

# **Project Tékponon Jikuagou**

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

### **Annual Progress Report: October 2013-September 2014**

---

**Submitted: October 31, 2014**



**USAID**  
FROM THE AMERICAN PEOPLE



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

## OVERVIEW

The six-year Tékponon Jikuagou Project, led by Georgetown University's Institute for Reproductive Health (GU/IRH) in collaboration with CARE-International and Plan-International, 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. Tékponon Jikuagou relocated to Benin in September 2012 and laid the project's management, program, and research foundation in 2012/2013. Twenty-four months later, with support from USAID, the MOH and other FP stakeholders, a package of pilot social network activities is in full implementation in two Health Zones in Couffo Department, with all 90 pilot villages implementing the complete Tékponon Jikuagou package as of April, allowing eighteen months of pilot implementation in Phase 1 villages and twelve months in Phase 2 villages before the endline is conducted in November 2014. USAID-Washington, following positive findings from the USAID Management Review of the project, approved a much-needed cost-extension mid-2014, allowing a sixth year to complete and evaluate the pilot and expand the package to two additional health zones during scale-up.

The Tékponon Jikuagou intervention package (see graphic) aims to leverage social networks to diffuse information and ideas, in order to create an environment where women and men can exercise their desire to space or limit births. Community-identified influential social groups and opinion leaders catalyze discussions related to planning births and using modern FP methods. Radio programs and linkages between health services and influential individuals and groups create an enabling environment for FP use. Rigorous monitoring and evaluation is allowing us to continue refining the Tékponon Jikuagou package and test its effectiveness in changing FP attitudes, FP efficacy, and couple communication. Related research investigates qualitatively the impact of social networks on FP and the dynamic nature of unmet need for FP. Project monitoring and evaluation data, as well as cohort data of women and men residing in communities reached by the intervention, indicate that social diffusion is occurring beyond influential groups and individuals and normative changes are occurring in terms of public dialogue on unmet need and family planning by women and by men.

### 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** 

As this annual report attests, the October 2013 to September 2014 period is notable for the project's full-scale implementation of the pilot, still making refinements of components of the Tékponon Jikuagou package while laying foundations for scale-up. In terms of package refinement, we have found that getting the radio component 'right' was more difficult than imagined. An assessment was conducted early in 2014, about mid-point in the pilot time frame, to gain user perspectives of the intervention package and its potential for scale-up by other organizations. In the last six months of FY2014, much discussion on scale-up modalities and supportive processes has occurred. By year end, the project has defined its goal of expanding into two additional health zones while continuing to reach new villages in the two initial health zones – seeking depth (50% village coverage in three health zones) and breadth (working in a fourth health zone with NGOs outside of current consortium relationships - in the scale-up experience. We have defined new user organizations: Development projects operated by CARE and Plan will integrate the intervention package into their programs as well as an independent NGO that will be identified in early 2015 that will integrate the package into its programs.

Looking forward: There is much anticipation around the endline survey results, which should be available in early spring of 2015. Assuming that the endline study shows the approach is effective and that minimal package adjustments will be required, project staff will move forward with scale-up planning with new user organizations and then begin implementation by April 2015. New challenges include supporting our staff who were involved in developing and testing the pilot intervention to change roles during scale-up; they will need to begin supporting staff in new organizations to play the roles they played in the pilot phase. This 'passing the baton' step will be critical to testing the feasibility of package in new organizational settings and cultural contexts. Issues confronted in the pilot phase will continue, particularly the need to advocate for improved quality of FP services in areas where latent demand for FP is being unleashed through a social change process.

## KEY ACCOMPLISHMENTS IN YEAR 4: OCTOBER 2013 - SEPTEMBER 2014

Project Management & Coordination	
Partner Relations	<p><b>PAG Meetings</b></p> <p><b>PAG-Benin Coordination/Planning Meetings</b> (IRH, CARE, Plan staff in Benin) – These monthly meetings bring together all partners for discussions on implementation management, including close-out of the pilot phase. Most often staff from the Monitoring, Learning and Evaluation Committee (CSAE) present data from the monitoring system and small evaluation studies, to ensure data are part of the decision-making process. Only seven of twelve (60%) planned meetings were held during the year. Missed meetings were due primarily to partner travel to the field to support new components added to package implementation (radio, influential individuals, selection of influential men’s groups in villages without them, and preparing for ‘Each One Invite Three’ (EOI3) activities). One meeting was held in Azové to accommodate ongoing activities, and coordination and information exchanges also occurred via e-mail, telephone calls, and ad hoc meetings.</p> <p><b>PAG-USA Meetings</b> (IRH, CARE, Plan staff in the US) – These phone/Skype meetings are scheduled each month; a total of 11 meetings were held this year. The April meeting was replaced by the mid-year US PAG Meeting held on April 16-17 in Washington, DC. Meetings involved high-level discussion of strategy, program theory, shifting roles and responsibilities as staff moved into scale-up, and planning technical assistance prior to and after scheduled technical assistance visits. Additional ad hoc Skype meetings were held throughout the year, including a meeting between IRH, CARE and Plan in September to discuss annual work planning and budgeting exercises.</p> <p><b>PAG-Benin and PAG-USA Coordination Meetings</b> (project managers in Benin and the US) – Meetings were planned to occur every two months, yet only one was held this reporting period, in June 2014. This is due, in part, to US-based staff travel to Benin. In addition, regular conference calls between each organization’s HQ staff and Benin staff have ensured sufficient sharing of information and decisions vertically and horizontally and project implementation has not been adversely affected. We will likely move to Benin-USA telephone meetings as needed in FY 2015.</p>
	<p><b>PAG All-staff Meetings</b></p> <p><b>Mid-Year PAG Meeting</b> (March 2014)  This mid-year meeting of almost all staff (several US-based staff did not attend) took place from March 17-20. The first part of the meeting was held from 17-18 March in Azové and brought together all of the USA and Benin staff to examine issues and solicit opinions discussed in the next paragraph; the second part was held in Cotonou to bring together managers from IRH, CARE, and Plan for decision-making and finalization of the work plan for April to September 2014.</p> <p>The March meeting focused on the different elements of the Tékponon Jikuagou package, analyzing what was working/not working well, and on other questions and issues that were arising from implementation. In particular, the group discussed the continuing lack of involvement of men’s groups and how to manage two sets of pilot villages – the first 60 villages in Phase 1 that had been supported since April 2013 and the 30 villages in Phase 2 that, as of April 2014, would implement the full Tékponon Jikuagou package. (Due to the Benin relocation and need to start the pilot quickly, Phase 1 villages started a set of Tékponon Jikuagou activities and added additional activities as they became available for implementation. Phase 2 village implemented the complete set of activities according to the planned sequence.)</p>

Key decisions included:

- Thinking more broadly about men's groups as they were being mapped in the village, allowing for more informal yet influential men's groups to be selected for Tékponon Jikuagou activities.
- A decision was made to test and later evaluate the modality of orienting influential individuals: half the villages would orient influential individuals at arrondissement-level meetings; half the villages would orient influential individuals at village-level meetings.
- Radio stations, which had begun broadcasting reflective dialogue discussions in January, needed to harmonize broadcasting times and programs across the two contracted radio stations.
- The Tékponon Jikuagou Pilot Committee, based in Couffo, was not functioning well and a plan to revitalize their work and role in overseeing pilot activities was developed.
- Finally, decisions on when to end project support to Phase 1 villages was determined (end of April), and how to close out activities in all 90 pilot villages was determined (holding arrondissement-level celebration events with Tékponon Jikuagou actors and MOH staff and providers in September).

During this PAG meeting, a second learning reflection session was held revolving around analysis of all Tékponon Jikuagou package components, with a particular focus on management issues relating to package implementation (described above), as well as observations of social change occurring at village level.

#### **Annual International PAG Meeting (August 2014)**

The annual international PAG meeting took place from August 4-7. The first two days of the meeting gathered all staff in Azové to address the many anticipated changes as the project transitions from pilot to scale-up. Goals of the meeting were 1) to come to a common understanding of how partner roles and responsibilities would change as they shifted from direct implementation to technical assistance and support to others implementing the package, and 2) to develop a work plan for completing the pilot phase and launching scale-up. The last two days of the meeting brought together managers from each partner organization for further discussion on new roles and responsibilities, selection of new health zones and CARE and Plan development projects that would integrate the package into their programs (i.e., become new user organizations), and clarification of preparation activities for scale-up. Several implementation decisions were made in preparation for the scale-up phase, including:

- Scale up would occur in four health zones. Plan, through its existing development projects, would reach 50% of all villages in the two health zones where TJ was being piloted. CARE, through its existing development projects, would also reach 50% of village in one health zone in Ouémé Department. A fourth health zone would be determined by April 2015, and involve expansion of the package by an NGO that was not linked through existing projects to CARE or Plan.
- Develop new reflective dialogue materials on themes not addressed in current stories, including a) unmet need and family planning from men's perspective, b) managing gender based violence, and c) unperceived need for family planning, especially during post-partum and breastfeeding periods.
- End radio testimonials being aired during the pilot phase, as they were judged counter-productive to gender equity goals of the project. For similar reasons, conduct an analysis of a sample of radio call-in discussions to determine if it made sense to keep call-ins as part of the radio component during the scale-up phase.

	<p><b>Continued Scale-Up Planning</b> (August-September 2014)</p> <p>In order to finalize FY2015 work plans and budgets, project staff continued conversations on various scale-up parameters, including the extent of scale-up given available resources, shifting roles and responsibilities of staff as they transitioned from piloting to supporting others to implement the package, and FP service availability to respond to increased demand. As the fiscal year ended, CARE and Plan were assessing which projects within their respective organizations would integrate the package during the expansion in three health zones. IRH was looking externally and developing a list of Beninese NGOs that could be potential scale-up partners in a fourth health zone. CARE and Plan projects that will integrate the package should be selected by the end of October 2014.</p>
<p>Partner Coordination Meetings with USAID</p>	<p>Project staff participated in two quarterly USAID partner meetings on December 5, 2013 and April 1, 2014 in Cotonou. Dr. Ben of IRH and Dr. Ghislaine of Plan represented the project at the December meeting, sharing information on the Tékponon Jikuagou package and the extent to which activities, including the baseline, were accomplished. The April meeting was focused on M&amp;E of USAID projects. Mariam Diakité of IRH shared monitoring data on diffusion of FP information through influential groups and individuals, results from the baseline study, progress of the on-going cohort interviews, and preliminary findings from the rapid assessment of implementation of the project package conducted by IRH in March. Following the presentation, there was a fruitful conversation with other USAID health partners about how Tékponon Jikuagou indicators might be used to measure early stages of behavior change in other FP-focused programs.</p> <p>There were no formal coordination meetings during the second half of the year due to staffing changes at USAID. A new HPN Officer arrived and later in the year a new USAID focal point was assigned to Tékponon Jikuagou. Both new staff members were provided an introductory briefing of the project. In addition, other opportunities to update Mission staff occurred as US-based staff providing technical assistance in Benin held debriefing meetings with USAID staff.</p>
<p>Technical Advisory Group (TAG) Meetings</p>	<p>The first TAG meeting of 2014 took place on March 12, 2014. Most organizations represented on the TAG were present, including USAID, Centre for Reflection and Action for Integrated Development and Solidarity (CERADIS), UNFPA, Réseau des ONG Béninoises dans la Santé (ROBS), Association Beninoise de Planning Famiale (ABPF), the Dutch Embassy, French Cooperation, PSI/Association Béninoise de Marketing Social, Division de Santé maternelle et Enfance (DSME), MOH, and the Mono-Couffo Departmental Directorate of Health, Faculty of Health Sciences, and IDEA and APC projects (USAID-supported).</p> <p>The meeting included a presentation of results of Tékponon Jikuagou's baseline household survey, sought TAG validation of the EO13 invitation card, and engaged members in discussion about how to increase male participation in project activities and how to ensure FP services availability in the intervention zone. As a result of the meeting, the TAG requested support from the MOH in ensuring FP services availability in the pilot and scale-up zones, and made a number of recommendations to project partners to ensure male participation in project activities.</p> <p>Requests to the MOH included:</p> <ul style="list-style-type: none"> <li>- Ensure trained FP agents are based in facilities serving Couffo through a three-pronged approach that includes: recruitment of new health agents trained in FP to address current shortcomings in the field; training in FP for agents present in the field, including a special program to improve nursing standards, since nurses are the most stable agents in the health centers; and use of mobile clinics to provide long-acting methods.</li> <li>- Improve the MOH's FP contraceptive supply system from the national level all the way down to health facility level.</li> <li>- Consider offering free FP services, in view of cited financial barriers to uptake by clients.</li> </ul>

		<p>Recommendations to increase male participation included:</p> <ul style="list-style-type: none"> <li>- Review the criteria to identify and select men's influential groups in villages, with a focus on men's livelihood support associations like SONABI, ZIM and other agricultural cooperatives.</li> </ul> <p>Broadcast/disseminate men's testimonials on their satisfaction with FP and FP method use.</p> <p>The second bi-annual TAG meeting, originally scheduled for September 2014, was delayed to October 22 due to a lack of availability of key individuals at the Ministry of Health. (Although not technically part of this report, an important recommendation from the October meeting was to move the project's technical advisory function to the MOH's FP/RH Technical Working Group that is overseeing FP revitalization efforts in Benin. This will occur by early 2015.)</p>
Comité de Pilotage	Pilot Committee (Comité de Pilotage) Meetings	<p>The Pilot Committee did not meet this reporting year. They were to meet in the first quarter, but never called a meeting. In an effort to revitalize this structure, CARE and Plan Field Supervisors met with the Committee Chairman (Mayor of Klouékanmey) in early 2014 to encourage him to set a date for the next quarterly meeting and in March proposed a new way for the project to support meeting planning. As this report is written, a date has not yet been set and the pilot is closing down. It appears the approach was unsuccessful in terms of fostering multi-sectorial sharing between the MOH and civil society groups.</p>
Supervision	CARE & Plan Field Coordination Meetings	<p>CARE and Plan staff met almost monthly this fiscal year to coordinate implementation activities, discuss implementation issues, and collaborate on development and field-testing reflective dialogue materials found in the package. These meetings are appreciated by the participants and have improved overall understanding and coordination of the project at field implementation level.</p> <p>Eight meetings were held. In October, discussions centered upon lessons learned from the annual project review; updates on the revised orientation plan for catalyzers, coaching issues and strategy, and distribution of tools tested by facilitators; selection of influential individuals; and 'network reconfiguration' strategies for introducing catalyzers to health workers and strengthening health center linkages. November discussions centered upon findings from field tests of activity cards (activity cards 5, 6, and 7), the slightly revised project vision, and a review of data collection tools. The December meeting was disrupted by end-of-year holidays. Three meetings were held in January, February, and March that included participation of national coordinators (Drs Bello and Ghislaine). These meetings covered planning for the mini-PAG meeting in March and encouraged harmonization in planning and implementation of the different activities. The frequency of these meetings decreased in the summer months, but missed meetings were replaced by informal meetings on an as-needed basis, or by larger meetings like the international PAG meeting in August. Overall, three coordination meetings provide a forum for joint planning, identification of challenges, and harmonization of project approaches. The June meeting, in particular, allowed the project team to organize the 'Each One Invites Three' (EOI3) campaign.</p>

Supportive supervision of field staff	<p>In an effort to be more responsive to implementation realities of the pilot, early in 2014, Plan-Benin instituted weekly coordination meetings and activity planning at field level. During the January to March 2014 quarter, twelve (12) coordination meetings were held, during which an update of activity achievement against planned activities was assessed. A similar exercise was conducted by the national coordination team each month. These meetings have allowed better monitoring of Plan's planned activities against the global work plan and have led to more results-oriented weekly schedules of field staff. CARE reported no changes to their current supervision structure in this reporting period.</p> <p>In addition, CARE and Plan managers, based in Cotonou, each completed 12 supervision visits in their respective zones, support which was greatly helpful for Tékponon Jikuagou facilitators and supervisors. Additionally, CARE organized a joint supervision visit with the zonal health department to visit all health centers to monitor the execution of the EO13 activity. The zonal health department strongly recommended continuation of the initiative, which it felt could eventually be adopted at the zonal level to engage health agents and communities more in family planning.</p>
Joint Coordination Trips	<p>Four joint coordination trips were planned this year, but only two were carried out due to scheduling challenges of the MOH representative who participates in these visits.</p> <p>The first coordination visit from January 20-24 included MOH and TAG representatives, along with Plan, CARE and IRH staff. A particular focus of this visit was on strengthening collaboration between Tékponon Jikuagou field agents and health center providers. The group visited the zonal director of the Mono-Couffo health department, the zonal FP manager and health providers in facilities in Adjahomé, Lalo, Misinko, Aboukandji, Lokoba and Lagbavé, representing six of eleven health centers operating in project-supported areas. The coordination team recognized the shortcomings of FP services, particularly frequent staff transfers as well as frequent staff absence from health centers to attend meetings in Cotonou, and the absence of a full range of FP products. The MOH and TAG representatives committed to take necessary measures to advocate for improved services, and reiterated their satisfaction with efforts to help MOH staff better understand the Tékponon Jikuagou package.</p> <p>A second coordination visit took place from May 19-23. The focus of this visit was strengthening coordination of Tékponon Jikuagou at the department and health zone level, particularly in anticipation of the EO13 campaign that was scheduled to begin in June. The team, which included representatives of the project, the MOH and the TAG, visited six villages participating in the project and spoke with group catalyzers and influential individuals. They also visited four health centers, four local mayor's offices, and the two radio stations broadcasting Tékponon Jikuagou content (Radio Lokossa and Couffo FM). The team had the opportunity to attend a Community Council meeting as well as several communities in one of the health zones. The team took the opportunity to advocate at all levels – community, zonal and departmental – the provision of EO13 invitation cards, and to offer recommendations for improving the project partnership. Top recommendations included:</p> <ol style="list-style-type: none"> <li>1. Reinvigorate the Pilot Committee (Comité de Pilotage).</li> <li>2. Eliminate those radio testimonials that are poorly done, i.e., that are more like FP promotion stories rather than life experiences managing social barriers to seeking and using FP.</li> <li>3. Systematize community linkages to health structures through exchange of contact information and planning with group catalyzers, engagement in EO13 trainings and joint supervision missions from the zone or department level.</li> <li>4. Seek resources for FP training for improved service provision and counseling skills among health workers</li> </ol> <p>A third joint coordination visit was delayed, and is now scheduled to take place in October 2014.</p>

**Implementation of Pilot Social Network-based Interventions**

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Social Mapping</p>	<p>Completion of community social mapping in intervention villages</p>	<p>Early in the October-December quarter, CARE and Plan completed community social mapping in 30 Phase 2 villages, leading to 109 catalyzers and 137 influential people newly selected. In all 90 pilot villages, a total of 309 catalyzers and 469 influential people were selected and oriented to project activities.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Influential Individual Activities</p>	<p>Test and finalize influential individuals' orientation materials</p> <p>Orient influential individuals and seek their engagement</p>	<p>Field staff finalized draft materials to be used during the orientation of influential individuals with Plan USA technical assistance in mid-November. Revisions aimed to further simplify materials and included reducing the number and types of questions discussed. A question about how to represent health facilities as images in infographic cards required a small survey with community members in late November, and some images were also adjusted to be more gender and Islamic-representative. Final feedback was shared with IRH in early December and changes in infographics and other materials were finalized by IRH's communications expert before being sent to the field in mid-December.</p> <p>Orientation of influential individuals took place in January and February. Facilitators were trained on the materials content and approach to working with influential individuals in December. To expedite orientation of Phase 1 village influentials, CARE and Plan decided to conduct orientations by arrondissement, rather than by village. In total, 155 persons (78 women and 77 men) were oriented in Plan zones, and 179 persons (94 women and 85 men) in CARE zones. A second set of orientations for influential individuals in the 30 Phase 2 villages was held in June; half the villages were oriented at the arrondissement level and half at the village level to assess which modality worked best from the staff and influential individuals' perspectives. CARE oriented a total of 51 influential individuals, while Plan oriented a total of 76 influentials.</p> <p>During the orientation, influential individuals identified several activities they wanted to do to support community engagement in addressing unmet need. Among these activities were:</p> <ul style="list-style-type: none"> <li>• Supporting group catalyzers in their activities;</li> <li>• Sharing information in convents and churches;</li> <li>• Resolving conflicts in homes and communities that may arise due to Tékponon Jikuagou activities, such as reflective dialogues, which treat sensitive subjects and lead to new attitudes and ideas;</li> <li>• Asking village leaders to introduce a Tékponon Jikuagou discussion point in all their regular meetings</li> <li>• Bringing pregnant women and women with children less than 5 years who do not belong to any group to follow the discussions within a group.</li> </ul> <p>The infographic cards used at influential orientations were finalized between the Phase 1 and Phase 2 orientation sessions, and 200 sets of infographic cards were printed and distributed during Phase 2 orientations (Phase 1 individuals received final draft versions.) These cards presented data on unmet need for FP from the baseline in a visual manner to orient influential individuals on the need to take action.</p> <p>After orientation, CARE implemented monthly "check-ins" with influential individuals. These are completed during regular monitoring visits by field staff, and revealed that influential people were very engaged, and had dedicated themselves to activities they had identified during orientation. CARE completed a total of 228 check-ins.</p>

Development of Radio Component	Record and air radio broadcasts in communities throughout Couffo Zone	<p>Based on decisions made at the International PAG Meeting in September 2013, Plan developed MOUs in October with the two radio stations with which they already had contracts. A third radio station was not responsive, and was dropped after the team determined it did not significantly add to the radio listenership area.</p> <p>In November and December, all six chapters of the 'Choice story' (found on story cards used during group reflective dialogues) were recorded by radio station production staff, along with recordings of catalyzers facilitating discussions in their groups (three groups in Plan villages, three in CARE villages). Broadcasts of stories and questions read by radio actors began airing on December 23, two broadcasts per day (daytime/evening) on Mondays, followed by recordings of actual groups reading and discussing the same story (daytime/evening) on Tuesdays. Thus, the listening audience heard the story and questions first, and then the story and questions with interaction of catalyzers and village groups the next day.</p> <p>Airing of Tékponon Jikuagou stories and group discussions continued through September 2014. Sessions broadcasts included call-in opportunities for listeners to express their opinions or ask questions, and many (mostly men) participated in these conversations. Many rebroadcasts were done by both radio stations for free because of the popularity of the program. During the period, each radio station also recorded testimonials of influential people identified in the two intervention health zones, and incorporated spots on EO13 to raise awareness of the campaign and help listeners recognize invitation cards to seek FP information and services.</p> <p>Several recommendations related to the radio component were agreed upon at the international PAG meeting in August:</p> <ul style="list-style-type: none"> <li>○ Discontinue broadcasts of the testimonials of influential people because of challenges ensuring their quality. There was evidence that some stories might be reinforcing negative gender norms and attitudes instead of combatting them.</li> <li>○ Advocate with technical partners and health authorities to ensure air time for accurate medical information on side effects of methods to help address rumors and false information.</li> <li>○ Continue airing spots on the green line (call-in hot line operated by PSI/ABMS) so that listeners know where to go for correct information on family planning and reproductive health.</li> </ul>
	Collect monitoring data on radio activities from radio personalities	<p>Radio monitoring tools were developed by Plan and sent to radio stations as they received their first pre-recorded sessions. Supervisors and field agents then completed activity reports on the quality of radio broadcasts (broadcast date, duration, content, call-ins).</p> <p>The Voice of Lokossa broadcast 37 Tékponon Jikuagou program segments between December 2013 and September 2014. Some of these were interactive sessions, during which the station received a total of 564 calls from listeners, of whom 514 (91%) were men and 50 (9%) were women. Another radio station, Couffo FM, broadcast 12 Tékponon Jikuagou program segments and received 479 calls, of which 453 (95%) were from men and 26 (5%) were from women.</p> <p>In addition, each radio station recorded and aired testimonials of influential individuals from the intervention communities. Voice of Lokossa recorded 2 testimonials by women and 4 by men, while Couffo FM recorded 3 testimonials by men and women each. Overall, Voice of Lokossa broadcast these testimonials 15 times before they were discontinued for reasons discussed earlier in the report.</p>

Health Center Linkages	Initiate activities to link health center staff with Tékponon Jikuagou groups	<p>A four-point approach to creating health service linkages was systematized during this project year and fully implemented in Phase 2 villages. Providers are invited to interact at specific events during Tékponon Jikuagou package implementation – community social mapping, orientation of influential groups, orientation to the ‘Each One Invites 3’ campaign, and at closing celebrations.</p> <p>Health service providers, particularly nurses and FP providers in nearby health facilities, participated in the first day of orientation for catalyzers in Phase 2 villages. Providers and catalyzers took the opportunity to exchange contact information and schedules to facilitate communication and in-person visits to health center. This services linkage was not systematic in Phase-1 villages.</p> <p>Careful preparations were undertaken to ensure linkages with and support by providers for the ‘Each One Invites 3’ campaign as well. Facility-based service providers were oriented to the campaign’s goals and instructed on how to recognize and collect referral cards. (See next section.)</p>
	Each One Invites Three (EIO3) Campaign	<p>The EIO3 strategy, along with a draft version of the FP invitation card, was presented to the TAG in March 2014. The response to both the strategy and the card was positive. With the incorporation of a few small suggestions, the card was field-tested and 13,500 cards were printed in preparation for the upcoming campaign planned for July-September 2014.</p> <p>CARE and Plan Supervisors contacted zonal health agents in April and May to inform them about the campaign. The EIO3 strategy was presented and information exchanged how health centers could properly support the campaign’s success. In June, the <i>Association Béninoise pour la Promotion de la Famille</i> (a Planned Parenthood affiliate), supported by IRH, conducted a contraceptive technology update for health providers (midwives and nurses) in the project intervention and control zones, as it was felt this training was important to the success of the EIO3 campaign, given the uneven FP skills of providers, and also because the project is creating demand and it is important to respond with good quality services. During these trainings, project staff informed providers of the upcoming campaign and their needed support. A total of 51 midwives and nurses (26 in the intervention zone, 25 in the control zone) were trained in contraceptive technology with a focus on good counseling skills and managing side effects.</p> <p>The EIO3 campaign took place from July-September. A total of 12,975 referral cards were distributed to catalyzers in two zones – 6,212 in KTL (Klouékanmè, Lalo and Toviklin) health zone and 6,763 in ADD (Aplahoué, Djakotomey and Dogbo) health zone. Health providers received women, men, and couples who sought FP services inspired by the campaign, and reports indicate that the influx to some centers was at times overwhelming. The Physician Coordinator of the Health Zone and Statistician worked with staff before and during the campaign to ensure that health workers provided a warm welcome.</p> <p>A monitoring system to evaluate the campaign effect was developed by May. A joint supervision visit took place in August involving CARE and MOH staff from the ADD health zone, and the Department MOH. The team reviewed the general progress of the campaign, as well as the data that were collected regarding numbers seeking services and adopting FP methods. Data analysis is underway.</p>
Catalyzers	Orientation of 90 new catalyzers in Phase-2 villages	In October, Plan and CARE revised the catalyzer orientation, from a two-day to a three-day agenda, to allow sufficient time for catalyzers to become comfortable with using all of the materials (stories/activities). HQ staff reviewed and revised the orientation plan further to allow more time practicing and receiving feedback using the materials in “classroom” settings, and less time using Tékponon Jikuagou materials in a village practicum setting.

		<p>Plan oriented 44 group catalyzers in Phase 2 villages in the January-March 2014 quarter. All catalyzers received a three-day orientation, except for two, who missed the training and instead received individual orientations. CARE oriented 42 catalyzers in the new villages out of the 45 expected; three identified catalyzers missed training due to illness or delivery and instead received individual orientations.</p> <p>During these orientations, health workers participated during the first day to establish a personal relationship between catalyzers and health providers (mostly nurses and midwives), with the aim of creating connections that will allow providers to approach influential groups and vice versa for FP information.</p> <p>Very few men's groups were initially selected in Phase 2 villages causing concern that diffusion would be too tilted towards women's social networks. During the March PAG meeting a decision was made to ensure each village had one men's group by adjusting selection criteria to include more informal men's groups. By April, CARE had identified 11 additional men's groups, one in each village that had not formerly had any men's groups, and oriented one new (male) catalyzer per group. Plan identified 12 informal men's groups and trained one catalyzer per group, along with five catalyzers who had missed their original orientation.</p> <p>During this period, activity cards were further revised and a total of 104 sets of activity cards were printed for CARE and Plan health zones – enough for catalyzers in all Phase 2 villages, including the additional male catalyzers that were oriented.</p>
	Catalyzer coaching	<p>Several months after Phase 1 catalyzers started working with their groups it became clear that many had problems using the reflective dialogue materials. A coaching strategy was launched and a coaching guide developed to help facilitators systematically coach lesser-performing catalyzers to improve their skills and comfort level using Tékponon Jikuagou materials. (In addition, the issue was addressed by extending the period of catalyzer orientations to three days as well as further simplifying materials.)</p> <p>Project language to define this process emerged, e.g., catalyzers were 'graduated' when they showed a level of ease in using materials and facilitating discussions. This unfortunately also led to a predominant focus by field staff on making sure every catalyzer could graduate, regardless of the number of coaching visits to individuals, which was counter-productive in a six-month social network process which needed to be 'light' in supporting catalyzers. Upon reflection in January and March, the language of 'graduation' was dropped and monitoring indicators on number of coaching visits were dropped. In addition to other corrective actions noted in the first paragraph, and a shift was made towards facilitators helping lesser-performing catalyzers find village "allies" to support their work with materials, e.g., by enlisting friends with higher-level French reading skills. Subsequently the coaching guide was revised; all references to "graduation" were removed and the idea of Tékponon Jikuagou as a six-month intervention (not a long-term intervention) emphasized.</p> <p>Starting in April, CARE and Plan began to identify strong catalyzers and influential individuals as part of the phase out strategy in Phase 1 villages. Strong catalyzers were paired or linked with those needing additional help to ensure that support occurred without the help of facilitators. Coaching of catalyzers by facilitators ended in April.</p> <p>In the Phase 2 villages, catalyzers benefitted from a longer orientation (3 days instead of 2), with more focus on becoming familiar with all of the materials. They absorbed better and became more comfortable with revised materials during three days, which has reduced the need for intensive coaching.</p>

Revision of Reflective Materials	Finalize catalyzer and influential individual intervention materials	<p>All materials, stories and activity cards were field-tested and revised based on catalyzer and facilitator feedback on what worked and what needed to be changed, and discussed during Danielle Grant's November trip. No revisions were made to the stories, but one of the activity cards was dropped because it was too challenging to use and groups did not like it.</p> <p>In September, catalyzer focus groups provided further feedback on the quality and usability of the revised activity cards. Findings from these focus groups were discussed at the annual International PAG Meeting in August, which together decided to develop three new stories based on cohort data to cover missing themes. (See earlier section on the August PAG meeting.)</p> <p>Likewise, discussed elsewhere in this report, materials for use with influential individuals were developed, field-tested, and further modified before their finalization in the Jan-March quarter.</p> <p>Bags to hold materials and keep them in good condition were distributed to all group catalyzers in March and April.</p>
	Hold close-out ceremonies to thank catalyzers and influential individuals	<p>Close-out ceremonies for Tékponon Jikuagou activities were held at arrondissement level for the 45 villages of KTL health zone on September 18-20, in Klouékanmè, Lalo and Toviklin, respectively. Close-out ceremonies for ADD health zones were held on September 23-25 in Djakotomey and Dogbo. Ceremonies recognized the efforts of catalyzers and influential individuals, who received a certification of recognition to acknowledge their participation. A total of 681 certificates were distributed. Health workers, mayors and other local officials were also recognized for their participation and engagement in the project. These ceremonies were attended by local authorities in concerned municipalities; all indicated a willingness to continue encouraging reflection, couple communication, and family planning-seeking in their role as influential people.</p>
<b>Research, Monitoring &amp; Evaluation</b>		
Research	Disseminate baseline study results	<p>The baseline report is now available in English and French. Two dissemination meetings were held in Benin to share methodology and results. The first, held on February 21, included representatives of the MOH's DSME division and the USAID Mission, as well as MOH partners engaged in FP efforts. A second meeting was held March 12 to present results to the TAG.</p>
	Analysis of Round 1&2 In-depth Interviews	<p>The project is following a cohort of 25 men and 25 women in intervention areas, who are interviewed every six-eight months. Cohort members represent a range of FP need statuses (met/unmet/no need) and social network status (influencer, connector, isolate). Interviews explore content, quality, and frequency of FP information-sharing within respondents' networks as well as interviewees' understanding of their unmet/met need status and reasons for using (or not) FP. Between October 2013 and September 2014, data from the first two rounds of cohort interviews were analyzed by IRH staff at headquarters and in the field, using a variety of analysis techniques and Atlas.ti software.</p>
	Conduct mid-term assessment of package implementation	<p>To answer questions raised about acceptability and ease of using different materials that form the basis of reflective dialogues, IRH conducted a qualitative study that focused on group catalyzer experiences using materials, facilitating group dialogues, and managing community expectations of the project. Key informant interviews provided perspectives by formal leaders and health care providers and program supervisors. The information was critical in guiding adjustments in the intervention package, allowing an evidence-based approach that was acceptable to all partners. The final report is attached in Appendix A.</p>
	Round 3 In-depth Interviews	<p>Round 3 of cohort interviews took place in September 2014. Findings from Round 1 and Round 2 informed the revision of interview guides for Round 3. Longitudinal analysis to identify changes over time will be conducted after IRH receives data from Round 3 interviews. Once Rounds 1 through 3 data analysis is complete, findings will be shared at Cotonou and Washington, DC dissemination meetings, which will focus on changes in unmet need over time and factors influencing changes.</p>

	Disseminate findings of the rapid assessment of FP services in Couffo	The rapid FP assessment was completed in July/August 2013 and identified gaps in training and services. Status reports for each health facility were developed and distributed in October to the Ministry of Health, Mono-Couffo Health Department, MOH, PSI, ABPF, and USAID.
	Costing study on Tékponon Jikuagou package implementation	A costing study is underway to measure the costs of implementing the Tékponon Jikuagou package, using cost data from CARE and Plan. IRH selected Dr. Hugh Waters, a health economist, to guide and support the costing research, and worked with him to finalize preliminary study objectives, timelines, and draft and test data collection tools. Data collection began this summer, with a field visit scheduled in late October 2014 to finalize data collection with finance and program staff in Benin.
Monitoring, Learning & Evaluation	Monitoring, Learning and Evaluation (CSAE) Committee Meetings	<p>Meetings of the CSAE continue monthly with IRH, CARE, and Plan MLE staff. Each CSAE member is responsible for correcting and validating the data they receive before passing it to IRH for compilation; their involvement in the process is important to assure quality data and to determine accuracy and plausible explanations of numbers. See Appendix B for a presentation of the monitoring results made at the International PAG Meeting in August.</p> <p>The October meeting was combined with a field visit for data quality monitoring, which allowed the team to identify difficulties and solutions to assuring the quality of the data coming from group catalyzers. The November 28 meeting was devoted to data analysis and lessons learned. Each committee member updated the group on their activities and data improvement efforts. The December meeting did not take place due to the holidays, but the January 24 meeting took place in Azové with the participation of a TAG representative.</p> <p>On February 27, the CSAE met to finalize indicators and the collection tools for new package components being introduced - the radio activities and activities of influential individuals. During this meeting, the data collection process was revised in order to address delays with submitting data to IRH.</p> <p>Starting in February, the CSAE decided to reduce meetings from monthly to bi-monthly. As such, the March/April meeting was held on May 13 in Azové. Team members analyzed monitoring data, discussed lessons learned, and identified the strengths and weaknesses of each individual component of the intervention package. One particular weakness raised by the data was the missing link to health providers; few providers were participating in group discussions. In addition, radios were re-broadcasting “interactive” Tékponon Jikuagou programs, which meant that listeners were not able to call in with questions (or listener participation to be counted). Finally, the team compiled data on the total number of group discussion participants and diffusers, and discussed why numbers of the latter group sometimes exceeded those of the participants. For each point, the group came up with recommendations for addressing issues and decisions were taken in consultation with IRH HQ staff.</p> <p>The meeting held on June 6 focused on determining indicators for the ‘Each One Invite 3’ campaign, along with a strategy for collecting data.</p> <p>At the final meeting of the fiscal year, held August 28-29, community social mapping data were analyzed by health zone. The team also compiled the number of catalyzers and influential individuals oriented in order to ensure recognition with a certificate at the closing ceremony.</p>

	Monitoring, Learning and Evaluation (CSAE) Field Visits	The CSAE conducted four quarterly monitoring visits to intervention areas as planned. Visits took place October 28–3, January 21–24, May 13–16, and July 21–25. See description, above. This offered the opportunity for this team to validate the data and to better understand the real context for data and indicators being collected.
	Collection of monitoring data and reporting	Activity reports by catalyzers are a key information source in the MLE system. Data continue to be collected regularly from all catalyzers; on rare occasions some catalyzers do not report. Data synthesis is done every three months (see above description of CSAE). In addition, data on influential individuals are collected monthly by CARE and Plan facilitators. Both radio stations (Voice of Lokossa and Couffo FM) send their reports to Plan, who shares with CARE, so that indicator tables can be completed. Data are collected bimonthly in two phases, the first in Phase 1 villages and then Phase 2 villages. Data for the ‘Each One Invites 3’ campaign, which lasted 3 months and ended in September 2014, will be collected directly from health facilities with the help of zonal MOH statisticians.
Gender - Cross Cutting	Gender reflection activities	Plan’s Gender Officer led the project team in two gender reflections, one during each of the semiannual PAG meetings. These will continue, as they provide a way to deepen personal understanding as well as remind staff of how gender issues are influencing unmet need.
	Strategies for increasing male engagement	<p>Throughout the year, the team has actively sought understanding of issues relating to lack of male engagement in Tékponon Jikuagou group activities. Field visits by staff and Plan’s gender expert engaged men’s group and other community members in discussions about barriers to engagement. Staff analyzed this issue further during the PAG Meeting in March. The issue was also brought to high-level stakeholders at the March TAG meeting.</p> <p>It may be that men’s networks operate differently than women’s and there needs to be more community normative shift around men’s roles in FP in order to engage men under Tékponon Jikuagou. Monitoring data indicate that men are more active diffusers of project information, even though in absolute numbers, they are less engaged in groups. In terms of group participation, 73% of group participants are women, and 27% are men. However, the percentage of participants who report diffusing project messages is slightly higher among men (55%) than women (51%). One solution implemented in the second half of the year that appears to be working is selecting less formally constituted men’s groups, which are judged influential by communities. These newly oriented male groups have been very active, leading discussions regularly. In addition, a new story written from a male perspective (based upon cohort research data and other sources) will be developed and integrated into the story card series for use during the scale-up phase.</p>
<b>Communication/Dissemination</b>		
	Share lessons learned and results of Project Tékponon Jikuagou	<p><b>Conferences and Meetings</b></p> <p>1) Tékponon Jikuagou partners presented intervention materials and lessons learned in five sessions at the International Family Planning Conference in Addis Ababa in November 2013. One presentation highlighted the project’s social networks approach in changing social and gender norms; a second compared social network analysis results from Mali and Benin; another explored the programmatic implications of the project’s definition of unmet need; and a final session included a skills building session using Tékponon Jikuagou’s community social mapping guide. Field staff also contributed to a panel organized by the USAID Benin Mission’s Health Team with a presentation about socio-cultural barriers to FP use in Benin. Presentation slides from all of the sessions below are attached in Appendix C.</p> <ul style="list-style-type: none"> <li>• <a href="#">Applying stigma as a conceptual framework to address unmet need for family planning: A new way forward?</a></li> <li>• <a href="#">Different methods, different cultures, different approaches – comparing social network analysis results of unmet need in Mali</a></li> </ul>

[and Benin](#)

- [Programmatic implications of definitions: unmet need for family planning](#)
  - [From research methodology to community-action methodology: Applying social network analyses to tackle unmet need for family planning in Benin](#)
  - [Le Bénin au point de décollage de la Planification familiale](#) (Translation: “Revitalization of Family Planning in Benin”)
- 2) IRH presented on the social network approach during a session at the American Public Health Association’s annual conference in November 2013.
  - 3) Partners facilitated a skills-building session using Tékponon Jikuagou community social mapping tools to about 40 people at the USAID Mini-University on March 7. Informal feedback was very positive, and the presentation is archived on the Mini-U website.
  - 4) IRH’s Director of Research presented the Tékponon Jikuagou project approach at the Society for Applied Anthropology in March 2014.
  - 5) IRH presented Tékponon Jikuagou from a research perspective to generate interest in social network approaches and related scale-up during the USAID-hosted Brown Bag Lunch for USAID and other cooperating partners in April.
  - 6) Plan and IRH co-facilitated a workshop session, “Who’s Got Influence: Participatory Mapping of Social Networks.” at the Global Health Practitioner’s Conference (CORE) in May 2014.

#### **Communications Products**

- 1) In July, IRH designed and produced **exhibit banners** for use in Benin during conferences and other venues. See Appendix E for a photo of the new banners!
- 2) **Website:** IRH continues to maintain the IRH website ([www.irh.org](http://www.irh.org)) as a place to share updates and accomplishments of the project. Project briefs and reports developed over the course of the year are posted in the IRH Resource Library. Soul Beat Africa, a website dedicated to communication, media and social development in Africa, featured a description of the Tékponon Jikuagou Project approach and intervention on its website.
- 2) **Video:** Plan’s Deputy Regional Director visited Azové February 12 to learn more about the project and visit an influential group in the field. During the visit, the catalyzer of group “Hondjin” led a reflective discussion using intervention materials to allow the Regional Director to observe the kinds of reflective dialogue discussions used by the project. Plan’s West Africa Regional Office communications team also visited Dolohoué Soglonouhoué from February 17-19 to attend group reflective discussions; a video of the visit, and some of the groups’ interaction, was produced afterwards and can be seen on YouTube.
- 3) **Briefs:** The Tékponon Jikuagou team produced three project briefs to highlight different aspects of the project approach and research to global and Benin audiences. The first, “Overcoming social barriers to family planning use: Harnessing community networks to address unmet need,” describes the challenges that Tékponon Jikuagou aims to address with its innovative social networks design. The second, “Social networks and social change: New program approaches to reducing unmet need for family planning,” focuses on the intervention package and how its social network approach differs from traditional behavior communication change (BCC) strategies. The most recent brief, “Preliminary Findings of the Tékponon Jikuagou Pilot: Testing a Community-driven Approach to Reduce Unmet Need through Social Network Interventions in Benin,” designed for the Benin-based donor audience interested in potentially supporting package scale up, highlights early evidence of the success of the intervention. All briefs are available in English and French. (See Appendix D)
- 4) **eNewsletter:** IRH shared news and updates on Tékponon Jikuagou several times in its monthly eNewsletter, which reaches over 2,000 individuals within the global FP/RH community. In March, the project was the feature piece in the IRH eNewsletter, overviewing top takeaways from formative research and baseline results. April shared news about the project’s “vision tapestry”

		<p>created by a local Beninese artist and May's eNewsletter highlighted Tékponon Jikuagou's "Who's Got Influence" session at the Global Health Practitioner's Conference (CORE). Both September and October's eNewsletter shared recently-produced project briefs.</p> <p>5) <b>Blog:</b> IRH continues to use its blog to disseminate exciting project developments and results. In March, IRH published a reflective blog on top takeaways from the formative research and baseline results called: "Social Networks' influence on Family Planning: Some fascinating findings from Tékponon Jikuagou." In April, IRH published a blog called, "<a href="#">From sketch to tapestry</a>: Tékponon Jikuagou's vision by Beninese artist."</p> <p>6) <b>Social Media:</b> Throughout the year, project updates, accomplishments, photos, and blogs were regularly highlighted IRH's normal social media engagement—especially surrounding specific social/digital campaigns and relevant holidays.</p>
	<p>Write and submit project-related articles to peer-reviewed journals.</p>	<p>1) IRH submitted an article in June 2014 entitled "Applying a Stigma Framework to Unmet Need in Mali" to the ICFP Conference organizers to be included in a special addition of the International Journal of Obstetrics and Gynecology that will highlight papers of highly-rated abstracts from the November conference.</p> <p>2) IRH submitted an article in October 2014 entitled "From theory to practice: Applying participatory social network mapping to address unmet need for family planning in Benin" to be considered for a special <i>Participatory Visual Methodologies and Global Public Health</i> edition of the Global Public Health Journal.</p> <p>We are anticipating publication of both articles in 2015.</p>

## ANNUAL WORK PLAN AND INTERNATIONAL TRAVEL SCHEDULE (October 2014 – September 2015)

	Objectives	Planned Activities	Tentative International Travel
Project Management & Coordination	Partner Relations	<ul style="list-style-type: none"> <li>• Project coordination and planning meetings (particular focus on scale-up planning) <ul style="list-style-type: none"> <li>• USA PAG meeting (April 2015)</li> <li>• International /all staff PAG Meeting (August 2015)</li> <li>• Benin PAG meetings (monthly)</li> <li>• USA PAG strategic management coordination calls (monthly)</li> </ul> </li> <li>• Benin staff participation in USAID quarterly partner meetings (as called by USAID)</li> </ul>	<p>International PAG Meeting (August 2015) – Burgess, Lundgren, Igras, Rubardt, Grant</p> <p>US PAG Meeting (April 2015) – Igras, Diakitè</p>
	TAG/DSME Technical Working Group	<ul style="list-style-type: none"> <li>• The TAG will evolve as the pilot phase ends. It will be integrated into the DSME Technical Working Group on FP/RH from December onward.</li> </ul>	
	Pilot Committee (Comité de Pilotage)	<ul style="list-style-type: none"> <li>• The Pilot Committee will evolve as the pilot phase ends and may merge with zonal MOH structures, e.g., integrate scale up activities into annual work plans of the MOH in Couffo and Ouémé health zones and use MOH forums to advocate for FP service improvements (as called by the MOH)</li> </ul>	
	Supervision	<ul style="list-style-type: none"> <li>• Supervision visits by CARE and Plan Field Supervisors (monthly)</li> <li>• Supervision by CARE and Plan Managers (monthly)</li> <li>• Quarterly field visits by CARE, Plan, IRH, MOH in scale-up areas (April, July, September)</li> </ul>	
Scale-Up Preparation	Preparation for Scale-up through New User Organizations (October-March)	<ul style="list-style-type: none"> <li>• Exploration and final selection of new user projects/NGOs</li> <li>• Distance training/orientation of current staff on new technical assistance roles, outreach to new organizations, and conducting organizational capacity assessments (weekly)</li> <li>• Conduct organizational capacity assessments of new user organizations/projects to integrate and implement the package to help define technical assistance needs prior to scale up (November-January)</li> <li>• Training (TOT) workshop for staff to build skills in training, coaching, and supporting new user staff to implement the social network package (January)</li> <li>• Orientation of new user organization staff on package concepts (unmet need, gender equality, social networks, reflective dialogue for social change) (March)</li> <li>• Launch meeting (before beginning interventions) with new user organizations/projects to create an operational work plan for implementation</li> </ul>	<p>Field Guide development – field visit (October 2014) - Cat Toth</p> <p>Training of trainers for CARE/Plan staff and practicum for new user staff + Endline Results Review to determine if package needs adjustments (late January/early February 2015) – Rubardt, Grant, Igras, Lundgren</p> <p>New partners meeting to finalize integration strategy and work plan</p>

		<ul style="list-style-type: none"> <li>and technical assistance (March/April)</li> <li>• Development of a “How-To” Field Guide for use by organizations implementing the Tékponon Jikuagou intervention package (October-January)</li> <li>• Translation of radio programs into local languages (Ouémé Department) (April)</li> </ul>	(March 2015) – Igras, Grant, Rubardt
Scale-up Implementation	Implementation through New User Organizations (April-September)	<ul style="list-style-type: none"> <li>• Community sensitization to new activity (April)</li> <li>• Community social mapping and selection of catalyzers and influential individuals (April/May)</li> <li>• Catalyzer and Influential individual orientations (June)</li> <li>• Each One Invites 3 campaign orientation and implementation (September)</li> <li>• Coaching and field supervision (ongoing)</li> <li>• Project activity monitoring (ongoing)</li> </ul>	
	Project Coordination and Technical Assistance during Scale-up Phase	<ul style="list-style-type: none"> <li>• Define and support the evolution of coordination structures: PAG-Benin, PAG-USA, MLE Committee and TAG (ongoing)</li> <li>• Define roles and responsibilities, as well as lines of communication for IRH, CARE and Plan staff during the expansion phase (January-March)</li> </ul>	
Research, Monitoring, Learning and Evaluation	Cohort Interviews and Analysis	<ul style="list-style-type: none"> <li>• Refine analysis strategies for Rounds 3 &amp; 4 as well as longitudinal analysis, building on each round of data analyzed (October-December)</li> <li>• Conduct Rounds 3 &amp; 4 (final) cohort interviews in pilot communities (December)</li> <li>• Analyze collected data (January-March)</li> </ul>	
	Costing Study	<ul style="list-style-type: none"> <li>• Collect and/or verify costing data from Plan and CARE field staff, including gathering in-country data on staff time allocations (October-November)</li> <li>• Analyze data to derive costs-to-implement per intervention component (November-December)</li> </ul>	Data collection with Plan and CARE finance/program staff (October 2014) – Burgess
	Close out MLE system pilot phase / Develop and implement MLE plan for the expansion phase	<ul style="list-style-type: none"> <li>• Finalize collection and reporting of monitoring data in pilot villages (by December)</li> <li>• Design with TJ and new project staff an MLE system and data collection tools for the scale up phase (October-April)</li> <li>• Continue bimonthly MLE Committee meetings between IRH, CARE, Plan, providing regular feedback of findings to PAG and reflection on pertinence of scale up monitoring data collection to monitor activities, identify implementation bottlenecks (bimonthly)</li> <li>• Continue quarterly field trips to monitor data collection ensure data quality</li> </ul>	

<b>Communication &amp; Dissemination</b>	Develop and disseminate research and program findings in conferences and meetings	<ul style="list-style-type: none"> <li>• Share endline findings on the pilot’s effectiveness and implementation lessons learned at central/Cotonou and Couffo Department levels</li> <li>• Mariam Diakité will attend the Men Engage Conference in India in November 2014 to present on how Tékponon Jikuagou engages men to reduce unmet need for family planning (November)</li> <li>• Develop a 1-page informational sheet on Tékponon Jikuagou as a leave-behind piece for presentations, conferences and general distribution (January)</li> <li>• Presentations are planned for additional international conferences, assuming abstracts are accepted including APHA and Applied Anthropology Association (November, December)</li> </ul>	MenEngage Conference (November 2014) – Diakité
	Write and submit project-related articles to peer-reviewed journals.	<ul style="list-style-type: none"> <li>• IRH will submit an article on unmet need to the Global Health Science and Practice Journal or another peer reviewed journal (August/September)</li> </ul>	

## **LIST OF APPENDICES**

**Appendix A: Mid-Term Qualitative Assessment Report**

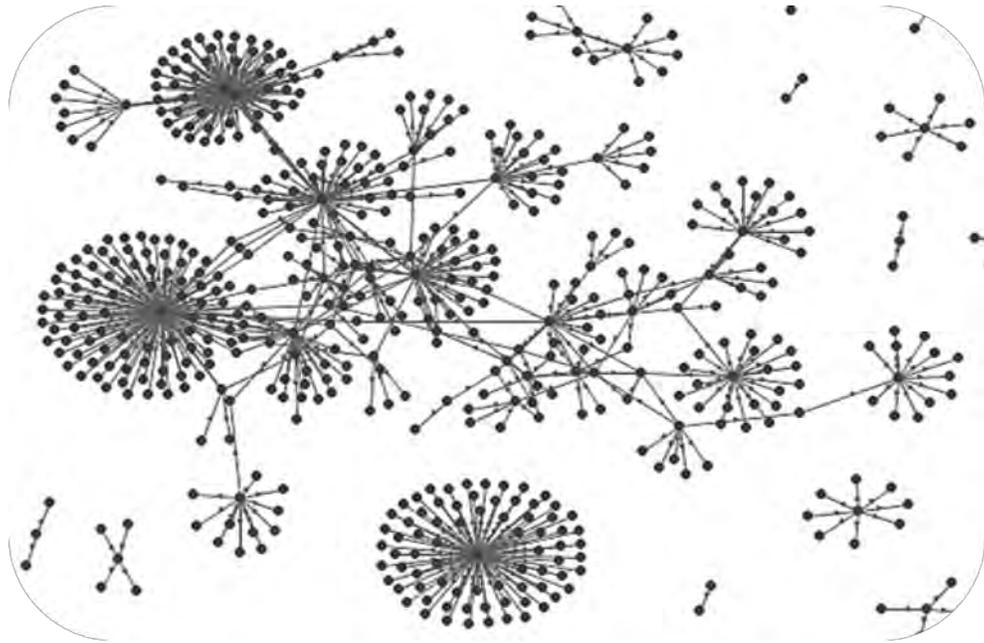
**Appendix B: Summary Presentation on Project Monitoring Data, August 2014**

**Appendix C: Presentations made at the International Conference on Family Planning, November 2013**

**Appendix D: Brief: *Social networks & social change: New program approaches to reducing unmet need for family planning***

**Appendix E: Tékponon Jikuagou Banner**

**APPENDIX A:**  
**Mid-Term Qualitative Assessment Report**



# Mid-Term Qualitative Assessment Report

**Tékponon Jikuagou: Benin 2014**

**Authors:** Sarah Burgess and Mariam Diakité



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

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

**Tékponon Jikuagou Project**

Institute for Reproductive Health  
Georgetown University  
1835 Connecticut Avenue, NW, Suite 699  
Washington, D.C. 20009 USA

[irhinfo@georgetown.edu](mailto:irhinfo@georgetown.edu)  
[www.irh.org/projects/tekponon\\_jikuagou/](http://www.irh.org/projects/tekponon_jikuagou/)

**ACKNOWLEDGEMENTS**

The authors would like to acknowledge the contributions of all staff members of CARE International and Plan International, and the Institute of Reproductive Health, who provided input to this assessment and analysis project. We are particularly grateful to Léonie Kpoto and Antoine Sohoun, whose work facilitating and translating was essential for this project. Other staff members who provided key input and support include: Calixte Aho, Modeste Anato, Hilaire Assogba-Wounon, Laurette Cucuzaa, Jean-Baptiste Dansou, Danielle Grant, Félix Koudoukou, Ben Moulaye Idriss, Susan Igras, Jennifer Keuler, Caroline Kounde, Rebecka Lundgren, Marcie Rubardt, Sophie Savage and Linda Sussman.

# TABLE OF CONTENTS

<b>Introduction</b> .....	<b>1</b>
Objectives.....	2
Methodology .....	2
Initial Design and Planning.....	2
Sample .....	3
Field Research .....	3
Limitations.....	4
<b>Key Findings</b> .....	<b>5</b>
Catalyzer Satisfaction, Performance and Training.....	5
Challenges for Catalyzers.....	5
Catalyzer Satisfaction .....	9
Facilitator-Catalyzer Relationship.....	10
Activity Dynamics and Community Responses .....	12
New Information, Dialogues and Impacts .....	12
Community Diffusion/Ripple Effects.....	12
Age and Participation .....	14
Gender and Participation .....	15
Radio Programs: Complementary to Community Activities.....	18
Some Continuing Community Tension .....	18
Phase-Out Ideas .....	21
Health Services Links.....	22
Uneven Engagement with Tékponon Jikuagou.....	22
Uncertain Supply Chains, Quality of Care .....	23
Financial Barriers to FP Services .....	25
Gender and Power Dynamics at Service Points.....	26
Influential Involvement .....	27
Diversity of Involvement.....	27
Diversity of Challenges, Successes, and Suggestions.....	27
Orientation Strengths and Weaknesses.....	28
Desire For Financial/Material Support.....	28
A Leader Without TJ's Orientation .....	28
<b>Conclusion</b> .....	<b>29</b>
<b>Annex: Complete Scale-Up Implications Table</b> .....	<b>30</b>



## INTRODUCTION

This report for Tékponon Jikuagou (TJ) activities discusses key findings from an assessment exercise conducted between March 13-15 and March 20-21, 2014, in Couffo, Benin.

Tékponon Jikuagou is a six-year project, funded by the United States Agency for International Development (USAID) and implemented by Georgetown University's Institute for Reproductive Health (IRH), in partnership with CARE International and Plan International. The project aims to break down social barriers to family planning (FP) through social network interventions, in order to reduce unmet need for family planning.

The TJ package consists of five different intervention components (listed in the graphic above). Each component prompts reflective discussion about fertility desires and FP, or creates linkages between people and health services. The two components discussed most throughout this evaluation are the influential groups, led by people known as catalyzers, and the engagement with influential individuals. The focus was on these components because at the time of the evaluation, these two activities had been most widely implemented, and other activities (radio and health center linkages) were just starting up.

Tékponon Jikuagou is a pilot effort, and this assessment was conducted mid-way through the pilot phase to inform further refinements of the package. At the time of the assessment exercise, in Couffo, CARE was implementing the TJ packages in the ADD (Aplahoué-Djakotomey-Dogbo) health zone, and Plan was implementing the package in the Klouékanmè-Toviklin-Lalo (KTL) health zone. Plan and CARE staff members known as facilitators supervise project activities on the ground.

If the TJ package is effective in reaching its goals, IRH and partners will scale up the intervention to other parts of Benin, and possibly other parts of West Africa. This report is one of several assessments being conducted to inform finalization of the TJ package, prior to its scale-up. Report sections draw on direct quotations and provide deeper analysis on subjects that are of particular interest to the project, such as gender, and how the intervention is received by the wider community. Throughout the report, orange boxes summarize the report sections, and highlight implications for scale up.

The remainder of the introduction details the objectives, methodology and limitations of this exercise. The key findings section is divided in four main sections, each one exploring a particular key project issue.

- **Catalyzer Satisfaction, Performance and Training.** Catalyzers, or leaders of influential groups, are identified through a community mapping process. After agreeing to participate in TJ, they facilitate discussion about FP in their social groups. This section looks at their experiences and challenges, examining issues such as literacy and facilitator-catalyzer relationships.
- **Activity Dynamics and Community Responses.** Another goal of this exercise was to investigate the acceptability of the TJ activities in communities. This section explores some

## 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



project impacts, and looks at how people in different gender and age groups participate in the project.

- **Health Center Links** This section looks at how the project is working to create linkages between community networks and health workers, and also discusses the general availability of FP products and care in the project areas.
- **Influential Involvement** TJ identifies influential individuals to engage in the intervention; these actors are known simply as “influentials” within the project, and throughout this report. Influentials, who are key actors in the intervention, are identified in a community mapping process, and receive information about reproductive health and unmet need in their communities. They play an important role in creating permission in their communities to talk about fertility and unmet need. This section, based on interviews, also looks at their key challenges and experiences.

The conclusion of this document summarizes the general key findings, and makes recommendations for discussion items during scale-up.

## **OBJECTIVES**

The goals of the assessment project were to:

- Provide data and insights on the Tékponon Jikuagou (TJ) intervention package, so that project partners CARE, Plan and IRH can improve or modify the program if necessary for scale-up.
- Provide insights to the exit strategy (phase-out, or the process by which the TJ intervention package stops officially running in communities).
- Explore the recurring package implementation challenges and develop strategies to address them.

Although this process was called an assessment, it was **not** designed to be a performance evaluation of implementing partners CARE and PLAN. Rather, the assessment was a collaborative exercise, wherein partners contributed to the methodology, interview questions, and provided valuable feedback and recommendations for analysis. Early findings were shared in a PAG (Partners Advisory Group) meeting, and partners drew on findings in discussions about how to continue to improve the project for scale-up. Findings will continue to be distributed and discussed with the dissemination of this longer report.

## **METHODOLOGY**

The process for designing and completing this exercise was as follows:

### **INITIAL DESIGN AND PLANNING**

IRH Staff (Sarah Burgess and Mariam Diakité) drafted the initial themes and methods for this exercise, drawing on input from staff at CARE and PLAN. Staff in the field and at headquarters contributed their ideas for the most pressing and important programmatic issues to examine. IRH then designed focus group and interview questionnaires to provide input to these questions.

Questions also involved using various visual prompts and activities, in order to keep participants engaged and interested throughout the process, and provide a wide, varied scope of data.

## SAMPLE

While considering the sample of people who would participate in this exercise, IRH staff wanted to reach as many catalyzers as possible, but needed to remain within time and budget limitations. At the time of data collection, there were a total of 281 oriented catalyzers throughout the KTL and ADD zones. The assessment team planned to conduct eight focus groups with six catalyzers each, for a total of 48 catalyzers. The team felt that this number was sufficient enough to capture a broad range of experiences of catalyzers, but small enough so that in-depth qualitative data analysis would be feasible.

Working with field staff at CARE and Plan, IRH organized the eight focus groups around three different categories: gender, performance level, and implementing partner zone. Each focus group was made up of either men or women; high performing or low performing; and KTL or ADD based catalyzers. There was one focus group for each possible combination of categories.

FOCUS GROUP AND INTERVIEW PARTICIPANTS	
CARE Intervention Zone (ADD)	Plan Intervention Zone (KTL)
<b>Four focus groups</b> (6 participants each) <ul style="list-style-type: none"><li>• High-performing women catalyzers</li><li>• Low-performing women catalyzers</li><li>• High-performing men catalyzers</li><li>• Low performing men catalyzers</li></ul>	<b>Four focus groups</b> (6 participants each) <ul style="list-style-type: none"><li>• High-performing women catalyzers</li><li>• Low-performing women catalyzers</li><li>• High-performing men catalyzers</li><li>• Low performing men catalyzers</li></ul>
<b>Five interviews</b> <ul style="list-style-type: none"><li>• Two health workers</li><li>• Three community leaders/influentials</li></ul>	<b>Four interviews</b> <ul style="list-style-type: none"><li>• One health worker</li><li>• Three community leaders/influentials</li></ul>

During the data collection process, the assessment team reached saturation-- that is, interviewers heard the same responses repeatedly by the end of the process, and were collecting very little new information about the experiences of catalyzers.

While designing the process for interviewing influential individuals, IRH aimed to gather a diverse range of perspectives. IRH wanted to reach people who are officially influentials selected and oriented by TJ, and also hear the perspectives of community leaders who are not directly involved in the intervention. In each region of KTL and ADD, IRH interviewed a midwife, and three community leaders, who were both official TJ influentials and other community leaders. IRH asked partners CARE and PLAN to organize the interviews, and include participants from a wide variety of backgrounds. Interviewed participants were official, project-oriented Influentials or not; men or women; and acted in religious, social or political life.

## FIELD RESEARCH

Field research took place on March 13-15 and March 20-21, in the area of Couffo, Benin. The research team included:

- IRH staff Mariam Diakite, Susan Igras, Sarah Burgess
- USAID Senior Program Research Advisor Linda Sussman
- Hired field researchers Antoine Sohou and Léonie Kpoto
- Translators Félix Koudoukoui and Calixte Aho

Field researchers received in-depth orientation to the field research tools, and a refresher on data collection methods and ethics. They worked collaboratively to translate the data collection tools from French to Adja. Having already worked with IRH for previous TJ focus groups and interviews, they were familiar with the objectives of TJ, and qualitative research methodology.

### LIMITATIONS

Although every effort was made to ensure that this exercise was as comprehensive as possible, given the short time frame and limited resources, the exercise had some limitations which should be considered throughout review of this document.

#### **Lack of low performing and unengaged catalyzers**

As discussed above, catalyzer focus groups were divided into high and low performing catalyzer focus groups. As each implementing organization's facilitators are most familiar with the performance of their catalyzers, they were asked to categorize people into groups of low and high performing, based on their own assessment of performance. However, upon reviewing data, it seems that catalyzers across groups had very similar answers, although there were some subtle differences between groups. It is possible that each organization suggested catalyzers that they knew were responsive and high-performing enough to show up and participate in focus group discussions, thus limiting the exercise's ability to collect data on truly unengaged and underperforming catalyzers, if there are any. Comparisons in this document between high and low performing catalyzers are limited in scope. More efforts to reach and understand truly low performing catalyzers, if they exist, can be made in further research and assessment.

#### **Gender Questions**

Understanding how to engage men, and the ways that women and men experience TJ was an important goal of this exercise, and thus the catalyzer focus group discussions were split into men's and women's groups. However, within these groups, certain men and women catalyzers have both single-gender groups and mixed groups. It is possible, for instance, for a man catalyzer to have a group which is mostly women. Comparing the testimonies of men and women catalyzers can provide some comparisons between the experiences of men and women, but these comparisons are limited, as both men and women catalyzers had mixed gender groups as well.

#### **Courtesy Bias**

When conducting focus groups and interviews, field researchers explained to participants that the interviews and focus groups were not performance evaluations, and that they should feel free to be critical of the program. And indeed, throughout the assessment, certain participants did offer constructive criticisms of the TJ program, which will be discussed throughout this report. However, they also had mostly positive things to say about TJ, and reported overwhelmingly positive results in their communities. Some of this feedback could have been due to courtesy bias—that is, participants responding to please the interviewer.

#### **Time Constraints**

The TJ project, and its impacts and results—are extremely complex, and relate to complicated issues such as behavior change, gender, sexuality, community links with health services and social network diffusion. Given the set time and budget for this exercise, results are limited. Each of the topics discussed in this report could merit deeper research and analysis.

IRH and implementing partners will know more about the results of the program—both positive and negative—through other ongoing qualitative and quantitative research initiatives. The

following sections do not offer definitive, final conclusions on these topics, rather, they are designed to prompt discussion among project partners.

## KEY FINDINGS

### CATALYZER SATISFACTION, PERFORMANCE AND TRAINING

As catalyzers play a central role in TJ, understanding their experiences was a key goal of this exercise. The following section discusses challenges catalyzers face (including literacy and translation issues, activity leadership, motivating participants, financial issues, and community norms), and also looks at how gender and performance level relates to these challenges. Then, the report explores issues of catalyzer satisfaction and the facilitator-catalyzer relationship, before moving on to examine issues of community response.

#### CHALLENGES FOR CATALYZERS

Catalyzers are selected because they are leaders in influential social groups. When they agree to conduct TJ activities, in many ways they are agreeing to continue work that they are already doing—participating or leading a group activity. However, the service that catalyzers do through TJ—fostering dialogue about sensitive issues such as FP and social norms—is difficult, and catalyzers described a variety of challenges, and sometimes discussed creative ways of addressing them. The following section explores issues voiced in response to a question specifically about challenges, as well as difficulties that catalyzers mentioned in other parts of the focus group discussions.

#### Literacy and Translation Issues

In each catalyzer sub-group (high performing men and women, and low performing men and women), reading and translating project tools, including story cards and activity cards, was by far cited as the most pressing challenge.

The TJ activity cards and story cards are written in French, and catalyzers generally must translate them into the local languages of Fon or Adja before leading their groups. Even if the catalyzer reads French well, this task can be difficult. As one man catalyzer explained that he understood French, and reading wasn't difficult, but translating to Adja was difficult. For others, the small size of the text in some activity cards can make reading particularly difficult; completing the required activity report forms can also be challenging.

Catalyzers are required to have a basic level of literacy before agreeing to lead their groups in reflective dialogues. However, these catalyzers highlight that even though they are literate, actually engaging and understanding the materials still takes time and effort. One woman explains this challenge:

“It takes us much time, wherever we are...when the time of activities is drawing near, we must return to the house and read the story or activity, and understand before going to the meeting...if not, we will not know what to do in front of our comrades. It takes us much time!”<sup>1</sup>

---

<sup>1</sup> In original Adja to French translation : « Cela nous prend beaucoup de temps quelque soit l'endroit où nous nous trouvons quand l'heure des activités du groupement s'approche, nous devons revenir à la maison lire l'histoire ou l'activité comprendre avant d'aller à la réunion si non nous ne saurons quoi faire devant les camarades. Ça nous prend beaucoup de temps. »

However, certain catalyzers, particularly women, described their own tenacious efforts to address these challenges. One catalyzer relied on her husband for help; another asked a student for assistance filling out the required catalyzer forms. If the materials were available in Adja, or in another appropriate local language, catalyzers would have to spend less time translating, and TJ could have a higher degree of quality control on the project's diffused messages.

### **Difficulties Leading Activities**

Catalyzer materials include a set of activity cards, designed to lead the group in engaging, reflective dialogues. The activities include small group discussions, role-playing games, and an activity called "agree or disagree" where participants move to different areas depending on how they feel about a statement about gender or FP.

While story cards (discussed in a later section) were generally said to be successful, catalyzers described multiple challenges while leading activities. For instance, some indicated simply that the activities were difficult to explain or understand; another said there were too many directions; another said it was difficult to encourage participants to follow the directions. "Some of the activities are very long, and in speaking about them often I become lost<sup>2</sup>" explained one catalyzer.

While designing activities, the TJ partnership went to great lengths to ensure that the activities were educational, and allowed participants to discuss or role-play situations about family planning they might encounter in their everyday lives. In some activities, people say if they agree or disagree with certain statements, in others they act out a conversation about FP. Data from this analysis shows that catalyzers, and group participants, place a high value on activities that are simple and easy to lead. More analysis about catalyzer group participants using TJ materials to learn how to address difficult situations in everyday life is offered in the following section about use of story cards.

However, not all catalyzers, particularly ones from the high-performing group, shared this perspective. Some women appreciated the interactive qualities of the activities. It is telling that women from the high-performing group seemed to like activity cards. If TJ is to be replicated in urban areas, where women will probably have more literacy skills or leadership experience, the activities could be easier to implement. Role-playing activities can be extremely valuable; it could be that these particular catalyzers are just not prepared to lead them; it could be hasty to eliminate them at this point. Rather, we can continue including them as part of the full package, and provide catalyzers an array of different kinds of activities so that they can choose which they are most comfortable leading.

### **Motivating Other Group Members and Managing Dialogue, Particularly without Payment and for Longer Activities**

Although many catalyzers indicated that community participants were deeply motivated and interested in TJ, others described some trouble in motivating participants to take part in activities, especially when participants were not being paid to do so. Due to norms set by other development projects, participants often expect to be paid when they participate in interventions. One catalyzer explained that when people hear the word project, they see money. Another said it was difficult to motivate people to participate in discussions, when they believe the catalyzer is making money when they were not.

---

<sup>2</sup> In the original Adja to French translation : « Parce qu'il y a des activités très longue et en parlant de ça je me perds. »

Indeed, being a catalyzer also requires a certain level of charisma and public speaking skills, and some catalyzers reported difficulties keeping the group engaged. “Managing people is always hard”<sup>3</sup> said one man catalyzer. Multiple catalyzers also mentioned that it could be difficult to engage people throughout longer activities. Throughout this exercise, it was at times unclear if these difficulties were due to a lack of speaking skills, or because of the length or quality of TJ activities.

### **Catalyzer Desire for Financial Compensation for Their Work**

Multiple catalyzers highlighted that it was difficult to lead discussions without themselves being “motivated” with payments. The word “project” may evoke expectations of per diems and payouts. Due to the legacy of previous development projects, catalyzers may expect some form of payment while working with the project. In addition, as described in the previous section about translation, catalyzers are indeed doing difficult work on behalf of the project. “This takes us much time, and we make nothing” said one woman catalyzer.<sup>4</sup> On the other hand, another catalyzer mentioned lack of reimbursement as a challenge for him, but also noted that he has known since the beginning that working with TJ is volunteer work.

Given that TJ is a volunteer-driven initiative, it is difficult to imagine a scalable project where all community level volunteers, no matter what their result and level of effort, are paid. Providing cash hand-outs could also create complicated social dynamics within communities. However, to address this issue, perhaps more effort can be made to reduce catalyzer workload, by further simplifying and translating the materials and thus reducing the time needed to review and prepare for TJ activities, as discussed in the previous section.

### **Community Norms around Discussing Family Planning and Sex**

Given that TJ aims to address the problem of stigma around FP and sex, it is unsurprising that certain catalyzers encountered challenges related to this barrier. The project team already knew from formative research that social norms could be serious barriers to FP discussions. However, considering the frequency with which other challenges like translation came up, this challenge was cited relatively infrequently. Various barriers were at times related to gender norms. These challenges are described in greater detail in the following section about community response. The infrequency with which catalyzers cited this issue suggests that in general most community members are open and interested in discussing the themes brought up by TJ.

### **Desire for Health Agent Assistance**

The desire for a health agent to provide support catalyzer discussion groups also came up in multiple focus group discussions. This issue is further discussed in a later section about health care linkages.

### **Comparing Challenges for Catalyzers Across Groups**

Interestingly, catalyzers across the four sub groups (high performing men and women; and low performing men and women) cited similar challenges. The table below lists the two to three most cited challenges specifically mentioned in response to the question about challenges. While looking at these, it is important to bear in mind that this was not a survey or individual interview exercise, and that people tended to mention items that their peers had already mentioned. Also, not all catalyzers responded to every question. Also, this table is not exhaustive, people brought

---

<sup>3</sup> Original Adja to French translation : « La gestion des Hommes est toujours difficile. »

<sup>4</sup> Original Adja to French translation : « Ça nous prend beaucoup de temps et on ne gagne rien dedans. »

up other challenges at other points throughout focus groups. However, this table still provides some interesting insights for topics that are pertinent across groups.

CATALYZER'S MOST MENTIONED CHALLENGES IN QUESTION SPECIFICALLY ABOUT CHALLENGES		
	Men	Women
<b>Low-Performing</b>	<ul style="list-style-type: none"> <li>• Translation</li> <li>• Motivating other group members to participate</li> <li>• Absence of a health agent</li> </ul>	<ul style="list-style-type: none"> <li>• Translation</li> <li>• Leading activity cards</li> </ul>
<b>High-Performing</b>	<ul style="list-style-type: none"> <li>• Translation</li> <li>• Leading activity cards</li> <li>• Motivating other group members to participate</li> </ul>	<ul style="list-style-type: none"> <li>• Translation</li> <li>• Leading activity cards</li> </ul>

Interestingly, people from all groups describe similar challenges: translation and leading activity cards. Although it is unfortunate that so many catalyzers are experiencing the same kinds of challenges, it is good news for scale-up that there is not a wide variety of different kinds of problems across different groups. Addressing these two specific, major challenges could greatly improve catalyzers' experience with TJ.

One notable difference, however, is that men tended to mention more often difficulties motivating people to participate. Some of these men are leading groups with both men and women participants, and others are leading groups with only men participants.

The fact that men catalyzers seem to experience more trouble motivating participants is unsurprising, given that the project is experiencing ongoing challenges in engaging men. The challenge is not only that field staff workers are experiencing problems identifying men's groups, but that it is hard to engage men with TJ materials, once they are exposed to them. Thus, pinpointing the topics which do interest men may be a key factor in engaging men. Issues that may be of particular interest to men are discussed in a later section.

**Implications for Scale-Up**

Some of these challenges are inevitable. For instance, as TJ aims to address stigma in communities, it is expected that stigma will remain a challenge for catalyzers. However, some of the challenges may be addressed in expansion with a few changes to the TJ intervention. The following table suggests some possible modifications to address these issues.

SUMMARY TABLE: CATALYZER CHALLENGES	
Finding	Strategy for Addressing in Scale-Up
Literacy and translation challenges	<ul style="list-style-type: none"> <li>• Further simplify language on cards</li> <li>• Where possible, translate cards into local language such as Adja and Fon.</li> </ul>
Activity challenges	<ul style="list-style-type: none"> <li>• Further simplify activities</li> <li>• Consider removing most complicated activities for scalable package.</li> </ul>
Catalyzer or group participant desire for financial compensation for their time.	<ul style="list-style-type: none"> <li>• Include section in catalyzer orientation about TJ's volunteer model.</li> <li>• Include role-play section in catalyzer orientation about how to handle situations where group participants ask why they are not being compensated.</li> <li>• Reduce burden on catalyzers by translating and simplifying tools.</li> </ul>

## CATALYZER SATISFACTION

Analysis for this assessment focused on challenges to be addressed before scale-up. Many catalyzers also spoke at length about the satisfaction they experienced from being a catalyzer. While preparing for scale-up, it is also important to replicate what is going well in the pilot project.

### Story card's high acceptability

Overwhelmingly, catalyzers enjoyed working with the story cards, and said they were well-received, easy to explain and fun to share. One catalyzer elaborated, "Stories....are easy for me because people understand them easily."<sup>5</sup> Although the stories are not direct role playing activities (in contrast to activity cards) one catalyzer highlighted that the stories do provide models for how to deal with difficult situations in daily life. One woman explained: "People like [the stories], because there is a lot of advice in the stories. In listening you know how to approach your husband, so he understands you."<sup>6</sup> Another noted, "stories are the easiest for me, and the most precious"; and another "even if you stop the stories, the members of the group will, yelling, ask you to repeat it."<sup>7</sup>

This finding has implications for the scalable package design. Good, compelling, sharable stories that allow people to practice speaking about FP in their communities, could increase the likelihood that TJ messages will "stick" after the project is over, making the package more sustainable. Even if some role-playing activities are cut because they are judged too complicated, participants can still learn communication skills through story activities. Story cards could be modified to allow listeners to further imagine how to apply the lessons from the story to their everyday lives.

### Rewarding Work

Certain catalyzers articulated that being a catalyzer could be rewarding, and that speaking in public came naturally or was fun. One woman explained that speaking publically, and answering questions is an enjoyable and easy task for her. "Mastering a crowd is easy"<sup>8</sup> said one catalyzer, words that also suggest he enjoys doing so. Catalyzer orientation already includes some elements of public speaking training; these elements can continue to be stressed during scale-up, to increase the number of catalyzers with high levels of satisfaction.

**SUMMARY TABLE: CATALYZER SATISFACTION FINDINGS**

Finding	Implications for Scale-Up
Story telling success	Continue using stories. Consider how role-playing could be integrated into storytelling, if role-playing activities are cut back or simplified.
Public speaking	Continue to emphasize public speaking in catalyzer orientation, help those who do not have these skills to build them.

<sup>5</sup> Original Adja to French translation : « L'histoire et appui sont faciles pour moi car les gens le comprennent facilement. »

<sup>6</sup> Original Adja to French translation, "Les gens aiment parce qu'il y a beaucoup de conseils dans l'histoire. En l'écoutant tu sais comment aborder ton mari pour qu'il te comprenne. »

<sup>7</sup> Original Adja to French translation : « C'est l'histoire qui est la chose la plus facile pour moi et le plus précieux » and « même si tu termines l'histoire les membres du groupe vont te demander de reprendre et ceci en criant. »

<sup>8</sup> Original Adja to French translation : "La maitrise de foule m'est facile. »

## FACILITATOR-CATALYZER RELATIONSHIP

During the focus group process, groups of high and low performing catalyzers were asked to discuss the qualities of “Pierre” a hypothetical good facilitator and “Jacques” a hypothetical facilitator who needs advice about how to do a better job. The assessment team expected to see different results between low and high performing groups, which would suggest different kinds of relationships between facilitators and high and low performing catalyzers.

The below table lists the major themes which came up in response to the question about the qualities of the good facilitator. This list is not comprehensive, but features major discussion points which came up in each group.

WHAT DOES PIERRE, THE GOOD FACILITATOR DO?		
	Men	Women
<b>Low-Performing</b>	<ul style="list-style-type: none"> <li>Assists with materials comprehension and translation</li> <li>Avoids becoming angry with catalyzers or has kind relationships with them.</li> </ul>	<ul style="list-style-type: none"> <li>Provides support to catalyzers in leading TJ activities</li> <li>Encourages good relationships between catalyzers and wider community</li> </ul>
<b>High-Performing</b>	<ul style="list-style-type: none"> <li>Assists with materials comprehension and translation</li> <li>Encourages good relationships between catalyzers and the wider community.</li> </ul>	<ul style="list-style-type: none"> <li>Provide support to catalyzers in leading TJ activities</li> <li>Provides support to catalyzers in addressing problems and difficulties</li> </ul>

The repeated, detailed discussion of positive attributes of facilitators suggests strong, supportive relationships between many catalyzers and facilitators. Indeed, comparisons show that low and high performing catalyzers, from both men’s and women’s groups, describe similar habits and characteristics of strong facilitators: help understanding materials, encouraging good relationships in the community, support in leading TJ activities.

One woman from a low-performing group described a supportive facilitator who took many different approaches to helping her:

If our facilitator comes, she asks us what we have done today, we take out the notebooks, and she helps us to translate the activities and stories in Adja, so we don’t have any difficulties to explain to our comrades, and sometimes she comes to our discussion meetings to see how the work is going.<sup>9</sup>

Another woman from a high-performing group had a similar description of her facilitator:

If our facilitators come, they ask us questions about what we have not understood, and the difficulties we have had. They come to session with me to support me.<sup>10</sup>

<sup>9</sup> Original Adja to French translation: “Si notre animatrice vient elle nous demande ce qu’on a fait aujourd’hui, on sort les cahiers et elle nous aide à traduire les activités et les histoires en Adja pour qu’on n’aient pas de difficultés à expliquer à nos camarades et des fois elle vient à nos séances de discussion pour voir comment on fait le travail. ”

<sup>10</sup> Original Adja to French translation: “Si nos facilitateurs viennent ils nous posent des questions sur ce qu’on n’a compris et demande à savoir des difficultés qu’on a. Comme cela ils viennent participer aux séances avec moi pour m’appuyer. »

This suggests some uniformity of the quality of facilitation across the project—facilitators are providing support and encouragement to catalyzers, even if they are perceived to be performing well.

While the first question was designed to start the discussion among catalyzers, the second question was designed to allow catalyzers more room to give feedback to facilitators. Due to the nature of the activity, it was not possible to directly ask catalyzers what their facilitators could be doing better. The question about “Jacques” the hypothetical facilitator, gave catalyzers room to discuss how a facilitator could improve.

WHAT ADVICE WOULD YOU GIVE A FACILITATOR WHO WANTS TO DO A BETTER JOB HELPING THEIR CATALYZERS?		
	Men	Women
<b>Low-Performing</b>	<ul style="list-style-type: none"> <li>• Encourage catalyzers to meet up together.</li> <li>• Be available to catalyzers</li> <li>• Avoid becoming angry with catalyzers</li> </ul>	<ul style="list-style-type: none"> <li>• Be available to catalyzers</li> <li>• Help with TJ materials comprehension and translation</li> <li>• Visit catalyzer sessions</li> <li>• Provide FP advice</li> </ul>
<b>High-Performing</b>	<ul style="list-style-type: none"> <li>• Be available to catalyzers</li> <li>• Provide advice on addressing problems or difficulties.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide support to catalyzers in leading TJ activities</li> <li>• Provide support to catalyzers on addressing problems and difficulties</li> </ul>

Across several different groups, catalyzers suggested that facilitators should be available to catalyzers, answering their calls or visiting often, suggesting they appreciate the in-person support from catalyzers. Catalyzers also frequently mentioned, facilitators who help catalyzers work through problems, suggesting that this quality is also noticed and appreciated.

Men classified as “low performing” mentioned often, in both questions, that facilitators should not become angry with catalyzers, or suggested that facilitators should speak kindly to catalyzers. It is possible that facilitators working with low performing men face particular challenges, and need more guidance and instructions on how to be supportive towards those who are not performing well.

One quality mentioned throughout the coaching guide—positive reinforcement—came up rarely in the focus group questions about facilitators. The coaching guide advises that “praise can help motivate the catalyzer.” Yet, praise was an act that was hardly mentioned throughout the focus groups—for either the good catalyzer Pierre, or the hypothetical catalyzer Jacques. Or, praise could be rarely mentioned because facilitators spend more time engaging with catalyzers about what is difficult or challenging. In either case, if positive reinforcement is an important part of the TJ package, it could be valuable to reinforce the value of praise to facilitators, or find ways to encourage more private meetings between facilitators and catalyzers, where facilitators may be more likely to provide catalyzers with praise.

## SUMMARY TABLE: FACILITATOR-CATALYZER RELATIONSHIP

Finding	Implications for Scale-Up
Little mention of facilitator positive reinforcement	Stress the value of positive reinforcement in facilitator training for scale-up.
Low-performing catalyzers describe complicated, sometimes difficult relationships with facilitators.	Stress kindly behavior towards catalyzers during scale-up, provide facilitators support they need to give positive support.

### ACTIVITY DYNAMICS AND COMMUNITY RESPONSES

Another key objective of this exercise was to explore community responses to the TJ project. The following sub-sections explore new dialogues, diffusion, the impacts of age and gender on participation, community responses to radio, and phase-out ideas. Analysis in certain sections examines how responses differ among men, women, and high performing and low performing catalyzers. The assessment team did not interview or engage catalyzer group participants, thus limiting the scope of this analysis, though the catalyzers did provide many interesting insights that will be helpful as the project scales up.

#### NEW INFORMATION, DIALOGUES AND IMPACTS

Many study participants emphasized that TJ had brought new information to their villages. Two catalyzers explained that the people in his group regretted not having this information earlier. Speaking about what a village is like when TJ arrives, one catalyzer compared the song to a hit song people can't stop talking about. Since TJ, many participants explained, villagers are more likely to have discussions about many topics related to the intervention, including couple relationships, infant mortality, sex, family planning, and finally birth spacing, the topic which seemed to come up the most.

Alongside these dialogues, catalyzers and influentials described particular changes, including improved financial stability, use of more reliable FP methods, fewer unwanted pregnancies, increased use of health services, increased use of family planning, improved couple relationships and improved maternal and child health. Again, reduction of closely spaced pregnancies was another often-mentioned topic of change.

Although it is encouraging to hear these responses, it is important to keep in mind that there is a limit to the amount of change that catalyzers and facilitators could have possibly witnessed in such a short time period. Speaking about TJ's impacts, for instance, one influential said that since TJ, poverty has finished: a clear exaggeration. Although the research team made every effort to encourage participants to provide honest answers, due to courtesy bias, or a desire to portray the program in a positive manner in order to receive support, some respondents may simply have given responses they perceived would please the team. Findings from the household surveys and interviews can confirm or deepen understandings of the degree of change in these areas.

#### COMMUNITY DIFFUSION/RIPPLE EFFECTS

Several comments throughout focus groups indicated that TJ messaging can reach people beyond catalyzers, and initial members of catalyzers' organized groups. Many catalyzers emphasized that TJ activities brought new participants to groups, who often actively engaged in discussions. Others spoke about how group members diffused messages to their own networks. Some participants, some catalyzers explained, diffuse information throughout their networks, attracting more

participants to TJ groups. One catalyzer said that groups in her village without a catalyzer wanted a catalyzer; another said that another village had requested that she come do TJ activities with them, but her facilitator had told not to do so. One woman catalyzer explained that, « people even ask for photocopies of what we're reading »<sup>11</sup> so they can pass on information to their spouses.

Comparing how men and women catalyzers describe diffusion within their groups can provide insight into how men and women might be diffusing information differently, and what particular topics might appeal more to men. To better understand the issue of diffusion, we examined responses to a question about whether catalyzers agree or disagree that TJ makes *groupements* grow. While these groups do provide some insights into diffusion, further research and analysis is needed to understand the full scope and nature of diffusion of TJ messages. It is important to remember in the following section, that some men and women catalyzers are working with mixed groups.

### **Women Catalyzer's Experience of Growing Groups**

Most women catalyzers agreed that catalyzer groups often grew after they started conducting TJ activities and many described lively, varied discussions with the new participants. Some described dramatic changes: "We are 11 in our group, but after the discussion we are as many as 30"<sup>12</sup>, said one woman catalyzer.

Speaking about what attracts more participants; women catalyzers mentioned an array of topics, including couple communication and family planning. One woman catalyzer explained that discussions about couples were particularly popular, saying that, "people come because of the stories about couples, they go to their homes and speak to their neighbors who come also to the following meeting."<sup>13</sup> Another added that meeting newcomers want to space children to have less infant mortality.

Many catalyzers provided details which alluded to lively conversations. One woman catalyzer recounted a story about a group participant who did a testimony about her own life. Certain catalyzers also stressed TJ group activities provided a framework for people to discuss topics that weren't always easy to discuss outside of the project. One woman explained, "to speak about it, women have shame and as they have started to learn that we talk about these activities, they take advantage to join the group to listen."<sup>14</sup>

The data from these discussions suggests that TJ activities are compelling to many women in the project site, to the point where *groupements* attract new participants and engage them in compelling conversations that they might not have otherwise. Certain of these participants also described newcomers who might not always be in agreement is TJ's messaging; this dynamic is described more in a later sub-section about community tension.

### **Men's Catalyzer's Experience of Growing Groups**

Speaking about reasons why more people came to groups, men catalyzers mentioned many of the same factors as women: interest in birth spacing, family planning, and couple communication.

---

<sup>11</sup> Original Adja to French translation, « Les gens demandent même la photocopie de ce que nous leur lisons »

<sup>12</sup> Original Adja to French translation : « Nous sommes 11 dans notre groupement mais après la discussion on va jusqu'à 30. »

<sup>13</sup> Original Adja to French translation : « les gens viennent parce que c'est des histoires qui parle des couples et quand ils vont à la maison ils en parlent à leurs voisins qui viennent aussi au prochaine réunion. »

<sup>14</sup> Original Adja to French translation, « cela concerne tout le monde mais pour parler de ça, les femmes ont honte et comme ils ont commencé par apprendre qu'on parle de ses activités, elles profitent pour rejoindre le groupe afin d'écouter. »

Indeed, couple communication came up several times in focus groups with men catalyzers. One man stressed that additional people who come to his group are often women or couples looking for advice, and that the discussion helped them to have less conflict at home. Another reported that women ask questions because they want to better understand, especially those women who are in conflict with their husbands. One man catalyzer explicitly mentioned that people come for more information about their sex lives.

Although men catalyzers also mentioned dynamic conversations, from their descriptions, men’s groups seem slightly less lively than women’s groups. Several men also described newcomers who asked questions, but there were less explicit mentions of people giving testimonies of their own lives, or diffusing information to their neighbors. One man catalyzer said that people who are not members participate in the discussions so much that the group members have trouble getting a word in.

**Comparing Experiences of Men Catalyzers and Women Catalyzers**

The data here is not explicitly clear. Men and women catalyzers mention curiosity about similar topics. Couple communication seemed to come up slightly more in men-led groups, suggesting this topic may be of particular interest to men. Or, it could also be that women seek advice on how to approach their husbands from men catalyzers, suggesting that men can play a key role in diffusing information among women, or that men catalyzers can act as role models and important resources for women within their communities. For scale up, this further underlines the importance of finding and training men catalyzers—they can be important resources to women as well as men.

SUMMARY TABLE: COMMUNITY DIFFUSION	
Diffusion Finding	Implications for Scale-Up
Women, men and couples attend both men’s and women’s groups for advice on couple communication.	Continued awareness of the importance of engaging men’s groups, not just for men but also for women seeking advice. Include materials on couple communication and conflict resolution.

**AGE AND PARTICIPATION**

Although there were a few exceptions, in general, catalyzers said that young people rather than older people were more likely to participate in TJ discussions. However, one participant said that unmarried young people were unlikely to participate.

There were several explanations provided for why young people might be more interested in participating. Young people could also be more informed about FP than their elders, or be less embarrassed to speak about reproductive health issues. “Older people are not used to speaking about these things, the young people don’t see anything as taboo”<sup>15</sup> said one catalyzer, who was perhaps making an over generalization. One catalyzer said that TJ discussions had attracted more young people to her group, which had originally been all older people.

Another common explanation was that young people are more sexually active or fertile; elders sometimes left because they thought the conversation did not concern them. “It’s true, the young people speak more than the old people....the aged people retire, saying that they are already

<sup>15</sup> Original Adja to French translation, « Les personnes âgés n’avaient pas l’habitude de parler de ces choses, les jeunes ne prennent plus rien comme tabou. »

old.”<sup>16</sup> Another pointed out that woman who had gone through menopause were no longer concerned about family planning.

However, according to at least one catalyzer, elders can participate and could positively influence younger people. “The old people also like [the discussion].....in going to their homes, these older people gather their daughters in law, and speak to them about what they learned.”

Indeed, elders do have important social influence and wider social networks, and can hold important community positions as trusted advisors. To further engage them, the project could consider adding activities that specifically engage older people, or working with catalyzers to build further strategies for including this group in conversations.

**SUMMARY TABLE: AGE AND PARTICIPATION**

Finding	Implications for Scale-Up
Younger people tend to participate more than older people in TJ conversations; older people may even leave. Yet, older people can play a role in diffusion when they do engage.	Consider adding a discussion question in the TJ activities about how FP is a community issue and all can help address it.

### GENDER AND PARTICIPATION

TJ is experiencing challenges engaging men. There are few all-men groups participating in TJ, and monitoring and evaluation (M&E) indicators generally show that men are less engaged. The project is searching out ways to change that. To better understand the gender dynamics, the evaluation analysis team looked closely at the responses in two different activities: “Agree or disagree” and “TJ Village, Before During and After” to better understand how men and women are engaging with the program differently.

#### *Why Women Participate More, And What Some Catalyzers Do About That*

In an activity called “Agree or Disagree” catalyzers were asked to agree or disagree with the following statement: “women speak more than men during activities”, and elaborate about how or why. The majority of women and men catalyzers affirm that women tend to discuss subjects linked to family planning more than men, due to their societal status and particular fertility desires.

Speaking about why women participate more than men, catalyzers often provided explanations linked to women’s physiology; their societally defined, gendered roles; or their disadvantaged status. One man catalyzer explained that women speak more because, “women suffer more than men in maternity”.<sup>17</sup> One woman noted, “it us, the women, the engine managing all the problems.”<sup>18</sup> A man explained, “they want their liberty, which makes them speak more.”<sup>19</sup>

Another woman explained that there were not many spaces for women to discuss these topics outside of the TJ discussion groups. “Women speak more than men, because men do not give women the liberty to express themselves, thus women take advantage of these occasions to speak

<sup>16</sup> Original Adja to French translation, « C’est vari les jeunes parlent plus que les personnes âgés....ces personnes âgées se retirent en disant qu’ils sont déjà vieux »

<sup>17</sup> Original Adja to French translation: « Les femmes souffrent beaucoup plus que les hommes sur la maternité. »

<sup>18</sup> Original Adja to French translation : « C’est nous les femmes le moteur qui gère tout les problèmes. »

<sup>19</sup> Original Adja to French translation, « Elles veulent leur liberté ce qui les fait parler plus. »

a lot” said one woman catalyzer.<sup>20</sup> TJ seeks men’s and women’s discussion on family planning, and designed the intervention to create dialogue among both men and women, to reduce barriers to unmet need. It is interesting that the response from this catalyzer suggests that TJ catalyzer groups are correcting an imbalance in a society where women may not always have freedom to speak openly. Although the project can and should endeavor to engage men, it could also be considered a success that women are participating so much in TJ activities, when in other areas they may not be able to do so.

Others mentioned that men might participate less because they want many children, and thus are less interested in conversations they perceive to be about family planning. One man said that men focus on what to do to have more children. Surely he was making a generalization, but nonetheless making the important point that many men do desire large families.

Certain catalyzers of both genders described taking their own actions to engage men. Many focus group participants noted that men do speak, and some catalyzers alluded to working hard to engage men, and even to change their beliefs about FP. For instance, one man catalyzer said, “But also we obligate men to speak.”<sup>21</sup> Another woman catalyzer reported going to a man’s home to advocate for the value of FP, explaining that men often “do not like that they think that FP is coming to prevent them from having many children, so we go to men’s homes to convince them...we talk to them about the advantages of FP until they are convinced.”<sup>22</sup> Another woman counseling couples in conflict: “the catalyzer must be ready to speak, to approach the husband of those who are not up to date about the teachings of TJ.”<sup>23</sup>

The responses of these catalyzers highlight two significant barriers to engaging men. First, men may have different fertility desires from their partners. This desire could stem from multiple and complex social, cultural and economic forces (see [TJ formative research](#)). The project aims to address this barrier by encouraging couple communication. The other issue is that men could see pregnancy and FP as a woman’s issue. Messaging and activities could continue to explain why a woman’s challenges in pregnancy are the concerns of a couple, not only the problems of the woman. Also, the project could continue efforts to tap into issues that are of deeper interest to men, which will be discussed in the following section.

Finally, it is noteworthy that many catalyzers seem to be doing community advocacy work by educating men about FP, and convincing them that it is acceptable. M&E indicators could shift to capture and record this particular kind of advocacy work that catalyzers are doing.

### **Changes and Issues that Resonate With Men and Women**

In order to better understand what topics and results are more compelling to men and women, analysis also examined the topics most often mentioned by men and women catalyzers as they spoke about the a hypothetical village before, during and after the intervention. Although these are the responses of catalyzers—and not participants—they still provide insights into differences

---

<sup>20</sup> Original Adja to French translation: “Les femmes parlent de ça plus que les hommes care les hommes ne laissent pas la liberté aux femmes de s’exprimer donc par ses occasions les femmes profitent pour beaucoup parlé. »

<sup>21</sup> Original Adja to French translation: “Mais aussi nous obligeons les hommes à parler.”

<sup>22</sup> Original Adja to French translation, « Souvent c’est des hommes qui n’aiment pas parce qu’ils croient que la PF vient les empêcher de faire beaucoup d’enfants, donc on va chez ses hommes pour les convaincre...on lui parle surtout des avantages de PF jusqu’à ce qu’il soit convaincu. »

<sup>23</sup> Original Adja to French translation, « Le catalyzer doit être prêt pour parler, aborder le mari de ceux qui ne sont pas au courant des enseignements de TJ. »

in how men and women see the program. The table below details common responses in men’s and women’s focus groups.

WHAT IS A VILLAGE LIKE BEFORE TÉKPONON JIKUAGOU COMES TO IT?	
Women	Men
<b>Before</b>	
<ul style="list-style-type: none"> <li>• Birth spacing and discussions about birth spacing are rare.</li> <li>• Couples experience conflict.</li> <li>• People have discussions about how to have many children.</li> </ul>	<ul style="list-style-type: none"> <li>• People have many children, talk about having many children, or desire having many children.</li> <li>• People use withdrawal or speak about withdrawal and abstinence</li> </ul>
<b>After</b>	
<ul style="list-style-type: none"> <li>• There is improved health and welfare for women and children.</li> <li>• There are better couple relationships and more peaceful households.</li> </ul>	<ul style="list-style-type: none"> <li>• There is more dialogue about FP, child spacing, the TJ project.</li> <li>• There is more child spacing.</li> </ul>

It is telling to examine similarities and differences between men and women in these responses. In the “before” question, both men and women mention that in the days before TJ, discussion about various TJ topics (like birth spacing) was rare, and that many people wanted many children. In the after category, men tended to mention increased dialogue about project impacts, while women mentioned more direct, profound impacts like improved health and better relationships.

One notable difference here is that men mentioned, in multiple focus group discussions, that use of withdrawal and abstinence was common practice. Although they do not go into great detail about their method choice during the project, withdrawal and abstinence are not mentioned in the question about village life during or after TJ, suggesting that men notice and appreciate the change in method use.

To engage men, it could be worth exploring if dialogue about withdrawal could create interest and increase men’s participation in TJ. Speaking about TJ, one influential went into great detail about his experience using withdrawal with his wife, suggesting that there may be cultural permission to discuss the issue openly in certain circumstances.

However, any such materials will have to be carefully tested, as detailed discussions about sex could also cause negative reactions among conservative community members. Also, discussions about withdrawal could potentially lead to conclusions that with modern methods, men are entitled to sex, how they want it, at any time. Thus, conversations that highlight that people who use modern methods do not have to rely solely on withdrawal can also stress the importance of couple communication and consent before sex.

## SUMMARY TABLE: GENDER AND PARTICIPATION

Finding	Implications for Scale-Up
Men may be less likely to participate because pregnancy/childbirth/FP is viewed as a women’s problem.	Continue to create dialogue about how childbirth is the problem of the couple, not just the women.
Some catalyzers describe trying to convince men of the value of FP.	Create M&E indicators to monitor and track this particular kind of work.
Men articulate the use of withdrawal as a major characteristic of village life before TJ.	Consider integrating materials that provoke dialogue about the use of withdrawal, improved emotional and sexual relationships for couples, and other issues salient to men.

### RADIO PROGRAMS: COMPLEMENTARY TO COMMUNITY ACTIVITIES

Focus group data suggests that radio programs are complementary to other parts of the TJ package. They may reach particular audiences: men, and those able to afford radio, or who are most likely to listen. Radio programs may reinforce and legitimize catalyzer activities, and give more opportunities for people to participate in the intervention. Others noted that the two interventions offered different kinds of participation engagements: anyone can participate in the TJ group activities, but you must call in for participation on the radio. One interviewee criticized the TJ radio program, saying that it aired at a time that was too early, and inconvenient. There was slightly less data on this issue, in part because the radio component of the intervention began only 3 months before this evaluation exercise.

### SOME CONTINUING COMMUNITY TENSION

Although most dialogue in focus groups suggested that TJ increases community discussion, many catalyzers and influentials mentioned some ongoing tension in the communities where they work. In order to understand this dynamic, we can examine the responses to a question posed to catalyzers about why community participants leave TJ discussion groups. It is important to note that due to time constraints, we were not able to collect information about if participants who left also came back at a later time.

Speaking about this topic, catalyzers brought up several reasons, some of which have already been discussed in other parts of this report. Tension with participants over money, for instance, is not only a challenge for catalyzers (discussed in a previous section) but it is also cited as a reason that leads some participants to leave. Other catalyzers said that people beyond reproductive age also tend to leave. Further reasons for tension and participant departure discussed in this section relate to participants’ attitudes and beliefs about FP, fertility, gender and reproduction.

#### *Negative Beliefs on FP: Fear of Sterility, Side-Effects or Religious-Based Objections*

For some catalyzers, negative beliefs about FP led people to leave discussion groups. Some participants link FP to sterility. One man catalyzer explained that, certain people do not like hearing about TJ, because there are people who use injections and can’t conceive anymore. Another said, “men say that planning activities bring sickness.”<sup>24</sup> For others, family planning interrupts what they see as divine destiny. Another catalyzer explained that spacing is in conflict with God’s will. Interestingly, men catalyzers mentioned the religious-based objections more than women.

<sup>24</sup> Original Adja to French translation : « Les hommes disent les activités de planification amènent plusieurs maladies. »

### *People Want Many Children, or Closely-Spaced Children, or See the Project in Conflict with their Fertility Desires*

Other catalyzers reported that some community members see TJ as a project in conflict with their fertility intentions. Speaking about those who dislike TJ, one catalyzer explained, “those who do not like TJ discussions, say often that they are capable of supporting whatever number of children, and TJ wants to make couples lazy” said one man catalyzer.<sup>25</sup> One woman articulated that some people do not want someone telling them how to space their children. Another said that people, “do not like to hear that we tell them to bring their wives to the hospitals for planning, because they want to have closely-spaced children.”<sup>26</sup> In response to another question, one catalyzer said that people could see the project as an outside intervention, elaborating, “...there was someone who asked one day, is TJ is the program from white people, to cut off births and reduce them in Africa?”<sup>27</sup> This catalyzer described her response in this way: “I tell them it’s to have peace in the household.”<sup>28</sup>

### *Tension Around Norms of Reproduction and Gender*

Community tension can also stem from group discussions which may challenge community norms around gender and reproduction. Certain catalyzers, particularly ones from the high-performing women’s groups, said social pressure could prevent people from participating in TJ groups. “There are older women who do not allow family planning for their daughters-in-law, because this technique delays the daughter-in-law in giving birth”<sup>29</sup> said one catalyzer. These words suggest that TJ discussion groups may be perceived to be challenging expectations around women’s roles in bearing children. Gender-based tension can also be observed in groups that get bigger. Speaking about a group which grows when more husbands come, one group member explained, “Certain men come to listen but do not respect the given teachings. The women listen but are incapable of doing because they have fear of their husbands, [they] come look for solutions to their problems even after the meetings.”<sup>30</sup> Although it is hard to know the details of what happened in this particular group, it seems likely that these men desire to assert their control in a space where discussions that challenge normative gender roles may be taking place.

---

<sup>25</sup> Original Adja to French translation: “Ceux qui n’aiment pas les discussions TJ, disent souvent qu’ils sont capables de supporter n’importe quel nombre d’enfants et TJ veut rendre paresseux les couples.”

<sup>26</sup> Original Adja to French translation, «...Surtout ils n’aiment pas entendre qu’on leur dise d’amener leurs femmes dans les hôpitaux pour les planifications car ceux-là veulent faire des enfants rapprochés. »

<sup>27</sup> Original Adja to French translation, « ...il y a quelqu’un qui m’a demandé un jour si TJ n’est pas le programme des blancs pour leur couper les naissances et les réduit en Afrique. »

<sup>28</sup> Original Adja to French translation : « je leur explique que c’est pour qu’il ait la paix dans le foyer. »

<sup>29</sup> Original Adja to French translation, “Il y a aussi des femmes âgées qui refusent à leur belle fille les planifications car cette technique pour elle retarde ses belles filles dans l’accouchement.”

<sup>30</sup> Original Adja to French translation, « Certains hommes viennent pour écouter mais ne respectent pas les enseignements donnés. Les femmes écoutent mais sont incapables de faire car elles ont peur de leur mari et viennent chercher des solutions à leurs problèmes même après les rencontres. »

## WHY DO PEOPLE LEAVE TJ DISCUSSION GROUPS?

	Men	Women
<b>Low-Performing</b>	<ul style="list-style-type: none"> <li>• Community tension over money</li> <li>• Older members do not want to participate</li> <li>• Belief that God has ultimate control over fertility</li> <li>• Fear of side effects of birth control</li> </ul>	<ul style="list-style-type: none"> <li>• Community tension over money</li> <li>• Older members do not want to participate</li> <li>• Community members do not want to space births, use modern methods, or discuss these topics.</li> </ul>
<b>High-Performing</b>	<ul style="list-style-type: none"> <li>• People affirm they are capable of controlling their own fertility</li> <li>• Activities take too long, or people busy with other work.</li> </ul>	<ul style="list-style-type: none"> <li>• People busy with other activities</li> <li>• Older members do not want to participate</li> <li>• Community members do not want to use modern methods, do not want their wives/daughters to use modern methods, or fear side effects.</li> </ul>

### *Discussion: Responding to Community Tensions*

Moving from pilot to scale-up, Tékponon Jikuagou wants to ensure that the project is acceptable in Beninois communities. Much of the data from this evaluation showed that indeed, the project is acceptable and appreciated. Although it is unfortunate to hear about community tension, some community tension is to be expected, and is a sign that there is need for increased dialogue about FP and gender. Some of the beliefs leading to community tension—such as belief that injectable birth control causes infertility—are beliefs that TJ is already addressing through their activity set, and by linking community members to providers. If FP was completely acceptable in communities, there would be no need for a TJ project.

Reluctance to use hormonal/injectable birth control can be deep-seated, and also related to experiences with the side effects of many methods of birth control. Providing community education, and health worker training about how to manage or address false rumors about methods and about fertility awareness may allow those reluctant to use hormonal birth control to find a method that works for them.

However, it is more concerning when participants speak about TJ in a way that suggests they believe that the intervention is in conflict with their fertility intentions. This is not the goal of the project, which aims to increase community dialogue about family planning, and thus reduce unmet need. Since TJ uses multiple mediums to create dialogue, and involves hundreds of different participants, it is possible that some of the various iterations of TJ's messages morph into messages about people needing to limit their number of children. While scaling-up, it is important to continue re-iterating that Tékponon Jikuagou is a project which aims to increase people's ability to plan their reproductive futures. The project does not aim to dictate family size or prevent people from achieving their reproductive desires.

**SUMMARY TABLE: COMMUNITY TENSION**

Finding	Implications for Scale-Up
Tension due to beliefs about modern methods	<ul style="list-style-type: none"> <li>• Continue activities which help people engage with unsupportive family members, continue dispelling myths about modern methods.</li> <li>• Include education about fertility awareness methods (FAM) to provide an option to those particularly concerned about side effects.</li> </ul>
Tension due to belief that TJ is trying to control people's fertility.	<ul style="list-style-type: none"> <li>• Continue stressing that TJ aims to help individuals achieve their reproductive desires, not control their fertility. Engage participant about this difference, early in project implementation.</li> </ul>

**PHASE-OUT IDEAS**

In another part of the focus groups, participants offered their ideas for what should happen after TJ ended formal activities. Some were optimistic about the sustainability of the project's messages, even after the program had left: Many catalyzers insisted that they would keep the dialogue materials, or speak about TJ issues from time to time. One leader insisted he would continue activities, even after the departure of the project. Others highlighted that even after the project left, people would remember the lessons of TJ.

Others wanted support for continued activities, after the departure of the project. Certain participants asked that TJ activities continue. One stressed the need for continued collaboration with local authorities and health workers. Some wanted catalyzers to be paid to continue doing TJ activities. An influential religious leader suggested installing a "siege" or headquarters to continue providing information, even after the end of the project.

However, some were pessimistic about the project's sustainability. Certain catalyzers worried that TJ's departure would surprise their village, activities and messages would be forgotten.

It is important to be as transparent as possible about the project's timeline from early on, to avoid misconceptions about how long the project will stay, or what else implementing NGOs will do. It is also worthwhile to invest resources in making durable activity cards, tools, and protective bags, to allow catalyzers to continue using project materials after the project has departed.

**SUMMARY TABLE: PHASE OUT**

Phase Out Finding	Implications for Scale-Up
Uneven ideas about how project will end, what will happen after project.	<ul style="list-style-type: none"> <li>• Manage expectations for how the project will end during catalyzer orientation. Also teach catalyzers to manage expectations among their group members.</li> </ul>
Many catalyzers say they will keep doing activity cards, once project is over.	<ul style="list-style-type: none"> <li>• Continue creating durable, re-usable cards that will last for over time.</li> </ul>

## HEALTH SERVICES LINKS

Linking influential groups and individuals to health care providers is a key part of Tékponon Jikuagou's project goals. The project was originally located in Mali, where family planning services were consistently available in project sites. After a political coup in Mali, the project re-located to Benin, and in consultation with the MOH, selected Couffo department to develop and test TJ, while ensuring CARE and Plan were able to operate in the area. In Benin, services are generally less developed: many services only provide three methods and many providers are not trained in client-centered FP counseling.

Many catalyzers reported that linkages with health services were extremely valuable: they had been in touch with health workers, who were helpful resources for their discussion groups. Certain catalyzers also described responsive health workers, who are able to offer community members services that they need. However, other catalyzers wanted stronger connections with health workers, or described barriers that community members faced while seeking care. Quality of care can be poor, supply chains uncertain, services too expensive. Gendered power dynamics can prevent people from accessing services, even if they make it to the health clinic.

In such a complex environment, creating demand, and ensuring that new demand can be met, is challenging. To address these demands, the pilot project is currently supporting training of clinical providers in contraceptive technology and counseling, to support quality of care in the project implementation zone. As TJ expands, implementing organizations can continue to build links with health workers, check and monitor available health services, and take steps to improve services if necessary.

## UNEVEN ENGAGEMENT WITH TÉKPONON JIKUAGOU

Data from this exercise suggests that there is a wide range of health care worker involvement in TJ activities. Among the three health workers interviewed, two knew TJ and were involved in it; however, one of these health workers was the wife of a facilitator. Another did not know the project, but was otherwise actively involved in community engagement on FP.

In focus groups, catalyzers reported a variety of relationships with health workers. Some reported no collaboration. "In our activities, no health agents have come to help us in sessions" said one catalyzer.<sup>31</sup> Others reported that health workers came, and that their presence was helpful to providing technical information that catalyzers could not necessarily provide. One woman explained, "there are questions to which we cannot respond, so our group members require that we call health agents so that they can see and understand" said one woman, whose words also suggests that her group participants are very engaged.<sup>32</sup> Another suggested that health agents can even provide valuable motivational support: "they call me and congratulate me on work that is well done."<sup>33</sup>

Indeed, health workers seem to be often providing technical knowledge that is necessary for productive conversations about family planning. However, in one case, a catalyzer explained that

---

<sup>31</sup> Original Adja to French translation, « dans nos activités, il n'y a aucun agent de santé qui soit venu à notre aide en séance ou soit pour accompagnement. »

<sup>32</sup> Original Adja to French translation : « Les agents de santé viennent à notre aide parce qu'il y a des questions auxquelles nous nous ne pouvons pas répondre, alors nos membres exigent à ce qu'on appelle les agents de santé pour qu'ils puissent voir et comprendre claire. »

<sup>33</sup> Original Adja to French translation : « Ils m'appellent et me félicitent de mon travail bien fait. »

she did not need a health worker yet, because she had yet to be confronted with a question she could not answer. Although it is possible this catalyzer feels and is very knowledgeable about FP, or is receiving only simple questions from her group, it is also possible that she is answering questions she is not qualified to answer. Such testimonies further underscore the value of the presence of health workers in creating quality conversations about FP.

Influentials—whose experiences will be further explored in a later section—also described a diverse range of contact with health workers. One spoke to health workers from time to time. Another had contacts from a previous AIDS project, and now refers people to the center in his work with TJ. A woman influential, on the other hand, had no contact with health workers, and did not know them.

Many catalyzers expressed a desire for more formal collaboration between health workers and catalyzers. “It is necessary to increase the trainings of health workers and catalyzers together about the work of TJ”<sup>34</sup> said one man; “there must be understanding between health workers and catalyzers so there can be mutual aid.”<sup>35</sup> One woman reported that basic education about the project made a notable difference in health workers’ involvement in the project.

“The health agents heard about it, and the head nurses were called to inform [the health agents] that they must help the populations and serve those who need planning. And the health agents appreciated it, and even said they would do all to support TJ.”<sup>36</sup>

However, one suggested that training health workers on TJ doesn’t necessarily mean that they will participate. Although her health agents had been informed about TJ in a meeting, no one had come to help her.

Nevertheless, words of these catalyzers corroborate one of the key theories of the TJ intervention: strong social networks can be harnessed for positive health impacts. If only catalyzers and health workers could be in touch, many suggested, work for both parties would be so much easier. TJ, as a whole, is endeavoring to link networks of influential groups and people with health workers, as these catalyzers are suggesting, through orientation sessions that include catalyzers and health workers, radio programming and Each One Invites Three. Data from these focus groups suggests that these efforts are in line with community needs, and could have beneficial impacts.

#### UNCERTAIN SUPPLY CHAINS, QUALITY OF CARE

Interviews with health workers and catalyzers suggested a wide range of quality of care. Some reported high quality of services; others reported low quality, other reported mixed or inconsistent experiences.

The three health workers interviewed in this process offered a range of contraceptive options available for patients.

---

<sup>34</sup> Original Adja to French translation : « Il faut multiplier les formations des agents de santé et les catalyzeurs ensemble sur les actions de TJ. »

<sup>35</sup> Original Adja to French translation : « il doit avoir entente entre agents de santé et catalyseurs pour qu’il y a ait entre aid. »

<sup>36</sup> Original Adja to French translation : “Les agents de santé entendent parler cela et les majors sont appelés à informés qu’ils doivent aider les populations et server ceux qui seront dans le besoin du planning. Et les agents de santé ont apprécié et ont même dit qu’ils feront tout pour accompagner TJ. »

- One midwife reported that she had several methods available (IUDs, implants, pills, condoms, cyclebeads) but she was also interested in carrying more.
- Another had injectable, implants, and condoms, could refer women elsewhere for pills, and could demonstrate the Standard Days Method (SDM) on one available set of CycleBeads; she had IUDs but did not know how to administer them.
- The third reported that pills, injectables, condoms, CycleBeads, IUDs and the implant were available. On the day of the interview, she had inserted IUDs, and she said that her nursing aides were trained to provide injections, pills, condoms and SDM.

These services may be available most readily during state-run campaigns, when services are free for users.

These health workers seemed particularly well-stocked and well-trained; and several catalyzers reported experiences with high quality services. “In my area, all is available and even free at certain times” said one man catalyzer.<sup>37</sup> One woman was particularly praising of her local health services, saying “no matter where you are from, the health agents will give you their advice, and if possible do analysis to see what really works for you.”<sup>38</sup> Another simply said, “[People] go there easily, and the things are available”<sup>39</sup> and “products are available, and even free at certain times.”<sup>40</sup> These responses suggest that in at least some areas, services are consistently available and of acceptable quality.

However, others reported a lack of services in their area, or poor quality of care. “In our area, not everything is available, and the health agents prevent women from taking what is available”<sup>41</sup> said one man catalyzer, who unfortunately did not elaborate further on how health agents did this. Nonetheless, his words indicate an issue regarding provider-client interaction and respectful treatment. “At the moment, the products are available but nevertheless the midwives do not respectfully treat the women that we refer”<sup>42</sup> said one man catalyzer. Another man catalyzer said there was no health center in his village. Another said that, “there is difficulty, especially with the availability of [health workers]...this leads to looking left and right...those who want to do family planning, many end up without doing it.”<sup>43</sup> One catalyzer said there was no health center in his community and he had to refer his participants to another town for services. A village leader, or elected official, also said that the local health worker was not well trained, and did not treat people well. Health workers also explained that a recent strike had an impact on their ability to provide consistent services.

Other catalyzers explained that services were intermittently available in their area, or only available to those with means. “The services and products are not always available at every

---

<sup>37</sup> Original Adja to French translation: “chez moi, tout est disponible et même gratuit à un certain moment.”

<sup>38</sup> Original Adja to French translation, “de n’importe où tu viens les agents de santé vont te faire les propositions et si possible te faire des analyses pour voir ce qui te convient réellement.”

<sup>39</sup> Original Adja to French translation, « Ils y vont facilement et les choses sont disponibles. »

<sup>40</sup> Original Adja to French translation, « les produits sont disponibles et même gratuits a des moments donnés. »

<sup>41</sup> Original Adja to French translation: “chez nous, tout n’est pas disponible et les agents de santé contraignent les femmes à prendre ce qui est disponible.”

<sup>42</sup> Original Adja to French translation : « par moment, les produits sont disponibles mais pourtant les sages femmes n’accueillent pas bien les femmes que nous les référons. »

<sup>43</sup> Original Adja to French translation : « Il y a difficulté surtout sur la disponibilité des sages femmes et des majeurs. Ce qui fait tourner à gauche et à droite ceux qui veulent faire la planification et beaucoup finissent sans le faire. »

moment, they are missing at times” said one woman catalyzer.<sup>44</sup> “Not everything is available in our health center” said one catalyzer.<sup>45</sup> One noted that services had recently improved after health workers received training, and that “the products are now available.”<sup>46</sup> Another said that a town crier comes through town to alert everyone when everything is available, but then a week later services or products are no longer there. These catalyzers suggest that certain health centers have issues with their product supply chains.

TJ has taken steps to improve health services in parallel to increasing demand. Before the Each One Invites Three campaign, the *Association Beninoise for la Planification Familiale* provided health workers with training to improve counseling and technical knowledge. The project is also engaging with Ministry of Health officials to encourage them to bolster services in TJ project areas. During scale-up, it will be important to continue engaging with the Ministry of Health, to ensure that quality and consistent services are available in areas where TJ will operate. Also, TJ can prioritize scaling up in regions where services are available and consistent.,.

### FINANCIAL BARRIERS TO FP SERVICES

Along with issues of quality to care, financial barriers seem to be a key obstacle for those seeking health services. Speaking about why women did not use family planning, lack of financial means was cited as a key reason by a health worker in an area where Plan operates. One catalyzer explained that availability depended on the means of the patient.

One midwife went into detail about the pricing at her health center. The Jadelle implant costs 2000F, or about \$4, with insertion, and the depo shot costs 700CFA, or about \$1.50. It is possible that women also have to provide pay-offs to health staff when seeking services, in addition to paying for a method, although this exercise did not collect data on this issue. In a country where the gross domestic product per capita in 2012 was \$752<sup>47</sup> and women may have limited access to household money, such costs are significant. One midwife shared a story of a woman whose husband did not give her money for FP. The midwife asked her to provide only 100CFA for a client booklet, but the woman could not provide this money and left. Speaking about what TJ could do to encourage women to use health services, an influential said that products should be available and free; another influential said the same thing, noting that many people do not have amount of money necessary to buy products.

In interviews, health workers spoke about recent FP campaigns (unaffiliated with TJ), in which family planning services are provided, free of charge. Such campaigns may also include community outreach. Uptake of services apparently increases during these campaigns, according to one midwife, who explained that during campaigns they have more clients than usual. Another midwife reported that 17 clients had come for family planning since October, and 15 of these women had come during the free services campaign. One midwife suggested that when free services are available, women may feel empowered to seek it and tell their husbands afterwards and that otherwise, husbands will not help with FP costs.

The financial barriers to FP services will be important to consider while evaluating the impacts of the program. Although TJ can reduce stigma around FP, it is not providing free services, which

---

<sup>44</sup> Original Adja to French translation, “les services et les produits ne sont pas à tout moment disponibles, il y a manquant des fois.”

<sup>45</sup> Original Adja to French translation: “tout n’est pas disponible dans notre centre de santé.”

<sup>46</sup> Original Adja to French translation, “les produits sont maintenant disponible.”

<sup>47</sup> World Bank, GDP Per Capita Benin in Current US Dollars, <http://databank.worldbank.org/>

may be a key barrier for many women seeking contraception. This will be an important dynamic to consider while evaluating the impacts of the Each One Invites Three campaign.

### GENDER AND POWER DYNAMICS AT SERVICE POINTS

Gendered power dynamics continue to be a barrier for those seeking family planning services in Couffo. According to the 2003 law on Reproductive and Sexual Health, all men and women in Benin have the right to choose a family planning method.<sup>48</sup> Yet, there seems to be widespread confusion about whether women are allowed to access family planning services without the permission of their husbands, both among health workers and those seeking services. “I can leave one commune to go do my family planning in another, but obligatorily accompanied by my husband” said one woman catalyzer. Another explained, “in our village, the health agents ask first for the presence of the husband of the woman who came to do planning. To assure that he accepted that his wife is doing FP.”<sup>49</sup>

One health worker said that she could give a woman FP without her husband’s permission, but it would have to be “secret” ; another asked FP clients if their husband is aware of their intention to use. Another health worker said that she feared that she would have to go to court if she provided a woman with FP without her husband’s permission.

Part of the issue here could be that the rules enforced by community pressure are different than those stated in the national law. When a health worker says that she fears she would be called to court if she provided a woman with FP without the husband’s permission, she could be articulating a fear about defying community norms and facing local repercussions, and not necessarily the national court system. Nevertheless, educating health workers about the national law which guarantees access to FP may enable them to provide more women with services. TJ is currently including education about this law in its training for health care workers. However, strengthening other aspects of TJ discussed throughout this report—like community activities on couple communication—could be another important way to address this issue.

**SUMMARY TABLE: HEALTH CENTERS**

Health Center Finding	Implications for Scale-Up
Catalyzers unevenly engaged with health workers.	Continue efforts to standardize linkages between catalyzers and health workers.
Uncertain quality of care, availability of products.	<ul style="list-style-type: none"> <li>• During scale-up, consider coordinating certain TJ activities with existing public campaigns that deliver free services during certain periods. Advocate with MOH for free services and availability of products.</li> <li>• Continue stressing the importance of health worker training during scale-up. Select areas for scale-up where health care services are already high quality.</li> </ul>
Women often unable to access health services without permission of their husbands.	<ul style="list-style-type: none"> <li>• Educate health workers about Benin’s 2003 reproductive rights law, while recognizing that education about this law may not solve a larger systematic problem. Strengthen other aspects of TJ relating to couple communication.</li> </ul>

<sup>48</sup> Source, UNFPA newsletter.

<http://www.unfpa.org/public/cache/bypass/parliamentarians/pid/3615;jsessionid=233BA298DC376F4CB002AC934A5E91FB?newsLid=7292>

<sup>49</sup> Original Adja to French translation: “Chez nous les agents de santé demandent d’abord la présence du mari et celle qui vient faire le planning. Pour s’assurer qu’il a accepté que sa femme fasse le planning. »

## INFLUENTIAL INVOLVEMENT

During the social mapping process that begins the TJ intervention, the project identifies individuals who are influential in their communities. These individuals can be formal, elected leaders, or people who are influential in other ways. Once these individuals agree to work with TJ, they attend an orientation about the intervention, where they receive training and tools that encourage them to take actions that increase dialogue and access to FP in their communities. These actors play a different role than the catalyzers, whose work was described in previous sections.

The project (and this report) refers to these engaged individuals as “influentials.” Influentials describe a range of involvement in the project, and discuss work in diverse conditions where knowledge about FP varies. Influentials have a range of opinions about how to improve the TJ orientation process, and like catalyzers, many want financial motivation. The flexibility of the influential individual component seems to be one of its greatest strengths; this flexibility could be replicated in the scale-up process. Further findings will be discussed in the following section.

### DIVERSITY OF INVOLVEMENT

Unlike catalyzers, influentials do not conduct a uniform set of activities, rather, they are able to create their own ways of engaging with TJ issues, and do so in a variety of ways. Interviews for this exercise included discussions with the following individuals who act as influentials for TJ:

- A traditional healer who spoke about FP and women’s health to a wide audience in a public setting.
- A pastor who speaks about FP and health services to his congregation.
- An older woman who counsels couples in conflict.
- A retired military officer who organized discussions in his community about family planning and birth spacing.
- A messenger who speaks to women’s groups about TJ topics after their meetings (much like a catalyzer).

As this list shows, influential individuals are engaged in a variety of ways. This flexibility seems to allow people to work in spaces where they feel comfortable, and are already established.

### DIVERSITY OF CHALLENGES, SUCCESSES, AND SUGGESTIONS

Influentials engage with TJ in diverse ways, and they also describe a diverse range of challenges and successes. For instance, the influential who conducted activities similar to those of a catalyzer described challenges similar to those of a catalyzer. At times he had difficulties explaining the materials to others,, but in general he found the community to be receptive to his work. The influential who worked often with couples found speaking to women about TJ issues to be easy, and not shameful, and said there was now more birth spacing in her community.

Influential individuals also had a diverse range of suggestions about how to improve the program. One influential wanted more meetings; another wanted a project headquarters that would continue permanently, and a video project to encourage sustainability. The woman influential who worked with couples wanted to include more aspects of maternal/child health in the program, and suggested also teaching people to weigh babies, and more formal contact between health agents and influentials.

### ORIENTATION FOR INFLUENTIALS

Influentials also had a range of opinions on how orientation could be improved. One influential wanted material items like a bike or a flashlight. There were mixed opinions on the ideal location for influential orientation; one said he indicated that he prefers the *arrondissement* level, because he said it allowed more villages to be informed about TJ ; another said she preferred the village level, for convenience ; another liked having it at the village level, but not in someone’s home , another did not have a preference. For scale-up, it seems that there is value to offering influential orientation in a number of different locations, both locally and at the *arrondissement* level, to serve the needs of influentials who have varying amounts of mobility.

### DESIRE FOR FINANCIAL/MATERIAL SUPPORT

Like the catalyzers, many influentials expressed a desire for “motivation”: financial or material compensation for their work. One influential wanted more support so they could do more work in other areas; some suggested also motivating other TJ participants.

### A LEADER WITHOUT TJ’S ORIENTATION

This assessment also looked at the experiences of a community leader who had not attended TJ’s orientation, to compare his experiences and work with the experiences of those formally implicated in the program. This leader, an elected official, served as a link between the villages and the administration at the commune level. While he worked in an area where TJ is functioning, he lived in another area not reached by the intervention. While he was aware that the program was functioning, he did not know much about TJ. He explained that his secretary attends meetings about TJ, and reports back to him.

However, this official also said that he conducts other activities around family planning. He explained that that he is invited to meetings attended by health workers and other village leaders, where family planning and birth spacing are topics of discussion. Although this leader was not very knowledgeable about FP, he articulated views about family planning that are in line with the project’s mission. He explained that planning benefits men and women, and that closely spaced children can create financial burdens for families. He stressed the need for couple communication and men’s involvement. Many of his views were in line with the intervention’s approach.

It is possible that this leader is articulating views reported back to him by his secretary. However, it is also possible that this leader holds these views, independent of TJ’s influence. His words could indicate that in areas where TJ intervenes, there may already be networks working to create dialogue and acceptance for family planning. Throughout the social mapping process, it is important to continue identifying and working with these networks.

**SUMMARY TABLE: INFLUENTIAL INVOLVEMENT**

Finding	Implications for Scale-Up
Influential engage in TJ in diverse ways, according to their own contexts.	<ul style="list-style-type: none"> <li>Continue encouraging a broad range of activities among influential, as this approach allows people to play up their own strengths within their communities.</li> <li>Consider holding orientations at both village and <i>arrondissement</i> level, to meet the varying needs of influentials.</li> </ul>
Leaders not engaged in TJ may be engaging in their own activities.	Continue engaging groups and individuals already working on FP in the community mapping process.

## CONCLUSION

This rapid evaluation provides some evidence that TJ is having impacts on the communities where it works. Across focus groups and interviews, people spoke about how the program is changing relationships and family planning. The extent of these changes and impacts, however, is difficult to evaluate through this exercise; the project will receive more information from the larger scale qualitative and quantitative research studies.

This document contains an appendix which summarizes the key findings and implications for scale-up. Broadly, the findings can be summarized as such:

- **Catalyzer Discussion Groups** report creating lively dialogue in their groups about a wide variety of topics relating to FP, gender, and other topics. Catalyzers continue to face challenges relating to literacy, translation, and complex activities. Catalyzers are performing challenging work and many desire to be paid; addressing their challenges could make their work easier and more effective.
- **Activity Dynamics and Community Responses** Catalyzers report creating dialogue in their communities, and also report changes relating to FP use. Women and young people tend to participate the most in catalyzer discussion groups. Negative community beliefs about family planning can create challenges for catalyzers working to create dialogue. For scale-up, the project can make specific efforts to involve groups that seem less engaged.
- **Health Services Linkages** Health workers in Couffo have a wide range of involvement in TJ activities. Also, catalyzers report that the quality of care, and availability of services, can vary widely. Although a 2003 law in Benin guarantees that women can access FP independently, many health workers still require a woman to have a husband's permission before she can access FP.
- **Influential Involvement** Influentials are engaged with the program in a wide variety of ways, and describe challenge that relate to their particular activities.

Indeed, this exercise showed that catalyzers, health workers, and influentials face a variety of challenges while implementing TJ, and while providing services and information to their community. The exercise also showed, however, that many of them are tenaciously dedicated to improving their communities, and often come up with creative solutions to these issues. Many of their suggestions and actions are used in recommendations for scale-up. All recommendations are summarized in the annex table at the end of this report.

Finally, these research findings continue to highlight the dynamic, changing and unstable nature of unmet need and gender roles. Health services may be intermittently available, meaning a woman may have access to health services one month, and have unmet need the next month. Access to contraception can change gender roles, allowing women to be more active in the economic sector. Men can prevent women from accessing contraceptives, but also be deeply engaged and interested in FP. TJ may be reducing community stigma, but stigma continues to be a barrier for many catalyzers. One of the strengths of the TJ package, and one element that should be preserved in scale-up, is the package's overall flexibility, and ability to adapt to the changing, complex dynamics of each particular community.

## ANNEX: COMPLETE SCALE-UP IMPLICATIONS TABLE

SUMMARY SHEET: CATALYZER CHALLENGES, SATISFACTIONS, RELATIONSHIPS	
Catalyzer Challenge	Strategy for Addressing in Scale-Up
Literacy and translation challenges	Where possible, prioritize translating activity cards into local languages such as Adja and Fon.
Activity challenges	<ul style="list-style-type: none"> <li>• Further simplify activities</li> <li>• Consider removing most complicated activities for scalable package.</li> </ul>
Money tension with participants, lack of financial reimbursement	<ul style="list-style-type: none"> <li>• Include section in catalyzer orientation about TJ's volunteer model.</li> <li>• Include section in catalyzer orientation role playing money questions that might come up in <i>groupement</i> settings.</li> <li>• Reduce burden on catalyzers by translating and simplifying tools.</li> </ul>
Catalyzer Satisfaction	Implications for Scale-Up
Story telling success	Continue using stories for scale-up. Consider how role-playing could be integrated into storytelling, if role-playing activities are cut back or majorly simplified.
Public speaking development	Continue to emphasize public speaking in catalyzer orientation, help those who do not have these skills to build them.
Catalyzer/Facilitator Relationship	Implications for Scale-Up
Low mention of facilitator positive reinforcement	Stress the value of positive reinforcement in facilitator training for scale-up.
Low-performing catalyzers describe complicated, sometimes difficult relationships with facilitators.	Stress kindly behavior towards catalyzers during scale-up, provide facilitators support they need to give positive support.

## SUMMARY SHEET: SCALE-UP SUGGESTIONS

### COMMUNITY RESPONSES

Phase-Out Finding	Implications for Scale-Up
Uneven ideas about how project will end, what will happen after project.	Manage expectations for how the project will end during catalyzer orientation. Also teach catalyzers to manage expectations among their group members.
Many catalyzers say they will keep doing activity cards, once project is over.	Continue creating durable, re-usable cards that will last for many years and uses.
Health Center Finding	Implications for Scale-Up
Catalyzers unevenly engaged with health workers.	Continue efforts to standardize linkages between catalyzers and health workers.
Uncertain quality of care, availability of products.	<ul style="list-style-type: none"> <li>• Consider coordinating scalable project with campaigns that deliver free services. Continue advocating with MOH for free services and availability of products.</li> <li>• Continue stressing the importance of health worker training during scale-up. Select areas for scale-up where health care services are already high quality.</li> </ul>
Women often unable to access health services without permission of their husbands.	Educate health workers about Benin's 2003 reproductive rights law, while recognizing that education about this law may not solve a larger systematic problem. Strengthen other aspects of TJ relating to couple communication.
Influential Person Finding	Implications for Scale-Up
Influential engages in TJ in diverse ways, according to their own contexts.	<ul style="list-style-type: none"> <li>• Continue encouraging a broad range of activities among influential, as this approach allows people to play up their own strengths within their communities.</li> <li>• Consider holding orientations at both village and arrondissement level, to meet the varying needs of influentials.</li> </ul>
Leaders not engaged in TJ may be engaging in their own activities.	Continue engaging groups and individuals already working on FP in the community mapping process.
Diffusion Finding	Implications for Scale-Up
Women, men and couples attend both men's and women's groups for advice on couple communication.	Continued awareness of the importance of engaging men's groups, not just for men but also for women seeking advice. Include materials on couple communication and conflict resolution.
Age and Participation Finding	Implications for Scale-Up

Younger people tend to participate more than older people in TJ conversations; older people may even leave. Yet, older people can play a role in diffusion when they do engage.	Make a strategic decision whether to stress the engagement of older people among catalyzers and in activities, or through other project components.
<b>Gender Finding</b>	<b>Implications for Scale-Up</b>
Men may be less likely to participate because pregnancy/childbirth/FP is viewed as a women's problem.	Continue to create dialogue about how childbirth is the problem of the couple, not just the women.
Some catalyzers describe trying to convince men of the value of FP.	Strategically decide if this is a role TJ wants catalyzers to play, and if so, empower them with skills to do it well.
Men articulate the use of withdrawal as a major characteristic of village life before TJ.	Consider integrating materials that provoke dialogue about the use of withdrawal, improved emotional and sexual relationships for couples, and other issues salient to men.
<b>Community Resistance Finding</b>	<b>Implications for Scale-Up</b>
Resistance do to stigma, beliefs about modern methods	<ul style="list-style-type: none"> <li>• Continue to conduct activities which help people engage with unsupportive family members, continue dispelling myths about modern methods.</li> <li>• Include education about fertility awareness methods (FAM) to provide an option to those particularly concerned about side effects.</li> </ul>
Resistance due to belief that TJ is trying to control people's fertility.	Continue stressing that TJ is about supporting people achieving their reproductive desires, not controlling their fertility. Engage influentials about this difference, early in project implementation.

**APPENDIX B:**  
**Summary Presentation on Project Monitoring Data**  
**August 2014**



**USAID**  
FROM THE AMERICAN PEOPLE



# Tékponon Jikuagou

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

# Que nous disent les données du monitoring?

*Avril-juin 2014*



# Processus de collecte et utilisation des données

## Catalyseurs

Outil:  
Cahier du catalyseur

## Facilitateurs

Outils:  
Fiche synthèse mensuelle du village  
Fiche synthèse mensuelle du mapping  
Fiche synthèse mensuelle de l'orientation des catalyseurs

## Coordinateurs 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 suivi

## CSAE + PAG

Revue,  
analyse,  
prise de  
decision



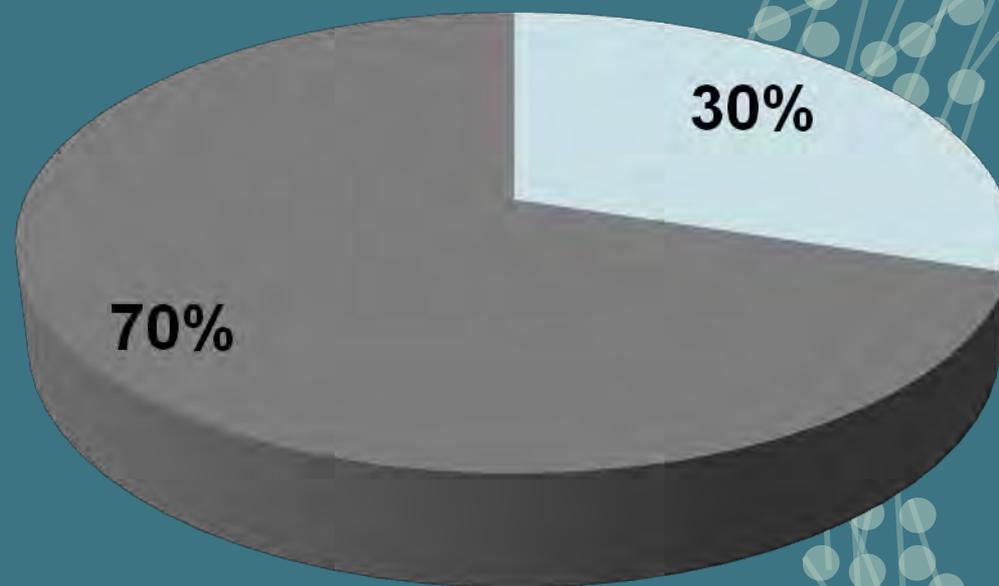
1

# ENGAGER LES COMMUNAUTÉS DANS LA CARTOGRAPHIE SOCIALE



# 100% Villages atteints pour l'Identification des groupements/personnes cibles

Villages couverts: n= 90

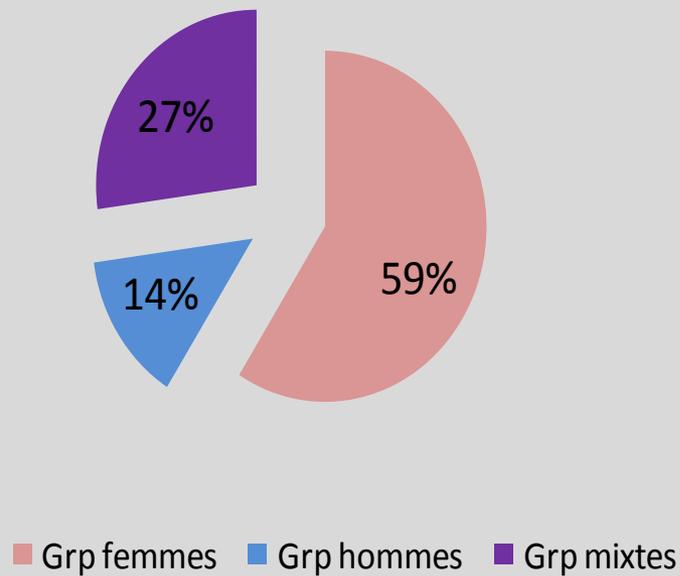


■ Nouveaux villages    ■ Anciens villages

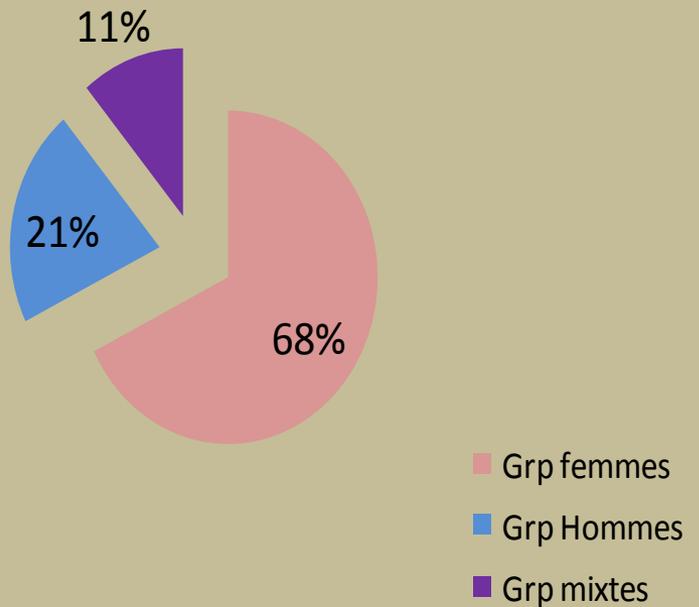
# Types de groupements sélectionnés

n=294

**Phase 1**  
n=195

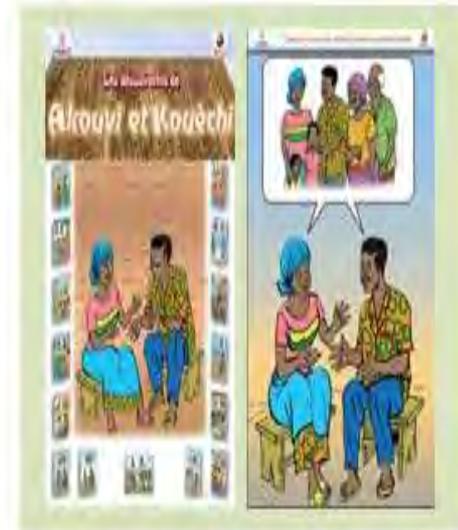


**Phase 2**  
n=99



2

## GUIDER LES GROUPES INFLUENTS DANS LES DIALOGUES

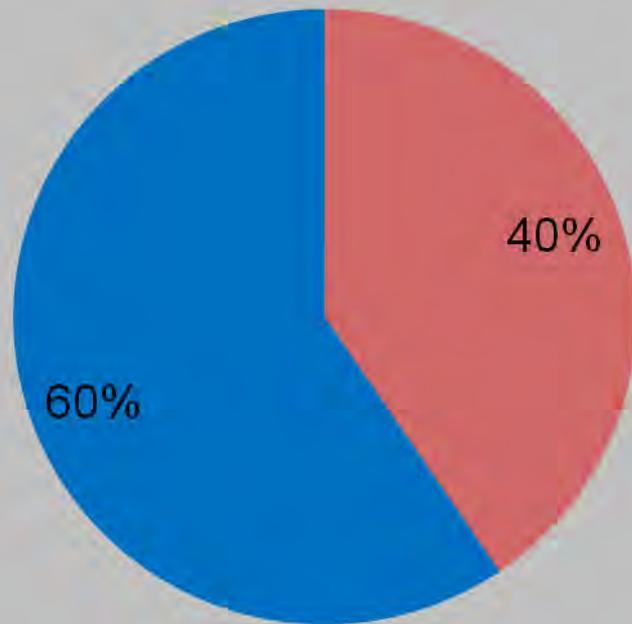


# Nombre de catalyseurs orientés

n=309

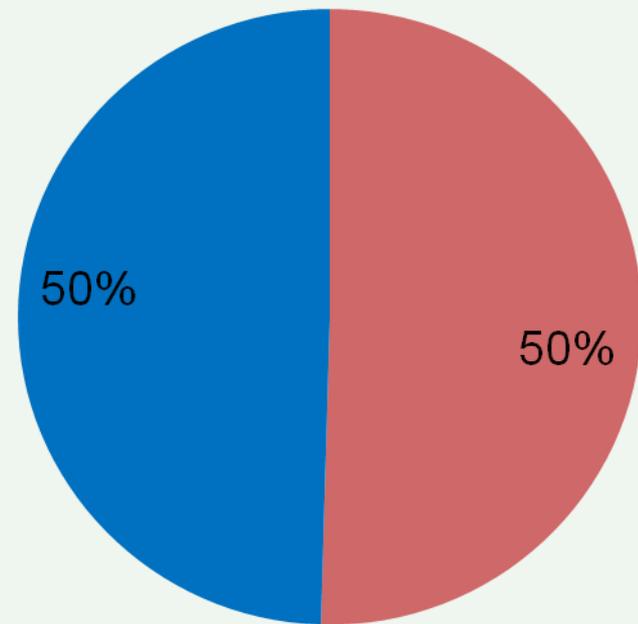
## Phase1: n=200

■ Femmes ■ Hommes



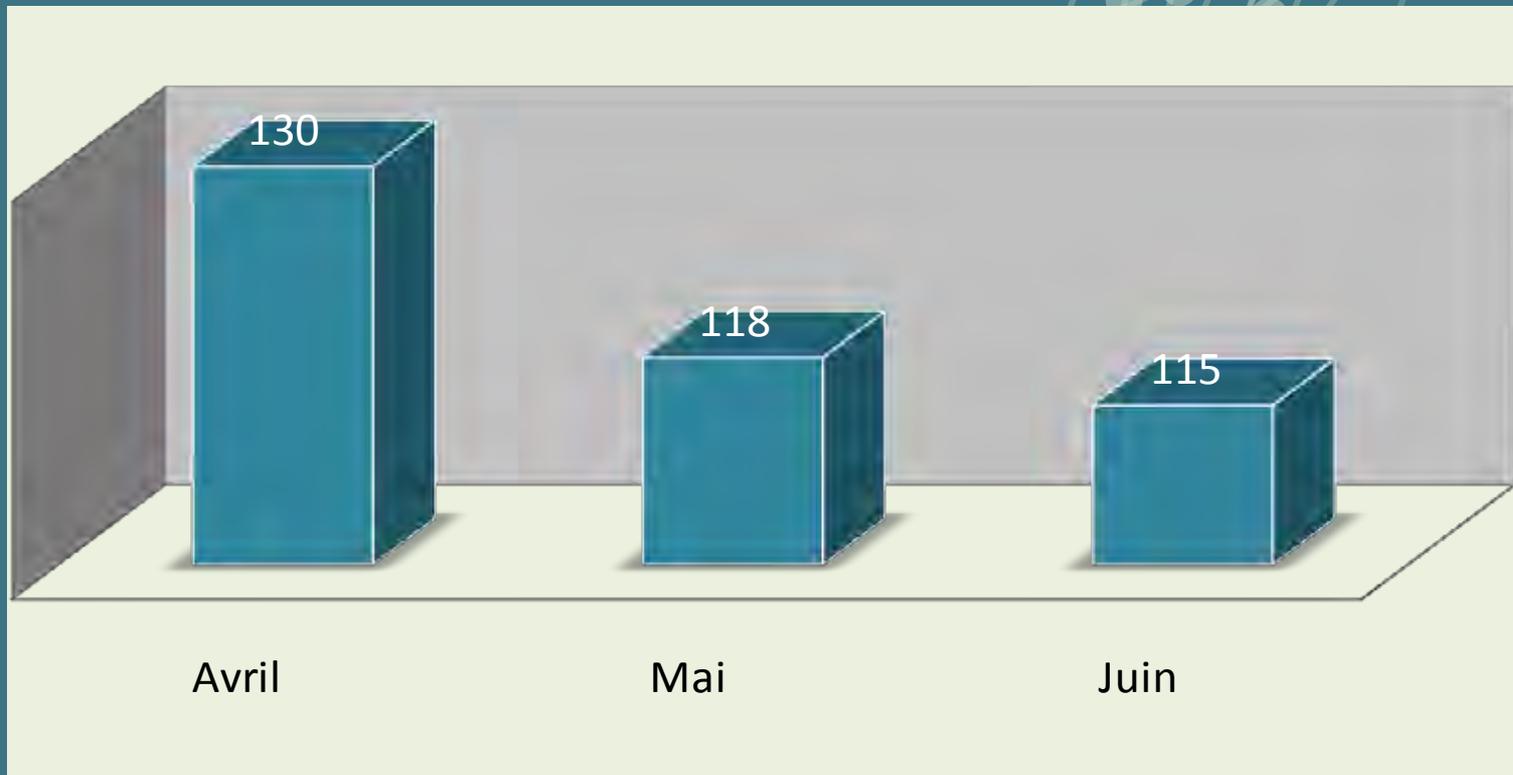
## Phase2: n=109

■ Femmes ■ Hommes



# Nombre de sessions de coaching des catalyseurs faites par les facilitateurs, Phase 2

□ Coaching

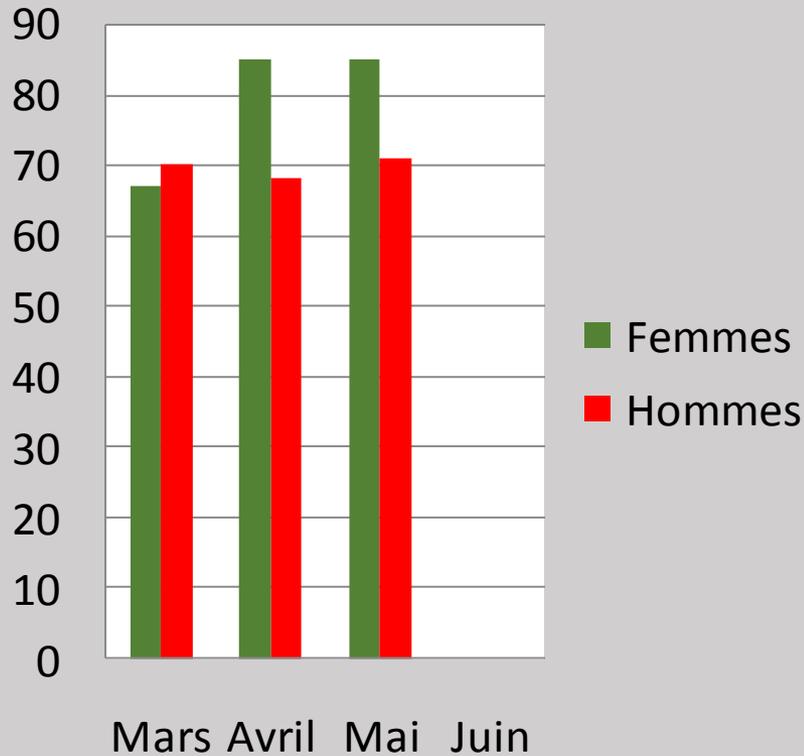


# Pourcentage des catalyseurs orientés actifs (qui ont réporté); Phase 1: n=281

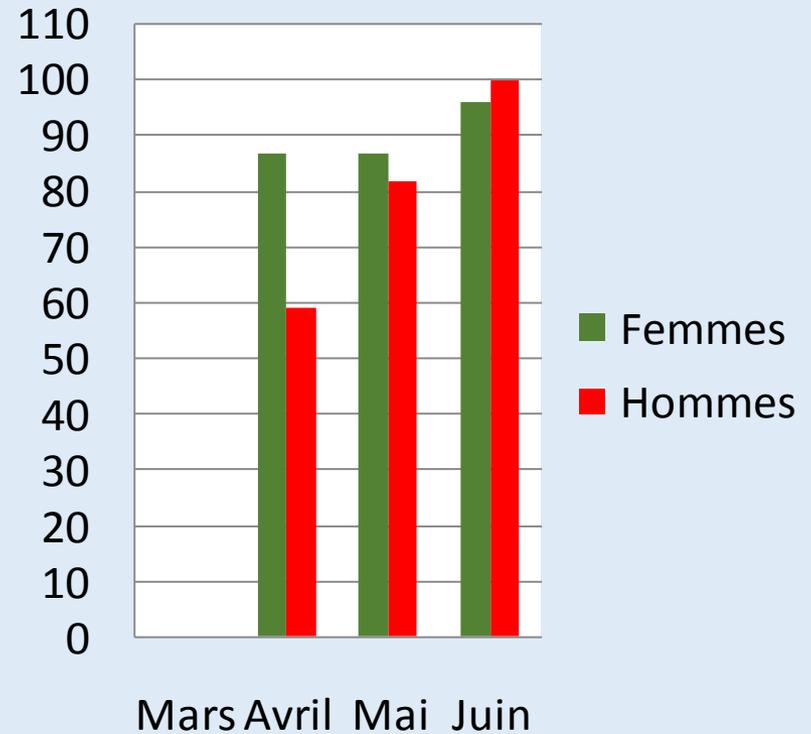


# Pourcentage des catalyseurs orientés actifs (qui ont réporté), n=299

## Phase 1, n=200

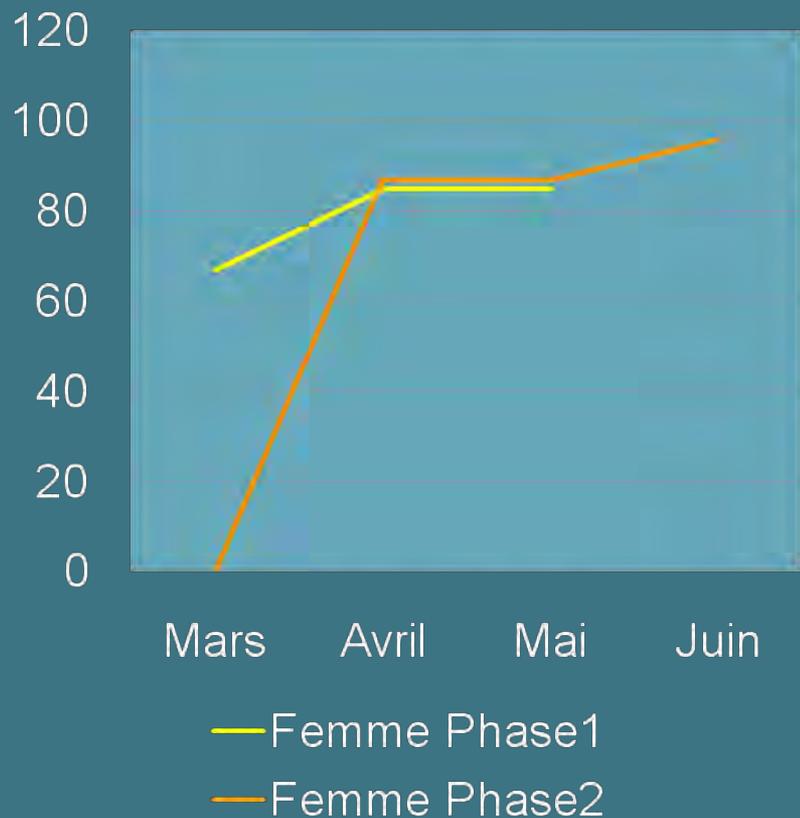


## Phase 2, n= 99

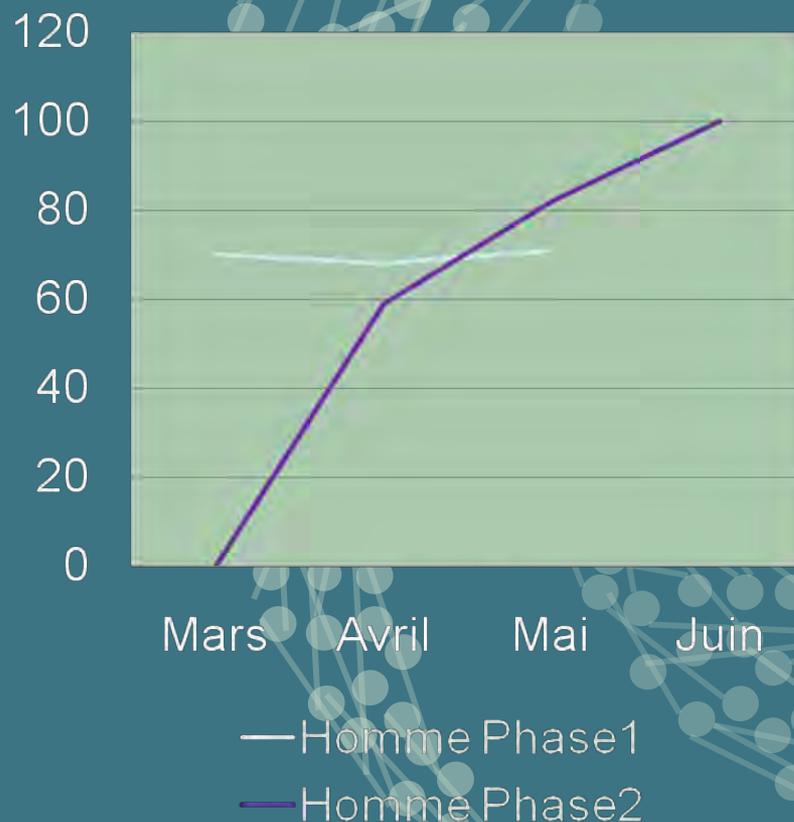


# Pourcentage des catalyseurs actifs par sexe: phase 1 et Phase 2 (%)

## Femmes



## Hommes



# Les abandons dans les villages

## Phase 1

### Catalyseurs

Femmes: **9**

Hommes: **16**

### Groupements

Femmes: **4**

Hommes: **0**

Mixtes: **18**

Phase 2: Aucun abandon

# Les matériels de discussion

## Histoire



## Carte d'activité



# Pourcentage de discussions des groupements avec utilisation des différents matériels (n=3719)

Phase 1, n=3286

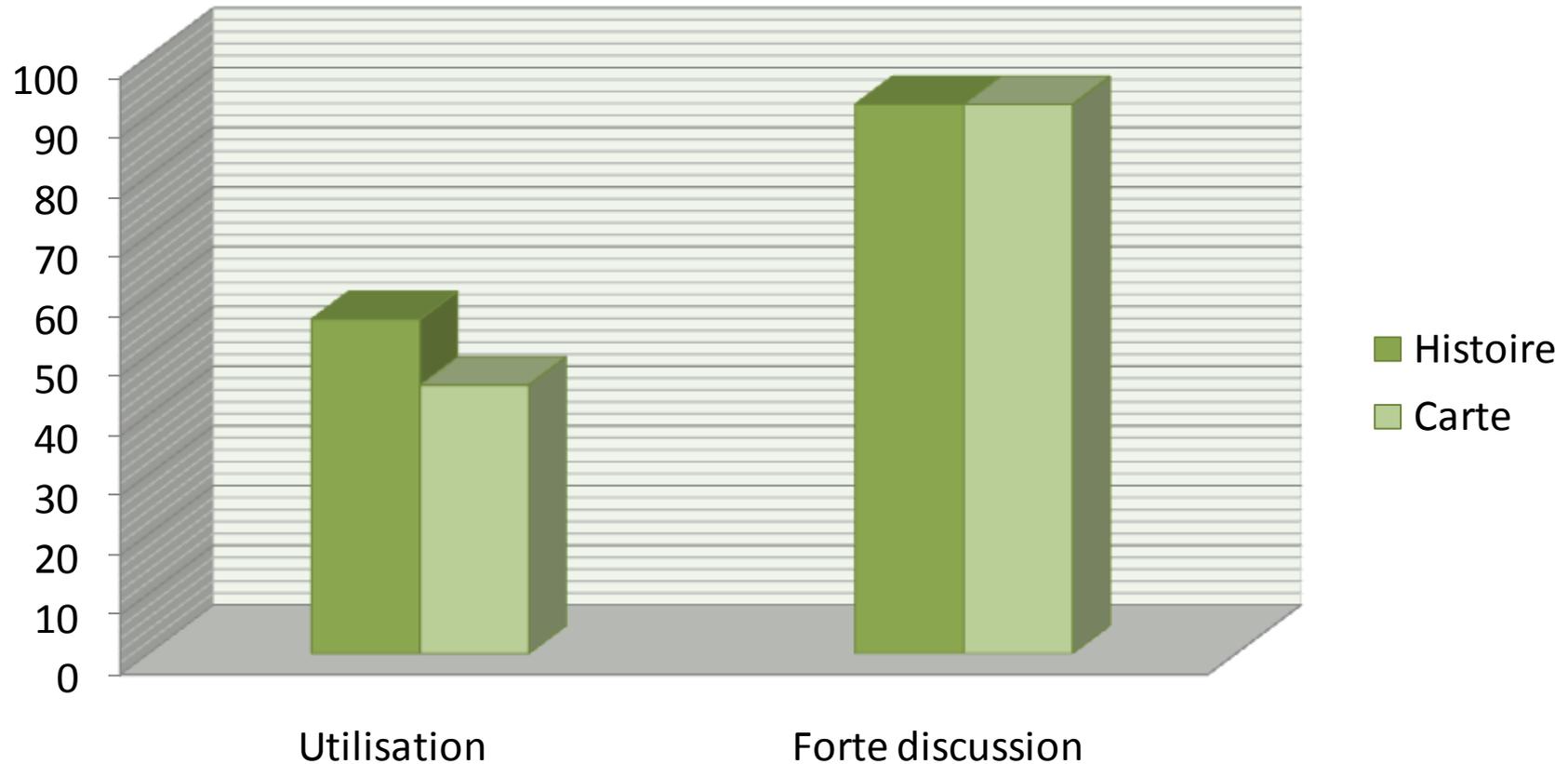
TOTAL	Histoires 56%	Cartes 44%
Grp Femme	58%	42%
Grp Homme	55%	45%
Grp Mixte	54%	46%

Phase 2, n=433

TOTAL	Histoires 53%	Cartes 47%
Grp Femme	54%	46%
Grp Homme	50%	50%
Grp Mixte	50%	50%

# Pourcentage de l'utilisation des matériels de dialogue et l'enclenchement des discussions

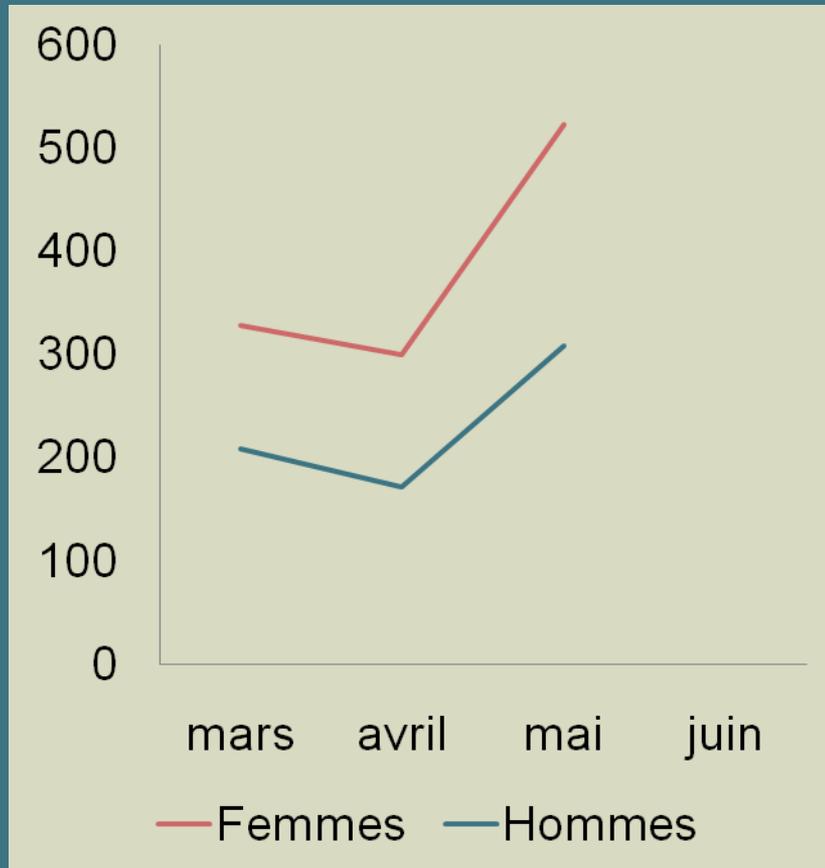
P1 et P2 (n=3719 réunions)



# Nombre d'accroissements des participants à la discussion par rapport à la réunion.

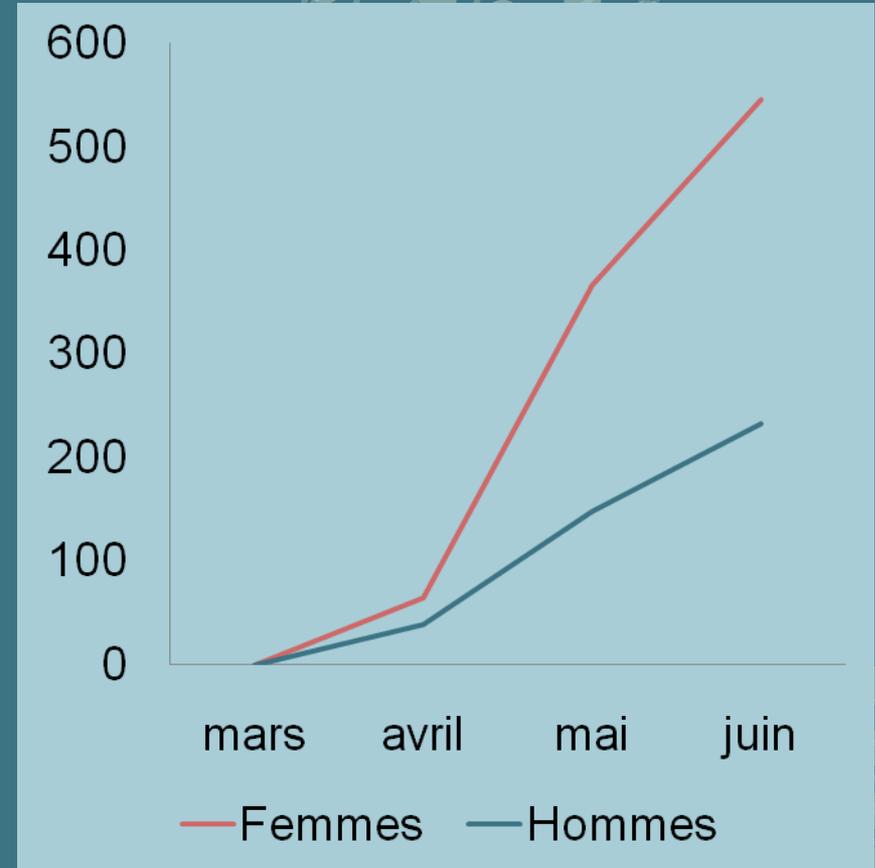
## PHASE 1

Moyenne F= 558; H= 249

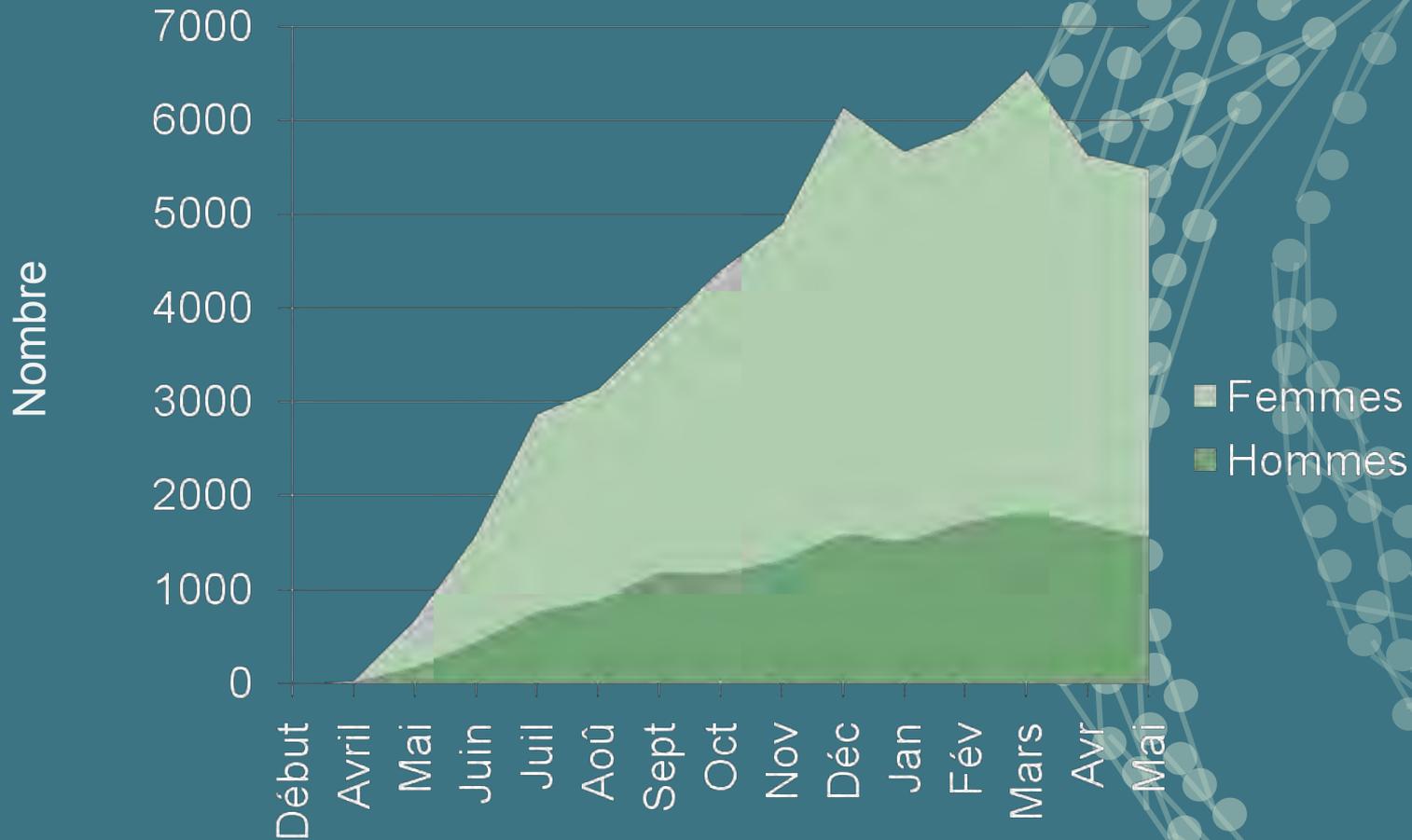


## PHASE 2

Moyenne F= 325; H= 140

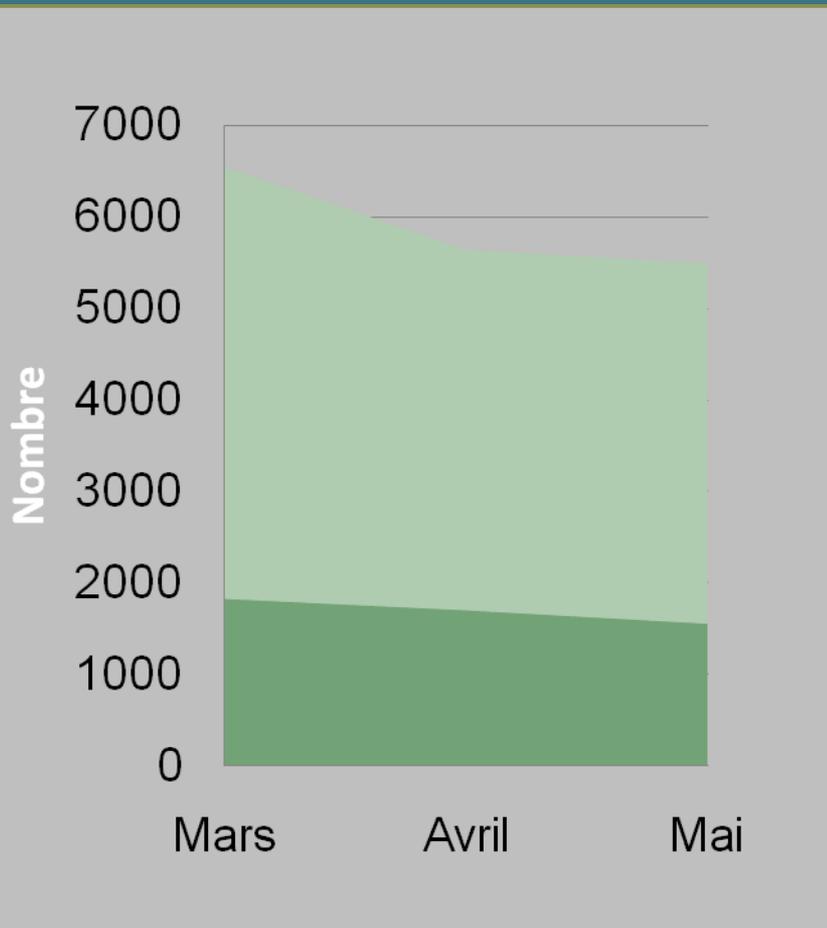


# Nombre de diffusions des discussions dans les réseaux des participants par Genre, Phase 1

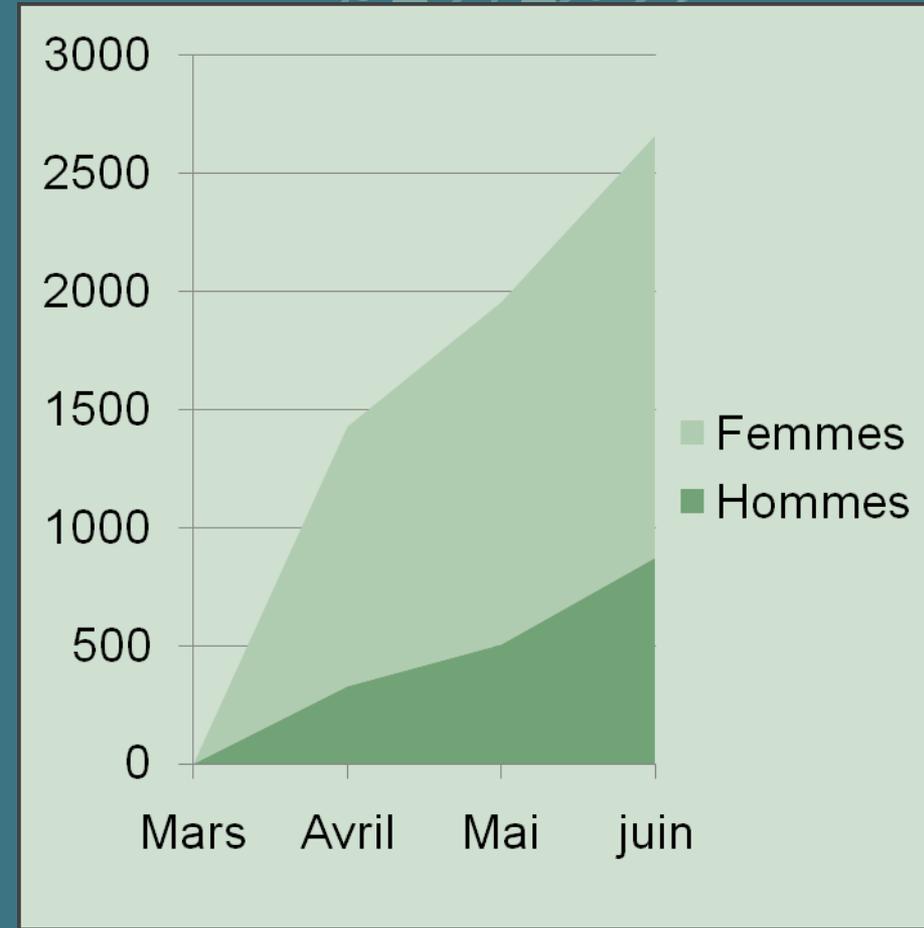


# Nombre de diffusions des discussions dans les réseaux des participants par Genre et par Phase

## Phase 1



## Phase 2



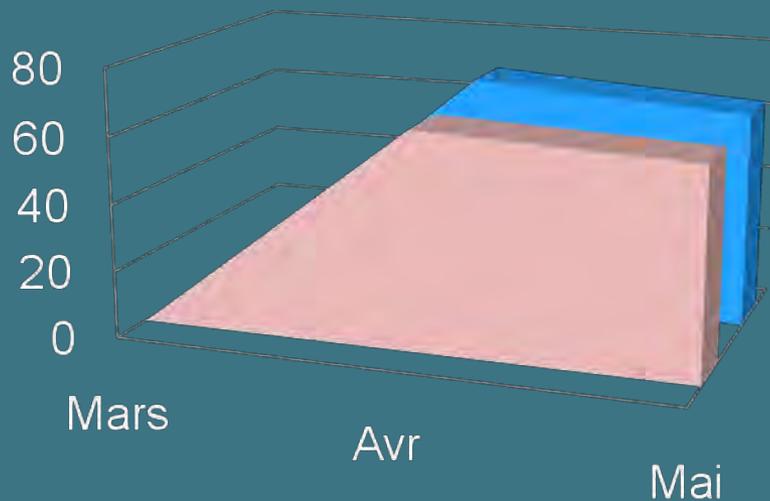
# Pourcentage de diffusions des discussions dans les réseaux des participants par Genre (%), Phase 1



# Pourcentage de diffusions des discussions dans les réseaux des participants par Genre et par Phase

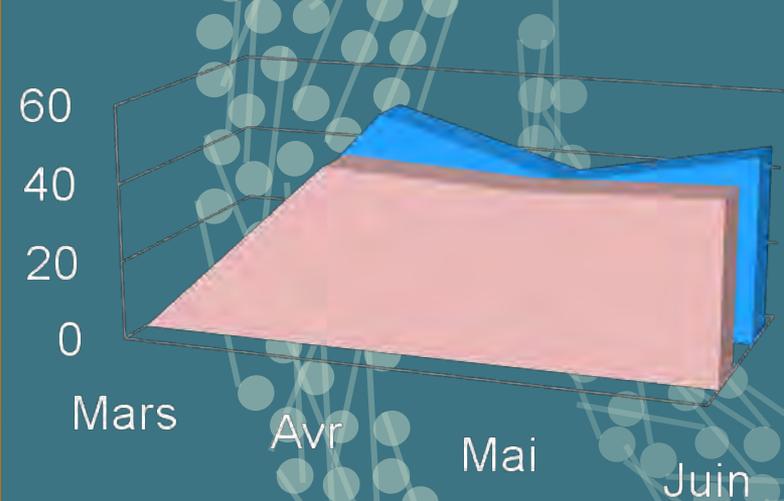
## Phase 1

Femmes Hommes



## Phase 2

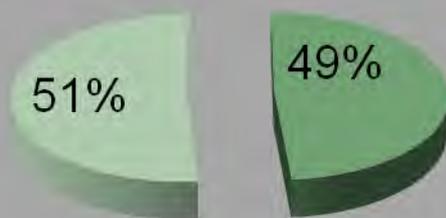
Femmes Hommes





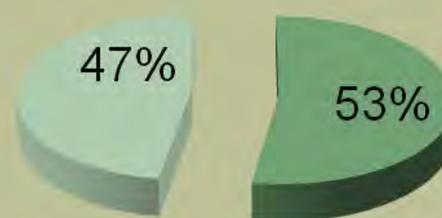
# Pourcentage de personnes influentes sélectionnées par sexe (%). n=459

**Phase1**  
n= 322



■ Femmes  
■ Hommes

**Phase2**  
n=137

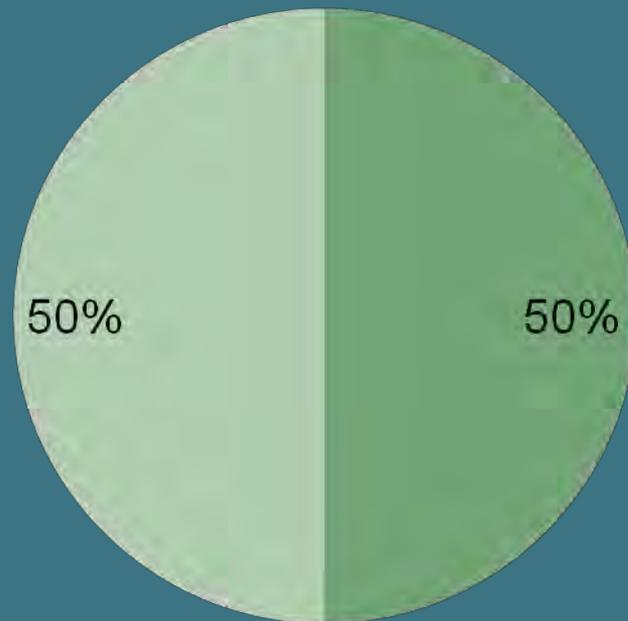


■ Femmes  
■ Hommes

# Pourcentage de personnes influentes orientées par sexe (%). n= 404

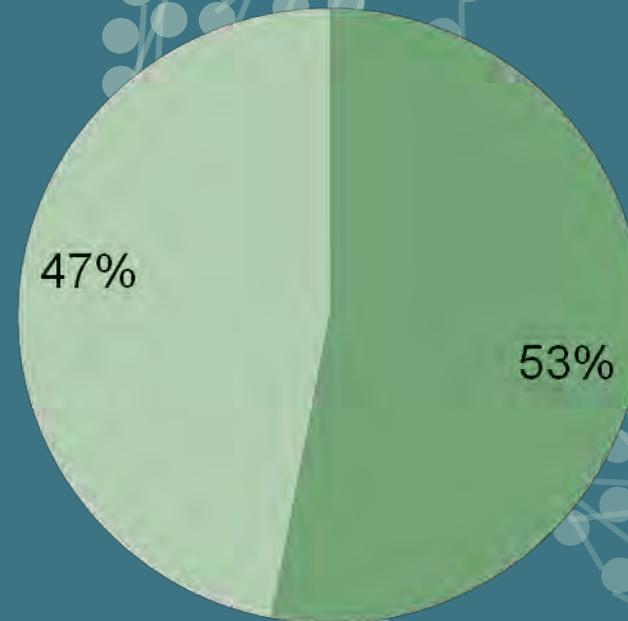
## Phase 1

■ Femmes ■ Hommes



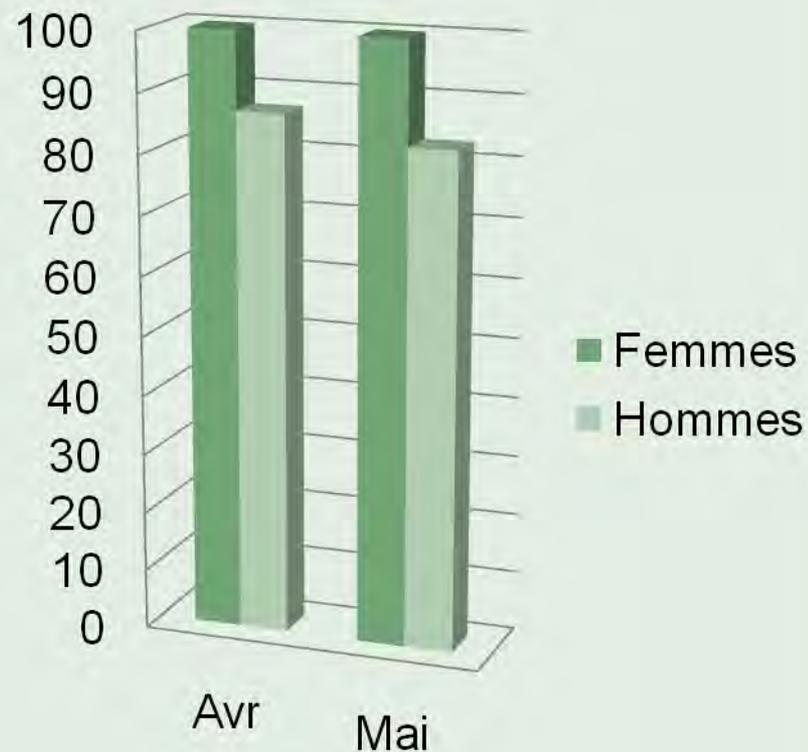
## Phase 2

■ Femmes ■ Hommes

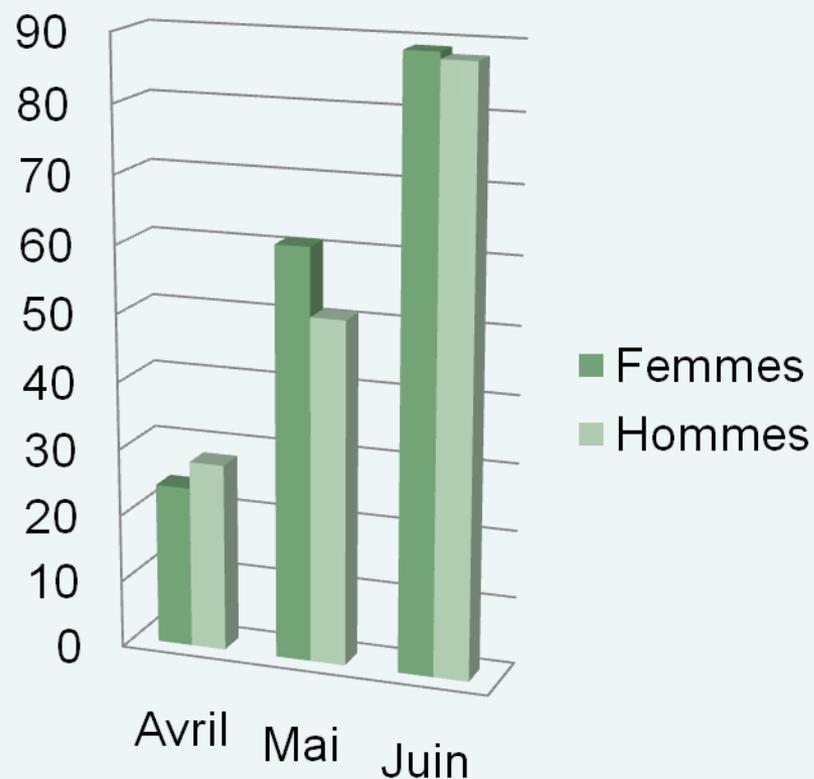


# Pourcentage de personnes influentes orientées rencontrées: (nombre de rencontres=739)

## Phase 1



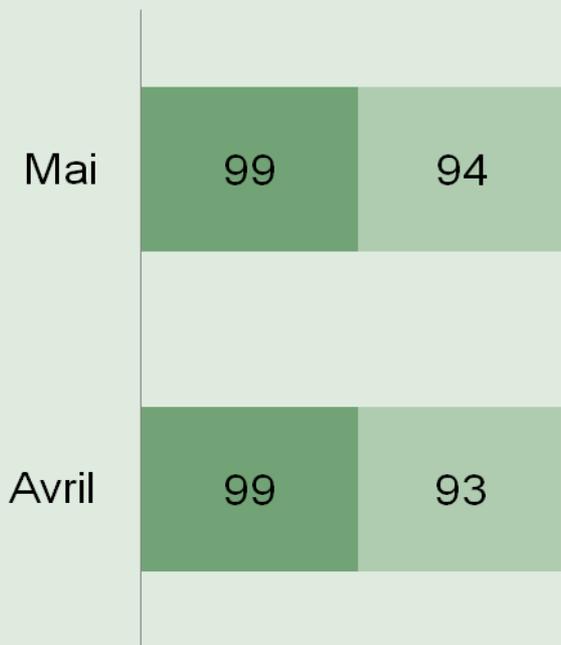
## Phase 2



# Pourcentage de personnes influentes rencontrées actives (%)

## Phase 1

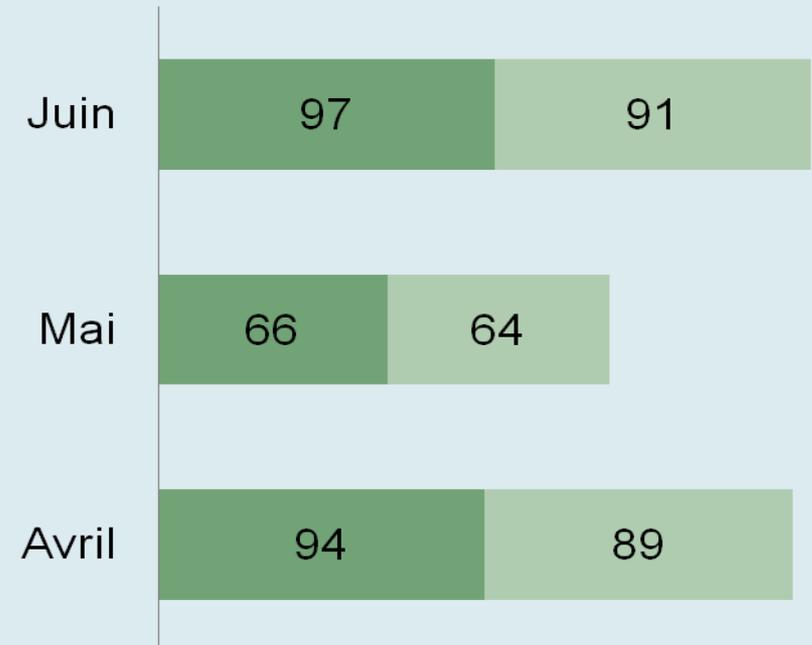
Femmes Hommes



**Abandon Phase 1**  
Femmes: 4 ; Hommes: 0

## Phase 2

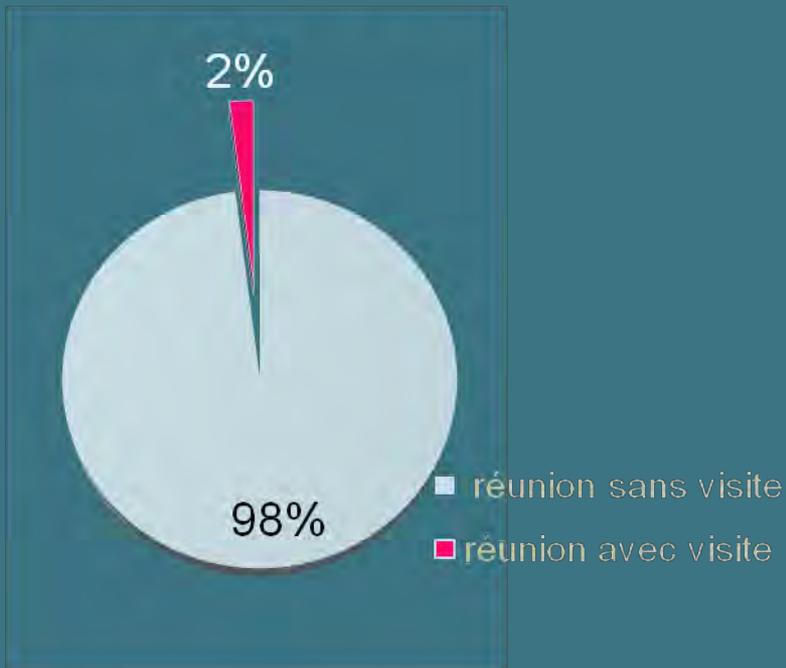
Femmes Hommes



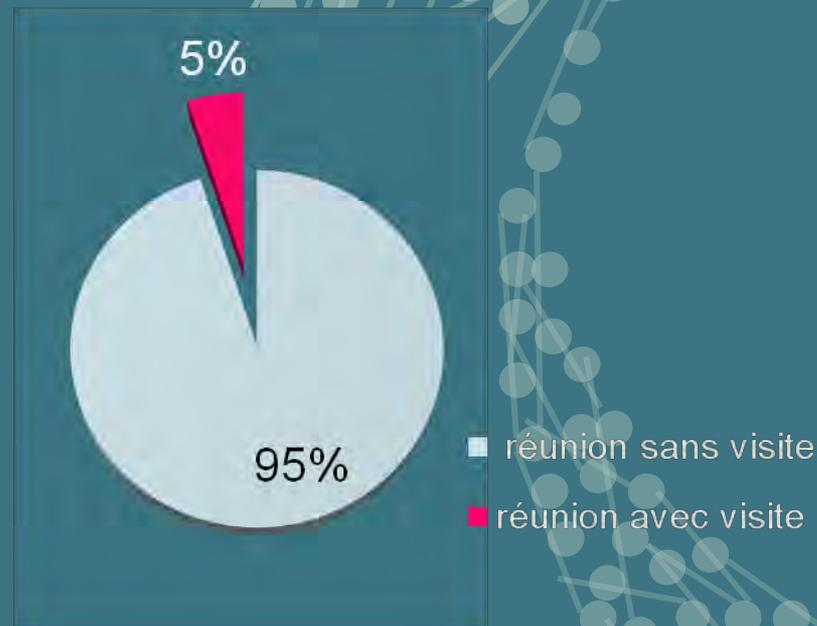
**Abandon Phase 2**  
Aucun

# Participation d'agents de Santé aux discussions des groupements

Phase 1, n= 3286



Phase 2, n= 433



5

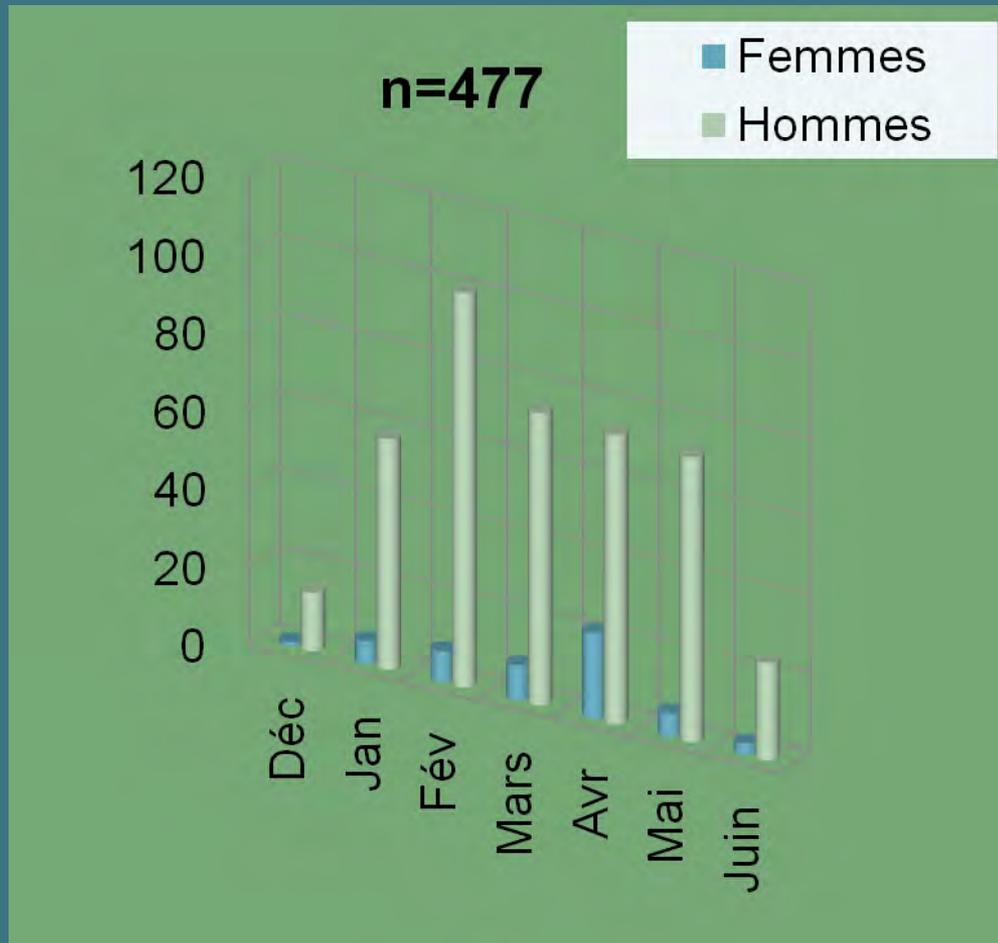
**RELIER LES PRESTATAIRES  
DES SERVICES DE PF AVEC  
LES GROUPES INFLUENTS**





# Nombre d'appels reçus au cours des émissions: Voix de Lokossa, (38 diffusions)

## # Appels



63%  
Interactives

57%  
Discussions  
PF

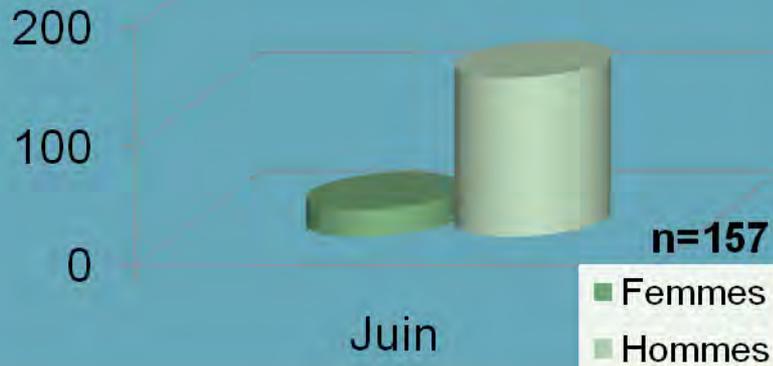
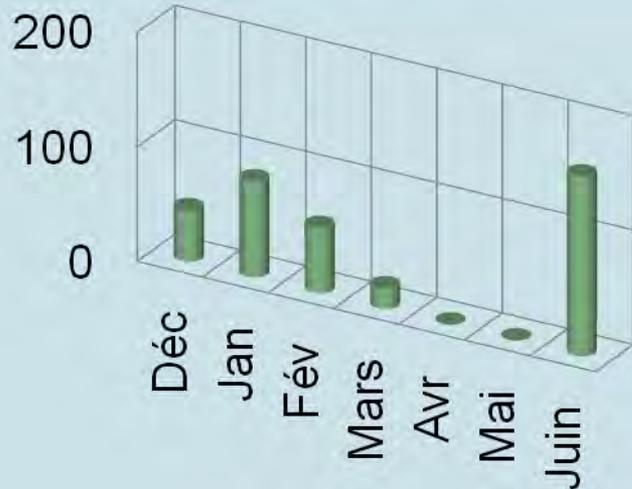
43%  
Discussion  
PF&Genre

Témoignages  
53% Femmes  
47% Hommes



# Nombre d'appels reçus au cours des émissions: Couffo FM, (27 diffusions)

# Appels n=361



70%  
Interactives

74%  
Discussions  
PF

26%  
Discussion  
PF&Genre

Témoignages  
50% Femmes  
50% Hommes

**MERCI!**



**APPENDIX C:**

**Presentations made at the International Conference on Family Planning  
November 2013**

# Addressing Stigma through Social Networks to Reduce Unmet Need for Family Planning: A Conceptual Framework

MARIAM DIAKITE  
ICFP 2013



**USAID**  
FROM THE AMERICAN PEOPLE



## We will consider...

- **how social networks influence family planning attitudes and use**
- **Whether stigma acts as a barrier to diffusion of family planning**
- **a conceptual framework to apply stigma to family planning**



# Tékponon Jikuagou

**Leveraging social networks to influence attitudes, beliefs, social/gender norms related to fertility and FP**

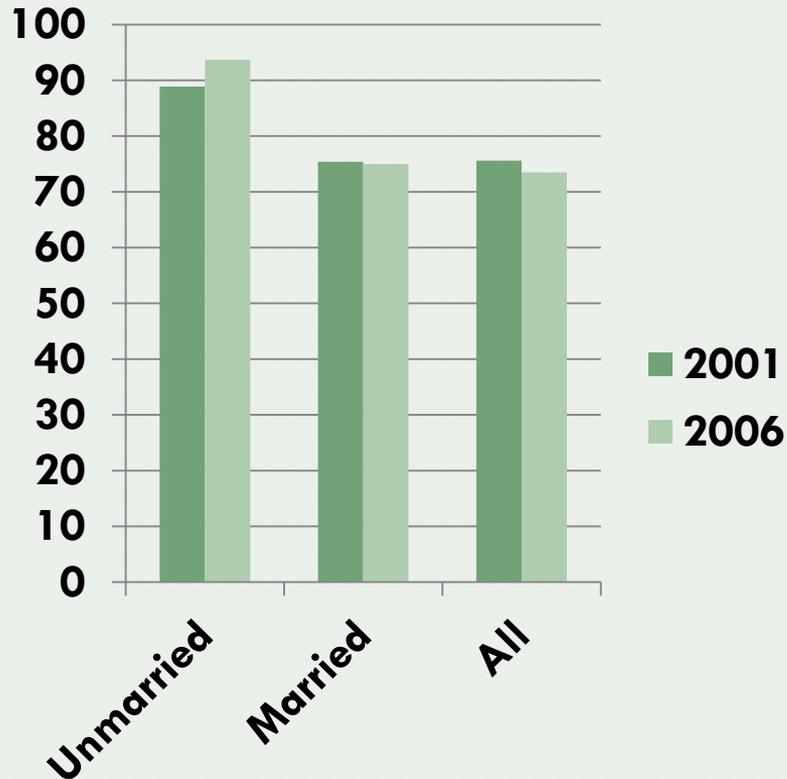


- **Ethnography and social network mapping in Koutiala and Bandiagara, Mali**
- **Formative research, participatory social mapping and household survey in Couffou, Benin**
- **Implemented with CARE and Plan International**

# After more than 20 years of investment in Mali...

Unmet need increased from 26% to 31% (1996 to 2006)

### WOMEN, KNOWLEDGE OF MODERN METHODS



### DESIRED FERTILITY RATE HAS STAYED THE SAME...



... AND MODERN  
CPR REMAINS AT 6%

# Methods



## Ethnographic Research

(6 FGDs, 32 in-depth interviews, mapping in Mali)



## Household Social Network Census

(726 interviews in Mali)



## In-Depth Interviews

(25 men/25 women in Mali)



## Baseline Household Survey

(1080 men/1080 women in Benin)



# Stigma?

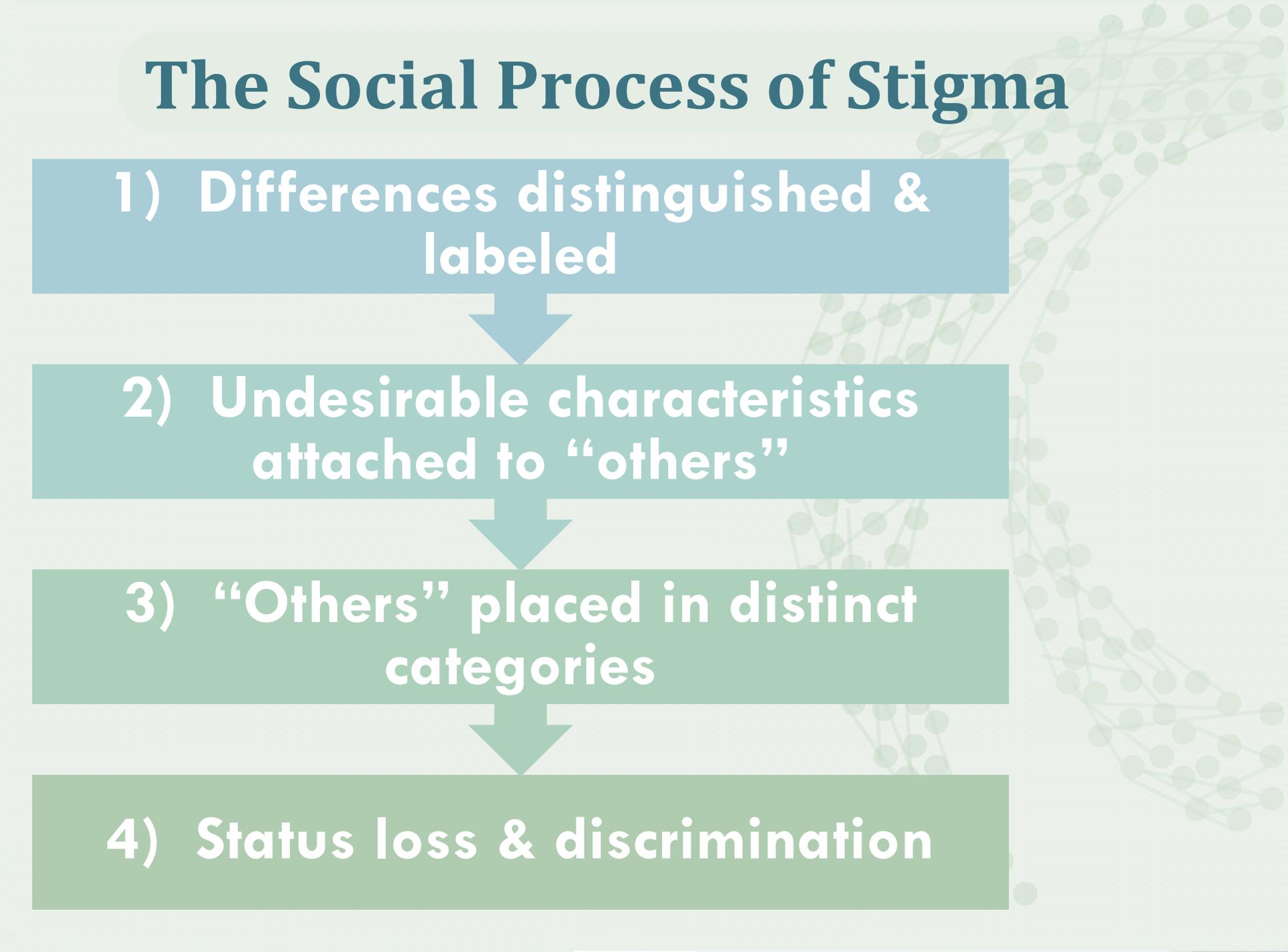
**“Socially  
constructed and  
reproduced  
locally  
and relies on..”**  
(Link & Phelan, 2001)

**Power disparities**

**inequalities**

***ideals of womanhood***

# The Social Process of Stigma



**1) Differences distinguished & labeled**



**2) Undesirable characteristics attached to “others”**



**3) “Others” placed in distinct categories**



**4) Status loss & discrimination**

# The Social Process of Stigma

1) Differences distinguished & labeled

2) Undesirable character attached to “others”

3) “Others” placed in categories

4) Status loss & discrimination

“In my view it is shameful to discuss FP. I have never invited the health workers here to discuss FP as I don't think it is compatible with the spiritual norms of our brotherhood. I would never do this without authorization of my spiritual leader.”

# Family Planning Stigma

Labeling

Exclusion

Discrimination

24%

Men whose wives use FP lack authority

26%

Women who use FP have multiple sex partners

# Family Planning Stigma

Labeling

Exclusion

Discrimination

27%

Individuals who use FP are excluded

8%

It is shameful to be associated with a woman who is known to use FP

# Family Planning Stigma

Labeling

Exclusion

Discrimination

26%

Believe that if people found out they were using FP, they would be teased/criticized

18%

Believe that if they used FP and their husband found out, the husband would beat them

# Social networks, stigma and diffusion

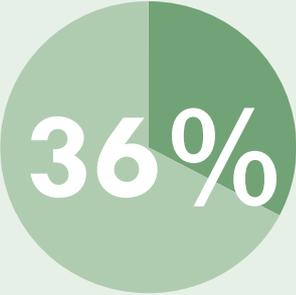
## SOCIAL LEARNING

Network members exchange ideas and information; and evaluate the relative benefits of innovation

## SOCIAL INFLUENCE

Network members follow norms of gatekeepers to gain approval and avoid conflict

## STIGMA INFLUENCES DIFFUSION

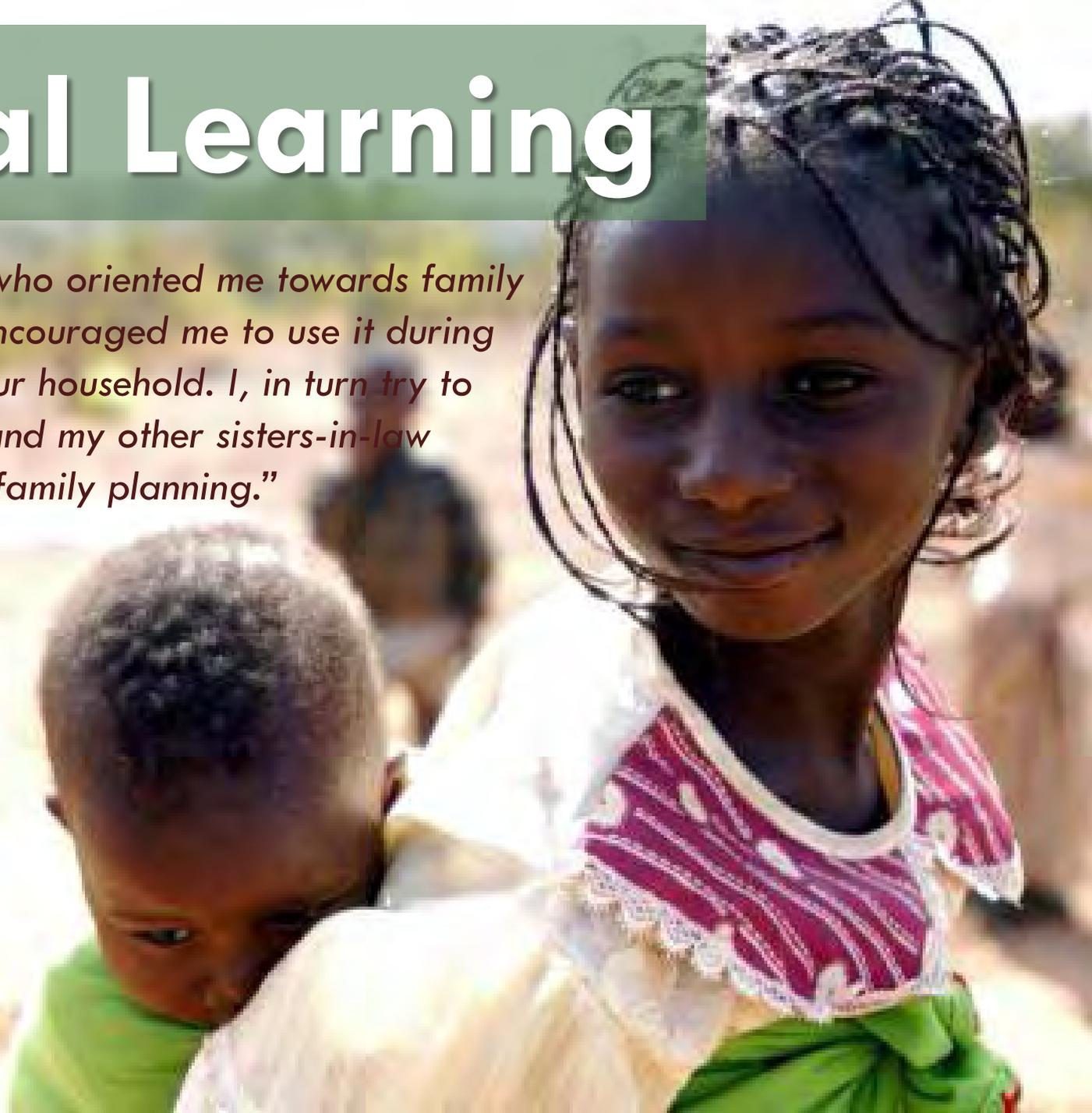


36%

of women say it is not acceptable to talk about family planning

# Social Learning

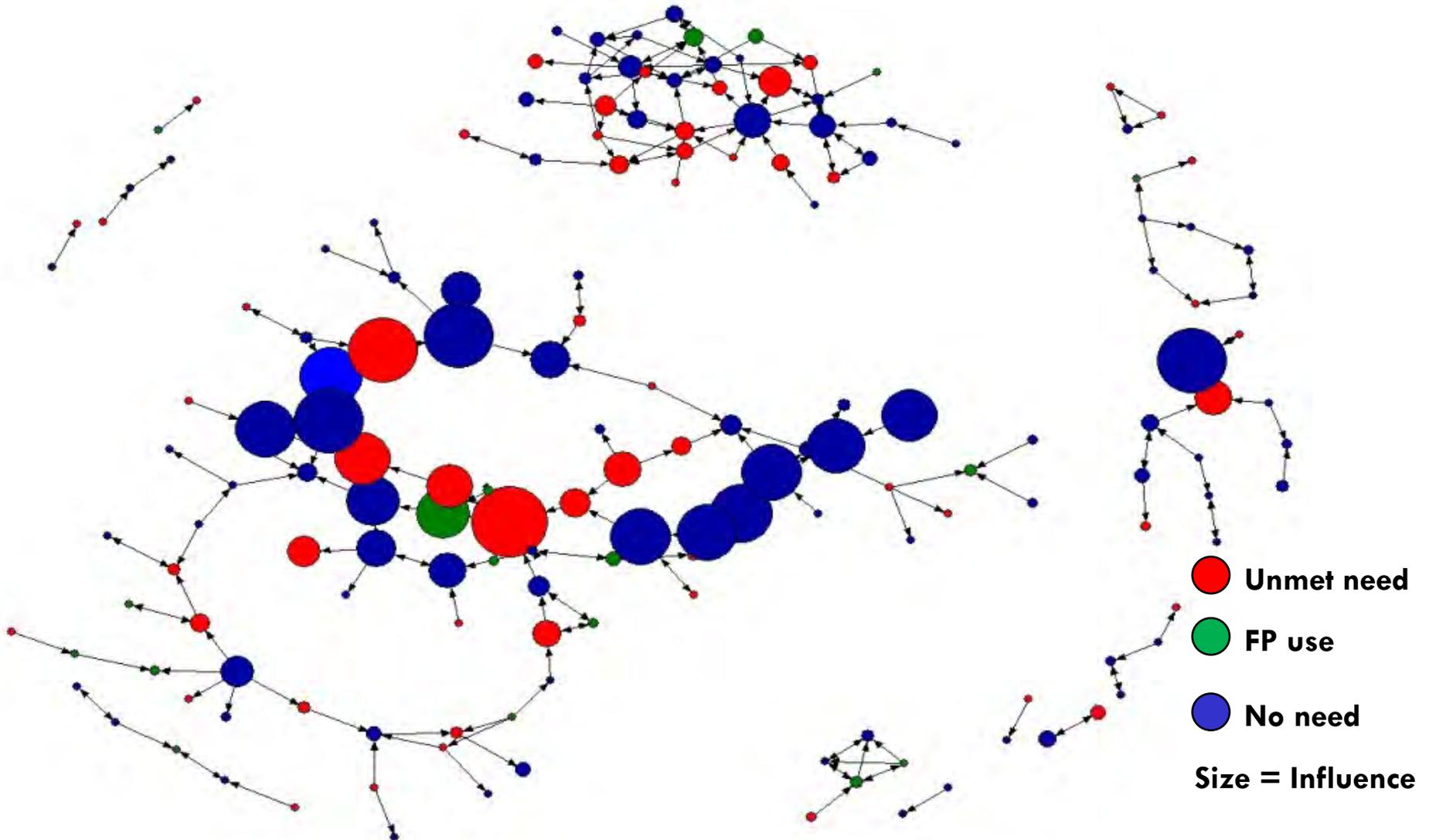
*“It is my sister-in-law who oriented me towards family planning. She really encouraged me to use it during our conversations in our household. I, in turn try to sensitize my co- wife and my other sisters-in-law about the benefits of family planning.”*





# Social Influence

# Reaching the tipping point.... (Unmet need among women by influence)





**“Women pretend they don’t know about FP even though the health worker has explained it. Me too. I pretend I don’t know anything about FP. Besides the outreach worker I have never spoken to anyone about it. No one knows I use FP. I am hidden!”**



**“Even if you speak of FP with a user she will say she has never seen or heard of FP. She will swear on God’s name that she doesn’t know about FP. If people learn that you use FP they will say you are a bad Muslim, a prostitute, an assassin – everything terrible that one could imagine in life.”**



# Couple Communication

# Husband & Wife discordance: % of men & women who incorrectly predict spousal approval of FP

Study Site	According to...	
	Men	Women
Bougoro	30 - 36%	13%
Doucombo	46 - 53%	43 - 46%

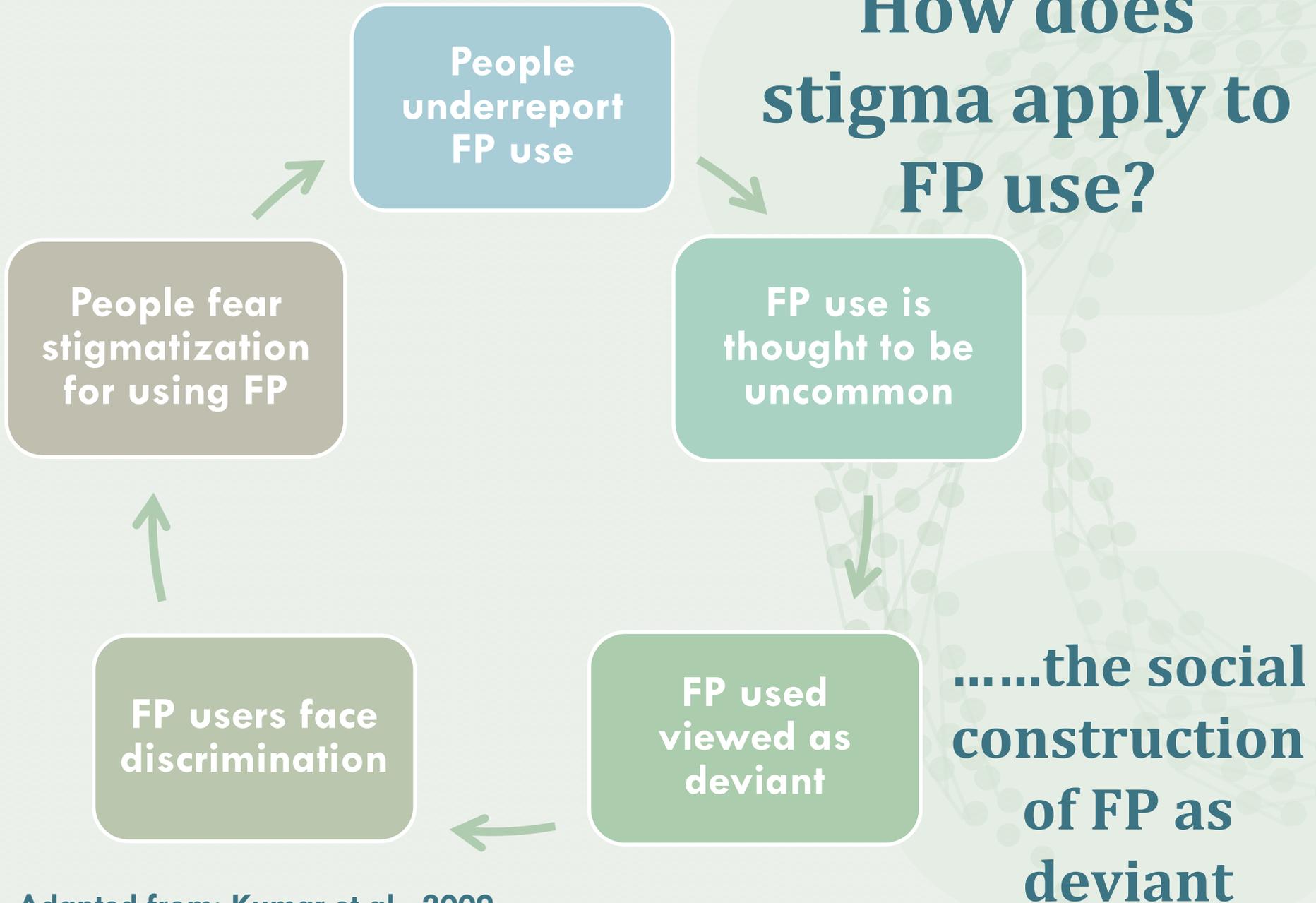
Bougoro: N=118 nominating men, 156 nominating women

Doucombo: N=106 nominating men, 73 nominating women

A group of young men are seated in a room with a thatched wall. The man in the foreground is resting his chin on his hand, looking thoughtful. He is wearing a dark grey shirt over a white t-shirt. To his right, another man is wearing a white t-shirt with a red ribbon logo. The background shows a wall made of vertical wooden poles and horizontal thatch. The text is overlaid on a green semi-transparent box on the left side of the image.

**“I don’t know what my wife thinks about family planning because we have never talked about it. In our culture men and women should not talk about these things – this is the reason I have never discussed FP with my wife.”**

# How does stigma apply to FP use?



# Social networks influence FP stigma

Linear regression: Stigma index	Standardized coefficient
Number of network members	<b>-0.265*</b>
# network members approving FP	<b>0.193*</b>
% of members in both networks	<b>-0.151*</b>
Not significant: age, education, in polygamous marriage, parity, husband in network, % women in network	

\*  $p < 0.001$

# Social networks, stigma and family planning (method use vs. unmet need)

<b>Logistic regression: method use vs. unmet need</b>	<b>Odds ratios</b>
<b>% of members in both networks</b>	<b>1.74*</b>
<b>Number of members in network</b>	<b>0.881**</b>
<b>% of network members who approve of FP</b>	<b>0.488*</b>
<b>Stigma index</b>	<b>0.202**</b>
<b>Not significant: age, education, in polygamous marriage, parity, husband in network</b>	

\*  $p < 0.05$

\*\*  $p < 0.001$

# 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**



# Conclusions



- **Tacit stigma one of key barriers to contraceptive use among those with unmet need for FP**
- **Need to address gender norms to address stigma**
- **Social networks key driver / solution to stigma**



THANK YOU

**Mariam Diakité**

Institute for Reproductive Health,  
Georgetown University



**USAID**  
FROM THE AMERICAN PEOPLE





**Different methods,  
different cultures,  
different approaches:  
Comparing results of  
social network  
analysis of unmet  
need in Mali & Benin**

**Irit Sinai  
Mariam Diakite  
Rebecka Lundgren**



**USAID**  
FROM THE AMERICAN PEOPLE



# Tékponon Jikuagou

Leveraging social networks to influence attitudes, beliefs, social/gender norms related to fertility and family planning



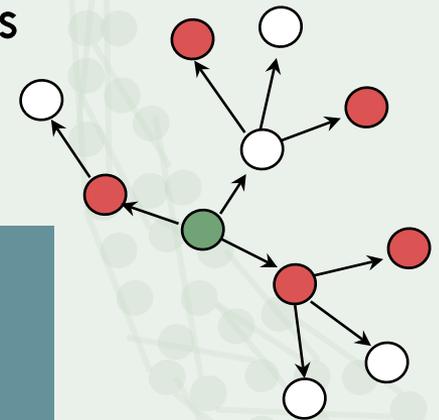
- **Ethnography and social network mapping** in Koutiala and Bandiagara, Mali
- **Formative research, participatory social mapping and household survey** in Couffo, Benin
- Implemented with **CARE and Plan International**

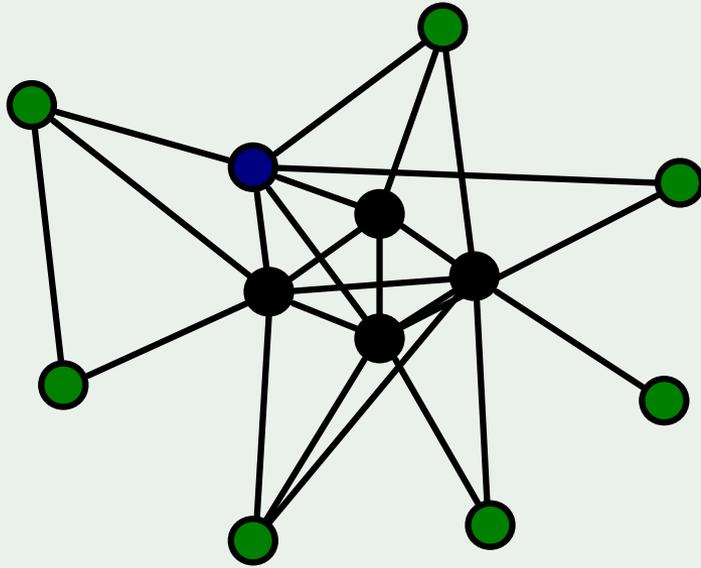
# Social network analysis: What is it?

**A theoretical perspective applied to research and programs**

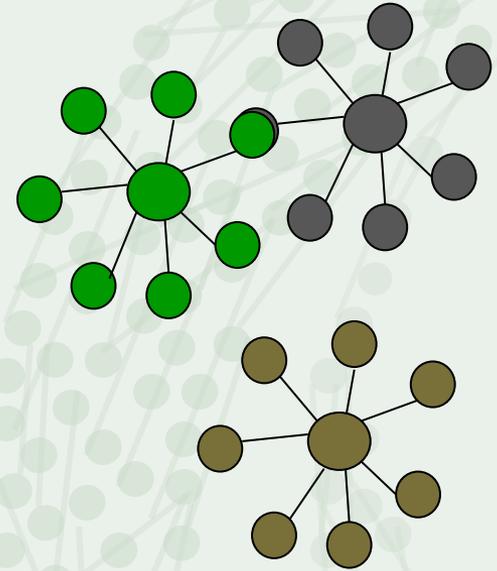
- Recognizes that individuals interact with, learn from, and get information from other people
- Focuses on **relationships**, not individuals

**“Who delivers the message, and in what interpersonal context, may be just as, if not more important, than the message itself, and may result in better, more relevant, and perhaps more effective programs.”** *Valente & Fosados, 2006*





**Community  
centered**



**Individual  
centered**

## Mali: married women of reproductive age

	Knows any modern method	Uses any modern method	Has unmet need for contraception
2006 DHS	85%	6.6%	27.6%
1996 DHS	65%	6.7%	27.5%



# Mapping Step #1

**Obtain a list of all adult men and women in the village, and assign each a code**

#	Nom	Surnom	M/F	Age	Statut matrimonial	Occupation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

# Mapping Step #2

**Identify from the list all women of reproductive age; men married to women of reproductive age; interview them**

**Response rate:**

- **92 % in Koutiala**
- **84% in Bandiagara**



**Interview obtains background information, unmet need status, attitudes toward child spacing, and a social network module**

# Eliciting social networks

Think of the people who provide you **material assistance**. For example, someone who loans you money, someone who buys things for you in the market, or someone who gives you food or clothes. Please tell me the names of three people that you go to for this type of support.

Think of the people who provide you **practical assistance**. For example, they help you take care of your children, or they can help with household chores, or they can help you with trading or agriculture. Please tell me the names of three people that you go to for this type of support.



# Analysis

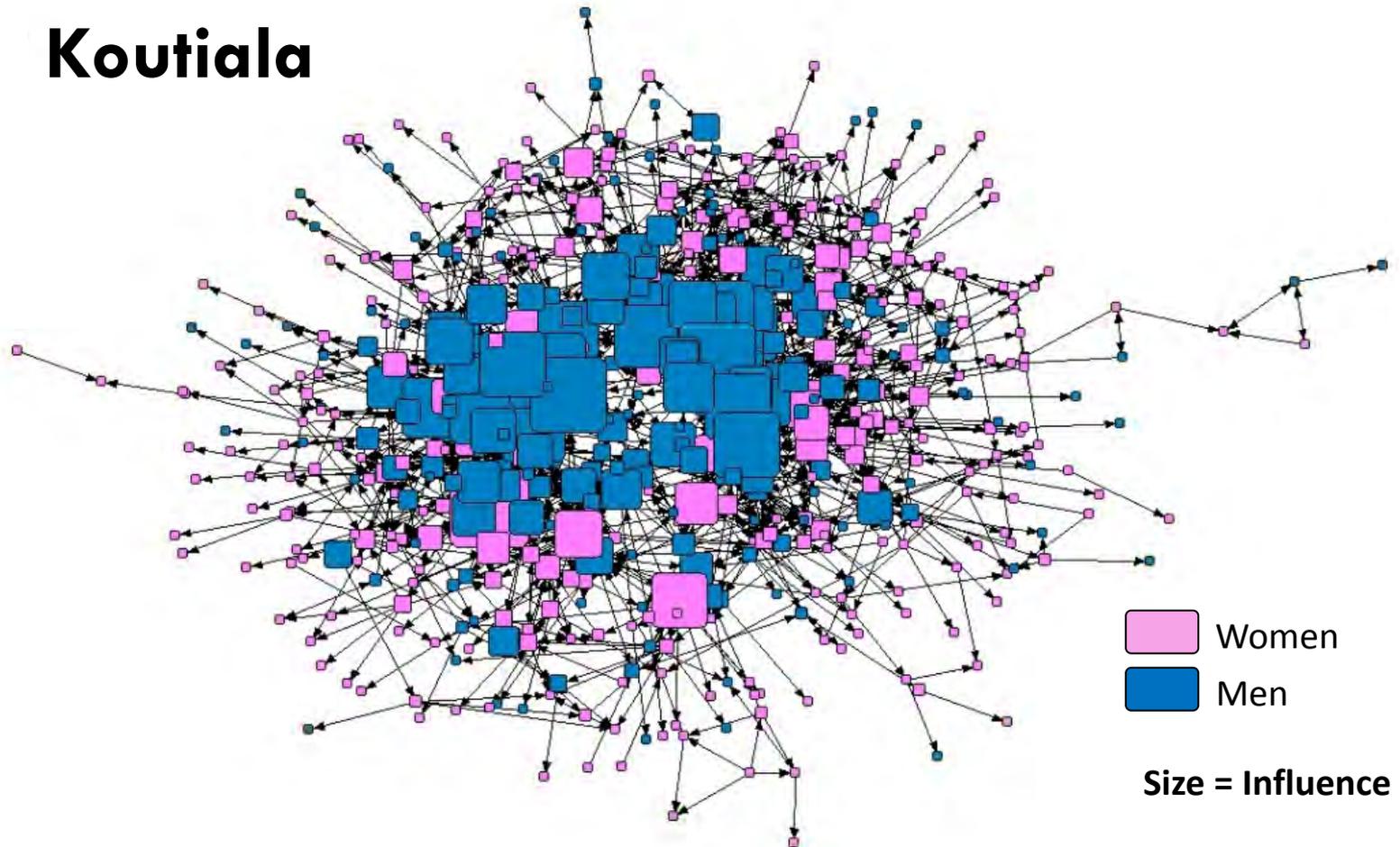
- Use SPSS to obtain **descriptive statistics** and **cross tabulations**, and identify respondent's **unmet need status**
- Used UCINET/NetDraw, a software package designed to analyze **network data**, calculate **network determinants**, create and organize **network maps**

# Respondent profile: Mali

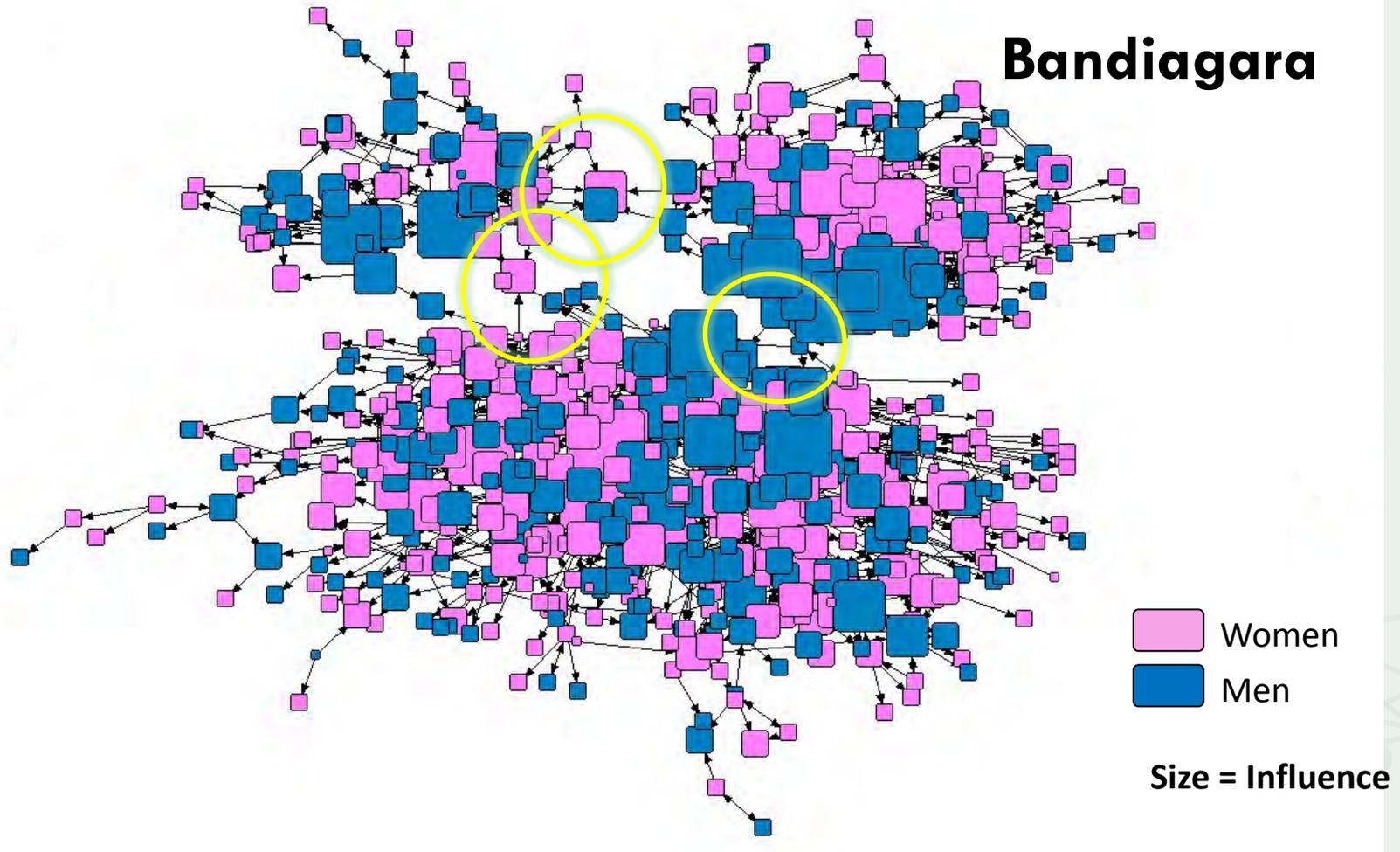
	Koutiala		Bandiagara	
	Women (n=217)	Men (n=149)	Women (n=208)	Men (n=152)
<b>Age (mean)</b>	<b>27.3</b>	<b>39.5</b>	<b>30.9</b>	<b>41.0</b>
<b>No. children (mean)</b>	<b>3.3</b>	<b>5.0</b>	<b>3.8</b>	<b>5.7</b>
<b>% with no education</b>	<b>95</b>	<b>97</b>	<b>94</b>	<b>87</b>
<b>% Moslem</b>	<b>84</b>	<b>90</b>	<b>100</b>	<b>99</b>
<b>% in polygamous marriage</b>	<b>54</b>	<b>37</b>	<b>48</b>	<b>32</b>

# Social network maps of villages

## Koutiala



# Social network maps of villages



# Community centered networks

- **Complete picture of the network**
- **Possible to identify individuals who are the most influential**
- **Possible to identify individuals who serve as information gateway (or bottlenecks)**



**But not practical on a larger scale**

# Benin baseline study methodology

**4320 respondents**

	<b>Women</b>	<b>Men</b>
<b>Communities in Couffo</b>	<b>1,080</b>	<b>1,080</b>
<b>Communities in Plateau</b>	<b>1,080</b>	<b>1,080</b>

- **Women of reproductive age (18-44); men married to women of reproductive age**
- **Random sampling**
- **Sample representative of the community**



# Respondent profile: Benin

	Couffo		Plateau	
	Women (n=1080)	Men (n=1080)	Women (n=1080)	Men (n=1080)
Age (mean)	29.7	38.0	29.7	37.8
No. children (mean)	3.7	5.7	3.2	4.6
% with no education	76.4	43.1	74.3	53.5
% Christian	31.8	26.0	49.7	41.2
% Vodun	42.3	55.7	4.8	7.4
% Moslem	0.3	0.1	15.6	16.3
% in polygamous marriage	45.0	41.9	37.1	31.7

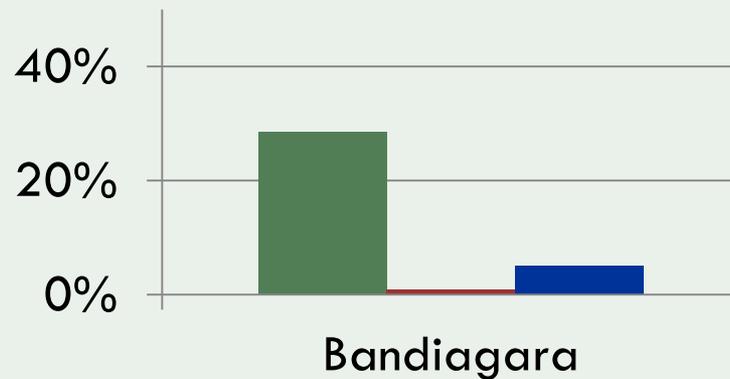
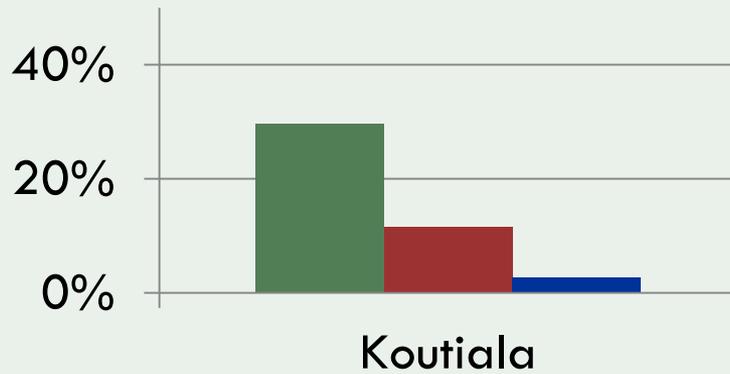
# Network characteristics

Women respondents	Mali		Benin	
	Community centered		Ego centered	
	Koutiala (n=217)	Bandiagara (n=208)	Couffo (n=1080)	Plateau (n=1080)
Mean number of members				
Material network	2.4	2.3	2.4	2.3
Practical network	1.2	1.0	1.6	2.0
<b>Women (%)</b>	<b>54.1</b>	<b>45.2</b>	<b>45.6</b>	<b>53.1</b>
Own family (%)	58.2	58.0	38.4	34.0
Spouse family (%)	33.1	34.8	49.5	44.4
Not family (%)	8.7	7.2	12.1	21.6

# Current family planning use

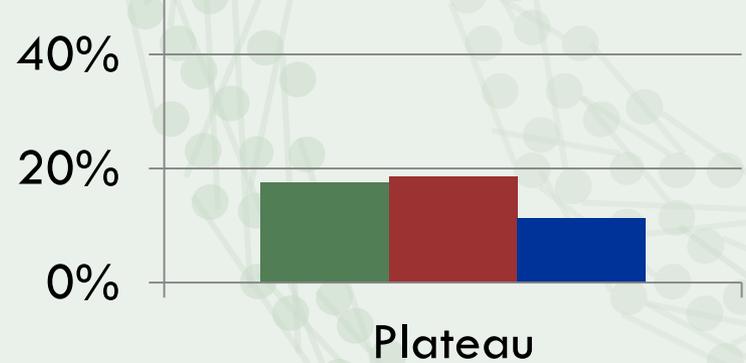
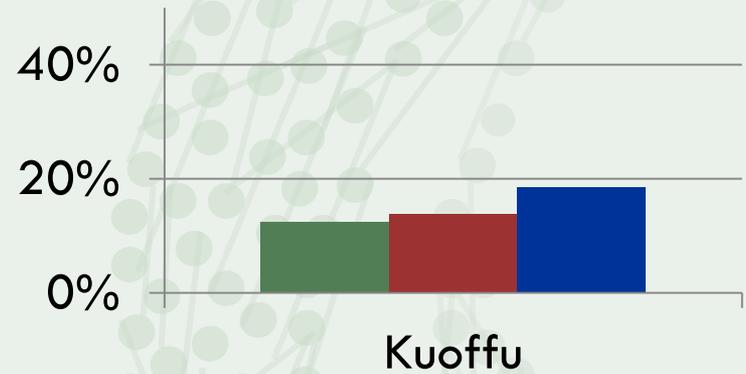
## Mali

### Community centered



## Benin

### Ego centered



■ Not using    ■ Modern    ■ Traditional

# Multivariate analysis

<b>Logistic regression of using a method</b> <b>1 = using method (modern or traditional)</b> <b>0 = unmet need</b>	<b>Benin, women</b>
	<b>Odds ratios</b>
<b>Individual characteristics</b> Age Parity In polygamous marriage Has some formal education	0.984 1.008 1.030 0.944
<b>Network characteristics</b> Husband is in network % members who are women % members in both networks # members	0.768 1.642* 1.489* 0.925**
Couffo Constant	0.599** 0.541

# Conclusion

- **Network characteristics** are important determinants of unmet need
- **Community centered analysis** appropriate for program development
  - Maps diffusion of new ideas throughout the group network
  - Measures ability to identify, mobilize and address problems
- **Individual centered network analysis** cheaper, simpler, and useful for program evaluation





**THANK YOU**

**LEARN MORE:**

[http://irh.org/projects/tekponon\\_jikuagou](http://irh.org/projects/tekponon_jikuagou)







# Programmatic implications of definitions: unmet need for family planning

**Irit Sinai**  
**Rebecka Lundgren**  
Institute for Reproductive  
Health, Georgetown University



**USAID**  
FROM THE AMERICAN PEOPLE



# Unmet need

**“The number or percent of women currently married or in union who are fecund and who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method”**

Source: Measure Evaluation PRH

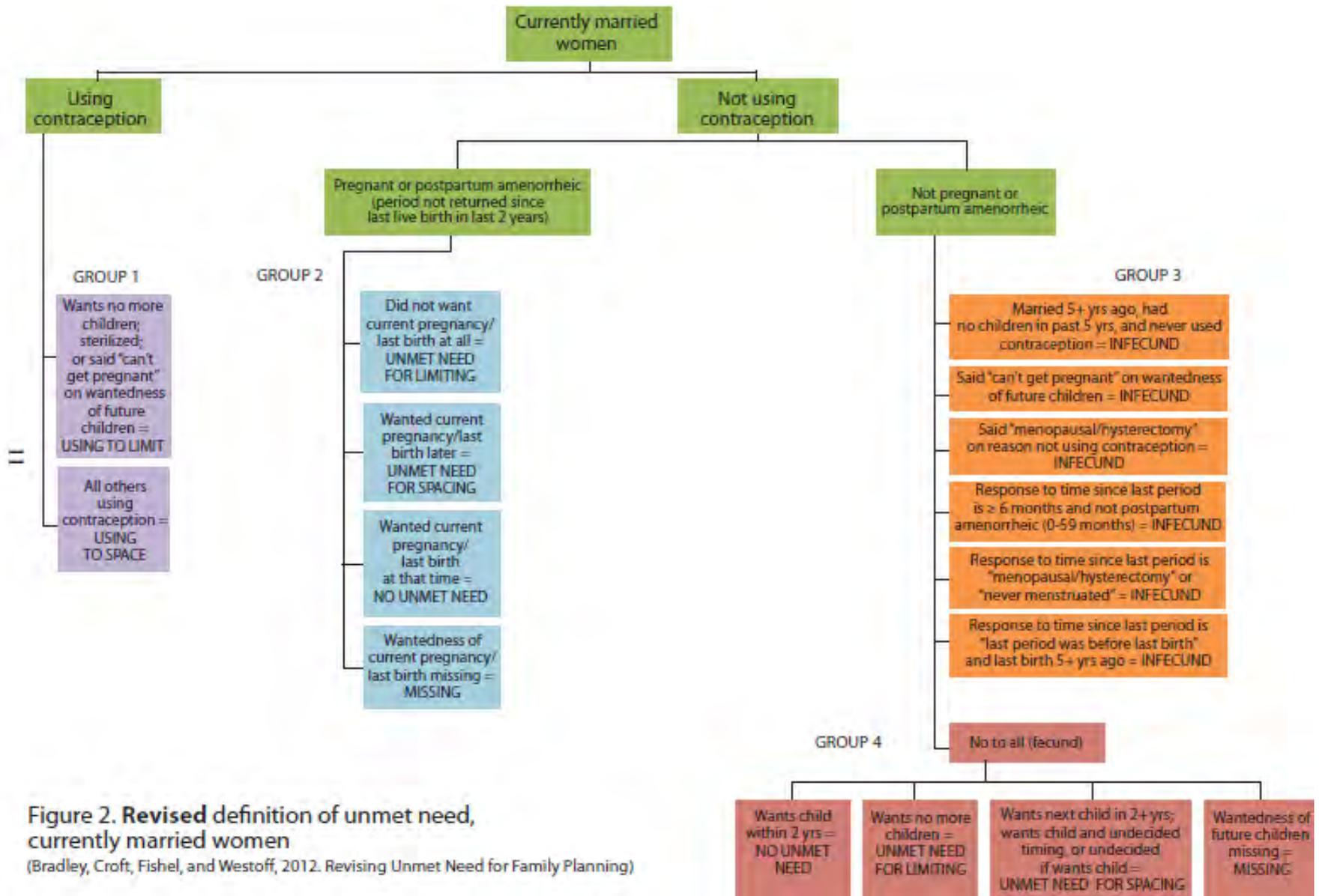


# Tékponon Jikuagou

**Leveraging social networks to influence attitudes, beliefs, social/gender norms related to fertility and FP**



- **Ethnography and social network mapping in Koutiala and Bandiagara, Mali**
- **Formative research, participatory social mapping and household survey in Couffou, Benin**
- **Implemented with CARE and Plan International**



**Figure 2. Revised definition of unmet need, currently married women**  
 (Bradley, Croft, Fishel, and Westoff, 2012. Revising Unmet Need for Family Planning)

Using  
contraception

GROUP 1

Wants no more  
children;  
sterilized;  
or said "can't  
get pregnant"  
on wantedness  
of future  
children =  
USING TO LIMIT

All others  
using  
contraception =  
USING  
TO SPACE

11



Pregnant or postpartum amenorrheic  
(period not returned since  
last live birth in last 2 years)

GROUP 2

Did not want  
current pregnancy/  
last birth at all =  
UNMET NEED  
FOR LIMITING

Wanted current  
pregnancy/last  
birth later =  
UNMET NEED  
FOR SPACING

Wanted current  
pregnancy/  
last birth  
at that time =  
NO UNMET NEED

Wantedness of  
current pregnancy/  
last birth missing =  
MISSING



Not pregnant or  
postpartum amenorrheic

### GROUP 3

Married 5+ yrs ago, had  
no children in past 5 yrs, and never used  
contraception = INFECUND

Said "can't get pregnant" on wantedness  
of future children = INFECUND

Said "menopausal/hysterectomy"  
on reason not using contraception =  
INFECUND

Response to time since last period  
is  $\geq 6$  months and not postpartum  
amenorrheic (0-59 months) = INFECUND

Response to time since last period is  
"menopausal/hysterectomy" or  
"never menstruated" = INFECUND

Response to time since last period is  
"last period was before last birth"  
and last birth 5+ yrs ago = INFECUND

Not pregnant or  
postpartum amenorrheic

GROUP 4

No to all (fecund)

Wants child  
within 2 yrs =  
NO UNMET  
NEED

Wants no more  
children =  
UNMET NEED  
FOR LIMITING

Wants next child in 2+ yrs;  
wants child and undecided  
timing, or undecided  
if wants child =  
UNMET NEED FOR SPACING

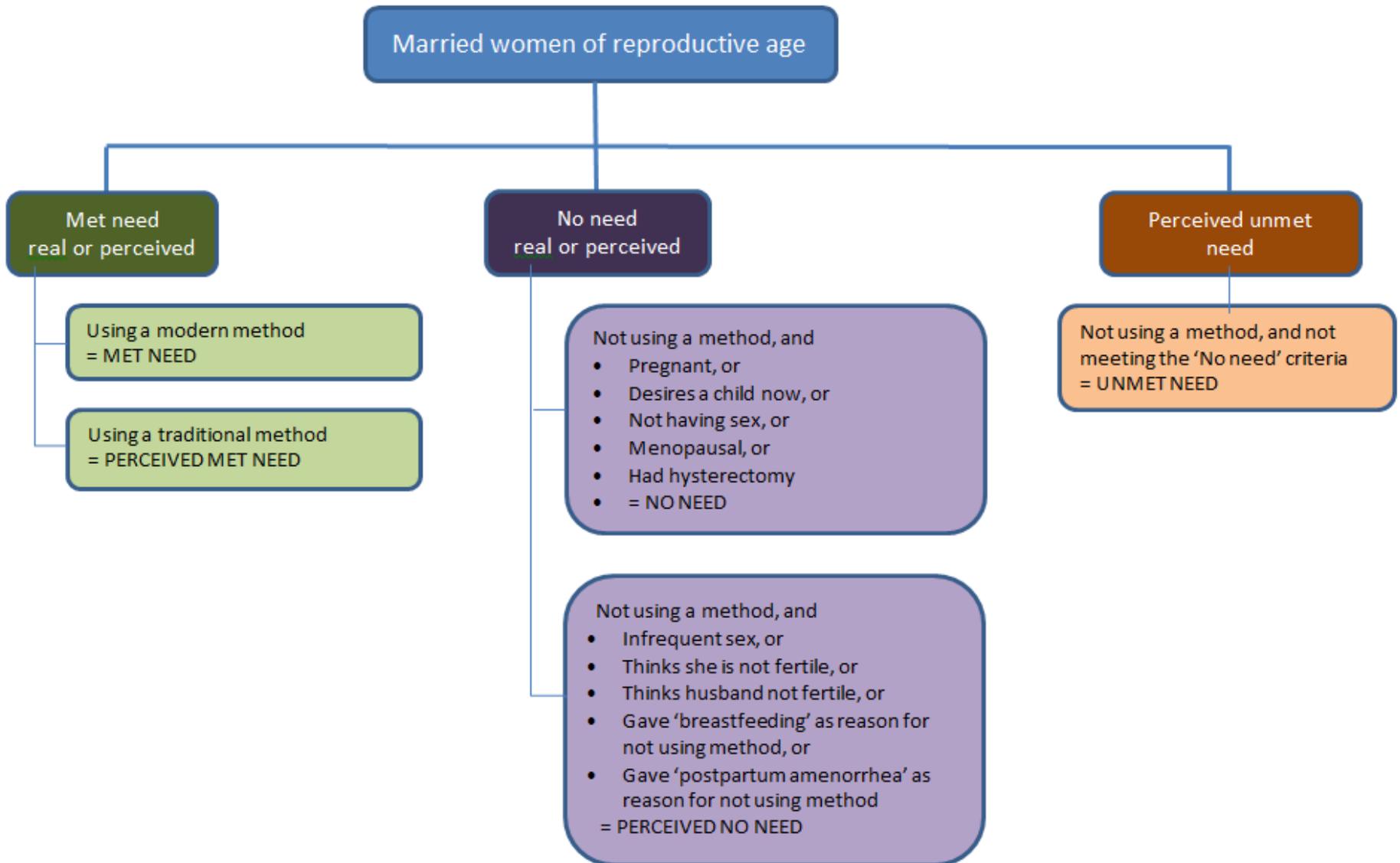
Wantedness of  
future children  
missing =  
MISSING

# A different approach to calculating unmet need for program design

**Perceived need** is a more useful parameter for programs



# What is perceived unmet need?



# Met need, real or perceived

**Met need**

Using a modern method  
= **MET NEED**

Using a traditional method  
= **PERCEIVED MET NEED**

# No need, real or perceived

## No need

**Not using a method, and**

- **Pregnant, or**
- **Desires a child now,**
- **Not having sex, or**
- **Menopausal, or**
- **Had hysterectomy**

**= NO NEED**

**Not using a method, and**

- **Infrequent sex, or**
- **Thinks she is not fertile, or**
- **Thinks husband not fertile, or**
- **Gave 'breastfeeding' as reason for not using method, or**
- **Gave 'postpartum amenorrhea' as reason for not using method**

**= PERCEIVED NO NEED**

# Perceived unmet need

**Unmet need**

Not using a method, and not meeting the 'No need' criteria

**= PERCEIVED UNMET NEED**

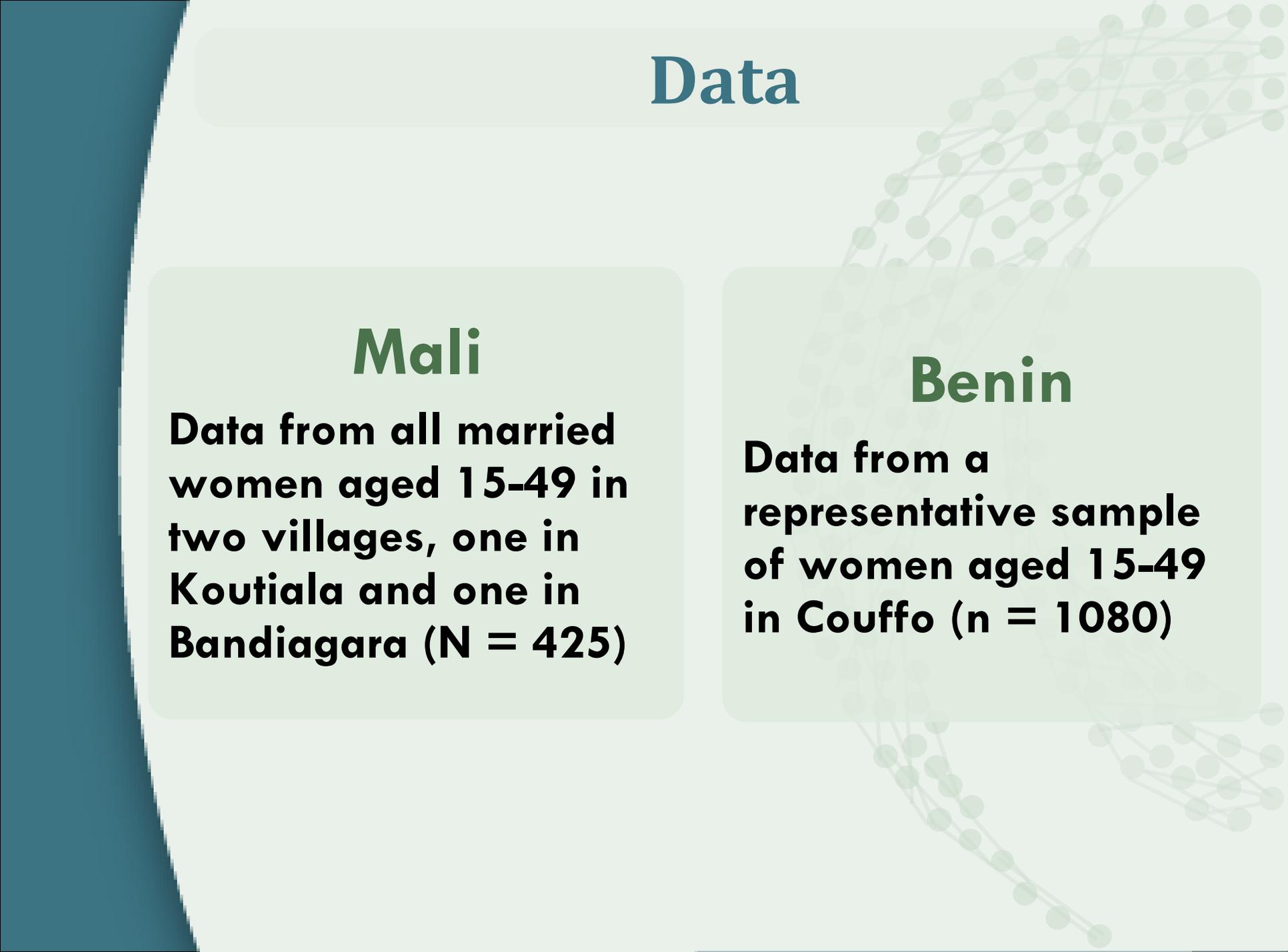
# Needed questions to calculate unmet need with this definition

1. **Are you pregnant now?** (yes = no need)
2. (if no to # 1) **Would you like to become pregnant within the next 12 months?** (yes = no need)
3. (if no to #2) **Are you currently doing something to delay or avoid getting pregnant?** (yes = met need, real or perceived)
4. (if yes to #3) **Which method are you using?**
5. (if no to #3) **Is it possible for you to become pregnant?**

# Needed questions to calculate unmet need with this definition

6. (if no to #5) **Why do you say that?** (real or perceived no need, depending on reason)
  
7. (if yes to #5) **You said that you do not want to become pregnant this year, but you are not using any method to avoid pregnancy. Please tell me why** (UNMET NEED or perceived no need)

# Data



## Mali

**Data from all married women aged 15-49 in two villages, one in Koutiala and one in Bandiagara (N = 425)**

## Benin

**Data from a representative sample of women aged 15-49 in Couffo (n = 1080)**

# Results

Married women of reproductive age

Met need

**Met need**

**Mali 10.4%**

**Benin 13.9%**

**Perceived met need**

**Mali 0.9%**

**Benin 18.6%**

Programs teaching couples that:

- Traditional methods are not effective
- Modern method are available and effective

No need

**No need**

**Mali 33.9%**

**Benin 32.8%**

**Perceived no need**

**Mali 19.9%**

**Benin 23.6%**

Programs teaching couples about pregnancy risk:

- Fertile days
- Postpartum
- Infrequent sex

Unmet need

**Unmet need**

**Mali 34.8%**

**Benin 11.1%**

Programs to:

- Improve access
- Increase choice
- Enable community



THANK YOU

[http://irh.org/projects/tekponon\\_jikuagou](http://irh.org/projects/tekponon_jikuagou)





# TÉKPONON JIKUAGOU

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



**USAID**  
FROM THE AMERICAN PEOPLE



# D'UNE MÉTHODE THÉORIQUE À UNE MÉTHODE PARTICIPATIVE:

Appliquer l'analyse des réseaux sociaux pour faire face aux  
besoins non satisfaits en Planification Familiale

**Susan Igras; Mariam Diakité;  
Heather Buesseler,  
Rebecka Lundgren**  
**ICFP 2013**



**USAID**  
FROM THE AMERICAN PEOPLE



**Institute for  
Reproductive Health**  
Georgetown University



# PROJET TEKPONON JIKUAGOU (TJ) AU BÉNIN

- **Six (6) ans**
- **Financé par USAID Washington**
- **Consortium : IRH (prime), CARE, PLAN**

Phase 1 (1 an): Recherche formative au Mali

**Phase 2 (1 an): Recherche formative au Bénin & conception de l'intervention**

Phase 3 (4 ans): Intervention et mise à l'échelle au Bénin

- Les interventions pilotes: zones sanitaires (ADD/KTL) dans le département de Couffo

# POURQUOI UNE APPROCHE DE RÉSEAU SOCIAL POUR FAIRE FACE AUX BESOINS NON SATISFAITS EN PF?

- Les principaux facteurs des besoins non satisfaits en PF sont les barrières sociales:
  - ✓ Désapprobation du partenaire et de la communauté,
  - ✓ Manque de communication / discussion sur le sujet,
  - ✓ Les fausses rumeurs sur les effets secondaires des méthodes de PF.

**Cependant, les réseaux sociaux peuvent influencer et soutenir les diffusions des informations et des nouvelles idées sur la PF.**

# RÉSEAUX SOCIAUX INFLUENCENT LA DIFFUSION À TRAVERS....

## L'Apprentissage Social

Les membres du réseau échangent des idées et des informations; et ils évaluent les avantages relatifs de l'innovation.

## Influence Sociale

Les membres du réseau suivent les normes du "gardien" afin de gagner l'approbation et d'éviter les conflits.



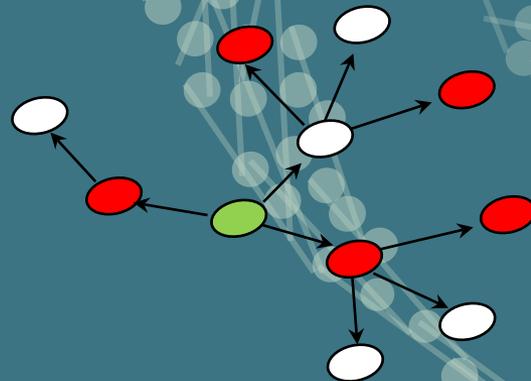
**MÉTHODE THÉORIQUE DES RÉSEAUX  
SOCIAUX APPLIQUÉE PAR TJ**

# RÉSEAU SOCIAL?

« ... un ensemble d'identités sociales telles que les individus ou encore des organisations reliées par des liens créés lors des interactions sociales.

Il se présente par une structure ou une forme dynamique d'un groupement social. »

[*Wikipedia.org*]



# CARTOGRAPHIE DES RÉSEAUX SOCIAUX: ETAPE 1

Avoir une liste de tous les adultes hommes et femmes du village et attribuer un code à chaque personne.

#	Nom	Surnom	M/F	Age	Statut matrimonial	Occupation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

# OBTENTION DES RÉSEAUX SOCIAUX

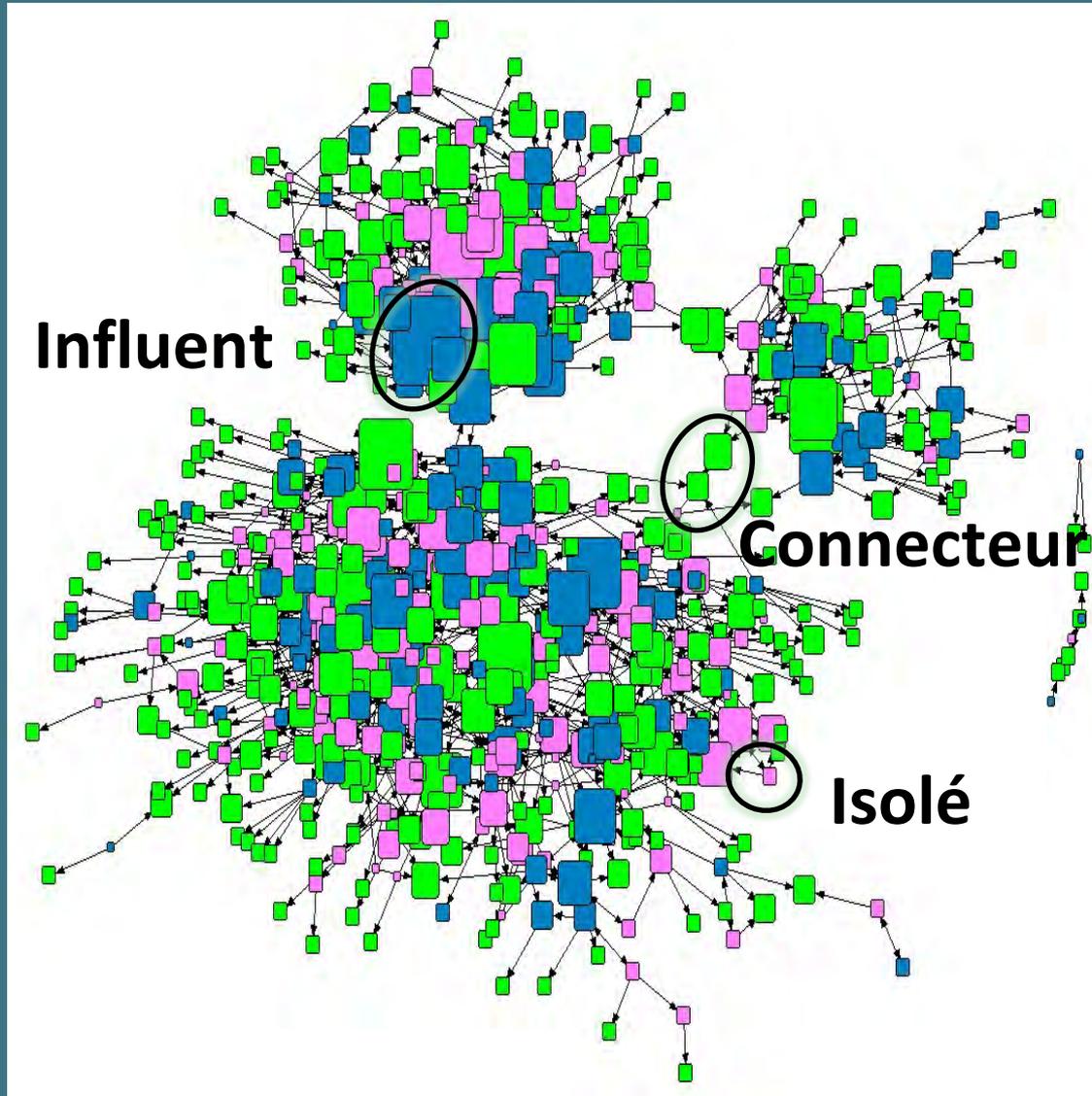
## Grille de réseau social

Réseau		Nom (a)	Code (b)	Relation (c)			Résidence (d)	Proximité (e)	Influence (f)	Approuve la PF (g)	PF acceptable (h)	Approuve l'usage secret (i)
Matériel	M1											
	M2											
	M3											
Pratique	P1											
	P2											
	P3											
Cognitif	C1											
	C2											
	C3											
Emotionnel	E1											
	E2											
	E3											
Mari												
Mère												
Belle-mère												
Coépouse 1												
Coépouse 2												

Pour les femmes, sonder : mari, mère, belle-mère, coépouses

Pour les hommes, sonder : épouses, père, relation masculine

# CARTOGRAPHIE DES RÉSEAUX SOCIAUX: ETAPE 3



Analyser à l'aide du  
Logiciel Unicet

-  Femmes
  -  Hommes
  -  Personnes Citées
- Taille = Influence

# Pourquoi une cartographie *sociocommunautaire*?

## Qu'est-ce qui doit être changé à la cartographie des réseaux sociaux?

- Développement d'un outil pratique pour identifier et localiser des réseaux sociaux et les personnes influentes dans le village.
- A impliquer comme catalyseurs du processus du changement social à travers les membres de leurs réseaux.
- Jouer le rôle de conciliateur dans la communauté en faisant des plaidoyers pour les discussions publiques portant sur les sujets liés aux barrières sociales.

### Traduction des Concepts Clés

- ❑ Réseau social → les groupes sociaux influents
- ❑ Leaders d'opinion → Personnes influentes
- ❑ Connecteurs & Influent → parmi les personnes influentes et les membres des groupes influents



# MÉTHODE PARTICIPATIVE DES RÉSEAUX SOCIAUX APPLIQUÉE PAR TJ:

## CARTOGRAPHIE SOCIOCOMMUNAUTAIRE

# CARTOGRAPHIE SOCIOCOMMUNAUTAIRE: ETAPE 1

- Introduction dans la communauté
- Rencontre avec les autorités locales
- Préparatifs de l'activité suivante



# CARTOGRAPHIE SOCIOCOMMUNAUTAIRE: ETAPE 2

Identification des groupements/personnes influents

1. Nom du groupement
2. Activité
3. Genre
4. Tranche d'âge des membres
5. Taille du groupe
6. Fréquence des réunions
7. Connectivité
8. Influence



# CARTOGRAPHIE SOCIOCOMMUNAUTAIRE: ETAPE 3

Pré-sélection  
des  
groupements  
potentiels à  
impliquer  
dans TJ

Partie II Sélection des groupes

Date: 07/08/2013

Département: COUFFO  
Zone d'activités: ADD  
Commune: AP LAYOUE  
Village: MOUENI  
Nombre de participants: 25  
Echelle: 30  
Agréé: MIE  
Docible: MIE

Groupement	Sexe	Tranche d'âge	Fréquence de réunion	Taille du groupe	Influence des membres	Connectivité
AGRY TONTINE	F		XX	X	XX	X
LOUAMPAK AVEC	F		XX	XX	XXX	XXX
MILONNONV TONTINE	H (jeunes)		X	XXX	XXX	XXX
GBENONDYOU AGR	F		XX	XX	XX	XX
LONLONGNON Mutualité de Sanké (Sanké)	F		XX	XX	XX	XX
MIAWE (Cobénédictariats) Groupe Fleuve (Sanké)	F		XX	XXX	XX	X
ALIDÉ SENOUHOU - Groupe Fleuve qui assiste Pécé	F		XX	XXX	XX	XXX
AYAME (Kadjakou) Groupe Fleuve qui assiste Pécé	F		XX	XXX	XX	XXX
MIDÉDJ (Kadjakou) Groupe Fleuve qui assiste Pécé	M		XX	XX	XXX	XX
MISSOGBÉ (Eyouhou) Groupe Fleuve qui assiste Pécé	H		XX	XX	XXX	X
AZELÉ (Cobénédictariats) Groupe Fleuve qui assiste Pécé	M		XX	XX	XXX	XX
MIAWE (Cobénédictariats) TONTINE (H) jeunes			X	XXX	XXX	X
ALOYIWÉ (Mégamunicipal) AVEC	F		XX	XX	XXX	XXX

L'Influence

La connectivité

La Fréquence de réunion

La Taille

La Tranche d'âge

# CARTOGRAPHIE SOCIOCOMMUNAUTAIRE: ETAPE 4

## Faire le Croquis du village

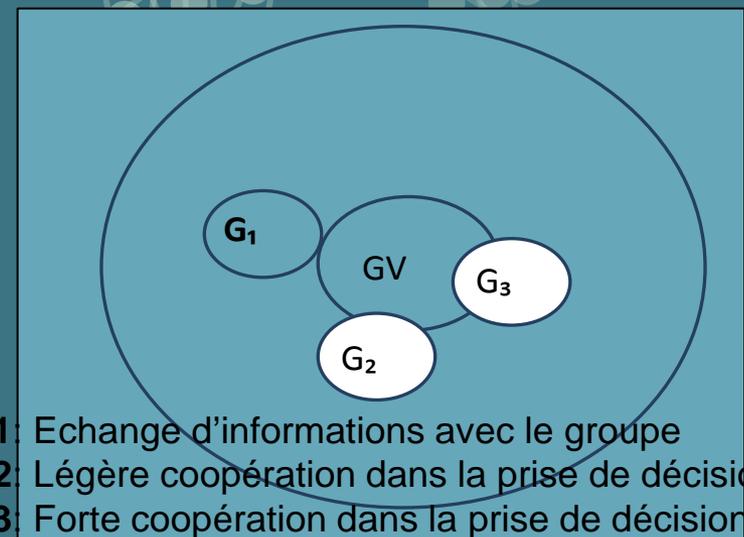
- Analyser le dynamisme social
- Constater le besoin en PF
- Identifier les personnes influentes



# CARTOGRAPHIE SOCIOCOMMUNAUTAIRE: ETAPE FINALE – VALIDATION

## Rencontre avec les groupements préselectionnés

- Connaitre l'attitude du groupe envers la PF: *série de questions*
- Confirmer leur influence dans la communauté: *Digramme de Venn*
- Guider la sélection des personnes influentes
- Solliciter leur implication dans les activités de TJ



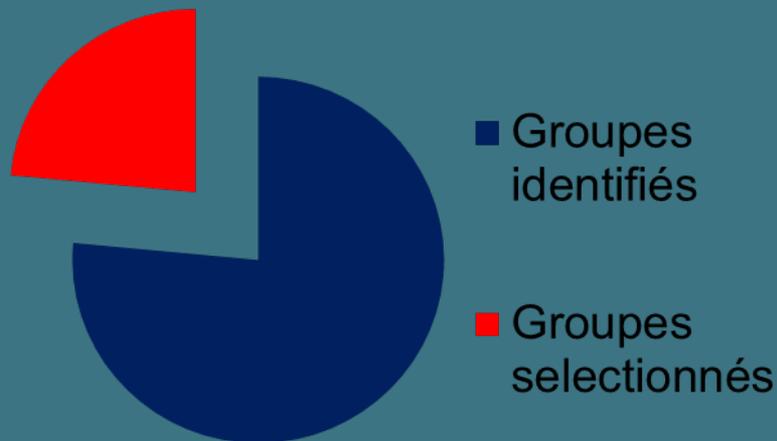


**RÉSULTATS: CARTOGRAPHIE  
SOCIOCOMMUNAUTAIRE**

# IDENTIFICATION ET SÉLECTION DES GROUPEMENTS DANS 47 VILLAGES

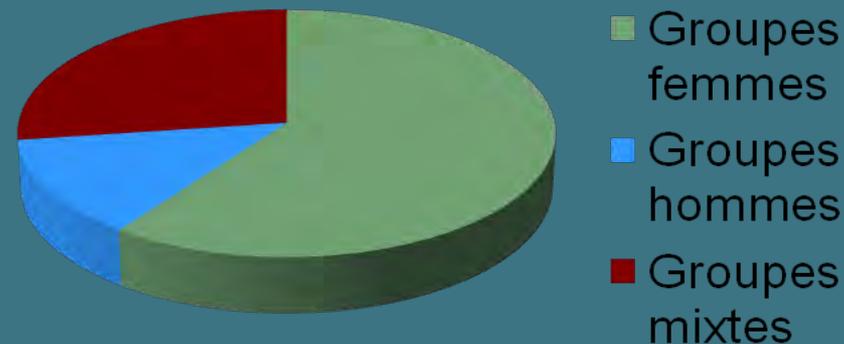
## Groupes identifiés

n= 478



## Groupes sélectionnés par genre

n= 147



# IDENTIFICATION ET SÉLECTION DES PERSONNES INFLUENTES

- **Une pléthore dans certains villages**
  - ✓ Résident dans le village
  - ✓ Ou dans une autre ville
- **Environs 4 à 5 personnes sélectionnées (femmes et hommes)**



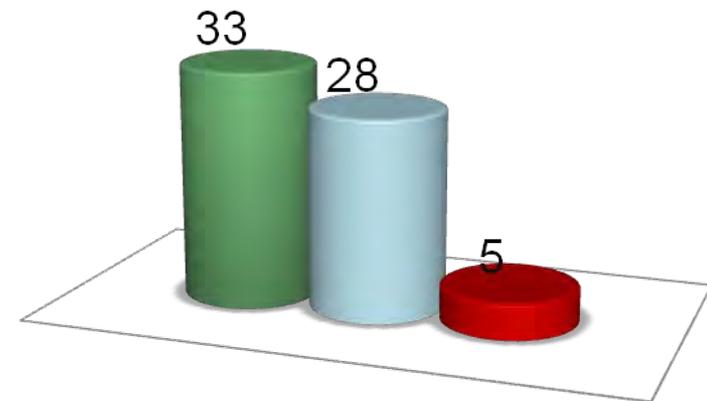
# IDENTIFICATION DES RELAIS EN PF

**Nombre relais qui sont catalyseurs et influents**

- **36 relais sont catalyseurs dans les groupements influents ( 6 femmes et 30 hommes)**

- **16 relais sont influents dans les communautés (6 femmes et 10 hommes)**

**Répartition des relais dans les village  
n=33**



- Villages avec relais communautaires
- Villages avec relais de PF
- Villages sans relais PF

# LA CARTOGRAPHIE SOCIOCOMMUNAUTAIRE NOUS AMÈNE AU DÉPART DE L'APPROCHE TJ

<b>Approche TJ – groupements et activités-catalyseurs</b>	<b>Autres approches de mobilisation sociale de PF</b>
<ol style="list-style-type: none"><li data-bbox="88 561 877 711"><b>1. Travailler avec peu de groupements (3/villages) stratégiquement sélectionnés.</b></li><li data-bbox="88 778 877 928"><b>2. Le catalyseur (animateur) est choisi par les membres au sein du groupement.</b></li><li data-bbox="88 995 877 1145"><b>3. Accent sur le dialogue et la discussion, pour une diffusion des sujets abordés.</b></li><li data-bbox="88 1212 877 1310"><b>4. Le projet suit le rythme d'activité du groupe.</b></li></ol>	<ol style="list-style-type: none"><li data-bbox="956 561 1707 654">1. Etablissent les groupes et ne ciblent souvent que les femmes.</li><li data-bbox="956 768 1785 861">2. Choisisent l'animateur qui peut ne pas être attractif pour le réseau.</li><li data-bbox="956 975 1765 1125">3. Accent sur le sujet abordé (messages), pour un changement de comportement individuel.</li><li data-bbox="956 1196 1717 1289">4. Le groupe suit le rythme d'activité du projet.</li></ol>

# CONCLUSION

<b>Approche TJ – Les influentes et activités catalysatrices</b>	<b>Autres approches de mobilisation sociale de PF</b>
<ol style="list-style-type: none"><li data-bbox="112 525 840 811"><b>1. Des leaders influents identifiés par la communauté (formels et informels).</b></li><li data-bbox="112 911 884 1189"><b>2. Action des personnes qui soutiennent l'idée de faire face aux besoins non satisfaits</b></li></ol>	<ol style="list-style-type: none"><li data-bbox="987 525 1647 739">1. Des leaders influents identifiés par le projet, (souvent formels)</li><li data-bbox="987 961 1692 1160">2. Un appui et coordination entre le projet et la communauté.</li></ol>

# CONCLUSION

## Approche TJ – connections réseaux avec les services PF

- **Cherche à connecter les relais en PF aux groupements – pour encourager la diffusion d'information à travers les réseaux influents et l'accès aux services.**

## Autres approches de mobilisation social de PF

- Font souvent des visites à domicile et des sensibilisations communautaires; cherche à étendre l'initiative/projet dans d'autres communautés.



**MERCI!**





# UNE POLITIQUE NATIONALE POUR AUGMENTER LA CONTRACEPTION MODERNE AU BENIN

*Equipe de la Direction de  
la Santé de la Mère et de l'Enfant (Bénin)*

**Panel 2.3.07**  
**14h30 à 15h50, jeudi 14 novembre, 2013**  
**Old Building, Small Conference Hall**

 **CONFÉRENCE INTERNATIONALE SUR LA  
PLANIFICATION FAMILIALE**  
ADDIS ABABA, ETHIOPIA **NOVEMBER 12-15 2013**

# LA PLANIFICATION FAMILIALE = SUJET TABOU

- **Depuis les années 1990, résultats encore insuffisants**
  - (3,4% en 1996 à 7,9 en 2011)
- **Place clé pour réduction mortalité maternelle**
- **Nécessité d'une politique ambitieuse en faveur de la PF:**
  - Implication des leaders d'opinion et des décideurs
  - Sécurisation des produits de SR, SRAJ
  - Prestataires qualifié et motivés
  - Services à base communautaire

# GENESE DE LA POLITIQUE DE PF

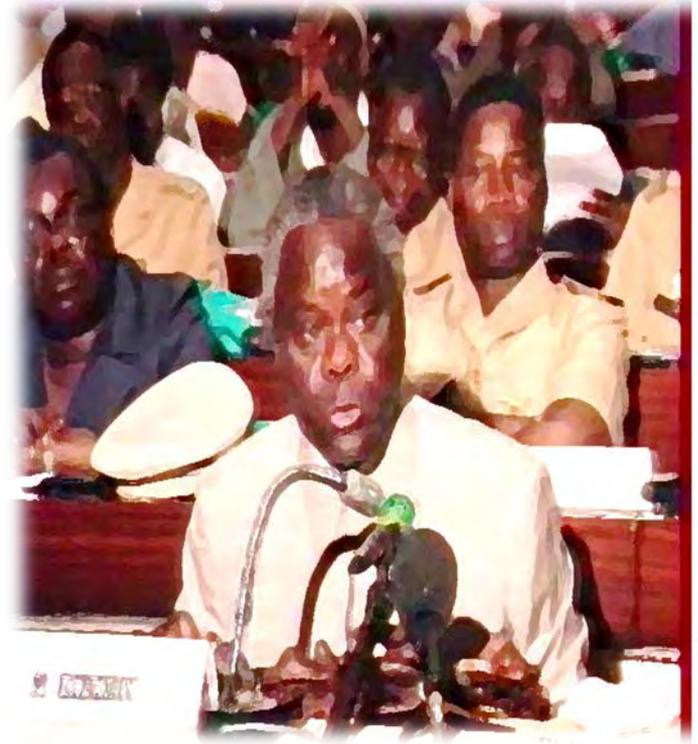
Période coloniale: politique pro nataliste et polygamie



1960: Indépendance



CIPD, Caire en 1994: 1<sup>er</sup> tournant de la politique



# AVANCEMENT DES LOIS

**2003:** Loi relative à la santé sexuelle et à la reproduction

**2004:** Code des personnes et de la famille

**2006:** Répression du harcèlement sexuel et protection des victimes

**2006:** Prévention, prise en charge et contrôle du VIH/Sida

**2012:** Prévention et répression des violences faites aux femmes



# CADRE GLOBAL DE LA POLITIQUE



# CINQ (5) DOMAINES STRATÉGIQUES

1. Prévention, lutte contre les maladies et l'amélioration de la qualité des soins y compris la réduction de la mortalité maternelle et infantile
2. Valorisation des ressources humaines
3. Renforcement du partenariat dans le secteur
4. Promotion de l'éthique et de la déontologie médicale
5. Amélioration du mécanisme de financement du secteur

# LA POLITIQUE S'EST INSPIRÉE DE

- Programme National de SR 2011-2015
- Stratégie Nationale pour la Réduction de la Mortalité Maternelle et Néonatale
- Stratégie Nationale de Repositionnement de la Planification Familiale au Bénin
- Stratégie Nationale de SPSR
- Stratégie nationale multisectorielle de SRAJ
- Plan de communication sur la SR

# ACTIONS STRATÉGIQUES

- Elaborer le plan d'action budgétisé pour la relance de la PF;
- Augmenter la part du budget pour la PF;
- Aborder des ressources issus de la consommation des produits contraceptifs ;
- Améliorer la gestion informatique des données;
- Intégrer les services PF dans le paquet complet d'activités des FS
- Mise en œuvre de la stratégie multisectorielle de la SRAJ ;
- Développer la PF au niveau communautaire

# CONCLUSION

- 
- Nouveau cadre politique et légal = environnement idéal pour le décollage de la PF.

- 
- Mise en œuvre des différentes actions (initiative régional post-Ouagadougou) + Synergie + bon système de suivi-évaluation =

- 
- Atteinte des OMD (prévalence contraceptive moderne à 15% d'ici à 2015).



# MERCI DE VOTRE ATTENTION



# MERCIS!



JSI Research & Training Institute, Inc.



**APPENDIX D:**

***Brief: Social networks & social change: New program approaches to reducing unmet need for family planning***



Tékponon Jikuagou is a USAID-funded six-year project that aims to reduce unmet need for family planning in Benin through social network interventions.

## Social networks & social change: New program approaches to reducing unmet need for family planning

In West Africa, after decades of programming, family planning knowledge has increased. Yet modern method use has made small gains, and unmet need for family planning remains stubbornly high. *Tékponon Jikuagou*, which loosely translates as “using all means to reduce maternal mortality,” responds to persistent low rates of family planning uptake in Benin. By applying social network theory and analysis, *Tékponon Jikuagou* moves the focus from targeting individuals with behavior change activities to thinking of individuals as members of formal and informal networks that influence ideas and behaviors. Working through a community resource present in Benin and throughout West Africa—resilient social networks—*Tékponon Jikuagou* seeks to engage network actors in reflecting on and addressing the social norms and barriers within their local context which contribute to unmet need for family planning.

### MODELS FOR SOCIAL CHANGE

*Social network approaches in tandem with communication for social change approaches can be used to influence social norms and family planning attitudes and practices. The social network approach hypothesizes that once family planning ideas and use have been adopted by influential groups and individuals 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 family planning method but also for continuation or switching. The communications for social change approach hypothesizes that public discussions by women and men on fertility and family planning will lead to greater social acceptance and family planning use by those desiring to space births. Combined, individual and normative changes should result and be sustained.*



## A SCALABLE PACKAGE OF SOCIAL NETWORK INTERVENTIONS

Instead of a blanket community outreach approach, social network interventions work with and through a different set of community network actors who may be more effective diffusers of new ideas and mobilizers of public dialogue than formal leaders or health workers alone.

Within the context of planning for feasible scale-up, the foundation for Tékponon Jikuagou activities is created through community social mapping, which is a participatory form of social network analysis. Social mapping identifies women's and men's groups and individuals judged most influential by their communities. These groups and individuals provide access to larger social networks. They also serve as catalysts of change, taking advantage of their roles as influencers and connectors within communities.

Using stories and activity cards, the project fosters the use of reflective dialogue to encourage women and men to determine for themselves whether their current attitudes and values are consistent with their hopes and vision for their lives, particularly as they relate to fertility, reproductive health and family planning. People are asked to share the story themes and ideas with others. Complementary radio broadcasts of Tékponon Jikuagou sessions reinforce and make use of public

platforms to share more broadly group reflective dialogue materials and discussions. Since formative research indicated limited interaction with local health providers, purposeful linking of these providers to influential groups creates new network connections, allowing information flow about family planning.

In sum, Tékponon Jikuagou maximizes the use of change agents (both individuals and groups) within social networks to facilitate comparison and reflection, to inform, and to



Illustrations, like these, help spark discussion about community or family dilemmas related to acting on child spacing desires and family planning.

model shifts to alternative behaviors, attitudes and norms. Links between change agents and others in the community are purposefully encouraged as a strategy to diffuse new ideas and discussions more broadly. Public discourse, inspired by community leaders and radio, creates an enabling environment for improved attitudes, norms and expectations.

## HOW DOES THE TÉKPONON JIKUAGOU INTERVENTION DIFFER FROM CONVENTIONAL FAMILY PLANNING OUTREACH INTERVENTIONS?

On the surface, social network interventions may appear similar to conventional family planning approaches that target women and men by working through existing community structures to provide information and services. The following are ways that social network program frameworks and approaches diverge from conventional approaches.

### Different Concept

- Tékponon Jikuagou is focused on unmet need rather than increasing contraceptive prevalence. It seeks to create greater understanding of unmet need, breaking down the unmet need category of those who are not using family planning and do not want to become pregnant into additional categories of those who may think they are

protected when they aren't, and those who feel they are unable to use family planning even when they wish they could. This framework facilitates better understanding of the dynamic nature of unmet need and allows creation of program responses to address each unmet need category.

- Tékponon Jikuagou identifies and addresses gender and other social factors that influence unmet need, e.g., stigma associated with family planning discussions and use of family planning, what is appropriate to discuss and with whom, fertility preferences, and household and couple decision-making around reproductive health and child spacing.
- Tékponon Jikuagou brings a scale-up mindset to intervention design, emphasizing feasibility and cost as important criteria. Tékponon Jikuagou also creates political and technical buy-in for scale-up through establishment of a multi-sectorial national technical advisory group and zonal advisory committee.

### Different Process

- In each village, Tékponon Jikuagou is working with community members and groups who are identified by their peers as influential, regardless of having formal leadership positions, in addition to working with leaders who are influential due to their formal roles (e.g. religious leaders, service providers).



### ENGAGE COMMUNITIES IN SOCIAL MAPPING

Supporting Material: *Community Social Mapping Guide*



### SUPPORT INFLUENTIAL GROUPS IN REFLECTIVE DIALOGUE

Supporting Material: *Catalyzer Orientation Plan, Coaching Guide, Reflective Dialogue Stories & Activity Cards*



### ENCOURAGE INFLUENTIAL INDIVIDUALS TO ACT

Supporting Material: *Facilitator Guide, Orientation Package for Influentials*



### USE RADIO TO CREATE AN ENABLING ENVIRONMENT

Supporting Material: *Pre-recorded Stories, Community Discussions*



### LINK FP PROVIDERS WITH INFLUENTIAL GROUPS

Supporting Material: *FP Invitation Cards, Campaign Orientation Guide*



## AT A GLANCE: TÉKPONON JIKUAGOU IN COUFFOUCETTE, AN IMAGINARY VILLAGE IN SOUTHWEST BENIN

### Establishing a foundation of social network action

After an initial meeting with village leaders, Tékponon Jikuagou staff help village volunteers conduct a community social mapping exercise. Different perspectives are represented in these participatory activities, including women, men, youth, health workers, and socially marginalized groups. Through this process, community members inventory existing social groups and rank them according to their degree of influence over health and well-being in the village. A physical map is created that represents the social organization of the village (e.g. most socially important institutions in the village, most forward-thinking neighborhoods, most influential people, etc.).

Tékponon Jikuagou staff then visit selected groups and individuals to engage them in activities to address unmet need for family planning. In Couffouette, the most influential women's group, a savings and loan group, agrees to participate, as well as an influential men's group of weekly domino-

players, and a mixed sex group engaged in youth activities. Similarly, influential individuals are visited to invite them to work on issues of unmet need. In Couffouette, these influential individuals are engaged in a variety of livelihoods, including a female charcoal seller, a male temple priest, a male primary school teacher, a female traditional birth attendant, and a male elder. For groups and individuals, it is not necessarily their livelihoods or formal positions that make them influential; rather it is the advisory roles they play within the community.

A change agent from each group is oriented over three days in the use of Tékponon Jikuagou's story and activity cards and trained in participatory group facilitation skills. About six weeks later, the influential individuals are oriented for one half day about unmet need, discuss baseline study findings on social barriers stopping women and men from acting on unmet need, and commit to actions of their choosing that will help the community talk about and address the issues.

### Activating the base and diffusing outward

After orientation, group change agents return home with a package of Tékponon Jikuagou materials. Each time the group

meets, time is spent on a story or activity card and related discussion. The group chooses the order in which they want to discuss the 18 different cards. At the end of each discussion, the change agent asks all group members to share with others outside the group. Sometimes other groups or individuals ask if they can borrow the materials.

About six weeks after groups begin Tékponon Jikuagou discussions, influential individuals begin to act on their commitments. A temple priest might encourage couples to discuss using family planning, for example, before a ceremony begins. A market woman might engage her regular customers in discussions of why men and women don't talk about child spacing in public. Through public actions, people see influential people talking about sensitive issues and will feel freer to talk. About once per month over several months, staff visit the change agents to encourage and build skills.

### Creating a socially-enabling environment for family planning use

Once groups commence activities, radio programs begin weekly broadcasts. Pre-recorded group discussions and call-

in lines for community members allow more public expression of views. Disk jockeys promote a local family planning hotline so listeners can talk with people who are well-informed about family planning.

During their orientation, group change agents meet and exchange phone numbers with the family planning provider from the local health clinic. This resource person may visit a Tékponon Jikuagou group to talk about family planning. Providers and groups may work together to implement a family planning campaign based on social diffusion processes. Women and men in Tékponon Jikuagou groups are given 'family planning invitation cards' to share with friends and relatives not using family planning. The cards encourage people to share positive family planning experiences and seek information and services at the local health center.

### Closing the Tékponon Jikuagou catalyst period

After a year of activities, all who have been actively involved come together for a celebration of service to their communities. Many will leave with a commitment to continue efforts to engage their neighbors and peers.

- Implementation of the Tékponon Jikuagou intervention is based on strategic versus community-wide participation. In a typical village, Tékponon Jikuagou activities are supported by three influential groups and five influential individuals, with the idea these people will diffuse new ideas and information to others.
- Tékponon Jikuagou's intervention goes beyond using a behavior change communication (BCC) approach that focuses on information and messages at the individual level, and catalyzes discussions among groups that help to break down family planning stigma and social norms that prevent women and men from talking about and acting on their unmet need for family planning.

## POTENTIALLY DIFFERENT OUTCOMES

Although too early to know—the evaluation of the pilot social network package will be conducted in early 2015—social network approaches that work with community-identified influencers, connectors, and important social groups, offer a new way to mobilize communities to address unmet need for family planning. Tékponon Jikuagou applies a program paradigm based on strategic participation of a small set of influential actors, coupled with public discussion and diffusion of new ideas raised through reflective dialogue. A community-based approach designed with scalability in mind, this low-resource, low-technology approach has potential to reach large populations. Ultimately, the Tékponon Jikuagou approach may be effective in reducing social barriers to women and men acting on their unmet need, getting at a core but poorly-addressed issue in many family planning programs.

## THE PARTNERSHIP

Tékponon Jikuagou is implemented by a consortium led by Georgetown University's Institute for Reproductive Health (IRH), in collaboration with CARE International and Plan International (including what was previously CEDPA). IRH is responsible for overall project direction and management as well as research, monitoring, and evaluation; while CARE and Plan International in Benin are responsible for developing and implementing social network interventions.

Each partner brings unique skills and experiences to the consortium: IRH brings expertise in social network theory, measurement methods, and experience in testing and scaling up pilot interventions; CARE brings expertise in grass roots sexual and reproductive health programs, including its Social Analysis and Action approach to influencing social norms through community reflection and dialogue; and Plan brings expertise in gender to build social and cultural contexts that support women's reproductive health, and its holistic, Child-Centered Community Development approach to working with communities. Together, consortium members provide a strong foundation of experience and community knowledge from which to develop, pilot, and if effective, expand a social network approach that is scalable, systematic, and broad in transforming communities.

This publication and the project featured were made possible through support provided by the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement No. AID-OAA-A-10-00066. The contents of this document do not necessarily reflect the views or policies of USAID or Georgetown University. Published July 2014.



INSTITUTE FOR REPRODUCTIVE HEALTH GEORGETOWN UNIVERSITY  
 CARE INTERNATIONAL  
 PLAN INTERNATIONAL  
[WWW.IRH.ORG/PROJECTS/TEKPONON\\_JIKUAGOU](http://WWW.IRH.ORG/PROJECTS/TEKPONON_JIKUAGOU)

**APPENDIX E:**  
**Tékponon Jikuagou Banners**

