ACQUIRE Evaluation and Research Studies

Community Awareness of and Attitudes toward Long-Acting and Permanent Contraception in Guinea

E & R Study #7 ◆ September 2006

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Executive Summary

Maternal, infant, and under-five mortality rates in Guinea are some of the highest in the world. Use of contraception, one way to improve these statistics, is quite low (contraceptive prevalence rate of 4.2%). To increase the access to and availability of contraception in Guinea, particularly of long-acting and permanent contraception, the ACQUIRE Project[1] has conducted a study to learn about community awareness of and attitudes toward long-acting and permanent methods (LAPMs) of contraception. Of particular interest was the intrauterine device (IUD), an extremely effective long- and short-acting method that has a high satisfaction rate among users and is economical from a programmatic standpoint. Results from this study are being used to develop a communications strategy and messages for educating communities about family planning in general and the IUD in particular.

More specific study objectives included the following:

1. To assess community knowledge about LAPMs, in particular the IUD;
2. To learn about community attitudes toward spacing and limiting of childbearing and toward LAPMs;
3. To identify potential barriers (individual, institutional, or social) that women and men may face in choosing LAPMs; and
4. To determine the types of messages and strategies that could be used to increase awareness and use of LAPMs in the study communities.

Methodology

Qualitative data were collected in 2004 through interviews with key informants (religious, women's, and community leaders, and providers) and focus-group discussions with women (ever-users and nonusers of modern contraception) and with men. Four communities—two urban and two rural—were chosen in the prefectures of Kankan and Siguiri of Haute Guinée . Most interviews and all of the focus-group discussions were carried out in Malinke, the local language. Data were analyzed using Atlas TI.

Results

Findings were based on transcripts for 11 focus groups and 11 interviews.

Community Attitudes toward Spacing and Limiting of Childbearing

According to individual and focus-group respondents, Malinke culture has traditionally preferred large families. Despite these social conventions, some participants indicated that smaller families have become preferable because of social and economic changes. Opinions on how decision making regarding family size is carried out varied across the focus groups.

[1] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health), a global leader with associate cooperative agreement funded by the U.S. Agency for International Development (USAID)/Washington, was awarded in October 2003 to EngenderHealth and its partners. Partners include the Adventist Development and Relief Agency International, CARE, IntraHealth International, Inc., Meridian Group International, Inc., the Society for Women and AIDS in Africa, and SATELLIFE.

Individual and focus-group respondents agreed that spacing between births is accepted and encouraged, because of the perceived benefits to mother and child. The desired spacing period, of two to three years, is said to originate in the Koran. During this time, abstinence and breastfeeding are used to space, and spouses must sleep under different roofs.

Unlike spacing, limiting does not appear to be sanctioned within communities. Many individual and focus-group respondents stated that Malinke culture opposes voluntarily ending one's fertility, and that very few individuals voluntary seek to do so. Limiting is considered more of an emergency approach, allowed under certain conditions, such as after a difficult pregnancy or delivery.

Contraception

Across the groups, family planning appears to be widely accepted when limited to the concept of spacing. Knowledge of contraception varied across different groups and individual respondents. Nonusers were more familiar with traditional methods (specifically, abstinence and breastfeeding) than with modern methods, although some had heard of the pill and injectables. In contrast, ever-users knew little about traditional methods but were familiar with the pill and injectables.

Many nonusers and male participants said they have little trust in modern methods. Some of the nonusers indicated that they disapprove of modern methods because friends who had used modern methods had reported side effects. One of the few modern methods that men supported was the condom, which was perceived as effective and safe because it produced no side effects, a common concern among male participants. Men in particular voiced concerns about women's use of modern contraception leading to unfaithfulness.

Despite the negative perception toward modern methods among some, support for contraception was also strongly evident, especially among ever-users of modern contraception. Ever-users appeared to have greater trust in modern methods, stating that these were more effective, had clear instructions for use, and had a specific dosage and expiration dates.

Much as with the focus groups, community, religious, and women's leaders were also divided in their support of modern contraception. Although all agreed about the benefits of spacing, some leaders considered modern contraceptive methods negatively, citing ineffectiveness and side effects (including infertility), while others disagreed.

Decision Making and Use

How the decision to choose contraception is made appears to be affected by a number of different factors: parity, the types of method chosen (condom, injectable, tubal ligation, etc.) and household structure (polygamous vs. monogamous), for example.

In these cases, women may often guard information about their decisions from their husbands, even after the fact. Although women use contraception secretly, male respondents appeared to be aware that contraceptive use occurred among women, although no man reported that he knew his wife was using a method. Women also keep their contraceptive use a secret from their co-wives. Besides co-wives and husbands, other barriers to use of modern methods include other family members (such as in-laws), lack of knowledge or misinformation about methods, religion, cost, and lack of availability.

Sources of information about modern contraception include conversations with friends or other women; messages on the radio, whether national or rural; "sensitization meetings" (meetings aimed at raising general awareness); health talks; and child vaccination visits.

The IUD

Knowledge of the IUD varied across participants and groups. For the most part, women in the ever-user groups had heard of the IUD. In each of the men's groups, respondents were more equally divided in terms of knowledge. Among nonusers, knowledge was low, with only a few participants in a couple of the focus groups reporting that they had heard of the IUD. Knowledge among individual respondents was low as well. Information sources for the IUD included friends, family, and health facilities, both in Guinea and neighboring Mali.

In some cases, participants indicated that they lacked sufficient information to form an opinion about the IUD. Some felt that with sufficient information, there would undoubtedly be individuals who would want to use the method. In three of the groups, opinions clearly weighed against the IUD. In one of the men's groups, many opposed its use because they felt it might lead to greater promiscuity. Another reason for opposition included fear that it would become dislodged.

Many ever-users, however, spoke favorably of the IUD. They described hearing from friends how it is an effective, reversible method, requiring no surgery, with no risks and no side effects. The few IUD users present referred to the lack of side effects when describing why they chose the IUD. Among all groups, positive aspects of the method included that it is not user-dependent, that it is discreet, and that it is effective.

Many individual and group respondents stated that husbands would pose the greatest barrier to a woman's use of the IUD, as they do with other methods. Other important barriers included parents and friends; the lack of method availability and lack of qualified providers to perform insertion; and fear of being "discovered" at health facilities by neighbors and friends.

Recommendations for IUD programming revolve around these barrier issues. Participants in the women's groups (ever-users of modern contraception and nonusers alike) said that the sex of the provider is less important than the skill level, because insertion by a skilled provider guarantees against side effects such as dislodgment and abdominal pain. The physical space where services are offered should maintain confidentiality. Sensitization sessions on the IUD should be implemented to overcome the lack of information about the method. Many (primarily ever-users of modern contraception) suggested that educational campaigns target men, so as to increase their involvement in family planning. Some also noted that religious leaders and community leaders should be included in educational campaigns, since they serve as gatekeepers in the community and communicate with members in the community, both in public and one-on-one. In terms of media, participants recommended the use of radio to communicate messages.

Discussion and Conclusions

Family planning overall is a widely embraced concept among the communities with whom we spoke. People recognize the benefits to birthspacing and, type of method notwithstanding, family planning in this sense is widely practiced. The challenge rests in working with communities to overcome prejudices to modern methods and to broaden the range and awareness of other methods, such as the IUD.

Key considerations for programming include the following:

- Communication efforts should provide information about family planning methods in general. Misinformation and misperceptions exist about the pill and injectables. Although lack of awareness is a bigger challenge for the IUD, myths nevertheless exist. Providing better information on such things as side effects, for example, might facilitate the introduction of the IUD.
- Given the strong desire to maintain the two-to-three-year period of spacing, communication efforts should present the IUD's versatility as both a long- and short-acting method, making it an appropriate method for the spacing interval desired by many.
- Prospects for introducing the IUD are quite positive. Because knowledge is low, informational efforts can focus on increasing awareness. Also, the method is discreet, has minimal side effects, and promises an immediate return to fertility upon discontinuation, which are three preferred characteristics noted among women participating in this study.
- Prospects for introducing vasectomy and tubal ligation as methods of choice will require greater educational efforts, as these methods' permanence is not a desired characteristic.
- More intensive educational work will need to be carried out with men's groups to overcome their resistance to being involved in family planning and to supporting their wives' use of modern contraception. Future projects should build on the success of previous projects targeting men as means of increasing women's access to contraception.
- Men recognize the importance of spacing in improving the health of mother and child, so these aspects should be emphasized in educational campaigns about contraception. Special attention should be given to facilitating communication between husbands and wives, to lessen suspicion around women's use of contraception.
- Educational efforts should include religious and women's leaders, who have played a role in the public eye as well as in one-on-one relationships with members of the community.

Among the populations with whom we met, the desire to space births is almost universal. Men and women believe in promoting the good health of women and children, and they see birthspacing as a means to achieving this. Although introducing permanent methods into the array of available methods in Guinea is a more challenging task, requiring more time and sensitization, the introduction of the IUD may prove an excellent fit in terms of the preferences and needs of the proposed project communities, where flexibility of duration, effectiveness, and immediacy in the return to fertility are key preferences. Building on the successes of past projects in family planning and working within the cultural fabric of the communities will promote greater awareness of the method and the possibility of helping individuals meet their family size expectations.

Introduction

Maternal, infant, and child health outcome indicators paint a dire picture for women and children in Guinea. Maternal death rates are among the highest in the world, with the maternal mortality ratio estimated at 740 deaths per 100,000 live births, or nearly twice the global ratio of 400 per 100,000 live births (WHO/UNICEF/UNFPA, 2000). Of the 192 World Health Organization (WHO) member states, Guinea ranks 28th for the highest rates of infant mortality (94.3 deaths per 1,000 live births) and 23rd for under-five mortality (160.0 deaths per 1,000 live births) (WHOSIS, 2003).

Use of contraception, recognized as an important means of preventing maternal mortality and promoting birth spacing conducive to better infant health, is quite low in Guinea. Awareness of at least one method of family planning among married women of reproductive age is 70.3%. (Knowledge of any modern method is slightly lower, at 69.1%.)[2] A closer examination of family planning awareness shows knowledge skewed toward the pill (63.2%), injectables (54.9%), and condoms (55.1%). Knowledge of more effective, more long-acting methods is considerably lower, with knowledge of female sterilization, the intrauterine device (IUD), and vasectomy at 32.5%, 15.3%, and 3.9%, respectively. The prevalence of any of these three methods does not exceed 0.5%, compared with 4.2% for any modern method (ORC Macro, 2005).

Little recent literature exists to explain the low prevalence of family planning in Guinea. Low demand may not necessarily explain this situation, given that unmet need for family planning is evident there. Among married women, unmet need for family planning is 24%, with 16% expressing a desire to space. Younger women (between the ages of 15 and 34) tend to indicate a desire to space, but demand shifts to limiting among women aged 35 and older.

Lack of availability and lack of knowledge, as well as religious and social factors, are a few of the barriers to contraception identified in prior studies. In describing the PRISM[3] Project's media campaign in Guinea, Blake and Babalola (2002) noted that spouses rarely discussed family planning and indicated that support for modern family planning methods was low. A qualitative study conducted among Guinean youth (aged 15–24) in N'Zerekore, Faranah, and Kankan indicated that although youths were highly aware of contraception, their knowledge was cursory, and much misinformation existed about specific methods (Center for Communication Programs, 2003). In another study conducted with unmarried men and women aged 15–24 living in Faranah, Kissidougou, and Gueckedou, distrust of modern methods abounded (Görgen et al., 1998). Participants in these discussions associated modern contraception with infertility and with increased promiscuity and prostitution, especially among young women. Surveys with religious leaders in the N'Zerekore, Faranah, and Kankan regions found that about one-third of them believed that family planning could encourage adultery (Blake and Babalola, 2002). Some also believe that specific methods are forbidden by Islam—in particular, permanent surgical methods.

Besides factors affecting demand, service-delivery issues may further impede availability and lead to subsequent low levels of use. A health facility survey conducted in Guinea identified a lack of essential equipment for reproductive health services, a lack of IUD commodities, and little mention

[2] All data that follow are from the 1999 Guinea Demographic and Health Survey (DHS) (DNS, 2000), unless otherwise indicated.

[3] Pour Renforcer les Interventions en Santé Reproductive et MST/SIDA, a project led by Management Sciences for Health.

of IUDs during family planning consultations (Eckert et al, 2002). Evaluators noted the need to focus counseling more on women's individual needs rather than on women's limited knowledge of contraception. A performance needs assessment carried out in the Conakry, Faranah, and Kankan regions revealed similar findings, with providers rarely engaging clients in discussions about their reproductive intentions (ACQUIRE Project, 2005). Linkages between family planning and antenatal or postpartum care were also found to be weak, such that only three out of 20 clients received information on family planning during these interactions.

To bring further clarity to demand and supply issues around family planning in Guinea, the ACQUIRE Project,[4] with technical assistance from Family Health International (FHI), has undertaken a research project to identify community awareness of and barriers to the use of long-acting and permanent family planning methods (LAPMs).[5] Of particular interest is the IUD, which overall is highly effective both as a long-acting and as a short-acting method, which has a high satisfaction rate among users, and which is economical from a programming standpoint. This study is one component of a three-phase program aimed at increasing awareness of and access to LAPMs in Guinea, thereby increasing the range of methods available to women beyond hormonal methods and enabling them to better meet their spacing and limiting needs.

The overall pilot program, which focuses on the Haute Guinea region, complements IUD training and supervision work already being carried out through PRISM. It involves close collaboration with PRISM, as well as with the Adventist Development and Relief Agency International (ADRA), an ACQUIRE partner, and Save the Children-U.S., both of which are training community members in health promotion. Results from this study are being used to develop a campaign strategy and messages for educating communities about family planning in general and about the IUD in particular.

[4] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health), a global leader with associate cooperative agreement funded by the U.S. Agency for International Development (USAID)/Washington, was awarded in October 2003 to EngenderHealth and its partners. Partners include the Adventist Development and Relief Agency International, CARE, IntraHealth International, Inc., Meridian Group International, Inc., the Society for Women and AIDS in Africa, and SATELLIFE.

[5] This terminology has been switched from "long-term and permanent" methods to long-*acting* and permanent methods to emphasize more the benefit of the method and less the duration of its use.

Study Objectives

As previously noted, the main objective of this study was to learn about community awareness of and barriers to the use of LAPMs—in particular, the IUD. More specific objectives include the following:

1. To assess community knowledge about LAPMs, in particular the IUD;
2. To learn about community attitudes toward spacing and limiting of childbearing and toward LAPMs;
3. To identify potential barriers (individual, institutional, or social) that women and men may face in choosing LAPMs; and
4. To determine the types of messages and strategies that could be used to increase awareness and use of LAPMs in the study communities.

Ultimately, the goal of the study is to use the information gathered to develop an information and communications strategy that will increase access and use of LAPMs, with a focus on the IUD.

Methodology

The data collection methods consisted of interviews with key informants and focus groups in the study communities. ACQUIRE/EngenderHealth developed the study protocol and guides for the focus groups and in-depth interviews, with technical assistance from FHI. These materials then underwent ethical review procedures both at EngenderHealth and FHI. They were translated into French and submitted to the Guinean Ministry of Health's research department, which approved them in September 2004.

As preparation for the study, program staff and a local consultant for EngenderHealth met with partners from PRISM, ADRA, the Association Guinéene pour le Bien- être Familial (AGBEF), and Save the Children, which are active in the two prefectures in Haute Guinea identified for the study—Kankan and Siguiri. The purpose of this meeting was to discuss the proposed protocol and to fine-tune many of the details of the project (such as the categories of key informants) so that it was tailored to the study communities. As a result of this meeting, four communities in all—two urban and two rural—were chosen in the prefectures of Kankan and Siguiri.

Two staff from FHI trained the data collection teams. The one-week training session consisted of instruction in qualitative methods, a revision of all of the study guides, role-plays, and a review of informed consent and ethical procedures. During this time, the guides were field-tested and adjustments were made.

The study design included individual interviews with 16 key informants. Service providers, leaders of women's groups, community leaders, and religious leaders (*imams*) were also interviewed.

Twelve focus-group discussions consisting of nine to 12 participants were also included in the study design. The stratification strategy consisted of groups organized across communities and sex. Eight of the 12 focus groups consisted of participants who were women of reproductive age (aged 16–44 years). Women's groups were further stratified by ever-use of modern contraception versus nonuse, so as to gain a better understanding of viewpoints regarding contraception from these two distinct groups. Because national estimates note that nearly three-fourths (73.5%) of women are married by age 20, the study design proposed inclusion of married women only.

The remaining four groups consisted of men. According to the 1999 Guinea DHS, men marry later than women; in addition, local partners noted that men as old as 60 have been visiting clinics seeking family planning for their wives. As a result, the age range for participants was 25–60. Although polygamy is common in the study regions, the study design did not stratify by type of marital union (polygamous vs. monogamous) for either men or women, to maintain a manageable number of discussion groups.

Participants were recruited with the assistance of community leaders. These leaders organized meetings, at which time the details of the study were shared and individuals invited to participate. Community members participating at this meeting were assured that their involvement in the study was voluntary. Verbal informed consent was also sought prior to focus-group discussions and individual in-depth interviews.

Data collection took place in October 2004. Most interviews and all of the focus-group discussions were carried out in Malinke, the local language in Haute Guinea. Five interviews were conducted in French. All interviews were taped. Those in Malinke were then translated from the tape and transcribed into French. Those in French were directly transcribed. All analysis was carried out in French.

Analysis codes were developed with assistance from FHI and a representative from Meridian Group International, Inc., an ACQUIRE partner and the agency heading the effort to develop the campaign strategy. Data were analyzed using Atlas TI. All coding was carried out by the principal author, an ACQUIRE/EngenderHealth staff member.

Analysis was restricted to the 11 focus groups and 11 interviews.[6] Table 1 below shows the number of interviewees and focus-group participants for each of the study communities.

Table 1: Description of study sample[1]

Prefecture/community	Data collection method	Type and number of respondent/s
Kankan/Salamani	In-depth interviews (3)	Community leader (1) Religious leader (1) Women's leader (1)
	Focus-group discussions (3)	Female ever-users of modern contraception (not available) Female nonusers (12) Men (12)
Kankan/Balandou	In-depth interviews (3)	Community leader (1) Provider (1) Women's leader (1)
	Focus-group discussions (3)	Female ever-users of modern contraception (9) Female nonusers (10) Men (12)
Siguiri/Kouradakoro	In-depth interviews (4)	Community leader (1) Provider (1) Religious leader (1) Women's leader (1)
	Focus-group discussions (2)	Female ever-users of modern contraception (7) Female nonusers (12)
Siguiri/Doko	In-depth interviews (1)	Community leader (1)
	Focus-group discussions (3)	Female ever-users of modern contraception (12) Female nonusers (12) Men (12)

[1] This table does not show focus groups or in-depth interviews that were excluded from the final analysis.

[6] We excluded one focus-group discussion and five in-depth interviews from the analysis because the informed consent procedures were not followed according to our study guidelines.

Results

Results were analyzed for 11 focus groups and 11 in-depth interviews across the study communities of Salamani, Balandou, Kouradakoro, and Doko, all located in the administrative region known as Haute Guinea.

In the following section, we will examine some of the economic and sociocultural issues defining the study region.

Context

Haute Guinée sits in the northeastern part of the country and borders Mali. The area is known for mining and less so for agriculture, because the land is so arid. More specifically, Salamani is an urban area of Kankan, where inhabitants are mostly involved in trading and farming. Balandou is a periurban area, with farming and trading as the main occupational activities. Kouradakoro (urban) and Doko (rural), both located in Siguiri, are known as mining areas. Karifamoriah, in Kankan prefecture, a periurban area with trading and mining activities, was selected to serve as the site for the pilot test.

The Malinke (or Mandinka, as they are also known) are the predominant ethnic group in Haute Guinée. Muslims are a majority in this region, with Sunni Islam being the branch most Muslims in the country and in this region follow (U.S. Department of State, 2005). The 2005 International Religious Freedom Report for Guinea cites the Ministry of National Islamic League's estimate that 70% of Muslims practice their faith regularly. Imams, religious leaders and teachers, play an influential role in communities in Upper Guinea (Blake and Babalola, 2002).

Early marriage (Görgen et al, 1998), pregnancy, and large families are the cultural norm among the Malinke in Haute Guinée (Levin, 2002). Like most of Guinea, society in Haute Guinée among the Malinke is patrilineal (Levin 2000; Blake & Babalola, 2002) and male-dominated (Blake & Babalola, 2002). Households consist of a man and his wife or co-wives, his children by these women, and his mother, even for at least part of the year (Levin, 2002).

Levin's qualitative study of childbearing decisions among Fulbe and Malinke women in Dabola (also in Haute Guinée) examined the role of women within these cultures. The study's findings underscored the importance of marriage and childbearing to women's social standing and access to resources within a household. Life stages rather than chronological years define women's life courses, and these stages are tied to marriage and childbearing. Thus, women in the second stage (or *sunkuru ni*) seek to have several children as soon as possible to establish themselves in their husband's household. In another example, *koro muso* (older women who have ceased childbearing after six or seven children) turn their attention to brokering household resources and other demands among their various children and their son's wives. In this way, mothers-in-law hold considerable influence in their sons' households.

Using this body of evidence presented as context, we now consider the findings from the focus groups and in-depth interviews conducted in the study communities.

Family Size

According to individual and group respondents, Malinke culture has traditionally preferred large families:

> *Avoir beaucoup d'enfants c'est mieux que de ne pas avoir beaucoup d'enfant*
> (Having many children is better than not having many)
> —male participant, Salamani

Having numerous children provides a father with extra hands to work on the farm. It provides the family, especially parents, with security in their old age, because it is expected that at least one of the many children will be successful in life. Child mortality, as a few respondents pointed out, further stresses the need for large families. Large families also carry symbolic importance, signifying strength, power, and social affluence. As men in one of the groups noted:

> *C'est la masse qui a la force*
> (It is the mass which has strength)
> —male participant, Salamani

Wealthy men are usually married to more than one wife, all of whom are to bear him many children.

Despite these social conventions, some participants indicated that smaller families have become more preferable, given social and economic changes. Community life had previously been more conducive to large families, with everyone in the community contributing to a family in the event of hardship. Modern times, however, have brought greater economic hardship. Parents can better support, feed, and educate a family with fewer children. Women, in particular, tied the idea of large families to suffering, indicating that women often bear the burden of caring for children alone:

> *…c'est la femme qui fait tout, donc quand tu feras beaucoup d'enfants la souffrance dévient grande, les hommes ne dépensent plus pour nous*
> (…it's the woman who does everything, so when you have many children, the suffering becomes great, men no longer want to support us)
> —female ever-user, Balandou

In the men's groups, a few noted that deliveries have become expensive and that expenses add up as you pay for the medical costs related to pregnancy and childbearing.

Opinions on how decision making regarding family size is carried out varied across the groups. According to some of the women participants, women themselves make the decision on family size, given the minimal role men play in family life. Others noted that the decisions are made jointly by men and women. In general, though, many participants stated that men tended to make decisions on family size, namely because they choose the number of wives they have. If a man wants fewer children, he marries fewer women:

> *Le problème de nourriture est assez difficile et quand on a assez d'enfants il y aura assez de raté parce qu'on n'aura pas le temps de s'occuper de tous ces enfants donc raison pour laquelle on doit se planifier et limiter aussi le nombre d 'épouses. Quand on a assez de femmes, on aura assez d'enfants..*
> (The problem of feeding a family is rather difficult, and when one has many children, it becomes a challenge because one won't have enough time to take care of them, that is why we should use family planning and also reduce the number of wives. When you have many wives, you will also have many children.)
> —community leader, Salamani

In addition to the couple, other individuals also appear to play a role in the decision-making process. Parents and parents-in-law were mentioned as influencing decision making, especially because women go to their in-laws' home after delivering for a period of abstinence and breastfeeding.[7] Co-wives were also described as having an indirect yet important role in family-size issues as well. Feelings of jealousy that exist among women may motivate them to bear many children to maintain a prominent role as the favorite wife. The fear that a husband will marry another for children also exists.

Participant #1:
C'est les hommes qui poussent les femmes á faire beaucoup d'enfants. Quand une femme leur dit quelle veut seulement 3 - 4 enfants il disant qu'il vont épouser une deuxième femme pour faire beaucoup d'enfants. Et par jalousie les femmes font maintenant plus quelles n'en voulaient. Actuellement avec l'introduction des produits de planification familiale et l'information les gens commencent à comprendre avec la cherté de la vie. C'est pourquoi les femmes ont eu l'idée de se planifier car cette lourde charge de la famille les appartient.
(It's the men who push women to have a lot of children. When a woman tells them that she wants only three to four children, they say that they're going to marry a second wife to have a lot of children. And out of jealousy women will have more children than they want. Now, with the introduction of family planning and products, people are starting to understand the high cost of living. This is why women have the idea about using family planning products and information, because this heavy responsibility toward the family rests on them.)

Participant #2:
Les hommes ne sont pas les mêmes il y a des hommes dés que leur femmes font un temps sans faire des enfants il se décide de marier une autre en disant de celle qu'elle ne fait pas d'enfants.
(Not all men are the same. There are men who as soon as their wives spend some time without having children, decide to marry another wife, saying that she can't have children.)

—female nonusers, Doko

According to many respondents, God and religion play a role in questions of decision making, family size, and family composition. Some respondents noted that individuals have a religious duty to see to the well-being of their children; consequently, one should only have as many children as one can support. This perception, which features a more active role for the individual, nevertheless contrasts with the perception voiced by others that God alone controls all aspects of childbearing. Although individuals essentially have no control over the number of children or composition of their family, they can be comforted to know that God will only provide them with as many children as they can support. It is interesting that some participants initially responded that God alone can decide the number of children, which may be considered a more normative response, but then followed their responses with a specific number of children, indicating that they did indeed have personal preferences.

[7] Participants noted that, according to religious and cultural tradition, women are supposed to abstain from sexual intercourse with their husbands during the duration of their breastfeeding. Some women may go to live with their families or with their in-laws during this time.

Spacing and Limiting

Individual and focus-group respondents noted that spacing between births is accepted and encouraged. In general, the appropriate spacing period is two to three years, although a few participants indicated four to five years as their ideal. The two-year spacing period is said to originate in the Koran, as well as having acceptability within Malinke culture. Religious leaders and discussion participants, in fact, noted that religious leaders preach that children should be spaced two to three years apart, with spacing achieved through both abstinence and breastfeeding. During this time, a husband and wife must sleep apart, under different roofs.

According to most respondents, the acceptability of birthspacing is rooted in its perceived benefits to both mother and child. Many referred to the need to give women an opportunity to "rest" between pregnancies, as well as to strengthen the health of the newborn. A few also mentioned the "peace of mind" spacing brings to the father, knowing that his wife and child will be in good health. Spacing also appears to have a greater importance given the contextual changes in daily life. Some participants described social and economic challenges as factors in the decision to space, citing that the cost of living is too expensive. Ever-users, in particular, spoke of the "suffering"—both physical and financial—that women experience when births are not well spaced.

From our data, it is unclear whether birthspacing is usually discussed between couples. A number of women (ever-users and nonusers alike) indicated that women make the decision to space births on their own. Many noted that the decision is an autonomous one because women "suffer" the consequences of ill-spaced pregnancies. They are the sole caretakers when children fall ill and also are the providers for children. Because their attention becomes focused on children, they are unable to meet their own needs. Men, on the other hand, are seen as having no involvement in family planning, birthspacing, and, in some cases, the care of their children.

Other women (ever-users and nonusers) noted that women and men together make the decision to space, although it is unclear whether this reflects the reality of the decision-making process or its idealization. In addition, it is unclear whether birthspacing results from an active discussion between couples or if couples simply follow social norms without much discussion. Participants in the men's groups reported that men decide, but that the decision is usually made with input from women.

Unlike spacing, limiting, at first glance, does not appear to be sanctioned within the communities. Some participants noted that within Malinke culture and religion, the individual is expected to marry and produce children, so limiting is not an option. As one participant noted, the pride of a woman is to have children by her husband; if a woman chooses not to have children, it can be grounds for divorce. Stopping one's fertility is not generally allowable, and very few individuals ever voluntarily seek to do this.

Limiting, though, is allowed under certain conditions. One imam noted that there are two situations in which ending one's fertility is allowable: first, in the event of a difficult pregnancy, and second, if a woman were to face a difficult delivery. In these scenarios, limiting is not seen as a choice but as a necessity or an act of God. Decision making does not rest in the hands of the couple, but rather in the assessment of the physician attending the birth or the client.

In addition, although the idea of actively terminating one's fertility may not be acceptable as a voluntary choice, attitudes toward the limiting of *family size* are less clear. A few men noted that family size could be limited by having fewer wives; others suggested that another way to limit family size is to lengthen the duration of spacing. Because a woman continues childbearing until she experiences menopause, she can produce fewer children by becoming pregnant every four or five years rather than every two years.

Contraception

Across the focus groups, family planning appears to be widely accepted, but specifically within the concept of spacing. Differences of opinion tended to occur over the type of contraception that should be used to space and how that decision should be made. In the section below, we will consider the knowledge about, attitudes toward, and use of contraception among respondents, as well as the contraceptive decision-making process.

Knowledge about, Attitudes toward, and Use of Contraception

Participants were asked to identify what women do when they want to prevent a pregnancy or space births. Responses revealed that knowledge of contraception varied across the different groups and respondents. Nonusers were more familiar with traditional methods (specifically, abstinence and breastfeeding) than with modern methods, although some had heard of the pill and injectables. In contrast, ever-users knew little about traditional methods, but were especially familiar with the pill and injectables. They noted that these are the two methods offered at health centers. Participants in the men's groups and most of the individual respondents seemed to be familiar with condoms, the pill, and injectables, as well as with breastfeeding and abstinence and other traditional methods. No one spontaneously mentioned vasectomy or tubal ligation as a method of contraception. (A discussion of the IUD appears below.)

Some female nonusers and male participants appeared to have little trust in modern methods. This particularly seemed to be the case among participants and leaders in Salamani. They trusted in the village female elders, who offer them traditional methods:

> **Interviewee:**
> *Y a d'autres qui évitent les grossesses à travers ces comportements, par les méthodes des vieilles femmes; eux préfèrent ça là que les méthodes hè modernes.*
> (And there are those who prevent pregnancy through their behavior, through the methods of the old women; they prefer these methods to modern ones.)
>
> **Interviewer:**
> *Pourquoi?*
> (Why?)
>
> **Interviewee:**
> *Parce ils ont confiance aux vieilles femmes que hè, comment on appelle hè, les,les, la modernisation de la santé, pour la santé arrive souvent à trompe, hè hè tropper les vieilles femmes, d'autres vieilles femmes ah eux, elles ne trompent pas hè.*
> (Because they trust in the old women, how does one say, the modernization of health often trips you up, and the old women, they don't trip you up.)
>
> —community leader, Salamani

Nonusers explained that friends of theirs who had used modern methods experienced side effects such as weight gain, headaches, prolonged or absent periods, and especially prolonged return to fertility, or even infertility. Men also voiced concern over many of the same side effects. In the following passage, one male participant explains what he sees as a relationship between injectables, amenorrhea (one of the known side effects), and infertility (one of the perceived side effects):

> *Vous savez, tant que la femme a ses règles, elle est fertile. Mais quand elle ne voit plus ces règles à cause des piqûres, elle ne peut pas faire des enfants.*
> (You know, as long as a woman has her periods, she is fertile. But when she no longer sees her periods because of injectables, she can no longer have children.)
>
> —male participant, Balandou

Many nonusers and male participants therefore disapproved of the use of modern methods. A few believed that all modern methods are irreversible, or that injectables can cause abortions. Modern methods were also seen as ineffective, with a few participants describing unintended pregnancies that their friends or they themselves experienced while using the pill. One of the few modern methods that men supported was the condom, which was perceived as effective and safe because it produced no side effects.

Men in particular voiced concerns about women's use of modern contraception leading to unfaithfulness to their husbands. Modern contraception allows a woman to have sexual relations without fear of pregnancy from either her husband or any potential lovers. Some men mentioned that the use of contraception requires a reasonable justification, usually illness. If a woman makes the decision to use a modern method with her husband's approval, the husband will face the ridicule of friends and family.

These individuals also expressed concern that adolescents and young women would use family planning before marriage. Some feared that a growing number of young women will seek modern contraception and, because they are protected from pregnancy, will behave promiscuously and irresponsibly. However, a few male and female respondents countered this perception; they described how young women, and especially their mothers, might see modern contraception as an opportunity to ensure that the young women continue in school with their studies.

Male participants also indicated that traditional methods are far cheaper than modern methods. Some indicated that family planning is necessary, especially because of the current economy, but that cost is a barrier to modern method use. One participant noted that after his wife began using injectables, she began experiencing side effects, and that the treatment required to deal with the side effects far exceeded the cost of the injectable.

Men in particular tended to view the tension between modern and traditional method use in terms of a cultural struggle. Facilitators and participants often referred to modern methods as the *methodes des blancs* (methods of the whites) and to traditional methods as *methodes des noirs* (methods of blacks). Traditional methods were linked to Malinke culture, and the advent of modern methods was one indication of the loss of social values and tradition. The decision to use breastfeeding and reside with one's in-laws until the infant is two or three was seen as a decision to adhere to culture. The advent of modern contraception has disrupted this tradition. As one participant noted:

> *Depuis que les blancs sont venus, on est devenu inquiet.*
>
> (After the whites arrived, things became uneasy.)
>
> —male participant, Salamani

In response, though, another participant in the same group stated the following:

> *On doit faire tout possible d'adopter les methodes des blanc qui sont bonnes. Mais il ne faut pas qu'on laisse toute notre culture a cause des coutumes de blancs. Donc comme ca, on peut faire quelque chose.*
>
> (One should do everything possible to adopt those methods of the whites that are good. But it's not necessary to leave behind all our culture because of the customs of the whites. In this way, one can do something.)
>
> —male participant, Salamani

Despite the negative perceptions of modern methods among some, support for contraception was also strongly evident, especially among ever-users. Ever-users appeared to have greater trust in modern methods, indicating that modern methods were effective and had clear instructions for use,

a specific dosage, and expiration dates. Although some had experienced side effects, they still supported use of the methods. Some noted that they could not understand why women would use traditional methods, or indicated that women used traditional methods because of ignorance regarding modern methods.

Much as was evident with the focus groups, community, religious, and women's group leaders were also divided in their support of modern contraception. Although all agreed about the benefits of birthspacing, some leaders considered modern contraceptive methods negatively, citing ineffectiveness and side effects (including infertility). In contrast, supporters felt that modern methods were safe and effective.

Tubal ligation was viewed positively across all groups and individual respondents, despite its not being mentioned as a method used to prevent pregnancy during initial discussions on contraception. Once they were specifically probed on this method, respondents indicated that they had heard of it. Across all groups, many described tubal ligation as a "life-saving" procedure to be used when a woman has a difficult pregnancy or delivery or if she has undergone multiple cesarean sections. Within this context, little opposition existed to the method:

> *On peut accepter cette méthode parce que c'est la souffrance qui fait que la femme accepte la ligature des trompes en vue de sauvegarder sa vie donc on peut ne pas refuser.*
>
> (One can accept this method because it is suffering that makes a woman accept tubal ligation in order to save her life, therefore one can't refuse it.)
>
> —female nonuser, Balandou

In this way, most participants saw tubal ligation as a method that is not chosen voluntarily but imposed because of circumstances.

Among a few participants, especially from the ever-user groups but also among selected individual and group respondents, there was recognition that a woman may choose tubal ligation because she no longer wants to be fertile and have more children. Within this particular context, they could not voice approval for the method:

> *Je considère cette méthode pour les femmes qui ont des maternités à grand risque de santé. Mais je ne la désire pas comme méthode de planification.*
>
> (I consider this to be a method for women with high maternal risks. But I don't want it as a method of family planning.)
>
> —female ever-user, Balandou

The question of why anyone would want to voluntarily become infertile was also raised during discussions on vasectomy. On many occasions, the description of vasectomy elicited laughter across the groups. Respondents noted that neither men nor women would approve of the method. They stated that polygamous men could never have a vasectomy because this would disappoint their wives, who may want to continue having children. Also, vasectomy was understood to impede ejaculation of the sperm.

Decision Making and Use

How the decision to choose contraception is made appears to be affected by a number of different factors: parity, the type of method chosen (condom, injectable, tubal ligation, etc.), and household structure (polygamous vs. monogamous), for example.

Some of the women in the nonuser groups reported that they wanted to have children and were therefore not at all interested in using family planning.

Facilitator:
Que pensez-vous du sujet qui nous réunit (planning familial)?
(What do you think about the subject that brings us together [family planning]?)

Participant #1:
Moi je veux faire des enfants d'abord, je n'ai jamais pris les produits pour espacer les enfants mais quand j'accouche, je veux faire deux ans sans qu'il n'y ait de contact entre mon mari et moi. Si je veux faire des enfants après deux ans, avec le contact c'est sans problème. Pour le moment, on ne prend pas les produits quand je finirai de faire des enfants alors je prendrai les produits pour me planifier.
(I first want to have children, I've never used products to space children but when I deliver, I want to avoid contact with my husband for two years. If I decide to have children after the two years, with contact, it's no problem. For now, I'm not taking anything but when I finish having children, then I'll use a family planning method.)

Participant #2:
Moi je n'ai qu'un seul enfant pour le moment, je ne dirai rien sur ce sujet d'abord parce que je veux faire des enfants.
(I only have one child at the moment, so I won't say anything on this topic because I want to have more children.)

—female nonusers, Balandou

Others mentioned that they used breastfeeding and abstinence (*refus catégorique*) to space their births. The decision to use this method was mutual. Men approve of breastfeeding and abstinence and do not protest the decision during the time wives breastfeed.

Facilitator:
Décrivez le processus de prise de décision à l'égard des méthodes d'espacement des grossesses.
(Describe the decision-making process with regard to methods for spacing pregnancies.)

Participant #1:
Ce que je sais, c'est de faire allaiter mon enfant. Il n'y a aucune décision à part de ça.
(As far as I know, it involves breastfeeding my baby. There's no other decision besides that.)

Participant #2:
Ce que je vois dans ça, c'est faire allaiter l'enfant sans s'approcher de son mari pendant deux ans. Dans mon cas, mon mari approuve ma décision.
(What I see with regard to that topic is to breastfeed the baby by abstaining from one's husband for two years. In my case, my husband approves my decision.)

—female nonusers, Balandou

Some women noted that this poses no problems among polygamous men, who can simply have intercourse with co-wives during the period of abstinence; however, it is seen as being more difficult for monogamous men:

Nous pratiquons la méthode MAMA qui est en fait basée sur l'abstinence. Elle est très efficaces et ne cause aucun problème de santé ni à la femme ni à l'homme.

C'est seulement difficile pour un homme monogame. Pour les polygames c'est simple car il y a d'autres femmes pour lui satisfaire.
(We practice breastfeeding, which is based on abstinence. It is very effective and doesn't cause any health problems, either to the woman or to the man. It is only difficult for a monogamous man. For polygamous men, it is simple, because there are other women to satisfy him.)

—female nonuser, Salamani

Few respondents discussed how the decision to choose breastfeeding and abstinence is made among monogamous couples, if at all, or what happens when an individual or couple does not abide by the practices of breastfeeding and abstinence before the two-to-three-year period is up. For example, within a polygamous household, a woman might cut short the period of breastfeeding and abstinence and resume relations with her husband to obtain or regain status as the favorite wife:

C'est par jalousie elle font un sevrage brusque et oubli le problème de contraceptif.

(Out of jealousy, she may all of a sudden wean and forget about the problem of contraception.)

—female nonuser, Doko

Ever-users of modern contraception indicated that one can usually learn about modern contraception through conversations with friends or other women, as well as through messages on the radio, both national and rural. Sometimes they may also receive information at health facilities (primarily health centers, but also hospitals) and sensitization meetings and health talks. Among ever-users, a few also mentioned that they received information from a provider while taking their children to a facility for a check-up or vaccinations.

Women often follow the introduction to contraception with a visit to the health center for additional information. Sometimes, a family planning counselor or other provider describes the different methods available (usually the pill and injectable) and then asks the woman to make a decision. In other instances, the provider may simply ask a woman which method she wants. Another source of method is the local market, although a few respondents noted that methods sold in this location are sometimes poorly stored and thus rendered ineffective.

Many ever-users of modern contraception reported that they made the decision to use a modern family planning method without consulting their husbands. In those instances where a woman makes the decision on her own, she also guards information about her choice from her husband, even after the fact.

Participant #1:
…Je suis partie sans le consentement de mon mari et jusqu'ici il ne sait si je prends la piqure.
(I went without my husband's consent and even now he doesn't know that I'm using the injectable.)

Participant #2:
Moi je me suis caché pour faire le planning familial dès que j'ai entendu a la radio.
(I have kept my family planning use a secret since hearing about it on the radio.)

—female ever-users, Kouradakoro

The context for why women keep contraceptive use from their husbands is unclear: Do women keep their use of contraception a secret after previously having been denied permission to use family planning? Or do women simply assume that their husbands will not approve? As previously noted, some men have negative attitudes toward modern methods, so it may be presumed that a man will oppose his wife's use of family planning. In addition, a few women noted some of the problems that

emerged as a result of their use of family planning. One woman, for example, described being sent home to her parents because she was using contraception and prevented a pregnancy for three years. To be welcomed back into her husband's home, she had to promise to have a baby:

> *Quand j'ai choisi les contraceptifs avant, j'ai fais 3 ans sans grossesse ce qui n'a pas plus à mon mari et il m'a renvoyé chez mes parents. Pour pouvoir rejoindre mon foyer j'ai promis d'avoir un enfant dans un mois. C'est ainsi que j'ai changé d'avis.*
>
> (When I chose contraceptives before, I spent three years without a pregnancy, which didn't at all please my husband and he sent me back home to my parents. To be able to rejoin my home, I promised to have a baby in a month. That's how I changed my mind.)
>
> —female ever-user, Balandou

Despite the fact that women use contraception secretly, respondents in the men's groups were aware that contraceptive use occurs among women, although no man noted that he knew that his wife was secretly using a method.

Women keep their contraceptive use a secret not only from their husbands, but also from their co-wives. Given the competition that exists among co-wives, ever-users are fearful that their co-wives will find out and tell their husbands. One ever-user respondent described how her co-wives learned about her use of contraceptives and told their husband. The woman almost faced a divorce as a result:

> *La femme changerait d'avis si ses coépouses apprenaient qu'elle pratique le planning familial. Mes coépouses m'ont rapporté à mon mari et j'ai failli quitter mon foyer.*
>
> (The woman will change her mind if her co-wives learn she is using family planning. My co-wives reported me to my husband and I almost had to leave my home [i.e. was almost divorced].)
>
> —female ever-user, Balandou

Besides co-wives and husbands, other barriers to the use of modern methods include other family members (such as in-laws), lack of knowledge about methods, religion, cost, and lack of availability. A woman who uses a method of family planning may decide to change or even end the use of contraception for such reasons as her spouse's disapproval, discovery by others, or side effects. As noted above, two ever-users described how they were forced to leave their homes or even faced the threat of divorce. Misconceptions about contraception were also observed, with a few people indicating that the pill and injectables are permanent methods.

In a few instances, the decision to choose a modern method was made by a husband and wife together. The introduction to contraception appears to be the same as in those cases in which women made the decision to use a method on their own, with the difference being that women may share information that they have obtained. In the following passage, a community chief (with one wife) describes how he and his wife arrived at the decision to choose condoms to space births:

> *…moi-même je suis planifié, donc chaque mois ma femme se rend au centre de santé alors elle discute ses problèmes alors qu'elle a eus au cours hè de ces deux premiers mois ou en tout cas des discussions qu'elle mène souvent avec la sage femme chargée du planning familial au centre de santé. Ma petite femme hè chaque fois que, qu'elle quitte aussi le centre de santé, elle vient m'expliquer de ce qui s'est passé entre elles c'est-à-dire que les à causeries qui se sont passées entre elles, parce moi-même, alors j'ai trouvé nécessaire avec ma femme nous avons trouvé nécessaire de, de se procurer des capotes au lieu de prendre les pilules ou*

bien des piqûres injectables ou bien hè comment dirais-je, un appareil pour placer donc elle a trouvé nécessaire de hè d'utiliser les capotes ; c'est ce qui fait que alors chaque fois qu'elle se rencontre avec la sage femme chargée du planning, elle vient me faire un compte-rendu...

(I myself use family planning, so each month my wife goes to the health center and then talks about problems she had in the two first months or in any case some discussions she often has with the midwife in charge of family planning at the health center. My little wife each time that she leaves the health center, she tells me about what happened between them, that is to say, the talks they had, then I found it necessary with my wife—we found it necessary to, to get condoms instead of taking the pill or the injectable or rather, how do I say it, an "apparatus" to place where she finds it necessary to use condoms such that each time she meets with the midwife in charge of family planning, she comes to give me an account...)

—community leader, Balandou

Although men generally appeared to be little involved in family planning, it is worth noting that a few respondents in the male groups as well as in the female ever-user groups described using condoms to prevent pregnancies. Some men who were using contraception, as well as ever-users of modern contraception in the women's groups, felt that the condom was the most desirable modern method because it would not lead to side effects—in particular infertility or delayed return to fertility. Condoms were also noted as being an effective way to protect oneself against diseases. It was not clear whether use of condoms occurred in relations both inside and outside of marriage.

As many respondents noted, the decision-making process for tubal ligation usually took place during an urgent situation, after a difficult delivery or multiple cesarean sections or if it appeared that a future pregnancy could present a life-threatening situation. In these instances, doctors played an important role in the decision-making process, informing husbands about the pregnancy or delivery risks that the client was facing.

The IUD

Knowledge of the IUD varied across participants and groups. For the most part, women in the ever-user groups had heard of the IUD. In each of the men's groups, respondents were more equally divided in terms of their knowledge. Among nonusers, knowledge was low, with only a few participants in a couple of the focus groups reporting that they had heard of the IUD. Knowledge among individual respondents was low as well. Information sources for the IUD included friends, family, and health facilities, both in Guinea and in neighboring Mali, which has a longer history with the method.

In some cases, participants felt they lacked sufficient information to form an opinion about the IUD; they had neither heard about it nor seen it, so they were not in a position to say whether people in the community would be willing to use it. Some felt that with sufficient information, there would undoubtedly be individuals who would want to use the IUD. Other participants and leaders of all three types expressed approval of the IUD after hearing a description of the method from interviewers.

In three of the groups, opinions clearly weighed against the IUD. One respondent in the group of nonusers, for example, had never heard of the IUD and reacted unfavorably when she heard that it is placed in the uterus:

Ce qu'on place dans l'uterus, je ne sui pas dans ça.

(That which has to be placed in the uterus, I just don't agree with.)

—female nonuser, Balandou

Among one group of ever-users of contraception, most reported having heard of the IUD, and, in particular, having heard good things about it, but they nevertheless noted that they would never use the method nor recommend it. (No reasons were given, and further probing was not carried out.) In one of the men's groups, many opposed the use of the IUD because they felt it might lead to greater promiscuity. They felt friends and family would question their supporting their wives for the same reason:

Participant #1:
La famille ne va même pas accepter.
(The family won't accept that.)

Participant #2:
La famille va dire que sa femme veux commencer à blaguer et elle deviendra promiscueuse.
(The family is going to say that your wife is going to start fooling around and will become promiscuous.)

Participant #3:
La famille ne sera pas contente.
(The family isn't going to be happy.)

Participant #4:
Les membres de la famille qui sont au courent vont tous être découragés.
(The family members who know about it will all be disappointed.)

Participant #5:
La famille n'acceptera pas. Et si tu l'expliques à tes amis, ils vont dire que tu est perdu.
(The family will not accept it. And if you explain it to your friends, they're going to say you're lost.)

Facilitator:
Encore, une autre question : Si vos amis entendent que vous avez accepté, qu'est-ce qu'ils vont dire ?
(Okay, another question: If your friends understand that you have accepted, what do you think they will say?)

Participant #6:
Ils vont te juger comme un fou parce que tu as authorisé ta femme d'être bordelle.
(They're going to think you're a fool because you've given your wife permission to be a whore.)

Participant #7:
Ce que les autres ont dit, c'est ça l'essentiel. Ils vont dire que c'set toi-même qui a mis ta femme dans la prostitution.
(That which the others have said is all there is to say. They're going to say that you yourself have led your wife into prostitution.)

Participant #1:
Ils diront que tu as mis ta femme à la disposition de tout le monde.
(They're going to say that you have put your wife at everyone's disposal.)

—male participants, Salamani

Men in this group in particular also described instances in which the IUD became dislodged and lost in women's bodies, leading to injury, sterility, or death.

In addition to the fear that the method would become dislodged, other negative perceptions and misconceptions were evident among group participants and individual respondents. One respondent described how a baby was born with an IUD that had become lodged on his forehead. Another, in one of the women's nonuser groups, explained that a friend of hers had dislodged the IUD during intercourse. Some women noted that the IUD string is visible, making it difficult to keep the method a secret from spouses. In a few cases, it appeared that people (both individual respondents and group participants) were under the misconception that the IUD was a permanent method.

Many ever-users, however, spoke favorably of the IUD; a few, including IUD users, said that they had recommended it to friends and other family members. They described hearing from other friends how it is an effective, reversible method, requiring no surgery, with no risks and no side effects. Providers emphasized the immediate return to fertility and the lack of side effects as advantages. The few IUD users participating in the discussions referred to the lack of side effects when describing why they chose to use the IUD.

Among all groups, other advantages of the IUD that were noted included the fact that women do not have to worry about forgetting the method; that it is a method that can be used discreetly; and, according to a few respondents, that it is a good method for young women who want to continue their studies and therefore want to prevent a pregnancy. A few of the men and ever-users also presented the IUD as an option to sterilization, indicating that it is a better method because it does not require surgery. Participants in two of the groups requested that the method be introduced into their communities.

Many individual and group respondents stated that, as with most other methods of contraception, husbands would pose the greatest barrier to a woman's use of the IUD. Some women (ever-users and nonusers alike) noted that husbands would not being willing to accept the IUD, although they did not offer much detail about why they thought this was the case. Parents and friends may also hinder women's use of this method. Another important barrier is simply the lack of availability of the method and of qualified providers to perform the insertions. Some women noted that the fear of being "discovered" at health centers by neighbors and friends might also pose a barrier. Providers concurred with many of the barriers that focus group participants identified. They also cited the lack of method and trained staff as barriers.

Participants' and individual respondents' recommendations for IUD programming revolved around addressing many of the same issues raised as barriers. They suggested that programs ensure that highly qualified providers offer IUD services. Responses indicated that the sex of the provider is of less importance than is his or her skill level in IUD insertions, mainly because the perception is that insertion by a skilled provider guarantees against side effects such as dislodgment and abdominal pain. Participants suggested that providers work out of hospitals or health centers. Overall, the physical space should be such that clients' confidentiality can be maintained. Providing confidentiality in IUD services was seen as a priority, given the barriers that husbands and parents pose to use. Ever-users of modern contraception also stressed proximity as an important characteristic for the setting, stating that the facilities should be close to communities, to facilitate access.

To overcome the lack of information about the method, respondents universally recommended that programmers should carry out sensitization sessions on the IUD. Some noted that with adequate education and information, people would be more open to using the method. Many (primarily ever-users) suggested that educational campaigns target men, to increase men's involvement in family planning and to minimize their acting as barriers to family planning. One women's leader and a

provider recommended that education be carried out at ceremonial events because these are one of the few places where men can be reached.

Some participants also noted that religious leaders and community leaders should be included in educational programs because of their role as gatekeepers in the communities. According to respondents, religious leaders discuss family planning broadly at services and during private consultations, with discussions focused on the need to space births using breastfeeding and abstinence. Among women leaders, these discussions take place on more of a one-on-one basis. Few respondents indicated that policy makers play an influential role in family planning.

In terms of media, participants recommended that radio be used to communicate messages. One provider also noted the importance of posters, especially in reaching out to individuals who might not have access to rural radio.

Discussion and Conclusions

Family planning overall is a widely embraced concept among the communities with whom we spoke. People recognize the benefits to birthspacing and, type of method use notwithstanding, family planning in this sense is widely practiced. The challenge rests in working with communities to overcome prejudices toward modern methods and to broaden the range and awareness of other methods, such as the IUD.

In this section, we will consider some of the factors that may have affected our study findings. We will then review some of the key findings, especially in the context of other literature and information gathered on related topics. Finally, we will conclude with some recommendations for future programming on the IUD in the study communities.

Potential Limitations

According to in-country experts consulted prior to starting the study, family planning is considered to be a private and sensitive matter in Guinea. For this reason, the study design proposed the use of same-sex facilitators and interviewers. However, there were not enough female interviewers and focus-group moderators to conduct all interviews and discussions with female participants. As a result, for some of the discussions with female participants, male notetakers documented the proceedings of the meetings. It is unclear whether this may have produced some hesitancy on the part of women to voice their comments during the discussions.

Another potential limitation of this study may be the assignment of participants, in a few cases, to incorrect groups. Although participants were administered a screening tool to determine their assignment, it was later determined that some of the women who were included in the nonuser groups had indeed previously used modern methods of contraception. In addition, not all participants were currently married; a few women who were single, divorced, or widowed participated in the discussions. The men's groups similarly included a few single men. In this way, some of the groups were not purely homogeneous, and so some participants may not have disclosed information as freely as if they had been in a group of individuals of the same marital status.

Translation from one language to another for the purposes of analysis usually results in the loss of many of the nuances in the discussion, such that the translation is less accurate in its representation of what really occurred. In this study, translation was a two-step process, requiring translation from Malinke into French. In addition, no written transcripts were made of the discussions in Malinke because the development of a standardized and written form of Malinke is rather new. We therefore expect that there was probably some level of variability in how the conversations were finally translated. In the end, these factors may have led to some loss of meaning from the original discussions.

We took a number of steps to address these gaps. Facilitators and notetakers reviewed key terms in Malinke and their respective translations to ensure a degree of standardization. Also, a small, selected sample of interviews were translated from Malinke into French by an independent translator to assess the accuracy of the transcripts. Final transcripts were compared against facilitators' and notetakers' notes to ensure quality. Analysis focused more heavily on themes than on which words were chosen and how responses were phrased. Lastly, findings from our focus-

group discussions and in-depth interviews were also compared with those obtained from a series of informal focus-group discussions organized by the program's communications and marketing campaign; both sets of themes and general findings proved similar.

Lastly, because this is a qualitative study with a small sample size, findings are not generalizable beyond the study populations. However, the use of qualitative methods enabled us to gather information about the perceptions and beliefs of the study population, information that may have been less easily obtained by quantitative inquiry.

Recommendations

Many of the findings about family planning, modern contraception, and spacing and limiting births that emerged from our discussions are not unique to our study. For example, Théophin (1999) noted that men in Guinea are little involved in matters of family planning, and Blake and Babalola (2002) revealed that family planning is not discussed much in households. Information on awareness from our focus groups and interviews mirrors findings from the Guinea DHS, with awareness of modern contraception weighted toward the pill and injectables. Spacing for two to three years between births is to be encouraged, as per Islamic teachings, whereas the limiting of births is strongly condemned.

Previous research also helps to explain many of the typical responses in the discussions. Much as with participants in our study, Levin (2002) noted that women in her study failed initially to define ideals for family size and composition. That study also indicated a strong sense of competition among co-wives in polygamous households—also found in our study communities—that existed as an influential factor in contraceptive decision making.

Findings from our study indicated that the combined use of breastfeeding and abstinence for two to three years after the birth of a child is a widely used and most socially acceptable method of family planning. Nevertheless, there appeared to be little mention of what happens when couples (or one individual in the pair) are reluctant to be abstinent for the designated time, despite indications from a few participants that such a situation was not unusual. The fierce competition among co-wives to obtain the status as the favorite wife further suggests that women might be willing to end the period of abstinence before the completion of the standard two- or three-year period. Théophin (1999) found that, in addition to breastfeeding and abstinence, couples in the commune of Kaloum also used withdrawal, a highly ineffective method, to space births. Given the strong desire to maintain the two-to-three-year period of spacing, communication efforts should present the IUD's versatility as both a long- and short-acting method appropriate for achieving spacing for any interval.

One of the first steps toward improving access to contraception in general is to provide better information about the range of family planning methods in general. Misperceptions about side effects related to the pill and injectable exist, particularly among men; these misperceptions result in rumors about modern methods in general. In addition, although lack of awareness of the IUD is more of a challenge than misinformation, some myths do exist concerning the IUD. Better information about modern methods in general, such as the pill and injectable, would not only help to improve the satisfaction of current users, but it would also help to increase acceptance among nonusers and men and would build greater acceptance for the introduction of the IUD.

In terms of programming to expand method mix beyond the pill and injectable, the prospects for introducing the IUD are quite positive. Women either know very little about the method or have primarily heard positive things about it. In this way, little energy needs to be focused on addressing

previous misconceptions or negative attitudes that women may have toward the IUD. Instead, programs can focus on letting women know the method exists. Also, the method is discreet, has minimal side effects, and boasts an immediate return to fertility, which are three preferred characteristics noted among women participating in this study.

For the two permanent methods examined in this study—vasectomy and tubal ligation as a method of choice (i.e., not in cases of difficult pregnancy or cesarean sections)—greater educational efforts will be required to broaden access to these methods. Part of the lack of appeal in the decision to choose either of these methods is that they are permanent methods and few individuals seem to voluntarily want to end their fertility. Increasing the acceptability of permanent methods will greatly depend on making the concept of limiting births more acceptable to individuals. In the meantime, the men's focus-group discussions suggest that there are barriers to tubal ligation for medical purposes. The fact that those using this method have largely had to seek it in another country (such as Mali or Liberia, for example) or pay dearly for it, as noted in the men's groups, indicates the need to increase the availability of this method in Guinea for those women who may need it. Women should also be offered the opportunity to choose the IUD for limiting births; as participants indicated, the IUD's effectiveness is long-acting and could therefore be used when surgery was to be avoided.

More intensive educational work will need to be carried out with men's groups to overcome the resistance that we encountered on the part of men to being involved in family planning and to supporting their wives' use of modern contraception. Other projects, such as PRISM's male motivation campaign and EngenderHealth's Men As Partners program, have recognized the barrier that men pose to women's use of family planning and have made men one of their primary focus groups for improving access to contraception. Future projects should follow this example.

Men recognize the importance of spacing in improving the health of mother and child, so these aspects should be emphasized in educational campaigns. Special attention should be given during the educational sessions to facilitating communication between husbands and wives, to lessen suspicion around women's use of contraception. Male sensitization efforts would address men's concern about promiscuity and side effects and frame modern contraception as a tool for better birthspacing. Some male participants also noted their desire to know about the experience with modern methods such as the IUD in other countries. Such information may help to minimize some of the perceptions of (and suspicion toward) modern contraception as being too culturally foreign.

Both men and women are aware that women may face consequences if their use of contraception is discovered by an unsympathetic husband. However, it appears that not all men are unsympathetic to women's use of contraception. Male sensitization campaigns should be coupled with better counseling for women, counseling that provides women with better skills for broaching and negotiating contraceptive use with their husbands.

In addition, educational efforts should include religious and women's leaders. (The inclusion of policymakers and community leaders will depend on the community, as some of our groups indicated that these individuals have little involvement in family planning.) These educational efforts are of critical importance because religious and women's leaders appear to discuss these issues both in public and at a personal level. Such efforts may provide further support in fostering community support for contraception in those circles not usually reached by activities at the general community level.

Conclusions

Among the populations with whom we met, the desire to space births is universal. Men and women believe in promoting the good health of women and children and see spacing as a means of achieving this. Although introducing permanent methods into the array of available methods in Guinea is a more challenging task, requiring more time and sensitization, the introduction of the IUD may prove excellent in terms of the preferences and needs of the proposed project communities, given that flexibility of duration, effectiveness, and immediacy in return to fertility are key preferences. Building on the successes of past projects in family planning and working within the cultural fabric of the communities will promote greater awareness of the method and its possibilities in helping individuals meet their family planning expectations.

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