USAID
FROM THE AMERICAN PEOPLE

THE USE OF FAMILY PLANNING METHODS IN MALI: THE HOW AND WHY OF TAKING ACTION

DHS Qualitative Research Studies 18

September 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by P. Stanley Yoder of ICF Macro and Mouhamadou Guèye and Mamadou Konaté of CAREF.

The Use of Family Planning Methods in Mali: The How and Why of Taking Action

P. Stanley Yoder
ICF Macro

Mouhamadou Guèye
Mamadou Konaté
CAREF

September 2011

Cover photos: © 2008 Caitlin Cohen, Courtesy of Photoshare, and © 2009 Devon Golaszewski, Courtesy of Photoshare.

This report presents findings from a qualitative research study conducted in Mali in 2010 as part of the MEASURE DHS project. ICF Macro, an ICF International company, provided technical assistance, and funding was provided by the Office of Population and Reproductive Health, Bureau for Global Health of USAID, Washington, under Contract No. GPO-C-00-08-00008-00. The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

Additional information about the MEASURES DHS project can be obtained by contacting MEASURE DHS, ICF Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (telephone: 301-572-0200; fax 301-572-0999; email: reports@measuredhs.com; internet: www.measuredhs.com).

Suggested citation:
Yoder, P. Stanley, Mouhamadou Guèye and Mamadou Konaté. 2011. *The Use of Family Planning Methods in Mali. The How and Why of Taking Action*. Calverton, Maryland, USA: ICF Macro.

TABLE OF CONTENTS

List of Abbreviations and Acronyms v

Acknowledgments vi

Executive Summary vii
Objectives vii
Methodology vii
Findings and conclusions viii
Women's accounts viii
Men's accounts of family planning ix
Providers of family planning ix
Overall x

Chapter 1: Introduction 1
1.1 Themes explored 1
1.2 Background 2
1.2.1 Fertility trends in West Africa 2
1.2.2 Fertility rates and preferences and contraceptive use in Mali 2
1.2.3 History of family planning in Mali 2
1.3 Purpose of this study 3

Chapter 2: Study Design and Implementation 4
2.1 Objectives and research design 4
2.2 Methodology 4
2.2.1 Methods 4
2.2.2 Selection of sites for data collection 5
2.2.3 Conversation guides 5
2.2.4 Training of field-team interviewers 6
2.2.5 Informed consent and ethical clearance 6
2.3 Data collection 6
2.4 Data analysis 7

Chapter 3: Women's Accounts of Their Lives and Use of Family Planning 8
3.1 Social and demographic factors 8
3.2 Childhood and adolescence 8
3.2.1 Size and shape of the parental family 9
3.2.2 Education 9
3.2.3 Girls' relations with friends 11
3.3 Premarital sex 12
3.4 The choice of husbands and girls' ideas of their future family 13
3.4.1 The choice of a husband 13
3.4.2 Early images of family size and shape 15
3.4.3 Achieving desired family size 16
3.5 Women's economic status and social networks 17
3.6 Women's experience with contraception 19
3.6.1 Reasoning of non-users (never used) 19
3.6.2 Reasoning of former users 21
3.6.3 Reasoning of current users 22
3.7 Comparison of groups of women by contraceptive use: ever and never 23

Chapter 4: **Triad Discussions with Men** 25
4.1 Support of birth spacing 25
4.2 Views of family planning and modern contraceptive use 25
4.3 Knowledge of modern contraceptive methods 27
4.4 Early notions of ideal family versus current reality 28
4.5 Consenting to and participating in family planning 29
4.6 Summary of why men support or oppose the use of modern contraceptives. 30

Chapter 5: **Interviews with Family Planning Providers** 32
5.1 Training in family planning among professional health care providers and CBVs 32
5.2 Contraceptive methods preferred by clients 32
5.3 Why women use or stop using modern family planning methods 33
5.4 Providers' and volunteers' suggestions for improving family planning services 34
5.5 Challenges to family planning services 34

Chapter 6: **Conclusion and Recommendations** 36
6.1 Circumstances of using family planning 36
6.2 Men's accounts 37
6.3 Family planning providers' perspectives 37
6.4 Limitations of the study 38
6.5 Recommendations 38

References 40

Appendices 41
A.1: Socio-demographic characteristics of female respondents according to their use of family planning (FP) 41
A.2: Distribution of women who have ever used and who have never used family planning, according to selected variables 42
B.1: Interview guide for married women 43
B.2: Interview guide for married men 45
B.3: Interview guide for family planning providers 47

LIST OF ABBREVIATIONS AND ACRONYMS

AMPPF	Association Malienne pour la Promotion et Protection de la Famille
CAREF	Centre D'Appui à la Recherche et à la Formation
CBV	Community- based volunteer (referred to in francophone West Africa as *relais*)
CNESS	Comité National d'Éthique pour la Santé et les Sciences de la Vie
CSCOM	Centre de Santé Communautaire
DHS	Demographic and Health Survey
EDSM	Enquête Démographique et de Santé au Mali
IPPF	International Planned Parenthood Federation
PRB	Population Reference Bureau
PRH	Population and Reproductive Health
TFR	Total fertility rate
USAID	United States Agency for International Development

ACKNOWLEDGMENTS

This report is derived from a translation of a report originally written in French by Mouhamadou Guèye and P. Stanley Yoder (*L'utilisation de la contraception au Mali: Comment et pourquoi utiliser une method?*). We wish to thank Jill Mac Dougall, who translated the text from the French, reorganized sections, and actively participated in the writing of this report.

We have many other individuals to thank for their participation in this study. We would first like to thank the research assistants from CAREF who participated actively in the training and the field interviewers who collected and transcribed the data. They worked long hours to interview respondents and to process a large body of information so that the data could be properly analyzed.

All of the respondents deserve our thanks for sharing their accounts of their experiences as well as their opinions on a wide variety of topics. The women in particular talked easily and freely about their own lives.

We also want to thank the USAID Mission in Bamako for their guidance and the health care providers in the study sites who helped the research team locate respondents and agreed to be interviewed. Finally, we extend our thanks to the PRH division of USAID Washington for their support and funding for this study.

EXECUTIVE SUMMARY

Objectives

This study examines the situation of women in Mali who use modern contraceptive methods and compares this to the situation of women who do not, in order to understand how and why women take action to use family planning. The research sought to discover if certain elements in social and family relationships influence the decision to use family planning or not. In Mali, as in many other West African countries, rates of contraceptive use have remained very low. How is it that some women who are not ready to become pregnant do not use family planning?

To compare women who use family planning to those who do not, this study explored a number of themes: women's experiences growing up, their participation in the choice of a husband, creating a family of their own, their knowledge of contraception, their fertility preferences, their access to services, their preferences for different types of services, and their socioeconomic status in the household. The study explored the relative importance of elements that affect the use of modern family planning methods from the perspectives of married women, married men, and service providers who offer family planning methods.

The major portion of the research was dedicated to interviews with women and analysis of their testimonies. Since Malian women who do use modern contraceptive methods are the exceptions, it is important to determine if their circumstances differ from those who have never used contraception, or have used it in the past but are no longer doing so. By examining the social and family context of women in these varying situations and the perspectives of women and men with regard to these issues, this study shows how women evaluate their own situation with regard to spacing the births of their children.

Methodology

The techniques of data collection included the following:

- In-depth interviews with married women
- Discussion groups with triads of married men
- Brief interviews with individual service providers, both professional and volunteer

Three regions of Mali were chosen for data collection: Bamako, the capital city; Koulikoro, east of Bamako, and Ségou, still further east of Bamako. In Bamako two neighborhoods in one commune and two in another commune were selected; in Ségou and Koulikoro, four sites were selected in each region, making a total of 12 sites. In each site selected, six women were interviewed and a discussion was held with a group of three men.

In each region two health care facilities that provided family planning services were identified. Health service providers were interviewed at these facilities. In the sites selected that had active community-based volunteers (CBV) attached to the facilities, the volunteers were also interviewed.

The study aimed to interview a sufficient number of married women and men to provide a wide range of experiences but with an amount of data that could be realistically processed in the time allotted. The study interviewed 72 individual women (37 current users and 35 current non-users), 12 groups of three men each, 12 service providers, and 7 CBVs. Women were interviewed with a semi-structured conversation guide after being screened for eligibility; groups of three married men were interviewed with a similar guide; family planning providers spoke in response to a series of specific questions. The conversations were recorded and transcribed in Bambara, then translated and typed in

French for analysis. The training in Bamako was directed by the ICF consultant in collaboration with CAREF, while the data collection, data processing, and much of the analysis was conducted by CAREF, an experienced research group based in Bamako.

Findings and conclusions

The findings of this study can be usefully presented according to whether they relate to individual knowledge or reasoning about the use of family planning, the role of social history and social circumstances in the use of family planning, and the factors that facilitate or impede the use of modern contraception.

It should be noted that, although there is an official national policy on population (*Politique Nationale de Population)* which aims at achieving a balance between socioeconomic development and population growth in Mali (EDSM 2006), modern methods of contraception and family planning are presented solely as methods for birth spacing. In fact, both women and men understand clearly the dangers to the health of a mother and her children posed by too short birth intervals. Both women and men interviewed also recognize that longer birth intervals lead to healthier children and thus fewer medical expenses for the family to pay. The exact length of a proper birth interval is not clearly defined in most peoples' descriptions, except to indicate that intervals of less than two years are too short and thus should be avoided.

Women's accounts

The research team explored the reasoning of women in the sample with regard to the use of contraception by considering three groups of women: those who had never used a family planning method, those who used one in the past but were not currently using one, and those who were using a family planning method at the time of the interview. The women who had never used contraception explained that they had no need for birth spacing because they had found that their births were spaced naturally, or that they feared side effects, or that their husband opposed it. Some of the women in this group said they might use family planning in the future if they thought it necessary.

Women who had used contraception in the past but were not current users gave two major reasons for discontinuing contraceptive use: 1) the desire to have another child; and 2) the side effects experienced in using a method. The side effects cited primarily concerned injectables, although a few also had problems with the pill. The majority of women who were current users explained that they were using a family planning method to space their births.

A comparison of women who had ever used family planning with women who had never done so reveals several intriguing differences in their social history. Women who had used family planning were far more likely to have participated in the choice of their husband. Similarly, women who had ever used family planning were much more likely to report having engaged in premarital sex than women who had never used family planning. This difference may be because they married at an older age, or that some women used contraception before marriage.

Since the use of contraception is exceptional in Mali, the research team expected to find that the history, social situation, and economic activities of women who use family planning might be different from those who do not. The study did find associations between having ever used family planning and certain experiences of becoming socialized, participation in finding a husband, and having children. However, the findings do not show systematic contrasts in the current social and economic status of users and non-users of contraception. The women's explanations for why they use family planning suggest why such a contrast was not found.

The fact that women say that they use family planning when their birth intervals become too short indicates that the demand for family planning is contingent and temporary, in large part dependent on the woman's assessment of her birth intervals and her desire to have more children. What is more, a woman's situation with respect to her birth intervals changes as her family grows.

The women who fall into the category of users or non-users change with each passing year. A woman assesses her need for a method to space her births over a period of weeks or months, and then her situation shifts: she uses a method, or she just waits and sees, or she becomes pregnant.

If the use of family planning is contingent on a woman's assessment of the length of her birth intervals and whether or not that constitutes a danger to her health and that of her baby, an opportunity for counselors of family planning services is created. Counselors can help women to reflect on their situation and consider what would be a proper length of time between births. Counselors should also recognize that a woman's situation with respect to birth intervals is constantly changing, and be ready to discuss her overall family situation when they meet.

A woman who decides to use family planning, of course, may not always be able to follow through on her decision. Although geographic access to family planning services remains a major problem in large areas of Mali, it is less so in the three regions of this study. A woman may be afraid of possible side effects, or her husband may oppose contraceptive use and she may be afraid to use family planning in secret. The study did not find examples of women who reported that they could not afford a method, although a few indicated that the time and expense involved was an impediment.

The study findings show that women (and men) understand the benefits of longer birth intervals for their own health and the health of their children. However, both women and men need assistance to apply this knowledge to their own situation. The key to wider use of family planning lies in assisting women and men to apply their understanding of the dangers of short birth intervals to their own situation once they have two or three children. Health care providers and family planning counselors for both women and men should be able to make a major difference in the use of family planning.

Discussions with women about their ideal family size revealed that very few had wanted less than five children when they married. The majority reported that they wanted a small family, which for them meant five, six, or seven children in total. These women did not have a particular strategy for achieving a certain number. At the same time, men often said they wanted several wives and lots of children; and some said they wanted as many as they could have. Some men did recognize, however, that they could not afford a second wife and might not have lots of children.

Men's accounts of family planning

All of the men in the triad discussion groups declared that birth spacing was essential to the well-being of the family. The major reasons cited for using modern family planning methods were for the sake of the health of the mother and the children, the financial burden of having many children too close together, and that traditional methods (such as plants or charms) or "natural" methods are not effective. The major reasons men cited for opposing modern contraception or ceasing to use a modern method were that side effects of these methods are uncomfortable for the woman and can prove dangerous to her health, or that contraception is a way of imposing birth control to limit the population of their communities.

Providers of family planning

Although all providers interviewed had a thorough grasp of modern contraceptive methods and most claimed they had received specific family planning training, it is not clear how precise this information was in relation to treating clients with side effects or in counseling women. Some health facilities, but not all, offer long-term contraception such as the IUD or a permanent method such as sterilization. Among the short-term methods that providers mentioned, two emerged as the most popular for women wishing to avoid or space pregnancy: the pill and injectables.

Long-term methods are available in about half of the facilities. In all cases, providers of contraceptive methods said clients preferred injectables over pills or other methods, because injectables are easier to hide from their husband if they are using contraception clandestinely, or that

they often forget to take the pill on a daily basis, whereas injectables only require a visit to the facility every three months. The *relais* (as CBVs are called in francophone West Africa) talked about the problems they had in increasing and improving their services. They said they were still hampered by a lack of communication with the health facilities and program directors.

Overall

The study findings show that both women and men understand the benefits of longer birth intervals for their own health and the health of their children. However, both women and men seem slow to apply the knowledge they articulated to their personal situations The gap between family planning knowledge and its practice could be narrowed by well-trained counselors who can provide a range of modern methods of contraception. Just as women's individual needs in regard to birth spacing shifts over time, the preference for one contraceptive method over another and the families' financial situation may also change, and the demand for family planning services can change as well.

CHAPTER 1: INTRODUCTION

This study examines the situation of women in Mali who use modern contraceptive methods and compares this to the situation of women who do not, in order to understand how and why women take action to use family planning. The research seeks to discover if certain elements in social and family relationships influence the decision to use family planning or not. In Mali, as in many other West African countries, contraceptive use rates have remained very low. Surveys have shown that factors such as knowledge of contraceptive methods and their availability play a role in the use of family planning, and that the social and economic condition of women must be considered. Surveys, however, are unable to deal with context or to elicit understanding of the reasoning behind decisions made or actions undertaken.

1.1 Themes explored

To compare women who use modern contraceptive methods to those who do not, this qualitative study explores a number of themes: women's experiences growing up, the selection of a husband, having children, knowledge of contraception, fertility preferences, access to services, preferences for different types of services, and socioeconomic activities in the household. The study explores the relative importance of factors that affect the use of family planning from the perspectives of married women, married men, and the service providers who offer family planning methods.

The Demographic and Health Surveys (DHS) provide a wealth of information on variables associated with the use and non-use of modern and traditional methods of contraception. However, survey data cannot provide detailed information on the experience of the survey respondents with contraception or their perspectives on the various methods of family planning available since they became sexually active. For example, we know little about the motivations to use contraception, the context of the decision, the satisfaction or disappointment with the method, or subsequent decisions resulting from these experiences. We also know little about the context of the use or non-use of contraceptive methods and the mechanisms or social dynamics that underlie these decisions.

Taking into consideration all these factors, this research explores primarily the question of the demand for family planning methods in Mali. Unless otherwise specified, the term "family planning" refers to modern methods of contraception. The provision of family planning services and contraceptive methods has been well documented over the past four decades, but what of the demand for them? Questions often raised include the following: What can explain the fact that men and women have adequate information but may not use family planning methods? Have they used contraception in the past? How is it that some women use a method clandestinely? What are the reasons that prompt a halt (temporary or permanent) to using a family planning method? What notions do people have of family planning in relation to their life goals that they have fashioned or that are fashioned by social norms?

Husbands also have an impact on the use of family planning. The study considers men's views on these issues, asking questions such as: What is the experience of husbands with the use of family planning by their wives? What motivates their adherence to or rejection of a family planning program? Are they part of a polygamous or monogamous family? How does this affect their decisions relating to contraception?

This study explores some of these questions as well as other points that emerged from the research. Seeking to understand the reasons behind family planning decisions through repeated interviews, we identified the questions that required further probing to include in the subsequent interviews, until the topic was thoroughly covered.

1.2 Background

1.2.1 Fertility trends in West Africa

Data from the Demographic and Health Surveys (DHS) have shown that fertility preferences and the total fertility rate (TFR) in many West African countries remains high. The lowest TFRs among these countries are in Ghana (4.1) and Liberia (4.2); the highest in Mali (6.6) and Niger (7.0). Those in the middle include Burkina Faso, Benin, Guinea Conakry, and Nigeria.

Among West African countries, Mali ranks as third in relation to high fertility preferences (6.0) and second in TFR (6.6). According to the most recent DHS survey in Mali (EDSM 2006), there have been few changes in fertility preferences, birth rates, or contraceptive prevalence since the 2001 DHS. This survey showed a national contraceptive prevalence of 6.9% among married women. The changes that drove fertility preferences down to 3.5 children in Ghana did not occur in Mali.

1.2.2 Fertility rates and preferences and contraceptive use in Mali

Fertility indicators and contraceptive prevalence at the national level show that Mali has barely begun the fertility transition. The 2006 report also indicates that: 1) 25% of Malian women are not aware of modern contraceptive methods; 2) 19% of women living in union have used a modern method at some point in their lives; and 3) the rate of current use of any modern method of contraception at the national level is 7%. However, 31% of married women or those living in union declared that they wished to delay another pregnancy or to avoid future pregnancy, but they were not using any contraception. This statistic provides an indication of substantial unmet need for family planning.

Fertility rates and contraceptive prevalence vary widely according to socio-demographic indicators, particularly women's level of education, urban or rural residence, region of the country, and to some extent wealth. In the EDSM 2006 the mean ideal number of children desired among women who had never attended school is 6.6 compared with 4.7 among women who had attended secondary school. Modern contraceptive use among women who never attended school is 5%, whereas among women with secondary or higher education it is 23%. Current use of modern family planning in Mali ranges from 2% in Mopti to 17% in Bamako. The vast majority of Malians using contraception do so in order to assure adequate intervals between births. Two-thirds of current users are using contraception for birth spacing purposes only, according to the EDSM 2006.

The EDSM 2006 also shows variations in contraceptive knowledge, use, and ideal number of children by region and urban-rural residence. Nationally, 75% of married women know of at least one contraceptive method. This proportion varies greatly by region, from 48% of women in Gao and 49% in Mopti to 93% in Bamako. The ideal number of children desired is highest in Timbuktu (8.1) and Mopti (7.8), and lowest in Bamako (5.1). The highest contraceptive prevalence is found in Bamako, Ségou, and Koulikoro, and the lowest in Mopti, Gao, and Timbuktu. Overall, the prevalence of modern contraceptive use is 4% in rural populations and 13% in urban populations.

1.2.3 History of family planning in Mali

In 1972 modern contraceptive methods were officially accepted and introduced when the government launched the *Association Malienne pour la Promotion et la Protection de la Famille* (AMPPF), with the assistance of the International Planned Parenthood Federation (IPPF). Fifteen years later, 4.7% of women living in union were using family planning, according to the EDSM 1989. The AMPPF remains the main organization offering reproductive health services. The policies and legislation of the Malian government have continued to promote family planning services, including an action plan following the 1994 Cairo conference, a reproductive health strategic plan for 2004-2008, and a national reproductive health communication program from 2007 to 2011.

In spite of these efforts, the indicators show little change in fertility rates or contraceptive prevalence among the Malian population. A recent study of trends in contraceptive use and unmet need for family planning (Mariko et al. 2009), based on three DHS surveys conducted in Mali over the past decade, shows virtually no change in either the TFR or women's ideal number of children. According to the study, the TFR was 6.7 in 1996, 6.8 in 2001, and 6.6 in 2006. The ideal number of children was 6.2 in 2001 and 6.3 in 2006.

The proportion of women using contraceptive methods also changed little between 1996 and 2006. There was a slight increase in contraceptive use among women who said they did not want to become pregnant in the near future (23% in 1996, 25% in 2001, and 27% in 2006). If only women living in marital relationships are considered, the figures are respectively 26%, 29%, and 31%. Although the 2009 study shows that there has been almost no change in these indicators, it offers little explanation for the findings.

So how can the low use of family planning in Mali be explained? The Population Reference Bureau (PRB) conducted a research tour for journalists on reproductive health in Mali (Population Reference Bureau 2010). Their report shows that one reason contraceptive use remains low is the lack of adequate family planning supplies and personnel to distribute contraceptive methods and counsel clients. Because of this, the unmet need for family planning cannot be satisfied. Another reason for low levels of contraceptive use emerges from the follow-up study of a 2006 family planning campaign conducted by CAREF that found many women fear the side-effects of methods such as the pill or injections (Guèye et al. 2007). Also, Sarah Castle has conducted studies of the clandestine use of family planning among Malian women, showing that some women use modern contraception despite opposition from their husband (Castle 2007).

According to the EDSM 2006, about 60% of married women reported wanting more children, but one-third of women said they prefer to delay their next pregnancy or do not want any more children, but they are not using any contraceptive method. How is it that some women who are not ready to become pregnant do not use family planning, even when it may be available?

The EDSM 2006 also asked women who were not currently using a modern family planning method if they ever intended to use one in the future. One-third (34%) responded that they intended to use one in the future, over half (55%) declared they would never use one, and 11% said they were not sure. Among the 55% with no intention to use family planning, the reasons given included the following: 1) They simply do not like contraceptive methods (32%); 2) They want to have as many children as possible; 3) Their spouse/partner is against contraception (9%); 4) They have no knowledge of contraceptive methods (9%); and 5) They are no longer fertile.

1.3 Purpose of this study

This study aims to provide information that has been lacking concerning the history of past contraceptive use, women's explanations for use and non-use of family planning, the social dynamics that may affect family planning decisions, and how women and men view the effects of birth spacing on women's and children's health. This information will help bring to light other questions linking life history and specific periods to events in individuals' reproductive history and how these inform actions taken. In this way we seek to determine how and why individual married women choose to use modern methods of family planning in Mali.

Since women who do use contraceptive methods—currently or in the past—are the exceptions, it seems crucial to determine if their circumstances differ from those of women who have never used a modern method. It is important to understand how women choose to continue or interrupt their use of family planning methods and to compare them with women who have never used a family planning method. By examining the social and family contexts of both groups of women in their varying situations, and by considering the perspectives of women and men with regard to these issues, this study shows how women evaluate their own situation with regard to spacing their births.

CHAPTER 2: STUDY DESIGN AND IMPLEMENTATION

2.1 Objectives and research design

As stated in the introduction, the overall purpose of this study is to determine how and why individual married women choose to use modern methods of family planning in Mali in contexts where the vast majority of women do not use family planning in spite of relatively ready access to these services. Since users are the exception, a key question is: what, beyond variations due to wealth, education, urban or rural residence, and region, leads some women to use family planning while others in their communities reject it? How are women who use family planning different than those who do not?

This study sought at the outset to address a number of specific research questions:

- What motivates a woman to delay her next birth or to limit the number of children?
- What do women consider when they wish to delay or avoid pregnancy?
- From the woman's perspective, what are the disadvantages of births at close intervals?
- With whom do women discuss their wish to delay or avoid pregnancy?
- What contraceptive methods have they used in the past?
- Where do they obtain family planning methods?
- What contraceptive methods do they prefer?
- What do they think of traditional methods?
- What do women who do not use family planning take into consideration?

Although married women are the primary focus of this research, the study also takes into account that their decisions regarding the use of contraception are part of a dynamic involving their husband and the potential providers of family planning services. Questions addressed in this study also concern husbands' perceptions of the benefits and drawbacks of birth spacing and contraception, and their image of an ideal family size. Family planning providers were also asked their opinions on the methods preferred by their clients and their views on why clients adopt modern contraceptive methods.

The interviews with women asked them to describe their experiences in growing up in their paternal or alternative families, how they spent their time as adolescents, and how they chose or were given a husband. This approach had several purposes: to put the women at ease and facilitate a discussion of issues that might be sensitive; to check on possible associations with later events, including the use of family planning; and to provide a social and historical context for their actions in using contraception.

The research team made several assumptions based on prior studies of family planning in Mali. They assumed that use of a contraceptive method is nearly always to space births rather than to limit the total number of children. They also assumed that, since so few respondents in the most recent DHS said that they did not use contraception because of price or access, women are not prevented from using family planning methods because the service points are located too far from their residence, or that the price is not affordable in the regions of the study. It is true, of course, that access to family planning services is poor in some regions of the country, but judging from the regional use rates, access is better in the regions of the study than elsewhere (EDSM 2006).

2.2 Methodology

2.2.1 Methods

This study employed three qualitative techniques to collect information on family planning among women, men, and health service providers in three regions of Mali:

- In-depth interviews with married women
- Discussion groups with triads of married men
- Brief interviews with individual service providers, both professional and volunteer

2.2.2 Selection of sites for data collection

Three regions of Mali were chosen for data collection: Bamako, the capital city; Koulikoro, about 60 km east of the capital, and Ségou, about 200 km from Bamako east along the Niger River. Each of these three regions shows family planning usage rates that are relatively high for Mali. In each region 4 sites were selected for data collection, for a total of 12 sites. In each site six women were interviewed and a discussion was held with a group of three men.

The sites were selected to provide a sample from a range of residence situations (urban, peri-urban, rural). The sites in Bamako were two neighborhoods in Commune I and two neighborhoods in Commune IV, chosen because their level of social services and living conditions were typical of the city. One of the two urban neighborhoods selected in Bamako included a ProFam Health Center that offered longer term family planning. In the region of Ségou, data were collected in two sites in each of two districts (*cercles*): Ségou and San. In each district one site was peri-urban and one site was rural. In the region of Koulikoro, the same selection formula was followed. Data were collected in two sites in each of two districts (*cercles*): Kati and Dioila. In each district one site was peri-urban and one site was rural.

The main health centers were selected from each of the two communes in Bamako and each district in Ségou and Koulikoro for a total of six community health centers (CSCOM). In each of these health centers, two providers of family planning were interviewed. Community volunteers were also interviewed in Ségou and Koulikoro.

The study aimed to interview a sufficient number of women and men to provide a wide range of experiences but with an amount of data that could be realistically processed in the time allotted.

2.2.3 Conversation guides

The interviews conducted with individual women were semi-structured and open-ended in that the research team had prepared a series of very general questions to get women to talk, and some follow-up questions were also suggested. The women were first asked to talk about their childhood and adolescence, their engagement and marriage, their current economic situations, and their experiences in having children and using family planning. These areas of inquiry and general questions were developed during the training with all members of the study team. The topics and questions were developed in French and then translated into Bambara, which is the main national language spoken in Mali. All interviews with women were conducted in Bambara. The English version of the guide for in-depth interviews with women can be found in Appendix B.1.

The discussion guides for the groups of men were also developed in French during the training of interviewers and then translated into Bambara. These discussions centered on three themes: the pros and cons of birth spacing, men's own experience in using contraceptive methods, the form and size of the family they wanted and their efforts to achieve those goals. (See English version of the triad discussion guide with men in Appendix B.2.)

Interview guides with family planning providers and CBVs were developed in the same fashion. They were asked about their prior training in family planning methods, their current job responsibilities, the contraceptive methods clients preferred, the methods they recommend most often to their clients, and their opinions as to how and why their clients use or do not use modern contraception. (See English version of the interview guide for service providers in Appendix B.3.)

2.2.4 Training of field-team interviewers

After the initial preparation of the research plan with the consultant from ICF Macro and the CAREF team, training sessions for interviewers were held for one week in Bamako. Training participants included two research assistants to conduct the in-depth interviews with women, two research assistants to conduct the interviews with family planning providers and to lead the discussion groups with men, and two research assistants to transcribe the recorded conversations in Bambara and translate the transcripts into French. The activities included a review of the objectives of the study and the research questions, followed by a refining of the interview and group conversation guides in French, and then a translation into Bambara. The training also included a review of interviewing techniques and enhancing interviewing skills of the field workers. Two rounds of pretests with women and with groups of men from nearby neighborhoods were conducted. The results of the pre-test were then discussed in the group. Each of the training participants signed a form stating that they would follow the rules that guaranteed confidentiality and anonymity of the data.

2.2.5 Informed consent and ethical clearance

The research assistants who conducted the field interviews presented an informed-consent form to potential participants that identified the institutions involved in the study, explained the study objectives, stated that participation was entirely voluntary, and assured the respondents that any information collected would be confidential: that is, no names would be attached to the interviews, and no one outside the research team would have access to the information collected. The form explained that the participants could choose not to respond to any aspect of the questioning process, and that they could stop the conversation at any time. The form also asked permission to record the conversation. Interviews would not begin until the respondents indicated that they understood the consent form and accepted the conditions.

Before the data collection began, ethical clearance was obtained from the Comité National d'Éthique pour la Santé et les Sciences de la Vie (CNESS). The CNESS is composed of about two dozen retired university professors and physicians who review study proposals and provide ethical clearance in Mali. The proposal and drafts of the conversation guides were submitted to this committee for consideration. After the documents were read, the CAREF study directors and the consultant from ICF Macro met with the committee to respond to questions and resolve any remaining issues.

2.3 Data collection

To be eligible to participate in the study, women needed to be married, have at least one child, and agree to participate through the consideration of an informed consent form. The study also sought equal numbers of current users of family planning and non-users. The teams used a brief screening instrument to collect basic demographic information and to assess women's eligibility for the study.

To identify women eligible for participating in the study, the research teams employed two strategies. First, the research team selected 20 households at random (two stages: random selection of enumeration areas and then of households) in each district/commune for visits by the research team to check for eligible respondents. In this manner they identified six women per district who were non-users of family planning. A few current users were also identified in this manner and were included in the sample. Additional current users were identified from the list of clients for family planning services from the local health center, for a total of six current users in each district.

The identification of participants for the group discussion with married men was more informal. The teams approached groups of men gathered in public places and asked for volunteers among married men. Those who volunteered assembled nearby in a more private space for discussion. The service providers interviewed were the nurses and midwives who offered family planning services in the facilities selected for the study.

Table 1 shows the location and nature of the data collection sites and the number of interviews conducted. As mentioned, in Bamako data were collected in two neighborhoods of Commune I and Commune IV. The names in the regions of Ségou and Koulikoro identify either a neighborhood on the edge of town or a village. The research team failed to locate one of the community volunteers in Koulikoro, so seven volunteers were interviewed rather than the intended eight. In addition, the team discovered that some women bought their contraceptives from street vendors who sell medicines. Therefore, three such ambulatory vendors were subsequently interviewed. These three vendors are not listed in the table.

Table 1 Location and number of interviews conducted

Location	Interviews with women	Triad discussions with men	Interviews with professional FP providers	Interviews with CBVs for FP[4]
Bamako[1]				
Sikoroni	6	1	1	
Nafadji	6	1	1	
Lassa	6	1	1	
Taliko	6	1	1	
Ségou				
Pelengana[2]	6	1	1	
Sékoro[3]	6	1	1	2
Somo[3]	6	1	1	2
Parana[2]	6	1	1	
Koulikoro				
Samakébougou[2]	6	1	1	2
Kambila[3]	6	1	1	1
Dioila[2]	6	1	1	
Wakoro[3]	6	1	1	
Total	**72**	**12 (36 men)**	**12**	**7**

[1] All study sites in the city of Bamako were considered urban.
[2] Peri-urban sites
[3] Rural sites
[4] All interviews with community volunteers were conducted in sites where USAID had promoted CBV services.

The data collection teams alternated data collection and processing in the offices of CAREF. Data collection began in Bamako, where interviews and discussions were conducted in October, 2010. The individual conversations as well as the group discussions were tape recorded with permission from the respondents. The teams began their work in the district of the capital so that the CAREF study supervisors could monitor the quality of the field research teams' performance and supplement any missing elements in the question guides. This step allowed for quality control and additional training before the field research teams went to the Koulikoro and Ségou regions. The teams worked in Koulikoro in November, 2010, and in Ségou in January, 2011.

2.4 Data analysis

The transcripts of all recordings were entered in French into Microsoft Word and coded by themes and sub-themes of interest to the study. The coding of key passages was done with repeated reading of the transcripts to discover the way women and men spoke about the various topics. The coded passages were then arranged in tabular form by themes to make it possible to easily read all the quotes of women or of men related to a particular topic or theme. These tables could also be searched by key words in Word; they constitute a rich source of data that can be easily consulted.

Basic demographic and social information for the female respondents obtained from the screening instrument were also entered into SPSS to facilitate access and the preparation of tables. These variables include the type of parental family, experience with sex before marriage, ideal family size, experience with side effects, and reasons for using or not using family planning methods.

CHAPTER 3: WOMEN'S ACCOUNTS OF THEIR LIVES AND USE OF FAMILY PLANNING

This study was designed to elicit information about women's experiences to look for patterns that could explain the use of modern methods of contraception. As mentioned, we were trying to determine in what ways the family history and current social situation of current users of family planning might be different from those who did not use family planning. Given that the use of family planning is so exceptional in Mali, we wanted to see if other aspects of users' lives might also prove to be exceptional. In-depth interviews with the 72 women participants explored their histories, their current socioeconomic situations, their family life, and the reasons they used or did not use modern contraceptive methods.

3.1 Social and demographic factors

The instrument used for screening potential participants for this study asked for information about basic socio-demographic variables: age, marital status, education, economic activity, number of births, and number of living children. The screening also allowed us to divide women into categories according to their use of family planning: current users and those who were not currently using contraception. Following the interviews, the study team could further classify the women into three groups: those who had never used family planning, those who were currently using it, and those who had once used family planning but were not currently using it. Appendix Table A.1 shows the socio-demographic characteristics of the three groups of female respondents.

The women in our sample ranged from age 20 to age 50. The proportion of women age 35-50 was higher in the group that had never used family planning (9 of 18) than in the group of current contraceptive users (10 of 37).

This study interviewed only married women. In Mali three types of marriages are practiced: civil (the state), religious (the mosque or church), and traditional (the lineage). Civil marriages are those that are registered in the local civil registry. Religious marriages are those with a ceremony officiated by a religious authority. Traditional marriages are those that involve the exchange of gifts over time according to traditional practice. While some women had celebrated all three types of marriages, they were considered married if they had participated in any one of the three types. The appendix table shows that about one-third of women are in a polygamous marriage (25 out of 72).

Most of the respondents were engaged in some kind of work to earn an income. Only 15 of the 72 women said they were not working outside of the home and the fields. Among the 57 who said they were working, 44 worked as small traders or food vendors.

The women in our sample have reached a relatively high level of fertility, and most said they intended to have more children. One-fourth of the women have had five or six births, and one-fourth have had seven or more. Among the 18 women with seven or more live births, eight have lost at least one child. This number can be seen in the appendix table by comparing the number of women who had seven or more live births (18) with the number of women who have seven or more living children (10).

3.2 Childhood and adolescence

The study team asked about the women's experience growing up, in part so that women would have the opportunity to describe aspects of their lives that were not likely to be private or controversial, and to check for connections to the founding of their own family later on. We were particularly interested in the size and shape of their parental families, their education, how they spent their leisure time, and their network of friends when they were girls.

3.2.1 Size and shape of the parental family

The mothers of most of these women had had many children. This outcome may be the result of their mothers' wish to have a large family and/or marriage at a young age. The following comments on the number of siblings in their parental families are typical:

> *I could not really say how many children my mother had, but I do know that nine are still living today: four boys and five girls.* [Lassa]

> *My mother had 12 children: five boys and seven girls. One of them died this year, the one just younger than me.* [Wakoro]

It was not unusual for women to say that they grew up with many siblings, a polygamous family, and several married brothers of their fathers all living within the same compound. One woman said of her parental family:

> *It's a really large family. There are my parents, my brothers and sisters, and my mother's co-wives. My mother had 10 children: seven boys and three girls. Several of the co-wives of my mother had two children, others had three. My father was polygamous; he had four wives.* [Lassa]

Many women came from families that had lost a number of young children. A few women said that their mother had lost half or more of their children, as shown by the comments below:

> *My mother gave birth to 10 children, but sadly, she lost a lot of them… she lost five children, so there are only five left: four girls and one boy.* [Nafadji]

> *My mother had many children, but several of them died. There are only four of us left, whereas my mother had 12 children in all.* [San Parana]

> *I spent my childhood with my mother in Koulikoro. There were many of us in the family, for my mother gave birth to 10 children; but now, I am the only one left.* [Sikoroni]

These examples bear witness to the fact that the loss of a sibling was part of their own experience in growing up.

About one-third of the women in our sample grew up in families that did not include their biological parents. While such situations are sometimes the result of the death of one or both parents, it is more often the result of parents placing their daughter in another family so she can attend school, or to strengthen family ties, or so as to find employment for her.

3.2.2 Education

Although Mali has made good progress in the past 20 years in girls' education, quite a few women in the sample had never been to school. The sample did include some women who completed the two cycles of primary and middle school (six years and three years), but more of them completed only a few years of the first cycle (*Fondamental 1*). A number of women reported that their parents had not enrolled them in school, but they did not know why their parents had made this choice. An example of such a situation comes from a woman from San Parana:

> *None of us ever went to school, but I do not know why. I am very sorry not to be able to write my own name. If you have not been to school, you really cannot find much work.*

Another woman, interviewed in Wakoro in Dioila district of Koulikoro, had this to say:

I don't know why they never signed me up for school. I do know that they sent my brother to school.

In Mali children are not expected to question the decisions of their elders, but simply to accept. Thus it should not be surprising that parents do not explain their reasoning for decisions to their children.

Some women did explain their parents' reasoning, although they would not have been permitted to question it. Some of their parents, particularly fathers, had expressed a preference for Koranic school.

My aunt wanted to enroll me in school, but my father refused. My father was a marabou. He asked my aunt to enroll me in Koranic school, but she did not follow through. [Samakébougou]

The report of another woman illustrates the impact that religious principles can have on enrollment in school.

I never went to school. I attended Koranic school with my brother. Our father used to say that he did not want us to attend school. He wanted us to learn the word of God. Nevertheless, all of my other brothers were enrolled in school. [Samakébougou]

The conversation that followed this declaration did not explain how or why the brothers were able to attend school. The rising rates of enrollment in modern education suggest that this exclusive preference for Koranic school has diminished in Mali in recent years.

For some families, having a child work at home helps them survive economically, as a woman from Kambila indicates:

My parents did not send me to school. When I was a child, I helped my mother around the house, went with her to the fields, and in her business.

For families with very few resources, sending a child to school means forgoing the child's help at home. A mother who has no girls to assist her with work in the household will have less time to earn a supplemental income. The need to do household chores affects girls much more than boys, particularly when they are the only girl. As a respondent from Wakoro observed:

When I was young, I had to do household chores all alone, for all my older sisters were already married, and the younger children were all boys.

Nearly all those who had never attended school or who left after a few years were sorry they were not educated. A woman from Lassa explained:

I am very sorry that I never went to school. People in my situation cannot find work, even cleaning. My parents lived in a village, and my older brother attended school but did not finish. I do not earn much money with my selling.

Those who had never gone to school understand that they have far fewer opportunities to earn a good income than their friends who had at least several years in school. Being illiterate is truly a handicap for women.

Finally, it seems important to consider factors that affect whether girls remain in school once enrolled. Some girls left school because their family was no longer able to pay school fees, they wished to earn money in petty trading, they were unable to perform well, or they just wanted to leave.

I went to school until the fourth year, but I dropped out myself. No one else is responsible for that. [Samakébougou]

I attended school until the ninth year. I decided then to drop out because I did not like it. [Taliko]

I did attend school, but I had to drop out because my parents and my fiancé did not have the money for school fees. [San Parana]

When I was young I enjoyed being a vendor. That is why I left school after the first year. [Nafadji]

Some women stated that they were taken out of school when they were married off at a young age:

I was attending school, but after getting married, my studies were interrupted. I left school during the fifth year when I became pregnant. [Dioila]

When I obtained my D.E.F. diploma, I went to a professional school called INTEC at Djicoroni… After getting married I moved to live with my husband in Sikoroni, and I was unable to complete school. [Sikoroni]

As indicated earlier, some families wanted their sons to attend public school, but not their daughters.

I never went to school. The local teachers wanted me to attend school, but my father refused. In those days people did not want their children in school, particularly girls, but they did want boys to attend. I have a brother who attended school and now he has a job. [Lassa]

Although some families prefer a religious school, a distinction between boys and girls in the type of religious school chosen may still prevail. A medrasa is an Islamic school with a standard curriculum, while a Koranic school mainly trains pupils to recite the Koran.

No one in my family went to public school. The boys were sent to the medrasa and the girls to Koranic school. [Sikoroni]

The preference for sending boys to school can be explained in three ways. Some families believe that an investment in boys' education benefits the family more than educating girls does, since a girl will leave her family to join her husband. Another reason often given is that girls are unlikely to go far in school since they will get married just after puberty. Finally, girls are expected to help their mother by taking care of their younger siblings at home. In some cases, as suggested by individual accounts, girls are so involved in the trading and food vending work of their mothers that they remain out of school to help their mother.

3.2.3 Girls' relations with friends

Young Malian girls gather with their cohorts to talk and participate in recreational activities involving games or dancing such as the *balani* and the *djembe*. The former refers to an instrument such as a xylophone but now often denotes an evening of dancing to music that is locally popular. The latter refers to a drum but also to major music events and evening parties.

According to the women interviewed, parents are very concerned about their daughters' social relationships. Of particular concern are the negative influences and the possibility of their daughters engaging in sexual relations and losing their virginity, a concern that grows as girls approach puberty.

Some women had parents who were extremely protective, going so far as refusing to let their daughters have any female friends. That was the case of a woman from Pelengana*: I had no friends.*

My father did not allow me to go out at all. A woman from Samakébougou said she had an aunt with the same approach:

> *My aunt was so strict that I really could not make friends. I sold things in front of the door of our house. When she saw friends of mine around the door, she would come out right away.*

Some parents were so concerned their daughter would become sexually involved before marriage that they would arrange for her to marry at a very young age, sometimes even before puberty.

> *As I said, I was married very early, so I really had no life as a young girl. I had that life with my husband. When I got married my breasts had not yet begun to grow. I was only 15 years old.* [Lassa]

Other women had far more freedom during their childhood and youth.

> *We would get together often to watch television all evening. We would dance and others would applaud.* [San Parana]

> *I enjoyed playing with boys, going into the bush, rolling big tires. I did not like going out with other girls, and so people would say I was a tomboy.* [Samakébougou]

In short, the control that parents or guardians had over their daughters' social relationships and sexuality varied widely. The narratives included accounts of girls tricking their parents to be with their friends at night. In some cases, such events did, in fact, lead to early initiation into sex.

3.3 Premarital sex

The traditional values of societies in Mali prohibit sex before marriage, as do Islam and Christianity, which are the religions of nearly all the people in the country. However, religion is not usually invoked to explain why sexual relations are prohibited before marriage. Many women in the sample came from strict Muslim families, but they tended to cite family pride rather than their religion as the main reason for avoiding sex before marriage. The notion of the family's honor depending on their daughters' virginity at marriage was cited by a number of women in our conversations, whatever their religion. Women spoke of this not only in relation to their upbringing but also in how they were educating their own daughters.

The respondents spoke of being warned against premarital sex by their mothers, aunts, or older sisters. The following accounts show the various ways of describing their approach to protecting a girl's virginity:

> *In our community all parents want their daughter to be a virgin on her marriage day. Achieving this is a source of pride for a mother, and we want our daughters to do the same.* [Nafadji]

> *My grandmother did not accept that I go out, especially at night. She kept advising me to keep my virginity.* [Lassa]

> *The truth is that I never had sexual relations with any man except for the one who became my husband. I did have boyfriends but they never touched me. Even my future husband did not touch me until I was 15 years old.* [Somo]

Not all young women were virgins when they married. As shown in Appendix Table A.2, 26 of the 63 women interviewed who commented on the issue reported that they had had sexual relations

before marriage. These early sexual relations usually did not involve the use of contraception, and thus put the girls at risk for pregnancy and sexually transmitted infections.

> *I fell in love with a man, and with him I had my first child. And I have had three children with my husband. That first affair with a man happened in Bamako where he still lives. After that happened, I returned to the village to get married.* [Somo]

> *I had my first sexual partner when I was 17 or 18. We spent at least a year together. We were having sex, but we did not use contraception.* [Kambila]

A few respondents mentioned they had engaged in sexual relations or promised to do so in order to get money or gifts from their potential partners.

> *When I was young I got money from my sexual partners, but I never showed it to my parents. With one of my partners I had a child and he married me later on. I met this partner when I was 16 and I was in my seventh year of school.* [Nafadji]

> *I was very hard-headed when I was young. My older brothers would beat me when I went out, but I still kept going out. I had a lot of boyfriends when I was young, and I could get money from them. There were four of them. No, I am not sure how many there were. I would often leave my fiancé to be with one of the others. I got along very well with them. I could take their money but never really gave in to their advances… The only one to whom I gave in was the man that I married. Even now when I return to the village they contact me as before.* [Lassa]

The following dialogue with a woman from Wakoro shows how critical virginity at marriage has been for some families and suggests that it is more important than being faithful after marriage.

> R: *I got married when I was 17 years old. I still spent three years at home, and during that time, I took up with a young man. We had a sexual relationship. I did not use contraception, and thank God, I did not become pregnant.*
>
> Q: *Did your husband know about this?*
>
> R: *No, he should never know about it* (laugh). *Around here a girl cannot pursue other men until she gets married. We used to be afraid of men when we were young and went out at night. Our mothers advised us not to follow boys before getting married, for if you got pregnant, or you begin sexual relations, and your husband finds out you are not a virgin, it will be humiliating for the girl and her parents. So it's best that a girl wait until she gets married, and once that happens, she can have boyfriends.*

It is of course difficult to hide the loss of virginity at marriage, yet, with discretion, one can maintain relations with another man after getting married.

3.4 The choice of husbands and girls' ideas of their future family

The researchers thought that the participation of a young woman in choosing her husband and her ideas about the size and shape of her future family might possibly influence her use of contraception after marriage. Thus questions were asked about the way the respondent's husband had been chosen, her age at marriage, and how she had earlier envisioned her ideal family.

3.4.1 The choice of a husband

Three ways of moving toward marriage were identified among the respondents: 1) a marriage in which the woman was able to approve of the selection of her future spouse; 2) a marriage arranged by the family without consultation of the bride; and 3) a marriage forced on the woman. Information

about how the husband was chosen exists in 60 of the 72 interviews. Women were considered to be in a "love marriage" if they themselves had chosen their husband or had approved of the family's choice (25 cases). Marriages were considered "arranged" if the husband was chosen by family members without consulting the woman (32 cases). Marriages were considered as "forced" if the woman specifically stated that she was forced to marry her husband (3 cases). Thus marriages arranged without consulting the bride proved the most common.

Marriages may be arranged by parents when a girl is very young, or even before she is born. A father can promise his daughter in marriage to a good friend or a close relative. As a woman from Lassa remarked: *In our community a girl will become engaged at an early age.*

Committing a girl to a relative is not uncommon. As another woman from Lassa reported:

> *My parents lived in the village as did the parents of my husband. He was living in Bamako and I was in Kita. We became engaged before we knew each other. Two years after* (engagement) *he came to Kita to see me…*

According to a number of the women, such arrangements are still common in some communities. Women who had their marriage arranged by their family without their consent described their experience in similar ways.

> R: *In our community the bride and groom do not know each other. Their parents have arranged the marriage among themselves, so the newlyweds meet each other when they marry. My husband is the son of a good friend of my father. Here people do not ask the opinion of the woman; if you show you are reluctant, they may beat you. It's only now that I see that people ask the opinion of the girl about her future husband.* [Lassa]
>
> Q: *Did your parents ask for your opinion about your future husband?*
>
> R: *Ha! Here people do not do that, for if you ask the girl's opinion, if she were to refuse, in a community where everyone is related, it would cause problems. The majority of marriages in our community are like that. My marriage also was to a relative.* [Koro]
>
> *It was an arranged marriage. My husband is my cousin. The marriage was arranged by my aunt, and I did not know him. Around here the opinion of young women does not matter much. The parents decide for you. All my sisters were married in this way.* [Kambila]
>
> *My parents married me to the son of my aunt…Arrangements were made when I was 10 years old and we were married when I was 15. Before we got married we had never tried to speak to each other.* [Wakoro]

This last respondent went on to say that sometimes a girl will flee to Bamako to avoid getting married. Some of these girls end up returning to the village and marrying the designated husband, while others get married to someone they choose in Bamako.

A substantial number of women (25 of 60) were able to choose their husband or accepted the choice of their family when asked for their opinion.

> R: *It was the man who I wanted.*
>
> Q: *Was your marriage forced in any way?*
>
> R: (smile) *No, not at all. I approved.* [Dioila]

It was the man who I wanted. It was my parents who proposed the marriage. He also comes from Kambila. He had gone away to work but when he came back my parents proposed that we marry. [Kambila]

Before I got married my parents asked for my opinion. I accepted because I wanted to get married at that time. [Taliko]

Q: *Did your uncle ask for your opinion* (about marriage)*?*

R: *Yes. I told my uncle that I loved him.* [Samakébougou]

Only three women said that they were forced to marry their husband.

I was 15 years old when I was married off. It was a forced marriage. [Lassa]

My parents gave me to this man whom I did not love. I wanted to marry my boyfriend, but in our community, the man a girl loves is never the one the parents choose. [Dioila]

The issue of a woman being forced to marry at a young age may be related to the use of contraception in that it illustrates limitations in the choices women have to shape their own families.

3.4.2 Early images of family size and shape

The conversation guide allowed interviewers to probe women's ideas about their future family before they got married. We were interested in hearing their earlier thoughts about the size of their future family, whether they preferred to have boys or girls, their ideas about being in a monogamous or polygamous marriage, and other aspects of family life.

Out of a total of 72 women, 53 spoke to these topics. Eight said they had no particular ideal family in mind before they married. Some were very young at that point and had never thought much about having a family. A few were even surprised or puzzled by the question:

Q: *What image did you have about your future family?*

R: *When I was young, I never thought about such things* (laugh). [Nafadji]

A small number of women said they relied on what God gives and they did not have a preference about the number of children they would have. They said it is not up to them to decide on the number or sex of their children. Even some who actually gave a number of desired children said that in the end, it is up to the Lord, and that whatever the divine will is, is good.

It is God who gives the number of children one can have and it is God who says how many that will be. [Koro]

As far as children are concerned, I am ready to accept any number that God gives me. Whether it is girls or boys, all that depends on the will of God. [Somo]

I never had any wishes about this. I have always just relied on God and on God's will. [Somo]

It is important to note that this reliance on God's will does not necessarily preclude the use of family planning, as becomes apparent in the testimonies on contraceptive use (see section 3.6).

Among the 53 women who discussed their earlier ideas about having families, 32 said they had wished for a small family, and only 6 said they wanted a large family with many children. Among the 32 who spoke of a small family, 7 said they hoped for five or six children, and one woman said

she wanted seven. This result shows that the idea of a "small family" is somewhat relative. In fact, it corresponds closely to the desired number of children in general, as indicated in the EDSM 2006, the most recent DHS survey in Mali. A woman from Somo who had used family planning in the past explained:

> *As far as children are concerned, I had asked God to give me fewer children* (laugh)*… for example seven children or eight at the most. That would be enough for me.*

A few women reported that they had envisioned living outside Mali after getting married. A woman from San Parana said:

> *My image of marriage was that I would first complete my education, and then marry a white man overseas. At that time I wanted one boy and two girls.*

Such a desire may not be as rare as one might think, if one is to believe this woman from Nafadji.

> *Times have changed. These days some women want to get married and leave the country. I never had that intention myself. I never had any idea about the size and shape of my future family; besides, I don't like that idea.*

In contrast to some societies in other parts of the world, no preference for having boys was found in the descriptions these women gave. Some women said they wanted more boys than girls, but many women wanted an equal number of each. Others expressed the desire to have more girls than boys:

> *I wanted to have two boys and three girls.* [San Parana]
>
> *I wanted five children; three girls and two boys, but I had only two children.* [Koro]
>
> *I wanted to have from two to four girls, for boys are just good for nothing.* [Samakébougou]

3.4.3 Achieving desired family size

Many women who expressed earlier or current wishes to have a specific number of children did not have a strategy for satisfying their desire. Even if they had a specific number of children in mind, they might not use family planning to attain their objective and would simply pray that God would satisfy their wish.

> R: *I wanted to have four children: two girls and two boys.*
>
> Q: *Today you have six children. What changed your mind?*
>
> R: *It is the work of God* (laughs). *It's only recently that I learned about family planning; otherwise I would never have had all these children. And when I began using contraception, I did not really want any more children. But now I am pregnant. It is the will of God.* [Lassa]
>
> *I had wanted to have two boys and two girls, just as my sister with whom I grew up. But all that depends on the will of God.* [Koro]

Some women said they did not want to have lots of children but that this desire might be counter to what a husband would like. A woman from Kambila describes her situation as follows:

I wanted to have three or four children, but I changed my mind. I expect to have more children. My husband did not accept that I use family planning, so I do not have any plans to do so.

Some women struggle against their husband if the number of children they want is smaller than what he wants. They try to persuade their husband to accept a smaller number, or they pretend not to understand when they argue.

I do not want to have many children, for life is difficult. We have to buy food and medicine. It's a major burden. I wanted to have five or six children. My husband told me that if I do not have lots of children, he would take a second wife. I made him understand that if we can assure the good education of these four children, they would care of us better than if we had a lot more. Now he says nothing more about this. [Samakébougou]

A few women had to reduce the number of children they wanted because of financial difficulties:

I had wanted five children. Right now I have only two children, but I don't think I will ever have five. These are hard times. I would like to have another two so I have four, and that will be all for me. [Kambila]

We did not find any cases of women who wanted a certain number of children and who had a clear strategy for making that happen. It is important to remember that family planning in Mali is presented as a method to space children, not as a strategy to limit the total number of children.

According to our interviews, the majority of women preferred being part of a nuclear family living independently as a family rather than living in a compound with a group of married brothers of her husband and their parents. The women gave two reasons for this preference. One, living in a large compound means spending long hours in cooking, cleaning, and other domestic chores. Two, living with the wives of brothers and sisters-in-law can often lead to disagreements. The examples below illustrate such situations:

Originally, I wanted to live alone with my husband rather than living in a large family, because in large families, you often have lots of problems. [Taliko]

(I wanted) *a small family where there are not lots of people. I had the idea to have two girls and two boys.* [San Parana]

I wanted to get married and be part of a small family for my own good… in large families there are just too many problems. [San Parana]

3.5 Women's economic status and social networks

Although husbands in Mali are expected to bear the major financial responsibility for the household, wives are also expected to contribute. All rural women work in their fields for basic sustenance, but they, as well as urban women, need money for household needs.

Only a few women in this study were employed in salaried work or in a professional training program. The majority (6 out of 10) engaged in small commercial ventures to bring in some income. These include selling their wares in the market and working as hairdressers. The majority of women said that they did not earn much money in this way. A few of these small-scale vendors said they were not really working to earn an income. As a woman from Lassa stated: *I do not work. I do a little selling… this business does not provide much income.*

A number of women had dropped out of school in order to engage in petty trading. One woman from Lassa explained: *I left school to become a trader… I still am… I had all my kids while I was doing this.* Others saw selling their wares or services as a secondary activity, something they do in addition to home making and farming.

> *We sell food according to the season. When it's the rainy season we sell the products of the rainy season. Now we are selling oranges, mangoes, watermelon, grilled corn…* [Lassa]

> *In the rainy season I work in the fields. In the dry season I sell millet beer.* [San Parana]

> *Since I have a refrigerator, my servant sells cold water and ginger juice in town, and I sell meat on skewers.* [Sikoroni]

Even women who are employed may engage in commercial activities to supplement their income, as is the case for this teacher.

> *I teach in a school here in Kambila. In addition to teaching, I also sell items at my home.* [Kambila]

Another key element of women's economic status is the tontine. A tontine is an informal community association that acts not only as a sort of loose savings and loan bank or cooperative, but also as an exclusively female social network. These associations are formed among women who are linked by neighborhood or family ties, or engaged in the same work activities.

> *I belong to a tontine… Women in the neighborhood get together to work on peanuts we then sell and use the profits to buy clothes…* [Somo]

> *I'm part of a tontine with the women at the* lycée (high school) *set up by our school committee…* [Pelengana]

> (Our tontine started with)*… a project to learn how to dye cloth and to dress hair…* [Sikoroni]

Tontine members contribute money and goods (such as soap, dishes, clothes) to a collective fund on a weekly or monthly basis. These funds are distributed to members in turn or can be allotted to members with special needs (pregnancies, illnesses) or for celebrations (marriages, baptisms, funerals). The tontines are usually structured as clubs, with officers such as president, secretary, and treasurer who are elected by the group.

The popularity of these associations, which cross all demographic categories, and their importance to women's independent social structure are considerable. The periodic gatherings are occasions to discuss their financial situations, collect dues, and allot sums, as well as occasions for women to eat together and discuss other aspects of their lives. Hosting an occasional tontine meeting is an obligation and a source of pride.

When asked about associations they might participate in, 50 out of the 61 women who spoke of any associations said they belonged to at least one tontine and sometimes two. The other 11 gave several reasons for not joining a tontine or for having quit. 1) They had recently moved into the community and did not know the members enough to trust them. A woman originally from Guinea but now living in Bamako (Taliko) declared: *I belonged to a tontine in Guinea, but I haven't tried here yet, even though I know there are Guinean women who do that here.* 2) They were not able to save enough money to pay their dues. 3) They feared or had experienced conflicts in the group, principally because the members disagreed on the equity of the distributions.

The principal explanation women gave for not participating in a tontine was that their husband objected, ostensibly for the reasons given above, but often for no apparent reason. It is not impossible that the husband objected simply because these associations are exclusively women's ventures outside of their control.

Participation in such associations does provide an opportunity for women to share information about their lives, their families, or their problems, but we have no evidence about the topics discussed, which could include family planning.

3.6 Women's experience with contraception

As the DHS surveys have shown, most women in Mali have never used modern contraception. As mentioned, our study originally selected an equal number of women who were current users and not current users of family planning. Current users were women who were using a modern method of family planning on the day of the interview or had done so in the past six months. Non-current users covered all women who had not used contraception during the preceding six months, including those who had never used a modern method.

Once the interviews were conducted, this second category, for heuristic reasons, was sub-divided into women who had never used contraception and those who had used in the past. Thus we can classify women into three groups:

- Women who had never used modern contraceptives
- Women who had used a method in the past but were not currently using any method
- Women who were using a modern contraceptive method on the day of the interview or had used a method within the past six months

Explanations for choosing to use or not to use family planning, with insights into the women's reasoning process, emerge from the interviews conducted with women from each of these three groups.

3.6.1 Reasoning of non-users (never used)

The screening instrument used to identify women eligible for inclusion in our sample identified 36 who were current users and 36 who were not currently using contraception. (During the data processing, the research team discovered that one woman was actually a current user rather than a past user, so the study ended up with 37 current users and 35 non-current users). One-half of those who were not current users had used family planning sometime in the past, and one-half had never used contraception. Therefore, only 18 of the 72 women interviewed had never used any modern contraceptive method. This section discusses their way of reasoning.

Five of these 18 women said they did not need a method because their births were spaced naturally. In other words, even without modern contraception, they had children only every two or three years and were satisfied with that. Four of the women said they were afraid of the side effects of modern methods and four others said their husband was opposed to family planning. Only one said she knew nothing about family planning, while another said that she was having trouble conceiving, and a third said that she could not afford a modern method. Only one stated she was categorically opposed to family planning.

The reasons cited for not using contraception were mainly: 1) Family planning was not necessary because the individual's pregnancies were spaced naturally; 2) Their husband was opposed; 3) They had a distaste for medical interventions or a fear of side effects; and 4) They became sexually active or married off at such a young age that they knew nothing about family planning methods or had little to say in the matter. Each of these is illustrated below.

1) Natural spacing, which is probably due to the protection from pregnancy some women have when they are breastfeeding, was often described in terms such as:

> *As long as the baby is not walking, I don't have a period. When the child begins to walk, a little after that, I get pregnant.* [Lassa]

2) Among the four women who gave their husband's opposition as a reason for not using family planning, one said:

> *I've heard about family planning, but my husband refuses… I tried traditional methods but they didn't work… I really would like to use family planning, because I'm really tired… Five pregnancies and only one year between births…*[Kambila]

3) Another reason given for rejecting family planning was the distaste for medical intervention and the fear of side effects. Rumors about the dangers of family planning methods do circulate among women, as seen in this dialogue with another respondent from Kambila.

> Q: *Did you use family planning when you were young?*
>
> R: *No, I have never used family planning.*
>
> Q: *Do you know about family planning?*
>
> R: *I have heard people talk about family planning during the health education sessions at the health center.*
>
> Q: *Why have you never used FP?*
>
> R: *No particular reason. I am afraid of FP; people say it is not good for you, and I hate taking medicine, pills and injections.*

4) A last reason for not using family planning emerges from the statements of women who became sexually active or were married off at a young age. The following comment comes from a woman who was married at age 14 to an older man she did not know.

> *Right after I was married, a month later, I got pregnant… so I had my first child at 14… I knew nothing about pregnancy or birth spacing… Less than a year later, I got pregnant again… there's less than a year difference between the third and the fourth children either.* [Pelengana]

It should be noted that although a few women made a connection in their explanations between early marriage and not using family planning, we recognize that this situation does not preclude the use of family planning later in life.

Although all the respondents had knowledge of family planning methods, some did refer to a moment in their past when they knew nothing about how to prevent unwanted births.

> *I had a partner when I was 16 years old and in my seventh year in school. I had my first sexual experience with him, and we spent about two years together. During this time we did not use contraception; I did not know about it, and family planning was not available in our area.* [Nafadji]

Among this group of women, the wish to space births appeared as the only valid reason to use family planning.

> *My mother told me never to use family planning before you begin getting pregnant or it could cause problems. It is best to see how it goes, how long it is between*

pregnancies. If they're too close, then you can think about family planning…my mother said her pregnancies were too far apart. [Wakoro]

I have never used family planning, for my pregnancies come far apart. Thus I have not been interested in using family planning. [Nafadji]

The testimony of the following woman, who enjoys natural spacing and does not use contraceptives but who advises and aids her sisters who are experiencing births at close intervals to use family planning, is of particular interest.

The purpose of family planning is to allow the mother to rest and the father to avoid lots of expenses for the health of his kids. I've never used it because my pregnancies are far apart… I have talked to some women here who get pregnant while they are still nursing a baby… They are the ones who need family planning advice. But I can go up to three years between pregnancies so I don't need it… If I were to have kids too close together, people would say I am punishing one child in favor of the other…Some women understand and come to me for advice. I offer to keep their pills at my place and they come here every day to get their dose… these are women whose husbands are opposed to family planning. [Nafadji]

3.6.2 Reasoning of former users

The research into the reasoning of women who had previously used contraceptives but were not currently using them focused on why they had discontinued use. Out of a total of 72 respondents, 17 had previously used contraception but were not current users. Two respondents said their husbands did not agree to the use of family planning. Other reasons infrequently cited were the inefficiency of the method, miscarriage, and menopause.

In the group of former users, two major reasons for discontinuing family planning were given: 1) the desire to have another child; 2) the side effects experienced in using pills or injectables. Seven women said they had ceased using a modern method because they wanted to have another child. Six said they stopped because of side effects.

The side effects cited primarily concerned injectables, though a few women also had problems with the pill. Some women said they had fallen seriously ill after the injection. Women complained of abdominal pains, the absence of periods, or, on the contrary, excessive bleeding.

I stopped because of an illness from the injectables that I'd started after my fifth pregnancy. I was bleeding all the time, my periods never stopped. [Dioila]

When my last child started walking, I took the injection. I got really sick and that scared me. I didn't have a period for eight months. With traditional methods, all goes well, but these modern methods make you sick…[Lassa]

Recently the pills have begun to cause problems for me: intense back pain, abnormal menstruation. I just decided to stop, that is how I have this pregnancy. [Pelengana]

When asked if she had gone to the hospital, the woman quoted just above said no, she had just stopped. Family planning providers cannot always follow through in treating women who have side effects.

Some women said they preferred injectables over the pill. A former user of both the pill and injectables said:

Some of my friends told me if a woman needs family planning, she should take the pill because she'll have a period every month… with the injectables, the blood coagulates

in the abdomen and you can get stomach aches and have a big belly… Between my second and third child I took the pill, but since I forgot some days, I got pregnant… So I decided to try the injectables… Although I stopped a year ago, I didn't have any problems when during that time (while using injectables). [Dioila]

The issue of discontinuation of family planning methods because of side effects has often been cited in family planning studies, and it is clear that side effects caused some women in our sample to drop family planning.

3.6.3 Reasoning of current users

Thirty-seven women participating in this study were considered current users of modern contraceptive methods. The majority of these women (20 of the 37) explicitly said they used modern contraceptive methods to delay pregnancies and space their births.

My first pregnancies were very close together… so I asked the community health worker about family planning... At first, I used the injectables. After two years I stopped to have another child… then I had some problems with the injectables, so I started on the pill… I don't have any more problems. I don't have a child suckling with another one on its way. So I can go about my tasks with no more problems. [Wakoro]

My pregnancies were too close together… This affected me and the children… My husband and I decided to use family planning… But if he asked me to stop, I would. [Koro]

Many current users expressed satisfaction with their contraceptive methods, as these comments illustrate:

R: *I started family planning after my second child. I did it on my own because I realized I'm a woman who has closely spaced pregnancies, judging from the space between my first and second child.*

Q: *How did you hear about family planning?*

R: *A midwife told me about family planning… I heard about injectables on TV… I bought the injectables at the pharmacy and she* (the midwife) *gave it to me at her home…I had some problems at first, like I didn't have a period for six months, but nothing major.*

Q: *How about having another child?*

R: (laugh) *I don't really know, but I am going to just watch for awhile.* [Dioila]

Family planning is a good thing for women. Women can avoid pregnancy while they still have a baby to carry around. Spacing births gives mothers more confidence. Closely spaced births tire both children and mothers, and keep mothers from prospering. [Somo]

The same respondent indicated that husbands are often opposed to family planning.

Husbands around here object to family planning, but I don't know why. Women who are concerned about themselves may use family planning without the knowledge of their husbands… Some say it's for more children or that their mother never used family planning. I use family planning without my husband's knowledge. I talked

about using family planning with my husband; he didn't say anything so I figured he didn't agree. [Somo]

Another woman said she also hid the fact she was using family planning from her husband.

To tell the truth, I hid to take my pills… I take oral contraceptives without my husband knowing… he wouldn't be happy if he learned that. I have been using family planning for a long time without my husband's knowledge [Lassa]

Women using contraceptive methods gave other reasons besides spacing births. Six said they did not want more children any time soon because of financial reasons, and that they thought the household could not afford the expenses of a larger family. Four had suffered from difficult pregnancies and wished to avoid more. Three had had caesarians. Only two declared categorically that they did not want any more children.

In sum, nearly all women interviewed understood that family planning can be used to space births, including those who have never used family planning. They recognized the positive effects of proper birth spacing.

Several of the women who had never used family planning were nevertheless open to using it in the future, as in the comments by a woman from Wakoro.

R: *Between my first and second child there was an interval of only two months, since my first child died and I became pregnant two months later.*

Q: *Did you not think of using family planning after this happened?*

R: *No, I was very young and I did not know about family planning. After the birth of my second child, three years passed before I had another child. I did not use a method of contraception, either modern or traditional; it was an act of God. The same thing happened with my other children, and my youngest is nearly three years old and I am not pregnant. However, it might be possible that things will change, and in that case, I will contact a community volunteer to find out about the family planning methods available.*

3.7 Comparison of groups of women by contraceptive use: ever and never

Although it is useful to divide the respondents into three categories in order to consider the reasoning behind their actions, membership in these categories is not static. A woman classified as a current user may not be using contraception a year from now, while a past user may well become a user again in the future. As with the woman from Wakoro cited just above, even women who have never used a modern contraceptive method might consider it later if their situation were to change.

To further examine the relationship between the respondents' narratives and their use of family planning, we will now consider the two broad groups in the sample: 1) those who have never used family planning; and 2) those who are using family planning currently or have ever used it in the past.

There were few significant differences in the respondents' accounts of their earlier lives according to whether women had never used modern contraception or had used it. All came from large families; many had experienced a number of deaths of siblings. The respondents had all been raised to uphold the value of virginity before marriage, but their girlhood experiences varied widely, from being virtually confined to being allowed a great degree of freedom. As for education, there was little difference in the distribution of school attendees—whether a medrasa, a Koranic school, or a public school—between women who had opted for family planning at some point and those who had

never used it. Similarly, no significant differences were found with respect to women's social status and economic activities.

Differences between the two groups, however, were found in relation to the nature of the household, premarital sex, and the role of the woman in approving the selection of her husband. Monogamous marriages were more common among contraceptive user (37 of 54) than among never users (10 of 18). One possible explanation for this difference is that women in monogamous marriages have the full responsibility of child-bearing and caring for children, while women who have co-wives can share these responsibilities.

Other experiences that this study found to vary significantly between users and never-users of family planning include those related to women having had sexual relations before marriage, women's roles in the choice of their future husbands, and the opinions of their husbands about family planning.

1. The study collected information on the issue of premarital sex from 63 of the 72 women in the sample. Among the group that had never used family planning, only 2 of 17 reported having had sexual relations before marriage, while among ever-users 24 of 46 had sexual relations before marriage. Two explanations help make sense of this result. First, women in Mali who had sexual relations before marriage very likely get married at an older age than those who do not, and thus have more control over their lives than a girl married at age 14. Second, women who have sexual partners before marriage may use contraception with their partners, placing them in the group that used family planning in the past. In our sample, however, only one of the women who had sexual relations before marriage reported that she used a family planning method, and several women said they had one or two children before getting married.

2. As indicated earlier, from the girl's point of view the choice of a husband may be forced, or arranged without her participation, or the girl may have given her consent to an arranged marriage or have chosen her future husband by herself. Among the women who had never used family planning, only 2 of the 14 said they had approved of the choice of a husband, while one woman reported that the marriage had been forced and 11 reported that it had been arranged without their approval. Among those who had used family planning, 23 of 46 had approved of the choice of a husband. As in the case of sexual relations before marriage, it seems likely that this difference may also be related to age at marriage. Certainly, young women who marry at age 19 or 20 rather than age 14 would have an improved chance of participating in the choice of a husband. Unfortunately, the respondents were not asked about their age at marriage.

3. Most respondents (54) spoke at some point about their husband's view on family planning and the need for his consent before they began using a method. Among the group that had never used family planning, 5 of 9 women reported that their husband had a negative opinion of contraception; while in the group that had used family planning in the past or were presently using it, 14 of 45 said their husband had a negative opinion of family planning. Two women in this group of 14 reported that they had used or were currently using a contraceptive method without their husband's knowledge.

As the interviews in this chapter show, a woman's decision whether or not to use modern contraception is contingent on her assessment of her own situation. The use of family planning is temporary and shifting over time as women's circumstances change and as they have more children. In addition, the decisions of Malian women to take action for family planning cannot be considered only as her own individual choice, but also the result of social interactions with family and friends. The most immediate agents involved in a woman's choosing to adopt family planning or not to adopt it are their husbands and their health care providers. These are treated in the next two chapters.

CHAPTER 4: TRIAD DISCUSSIONS WITH MEN

A total of 36 married men participated in the triad discussion groups. Four such discussion groups were held in each of the three regions of the research study (See Table 1 in Chapter 2). Groups of three men in four urban, four peri-urban and four rural sites assembled to discuss family life and family planning. The conversation guide used to orient the discussion can be found in Appendix B.2. The topics discussed included men's knowledge of and opinions on birth spacing and the benefits or drawbacks of family planning, early notions of their ideal family and satisfaction with their current family size and form, and their consent to or participation in family planning.

4.1 Support of birth spacing

Although the Malian national population policy aims at a balance between demographic and economic growth, family planning programs are based solely on the need for birth spacing for the health of the mother and child. In public health campaigns, little attention is paid to limiting births in order to ensure the financial well being of the household or the parents' ability to provide for the future of their children.

All of the men in the triad discussion groups said that birth spacing, whether by natural means or modern family planning methods, was essential to the well-being of the family. The primary reasons given were the health of the mother and the children and the lessening of the financial burden on the household.

> … (with birth spacing) *we can have fewer health problems with the baby, and the baby can breast feed properly. If births are spaced very closely together, the mother can no longer properly breast feed her baby…she can't take care of the child.* [Dioila]

Men repeatedly mentioned the health of the children as a major reason for spacing births. They understand that, when a woman is pregnant while she is still nursing another child or has to contend with two infants at the same time, health problems multiply. The mother cannot recover between pregnancies, deliveries, and breastfeeding, while also fully satisfying the needs of the older child.

The burden of births at close intervals and the benefits of well-spaced births emerge again from the following men's comments:

> *We would have less illness to deal with and fewer expenses to pay. For example, a woman who just gave birth and in one or one and a half years gets pregnant again … Can you imagine? A baby on the way while she is nursing the other and you, as a father, cannot get any peace.* [San Parana]

> *The main advantage is to allow children to thrive and profit from good nursing.* [Samakébougou]

Whatever their level of education or urban-rural context, men cited birth spacing as a major concern, as the comments of a man from Sékoro illustrate.

> *If births are not too close, the children will be stronger and healthier. Parents will have fewer problems and the family will prosper.*

4.2 Views of family planning and modern contraceptive use

Although all of the men agreed on the benefits of birth spacing, they did not necessarily agree on how this should be done. The majority interviewed said they were in favor of active family

planning and had used health services providing family planning. The immediate economic benefits of family planning were cited by several men.

> *After several close births, my wife and I decided to use family planning. I bought so many prescriptions during her pregnancy and my wife and the babies were always sick.* [Parana]

Others said they would rely on "natural" methods or God's will to assure the proper spacing of their children's births. Several said their wives' pregnancies were spaced naturally, i.e. at reasonable intervals of two to three years, and they saw no reason to use modern contraceptive methods. Some said they could regulate conception through limiting intercourse according to the "standard days" method. A few of the men interviewed talked about traditional methods outside of abstinence or controlled intercourse that were used in their community to prevent pregnancy. Traditional methods mentioned included plants and charms such as the *tafo* (a cord with knots and amulets that the woman ties around her hips), but most men agreed these were not effective.

A few respondents openly displayed a negative view of family planning. Among men who said they were personally opposed or who cited reasons others might oppose family planning, the reasons given were ideological or economic, and can be summarized as follows:

- Contraception is imported from the West as a way of reducing the African population. We do not share those Western values.
- We need more children to help at home and on the land.
- The number of children we have depends on God's will.

Several respondents, particularly from rural communities, said that modern contraception was imposed by the government, the cities, or the West to control population growth.

> *… we are farmers, the others are intellectuals who went to big schools, therefore we are not of the same mind…You want us to be involved in something we do not recognize.* [Samakébougou]

> *We hear that black people are more and more numerous and that white people want to stop this growth. Really, I can't accept this…* [Kambila]

Yet another man declared that controlling population growth in Mali did not correspond to their values, that large families were appreciated in Africa, contrary to the West.

> *This was not part of our socio-cultural reality… it has been imposed by the West… Our large families are a source of great pride… Someone with a big family can't be accused of lacking love for others in the world.* [Taliko]

While some men saw economic considerations as a reason for limiting births, others saw numerous children as a source of wealth.

> *We need help to work the land… City folks worry about jobs, but we have to worry about helping hands…. What exactly is your birth spacing system aiming at?* [Samakébougou]

Another reason for opposing modern contraceptive methods implied the loss of control over female sexuality, particularly among young girls. Some men interviewed feared that sexual relationships might become banal, leading to premarital sex or marital infidelity among women.

Contraceptives are supposed to space births… but I think they do more harm than good, because, today, young girls, our sisters and our daughters, rely on contraception to go out and do any stupid thing… [Sikoroni]

Using contraceptives among young girls just encourages adultery… because she knows she won't get pregnant… if contraception were limited to married women, it would be more beneficial. [Sikoroni]

A man from Taliko made a distinction between using contraception with his wife and his mistress.

Once a woman learns about family planning, you've been had, for she can use a method even without you knowing about it. So if you want more children, you will have to take another wife. The case of a mistress or a girl friend is different. I can use contraception with them… but I would never do so with my wife.

A man from Wakoro said much the same thing.

Many people do not feel comfortable using a condom with one's wife; however, many will feel fine about using a condom outside the home.

4.3 Knowledge of modern contraceptive methods

Although a few men declared they had limited or no knowledge of modern contraception, most respondents demonstrated a surprisingly sophisticated knowledge of the full range of short-term and long-term contraceptive methods available, as well as dosage and possible side effects. The methods most often mentioned included the male condom, the pill and injectables.

Many respondents had a detailed grasp of how to use pills and injectables, as the comments below indicate.

There's an injectable product that works for three months. [Sékoro]

As for the pill, you have to follow the arrow on the package and take one every day. [Wakoro]

Drawbacks to using these two methods were also cited. The two respondents from the rural community of Somo cited below indicate the wide range of the concerns expressed by men.

People say that some family planning methods can make a woman sterile, or she'll have complications when giving birth … (The use of contraceptives) *can explain the increasing number of miscarriages…*

When a woman uses (modern contraceptives), *she can have constant belly aches and when she stops and does give birth, she can have twins rather than just one child.*

Fear of side-effects from injectables and the pill often lead men to adopt only "standard day" methods.

(The methods I know about) *are the necklace, the three-month injectables, the pill, and implants. We use the necklace simply because there's no chemical product involved.* [Sikoroni]

Although widely known and accessible, male condoms are almost never used as a means of contraception in marital relationships. Despite the fact that condoms are not a chemical invasion, do not pose any health risk to the woman or children, do not complicate the chances for subsequent

pregnancies, and are an inexpensive and easily used method over which men have entire control, the male respondents categorically rejected using this method, especially with their wives.

> *… Most people are uncomfortable using condoms in the family. Lots of men use them outside… with girl friends…* [Kambila]

> *You can use contraceptives with your girl friend, but never with your wife.* [Taliko]

4.4 Early notions of ideal family versus current reality

Men were asked about their early visions of an ideal family and how their present reality corresponded to that. Had they thought about the number of children they wanted and how they would provide for them and their education before they were married? Although the number of wives for polygamists was not part of the conversation guide, it was a major concern for the men. Over a third of the participants had more than one wife, and most wished to have more. Out of the 36 men in the discussions, three-fourths were or wished to be polygamous.

> *We'd like to have many wives, but we don't always have the means. I'd like at least three wives.* [Sékoro]

> *If God gave me the chance, I would have up to four wives. As for the number of children… I want as many as possible.* [Wakoro]

> *I want to take a second wife and have 12 kids, 6 girls and 6 boys…* [Kambila]

> *At first, I wanted only one wife, but as the years went by I started wanting a second… I have 10 living children and I can't complain even if I have no more.* [Parana]

Asking respondents about their earlier visions of their adult married life often leads back to youthful dreams rather than what would be a reasoned plan for the future. Just as some women who claimed they wished to marry a rich man or live overseas (see section 3.4.2), many men shared their extravagant wishes, while qualifying these according to their own circumstances.

> *If God granted me this wish, I would have enough children to make up a village… At least 20, because there might be some handicapped ones in the lot.* [Sikoroni]

> *As a Bambara, my wish was to have four wives and so many children I forget their names… But the essential is to be able to provide for their needs.* [Samakébougou]

When asked whether they were fulfilling their earlier visions of an ideal family, some said they were still working toward that, but most said these had shifted as they faced their current reality. Reasons for reducing the number of wives or children they desired were in large part attributed to the financial burden of a large family.

> *I wanted three or four wives before, but now I have one who has given me four children which is sufficient… I can't afford any more...* [Somo]

Considerations such as their children's education and future, which had been absent from the earlier ideals, appeared as the men grew older and their family's size increased.

> *I have three children, two sons who are in school and a daughter. Besides attending school, I would like my children to have a technical training… my sons as mechanics and my daughter as a seamstress... It is hard these days to educate your kids as you would like… I don't have the means.* [Dioila]

There were some cases where men had imagined a small family but later revised their plan because of their current circumstances. One man whose earlier vision was a monogamous household became polygamous, saying things were easier with a second wife.

> *I realized that if the first wife gets sick, with the kids and all, it gets complicated for me. It's easier with two wives.* [Lassa]

While not necessarily revising their estimate of the number of children they wished for, several respondents claimed they needed more wives to produce children or they needed their wife to deliver more children, because a number had died.

> *I had seven children but three died.* [Sékoro]

> *Among these children, there are those who live and those who will die.* [Nafadji]

The respondents often expressed the need to produce more children because many died. Child mortality was also cited as a factor in the respondents' wishes for children of either gender, as long as they were healthy. As in the women's narratives, the general preference among men was to have an equal number of daughters and sons, as expressed by this man from Parana: *I dream of having as many boys as girls, and that they be brought up in the same conditions*.

But the loss of children often caused men to revise their plans. One respondent from Diolia said he had wished for three sons and three daughters, but since the couple had lost many sons, he wanted more births: *I have only two boys left, because five out of our eight children died… I am thinking of getting another wife because I want those six children.*

Finally, a few men were reluctant to say much about their ideal number of children and their plans, saying the decision was in God's hands: *I am happy with the number of children God gives me. I am grateful for the four He has given me so far.* Most men said they themselves would decide how many wives they would have, but God would decide the number of children. One respondent said his parents had decided on his first wife, but he himself could choose to have more. The following quote from a man from Lassa illustrates how men might take on more wives but not have any active role in the number of children: *I want to marry many wives and I'll be happy with the number of children God grants us.*

4.5 Consenting to and participating in family planning

Responses to the question of whether a wife could use family planning without their husband's consent were almost unanimously *no*. With only one or two exceptions where respondents declared family planning was strictly up to their wives or beyond their control, the men interviewed said they adamantly opposed their wives using contraceptives without their consent.

> *In my opinion, that is unacceptable. A woman cannot make that decision on her own. She needs to consult with her husband.* [Sékoro]

Many respondents said the use of family planning by a woman without her husband's consent was a cause for divorce. One respondent said husbands and wives need to communicate and that he had agreed to family planning with his three wives after discussing this with them. Most respondents wished their wives would at least try to reach agreement with them before using contraception. As one man from Taliko stated: *The woman can cajole the man into accepting. But forcing this* (doing it on her own) *does not work.*

Some respondents said they not only agreed to family planning but took an active role, declaring the husband and wife had visited family planning services and decided on a method together. Some respondents demonstrated such a sense of ownership in the process that they used the

first person to talk about female contraception, just as some men in the West say "We are pregnant" when referring to their wife's condition.

> *We decided to use pills and injections…because the births of our first two children were too close together.* [Kambila]

> *I decided to use family planning because of the expenses I had suffered with my first child.* [Somo]

Some respondents were so supportive of modern family planning that they wished to see greater promotion of these programs for the general population.

> *We should encourage anybody to use a method, because there's not enough work to go around and to feed everybody; an empty stomach leads to sickness.* [Lassa]

> *Just as they did with vaccinations and malaria prevention programs, people should go door-to-door to encourage family planning.* [Dioila]

4.6 Summary of why men support or oppose the use of modern contraceptives

Since husbands play such a crucial role in family dynamics and decisions to use family planning or not, their understanding and reasoning needs to be highlighted and reexamined in their social context. All of the respondents clearly recognized the advantages of short birth intervals, and the vast majority knew about contraceptive methods and made supportive declarations of family planning. However, it is not clear how many of the respondents were willing to take an active role in using modern contraceptive methods.

The major reasons men cite for using modern family planning methods can be summarized as follows:

- For the sake of the health of the mother and the children, it is important that women do not have children too close together.
- The financial burden weighs heavily on the head of the household when children come too close together.
- Traditional methods (such as plants or charms) or "natural" methods (such as standard days for intercourse or expecting that the lactation period protects against pregnancy) are generally not effective.

The major reasons men cite for opposing modern contraception or ceasing to use such a method can be summarized as follows:

- There are side effects to these methods that are uncomfortable for the woman and can prove dangerous to her health or that of her baby.
- Contraception is a way of imposing birth control to limit the population of our communities. It is up to God, not to man, to decide. We need more children to increase our wealth.
- Modern contraception encourages young women to have sex before marriage and wives to commit adultery.

Two paradoxes emerge from the men's testimonies:

1. Respondents cited the loss of children as both a reason to control birth spacing because they needed to assure the health of their babies, and as a reason to increase the number of births in order to replace children who had died.

2. Respondents said multiple children were a financial concern because of all the expenses involved in taking care of the baby and the mother and for raising the child. Yet, especially for parents with few resources, a child is considered as a source of wealth.

We will return to these paradoxes—as well as to how the testimonies of women, men, and family planning providers compare—in the concluding chapter of this report.

CHAPTER 5: INTERVIEWS WITH FAMILY PLANNING PROVIDERS

A total of 22 interviews were conducted with people who provide family planning services/products in the three regions of the study. Twelve professional providers were interviewed, one in each of the study sites. Seven community-based volunteers were interviewed among the four sites where USAID had sponsored a volunteer program. The original plan was to interview two CBVs in each or the four sites, but only one was reached in Kambila. In addition, three interviews were conducted with ambulatory sellers of pharmaceutical products in the Ségou region. These vendors of various medicines and pharmaceuticals who operate in public spaces (commonly referred to as *pharmacies par terre*) were interviewed because they were sometimes mentioned as a source of contraceptives in women's narratives and could indicate the preferences for one contraceptive method over another.

A loosely structured guide was designed for the interviews with the professional providers and CBVs (see Appendix B.3). The topics covered in the interviews included: the provider's training in family planning methods and counseling, their responsibilities and tasks, the approaches used with different clients, their satisfaction with their work, the contraceptive methods they prescribed, and the clients' preferences for one method over another.

5.1 Training in family planning among professional health care providers and CBVs

The nurses and midwives working in health care centers who were interviewed had for the most part received some training specifically directed toward family planning methods. They could all prescribe contraceptives such as the pill and administer injectables. The CBVs also had received some training in family planning but could only distribute pills or advise women to consider using family planning if in need and refer women to health centers for other methods.

When questioned about their training, these providers tended to talk about their formal education and having attended training programs in public health. Family planning providers, both professionals and volunteers, are expected to deal with a number of public health issues including maternal and child health, nutrition, malaria prevention, sexually transmitted infections, and HIV prevention.

Although all providers interviewed had a thorough grasp of modern contraceptive methods and most claimed they had received specific family planning training, it is not clear how extensive the training was in certain issues. It was unclear how much training they received regarding counseling clients regarding specific contraceptive method uses or how to treat side effects.

5.2 Contraceptive methods preferred by clients

Some, but not all, health facilities offer long term contraception such as the IUD or permanent methods such as sterilization. Among the short-term methods that family planning providers mentioned, two emerged as the most popular for women wishing to avoid or space pregnancies: the pill and injectables. These two contraceptives are offered in the 12 health facilities covered in this research and are, for the most part, available to clients who wish to delay their next pregnancy. Long-term methods are available in about half of the facilities. In all cases, family planning providers said clients preferred injectables over pills or other methods.

Health care providers explained clients' preference for injectables by two main reasons: 1) Injectables are easier to hide from husbands if women are using family planning clandestinely; and 2) Women often forget to take the pill on a daily basis, whereas injectables only require a visit to the facility every three months. Two provider comments illustrate the first reason:

Men do not have a good opinion of family planning, so the women have to hide what they're doing. [Samakébougou]

(Injectables are preferred) *for the simple reason that most women are hiding the fact they're using family planning.* [Wakoro]

If these impressions were held generally among providers, it would greatly complicate the involvement of men in the promotion of family planning.

Concerning the second reason given for clients preferring injectables over the pill, one provider observed: *They say they often forget to take their pill and they fear the consequences of their mistake*. [Somo]

Community volunteers working in family planning also noted that their clients prefer injectables over the pill. The same two reasons were given, i.e. the ease of an injection every three months and the discretion it affords women.

Street vendors operate in markets and other public spaces. They buy and sell pharmaceuticals that can be over-the-counter products or prescribed medicine that can be obtained through dubious means. Interviews conducted with three such ambulatory vendors show how family planning method preferences have shifted over time. One reported that he used to sell condoms but no longer carries them since there is so little profit and demand has slowed. Another reported that women who buy pills from them are very satisfied with their purchases and that the women have not had any problems. One said that women asked for injectables but that he has to refer them to the local health clinic or pharmacy. Thus even the underground market of pharmaceuticals can reveal a picture of current preferences for people wishing to space births.

Prices are not likely to be lower in these parallel markets since women can purchase most contraceptives at the clinic for a minimal fee. Reasons for purchasing pills from a street vendor may be because it is more convenient or because of a personal relationship. One of the respondents from Nafadji who gets her pills from a *pharmacie par terre* said she just did not have the time to go to the health center, so she buys them from a street vendor.

5.3 Why women use or stop using modern family planning methods

Professional health care providers and community volunteers were asked their opinions on why women choose to use a contraceptive method. The reason most often cited was the wish to avoid pregnancies and births at short intervals. A provider from Somo indicated: *Most women using family planning want to space their pregnancies*. Another from Kambila said: *For married women, the major concern is not having births too close together*.

Three of the respondents (two professionals and one community volunteer) indicated economic motivation, or poverty in the family, as a major factor.

Some will tell you their husband doesn't take care of her or the children when they are sick. It's a burden for her, seeing the difficulties in buying medicine and providing food, even clothes. [Pelengana]

Women seek family planning in order to reduce the family's expenses… Because the more children you have, the more the woman suffers. [Somo]

Two providers mentioned numerous births as a reason to begin taking contraceptives. This, they said, was due less to a desire to reduce the number of children than to avoid the toll on the woman's health.

Some even say they want to stop getting pregnant because of repeated complications during delivery. [Somo]

The third reason providers mentioned alluded to younger women who did not want to become pregnant before marriage. In Mali, contraceptive use rates are known to be higher among single women (EDSM 2006); however, since this study concerns only contraceptive use among married women, this reason is not relevant to the research except to indicate that women do not shy away from contraception itself because of any kind of taboo or innate fear.

Although the question of why some women discontinue use was not directly broached with the family planning providers, the answers are implicit in their accounts. Outside of the obvious reason that women wish to have another child, other reasons might be fear of their spouse's disapproval, and side effects, especially those due to injectables.

Even today, a woman came into the CSCOM complaining of bleeding for the past two weeks. [Wakoro]

Excessive and prolonged bleeding, abdominal pains, and irregular cycles are some of the side effects of injectables mentioned by providers; these same side effects also figured in the women's and men's accounts of this study. The absence of menstruation has already been cited in the women's narratives as a reason to cease using injectables. Providers say that frequently women who suffer from side effects do not go to the clinic for treatment, which also means they might not appear for their next injection. Providers also indicated that they were not well equipped to relieve women of side effects. They could prescribe or provide pain killers but were not prepared to staunch bleeding.

Our instructions are to give women Ibuprofen to stop the bleeding… We need training in how to cope with these problems. [Wakoro]

5.4 Providers' and volunteers' suggestions for improving family planning services

In order to increase the use of modern contraception, most professional providers said that there should be more family planning campaigns, particularly focused on men, whom they see as ill informed. Several said they made special efforts to advise men about family planning use and the need for birth spacing.

The group that is well placed to promote the use of contraception in their communities, that is the CBVs, known as *relais*, talked about the problems they had in increasing and improving their services. They said they were still hampered by a lack of communication with the health facilities and program directors, although this has improved somewhat. Despite the fact they had agreed to provide assistance without payment, many felt they should receive compensation, or at least be reimbursed for expenses.

At some point we were promised salaries, but this has not happened. [Somo]

We face the problem of travel expenses… it is not at all easy to visit women door-to-door. [Wakoro]

Our difficulties are numerous… even getting around is hard. [Sékoro]

5.5 Challenges to family planning services

One of the basic challenges in providing family planning services is the lack of communication between clients and health care providers. Family planning providers often attributed the lack of family planning to men's refusal to use it. Yet this is not the major reason for rejecting or discontinuing family planning cited in the women's and men's testimonies in this report. It seems important to change the nature of the communication with men in regard to family planning. These

service providers stated that men seem uninformed about family planning methods, but the discussions with men in this study indicate otherwise. We found that men were better informed than women about contraception in general. A way must be found for facility staff to discuss these issues with men from their local community.

Another challenge lies in the limited number of contraceptive methods offered. Care needs to be improved by offering more methods and by addressing side effects. Family planning providers understand the need for offering a wider range of contraceptives, and that not all women will best be served with only pills and injectables. Condoms, implants, and the IUD may also prove useful for some. The nurses and midwives said they are unable to adequately address side effects. Care providers must be able not only to address side effects during counseling but also to offer treatment when needed to relieve symptoms.

Finally, if CBVs are to play a part in promoting family planning, donors or the government should clarify their working conditions. At the moment, they appear uncertain about their role and their compensation. Obtaining reimbursement for their expenses would be one way of improving their situation.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Circumstances of using family planning

The findings of this study point to four key conclusions about users and non-users of family planning among married women in three regions of Mali. First, women and men understand the dangers posed by short birth intervals for the health of the mother and her children. Second, they understand the benefits of contraceptive use, and few are opposed to family planning on principle. Third, women's experiences in becoming socialized, finding a husband, and having children are associated with the practice of family planning and women's ability to use contraception. Fourth, both women and men, often fail to apply their knowledge of the spacing of births to their own situation.

Since contraception prevalence is low in Mali, we expected to find that the history, social situation, and economic activities of women who are currently using family planning would be different from those of women who are not using currently using family planning. The findings do not show systematic contrasts in the current social and economic status of users and non-users of contraception. However, the findings do suggest an explanation for why this is not the case. The demand for family planning is contingent and temporary in large part, dependent on the woman's assessment of her birth intervals and her desire to have more children. In addition, a woman's situation with respect to her birth intervals changes over time as her family grows. A woman assesses her need for a method to space her births over a period of weeks or of months, and then her situation shifts: she uses a method, or she just waits and sees, or she becomes pregnant.

The women who had never used family planning explained that they had no need for birth spacing since their births were spaced naturally, or they feared side effects. Several also stated that their husband opposed family planning. Some of the women in this group said they might use family planning if their birth intervals became too short. Women who had used contraception in the past but were not current users gave two major reasons for discontinuing use: the desire to have another child, and the side effects experienced in using a method. The side effects cited primarily concerned injectables, though a few also had problems with the pill.

Several differences were found in the experiences of women who had ever used family planning and those who have never done so in relation to the nature of the household, premarital sex, and the role of the woman in approving the selection of her husband. Monogamy was more common among contraceptive users than among non-users. It was more common for women who had used or were using a method to have chosen or approved of their husband than women who had never used contraception. Similarly, women who were current users or had ever used family planning were more likely to have had premarital sex than non-users. Such an apparent association could be the result of having had a longer time period between the initiation of sexual relations and marriage, or having used a contraceptive method before marriage.

The fact that the use of family planning is contingent on a woman's assessment of the length of her birth intervals and whether or not that constitutes a danger to her health and that of her baby creates an opportunity for counselors of family planning services. First, it is not clear what constitutes a very short interval for women. Reading between the lines of these accounts by women suggests that an interval of less than two years would be judged to be too short. Yet it is not clear to what extent women share this position. Those who stated that their births were spaced naturally said that their menstruation returned after their child had begun to walk which might suggest an interval of less than two years. Counselors can help women to reflect on their situation and consider what would be a proper length of time between births. In addition, counselors should not forget that a woman's situation with respect to birth intervals changes each time she has another child, and thus the woman's evaluation of her own need for family planning may have changed as well.

6.2 Men's accounts

All of the men in the triad discussion groups declared that birth spacing was essential to the well-being of the family. The major reasons cited for using modern contraceptive methods were: to ensure the health of the mother and children, to avoid the financial burden of having many children too close together, and because traditional methods (such as plants or charms) or "natural" (such as relying on protection from pregnancy during lactation) methods are not effective. The major reasons for opposing modern contraception or ceasing to use such a method were the side-effects of these methods that are uncomfortable for the woman and can prove dangerous to her health, that contraception is a way of imposing birth control to limit the population of their communities, and that modern contraception encourages young women to have sex before marriage and wives to commit adultery.

The paradoxes that emerge from the men's testimonies can be explained by considering their context.

First, these married men cited the loss of children both as a reason to control birth spacing because they needed to assure the health of their wives and babies, and as a reason to increase the number of births in order to replace children who had died. These two understandings may be held by the same man but invoked in different contexts. A man who has just lost a young child and who believes that a short birth interval contributed to the loss may well help his wife to use family planning for a while so that she can recuperate. In the long term, however, he may want her to keep having children.

Second, the men said that having numerous children constituted a financial burden because of all the expenses involved in taking care of the baby and the mother. Yet, especially for parents with few resources, a child is considered a source of wealth. Children provide valuable labor in caring for the home, tending the fields, and even assisting in small commercial ventures. Additionally as children move into adulthood, they are expected to contribute to the household's wealth and to provide care for their elders. Compared to these long-term benefits, the immediate risks of increased expenses may seem bearable.

6.3 Family planning providers' perspectives

Some, but not all, health facilities offer long term contraception such as the IUD or permanent methods such as sterilization. Among the short-term methods that family planning providers mentioned, two emerged as the most popular for women wishing to avoid or space pregnancy: the pill and injectables. Long-term methods are available in around half of the facilities. In all cases, providers of family planning methods said clients preferred injectables over pills or other methods, because injectables are easier to hide from husbands if women are using family planning clandestinely; or women often forget to take the pill on a daily basis, whereas injectables only require a visit to the facility every three months.

One of the basic challenges is the lack of communication between clients and professional health care providers. Family planning providers often attributed the lack of family planning use to men's refusal to use it. Yet this is not the major reason for rejecting or discontinuing family planning that men or women themselves cited. Similarly, service providers stated that men seem uninformed about family planning methods, but the discussions with men in this study indicated otherwise. A way must be found for health facility staff to discuss these issues with men from their local community.

The family planning providers interviewed understand the need for offering a wider range of contraceptives, and that not all women will best be served with only pills and injectables. Condoms, implants, and the IUD may also prove useful to some. The nurses and midwives said they are unable to adequately address side effects. Care providers expressed the need for more training to address side effects during counseling, and training to offer treatment when needed to relieve symptoms.

6.4 Limitations of the study

This study could have been improved with several modifications. In interviews with the women, the research team might have spent less time on the eliciting of the experiences of younger years and more on obtaining details of the history of contraceptive use. Given the important role played by family planning providers, the study would have been stronger if more time had been spent in discussions with these providers, in particular to ask more about their interaction with clients. The study would have benefited from a more thorough pursuit of several of the guiding research questions articulated at the outset. Finally, the research team did not systematically ask respondents about their age at marriage or age at the birth of their first child. Such information could have been used to better interpret the associations between the use of contraception and early marriage and the approval of a husband by a woman and the role early marriage might play in impairing women's ability to take action in directing their reproductive health and determining their family size.

6.5 Recommendations

Efforts to increase the use of family planning in Mali have often focused on increasing contraceptive supply and access, since access remains poor in some regions. The expansion of family planning service sites will continue to be important in satisfying the unmet need for family planning. This study, however, focused on the challenges in increasing demand for family planning services, where access to supplies and services appears to be less of an issue than other factors. The findings suggest several strategies to increase the use of family planning in the three study regions, and perhaps more widely in Mali.

- ***Improving communication with married men***

The family planning providers interviewed believe that men know little about family planning methods and that most oppose the use of contraception. The discussions with men showed a different image. Many men, however, do not apply their knowledge to their own situation. The directors of family planning programs should find a way to discuss family planning with men in order to correct their own impressions and to assist men in applying their understanding of the benefits of birth spacing to actions that would benefit own families.

- ***Discussion of birth intervals with women at antenatal clinics***

Nurses and midwives should be sure to counsel women who attend antenatal clinics about the importance of longer birth intervals and discuss actions they can take to lengthen their next birth interval. According to the EDSM 2006, 88% of women in Bamako, and 63% nationally, visit an antenatal care center three or four times on average during a pregnancy. Therefore, the majority of women can be reached in this manner. Women who have given birth to their third or fourth child stand to benefit the most from such counseling, for they will have had the experience of several birth intervals already.

- ***Increasing support for service providers to offer a wider range of methods***

Although women, men, and service providers agree on the two methods most popular among women, and the reasons for this preference, it stands to reason that some women would benefit from the presentation of a wider range of methods. The family planning providers do understand the need for offering a wider range of contraceptives, and that not all women will best be served with pills or injectables. They may need assistance to follow through. Condoms, implants, and the IUD may prove useful to some.

- ***Training in counseling for service providers***

The nurses and midwives said they are unable to adequately address side effects. Care providers must be able to address side effects during counseling, but also to offer treatment when

needed to relieve symptoms. The providers need training in counseling techniques about possible side effects, how to best explain side effects to their clients, and be able to treat the symptoms of side effects when they occur. In addition, counselors need training in eliciting information from clients so they understand the overall family situation of clients and can help each woman consider her birth interval history to decide when and how to use contraception. It will be necessary to take time to help clients consider their own situation and decide on a spacing plan.

- ***Expanding the CBV network and improving support for community volunteers***

Community volunteers remain a vital force in communicating with women in their own language about their concerns and in referring women to clinics (as the French term *relais* indicates). Community-based health workers trained by the government or international NGOs to provide child health or malaria preventive advice and services should also be more adequately trained in the provision of family planning services. Such volunteers are part of the local population and should be trained to discuss the length of birth intervals with the women they know. The volunteers interviewed expressed disappointment about their relationship with health care facilities and their lack of compensation, issues which need to be addressed. In addition to these measures, the enlistment of male CBVs who could directly sensitize men should be investigated. Participants in the male triad discussions and the interviews with contraceptive vendors indicated that some were already filling this role. However, the men would not work solely as volunteers and would expect compensation.

The study findings show that both women and men understand the benefits of longer birth intervals for their own health and the health of their children. The key to wider use of family planning lies in assisting women (and men) to apply that understanding to their own situation once they have two or three children. The task of helping women see how they can apply their knowledge in their own situation can be accomplished by well-trained counselors who provide a range of modern methods of contraception. Just as women's individual needs in regard to birth spacing, preferences for one contraceptive method over another, and families' financial situations shift over time, the demand for family planning services also can change over time.

REFERENCES

Castle, S., M.K. Konaté, P. Ulin and S. Martin. 1999. A qualitative study of clandestine contraceptive use in urban Mali. *Studies in Family Planning* 30(3):231-248.

EDSM 2006 [Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de Statistique et de l'Information du Ministère de l'Economie, de l'Industrie, et du Commerce (DNSI/MEIC) et Macro International Inc.]. 2007. *Enquête Démographique et de Santé du Mali 2006*. Calverton, Maryland, USA: CPS/DNSI et Macro International Inc.

Guèye, M., M.K. Konaté et F. Djènèpo. 2007. Etude qualitative sur les effets de la campagne nationale en faveur de la planification familiale de 2006 et les obstacles à la planification au Mali. Rapport de l'étude, non-publié. Bamako.

Guèye, M. et A. Nikièma. 2008. Évaluation de l'offre des services de planification familiale au Mali. Rapport non-publié. Bamako : Ministère de la Santé et CAREF.

MacDonald, P. and S. Snyder. 2009. Review of Mali's Family Planning Program. Unpublished report prepared for the Africa Bureau, USAID, Washington.

Mariko, S, M. Ayad, R. Hong, O. Kéïta, et M. Diop. 2009. *Pratique contraceptive et importance des besoins non satisfaits en matière de planification familiale au Mali, de 1995 à 2006. Analyses approfondies des EDSM 1995-1996, 2001 et 2006.* Rapports d'analyses approfondies des EDS No. 69. Calverton, Maryland, USA : CPS/DNSI et ICF Macro.

Population Reference Bureau. 2008. Family planning in Ghana, Burkina Faso, and Mali. http://www.prb.org/Articles/2008/westafricafamilyplanning2.aspx?p=1

Population Reference Bureau. 2010. Visit for journalists. http://www.prb.org/Articles/2010/Mali

APPENDICES

A.1: Socio-demographic characteristics of female respondents according to their use of family planning (FP)

	Never used FP	Has ever used FP	Currently using FP	Total
Age in years				
20-24	1	6	5	12
25-29	3	1	13	17
30-34	5	4	9	18
35-39	3	3	8	14
40 -50	6	3	2	11
Husband is monogamous or polygamous				
Monogamous	10	12	25	47
Polygamous	8	5	12	25
Level of public schooling attended				
None	10	10	21	41
Primary I (6 years)	5	3	8	16
Primary II (3 years)	3	4	4	11
Secondary (3 years)	0	0	3	3
College	0	0	1	1
Occupation (sector or activity) declared				
Agriculture	1	0	1	2
Hairdressing	0	0	4	4
Teaching	0	0	3	3
Clerk	0	1	0	1
Laundry washer	1	0	0	1
Housewife	4	6	5	15
Secretary in training	0	0	1	1
Health worker in training	0	1	0	1
Trader	2	4	3	9
Vendor	10	5	20	35
Number of live births				
1-4	7	10	19	36
5-6	6	4	8	18
7 or more	5	3	10	18
Number of children alive				
0	0	1	0	1
1-4	10	10	21	41
5-6	6	4	10	20
7 or more	2	2	6	10
Total	**18**	**17**	**37**	**72**

A.2: Distribution of women who have ever used and who have never used family planning, according to selected variables

	Never used FP	Ever used FP	Total
Education declared			
None	10	15	25
Public school	8	23	31
Medrasa	2	6	8
Koranic school	1	7	8
Level of public schooling			
None	10	31	41
Fondemental I	5	11	16
Fondememental II or more	3	12	15
Sexually active before marriage			
No	15	22	37
Yes	2	24	26
ND	1	8	9
Length of engagement			
Less than a year	4	9	13
More than a year	5	19	24
ND	9	26	35
Involvement in choice of husband			
Approved choice	2	23	25
Arranged marriage	11	21	32
Forced marriage	1	2	3
ND	4	8	12
Type of household			
Monogamous	10	37	47
Polygamous	8	17	25
Earlier notions of ideal family			
None	2	6	8
Small family	8	24	32
Rich husband	1	2	3
Raising family outside of current environment (other country or social context)	0	4	4
Large family, many children	0	6	6
ND	7	12	19
Number of living children (as declared)			
0	0	1	1
1-4 children	10	31	41
5-6 children	6	14	20
7 children or more	2	8	10
Number of children desired (as declared)			
0 children	1	0	1
1-4 children	5	19	24
5-6 children	3	7	10
7 children or more	0	4	4
Few children	0	3	3
Many children	0	1	1
ND	9	20	29
Might choose to use FP in the future			
No	8	2	10
Yes	5	26	31
ND	5	26	31
Perception of husband's opinion of FP			
Negative	5	14	19
Positive	4	31	35
ND	9	9	18
Wishes for more children			
No	5	23	28
Yes	9	16	25
ND	4	15	19
Participates in at least one tontine			
No	3	8	11
Yes	13	37	50
ND	2	9	11
Total	**18**	**54**	**72**

B.1: Interview guide for married women

THE USE OF CONTRACEPTION IN MALI		
PERSONAL HISTORIES OF WOMEN		
NUMBER	**TOPICS AND QUESTIONS**	**INSTRUCTIONS**
	Introduction We have come to see you to talk about some aspects of women's lives. Women find themselves at the center of everything these days. We are present in the beginning, the middle, and the end of things. Nothing can really work without us. That is why we have come to see you today and to talk about several subjects such as how you spent your childhood, your life as a young girl, your time in school, your first meeting with your future husband, your engagement time, your marriage, and your time as a mother. Could you please start by telling me talk about one of those topics?	
	TOPIC 1 **Childhood and youth**	
1 #	Where did you spend your childhood, and what was it like? ***E ye I ka denmisèniya kè mini – I bè se ka I da don a la ka donni fo an yé o la wa ?***	Probe # To learn about events that had a big impact on you as a child. # Your relationship with your parents, your brothers and sisters, your friends # What were your general impressions of social life in general? (your surroundings, family life, etc.)
2 #	What was your life like when you were young? ***I ka denmisèniya kèra cogodi ?***	Probe # Going to school # Things you did to earn money # Your leisure time, your friends # Your partners, your sexual experiences
	TOPIC 2 **Marriage and family life**	
3 #	How did you meet your husband? ***E ni cè ye ŋogodon cogodi ?***	**Verify** # The beginning of having sexual relations with him
4 #	What happened during your period of engagement? ***E ka labilali kèra cogodi ?***	**Verify** # What really triggered this engagement # The length of the engagement
5 #	Please tell me about the celebrations you did leading up to getting married? ***E ka furu tèmè na sira jumen ni jumen de fè ?***	**Verify** # Religious marriage # Traditional marriage # Civil marriage
6 #	What has life been like for you in your home? ***E bè se ka mun de fo an ye I ka furulasigi kan?***	Ask # Who are the people in your household? # What is your relationship with these members of your household? # What is your relationship with your husband like?
7 #	Please tell us about your activities outside the household. ***I ka so kono baaraw bo len ko a la, I bè bara were jumenw kè ?***	# Professional and economic activities # Social activities

THE USE OF CONTRACEPTION IN MALI		
PERSONAL HISTORIES OF WOMEN		
NUMBER	**TOPICS AND QUESTIONS**	**INSTRUCTIONS**
	TOPIC 3 **Maternity and offspring**	
8 #

B.2: Interview guide for married men

THE USE OF CONTRACEPTION IN MALI		
GUIDE FOR GROUP DISCUSSION WITH MEN		
NUMBER	**TOPICS AND QUESTIONS**	**INSTRUCTIONS**
	We have come to see you to talk about some aspects of family life. In our society, men are usually considered to have the main responsibility for running the household. That is why we have come to talk about a few topics relating to family life, such as the welfare of the family and the spacing of births. ***Anw sera aw ma bi an ka djè ka masala du tabolo dow kan. Sabu, an ka ladaw la, cè de yé dutigiyé. O kama, an sera aw ma an ka djè ka masala kèren kèren neyala denbaya ka lafiya tasiraw kan, I na fo ka furencè bila denw ni niogocè.***	
	TOPIC 1 **OPINION, KNOWLEDGE**	
1 #

THE USE OF CONTRACEPTION IN MALI		
GUIDE FOR GROUP DISCUSSION WITH MEN		
NUMBER	**TOPICS AND QUESTIONS**	**INSTRUCTIONS**
9 #

B.3: Interview guide for family planning providers

THE USE OF CONTRACEPTION IN MALI		
GUIDE FOR HEALTH CARE PROVIDERS		
NUMBER		INSTRUCTIONS
	We would like to speak to you a little about your activities in the health center: the services that you offer to clients, the family planning methods that you provide, the way that you advise clients about the various methods of family planning, the methods that clients like the most, and any ideas you have to improve the services.	
	QUESTIONS	
1	What are the health services that you provide here?	
2	Please tell us about any training that you have had related to providing family planning services.	If family planning training is not mentioned, ask why not?
3	Please tell us about the family planning methods you now offer.	
4	What modern methods of family planning do women use the most often?	Why?
5	What kinds of advice do you give to women about family planning?	
6	When women come to you for a method of family planning, what are they concerned or worried about?	
7	What do you do to reassure them?	
8	Please tell us what you think about your work in general.	
9	What problems do you often face in your work?	
10	How do you overcome these problems?	
11	What do you think could be done to improve the health services here?	
12	What should be done to increase the use of family planning services?	