

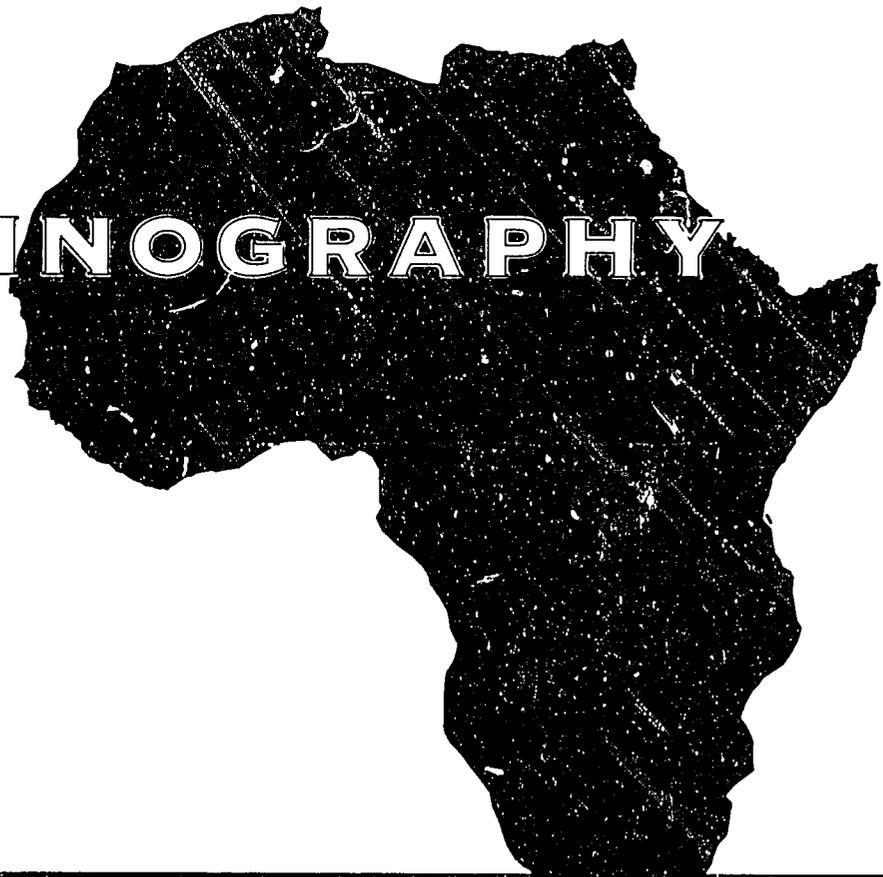
AFRICA CHILD SURVIVAL INITIATIVE  
COMBATting CHILDHOOD COMMUNICABLE DISEASES  
(ACSI-CCCD)

PN ABT-485

**WORKING PAPER:**

**ETHNOGRAPHIC RESEARCH FOR  
FAMILY PLANNING POLICY DEVELOPMENT,  
ABIDJAN, CÔTE D'IVOIRE, 1991**

**ETHNOGRAPHY**



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT  
Africa Regional Project (698-0421)



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Centers for Disease Control  
and Prevention  
International Health Program Office

**CDC**

## NOTES ON THE AUTHORS

RUTH P. WILSON, PHD, IS A MEDICAL ANTHROPOLOGIST WHO DEVELOPS, IMPLEMENTS, AND COORDINATES ANTHROPOLOGICAL INPUT TO SUPPORT OPERATIONAL RESEARCH ACTIVITIES FOR THE INTERNATIONAL HEALTH PROGRAM OFFICE, SOCIAL AND BEHAVIORAL SCIENCES BRANCH, IN THE TECHNICAL SUPPORT DIVISION, CDC ATLANTA. DRS S. DARRET, MD AND ESTELLE SHAW, MD ARE STAFF OF THE MINISTRY OF HEALTH AND SOCIAL PROTECTION. NANETTE BARKEY, SERVED AS THE AMERICAN PUBLIC HEALTH ASSOCIATION INTERN DURING THE IMPLEMENTATION OF THE STUDY. KATHLEEN A. PARKER, MPH (HEALTH EDUCATION) IS BRANCH CHIEF, SOCIAL AND BEHAVIORAL SCIENCES BRANCH.

THIS WORK WAS SUPPORTED AND MADE POSSIBLE BY THE AFRICA BUREAU, OFFICE OF OPERATION AND NEW INITIATIVES (ONI) AND THE OFFICE OF ANALYSIS, RESEARCH AND TECHNICAL SUPPORT (ARTS), UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (A.I.D.) THROUGH THE AFRICA CHILD SURVIVAL INITIATIVE - COMBATTING CHILDHOOD COMMUNICABLE DISEASES (ACSI-CCCD) PROJECT, AFRICA REGIONAL PROJECT (698-042) P. WASHINGTON, D.C.

THIS REPORT IS THE RESULT OF A COOPERATIVE EFFORT BETWEEN THE STAFFS OF THE INTERNATIONAL HEALTH PROGRAM OFFICE (CDC, ATLANTA), THE MINISTRY OF HEALTH AND SOCIAL PROTECTION IN CÔTE D'IVOIRE, THE INSTITUTE NATIONAL DE SANTÉ ET PROTECTION, THE CENTRE IVOIRIEN DE RECHERCHES ECONOMIQUE ET SOCIALES, THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH (ASPH), AND THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID). THE VIEWS EXPRESSED ARE SOLELY THOSE OF THE AUTHORS.

## ACKNOWLEDGEMENTS

WE THANK MRS. LYNN MOHAMMED, MRS. SYLVIA ACQUAH, MR. JAMES HERRINGTON, DR. MODUPE BRODERICK, AND DR. CHUCK DEBOSE WHOSE ASSISTANCE ENABLED US TO IMPLEMENT THE STUDY IN CÔTE D'IVOIRE. REVIEWS AND EDITORIAL ASSISTANCE WERE PROVIDED BY ANDREW VERNON, MELINDA MOORE, JENNIFER BRYCE, VIRGINIA STURWOLD AND JUDI KANNE.

ANY PARTS OF THESE MATERIALS MAY BE COPIED OR REPRODUCED FOR NONCOMMERCIAL PURPOSES WITHOUT PERMISSION IF CREDIT IS PROPERLY GIVEN.

ADDITIONAL COPIES IN ENGLISH (CATALOGUE NUMBER 099-4008) OR IN FRENCH (099-4009) ARE AVAILABLE UPON REQUEST FROM:  
ACSI-CCCD TECHNICAL COORDINATOR  
INTERNATIONAL HEALTH PROGRAM OFFICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
ATLANTA, GEORGIA 30333  
FAX (404) 639-0277

WORKING PAPER:

Ethnographic Research  
for Family Planning Policy Development:  
Abidjan, Côte d'Ivoire, 1991

Ruth P. Wilson,<sup>1</sup> Shegou Darret,<sup>2</sup> Kouamé Kale,<sup>3</sup>  
Nanette Barkey,<sup>4</sup> Constance Binde,<sup>5</sup> Yvonne Bosso,<sup>6</sup> Kathleen A. Parker<sup>1</sup>

- <sup>1</sup> International Health Program Office, Centers for Disease Control and Prevention, Atlanta, Georgia.
- <sup>2</sup> Ministry of Health and Social Protection, Abidjan, Côte d'Ivoire.
- <sup>3</sup> National Institute for Public Health, Abidjan, Côte d'Ivoire.
- <sup>4</sup> University of South Florida, Tampa, Florida.
- <sup>5</sup> Ivoirian Center for Economic and Social Research, Abidjan, Côte d'Ivoire.
- <sup>6</sup> Ministry of Women's Affaires, Abidjan, Côte d'Ivoire.

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT**

Africa Regional Project (698-0421)  
Participating Agency Service Agreement (PASA) No. 0421 PHC 2233

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Public Health Service  
Centers for Disease Control  
and Prevention  
International Health Program Office  
Atlanta, Georgia 30333

## Abstract

**Objectives:** An ethnographic assessment of family planning in Côte d'Ivoire was conducted in 1991 to determine attitudes about the changing shape and role of the modern Ivoirian family, and the actual and desired role of the government, society, and family in maternal health and birth spacing.

**Methods:** Data were collected from four sources: 1) individual interviews, 2) focus group (FG) interviews, 3) key informant interviews, and 4) field observations. A purposive sampling strategy identified 20 policy makers interviewed individually; 126 health providers who were interviewed individually (38) or in 14 focus groups (88); and 158 potential consumers interviewed in 25 focus groups. Consumer FGs were structured by age and gender, and included single adults (11), married men and women (8), and male and female adolescents (6).

**Results:** All three groups of respondents (policy makers, health providers, and consumer groups) agreed on the following: 1) that they wished to preserve extended family solidarity in the modern urban setting; 2) that the desire to preserve extended family solidarity does not preclude interest in limiting births; and 3) that fertility decisions are often influenced by a woman's spouse and her extended family. Respondents disagreed about consumer responsibility for maternal health service costs. Although policy makers and health providers were supportive of consumer payment for services, consumers were not.

**Conclusions:** 1) There is support for family planning among all three groups of respondents; 2) the target for family planning services should include mates and extended family, as well as reproductive-aged women; and 3) the issue of consumer willingness to pay for family planning services needs further study.

## Purpose

This paper reports selected results of a study designed to collect information for use in the development of culturally appropriate population policy and family planning services in Côte d'Ivoire. The Policy Ethnography for Family Planning Study (PEFPS)\* was requested by the Côte d'Ivoire Ministry of Health and Social Protection (MHSP) and the Regional Economic Development Support Office of the United States Agency for International Development (REDSO/USAID) to complement quantitative studies conducted for planning purposes. Qualitative data reported here on the importance of the extended family among urban Ivoirians and the complex web of decision-making for maternal and child health and birth spacing are discussed in the context of family planning program development. It is hoped that this study will contribute to the understanding of the importance of the cultural context in addressing the full integration of family planning services in the health services of Côte d'Ivoire.

## Background

Family planning, a preventive health measure, addresses maternal and infant mortality—two major health problems in African countries.<sup>1,2</sup> If African women were to have only the number of children they wanted, it is estimated that the average number of births would be reduced by 17%.<sup>3</sup> It is also anticipated that the high rates of Ivoirian maternal mortality (estimated at 428/100,000 in 1987<sup>4</sup>) would be reduced through elimination of certain high risk births. Maternal deaths are most likely to occur when a woman 1) becomes pregnant at an early age, 2) has short intervals between pregnancies, 3) becomes pregnant in her later years (i.e., 40 years and older), or 4) has high parity.<sup>2</sup> Infant mortality is also a serious problem in Côte d'Ivoire; the estimated infant mortality rate is 93/1000.<sup>5</sup> Infant deaths are associated with short birth intervals, extremes of maternal age (very young or very old), and multiparity.<sup>6</sup> In developing countries, these factors are further exacerbated by the lack of access to trained health personnel to identify and treat the complications of pregnancy.<sup>7</sup>

Côte d'Ivoire has a birth rate of 50/1,000 and a fertility rate estimated at 7.4 live births per woman.<sup>5</sup> At its current annual population growth rate (3.6% in 1985),<sup>8</sup> the Ivoirian population will double (from 13.4 million to 26.8 million) in 20 years. Although Côte d'Ivoire is the world's largest exporter of cocoa and an important exporter of coffee, the 1986 collapse of coffee and cocoa prices plunged the Ivoirian economy into a recession from which it has yet to recover.<sup>9</sup>

Voluntary use of contraceptives is the recommended strategy to reduce fertility rates, curb population growth, and decrease maternal and young child deaths. Côte d'Ivoire has one of the lowest estimated rates of contraceptive use in Western Africa (3%), with only 1% of women surveyed reporting use of modern methods.<sup>10</sup> However, there have been indications that an unmet demand for family planning services in Côte d'Ivoire exists. For example, although only 8% of

---

\* Policy ethnography refers to ethnographic data collection techniques that are used for policy formation and evaluation. Policy ethnography, like traditional ethnography, uses basic anthropological techniques: participant observation, key-informant interviewing, and structured and semi-structured interviews.

the 5,000 women in Abidjan interviewed in a reproductive health study in 1984 reported ever using modern contraceptives, 40% of those interviewed said they were interested in using them.<sup>11</sup> In 1987-88, another study of 1,207 Ivoirian women ages 15-49 near Bouaflé (a medium-sized Ivoirian town) found that 58% wished to limit family size, 47% wanted to space births, and 48% said they were ready to use modern contraceptive methods.<sup>12</sup> And in December 1990, three private clinics that provide family planning services in Abidjan recorded a surge in the number of users.<sup>13</sup>

During the past three decades, the Government of Côte d'Ivoire (GOCI) has taken a pro-natalist stance, encouraging rapid population growth. The combination of a declining economy and a rapidly growing population constrain efforts to improve the health status of the Ivoirian people. This has led to increased attention to population issues and the need to rethink population policy.

Prior to 1986, family planning services were provided only in the offices of private practitioners and at *Association Ivoirienne Pour le Bien-Etre Familial* (AIBEF) clinics located on the premises of the three university teaching hospitals (CHU), at government-sponsored maternal and child health clinics (PMI), and at free-standing clinics. Health providers in the public sector referred clients to AIBEF, to private practitioners, or to a group of religious sisters (PROVIFA) who provided counseling on natural birth spacing.

Indicators of change in the government's position on population issues include the following: 1) a proposal made by the government's Human Resources Development Policy Committee that a national population policy be formulated and a family planning program implemented; 2) the creation in 1991 of a post for a National Family Planning Coordinator; 3) the reversal of the law forbidding pharmacies to sell condoms; 4) the convening of a National Seminar on Family Planning;<sup>14</sup> and 5) the government's support for development of a joint GOCI-USAID family planning program.<sup>15</sup>

As a part of this effort, the GOCI sought to understand better the cultural context of population issues.<sup>16,17</sup> This ethnographic study was commissioned in the early phases of policy and program development.

## Research Setting

Côte d'Ivoire has an estimated population of 12.5 million, including members of over 60 ethnic groups; the most populous groups are the Baoulé, Krou, and Senufo. The research was focused in Abidjan—the commercial center of the country. Abidjan has an estimated population of 2.7 million residents. Approximately one-fourth of Abidjan's residents are immigrants from neighboring countries (Burkina Faso, Ghana, Liberia, Guinea, and Mali). Family structures are varied: some are polygamous, others monogamous; some live in extended families, others in nuclear families; some groups trace their descent through matrilineal lines, others are patrilineal.\*\*

Abidjan is divided administratively into 10 communes. Most health services are delivered at the CHUs and at a network of 10 PMIs—one per commune.

---

\*\* The authors are not aware of data that quantify differences in family structure.

## Methods

Focus group and individual interviews were the primary sources of data. Focus group (FG) interviews were conducted because previous experience has shown that this method of data collection can yield reliable behavioral and qualitative data on family planning issues.<sup>18,19,20</sup> Individual interviews were used when FG discussions were not appropriate. Semi-structured interview guides were used to conduct the individual and FG interviews with three types of respondents: a) policy makers (including governmental and non-governmental officials) involved in developing the new population policy; b) health providers (including supervisors of health centers, physicians, nurses, nurse assistants, midwives, and social workers) in both public and private sector facilities; and c) potential consumers of family planning services (male and female adolescents and adults representing different age groups; Table 1).

Discussions with key informants and field observations of Abidjan residents in their everyday activities were recorded in field notes by the ethnographer and one of the research assistants. Information from these informal discussions supplemented the primary data sources.

### Site Selection

Sites were selected purposively to represent the diversity of the city and the places where one might find the major stakeholders in family planning program development. Policy makers from governmental and non-governmental agencies were interviewed at their offices located in three communes—Cocody, Adjamé, and Plateau.

Health provider interviews were conducted at health facilities where the staff had been exposed to some aspects of family planning services. Sites selected included the three AIBEF clinics in Abidjan where family planning services are provided, one private clinic that offers maternal and child health (MCH) services, two private organizations that disseminate family planning advice, and four PMIs and three CHUs where family planning services are extended on an “unofficial” basis. These facilities were located in 6 of Abidjan’s 10 communes: Adjamé, Abobo, Cocody, Koumassi, Treichville, and Yopougon.

Consumers were interviewed at PMIs, employment centers, youth centers, and outdoor restaurants.

### Respondent Selection

#### *Key informants*

Key informants from the potential consumer and policy maker groups were based on their credibility as informants, their availability and willingness to speak frankly with the ethnographer, and their understanding of some aspects of family planning policy or program development. Key informants assisted in the selection of policy makers and their opinions added further insight to the issues of family planning in Abidjan.

### *Policy makers*

Policy makers were selected from a list, generated by five key informants and the research team, of officials in governmental and non-governmental agencies who were involved in the development of population policy in Côte d'Ivoire. The five policy level key informants were each asked to select 20 individuals from the list who should be interviewed. The 20 most frequently selected individuals were interviewed.

### *Health Providers*

The selected health care providers were health center staff who were experienced in delivering maternal and child health or family planning services. At each selected health care provider site, the research team presented the chief of staff with a letter from the MHSP that explained their mission, discussed the purpose of the study, and scheduled a date for the group interviews. The team attempted to conduct individual interviews of at least two professional health workers delivering services to reproductive-aged women or their children. If the chief of staff provided services to reproductive-aged women (for example, a chief of obstetrics and gynecology or a chief of the pediatric unit), he or she was interviewed individually.

The chief of staff selected FG participants from staff members who were responsible for taking care of mothers who had recently given birth, or women who were of reproductive age. The FGs consisted of health providers with similar professional status: nurses were interviewed in groups with other nurses, physicians with other physicians, midwives with other midwives.

### *Consumers*

Consumer interviews were conducted among adolescents and among married and unmarried adults. FG discussions were the only form of consumer interview conducted. The director of services at the employment agencies, health clinics, and youth centers requested volunteers for the FGs. At the outdoor restaurants, the research assistants asked volunteers to participate in the FGs. The characteristics used to select participants in the FG discussions were age, marital status, and sex. Interviewed in same-sex groups were the following: 1) male and female adolescents between the ages of 16-19; 2) unmarried men and women 20-30 years of age; 3) unmarried men and women over the age of 30; and 4) married men and women.

## **Research Staff**

The core research team included an anthropologist (RPW), a physician from the National Family Planning Coordinator's Office (SD), a medical sociologist from the National Institute for Public Health (KK), and three research assistants (NB, CB, and YB). Two of the six core team members were expatriates (RPW, NB).

Additionally, six Ivoirian interviewers who had the equivalent of at least two years of university training were trained to conduct and record the interviews. Two staff members were present at individual interviews: one posed the questions and took brief notes while the other recorded responses and took more extensive notes. Three interviewers were used for the focus groups: one posed the questions while two recorded responses.

## Interview Instruments

A draft interview guide was prepared that covered the main themes of the study: 1) the changing shape and roles of the modern Ivoirian family; 2) the role of government, society, and the family in maternal health and birth spacing; 3) the old population policy and the challenges and strategies for developing and implementing a new one; and 4) the challenges and strategies for integrating family planning into child survival activities. These four themes were considered important by policy makers and program managers attending a USAID-sponsored child survival conference in Swaziland, which had not been fully addressed by previous family planning surveys, such as Demographic and Health Surveys, KAP (knowledge, attitude, and practice) surveys, or situation analysis studies.<sup>\*\*\*</sup> This paper provides the results of responses with respect to two of the four themes addressed in the PEFPS: 1) the changing shape and role of the modern Ivoirian family; and 2) the role of government, society, and the family in MCH/birth spacing. These two themes were the only ones for which data were collected from all three groups of respondents. Table 2 lists these two themes and the questions used to interview respondents.

A draft interview guide was prepared in English, then translated into French. This first draft included questions on each of the four themes. The French version of the draft interview guide was reviewed, back translated, and revised by the core research group. The instrument was then pretested on several policy makers, health providers, and potential consumers. Based on the pretests, the research group determined which themes and open-ended questions should be included during interviews for each respondent category and interview format.

The interview guide for policy makers contained 35 questions that covered the four main themes of the study. Two interview guides were developed for health providers. The individual interviews contained 36 questions; the FGs contained 13 questions. Twenty-two of the questions were the same for health providers and policy makers. The 13 questions in the health providers' group interview guide covered only three of the four main themes. Theme 3 (issues related to the old and new population policy) was not addressed because the pretest indicated that nonsupervisory health providers in the FGs were not aware of and did not understand the old population policy enough to adequately address questions about the new one. Consumer FGs were asked 18 questions related to two of the main themes and several questions about teenage pregnancies. Pretest results indicated that consumers did not have adequate information to adequately address these themes, especially concerning the new population policy or the advantages and disadvantages of integrating MCH with child spacing.

All interviews were conducted in French with two exceptions: one consumer focus group was conducted in Djoula (a local trade language), and one policy maker interview was conducted in English. Each interview took from 45 to 90 minutes. Most of the questions were open-ended, and participants were allowed multiple responses to open-ended questions. Interviews were conducted from June 17 to July 31, 1991.

---

<sup>\*\*\*</sup> Policy maker and health provider interviews also contained questions that elicited information about respondents' professional training, vocation, and thoughts about the type of consumer information that might be useful for policy and program planning.

## Data Analysis

Analyses of the interviews were conducted in three stages: 1) during the period of data collection in the field; 2) immediately after the field work (when the preliminary report was written); and 3) prior to preparing the final manuscript. During the first stage of the analysis, the teams of interviewers expanded their interview notes following the individual interviews and FG discussions, resulting in a more detailed version of the responses. Transcripts of the interviews were typed and entered into data files. At weekly meetings, the core research team reviewed the results and developed a consensus on the interpretation of the data.

During the second stage of the analysis, similarities and differences in respondents' statements were identified, by question and by type of respondent. Using GOfer, a software program for text management,<sup>21</sup> a data file was created for responses to each question, by respondent type. Interviewers coded the data by systematically interpreting and categorizing phrases and concepts that appeared in the transcripts. Frequency tables of the codes provided an indication of the relative importance of a certain idea or value and allowed comparisons by type of respondent.

At the third stage of the analysis, an independent recoding of the data was done by a research assistant at CDC who was unfamiliar with the study results. The first author then compared the codings conducted at the second and third stages of the analyses, and reviewed the coding categories and the relative frequency of each category. Final synthesis of the data results was based on information from all three stages of the analysis.

## Results

### Respondent Characteristics

#### *Key Informants*

Key informants included two staff members from the MHSP, three USAID senior staff knowledgeable in maternal and child health/child survival programs and ongoing family planning policy activities, and two Ivoirian educators (one male social science professor at the university and one female instructor at a vocational training school). Also interviewed were two Ivoirian women who were street food vendors (one in her 20s, the other over 50), and one female seamstress in her early 30s.

#### *Policy Makers*

The 20 policy makers included 16 Ivoirians and 4 expatriates who were senior administrative staff at the MHSP, USAID, AIBEF, UNICEF, the United Nations Fund for Population Activities, and several other non-governmental organizations. Thirteen were men, seven were women.

### *Health Providers*

Thirty-eight individual interviews were conducted with health providers: 10 with men and 28 with women. Thirty respondents (79%) were married, and all but one had at least one child. Among the female respondents, the average number of children per woman was 3.4, with a range of 1-9. Among the nine male respondents who said that they had children, the mean number of offspring was 4.4, with a range of 1-9. Twenty respondents were midwives, 13 were physicians, 3 were nurses, 1 was a nurse's aide, and 1 was a social worker.

The 14 health care provider FGs included 88 persons. The average group size was 6, with a range of 4-8. Seven groups were composed of midwives, 3 of physicians, 2 of nurses, 1 of nurses' aides, and 1 of health agents from PROVIFA. Interviewers recorded sex, age, and number of children for respondents in 10 of the 14 FGs. The mean age of the 62 participants for whom age was recorded was 38 (range 26-54).

Most of the respondents in the individual (27/38) and FG interviews (13/14) were from the public sector.

### *Consumers*

Twenty-five FG interviews were completed with 158 potential consumers. The average size of the groups was 7, with a range of 5 to 10 participants per group. Table 1 shows the composition of the consumer FGs.

## **Theme 1. The Changing Role and Shape of the Modern Ivoirian Family**

### *Question 1. What is your perception of Ivoirian family life?*

Table 3 provides examples of responses to the questions on the modern Ivoirian family, by respondent type. These and other responses suggest that urban Ivoirians associate a positive value to being a member of a family consisting of many members. The family was generally described as *la famille élargie* (the extended family), which included one's spouse, children, parents, siblings, other relatives, and ancestors. Although the extended family was recognized by most as the major family structure, respondents also indicated that family size was becoming smaller. Statements regarding the smaller, nuclear family were made more frequently by policy makers and health providers than by consumers.

When asked about their own families, health providers in individual interviews recognized the nuclear unit as the core family unit in urban Abidjan. When mentioned, the nuclear unit was described by respondents as comprising a man, a woman, and all their children, the latter including either the couple's biological offspring and/or any younger kin for whom they assume responsibility.

All three categories of respondents volunteered statements about the problems associated with modern life. Among health providers and consumers, discussions of family life often centered

around the financial difficulties associated with providing housing and food for all family members in Abidjan where the cost of living is high and housing is scarce. Among consumers, the discussion topics in the FGs quickly moved from the structure of the family to the problems associated with modern life, and discussions about economic difficulties were often linked with concern about the need to limit the number of births [Table 3, Interview #205].

*Question 2. What aspects of the family life should be preserved for future generations?*

A range of the responses to the questions on the aspects of family life that should be preserved are indicated in Table 4. Participants in all three respondent categories used the term “solidarity” to express the strong bonds that link the individual to their lineage through the duties, obligations, rites, and privileges that are a part of that group. When asked to explain the meaning of “solidarity”, respondents used words and phrases such as “understanding”, “tolerance”, “fellowship in the large family”, “cohesion”, “hospitality”, and “a sense of community within the family life”. This sense of solidarity, or corporateness, was one of the values that Ivoirians in this study said they wanted to maintain as the family structure changes. Statements from respondents suggested that they saw no conflict between family solidarity and limiting fertility levels.

Among policy makers, health providers, and consumers, there was an expressed desire to retain the importance of family life, marriage (traditional and legal marriages were mentioned), education for the children (including both formal schooling and proper upbringing), and limiting births to the number of children one can afford.

The need to preserve marriage was a concern of men and women in all respondent categories. Observations at the Office of the Magistrate where marriages are performed suggest some insight into why this might be a concern. In each district, the magistrate performs marriages on a specific day of the week. During that day, a couple and their relatives assemble for a brief ceremony of approximately 20 minutes. On the day that marriage procedures were observed, all of the newlyweds were in their mid-to-late 30s and some of the men were older. When the anthropologist asked a key informant and the research team members why this was the case, she was informed that “young people cannot afford to be married”. A man must first have “a position” before he enters a civil marriage, and that takes a long time for many men in Abidjan. A couple might live together until the man finds a stable position. In another discussion, a male informant further explained why respondents were concerned about the institution of marriage. He said that “In the context of a dwindling economy, there is stiff competition among women for employed men”. The informant also explained that “Ivoirian men consider their home where their children are. And before a couple is formally married, whether by traditional or legal marriage, it is to a woman’s advantage to have many children. A man is less likely to leave a woman with whom he has children”.

*Question 3. What aspects of family life could be improved?*

Statements from all respondent categories mentioned that the education of children and adults and the need to increase the amount and quality of the communication between family members

were aspects of family life that could be improved. Some respondents also reported the need to limit births.

Sixteen policy makers referred to the education of adults or children as a way of improving family life. Most policy makers saw the state and the ministries as the primary force responsible for improving family life, although the family was mentioned in 5 responses and private associations were mentioned in 4. Comparatively, statements from health providers indicated that parents **and** the government were responsible for improving aspects of family life in Côte d'Ivoire. Health providers also mentioned that responsibility for improving family life should be shared by the family, the health providers, society, the elite, the religious chiefs, and the youth. Consumers specifically mentioned the role of staff at the PMIs (to educate and better care for women, and to inform the population about family planning) and of fathers (to be responsible for their children, honor legal marriage, and eliminate the practice of polygamy).

### **Theme 2. The Role of the Government, Society, and Family in Maternal Health and Birth Spacing**

#### *Question 1. What is the role of the government in promoting maternal health?*

Policy makers stated that the government's role in maternal health and family planning programs was to do the following: 1) to provide the infrastructure, equipment, and staff necessary to deliver basic health care services to the population; 2) to conduct research on the needs of the population; 3) to train the health providers; and 4) to determine and develop clear policies.

Health providers in public and private health centers identified the following five areas as the government's responsibility in maternal and child health: 1) to provide material and financial resources; 2) to train health personnel; 3) to sensitize and educate the population; 4) to create the substructures for delivering services; and 5) to establish standards of care and provide guidelines for service delivery.

Consumers said that they wanted the government to make all services and medications accessible by reducing or eliminating the cost of medication, and stocking the health centers with medications. FG participants often expressed hostility and anxiety when discussing the possibility of additional fees for contraceptive services. Particular sensitivity was expressed regarding increased cost of services without prior notification of the public. The need for the government to inform the population about changes in fee structure and service delivery was also mentioned.

#### *Question 2. What is the role of health providers in protecting maternal and child health?*

Although respondents in each category indicated that health providers were responsible for delivering services, health providers themselves perceived their role to also include informing, advising, and educating consumers. Responses of health providers in individual and FG interviews were similar, regardless of their affiliation with a public or private health facility or type of facility. In the two independent codings of the health provider data, the order of the

frequency of the coded responses was constant: highest ranked (as indicated by the greatest frequency of individual and FG interviews in which mentioned) was the role of informing, advising, and educating the public; preventive and curative responsibilities were second.

Comparatively, FG discussions among consumers indicated that they were primarily concerned with the conduct of the staff during the provider-client interaction. Thirteen of 45 statements by consumers in FGs responding to this question referred to the staff's need to receive and treat patients kindly. Spirited discussion of this topic occurred in every age group and type of consumer FG. Eight groups referred to the need for health providers to act in a professional manner when treating patients.

*Question 3. What is the role of the people in protecting maternal and child health?*

There was no particular trend to the statements provided by policy makers about responsibility for family maternal and child health. Policy makers said that the public's responsibility included paying for care, using the health services, educating oneself in order to be motivated, adhering to government guidelines, and being responsible for good health. In contrast, health providers' statements on the subject of the people's responsibility could be categorized into two subthemes: 1) understanding and practicing advice given by health providers, and 2) contributing to the cost of health services. Among consumers, respondents said that the people's role included assisting the family financially, sensitizing the population, observing proper hygiene, and helping the government to construct or equip the health facilities where family planning services could be delivered. Adolescent groups provided half of the statements that suggested providing financial assistance to families.

*Question 4. Who do you think has the responsibility for birth spacing?*

Respondents in all three categories viewed "the couple" as the unit responsible for spacing or limiting births. The prominence of this response remained, whether respondents were interviewed individually or in a group discussion. When asked about the meaning of "the couple", the respondents and the Ivoirian interviewers agreed that the term included the man and woman involved in a sexual union, as well as their kin who have some influence over the number of children a couple should have. Responses such as "the individual", "a man", or "a woman" were the least frequently cited by all respondent types.

In individual interviews of health providers, the second most frequently cited response referred to "the government" or "the health providers" (staff who deliver services) as having responsibility for birth spacing. In the 15 health provider FGs, statements from about half indicated that "the couple" had this responsibility, and one third placed the responsibility on the government.

The dominant response from the consumers interviewed was also "the couple", and statements from several consumer FG participants suggested that this dominant response may be the norm, but that the modern urban family structure is in a state of flux. Traditional and modern norms may govern sexual and marital relationships. For example, one consumer FG participant said, "It

is better if the two can reach an agreement; if not, it is the woman who has to take charge". A few statements from consumers indicated that the individual woman or man may have some influence in determining family size. For example, this statement from another consumer FG suggested the role that men may have in birth spacing: "Men need to be aware of the health risks [of pregnancy] for women and the alternatives, because men have a lot of influence". In this and other statements, respondents acknowledged male pressure on women to conceive and have children. Other statements from informants supported the belief that the more children a woman has with her mate, the more likely their union will be consummated by either traditional or civil marriage.

## **Field Observations**

During the course of the field work, the research team visited many sites frequented by Abidjan residents: health centers, hospitals, churches, homes, market places, grocery stores, night clubs, beauty shops, employment sites, government social services offices, university campus, and rural villages where some urban respondents go on weekends to spend time with their relatives. The integration of various aspects of different cultures was evident in the varied hairstyles and fashions, as well as in the diverse types and cost of durable goods sold in the central market in Treichville. Appreciation of formal education for children was voiced by participants throughout the study. The extent to which many modern concepts and practices, including health-related practices, have diffused into modern, urban Abidjan culture is impressive, and stands in stark contrast to the reported low usage rate of modern contraceptives.

It appeared that urban residents were avid consumers of modern health services at all of the health facilities that we visited: waiting rooms at the AIBEF clinics, PMIs, and CHUs were usually filled or overflowing with patients seeking care; and the pharmacists and drug sellers in the market places had a steady stream of customers. The influence of modern medicine was apparent from the type of medicines displayed in stores and sold in small markets and vendor stands all over the city and throughout the suburbs.

## **Discussion**

This paper summarizes similarities and differences among PEFPS respondents on two research themes: perceptions of the family, and the role of various social segments in providing maternal health services and child spacing. Individual and group interviews, field observations, and key informant interviews were used to identify and describe cultural factors that could assist in the development of a culturally appropriate population policy in Côte d'Ivoire. These data should be considered reliable for several reasons. First, each interview guide was translated into French, back translated, and pretested with subjects similar to our respondent population. Second, the focus groups represented a cross-section of the health provider and consumer populations. Third, the data from the health provider focus groups were consonant with and complemented those from individual interviews. Fourth, four of six members of the core research team were Ivoirian researchers who were involved during all stages of data interpretation and analysis and who were familiar with the local languages and cultural practices.

The data from the two study themes reported here and those reported in a larger report<sup>22</sup> have implications for both policy and program development.

### Implications of Theme 1: The Modern Ivoirian Family

1. *The large extended family is the valued form of family structure in modern Abidjan; respondents recognized the need to limit births.*

African societies are stereotypically categorized as preferring large number of children.<sup>23</sup> This might suggest that Africans have little interest in birth spacing or in limiting the number of births. However, a concern for the timing of births has traditionally been an important concern of African societies,<sup>24,25</sup> and has been suggested as the rationale for several fertility-inhibiting cultural practices, such as prolonged breastfeeding practices and postpartum abstinence for new mothers.<sup>26</sup>

Responses from the Abidjan PEFPS suggest that Ivoirians are also interested in limiting family size. PEFPS statements are supported by data from a 1990 study of new contraceptive acceptors at AIBEF clinics (a surge in the number of new users of modern contraceptives was observed)<sup>13</sup> and the Bouaflé studies indicating that 48% of reproductive-aged female respondents were interested in using modern contraceptive methods.<sup>12</sup>

Ivoirians' interest in limiting family size seems unfettered by their appreciation for strong, extended family linkages.<sup>14,27</sup> Solidarity reinforces social and biological ties, and it seems that an individual in an extended family may enjoy the benefits of being related to many people without giving birth to a lot of children. Statements from the PEFPS suggest that when there are too many relatives and too few resources to share, the concept of solidarity can be weakened, as can extended family links.

2. *There is a need to broaden the target for family planning services. If the target of family planning is not broadened, cultural practices m. present obstacles to individual fertility regulation.*

Perhaps in Abidjan and elsewhere in Africa, initial slow response to the acceptance of modern contraceptives may have been influenced by a culturally inappropriate marketing approach that focused on individual, fecund women rather than on a more relevant network of persons who can influence long term use of contraception. For example, early works by Fortes<sup>28,29</sup> documented the corporateness of societies that are organized in matrilineal or patrilineal descent groups. In either case, men wield considerable power in African family decision making because ancestry and inheritance rights are reckoned through maternal or paternal male relatives. Men (in their roles as spouses) were found to have a decisive role in a woman's decision to seek and use family planning services in the Abidjan PEFPS, in Zimbabwe,<sup>30</sup> and in Tanzania.<sup>24</sup> Recently, data from a study of women using family planning services in Abidjan indicated that the objection to a pregnancy by a mate was the most frequently cited reason for having an abortion (35%).<sup>31</sup> Taken together, these data suggest that program planners should target both men and women for family planning services.

In Côte d'Ivoire, kinsmen can exercise influence over a couple's family size. A woman's contraceptive practices may limit her births, but this might not result in a smaller family size. Child adoption, a cultural practice in Côte d'Ivoire and in other African countries, is supported by the corporateness of African extended families, as well as the concept of "solidarity," as discussed by one PEFPS respondent. Omari notes that child adoption is another way that African family structure can influence a woman's fertility decision.<sup>24</sup> An Ivoirian woman may volunteer to adopt a relative's child into her own household, or the decision may be thrust upon her by her spouse or by other relatives.<sup>32</sup> A woman may decide that it is to her advantage to have many of her own offspring rather than be perceived by relatives as having too few children. Therefore, family planning program planners should also target a broader range of family members. Family planning messages in the media might identify birth spacing and birth limitation as a concern of all family members (youth, young adults, and the elderly) and the MOH should consider marketing family planning to members of the entire extended family in Côte d'Ivoire.

*3. Instability in the economy seems to be influencing family structure, as well as marital and childbearing strategies.*

Although Abidjan residents expressed appreciation for the concept of solidarity, policy makers and health providers felt it burdensome when only a few family members can be employed and earn money for the family. The statements of respondents in the PEFPS suggest that Abidjan residents recognize the constraints that the economy is having on family structure and seek solutions at the individual and social level. Consumers wanted fathers to exercise more responsibility for their children, and policy makers and health workers wanted families to limit their births to the number each couple can support. Respondents stated that marriage is an institution that Abidjan residents would like to preserve, but economic forces seem to influence this institution too.

In Abidjan, marriage is the formal legitimization of a union that often existed previously, and respondents associate marriage with an increase in prestige in the community. Through marriage, a man publicly assumes the role of "provider" of the family and thus announces that he has obtained economic stability during a period when attaining this goal has become increasingly difficult. On the other hand, a woman who may have already given birth to several of her mate's children solidifies her children's inheritance and formalizes their kinship links through marriage. Respondent statements regarding the pressure on women to have children before marrying their mates (who may be financially unstable early in the relationship) are echoed by Bledsoe.<sup>33</sup> She states that "a woman can press her economic demands on a particular man, whether or not they [the couple] call their relationship a marriage, with far greater leverage if she has a child by him". In this cultural context, it is advantageous for a woman, especially if she is uneducated or from a family of lower socioeconomic status, to have numerous children with her partner without considering the importance of limiting or spacing births. According to Bledsoe, children can legitimize a woman's claim to her partner's resources and increase the probability that their relationship will be consummated by legal or traditional marriage. A sound population policy should focus on issues of employment, education, and providing men and women with job skills, as well as those of limiting births.

### Implications of Theme 2: Role of the Government, Society, and Family in Maternal and Child Health and Birth Spacing

1. *The government, health providers, society, and extended family members are perceived to have shared responsibilities for maternal and child health and birth spacing.*

In many Western societies, it is assumed that the individual (usually the woman in the case of family planning services) is responsible for health care decision-making.<sup>34</sup> Statements from the PEFPS respondents suggest that residents in Abidjan may perceive the responsibilities for maternal and child health and child spacing to be distributed to a larger social unit, not just the individual. As such, it might be acceptable for the government to develop plans for population control that indicate the individual's role within the context of family health, community health, and the health of the nation.

PEFPS findings regarding the influence of the couple and other family members in reproductive decision-making suggest that plans for the dissemination of contraceptive information and services should target fecund women, their mates, and other interested relatives. Support for this strategy is found in the population literature. According to Freeman (1987), "Small primary groups of relatives, friends, and neighbors are universally the people through whom most traditional and new behavior patterns are learned and validated".<sup>35</sup> For program managers using this approach, the structure of Ivoirian families can be viewed as an enabling factor rather than an inhibiting one. For example, family planning products could be marketed as commodities that can improve the quality of life for the extended family, a concept that supports the continuity of family solidarity and requires full support by all family members. If practiced by most adults (males and females), family planning may increase the number of employed adults in a family who can financially support extended family members who do not have jobs.

2. *Consumers' concerns about the costs of family planning services and access to contraceptive information have programmatic and policy implications.*

Differences in points of view expressed by health providers and consumers regarding the financing of family planning services by respondent categories have an historical framework. Prior to this study, consumers in Abidjan had enjoyed the benefits of 30 years of free service at the clinics and hospital. Although the current trend in economic development may encourage a fee-for-service system as a cost recovery effort,<sup>36</sup> consumers in Abidjan should be informed that the bulk of the cost is subsidized by the government and the fees consumers pay are nominal.

Adolescents in Abidjan and elsewhere in Africa<sup>37,38</sup> have expressed interest in contraceptive services. Adolescent respondents in the PEFPS were particularly concerned about the costs of family planning services. In the past, the youth were betrothed or married during their adolescent years, and the traditional social institutions, such as initiation schools, prepared them for their responsibilities in marriage and sexual relations. Westernization has brought the acceptance of extended adolescence during which teenagers pursue highly valued formal education with the hopes of obtaining a post in the civil service or in the private sector. At the same time, these

traditional institutions for training youth are collapsing and have not been selected as the guardians of new contraceptive technology.<sup>24</sup> For adolescent girls, an unplanned pregnancy usually means the termination of education,<sup>39,40</sup> or leads to an abortion. In Côte d'Ivoire, abortions are illegal, although PEFPS key informants and Huntington's work<sup>31</sup> discussed the availability and routine use of abortion as a method of family planning in Abidjan. In this regard, Abidjan adolescents may be similar to other African youth. Barker and Rich reported that Nigerian and Kenyan youth have more access to information about induced abortion than about family planning.<sup>38</sup> However, a population policy that makes family planning services available and affordable for adolescents can shield them from unwanted pregnancies and the need to seek septic illicit abortions.

3. *It is instructive that interpersonal skills in the area of patient-provider relations were ranked differently by health providers and consumers—a final issue with programmatic implications.*

The family planning literature has suggested that patient education and interpersonal communication skills are often overlooked but can influence new contraceptive acceptor and contraceptive continuation rates.<sup>41</sup> A Nigerian study of physician attitudes and practices provides a good example. Although physicians in the study reported having smaller family size than most Nigerians and were more likely to be practicing family planning, 40% believed family planning was foreign to their culture and that it promoted promiscuity.<sup>42</sup> Attitudes such as these could have an important effect on service delivery. It is recommended that health worker training should emphasize the two key components of quality service delivery: technical competence and interpersonal skills.

Caldwell and Caldwell have suggested that unilineal (matrilineal or patrilineal) descent systems and African religious beliefs have encouraged high fertility rates, and discouraged the use of modern contraception throughout sub-Saharan Africa.<sup>43</sup> Perhaps one reason for the slow adoption of modern contraceptive technology in Abidjan and throughout Côte d'Ivoire is the absence of cultural approaches that address the complex of deep-rooted values on which Ivoirian society is based. The delayed diffusion of contraceptive technology (relative to the diffusion of other technological advancements) is also undoubtedly influenced by government policy related to the accessibility of contraceptives and family planning information. Statements from the two themes discussed above suggest that traditional values about gender roles and the structure and role of the family may have a strong influence over an individual woman's decision to seek out and use modern contraceptives.

## Conclusions

Implications of the PEFPS data for Ivoirian population program and policy development include the following: 1) there is support for family planning among policy makers, health providers, and consumers; 2) family planning should be promoted as a means of increasing Ivoirian family solidarity; 3) the target for family planning services should include fecund women and their mates, influential members of their extended family, as well as youth; 4) health provider training

in family planning services should emphasize interpersonal as well as technical skills; and 5) the degree to which the consumers will financially support a fee-based family planning service is uncertain and needs further assessment.

Côte d'Ivoire is responding to a growing demand for family planning services. The MOH has developed a draft plan for population policy that includes norms and standards of care for public and private family planning services.<sup>44</sup> The results of the PEFPS can help to ensure that these services will be delivered in a way that is acceptable to the health providers who will deliver services, and to consumers. The need to obtain and use data that reflect the desires of the consumers when modifying policy and developing program strategies is apparent from this study. The challenge lies in the successful integration of these findings into policy and program.



## Acknowledgements

Funding for this study was provided by the United States Agency for International Development (USAID) Africa Child Survival Initiative-Combating Childhood Communicable Diseases Project (ASCI-CCCD) and the Ministry of Health and Social Protection in Côte d'Ivoire. The authors thank Mrs. Lynn Mohammed of REDSO/USAID, Mrs. Sylvia Acquah of the CCCD Project in Abidjan; Mr. James Herrington, the CCCD Technical Officer; and Dr. Modupe Broderick, the CCCD Project Officer, Côte d'Ivoire, and Dr. Charles DeBose (REDSO). For technical and editorial reviews we are indebted to Maureen Birmingham, Stanley Foster, Emmanuel Joseph, Cathy Melvin, Melinda Moore, George Stroh, Virginia Sturwold, and Andrew Vernon (Centers for Disease Control and Prevention), Chris Elias (the Population Council), Judith Timyan (Population Services International), and other peer reviewers.

## References and Notes

1. Fathalla MF. The challenge of safe motherhood. In: Wallace HM, Giri K, editors. *Health Care of Women and Children in Developing Countries*. Oakland, CA: Third Party Publishing Co., 1990; 219-228.
2. Singh K, Ratnam SS. Family planning: Clinical aspects. In: Wallace HM, Giri K, editors. *Health Care of Women and Children in Developing Countries*. Oakland, CA: Third Party Publishing Co., 1990; 204-218.
3. Maine D, et al. Prevention of maternal deaths in developing countries; program options and practical considerations. World Bank paper prepared for the International Safe Motherhood Conference, Nairobi, February 10-13, 1987. Cited in World Health Organization. *Maternal Mortality: A Global Factbook*. Geneva: WHO, 1991; p.14.
4. Conroy C, Pope C, Pierre-Louis R. Côte d'Ivoire Trip Report, July 30-August 9, 1990. Arlington, Virginia: MotherCare, John Snow, Inc., 1990.
5. UNICEF. *State of the World's Children 1993*. Oxford University Press, 1993.
6. Centers for Disease Control. *Family Planning Methods and Practice: Africa*. Center for Chronic Disease Prevention and Health Promotion and Division of Reproductive Health. Atlanta, GA: HHS,PHS,CDC, 1983.
7. World Health Organization. *Maternal Mortality: A Global Factbook*. Geneva: WHO, 1991.
8. RAPID. Côte d'Ivoire: Population et développement. *Resources pour l'Analyse de la Population et de son Impact sur le Développement*. Mars 1988.
9. U.S. State Department. Bureau of Public Affairs. *Background Notes. Côte d'Ivoire*. Department of State Publication 8119. Background Notes Series. Washington, D.C.: U.S. Government Printing Office, 1990.
10. Population Reference Bureau. *1991 World Population Data Sheet*. Washington, DC: Population Reference Bureau Inc., 1991.
11. USAID Côte d'Ivoire. *Project Identification Document (PID) for the family planning and health project in Côte d'Ivoire*, April 1991.
12. Tafforeau J, Timyan J. *Analyse. Enquete quantitative*. Bouafle, Janvier 1987. Also see: Tafforeau J. *Promotion of community participation in a primary health care program in a rural area*. Bouafle, Cote d'Ivoire. Report Baseline Survey. Center for Population and Family Health, Columbia University.

## References and Notes

13. Huntington D. Trip Report - Côte d'Ivoire, Population Council, 1991, (Unpublished).
14. Côte d'Ivoire Ministry of Health. Seminaire national sur la planification familiale en Côte d'Ivoire tenu du 1 Au 6 Avril 1991 à Grand-Bassam, 1991.
15. USAID. Proposal for integrating MCH/FP activities into the CCCD Project in Cote d'Ivoire. REDSO/WCA/GDO/HPN Division. October 1990. Also see: Project identification document (PID) for the family planning and health project in Cote d'Ivoire, April 1991.
16. Knodel J, van de Walle E. 1979. Lessons from the past: Policy implications of historical fertility studies. *Population Development Review*, 1978; 5(2): 217-246.
17. Ford TR, Arcury TA. Population and health in the developing world: Research perspectives for medical anthropologists. *Social Science and Medicine*, 1984; 18(10): 855-859.
18. Schearer SB. The value of focus group research for social action programs. *Studies in Family Planning*, 1981; 12(12): 407-408.
19. Haryono S, Nancy Piet N, Stirling F, Ross J. Family planning attitudes in urban Indonesia: Findings from focus group research. *Studies in Family Planning*, 1981; 12(12): 433-441.
20. Stycos JM. A critique of focus group and survey research: The machismo case. *Studies in Family Planning*, 1981; 12(12): 450-456.
21. Microlytics. Gofer 2.0, MS-DOS Version, 1989.
22. Wilson RP. Technical Report. Policy Ethnography for Family Planning, Cote d'Ivoire, 1991. Centers for Disease Control, International Health Program Office, 1991.
23. Frank O. The demand for fertility control in sub-Saharan Africa. *Studies in Family Planning*, 1987; 18(4): 181-201.
24. Omari CK. Socio-cultural factors in modern family planning methods in Tanzania. Lewiston, New York: The Edwin Mellen Press; 1989.
25. Mabogunje AL. The policy implications of changes in child-spacing practices in tropical Africa. In: Page HJ, Lesthaeghe R, editors. *Child Spacing in Tropical Africa: Traditions and Change*. London: Academic Press, 1981; 303-315.

26. Schoenmaeckers R, Shah IH, Lesthaeghe R, Tambashe O. The child spacing tradition and the postpartum taboo in tropical Africa: anthropological evidence. In: Page HJ, Lesthaeghe R, editors. *Child Spacing in Tropical Africa: Traditions and Change*. London: Academic Press, 1981; 25-71.
27. Timyan J. Report: Focus group discussions. Community Primary Health Care Project, Bouafle, Côte d'Ivoire. Columbia University, Center for Population and Family Health. Abidjan, Côte d'Ivoire; June 1987.
28. Fortes M. The Structure of Unilineal Descent Groups. *American Anthropologist*, 1953; 55:17-41.
29. Fortes M. *The Web of Kinship among the Tallensi*. London: Oxford University Press; 1949.
30. Mbizvo MT, Donald JA. Family planning knowledge, attitudes, and practices of men in Zimbabwe. *Studies in Family Planning*, 1991; 22(1): 31-38.
31. Huntington D, Mensch B, Toubia N. A new approach to eliciting information about induced abortion. *Studies in Family Planning*, 1993; 24(2): 120-124.
32. Etienne M. The case for social maternity: Adoption of children by urban Baule women. *Dialectical Anthropology*, 1979; 4:237-242.
33. Bledsoe C. Transformations in sub-Saharan African marriage and fertility. *The Annals of the American Academy of Political and Social Science*, 1990; 510: 115-125.
34. Caldwell, John C. Health transition: The cultural, social and behavioral determinants of health in the Third World. *Social Science and Medicine*, 1993; 36(2): 125-135.
35. Freeman R. The contribution of social science research to population policy and family planning program effectiveness. *Studies in Family Planning*, 1987; 18(2): 57-82.
36. World Bank. *Financing Health Care Services in Developing Countries*. Washington, D.C.: The World Bank; 1987.
37. Adetoro OO, Babarinsa AB, Sotiloye S. Socio-cultural factors in adolescent septic illicit abortions in Ilorin, Nigeria. *African Journal of Medicine and Medical Sciences*, 1991; 20:141-153.
38. Barker GK, Rich S. Influences on adolescent sexuality in Nigeria and Kenya: Findings from recent focus-group discussions. *Studies in Family Planning*, 1992; 23(3):199-210.

## References and Notes

39. Boohene E, Tsodzai J, Hardee-Cleaveland K, Weir S, Janowitz B. Fertility and contraceptive use among young adults in Harare, Zimbabwe. *Studies in Family Planning*, 1991; 22(4): 264-271.
40. Nichols D, Ladipo OA, Paxman JM, Otolorin EO. Sexual behavior, contraceptive practice, and reproductive health among Nigerian adolescents. *Studies in Family Planning*, 1986; 17(2): 100-106.
41. Bruce J. Users' perspectives on contraceptive technology and delivery systems: Highlighting some feminist issues. *Technology in Society*, 1987; 9: 359-383.
42. Covington DL, Otolorin EO, Janowitz B, Gates DS, Lamptey P, Ladipo OA. Physician attitudes and family planning in Nigeria. *Studies in Family Planning*, 1986; 17(4): 172-180.
43. Caldwell JC, Caldwell P. High fertility in sub-Saharan Africa. *Scientific American*, 1990; 262(5): 118-125.
44. Shaw E. Recherche ethnographique pour le développement d'une politique de planning familiale. Conference Presentation. The ACSI-CCCD Africa's Progress in Child Survival. Dakar, Senegal, 29 March- 2 April, 1993.

**Table 1. Types and Number of Interviews Conducted.\* Policy Ethnography for Family Planning Study, Côte d'Ivoire 1991.**

Type of Respondent	Number of interviews completed	
	Individual	Focus Groups
<b>1. Policy Makers</b>		
Government	10	-
Non-government	10	-
<b>SubTotal</b>	<b>20</b>	
<b>2. Health Providers</b>		
Physicians	13	3 (n=19)
Midwives	20	7 (n=45)
Nurses	3	2 (n=11)
Others	2	2 (n=13)
<b>Sub Total</b>	<b>38</b>	<b>14 (n=88)</b>
<b>3. Consumers</b>		
Single Adolescents 16-19		
Females	-	3 (n=22)
Males	-	3 (n=20)
Single Adults > 20		
Men < 30	-	3 (n=15)
Men >30	-	3 (n=20)
Women < 30	-	3 (n=20)
Women >30	-	3 (n=12)
Married Adults		
Men	-	4 (n=25)
Women	-	4 (n=24)
<b>Sub Total</b>		<b>25 (n=158)</b>
<b>Total</b>	<b>58</b>	<b>39 (n=246)</b>

(n) = number of total participants in focus groups

\* Informal discussions with 10 key informants were also conducted, but are not reflected in the Table.

**Table 2. The Two Themes (and subthemes) Addressed in this Report. Policy Ethnography for Family Planning Study, Côte d'Ivoire, 1991.**

<p><b>Theme 1. The modern Ivoirian family</b></p> <p><i>1) What is your perception of Ivoirian family life?</i></p> <p><i>2) What aspects of the family life should be preserved for future generations?</i></p> <p><i>3) What aspects of family life could be improved?</i></p>
<p><b>Theme 2. The role of the government, society, and family in maternal and child health and birth spacing</b></p> <p><i>1) What is the role of the government in promoting maternal health?</i></p> <p><i>2) What is the role of health providers in protecting maternal and child health?</i></p> <p><i>3) What is the role of the people in protecting maternal and child health?</i></p> <p><i>4) Who do you think has the responsibility for birth spacing?</i></p>

**Table 3. Examples of Respondents' Statements About Their Perceptions of the Ivoirian Family. Policy Ethnography for Family Planning Study, Côte d'Ivoire, 1991.**

Policy Makers

- Interview #20 "The family is the basis of society, so a society is constructed on the basis of the family. It is the value that should traditionally be recognized. It is a sacred value, so it should not be ignored."
- Interview #12 "With the ethnic diversity in Côte d'Ivoire, the definition of a family differs from one ethnic group to another. There are those who follow the patriarchal system and those who follow the matriarchal system (Akan and Senufo). Attachment to the family is very extensive and the bonds are very strong between the family members. The children are important according to the groups concerned. The value of the family cannot be considered in a general sense. If a FP [family planning] program is constructed, it must not be a standardized program in every country, but must be looked at according to the regions."

Health Providers

- FG 177 "The Ivoirian family is the African family. It is a very broad family. Almost everyone is a part of it (cousins, nephews, even the aunts). We are Africans and we should remain so. It is the lack of financial means; otherwise we should have many children, because children are very important. There is also polygamy, which has tended to decrease."
- Interview #107 "The family in Côte d'Ivoire is the same as in [the rest of Africa]. It extends to the cousins and nephews, who are added to the family nucleus formed by the father, the mother, and the children."
- Interview #112 "The Ivoirian families are very big. The people are unhappy. They live under bad conditions. When only one person works in the family, he/she has the responsibility for the whole family and even for the [other] relatives in the village. I myself take care of my relatives in the village. I have many charges. Almost all of my salary goes to my relatives. With each death, for example, grandiose funeral ceremonies are organized."

Consumers

- Male FG #223 "In Côte d'Ivoire, like everywhere in Africa, we have flexible families, from the ancestors to the last descendent. Family life in Africa is not unclear. We have very extended families."
- Teens FG #220 "In the Ivoirian family, the fathers are often absent. The children live with the mothers. In the European family, both parents live together. In the mixed family, it depends. In the village, the people live together, and the older relatives also live with the family."
- FG #205 "Life is difficult right now. Before, we had as many children as we wished. One could have ten children. There were no problems because one cultivated [farmed] to nourish them. Now, it is otherwise. Life is expensive. It is necessary to have only a few children in order to be able to care for them."

**Table 4. Examples of Respondents' Statements About the Meaning of Family Solidarity. Policy Ethnography for Family Planning Study, Côte d'Ivoire, 1991.**

Policy Makers

- Interview #5 "Solidarity must be preserved, but with subtle differences. The child belongs to the greater family, which cares for him even if the mother and father are not there. In the other countries where the limited family is well settled, if the mother has many problems and the father has as well, the child is left to himself, which causes stress and delinquency."
- Interview #15 "Community life, the ideal family, and the father, mother, three children, and grandmother—if she is still alive, she comes to visit from time to time."
- Interview #6 "The characteristic of social life here is the spirit of sharing with the family. This has ramifications on money. People with money are called upon to share resources and they support a great number of people. Those who care, have difficulty saving. They can't invest for the future. This is not a value judgement, but this is what I have observed."
- Interview #8 "Family solidarity, but adapt it so that each one takes his destiny by the hand without counting on someone with more means."

Health Providers

- FG Treichville "Solidarity, but it is necessary to fight against parasitism. Only the old people should be helped, because it is difficult to establish a budget by accepting everyone, which promotes parasitism."
- FG Yopougon "In the city where the people are emancipated, polygamy is less pronounced. The law will decide on its fate in the future. In any case, if it is not done openly, it is done in secret (mistresses). It is necessary to have fewer children and to live in a reduced family. It is necessary to plan the births in order to better care for the children."
- FG Cocody "Solidarity above all. Intervals between births are also important."
- Interview #109 "Between our children and those of other members of the family, it is necessary to hold on to the idea of affection; even if I no longer take care of these children, as in the extended family, it is necessary to maintain effective bonds between them and my children so that family solidarity does not disappear."

Consumers

- FG #202 "To live in solidarity, teamwork, fraternal and communal life."
- FG #207 "It is necessary to conduct a synthesis among two lives: modern life and traditional life. This allows us to develop and to better adapt ourselves to this course of life. We must not copy the western way of life. It is necessary to keep the African bonds, cultures, and solidarity while improving them."



FG #208

“The African family must always be broad and keep its solidarity. In my opinion, we must ask our children to limit births. It is necessary to have children as a function of one’s means. We must choose the nuclear family, also taking care of the [greater] family and preventing delinquency. It is necessary to advise and educate our children and give them a proper environment.”

FG #223

“It is necessary to preserve warmth because elsewhere it is the difference in people that one notices, especially in the European countries. It is necessary to preserve teamwork, solidarity.”