA representatives were present at this first meeting.

The TAG validated the TJ Logo, the name "*Tékponon Jikuagou*" which means "help in all ways possible to reduce child mortality", and the TAG and the steering committee missions. A decision was taken to review the list of TAG members, taking into account gender (most members being men) and a letter was sent to the various member organizations asking them to send women as representatives. In addition, to install a link between the TAG and the steering committee, the chairman of the steering committee joined the TAG as a member. An operational plan was developed, with the activities supported by TJ such as, 'ensuring services support to increased demand by ensuring health facilities had the more current normative documents for RH/FP'.

On Sept 17, 2013, the TAG held their second meeting of the year in the DSME conference room; all members were present except USAID. Six new members were present, all women, representing the following organizations: Population Reference Bureau/IDEA, Faculty of Health Sciences, Belgian Cooperation, Netherlands *Partenariat pour la Prise en charge Communautaire de la Santé Infantile* project (Partnership for Taking charge of Community Child Health (PRISE-C)), and *Association Béninoise de Planification Familiale* (Benin Family Planning Association).

Bottlenecks were identified in the TAG's functioning, such as: lack of Comité de Pilotage and TAG interactions (proposed solution: presence of a TAG representative at the Comité de Pilotage meeting and vice versa); the lack of long-acting FP commodities at some centers (proposed solutions: the Ministerial Representative stated that he had sufficient stock at central level and would approach the DDS to find out actual needs and deliver). Exchanges took place on scaling up (where, when and with which organizational partners) and discussions took place on the roles and responsibilities of partners, MOH, and TAG.

The TAG validated TJ reflective dialogue materials at this meeting.

	<p>Provide regular updates to and meet with USAID Benin and MOH DSME.</p>	<ul style="list-style-type: none"> • Meet monthly with USAID point person, followed by e-mail communications confirming decisions to all partners. • Establish formal meeting schedule with MOH point person and begin to meet regularly. 	<p>USAID</p> <p>Good communication has been set up between the TJ Project and the USAID Health Team (Dr Milton Amayun and Michelle Kouletio). The Health Team has greatly contributed to integrating the TJ Project in Benin into the FP program arena and revitalization efforts.</p> <p>The quarterly meeting of the health programs and projects funded by the Benin and Washington missions was held on January 25, 2013 at USAID premises. This opportunity was taken to share the concept of the TJ Project and to conduct advocacy vis-a-vis organizations providing FP to work with TJ to make services available and accessible in areas reached by TJ. The following were present at this meeting: the PNL (National Malaria Control Program), ARM3, CIDA, MCDI, CREC, DSME, PRB and TJ. Unfortunately, it was not possible to participate in two subsequent quarterly meetings due to travel and other commitments.</p> <p>TJ partners provide briefings to the USAID Health Team and the USAID Director during USA TJ Team's visits to Benin to provide information on current activities and exchange information on future events of mutual interest. Two meetings were held between the TJ Team and the US Ambassador to Benin to share the concept and current activities with him. At the request of the Ambassador and the USAID Director, a field trip will be organized to the intervention zone. This visit should be organized by the end of 2013.</p> <p>MOH</p> <p>TJ has integrated fully into MOH coordination and planning activities and has a recurring appointment to meet monthly to provide updates to the MOH. In case of absence or unavailability due to travel, these updates are done by email. (Ministry staff receive additional updates through attendance at TAG meetings.) TJ was also represented in two bi-annual meetings for technical and financial partners of the MOH; representatives also attended two quarterly work planning workshops, led by the technical working group for sexual and reproductive health and maternal health.</p>
--	---	---	---

<p style="text-align: center;">Materials Development</p>	<p>Finalize reflective dialog materials for use in social network-based interventions</p>	<ul style="list-style-type: none"> • Adapt the Creative Brief based on findings from the Benin formative research. • Test and finalize materials: stories and activity cards. • Introduce Round 1 reflective dialogue materials at community level and finalize Round 2 materials and tools for reflective dialogue. 	<p>A first set of TJ reflective dialogue materials, originally developed for use in Mali, was adapted to the Benin context, pretested and finalized in December 2012. CARE-USA TJ staff provided on-site technical assistance in December followed by on-site technical assistance by Plan-USA TJ staff in March 2013. Three major activities were carried out:</p> <ul style="list-style-type: none"> ○ Training TJ teams (facilitators, zone coordinators and national supervisors) on use of the reflective dialogue materials, from March 19-20, 2013 ○ Training catalysts to use the same tools on March 21, 2013 ○ Use of the reflective dialogue materials by catalysts within their group began in late March. Eighteen catalysts, nine per health zone (ADD and KTL) were included in this first round. ○ This marked the beginning of community interventions by the catalysts within influential social groups. <p>The reflective dialogue materials were finalized and validated by the MOH on September 17, 2013 (validation of phase 1). The printed material has been available in TJ's two health zones (KTL and ADD) since September. As of late September, only the Lalo catalysts in KTL health zone are not in possession of materials.</p> <p>According to catalysts, the materials are easy to use. Stories remain the most-used material because of the cultural practice of oral storytelling and how comfortable catalysts feel using stories versus activity cards. Conversely, the number of instructions on the Activity Cards should be reviewed to simplify their use.</p> <p>A 'How To' guide for field workers was finalized to guide use of the community social mapping tool, which leads to decisions on selection of influential groups and persons with which to work in each village to catalyze dialogue and debate. See Appendix C.</p>
<p style="text-align: center;">Interventions</p>	<p>Implement social network-based interventions.</p>	<p>Complete community mapping to identify social groups and influential individuals (leaders) with whom to work.</p>	<p>As of September 2013, mapping has been conducted in 64 villages (exceeding the target of 60 villages by September). This mapping has allowed us to identify 194 influential groups, 194 catalysts (one person from each group who catalyzes dialogue and activities), and 329 influential people willing to work with TJ to reduce unmet need. Since April 2013, 194 catalysts have led discussion activities in 64 villages around the dialogue materials. These activities are conducted approximately once per month during regular group meetings.</p>

		<ul style="list-style-type: none"> • Train catalyzers to use intervention materials to lead group discussions on FP and social barriers to acting on unmet need. • Support catalyzers in TJ activities. 	<p>By September 2013, almost all catalyzers (86%) had been trained and 85% had begun TJ activities in their groups. After several months it became apparent that some of the catalyzers required more support to facilitate TJ activities and on-site coaching began. This led to development of coaching guidelines. In addition, this led to the decision to train the next round of catalyzers over three days, instead of the original 2 days, to allow them more time to practice using the TJ materials (and reduces the need for coaching in the process). No village is ready yet for 'graduation,' that is, has reached a point where staff support to catalyzers is no longer necessary to do TJ activities.</p> <p>Final training for the remaining 28 catalyzers is planned for Oct. 16 - 19 (in Dekpo and Sokouhoue).</p>
		Orientation of TJ field staff on family planning.	While experienced in HIV/AIDS programming, field and Cotonou-based staff in CARE, Plan, and IRH did not have extensive program experience in community-based FP, thus an orientation was held June 20-21, 2013 to provide staff basic information on fertility and FP programming and contraceptive technology (general information on FP, contraceptive methods, management of false rumors, etc.).
		Complete a rapid FP services capacity assessment of local health facilities serving villages where TJ operates.	<p>In July, data collection by Plan and Care was completed in over 20 health facilities operating in TJ-supported areas. Analysis was completed in September and results revealed uneven FP services availability in areas where TJ operates, with gaps in trained providers and commodities availability in some sites. Not many relais connected to health facilities had been trained in FP.</p> <p>Results were presented and discussed at the international PAG meeting in September. Key findings by facility will be developed so that CARE and Plan can share and discuss the findings with the Comité de Pilotage, providing them evidence to organize targeted training in FP and to advocate for critical resources to address gaps in FP supply and service provision that exist, thus ensuring that supply can meet demand for FP created through TJ activities. (See Appendix D for the presentation of key findings of the rapid assessment.)</p>

		Making contact with influential individuals.	While CARE and Plan staff have worked with community leaders in past projects, the aim has been mostly information-sharing and coordination. TJ is pursuing a more activist approach by leaders, in which they themselves define what actions they plan to take to address unmet need for FP based on their interest and ability to act. Thus, contact was made by CARE and Plan with 329 influential people identified in two health zones in the last quarter to survey ideas around how influential individuals are considering contributing to TJ goals. These results were presented at the international TJ meeting in September and a strategy was discussed to work with influential individuals. Guidance will be provided to facilitators in 2014 to launch activities with/by the influential leaders.
Research	Barrier Analysis (Focus Group Discussions)	Hold focus group discussions (FGDs) with different groups, including users/non-users and men/women, to ascertain barriers and motivators to family planning use.	<p>Consultant-researchers hired for the cohort interviews were trained in late October to conduct a barrier analysis using focus group methodology to validate socio-cultural similarities between Mali and Benin related to FP use. The situational analysis (formative research) was completed in November 2012 to allow TJ to make several adjustments to the reflective dialogue materials that had already been developed. In addition, a pre-test of the community mapping tool was done in five villages in Couffo: Akouègbadja, Doko and Lagbakada (KTL), and Bota and Avedogo (ADD). The type of information collected focused on potential barriers, including people who influence couples' decisions around fertility and the use of FP, stigma related to FP use, and other social barriers related to public discussion about FP.</p> <p>Following the interviews, community mapping was done in each of the test villages with a group of married women of childbearing age and with a group of men married to women of childbearing age to learn about barriers and opportunities. In-depth interviews were also conducted with three community leaders. IRH, CARE and Plan staff participated in these latter activities, as well as the four consultant-researchers.</p> <p>Findings indicated that there were quite a few similarities with Mali and some important differences in social barriers and social network support. Please see next section.</p>
	Analyze formative research from Benin	Complete analysis of all formative research in Benin.	<p>A draft report compiling findings from the different sources of formative research (literature review, results of community social mapping, participatory community learning activities, key informant interviews, and focus group discussions) was circulated in November to partners for comments. The final report was included as an attachment in the semi-annual report for October 2012-March 2013.</p> <p>Based on these findings, IRH provided specific comments to CARE and Plan to use in finalizing TJ's reflective dialogue materials.</p>

<p>Conduct baseline in intervention and control communities.</p>	<ul style="list-style-type: none"> • Orient the contracted research organization to the project, research protocol, and tools. • Conduct a population-based survey in the intervention and control communities to establish a baseline. • Analyze data and write a report; disseminate results and share the report. 	<p>Prior to data collection, approval for the research protocols was obtained from the Cotonou-based <i>Institut des Sciences Biomédicales Appliquées</i> (Institute of Applied Biomedical Sciences) and Georgetown University (Institutional Review Board). Also, a study authorization letter was obtained from the Benin Ministry of Health.</p> <p>The survey included questions to map respondents' egocentric (personal) networks, gather information on unmet need as well as attitudes and other FP-related information following the project's results framework indicators. IRH (USA and Benin staff) technically supported Centre de Recherche d'Appui-conseil pour le Développement (CRAD) and oversaw all research activities.</p> <p>The Plateau was selected as a control area due to a similarity with Couffo in terms of the following criteria: 1) contraceptive prevalence rate, 2) rate of unmet need for FP, and 3) population density. (Mono, though closer in social and cultural terms, was not selected because of differences with the criteria mentioned above. Baseline results indicated that there were other differences between intervention and control sites and these socio-demographic data will be statistically controlled during endline research analysis.)</p> <p>On June 3, the preliminary report of the household survey was sent to the IRH and on September 23, 2013, program-focused findings were presented during the international TJ Project meeting in Bohicon. The baseline report has been drafted and will be shared at additional dissemination meetings for Cotonou-based stakeholders and the TAG in late 2013 and early 2014. See Appendix E for the draft report.</p>
<p>Conduct Round 1 & 2 cohort interviews in intervention and control communities.</p>	<ul style="list-style-type: none"> • Recruit, hire, and train researchers to conduct in-depth interviews. • Conduct cohort interviews with 25 men and 25 women in the intervention areas every six months. • IRH and interview team analyze data, supported by research staff in Benin and Washington, DC. 	<p>In January 2013, CARE and Plan facilitators helped IRH identify participants for in-depth interviews in each health zone. In all, 25 men and 25 women were selected to participate (in 12 villages, two in each commune). Selected participants represented a range of FP need statuses (met/unmet/no need) and social network status (influencer, connector, isolate). One round of 50 cohort interviews had been completed by CRAD interviewers by February 2013, just prior to beginning intervention activities. The first-round interviews explored content, quality, and frequency of FP information shared between network members as well as interviewees' understanding of their unmet/met need status and reasons for using (or not) FP.</p> <p>Interviews have been transcribed and translated in French, and summarized. The code book was 'field-tested' by the analysis team to ensure inter-rater reliability of analysts during coding. Data are in the process of being analyzed by a multi-cultural team of US and international TJ staff, using ATLAS-ti.</p> <p>A second round of cohort interviews was planned in this reporting period. Since the first</p>

			set of interviews was delayed due to issues obtaining IRB approvals and authorizing letters in Benin and the US, though, the second round will occur in November 2013.
Monitoring	Design and implement a project monitoring system, including activating Partner MLE Working Group.	Develop an MLE plan and begin collecting activity monitoring data.	<p>Drafting Workshop for the Project Monitoring Plan</p> <p>Development of the Monitoring, Learning and Evaluation (MLE) plan began prior to the current reporting period. A full draft plan was included in the semi-annual report submitted in May 2013.</p> <p>From March 13-15, 2013, a Cotonou-based workshop was organized to start finalizing the MLE Plan, including data collection tools, and to establish the MLE committee, comprised of staff responsible for MLE in each organization, CARE and PLAN zone coordinators, totaling five members. Participants validated said committee's terms of reference, which defines the roles and responsibilities of the various members involved in the process of collecting monitoring data.</p> <p>Subsequently, draft data collection tools were tested by the TJ Team from March 21-22, 2013 in Djakotomey municipality.</p> <p>A second MLE workshop was held from March 25-27, 2013 in Cotonou to finalize the plan and tools, led by IRH-Washington, DC research staff. The same staff met again to finalize the plan and the MLE process. During the workshop, monitoring indicators were refined and data collection tools were finalized, based on the tool pre-test. Reporting tools, such as the catalyst logbook, are designed simply, with illustrations, to facilitate use by village-level catalysts.</p> <p>Partners began collecting data using monitoring tools in April and continued to adjust the process in early months based on user feedback.</p>
		Hold monthly MLE Committee meetings to ensure consistency in data collection and provide regular feedback to the PAG for project decision-making.	<p>Monitoring, Learning and Evaluation (MLE) Committee</p> <p>The MLE Committee meets monthly to monitor indicators, to summarize information, and to provide it to the PAG to direct the program. These regular meetings are designed to improve the reporting system and ensure data quality. Since inception, there have been four meetings of the CSAE. Several meetings did not occur due to the TJ personnel being in the field.</p> <p>The MLE Committee began to share results with the Benin PAG during their regular meetings and on an ad hoc basis via email. A quarterly summary of data was presented during the International PAG Meeting in September to review trends and spark discussions on what was happening/not happening in terms of TJ package implementation.</p>

		Complete six M&E supervision visits (IRH).	All monitoring activities planned by IRH were conducted. These specifically involved supervising research (quantitative and qualitative data collection) and formative research.
		Complete two joint field visits(MLE Committee).	The MLE Committee made two successive field visits to enhance the quality of data reporting by catalysts. During these visits, a day dedicated to data analysis day took place to identify trends and improve monitoring strategies project-wide.
		Host a project wide 'reflection and learning' event to allow staff time to analyze and document intervention processes and challenges, and evidence of social change and networks changes observed at community level and project reactions/support of such changes.	<p>One component of M&E involves TJ's learning agenda, which is focused on experiential learning by project staff as interventions are rolled out. Reflection meetings are planned every six months to share and collect staff observations, engaging staff in analysis of what is working/not working within the interventions as well as documenting social changes observed at community level, such as diffusion, public dialogue, and gender attitude shifts.</p> <p>The first reflection meeting was held in September, as part of the International PAG meeting. Key findings from this half-day session are below:</p> <ul style="list-style-type: none"> • Signs of social change. There are definitely signs of social change being observed by staff. Tracing of change pathways revealed the non-linear nature of change and importance of social connections. • Reflective dialog materials. The materials work well in engaging people in discussions. Stories tend to bring out more reflection than the activity cards. TJ needs to further simplify activity cards and to adjust some of the requested activities that the cards ask villagers to do. Missing themes for reflective dialog was identified based on observations and questions asked during group reflections, including support for infertile couples (infertile couples don't see themselves as involved in TJ). There was also concern that men's perspectives were not highlighted enough in the stories. • Catalyzers and project support. Some catalyzers cannot function independently after their orientation – reasons of language and facilitation skills – so staff suggested a six-month refresher after the first orientation. In addition, staff need guidance on when to stop project support to catalyzers (passing the baton concept). There is need for a more systematic strategy to link catalyzers with health agents. • Community social mapping tool. Staff thought that the two-day activity works better when days are spaced out, i.e., not consecutive. Some questions need to be adjusted (they touch on sensitive issues and groups are not comfortable responding to questions that way they are being worded/asked). There is some concern whether the actual mapping activity provides sufficient new information to warrant the community's time to complete.

Communication/ Dissemination	Share lessons learned and results of Project TJ.	<ul style="list-style-type: none"> • Disseminate research findings and project progress information through a number of events and a variety of communication channels. • Develop a strategy to share research reports with a larger audience. 	<p>IRH presented results of the formative research in Mali using a social network census at the Population Association of America meeting in April and will share the project's stigma framework and findings at the October APHA conference. Several presentations on TJ will also be made at the International Conference on FP in Addis in November, including:</p> <ul style="list-style-type: none"> ○ Le Bénin au point de décollage de la Planification familiale ○ From research methodology to community-action methodology: Applying social network analyses to tackle unmet need for family planning in Benin ○ Different methods, different cultures, different approaches – comparing social network analysis results of unmet need in Mali and Benin ○ Applying stigma as a conceptual framework to address unmet need for family planning: A new way forward? <p>In addition, a workshop on social network approaches and use of community social mapping will be conducted by TJ staff within the IBP 'best practices' stream of the conference program.</p> <p>A plan for communications products and target audiences was drafted during the US Senior PAG meeting held in June 2013 to ensure that TJ information is shared more broadly within research and FP program communities, as well as locally in Benin.</p> <p>The Project TJ page on IRH's public website has been updated with new materials including a 2.5 page project description, presentations and program documents from the September international partners meeting.</p>
	Write and submit TJ-related articles to peer-reviewed journals.	Draft, edit and submit for publication an article on social networking based on the results of the social network census and mapping and the in-depth interviews that took place in Mali in 2011-2012.	Two articles based on information from the social network analysis research in Mali are currently under preparation with plans to submit to peer-reviewed journals. One article will focus on results of the social network analysis; the other will focus on the unmet need algorithm developed by the project.

SIX-MONTH WORK PLAN AND INTERNATIONAL TRAVEL SCHEDULE (October 2013 – March 2014)

	Objectives	Planned Activities	Tentative International Travel
Partner Relations	Hold Partner Advisory Group (PAG) meetings	<ul style="list-style-type: none"> • USA-Benin PAG updates meeting (telephone calls every 2 months) • USA-Benin PAG planning and reflection/learning meetings (2x/year – this FY meetings are planned for March and July 2014) • Benin PAG (1x/month) 	<ul style="list-style-type: none"> • International PAG Meeting / TA visit in March 2014: Igras, Grant, Cucuzza, Rubardt, (new IRH Program Officer, potentially) • International PAG meeting/TA visit in July: same as above, plus Lundgren
	Hold monthly project coordination committee meetings	<ul style="list-style-type: none"> • IRH will lead monthly coordination committees (Program/PAG and MLE Committees) in Benin. • IRH will lead Senior PAG meetings, planned monthly in the US (monthly telephone calls and one Washington, DC-based face-to-face meeting planned for May 2014) to ensure coordination, clear communication, systematic sharing of project activities and accomplishments, and to troubleshoot challenges or delays that may arise. 	
	Consolidate Benin TAG membership and organize first meeting.	<ul style="list-style-type: none"> • Hold regular TAG meetings hosted by MOH every six months. Meetings will focus on TJ support including advocacy for quality FP services, review of materials, planning and supporting the scale-up phase. • Comité de Pilotage meetings planned every 3 months. 	
	Provide regular updates to and meet with USAID Benin and MOH DSME.	<ul style="list-style-type: none"> • USAID-Washington meetings (every 2 weeks). • USAID-Benin (each month + quarterly program meetings for all health projects). • Quarterly program review meetings led by the MOH/DSME. 	

Materials Development	Revise materials based on field experience, TAG input and baseline data	<ul style="list-style-type: none"> • Ensure facilitators use all activity cards and stories to assess ease of use by groups by December 2013. • Review and revise reflection materials as needed (stories and activity cards), with an eye to contextualizing based on research and assessment findings and simplification and reformatting to facilitate use. • Develop radio broadcast content from written materials. 	TA visit in January by Rubardt
Interventions	Complete pilot social network-based interventions.	<ul style="list-style-type: none"> • Finalize plan of radio component of the TJ package and begin implementation by December 2013. • Finalize strategy for working with influential (the other remaining component of the TJ package to be implemented), orient TJ facilitators, and begin implementation by January 2014. • Facilitators to link local health workers to TJ groups between November and March. 	TA visit in Nov by Grant
Promotion of FP Services Access	Conduct activities to promote services availability	<ul style="list-style-type: none"> • CARE, Plan, and IRH to share results of the rapid assessment of FP services conducted in August 2013 with Comite de Pilotage and TAG to advocate for more trained providers, relais, and quality services including commodity availability at health center level (Nov-Dec 2013). 	
	Prepare for 2014 'Each One Invites 3' Campaign	<ul style="list-style-type: none"> • IRH to obtain approval from the MOH (central and zonal) for the social diffusion campaign that asks satisfied FP users to approach friends not yet using FP, talk about their satisfaction using FP, and encourage friends to seek information and services using an invitation card. • CARE to develop invitation postcard and guidance document to implement the campaign. 	TA visit in July by Rubardt, Cucuzza
Preparation for Scale-Up	Documentation of social network approach process	<ul style="list-style-type: none"> • Define TAG role in scale up and gain TAG consensus on their role. • Disseminate research findings and early results of pilot activities to inform central decision makers and influential FP actors of TJ progress and findings. 	
Research	Disseminate baseline survey results	<ul style="list-style-type: none"> • Planned meetings with MOH and TAG. • Finalize report of preliminary findings to share with MOH and USAID in Benin. 	

	Analyze Round 1 cohort interviews	<ul style="list-style-type: none"> • IRH and Plan staff to code and analyze Round 1 transcripts and prepare report of key findings by March 2014. 	
	Conduct Round 2 cohort interviews in intervention communities.	<ul style="list-style-type: none"> • Interviewers will conduct Round 2 in-depth interviews (November). The cohort includes 25 men and 25 women in the intervention areas, interviewed every six months, beginning before intervention activities started. Participants represent a range of FP need statuses (met/unmet/no need) and social network status (influencer, connector, isolate). The interviews will explore content, quality, and frequency of FP information shared between network members as well as interviewees' understanding of their unmet/met need status and reasons for using (or not) FP. 	Diakite to travel to US to work with Lundgren and research staff to prepare for second round analysis (potentially in March)
	Costing Study	<ul style="list-style-type: none"> • Confer with costing experts in the US about developing a plan and data collection tools that will allow costing of offering the TJ package (study to begin in 2014). 	
Monitoring	Continue to implement project MLE system	<ul style="list-style-type: none"> • Continue monthly MLE Committee meetings and regular feedback of findings to PAG. • Continue quarterly monitoring trips and data quality assurance. • Host a second learning and reflection meeting with all staff (March 2014). 	
Gender as a Cross-cutting Theme	Begin implementing gender reflection activities with project staff	<ul style="list-style-type: none"> • Implement a series of gender reflection activities with TJ staff, to be held during regularly-planned meetings (led by Plan). • Plan, CARE, and IRH to explore at village level why men are under-represented in TJ activities and revise project strategy in ways that accommodate male participation (first quarter). 	

Communication/ Dissemination	Develop and disseminate communications materials and engage in conference and meeting activities to increase project identification and share lessons learned and results of the TJ Project	<ul style="list-style-type: none"> • Develop and disseminate briefs on Project TJ: measurement of unmet need, formative research in Mali, overview and results-to-date of TJ pilot. • Disseminate electronically TJ's Community Social Mapping Guide (English and French versions). • IRH will present 5 papers at APHA and ICFP (see main narrative) and co-host and SNA Workshop at the ICFP. • IRH will present at the annual meeting of USAID research CAs in December 2013 • Develop info graphic and visual representation of TJ package (multi-use) • Continue to update the "Project TJ" page on the IRH website, www.tinyurl.com/terikunda-jekulu 	ICFP travel in November: Lundgren, Diakite, Moulaye
	Write and submit TJ-related articles to peer-reviewed journals.	<ul style="list-style-type: none"> • Finalize and submit for publication an article on social networking based on the results of the social network census and mapping and the in-depth interviews that took place in Mali in 2011-2012. • Draft an additional paper discussing analysis of the baseline household survey results. 	

ATTACHMENTS

- 1. Timeline of Key Activities through End of Project (Revised)**
- 2. International Partners Meeting (Sept. 2013) Agenda and Presentations**
- 3. Community Social Mapping Guidelines**
- 4. Health Facility Assessment Findings**
- 5. Draft Baseline Household Survey Report**

APPENDIX A:
Timeline of Key Activities through End of Project (Revised)

TJ Project – Key Activities Roadmap

SCALE-UP																		
MALI Project Startup, Formative Research and Initial Development of Interventions	Benin Launch	TAG 1 st Mtg			TAG 2 nd Mtg		TAG Mtg		TAG Mtg		TAG Mtg		TAG Mtg		TAG Mtg		TAG Mtg	
	Preparation for expansion									Scale-up phase (18 mo.)								
	SOCIAL NETWORK BASED INTERVENTION PILOT																	
	Interventions refined (Benin)				FP Sit Analysis													
	SN scalable materials development & testing				SN Activity rollout including staff and catalyzer training (24 mo.)													
	Comm-unity Intro		Catalyzer Training				Orient leaders. Add radio											
	Community social mapping																	
	Development of SU guides + finalization of TJ intervention pkg																	
	RESEARCH AND MONITORING, LEARNING & EVALUATION																	
	Benin SN assessment																	
		MLE design		MLE training		Data collection begins												
		Pilot Baseline								Pilot Endline						SU Phase Evaluation		
		Cohort IDIs				Cohort IDIs		Cohort IDIs		Cohort IDIs								
				Learning reflection				Learning reflection		Learning reflection		Learning reflection		Learning reflection		Learning reflection		
Oct 2010 – June 2012	Jul-Sept 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	Jul-Sept 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	
Project Startup in Mali		Project Startup in Benin, Development of Interventions, and Refine Pilot				Lay Scale-up Foundation				Expansion to Scale-up District Zones				Scale-up, Seed Activities for Next Expansion & Intervention Evaluation				
YEAR 1	YEAR 2		YEAR 3			YEAR 4			YEAR 5			YEAR 6 (proposed)						



Projet TJ – Feuille de Route des Activités Clés

MISE A ECHELLE																		
MALI Démarrage du projet, recherche formative, et développement initiale des interventions	Transfert au Benin/ Lancement	1e Réunion TAG			2e Réunion TAG		Réunion TAG		Réunion TAG		Réunion TAG		Réunion TAG		Réunion TAG		Réunion TAG	
	Préparation pour expansion										Phase de Mise à échelle (18 mo.)							
	PILOTE DES INTERVENTIONS BASEES SUR LES RESEAUX SOCIAUX																	
	Intervention raffinée (Benin)				Analyse Sit. PF													
	Développement et test des matériels pour mise à échelle				Mise en œuvre des activités y inclus la formation du staff et des catalyseurs (24 mo.)													
	Intro dans la Comm.		Formation Catalyseur						Orientation leaders / radio									
	Cartographie socio-communautaire																	
											Développement de Guides Mise a Echelle + finalisation Pqt TJ							
	RECHERCHE, SUIVI, APPRENTISSAGE ET EVALUATION																	
	Evaluation réseaux sociaux Benin																	
		Conception SAE		Formation SAE		Commence collecte de données												
		Etude Base										Etude Fin				Eval Mise à Echelle		
		Cohort Entr Appr				Cohort Entr Appr		Cohort Entr Appr		Cohort Entr Appr								
						Réflect Appr		Réflect Appr		Réflect Appr		Réflect Appr		Réflect Appr		Réflect Appr		
Oct 2010 – Juin 2012	Jul-Sept 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	Jul-Sept 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	
Démarrage du Project au Mali		Démarrage du Project au Benin, Développement des Interventions et Raffinement du Pilote				Poser les Fondations de la Mise a Echelle				Expansion au Zones de Mise a Echelle				Mise a Echelle, Activités de Base pour Prochaine Expansion, & Evaluation d'Intervention				
ANNEE 1	ANNEE 2		ANNEE 3			ANNEE 4				ANNEE 5				ANNEE 6 (proposée)				



APPENDIX B:

International Partners Meeting (Sept. 2013) Agenda and Presentations



Réunion Internationale du Projet TJ du Groupe Consultatif des Partenaires (PAG)
25-27 Septembre 2013
Objectifs et Ordre du Jour

Objectifs de la Réunion :

1-Réfléchir sur le chemin parcouru à ce stade de la mise en œuvre du projet TJ, où nous souhaitons aller d'ici à 2016, et ce que nous devons faire au cours de l'année 2014 pour y parvenir.

2-S'accorder sur de nouvelles composantes du programme TJ et leur intégration dans les activités en cours : a) rôle et stratégies des émissions de radio, b) rôle et diffusion des activités par des leaders influents, c) création de liens entre les groupes et les services de santé au niveau de la communauté et des établissements.

3-Partager les résultats de la recherche de base et les résultats de l'évaluation rapide des services de PF et déterminer les implications pour les stratégies et les composantes du Projet TJ.

4-Elaborer un plan opérationnel pour préparer la mise à l'échelle : a) finaliser la sélection de la zone de mise à l'échelle et du partenariat, b) parvenir à un consensus sur la façon de faire du TAG et du Comité de Pilotage des acteurs viables dans la préparation de la mise à l'échelle, c) discuter des éléments qui doivent ou non être mis en place pendant la mise à l'échelle et comment déterminer cela au plus tard au début de l'année 2014.

5-Réfléchir ensemble sur les changements observés au niveau de la communauté, en particulier les questions relatives à la mise en œuvre des composantes du Projet TJ et les réactions de la communauté à ces activités, aux dialogues de réflexion, aux changements relatifs aux questions de genre, et aux autres changements en matière de rôles sociaux, etc.

Mercredi 25 Septembre		
Horaire	Activité	Modérateur
9h00 - 9h15	○ Bienvenue et passage en revue des objectifs de la réunion (15 min)	Ghislaine
9h15 –11h00 (pause de 15 min pendant la session)	BLOC 1 – Faire le point : Quel est le chemin parcouru ? Où souhaitons-nous aller d'ici a 2016 ? Que devons-nous accomplir au cours de l'année 2014 ? <i>Résultat attendu : Nouvel accent sur et compréhension commune des objectifs et des approches de ce projet de recherche-a-la-pratique-a-la-mise à l'échelle</i> ○ Mises à jour organisationnelles : Que s'est-il passé depuis les réunions des mois de mai et de juin 2013 au Bénin et aux États-Unis (IRH, Plan, CARE – 15 min/org) ○ Examen et discussions au tour de système de monitoring et du tableau des activités clés (IRH, 30 min)	Ben
11h00-12h30	BLOC 2 : Réexamen de 2 concepts 'piliers' de TJ – l'approche de réseaux sociaux et sa mise à l'échelle - Quelles doivent être les pratiques de mise à l'échelle du Projet TJ ? <i>Résultat attendu : Passage en revue des principaux concepts et stratégies possibles de mise à l'échelle du Projet TJ</i>	Rebecka, Susan

	<ul style="list-style-type: none"> ○ Recyclage sur les réseaux sociaux et les approches des réseaux sociaux (15 minutes) ○ Recyclage sur les concepts de mise à l'échelle et leur application dans le projet TJ (15 min) ○ Discussions (60 min) 	
12h30-13h30	Déjeuner	
13h30-15h00	<p>BLOC 3 : Résultats des recherches de l'enquête des ménages - Qu'est-ce que cela signifie pour TJ ? <i>Résultat attendu : Idées sur ce qui devrait / pourrait être ajusté dans nos stratégies d'intervention des réseaux sociaux, et sur ce qui pourrait être ajoutée aux interventions à la radio et dialogues réflexifs.</i></p> <ul style="list-style-type: none"> ○ Présentation sur les résultats de l'enquête de base (30 min) ○ Discussion : Quelles étaient les attentes ? Quelles ont été les surprises ? Qu'est-ce que cela signifie pour TJ ? (60 min) 	Mariam
15h00-15h30	Pause	
15h30-17h30 <i>(pause de 30 min pendant la session)</i>	<p>BLOC 4 : Renforcer les services de PF pour répondre à la demande accrue - Que doivent faire nos partenaires et le Projet TJ en matière de services ? Comment peut-on optimiser les approches des réseaux sociaux ? <i>Résultats attendus : 1) Une série d'étapes et de responsabilités définies pour assurer que la disponibilité des services de PF réponde à la demande qui augmentera en raison des activités du Projet TJ. 2) Stratégies visant à lier les prestataires et les groupes qui seront mises en place dans le plans de travail de CARE et de Plan.</i></p> <ul style="list-style-type: none"> ○ Présentation des résultats à partir de l'évaluation rapide des services de PF : Quels sont les services disponibles et quelles sont les insuffisances ? (15 min) ○ Discussion sur les ressources disponibles pour réduire les lacunes au niveau des services et stratégies qui seront utilisées (45 min) ○ Discussion des stratégies pour associer les prestataires et les groupes sociaux - présentation d'une proposition suivie d'une discussion (45 min) 	Ghislaine, Bello, Danielle
18h00-19h00	<p>Session invitée : Dynamiser le TAG et le Comité de pilotage pour qu'ils accompagnent le Projet TJ dans ses efforts d'expansion (TJ interne : Ben, Rebecka, Susan, Bello, Marcie, Laurette, Danielle, Ghislaine, Linda) (TJ externe : TAG + Comité de Pilotage) <i>Résultat attendu : Consensus sur la manière dont le TAG et le Comité de Pilotage peuvent (ou ne peuvent pas) être des acteurs viables dans la préparation de la mise à l'échelle. Présentation à l'ensemble du groupe le jeudi.</i></p>	Ben et Susan
Jeudi 26 Septembre		
8h00-8h30	<ul style="list-style-type: none"> ○ Résumé de la journée du mercredi – Décisions et recommandations pour la conduite à tenir (30 min) 	Rapporteur : À déterminer
8 :30-12h00 <i>(pause de 30 min pendant la session)</i>	<p>BLOC 5 : Réflexion sur ce que nous avons appris sur les approches basées sur les réseaux sociaux. L'approche fonctionne-t-elle ? Dans quelle mesure est-elle différente des autres initiatives de mobilisation communautaire ? Les approches sociales basées sur les réseaux conduisent-elles à un changement social ? <i>Résultat attendu : Tirer les enseignements des expériences et des analyses menées par d'autres, et documenter les leçons apprises</i></p>	Susan, Mariam, Ben
12h00-13h00	<p>Bloc 5 (suite) -Réexamen du 3eme « pilier » de la mise à l'échelle et le paquet TJ y compris approche communautaire – Partage de discussion sur le 3eme pilier (le rôle accompagnent de TAG et Comité de Pilotage dans l'extension de TJ) + réflexion sur les discussions de Bloc 5 et ses implications sur l'approche communautaire de TJ (30 minute/thème)</p>	Ben
13h00-14h00	Déjeuner	

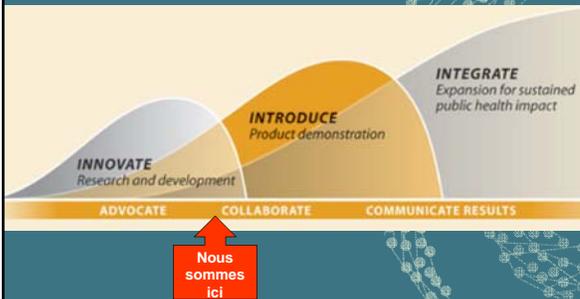
14h00-16h30 <i>(pause de 30 min pendant la session)</i>	BLOC 6B : Compléter l'ensemble de Paquet TJ : La radio et les leaders influents et les cartes d'invitation <i>Résultat attendu : Description détaillée des nouvelles composantes et un plan d'intégration de ces composantes dans les activités du Projet TJ.</i> <ul style="list-style-type: none"> ○ Présentations suivies d'une discussion sur les composantes proposées et les idées sur le contenu, la méthode et les rôles et responsabilités pour assurer l'intégration des deux composantes dans le programme TJ (60 minutes par thème) 	Ghislaine, Danielle + Bello, Marcie
Vendredi 27 septembre		
8h00-9h00	Session invitée : Définir la phase d'expansion (TJ interne : Ben, Rebecka, Susan, Bello, Marcie, Laurette, Danielle, Ghislaine, Linda) <i>Résultat attendu : Définition des voies d'expansion et ses implications géographique et en matière de partenariat : première sélection des organisations possibles du réseau avec lesquelles travailler au cours de la phase de mise à l'échelle. Présentation à l'ensemble du groupe à la prochaine session.</i>	IRH
9h00-9h30	<ul style="list-style-type: none"> ○ Résumé des discussions et des décisions prises jeudi 	Rapporteur : À déterminer
9h30-11h30 <i>(30 min de pause pendant la session)</i>	BLOC 7 : Préparation de la mise à l'échelle : Quand, où, avec qui et avec quel programme ? <i>Résultats attendus : 1) Consensus sur le processus de « graduation » des villages de la première phase 3) Idées sur ce qui devra constituer le programme du Projet TJ à mettre à l'échelle, y compris ses valeurs uniques. 2) Commencer à explorer les possibilités de partenariat sur les six prochains mois dans des zones géographiques déterminées.</i> <ul style="list-style-type: none"> ○ L'autre aspect de la mise à l'échelle - décider du moment propice pour « passer le relais » aux groupes et aux leaders de la première phase afin qu'ils puissent continuer le projet sans le soutien de TJ (60 min) ○ Présentation et discussion des paramètres proposés pour la mise à l'échelle qui ont été discutés lors de la session invitée (60 min) ○ Comment décider des parties du programme TJ qui resteront en phase post-pilote ? Quels outils sont nécessaires pour appuyer l'expansion du Projet TJ dans de nouvelles zones ? (30 min) 	Susan, Laurette, Marcie
11h30-12h30	Poursuite de nos réflexions sur le genre : la voie à suivre pour le personnel du Projet TJ, maintenant et pendant la mise à l'échelle	Maimouna
12h30-13h30	Pause déjeuner	
14h30-16h00	DERNIERE PARTIE : Passage en revue du plan de travail de l'AF 2014 et des prochaines étapes <ul style="list-style-type: none"> ○ Passage en revue du plan de travail global et discussion sur les ajustements en fonction des décisions prises au cours de cette réunion 	CARE, Plan
16h00-17h00	<ul style="list-style-type: none"> ○ Session de clôture / Prochaines étapes 	Ben

La Mise à Echelle dès le début: Commencer en tenant compte de la Fin

Ce dont tous les programmes doivent tenir compte pour l'éventuelle mise à échelle réussie



Chevauchement des phases, pas d'étapes discrètes



Source: PATH's Product Introduction Framework

La définition de la mise à échelle

« Les efforts délibérés pour augmenter l'impact des innovations essayés avec succès dans un projet pilot ou expérimental pour faire profiter davantage de personnes et encourager le développement de politiques et programmes sur une base durable »

ExpandNet

Des principes clés de la mise à échelle

- Utiliser une approche « systèmes » : ajouter une innovation à un système, affecte tous les parties/sous-systèmes qui ont pour résultat les services, l'assistance, etc.
- Des preuves doivent guider le développement d'innovation, la mise à échelle, et les approches d'exécution
- Etre conscient de l'équité et faire attention aux besoins et aux droits de groupes vulnérables. Services centrés sur les clients.
- Se concentrer sur la durabilité.

Des constats clés de la mise à échelle

- Impliquer plusieurs acteurs dans un processus participatif pour planifier et contribuer à la mise à échelle
- Etre prêt de « passer le flambeau » en renforçant la capacité des organisations qui utiliseront et soutiendront l'innovation
- La flexibilité est cruciale pour le processus de la mise à échelle. Saisir les occasions et gérer les contraintes

Innoven- en jugeant le potentiel du paquet TJ d'aller à l'échelle – le 'scalability'

- Serait-elle difficile à maintenir lors d'une phase d'extension?
- Pourrions-nous implanter avec les ressources disponibles?
- Compatible avec les valeurs, services, et capacités des organisations utilisatrices?
- Exigerait-elle les changements en logistiques pour assurer l'extension?
- Quel type de formation et appui soient nécessaires?
- Quelles adaptations devrait être faites?

2. Demandez rougeur! Solutions possibles?

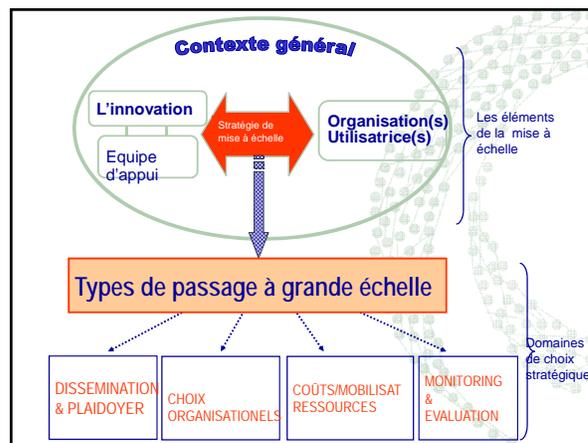
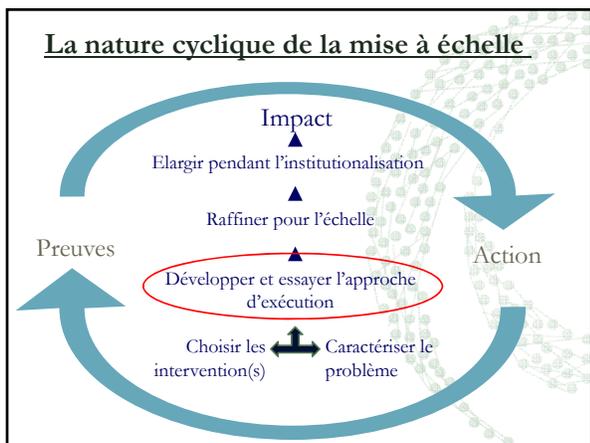


Introduire- les essais d'implémentation Des constats critiques pour la mise à échelle

- La documentation du processus d'exécution : Appropriée et suffisante pour faciliter l'apprentissage et l'analyse des pratiques réussies, pour guider la réplication dans l'élargissement au futur
- Les engagements des acteurs pour que l'innovation soit positionnée pour une mise à échelle éventuelle
- Des approches pragmatiques et adaptées : s'attendre à l'inattendu. Saisir les chances comme elles viennent !

Constats critiques (cont.)

- Renforcer la capacité et puis « certifier » les organisations/partenaires pour continuer l'élargissement
- Les champions peuvent jouer un rôle important à l'intérieur et l'extérieur des services qui sont élargis
- Commencer tôt le travail sur l'institutionnalisation. Prendre le temps et construire des preuves pour les donateurs et décideurs politiques y compris les données sur les coûts pour les responsables



Qui pourrait et voudrait introduire le paquet TJ dans leurs programmes?

Organisations Utilisatrices
Organisation(s) qui comptent d'adopter et d'implanter l'innovation a grand échelle

Possibilités:
MS, ONG, Reseaux d'ONG, Associations de femmes et d'hommes, ou une combinaison.

Qui va appuyer les partenaires et assurer qu'ils ont de la capacité d'utiliser le paquet TJ?

Equipe Ressource
Individus/organisations qui veulent promouvoir l'utilisation de l'innovation a grande échelle
Prestation de l'AT aux organisations voulantes adopter l'innovation

Possibilités-
Chercheur, gerants de programmes, formateurs, prestataires, représentants communautaires, décideurs de politiques
Représentants de diverses organisations
Localise dans un pays ou en dehors de pays
Incluent les staffs des organisations qui vont adopter l'innovation





Comprendre les Besoins Non-satisfaits en Planification Familiale dans le Couffo: Résultats de l'Etude de Base




Le but et les objectifs de l'étude de base

But: Avoir des informations sur l'utilisation et les besoins-non-satisfait en planification familiale dans les zones d'intervention et de contrôle.

Objectives:

- Calculer le besoin non satisfait
- Examiner les attitudes envers la planification familiale
- Etudier les caractéristiques des réseaux sociaux
- Identifier les différence entre la zone d'intervention et celle du contrôle (ceci sera contrôlé dans l'analyse de l'étude de fin)

Méthodologie de l'Etude de Base

4320 participants

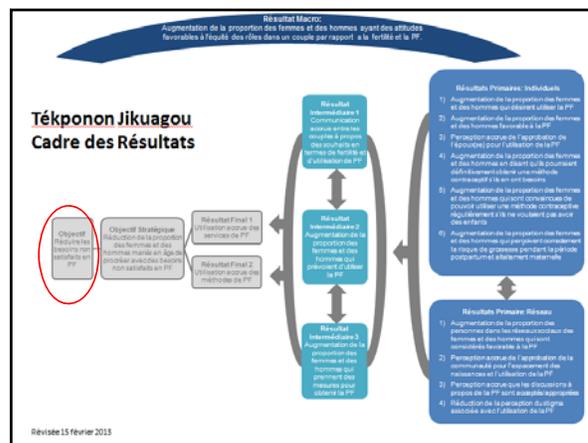
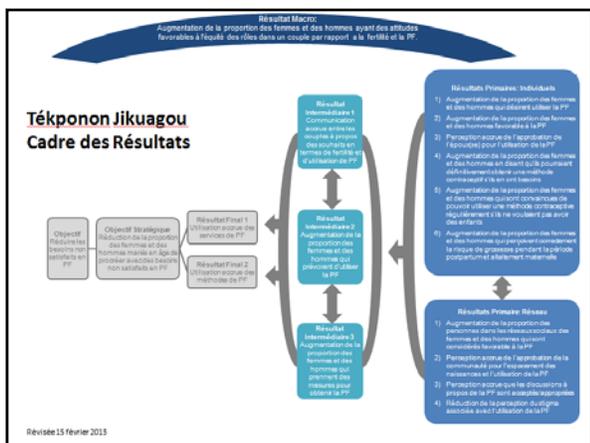
	Femmes	Hommes
Intervention		
2 Zones sanitaires du Couffo	1,080	1,080
Contrôle		
3 communes dans le Plateau	1,080	1,080

- Les femmes en âge de procréer (18-44); les hommes mariés aux femmes en âge de procréer
- Echantillonnage aléatoire
- Echantillonnage représentatif de la communauté
- Enquêteurs du sexe masculin (pour hommes) et du sexe féminin (pour femmes)
- Conduite par CRAD

Caractéristiques des participants

	Intervention		Contrôle	
	Femmes n=1080	Hommes n=1080	Femmes n=1080	Hommes n=1080
Age moyen	29.7	38.0	29.7	37.8
% mariage polygame	45.0**	41.9**	37.1	31.7
% sans éducation formelle	76.4	43.1**	74.3	53.5
Ethnicité (%)				
Adja	90.7**	91.0**	1.7	4.3
Fon	8.0	8.6	24.8	23.1
Yoruba	0.1	0.2	67.9	72.1
Religion (%)				
Catholique	8.7**	7.6**	16.9	20.1
Autre Chrétien	40.7	27.7	59.0	51.1
Musulman	0.3	0.5	15.6	16.3
Traditionnel	50.4	64.1	8.4	12.1
Besoin non-satisfait perçu	11.1		14.1	

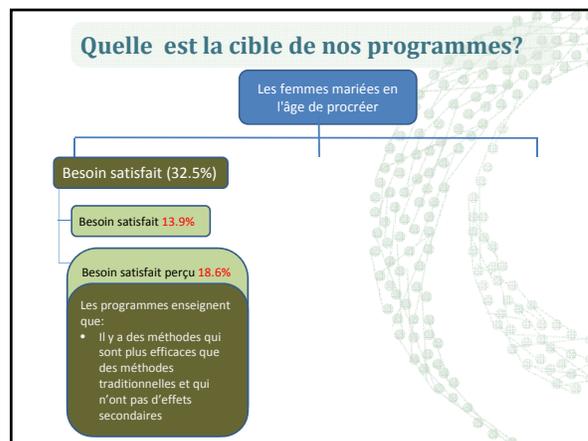
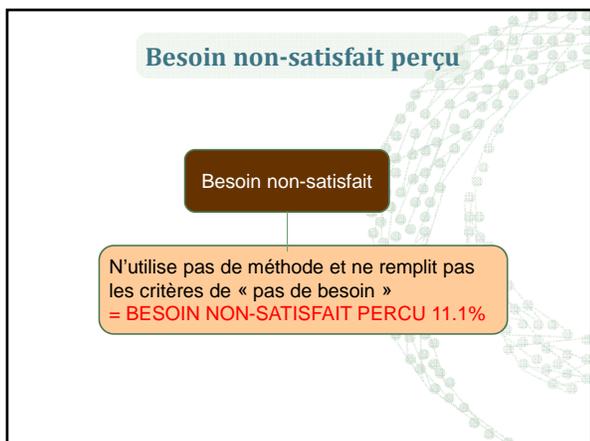
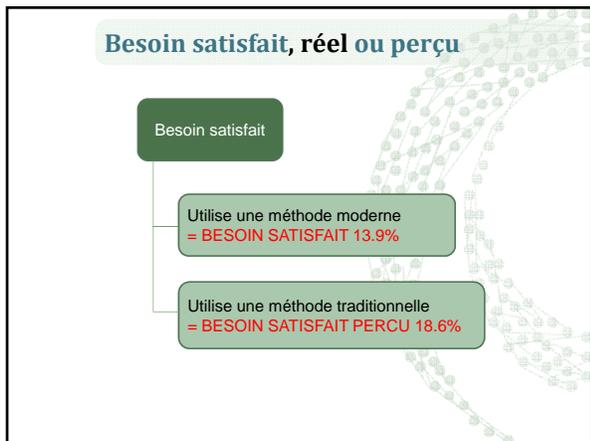
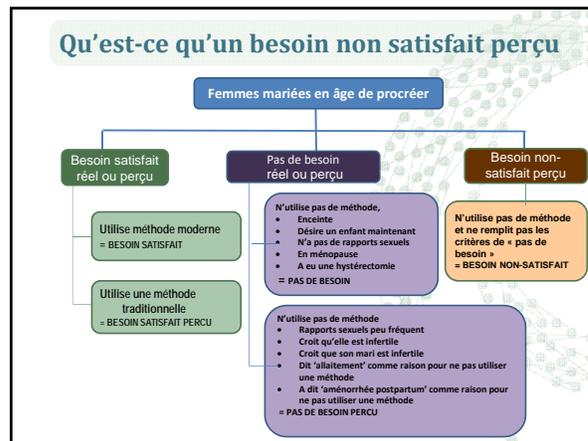
** indique un écart significatif à $p < 0.05$ pour les différences entre l'intervention et le contrôle

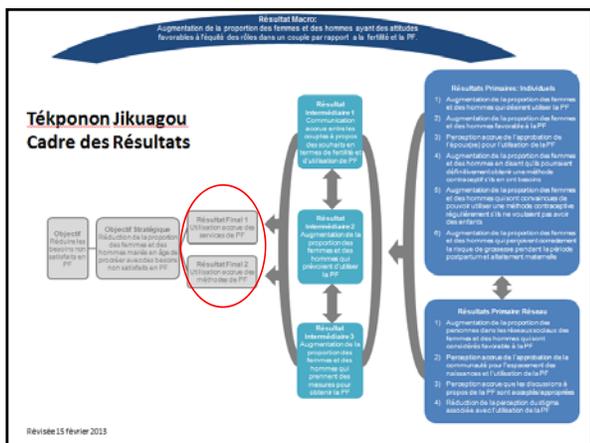
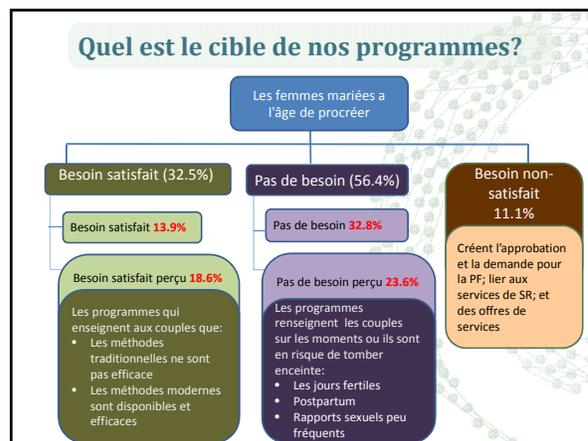
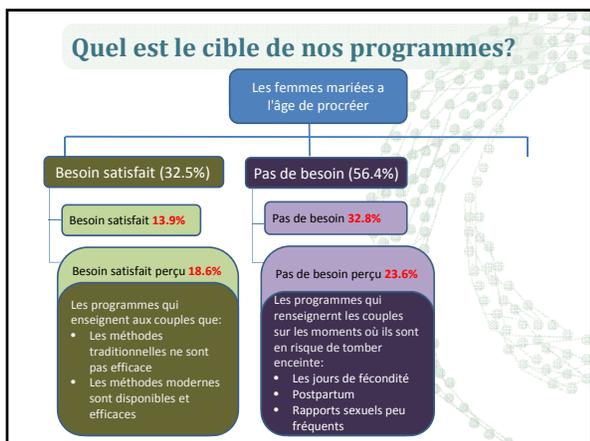


Qu'est-ce qu'un besoin non-satisfait perçu?

Une femme avec un besoin non-satisfait en PF...

- n'est pas enceinte
- souhaite éviter ou retarder une grossesse
- perçoit qu'elle est en risque de tomber enceinte
- N'utilise aucune méthode de PF (soit moderne soit traditionnelle)



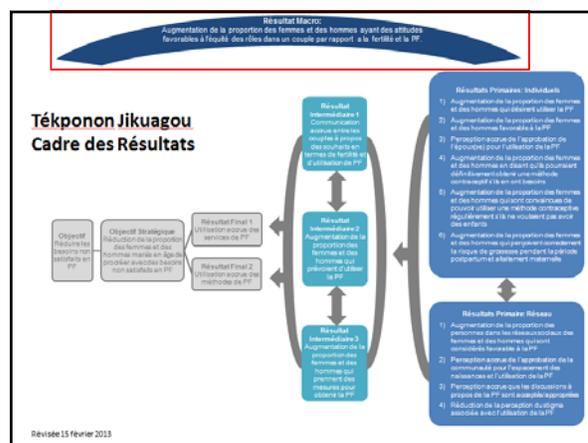


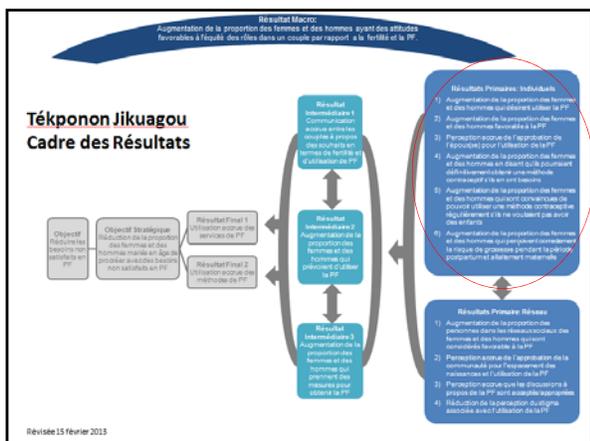
Utilisation des méthodes de PF

	Femmes	
% qui utilise une méthode moderne		Pas de PF et pas enceinte 51.0%
Stérilisation	0.3	
Pilule	1.2	
DIU	0.2	
Contraceptifs injectables	0.8	
Implants	2.9	
Préservatifs	3.1	
Méthode des Jours Fixes	4.9	Traditionnelle 20.8%
MAMA	0.4	
% qui utilise une méthode traditionnelle		Moderne 13.9%
Abstinence périodique	7.7	
Retrait	14.1	
Autre	1.9	

Utilisation des services de PF

% qui	Femmes
ont demandé aux agents de santé ou aux relais des informations sur une méthode de PF au cours des derniers 12 mois	9.6
ont visité un centre de santé communautaire ou de zone afin d'obtenir une méthode de PF au cours des derniers 12 mois	6.4
ont été accompagné par son mari pendant une visite a un centre de santé communautaire ou de zone au cours des derniers 12 mois	3.4
croient que l'agent de santé doit avoir de l'approbation du mari pour donner une méthode de PF à une femme	46.5





Attitudes envers l'utilisation de la PF

% qui sont d'accord avec ces déclarations	Femmes	Hommes
Les couples qui utilisent la planification familiale et qui ont moins d'enfants arrivent mieux à subvenir aux besoins de leur famille.	88.6	83.1
L'espacement des naissances est bon pour la santé des enfants.	93.5	96.1
Les hommes qui ont des femmes qui utilisent la planification familiale manquent d'autorité.	9.8	17.5
Les méthodes de planification familiale proposées dans ce village ont beaucoup d'effets secondaires.	33.2	48.9

Perception de l'approbation de l'époux du PF

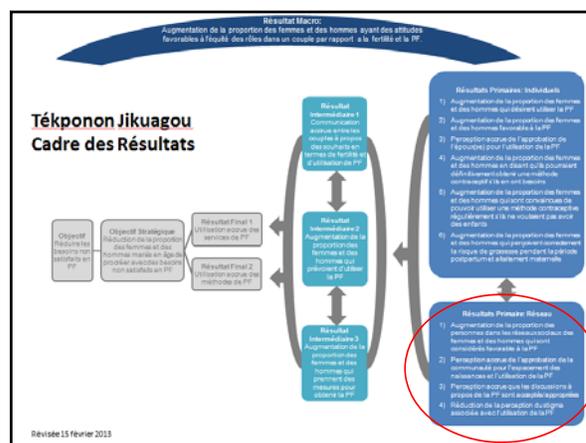
% qui	Femmes
pensent que leur mari approuve définitivement de la PF	32.1

Perception de la risque de tomber enceinte

% qui	Femmes
pensent qu'une femme qui allaite ne pourrait PAS tomber enceinte	27.2
pensent qu'une femme ne pourrait PAS tomber enceinte avant le retour de ses couches après une naissance	38.0

Auto-efficacité pour l'utilisation de PF

% qui	Femmes	Hommes
ont les informations dont ils ont besoin pour décider d'utiliser une méthode	52.0	43.9
savent où obtenir une méthode pour retarder ou éviter une grossesse	52.9	54.8
sont en mesure d'aller à cet endroit sans trop de difficultés	49.3	51.5
sont convaincus qu'ils seraient en mesure d'utiliser une méthode correctement chaque fois pour retarder ou éviter une grossesse	74.3	71.6



Perceptions de la communauté

% qui	Femmes
pensent qu'elle serait taquinée ou critiquée si les gens découvrent qu'elle utilise la PF	26.6
sont à l'aise en discuter la PF avec son:	
Belle-mère	48.1
Membre de son tontine ou autre groupement social	45.3
Homme autre que son mari	18.0
sont d'accord qu'il est acceptable de discuter la PF en publique dans son village	64.0

Caractéristiques des réseaux

%	Membres des réseaux des femmes
Nombre moyenne des membres	
Totale	3.11 (1-18)
Réseau matériel	2.43 (1-13)
Réseau pratique	1.59 (1-13)
Même genre	45.6
Relations	
Famille natale	38.4
Belle-famille	34.2
Entourage (pas famille)	26.0
Location	
Même ménage	39.8
Dans le village	34.2
Hors du village	26.0

Le stigma autour de la PF

% qui sont d'accord avec ces déclarations	Femmes	Hommes
Les hommes qui ont des femmes qui utilisent la planification familiale manquent d'autorité.	9.8	17.5
Les femmes qui utilisent la planification familiale ont plusieurs partenaires sexuels.	7.9	17.0
C'est honteux d'être associé avec une femme qui est connue comme une utilisatrice de planification familiale.	14.3	13.4

% qui	Femmes
pensent qu'elle serait taquinée ou critiquée si les gens découvrent qu'elle utilise la PF	26.6
pensent que si son mari découvre qu'elle utilise la PF, il va la battre	25.1

Révélation aux informations de PF

% qui	Femmes	Hommes
ont assisté à une réunion de groupement sociale au cours des trois derniers mois, et discuté:	26.8	14.5
l'espacement des naissances	10.3	8.6
la planification familiale	8.0	8.0
la communication du couple	12.2	6.9
les normes de genre	7.6	6.1
la prise de décision au sein du couple	7.4	6.3
ont écouté une émission de radio où l'on parlait des sujet suivants au cours des trois derniers mois		
l'espacement des naissances	43.6	63.0
la planification familiale	42.0	42.0
la communication du couple	34.4	34.4
les normes de genre	27.1	27.1
la prise de décision au sein du couple	26.6	26.6

Révélation aux informations de PF

% qui	Femmes	Hommes
ont entendu un leader du village ou un leader religieux discuter des sujets suivants au cours des trois derniers mois		
l'espacement des naissances	12.3	11.2
la planification familiale	10.8	11.2
la communication du couple	15.6	11.0
les normes de genre	11.8	9.6
la prise de décision au sein du couple	10.7	9.2
ont participé dans un groupement ou activité religieux ou on a discuté des sujets suivants au cours des trois derniers mois	21.3	8.1
l'espacement des naissances	8.3	3.9
la planification familiale	6.3	2.5
la communication du couple	15.0	3.6
les normes de genre	11.6	2.5
la prise de décision au sein du couple	10.3	2.8



Questions???

Discussion

Quelles sont les leçons les plus importantes à tirer de ces résultats pour renforcer notre travail?

- Cadre de résultats?
- Notre définition de besoin non-satisfait perçu?
- L'approche TJ?
- Le rôle of des normes sociales normes (genre, stigma) dans le besoin non-satisfait?



Constat de l'évaluation des centres de santé (CS)



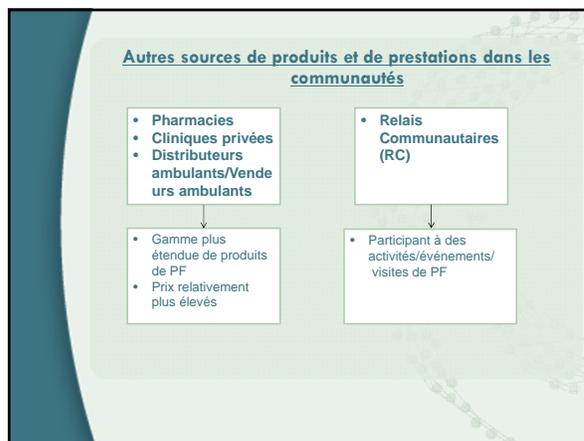
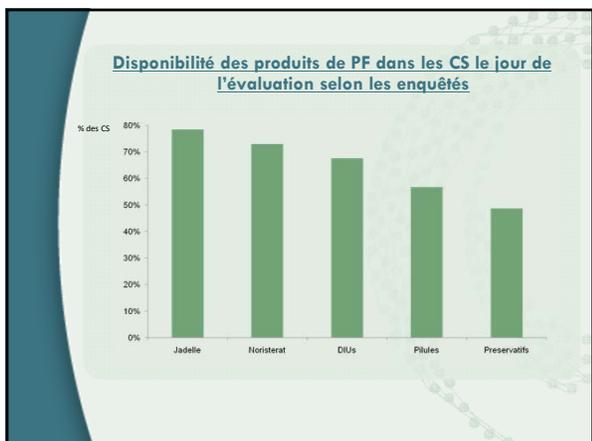
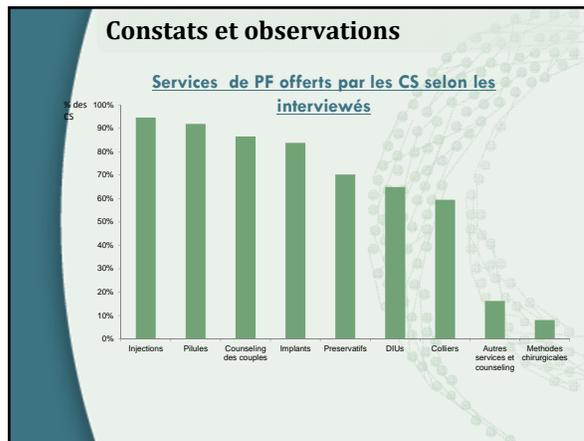
Objet

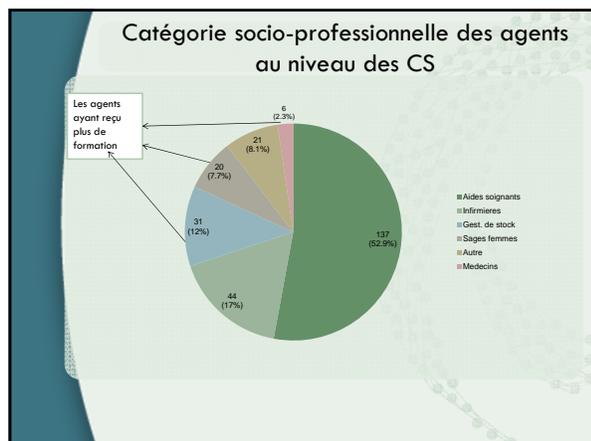
Faire une évaluation rapide des services de PF pour un plaidoyer auprès du ministère de la santé au Bénin et des autres parties prenantes afin d'améliorer l'accès aux services en :

- Étudiant le type, coût et disponibilité des produits et prestations de PF dans les communautés
- Constatant la disponibilité du personnel offrant des services de PF
- Évaluant les tendances de couverture de PF dans la zone d'intervention du projet TJ
- Identifiant les facteurs qui influencent les prestations de PF

Centres de santé (CS) ayant bénéficié de l'évaluation des services de PF

- 37 Centres de santé (CS) dans six communautés
- 16 CS dans les communautés de Aplahoue, Djakotomey et Dogbo couvertes par CARE
- 21 CS dans les communautés de Klouekanme, Lalo et Toviklin couvertes par Plan
- Données recueillies en juillet 2013





Pourcentage des CS ayant du personnel formé dans les domaines de PF

	Technologie contraceptive	Logistique contraceptive	Insertion des DIU	Insertion des implants	Collier
1 agent formé	41%	43%	43%	43%	35%
2 agents formés	13,5%	11%	19%	19%	19%
≥ 2 agents formés	16,2%	16,2%	5%	5%	13,5%

- ### Principales contraintes de la PF selon les enquêtés
- La culture "pro-nataliste"
 - Le refus des hommes (d'utiliser des contraceptifs ou de permettre à leurs femmes de les utiliser)
 - Les rumeurs/fausses idées liées à la PF
 - L'absence de rôles modèles dans la communauté
 - Les contraintes financières
 - Les ruptures de stocks des méthodes et insuffisance d'équipements
 - L'insuffisance de personnel formé pour l'offre des services de PF

- ### Facteurs susceptibles d'influencer l'offre et la demande de PF
- Développer et élargir la sensibilisation au niveau des communautés ; discuter des idées fausses et des craintes des effets secondaires
 - Sensibilisation médiatique, en particulier la radio
 - Counseling des couples, avec aussi des programmes qui ciblent les hommes et un counseling individuel pour femmes
 - Formation ponctuelle et accompagnement des RC en leur fournissant du matériel de IEC
 - Formation/information continue des sages-femmes et aides-soignants (soit 60,6 % du personnel)
 - Assurer la disponibilité des produits

Tékonon Jikuagou

Réduire les Besoins Non-Satisfaits en Planification Familiale à Travers les Réseaux Sociaux au Bénin

Que nous disent les données du monitoring? (Du début des interventions à Juillet 2013)

PAG international de TJ à Bohicon
25 Septembre 2013
Présenté par: Mariam Diakité

Processus de collecte des données

Catalyseurs
Outil:
• Cahier du catalyseur

Facilitateurs
Outils:
• Fiche synthèse mensuelle des villages
• Fiche synthèse mensuelle du mapping
• Fiche synthèse mensuelle de l'orientation des catalyseurs

Coord de zone
Outils:
• Fiche synthèse mensuelle des communes;
• Fiche synthèse mensuelle du mapping des communes
• Fiche synthèse mensuelle de l'orientation des catalyseurs des communes
• Tableau de benchmark

% Villages atteints pour l'Identification des groupements/personnes cibles

• ZS ADD

n= 45

• ZS KTL

n= 45

N est le nombre total des villages d'intervention à couvrir avant Janvier 2014

Types de groupements sélectionnés par Zone Sanitaire (ZS)

ZS ADD

(n= 101)

ZS KTL

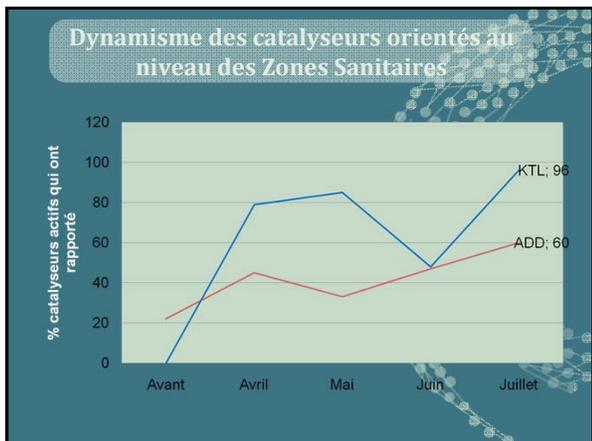
(n= 93)

ORIENTATION DES CATALYSEURS SELECTIONNES

ZS ADD
72% des catalyseurs sélectionnés sont orientés
 > Femmes: 39%
 > Hommes: 33%

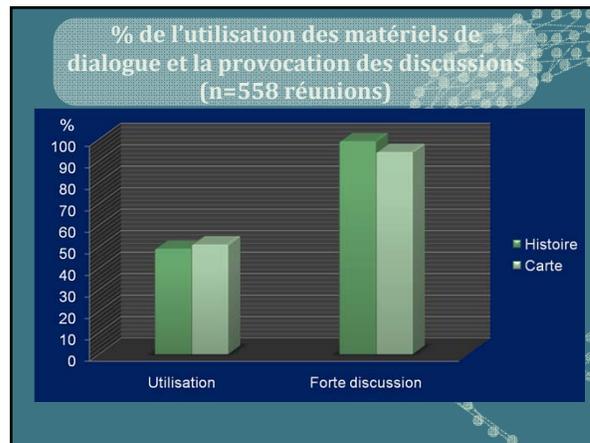
ZS KTL
100% des catalyseurs orientés sélectionnés sont orientés
 > Femmes: 35%
 > Hommes: 65%

87% catalyseur orientés parmi les sélectionnés



% réunions de groupe avec utilisation des histoires/Cartes (n=558)

	ADD	Histoires 47%	Cartes 53%	KTL	Histoires 50,4%	Cartes 49,6%
Grp Femme		45%	55%	Grp Femme	55%	45%
Grp Homme		67%*	33%	Grp Homme	50%	50%
Grp Mixte		46%	54%	Grp Mixte	39%	61%*



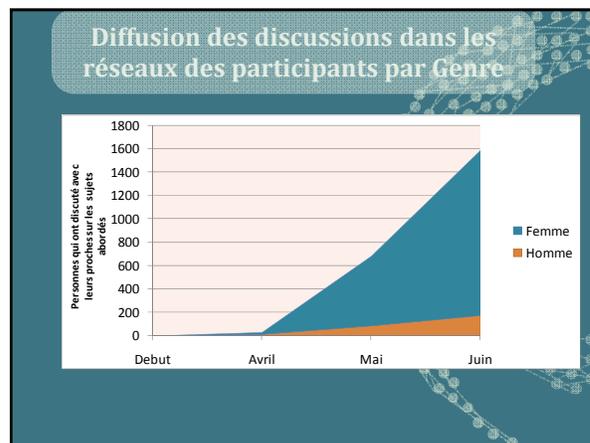
% des participants aux discussions

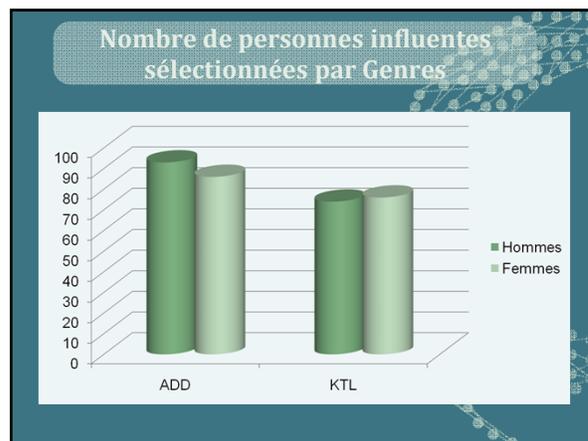
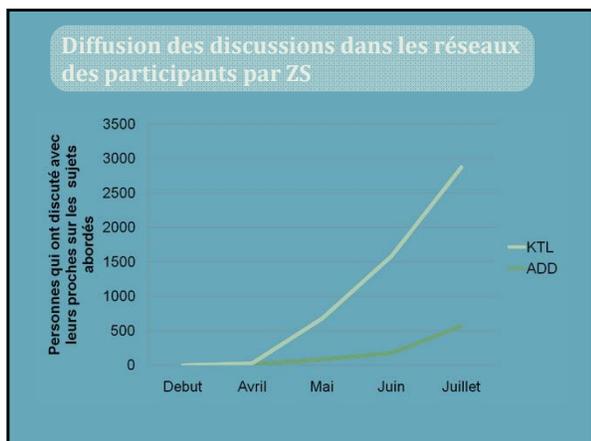
ADD
Femme: 116%
Homme: 135%

KTL
Femme: 93%
Homme: 93%

Plus de participations des hommes

Proposition du nouveau indicateur: Moyenne du nombre de participants à la discussion





Forces et Faiblesses au niveau des activités de suivi

Les points forts

- Remplissage correcte des outils
- Disponibilité des catalyseurs et des données au niveau des catalyseurs et des facilitateurs
- Fonctionnement du Comité de Suivi Apprentissage et Evaluation (CSAE)

Les difficultés

- Retard dans la collecte et l'acheminement des données

Recommandations

Convenir à une méthode de validation des données au niveau des organisations

AKPE!

APPENDIX C:
Community Social Mapping Guidelines



Guide to Community Social Mapping

Developed by
The Tékponon Jikuagou Project: Addressing Unmet Need for
Family Planning through Social Networks in Benin



TÉKPONON JIKUAGOU
INSTITUTE FOR REPRODUCTIVE HEALTH GEORGETOWN UNIVERSITY
CARE INTERNATIONAL
PLAN INTERNATIONAL

Guide to Community Social Mapping

TABLE OF CONTENTS

What is Community Social Mapping? Why Add Social Mapping to Your Project Toolkit?	1
Conducting A Community Social Mapping Exercise.....	2
Overview of the Process	2
Part I: Introduction to the Community.....	2
Part II: Learning About Influential Groups - Identification, Description and Analysis of Village Groups	3
Part III: Understanding the Community’s Social Dynamics and Socially Influential People via Mapping.....	5
Selecting Groups and Influential People with Whom to Engage in TJ activities.....	8
Part I: Selecting groups with whom the project would like to engage.....	8
Part II: Meeting the group leader and group members to seek their engagement in TJ activities and to identify the group catalyzer to be trained to use TJ reflective dialogue materials.....	10
Part III: Identify and Select Influential People to engage in TJ activities.....	12
Part IV: Meeting with a community’s Influential People.....	12
Part V: Validating Your Choices with Project Staff and with the Community	13

WHAT IS COMMUNITY SOCIAL MAPPING? WHY ADD SOCIAL MAPPING TO YOUR PROJECT TOOLKIT?

The Tékponon Jikuagou (TJ) project responds to low rates of family planning uptake and increasing unmet need for family planning in Benin (DHS 2012), which exist despite multiple efforts to increase information and access. TJ seeks to address the concept of unmet need among women who want to limit or space their births but who are not using contraception by addressing social norms and barriers which influence non-use despite access to services.

The project uses social network analysis to identify the most influential and connected networks in a community and to assess the influence of men's and women's networks on fertility beliefs, attitudes, desires, intentions and behaviors relating to family planning. Interventions then work with key actors in individuals' social networks, as well as the network structures themselves to promote reflection on existing social norms, allowing people to recognize for themselves how norms and attitudes may negatively influence reproductive health and family planning. It also capitalizes on these networks to diffuse reflection on and consideration of different social norms and attitudes as they relate to family planning and fertility.

In this context, TJ developed a set of participatory learning exercises, collectively named the *Community Social Mapping Tool*, which would facilitate discussions with communities to learn about groups and formal and informal leaders in a village and to gain a general understanding of how a community is socially organized. The tool helps outsiders to understand which groups and individuals are most socially connected and respected – those influencing social networks and the spread of ideas and attitudes – to help make decisions about which groups and people with whom TJ could work. A core part of exercises in the tool involves an innovative variation of community mapping, which focuses on learning about community social dynamics and organization.

CONDUCTING A COMMUNITY SOCIAL MAPPING EXERCISE

OVERVIEW OF THE PROCESS

The *Community Social Mapping Tool* is a set of exercises that are facilitated with community groups by project field agents to identify, list and select social groups and influential persons in communities to help the TJ team make the best decisions possible in terms of selecting two to three socially-influential groups and three to five socially-influential persons with whom to engage in project activities. Community social mapping is conducted in each village and involves meeting with community leaders to introduce the project and exercises, followed by several exercises to guide discussions and analysis with several groups in each village (that represent different viewpoints in each village). After the first meeting with village authorities, the exercises take several hours each day to conduct over a period of two days.

PART I: INTRODUCTION TO THE COMMUNITY

Objective: Obtain the permission of administrative and local village authorities to begin discussions with the groups.

Approximate duration: One hour

STEP 1: Introduce yourself to the important village authorities (village leader, the sub-prefect, the mayor, etc.).

STEP 2: Explain the objective and strategies of TJ in putting the emphasis on community participation through the groups and influential individuals.

STEP 3: Talk about communication strategies for social mobilization (examples: town criers, village leader's advisors, religious leaders, and community groups).

STEP 4: Ask the village leader's permission to meet with community representatives with whom to meet and discuss (that is, with whom to do several exercises in the tool). Propose working with 8-10 people who can offer different perspectives, including men, women, older women, and older men. ("We would like to invite two men, two women, one to two



older women, and one to two older men to participate for several hours in a discussion.”) Explain that you would like also to work also with pre-established groups in the village for these discussions. If possible, invite the groups cited as well.

NB: Within the TJ project, there was a concern to ensure that socially marginalized group perspectives were represented. CARE and Plan worked to identify these groups, if they were not mentioned during the meeting with the village leader.

STEP 5: Set up a meeting with the community representatives and invited groups to complete Part II.

STEP 6: Record the questions and responses before thanking participants for their time and effort given.

The facilitator should create a summary of the discussion. Don't forget to note 1) the date of the meeting, 2) the name of the region, 3) the name of the village, 4) the name of the project facilitator, and 5) a brief description of the participants including the number of women, number of men, age group, and important characteristics of the people (example: leaders, head of the group, advisor, etc.). Further, the discussion reporter should write a summary of interesting points from the meeting and carefully list the names of influential people who were cited in the discussion.

PART II: LEARNING ABOUT INFLUENTIAL GROUPS - IDENTIFICATION, DESCRIPTION AND ANALYSIS OF VILLAGE GROUPS

Objective: Identify active groups with potential to maximize social networks with whom to start TJ activities within the community.

Approximate duration: One to two hours

Materials: A grid for each group (see grid example, below)

Participants: Community representatives identified in Part I, 8-10 invitees from community groups

STEP 1: Introduce yourself and the project, even if everyone knows about it already. Explain to the group that it will be very interesting to hear their ideas on existing groups within the community and to more fully understand how these groups are organized. This activity will help the project work better within the community.

STEP 2: Ask the participants to list active, existing groups within the community, for example: village associations, community work groups, agricultural cooperatives, women's groups, savings groups, microcredit groups, etc.

NB: If this exercise would work better in small groups, ask the participants to divide into two or three groups to complete the activity.

STEP 3: Explain to the group that you will use a grid to describe and compare the listed groups. Show the grid. Write the names of the different groups in the top row.

Example of a grid

	Group Description	Group 1 Name	Group 2 Name	Group 3 Name
1	Objective/activities			
2	Women, men, or mixed?			
3	Age of group members			
4	Group size			
5	Meeting frequency			
6.	Opinion: Level of group connectedness with others in village			
7.	Opinion: Level of influence in the general community			

STEP 4: After listing all of the groups, explain the following activity to complete the grids. For each group, ask the participants to mark with an X or to put a certain number of stones in the appropriate box to describe the group, e.g., age range, size, meeting frequency, connectivity, and level of influence of each group.

The facilitator with the support of one participant should guide them in using the legend:

Example of a rating system to describe group characteristics

Category	Low Rating	Middle Rating	High Rating
3-Age of group members	X (young) = majority are 18-25 years old	XX (adult) = majority are 26-50 years old	XXX (old) = majority are over 50 years old
4-Size	X = 2-10 people	XX = 11-30 people	XXX = more than 30 people
5-Meeting frequency	X = less than one activity per month	XX = one activity per month	XXX = more than one activity per month
6- Connectivity (membership of group members in other groups)	X = 0 members	XX = 1-10 members	XXX = 11 members and more

7- Level of influence in the general community (Influence: to be well known by the majority of the community, who involves many people in his/her activities, who can mobilize many people)	X= Not too influential with other groups	XX= Influential with other groups	XXX= Very influential with other groups
---	---	--	--

STEP 5: Thank everyone for their participation. Ask if they have any questions. Explain that you will facilitate further discussions the following day with the people mentioned, groups mentioned, and further invitees if necessary.

At the end of the meeting, make sure that you have collected the information and labeled the grid with 1) the date of the meeting, 2) the name of the region, 3) the name of the village, 4) the name of the project facilitator, and 5) a brief description of the participants (number of women, number of men, age group, and important characteristics of the people [example: leaders, head of the group, advisor, etc.]). Further, the discussion reporter should write a summary of interesting points from the meeting and carefully list the names of influential people who were cited in the discussion.

PART III: UNDERSTANDING THE COMMUNITY’S SOCIAL DYNAMICS AND SOCIALLY INFLUENTIAL PEOPLE VIA MAPPING

Objective: Explore how the community organizes itself socially with the help of a community map.

Approximate duration: 1-2 hours

Possible materials: Flip chart paper and markers, earthen surfaces and colored powder, Post-Its, pebbles, bits of crayons or colored pencil, stickers

Audience: People invited by the facilitators: community representatives from Part II and the persons listed in Part II. The day before, invite these 10-12 people who represent the perspectives of men, women, older women, older men, and marginalized groups (defined by situation).

STEP 1: Introduce yourself. Present the project. Explain how the project would like to understand the organization of the community in terms of social structures.

STEP 2: Ask the group to divide into two groups (by sex) to develop a map, using the materials provided. Maps might include the following elements:

- All of the village
- Roads
- Neighborhoods
- Important businesses
- Health centers
- Religious centers
- Community meeting places
- Group meeting places
- Important houses
- Points of reference
- Other divisions
- Other important buildings

STEP 3: After completing the maps, ask each group to look at all of the maps. Then, take each map one by one and encourage the participants to discuss them, asking on each map the following points:

- How is this community organized socially?
- Are there neighborhoods where richer and poorer people live? Where are they?
- Are there neighborhoods where people are more 'modern' or more 'traditional'? Where are they?
- What other differences exist between neighborhoods?
- Discuss the borders between these social differences – are they visible and non-visible? Are they flexible? How?

Next ask the women participants to name people in response to the following questions, and then ask the men. Note the names of people mentioned.

- Which people (men, women, elders, religious leaders, formal and informal leaders, etc.) can influence – through their words and actions – discussions with other people about important ideas in the community?
- Who influences community members' thoughts and the discussion about the well-being of a family?
- Who are the people who can influence the way that people discuss birth spacing and family planning?
- Why are these people influential?
- Where do they live?
- What is their role in the community?
- Do they interact with each other? How?

Continue by asking the following questions of the whole group:

- Do you have a lot of emigrants to Cotonou?
- Do they have influence over community members in terms of the use of family planning?
- If so, how do they influence people? Are they in a group?
- Are there community health workers in this village?
- Do they work in family planning?
- Do they belong to any organized groups?
- Are many people literate in this village (read, write)? For example, if we want to work with you with images accompanied with text, in which language would you prefer the text?



Figure 2. A group of women draws their village.



Figure 2. A group of men draws the same village.

STEP 4: Thank everyone for their participation and ask them if they liked or didn't like the activity. Ask and respond to supplementary questions about the exercise.

At the end of the meeting, make sure that you have collected the information and labeled the grid with 1) the date of the meeting, 2) the name of the region, 3) the name of the village, 4) the name of the project facilitator, and 5) a brief description of the participants (number of women, number of men, age group, and important characteristics of the people [example: leaders, head of the group, advisor, etc.]). NB: Take a photo of the maps, especially if you did them on the ground. Further, the discussion reporter should write a summary of interesting points from the meeting and carefully list the names of influential people who were cited in the discussion.

SELECTING GROUPS AND INFLUENTIAL PEOPLE WITH WHOM TO ENGAGE IN TJ ACTIVITIES

Overview: Once discussions with community members are completed, the project team needs to meet to identify which groups and people they will approach later to start TJ activities. Part I in this section guides the team in analyzing groups with great social diffusion and networking potential. Part II lays out the first meeting with selected groups, designed to validate the group characteristics and influence, and to identify one group member to be trained to use TJ reflective dialogue materials within the group. Part III lays out the process of selecting three to five influential people and organizing a first meeting with them, designed to validate their leadership roles and assess favorability of their attitudes toward child spacing and use of family planning.

Purpose: Moving from a listing activity to meetings with potential groups and influential persons with whom TJ will work.

Objectives:

- Choose influential groups that can be involved in project interventions.
- Understand how the group works, the attitudes and aptitudes of the members regarding family planning.
- Confirm the degree of influence and connectivity of the group within the community.
- Identify influential people who will be involved in project interventions



Possible materials: None

Participants: Selected groups and individuals who seemingly have social diffusion potential - connectivity and influence - in their community.

PART I: SELECTING GROUPS WITH WHOM THE PROJECT WOULD LIKE TO ENGAGE.

The community grid provides a comparative listing of different groups that exist in the village. To choose the *most* interesting groups with whom to work, apply the following order of criteria:

1. Influence → 2.Connectivity→ 3. Meeting frequency → 4. Size of the group→ 5. Age group

Compare groups of women amongst themselves and groups of men amongst themselves.

Figure 3. Example of a village analysis of influential groups. In this case, the *Mugnou ton* (adult group), and *Dougou koro benkad* (youth group) are most influential and would be selected

Part II: Group Selection		Group Leader's First and Last Name: _____						
Department: _____		Date: _____						
Health zone: _____								
Commune: _____								
Village: _____								
Number of participants: _____								
Men: _____								
Women: _____								
		Goal/activities	Men, Women, Mixed	Members' age group	Group Size	Meeting frequency	Level of connectedness (between group members and other groups)	Level of influence in the general community
Selection Procedure								
			5	4	3	2	1	
<i>MUGNOU TON</i>		F	XX	XXX	XXX	XXX	XXX	XXX
<i>DANAYA</i>	agriculture	F	XX	XX	XXX	XX	XXX	XXX
<i>BENGADI KODALABOUGOU</i>	agriculture	F	XX	XXX	XXX	XXX	XXX	XXX
<i>SABOU GNOUMA</i>	agriculture	F	XX	XXX	XX	XXX	XXX	XXX
<i>WASSOLO KIN</i>	agriculture	F	XX	XXX	XXX	XXX	XX	XXX
<i>DOUGOU KORO BENKADI</i>	agriculture	F	X	XXX	XXX	XXX	XXX	XXX
<i>MEDINE 1</i>	agriculture	F	XX	XXX	XXX	XXX	XX	XXX
<i>MEDINE 2</i>	agriculture	F	XX	XXX	XXX	XXX	X	XXX
<i>CHAUFFEUR MOUSSO TON</i>	agriculture	F	XX	XXX	XXX	XXX	XX	XXX
<i>KOTOGNOKOTALA</i>	agriculture	F	XX	XXX	XXX	XXX	XX	XXX
	agriculture							

Legend:				
3-Members' age group	4-Group size	5-Meeting frequency	6-Level of Connectedness	7- Level of influence in the general community
X (young) = Majority 18-25 years old	X = 2-10 people	X = Less than 1 activity per month	X = 0 members	X = Not very influential in other groups
XX (adult) = Majority 26-50 years old	XX = 11-30 people	XX = 1 activity per month	XX = 1-10 members	XX = Influential in other groups
XXX (old) = Majority 50+ years old	XXX = more than 30 people	XXX = more than 1 activity per month	XXX = 11+ members	XXX = Very influential in other groups

STEP 1: IDENTIFY MOST INFLUENTIAL GROUPS

With the help of the selection grid, separate the most influential groups (with 3X). Among those groups, select the best connected.

STEP 2: IDENTIFY GROUPS THAT MEET FREQUENTLY

Next, amongst these groups, select those who meet most frequently. Amongst those groups, choose the ones with the most members.

STEP 3: MAKE FINAL SELECTIONS

Finally, select a group in the age group that interests you most.



In the case that you don't have the desired number of "very influential people" (those with 3Xs), you may start the same procedure with the 2X group of "influential people". In the case

that two groups seem to have the same level of influence, meet with each of the two groups in order to discern which is more influential (who can mobilize other people most effectively regarding health and leadership issues). In all cases, the facilitator should use his/her observations and knowledge of the community to make an objective choice.

PART II: MEETING THE GROUP LEADER AND GROUP MEMBERS TO SEEK THEIR ENGAGEMENT IN TJ ACTIVITIES AND TO IDENTIFY THE GROUP CATALYZER TO BE TRAINED TO USE TJ REFLECTIVE DIALOGUE MATERIALS.

Make sure to meet with the selected groups of women, men, youths, and with mixed groups (if mixed groups are influential) in their meeting places.

STEP 1: INTRODUCTIONS

Contact the president of each selected group in order to explain to him/her the purpose of the project and its expectations relating to the group. At the end of the discussion, set a time to meet with the members of the group.

STEP 2: DISCUSSION WITH MEMBERS OF THE GROUP

Begin by introducing yourself and talking about the project (the objectives, the expectations, etc.). Ask the group members to comment on the group activities, the objective, the size of the group, its community representative, meeting frequency, and the meeting place.

NB: Consider recording the keywords mentioned in group members' responses.

Ask the following questions:

- In many villages, the rate of infant and mother mortality is very elevated. Further, health workers note that the principal cause of their deaths is that births are too close together. What do you think of their observation?
- In your community, is it possible for a woman to space her births? If so, how? If not, what stops her from spacing her births?
- Does your group do activities to improve the health of mothers and their children in your community? If yes, what types of activities? If not, do you think you could?
- In your group, who are the most influential people? Amongst them, who has the capacity to mobilize group members and the community at large on the subject of maternal and child health?
- In your community, do you know one or multiple people who could have a great influence on the members of your community on this topic? Amongst them, who are the ones who have a positive attitude about this topic?

STEP 3: DETERMINE RELATIONSHIP TO OTHER GROUPS

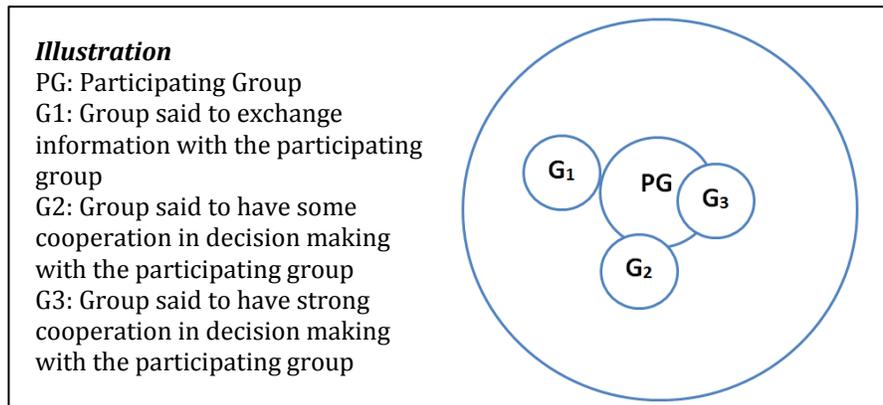
Procedure: Construct a Venn Diagram to establish relationships between groups.

Ask participants to cite the groups, associations, and institutions with whom they have a relationship.

Draw a large circle on flip chart paper or on the ground, and use a small circle in the middle of the larger one to represent the group that is present.

Finally, give the participating group other small circles that represent other groups in the community, and ask them to place them within the large circle using the following criteria:

- If there is information exchange between the groups, have them touch edges.
- If there is some cooperation in decision making between the two groups, slightly superimpose the circles.
- If there is strong cooperation in decision making, completely superimpose the two circles.



Ask for further examples of the type of information shared, decisions made, and who influences who between groups.

Also ask how they think they could get the majority of the community informed and mobilized on the importance of family planning.

NB: Before thanking the group for their participation, ask the participants if they would be interested in working with the TJ project and if they have any questions.

STEP 4: USE YOUR SKILLS OF OBSERVATION!

Facilitators should also observe each group that they meet. What additional information do these observations provide that gives clues to a group's influence and appropriateness for the project to engage them? The guide, below, should be completed after each group meeting.

Facilitator's Observation Guide – Meeting with Groups

	<i>Record your observations in this column.</i>
During the meeting, to what degree were you able to rally the members of the group around the topic?	
How did the discussion go within the group? (<i>Varied points of view? Respect amongst those with varying points of view? Etc.</i>)	
What did you observe about social cohesion within the group? Were there differences or opposition between members of the group during the discussion?	
Did the people mentioned within the group seem like informal leaders? Did you notice any other informal leaders?	
What did the dynamic of the group seem like in regard to the project's objectives?	

PART III: IDENTIFY AND SELECT INFLUENTIAL PEOPLE TO ENGAGE IN TJ ACTIVITIES

As with the groups, a selection process is needed to identify three to five influential people with whom to engage in TJ projects from the suggested names in the earlier phase of activities. Choose an average of five people amongst the names most cited during the community mapping activity (the meeting with the original representative group and the later groups of men, women, etc.) who were also noted as having a favorable attitude toward family planning. Go meet with them.

PART IV: MEETING WITH A COMMUNITY'S INFLUENTIAL PEOPLE

STEP 1: Host the first meeting with a group of people most frequently cited as influential in earlier exercises.

Begin by introducing yourself and talking about the project (the objectives, the expectations, etc.). Ask about their main activity as a group, their roles within the community, and about their interactions with other members of the community. Ask the following questions:

- In many villages, the rate of infant and mother mortality is highly elevated. Further, health workers note that the principal cause of their deaths is that births are too close together. What do you think of their observation?
- In your community, is it possible for a woman to space her births? If so, how? If not, what stops her from spacing her births?
- How do you think you could convince the majority of the community of the importance of family planning?
- Do you have advice to help our project succeed in your community?

NB: Before thanking him/her for his/her participation, ask the participant if he/she would be interested in working with the project and if he/she has any questions.

STEP 2: Use your skills of observation!

Facilitators should also use this meeting to gain information through observation. What additional information do your observations provide that gives clues to each influential person's appropriateness for the project to engage them? The guide, below, should be completed after the meeting with influential people.

Facilitator's Observation Guide - Meeting with an Influential Person

	<i>Record your observations in this column</i>
What is this influential person's perception of family planning?	
To what degree did he/she seem motivated to work with this project?	
During your visit, what were the indicators of influence that you noticed? <i>(For example: many requests or questions during the interview, presence of other important members of the community near him/her, etc.)</i>	
Other important observations?	

PART V: VALIDATING YOUR CHOICES WITH PROJECT STAFF AND WITH THE COMMUNITY

The information-gathering phase is now complete. In the village, the team now has a good idea of groups and influential people with whom it will engage in TJ activities. One final step is important before making final decisions: talk with other project staff and people in the community about the groups and individuals with whom TJ wants to work and gauge their reaction. If it is favorable, the team has made good choices.

APPENDIX D:
Health Facilities Assessment Findings

Constat de l'évaluation des centres de santé (CS)



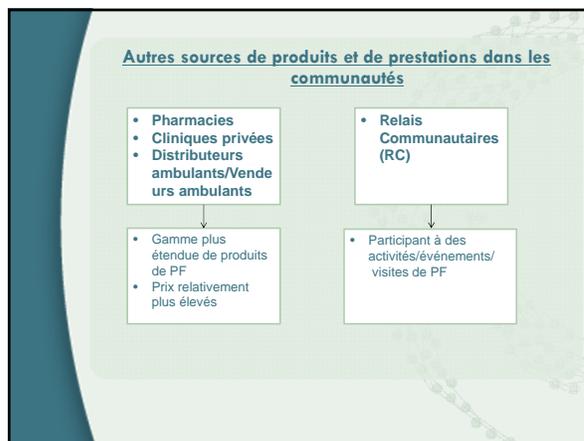
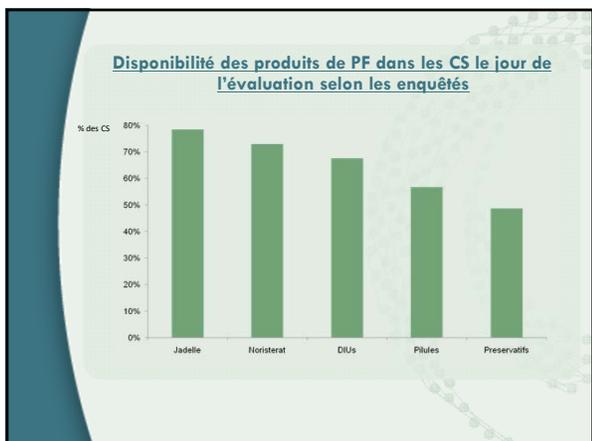
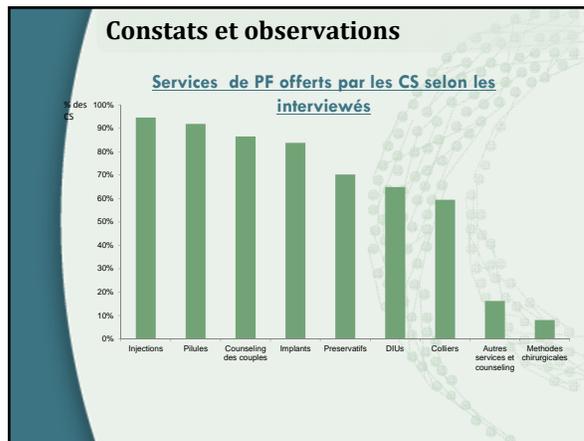
Objet

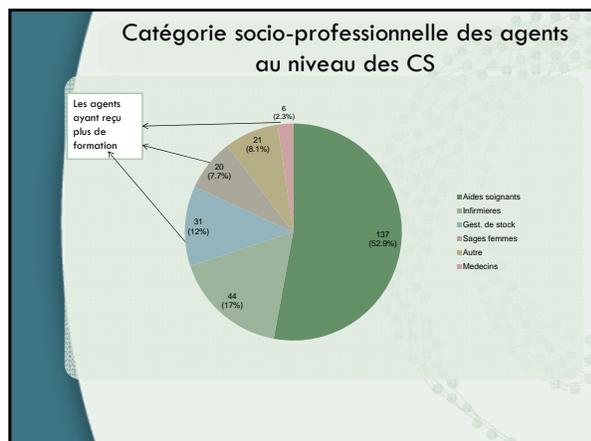
Faire une évaluation rapide des services de PF pour un plaidoyer auprès du ministère de la santé au Bénin et des autres parties prenantes afin d'améliorer l'accès aux services en :

- Étudiant le type, coût et disponibilité des produits et prestations de PF dans les communautés
- Constatant la disponibilité du personnel offrant des services de PF
- Évaluant les tendances de couverture de PF dans la zone d'intervention du projet TJ
- Identifiant les facteurs qui influencent les prestations de PF

Centres de santé (CS) ayant bénéficié de l'évaluation des services de PF

- 37 Centres de santé (CS) dans six communautés
- 16 CS dans les communautés de Aplahoue, Djakotomey et Dogbo couvertes par CARE
- 21 CS dans les communautés de Klouekanme, Lalo et Toviklin couvertes par Plan
- Données recueillies en juillet 2013





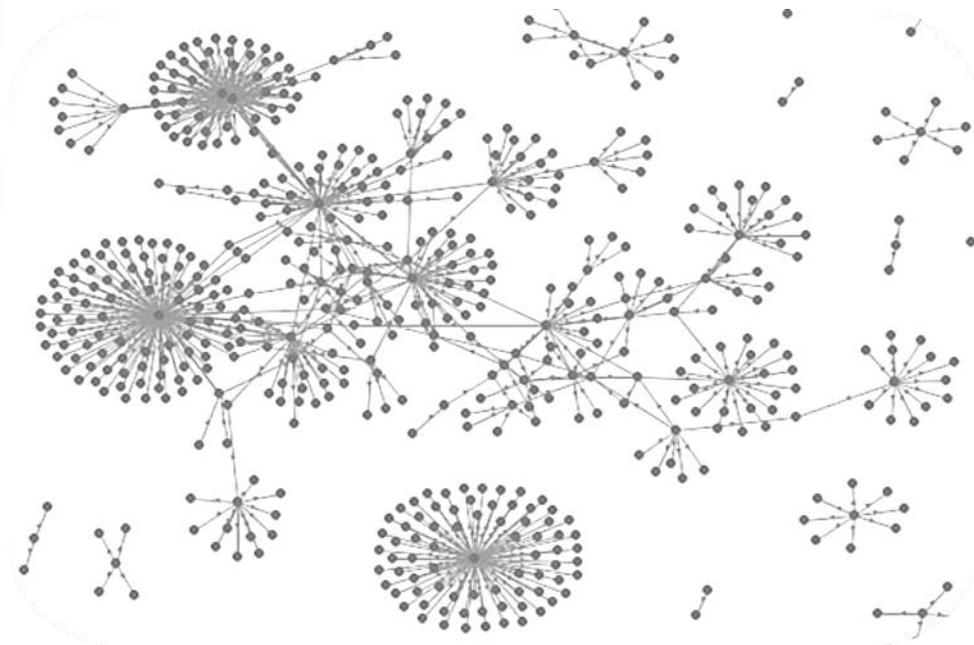
Pourcentage des CS ayant du personnel formé dans les domaines de PF

	Technologie contraceptive	Logistique contraceptive	Insertion des DIU	Insertion des implants	Collier
1 agent formé	41%	43%	43%	43%	35%
2 agents formés	13,5%	11%	19%	19%	19%
≥ 2 agents formés	16,2%	16,2%	5%	5%	13,5%

- ### Principales contraintes de la PF selon les enquêtés
- La culture "pro-nataliste"
 - Le refus des hommes (d'utiliser des contraceptifs ou de permettre à leurs femmes de les utiliser)
 - Les rumeurs/fausses idées liées à la PF
 - L'absence de rôles modèles dans la communauté
 - Les contraintes financières
 - Les ruptures de stocks des méthodes et insuffisance d'équipements
 - L'insuffisance de personnel formé pour l'offre des services de PF

- ### Facteurs susceptibles d'influencer l'offre et la demande de PF
- Développer et élargir la sensibilisation au niveau des communautés ; discuter des idées fausses et des craintes des effets secondaires
 - Sensibilisation médiatique, en particulier la radio
 - Counseling des couples, avec aussi des programmes qui ciblent les hommes et un counseling individuel pour femmes
 - Formation ponctuelle et accompagnement des RC en leur fournissant du matériel de IEC
 - Formation/information continue des sages-femmes et aides-soignants (soit 60,6 % du personnel)
 - Assurer la disponibilité des produits

APPENDIX E:
Draft Baseline Household Survey Report



Baseline Household Survey Report

Tékponon Jikuagou Project

Addressing Unmet Need for Family Planning through Social Networks in Benin

INSTITUTE FOR REPRODUCTIVE HEALTH

4301 Connecticut Ave NW
Washington, DC 20008 | www.irh.org

CENTRE DE RECHERCHES ET D'APPUI-SOUTIEN AU DEVELOPPEMENT

Agori Lot 192-AC 14875
Abomey-Calavi, Benin

This research 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 of USAID or the United States Government.



USAID
FROM THE AMERICAN PEOPLE



TÉKPONON JIKUAGOU
INSTITUTE FOR REPRODUCTIVE HEALTH GEORGETOWN UNIVERSITY
CARE INTERNATIONAL
PLAN INTERNATIONAL

TABLE OF CONTENTS

List of Tables & Figures.....	i
Acknowledgements.....	ii
I. Background	1
Definitions of FP Need	3
II. Baseline Survey Objectives, Design and Implementation	4
Sampling.....	6
Survey Instruments.....	6
Data Collection and Data Entry	8
III. Results	9
Background Characteristics.....	9
Network Characteristics	10
Family Planning Use	11
Reasons for Non-use.....	11
Utilization of Family Planning Services.....	12
Family Planning Need	13
Met Need, Unmet Need, and No Need (Real or Perceived).....	13
Perception of Post-partum Pregnancy Risk.....	14
Access to Family Planning Services and Self-Efficacy.....	14
Attitudes toward Family Planning.....	15
Perceived Advantage and Disadvantages of Family Planning.....	15
The Effect of Religion	15
Perceived Family and Entourage Approval	16
Stigma	16
Couple Communication	17
Perceptions of Couple Communication	18
Couple Communication about Family Size, Child Spacing, and Family Planning Use	19
Family Planning Talk in the Community.....	20
Study Limitations.....	21
Conclusions	22
Appendix A: List of Villages Surveyed for Baseline Evaluation.....	23
Intervention Zone (Couffo).....	23
Control Zone (plateau)	25
Appendix B: Current Contraceptive Prevalence by Religious Affiliation.....	30

LIST OF TABLES & FIGURES

Figure 1: Tékponon Jikuagou Result Framework.....	2
Figure 2: Tékponon Jikuagou Research Design.....	4
Table 1: Allocated Sample Sizes and Achieved Sample Sizes by Gender and Area.....	6
Table 2: Background Characteristics.....	9
Table 3: Network Characteristics.....	10
Table 4: Past and Current Family Planning Use (% women).....	11
Table 5: Reasons for Non-Use (% women).....	12
Table 6: Use of FP Services.....	13
Table 7: Need Status.....	13
Table 8: Self-Efficacy in Obtaining FP Services (% who agreed with the statement).....	14
Table 9: Perceived Advantages and Disadvantages of FP (% who agreed with the statement).....	15
Table 10: Perception of Community Support for FP Use.....	16
Table 11: Perception of Stigma Related to FP Use (% who agreed with the statement).....	17
Table 12: Perception of Stigma in the Community (% who responded 'yes').....	17
Table 13: Gender Norms and Couple Communication (% who agreed with the statement).....	19
Table 14: Couple Communication (% women).....	20
Table 15: Attitudes towards FP (% women who responded 'yes').....	20
Table 16: Sources of Information or Communication about FP (%, intervention zone, during the three months before interview).....	21

ACKNOWLEDGEMENTS

We would first like to acknowledge our Terikunda Jekulu Project partners, the Cooperative for Assistance and Relief Everywhere (CARE) and Plan International, for their support and technical assistance throughout the conception and implementation of this study. We also want to thank the following individuals for their critical contributions to the development of this report: Irit Sinai, Rebecka Lundgren, Jennifer Keuler, Heather Buessler, Mariam Diakite, Ben Moulaye, Etienne Koulon, Emmanuel Akakpo and [*will ask Mariam if there are others at CRAD who should be named*]. We thank the dedicated staff at the Centre de Recherche et d'Appui-conseils au Développement (CRAD) for their insight, collaboration, expert support and hard work. We express our sincere gratitude to all of the researchers and supervisors who conducted this research in the field, as well as those who recorded, cleaned and verified the data. Finally, we humbly thank the women and men in the departments of Couffo and Plateau who generously shared their opinions and experiences with us during the course of the study.

DRAFT

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?

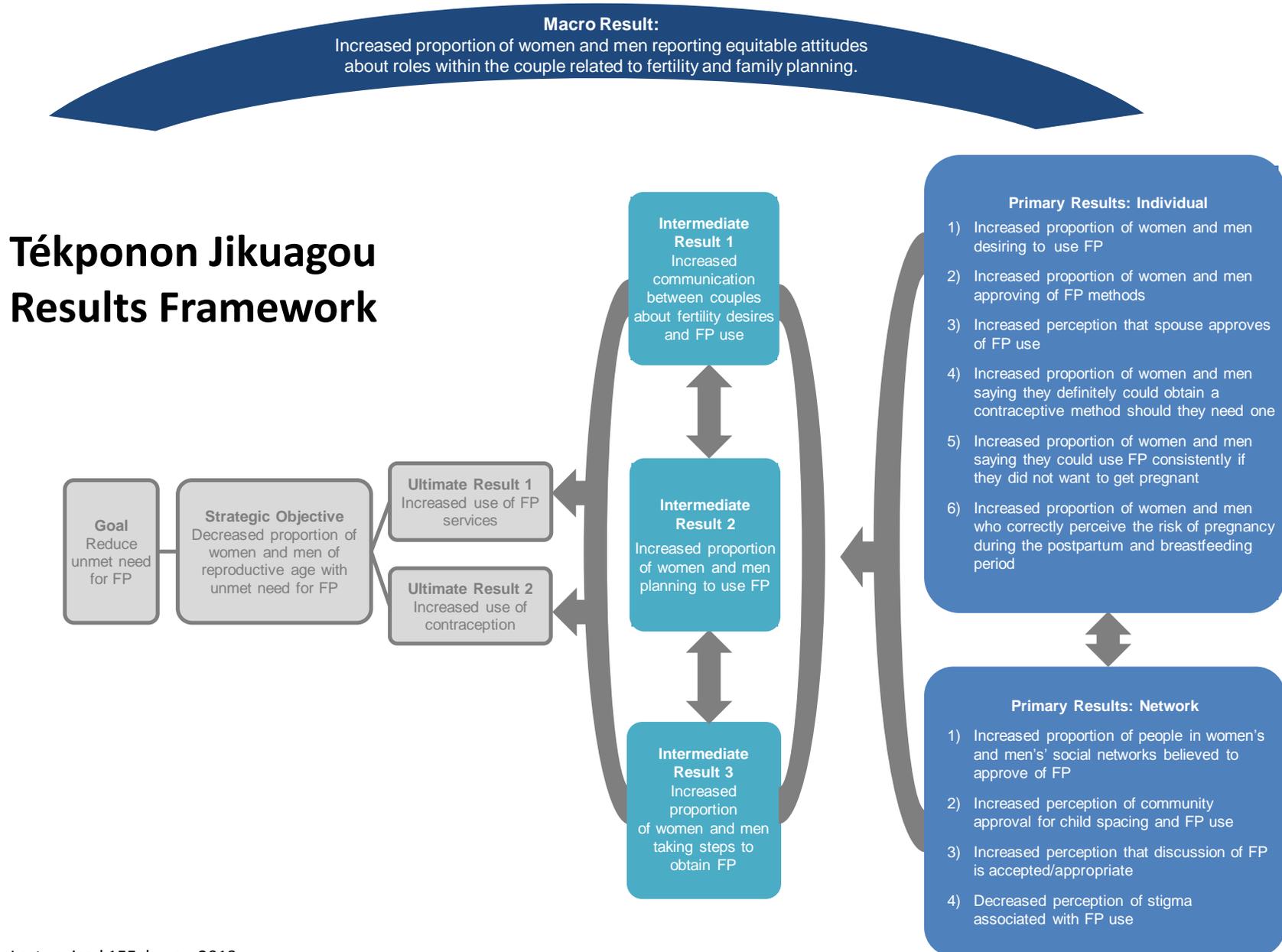
Many efforts to reduce unmet need have focused primarily on women and, in some cases, their partners, without taking into consideration the social networks in which reproductive health decisions are made. Recently in Benin, increasing attention has been given to the influence of men on women’s FP use. 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, Tekponon Jikuagou (TJ) 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 Tekponon 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.

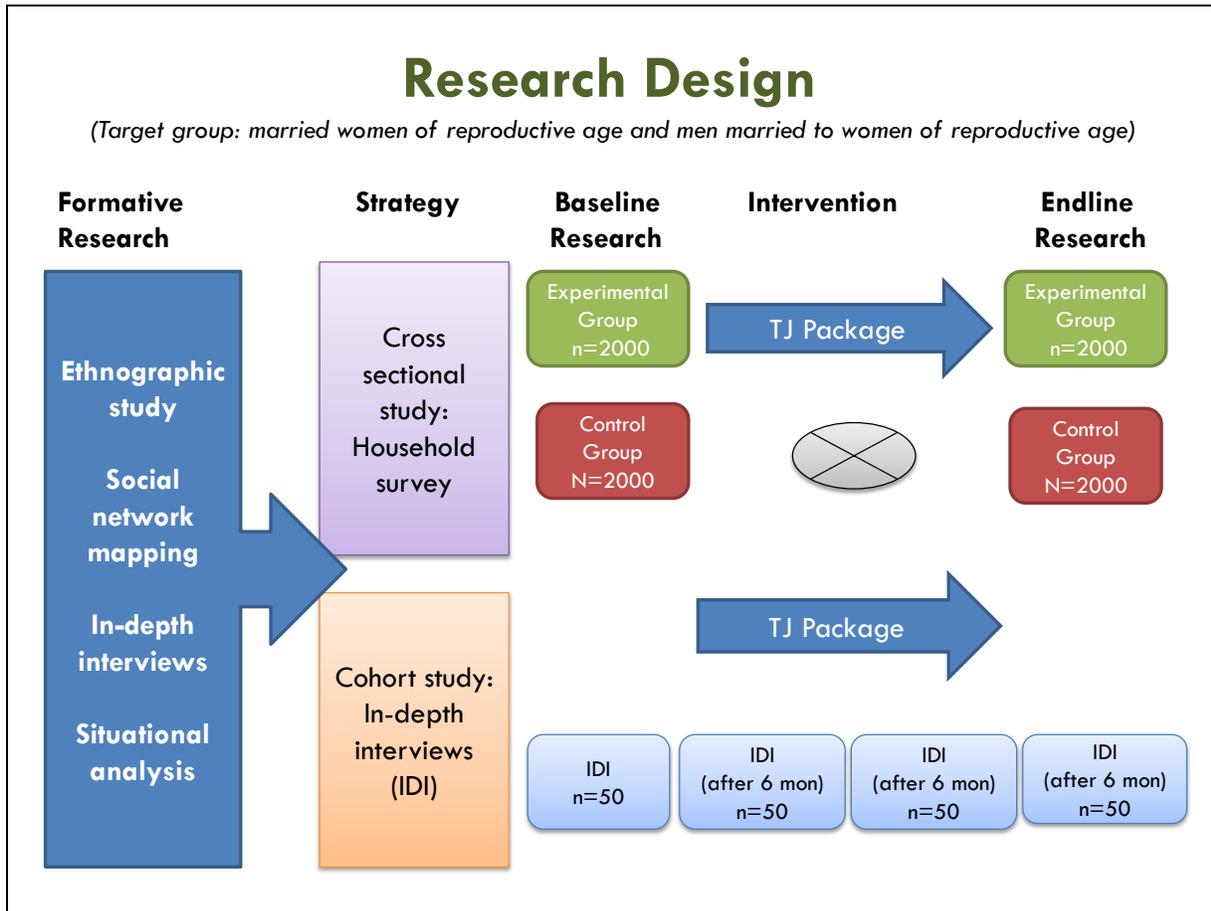
would consider a woman who is not breastfeeding exclusively but still postpartum amenorrheic as having unmet need, since she is biologically susceptible to pregnancy. In contrast, our definition considers this woman as having no need if she believes it is impossible to become pregnant in this state,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

Since Project TJ 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



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 TJ 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 TJ 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 will be controlled for during statistical analysis. 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 TJ 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.

Researchers visited 45 villages in the intervention areas and 45 villages in the control for a total sample of 4,320 participants, evenly divided into 2,160 women of reproductive age (18-44) and 2,160 men married to women of reproductive age. Table 1 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: Allocated Sample Sizes and Achieved Sample Sizes by Gender and Area

	Planned sample size			Achieved sample size		
	<i>Intervention</i>	<i>Control</i>	<i>Total</i>	<i>Intervention</i>	<i>Control</i>	<i>Total</i>
Women of reproductive age (18-44)	1000	1000	2000	1080	1080	2160
Men, married to women of reproductive age (18-44)	1000	1000	2000	1080	1080	2160

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 : Background Characteristics

	Intervention		Control	
	Women n=1080	Men n=1080	Women n=1080	Men n=1080
Age				
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
Marriage status				
Polygamous	45,0**	41,9**	37,1	31,7
Monogamous	55,0	58,1	62,9	68,3
Number of children				
Mean	3,4	5,7**	3,2*	4,6
Level of education				
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
Religion				
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
Ethnicity				
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.

Table 3 : Network Characteristics

	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 ¹		
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.

Table 4 : Current and Past Family Planning Use (% women)	Ever used		Currently using	
	Intervention n=1080	Control n=1080	Intervention n=1080	Control n=1080
Method	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
Never used a method	50,5	73,6**		
Not currently using a method and not pregnant			18,9	17,1
Currently pregnant			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
Fertility-related reasons		
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
Opposition to use		
Respondent opposed	3,7	6,5
Husband opposed	5,4	5,2
Others opposed	0,0*	1,2
Religious prohibition	1,7**	6,0
Lack of knowledge		
Knows no method	28,1**	13,4
Knows no source	5,7	5,0
Method-related		
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 is 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
Positive Statements				
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
Negative Statements				
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 B. 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
FP Use is Stigmatized				
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
FP Use is not Stigmatized				
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
Gender Roles in the Household				
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
Gender Norms Related to Child Spacing and FP				
Couple decides				
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
Woman decides				
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
Man decides				
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 TJ 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.

Most importantly for evaluation purposes are the significant differences between intervention and control areas.. Different ethnicities, religions, and other demographic and cultural differences resulted in significant differences in behavioral and social norms, including the outcomes Tekponon 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. 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.

We found that the intervention and control areas were quite different, 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.

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
BOTA		
ZOHOUDJI		
DJAKOTOMEY	KOKOHOUE	KANSOHOUE
		KOKOHOUE
	KPOBA	KPOBA
	SOKOHOUE	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

06

22

45

CONTROL ZONE (PLATEAU)

COMMUNE	ARRONDISSEMENT	VILLAGE
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
	ITA-DJEBOU	KOBEDJO
		ADJEGOUNLE
	TAKON	ADJAHOUN KOLLE
		ITA KO
		HOUEGBO
	YOKO	GBAGLA YOVOGBEDJI
	YOKO	
	ARAROMI ET KADJOLA	
	MORO	
SAKETE I	ODANREGOUN	
SAKETE II	WAHI	
3	16	45

APPENDIX B : 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