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アフリカにおける人口問題への新しいアプローチ

—人口、保健と家族計画プログラム—

New Methodologies in Population Problems in Africa
-Population, Health and Family Planning Programs-

平成8年7月

国際協力事業団
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- La population du Sénégal
  Yves Charbit and Salif Ndiaye eds. DPS/ CERPAA. Paris, 1994, 618 p.
- Fécondité et ethnie en Mauritanie
  Keumaye Ignegongba. CERPAA/CERPOD. Paris, 1991, 180 p.
  (1992 Winner of the Prix des Sciences Humaines de Paris V)
- Migrations africaines
  Yves Charbit and Nelly Robin, eds. (Joint program CERPAA/CERPOD/ ORSTOM)
  Special Issue of the Revue Européenne des Migrations Internationales, 1994, N° 3, 220 p.

FORTHCOMING

Sarah Hillcoat-Nalletamby : Family planning in Mauritius
Véronique Petit : Migrations and Dogon society (Mali)
Myriam de Loenzien : AIDS in rural Africa (knowledge and attitudes)

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国総研セミナー

テ ー マ：アフリカにおける人口問題への新しいアプローチ
－人口、保健と家族計画プログラム－
New Methodologies in Population Problems in Africa
-Population, Health and Family Planning Programs-

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場　　所：国際協力事業団本部　マインズタワー１１階　１１ＡＢ会議室

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D.ph. (Oxford University), French Doctorat D'Etat es-Lettre　人口学専攻

専門分野：人口調査手法
国際人口移動、家族計画・出生力、家族構造、保健問題等
フランス、アフリカ、カリブ海諸国における現地調査

職　　歴：国立人口学研究所リサーチフェロー
パリ大学社会科学部教授
World Fertility Survey , UNFPA, UNESCO, UNICEF, USAID, International Cildren Center等のコンサルタント歴任

著　　書：Yves Charbit and Salif Ndiaye, eds. *La population du Senegal* (1994), DPS/CERPAA Yves Charvit and Nelly Robin, eds. *Migration africaines* (forthcoming)

要　約

1970年代に開始された「世界出生力調査（World Fertility Survey ：ＷＦＳ）」や「人口保健調査（Demografic and Health Survey ：ＤＨＳ）」は、それまで満足のいくデータの不足していた開発途上国の出生、死亡、移住等に関する人口データを提供し、開発計画やプログラムの中に人口変数を組み入れることを可能にした画期的な調査であった。1994年にカイロで開催された「国際人口開発会議（ＩＣＰＤ）」以来、「人口と開発」を互いに分かちがたいものとして捉えるアプローチの重要性が広く認識されてきているが、このようなアプローチを推し進めていくためには、WFSやDHSのような国家レベルの定量的データに基づく調査のみでは不十分で、人口学に、人類学、社会学、経済学、そしてジェンダーの視点等を含めていくことが不可欠である。

パリ第５大学（ソルボンヌ）に1988年に設置されたアフリカアジア人口研究所（CERPAA）では学術的な研究として妥当で、なおかつ現実社会の問題解決のためにも役立つ、マルチ・ディシプリナリーな調査の手法を開発し、提言している。「村落調査研究（village monograph）」は、「人口学の手法と人類学の手法を組み合わせて人口や保健に関する地域社会の状況を調査する手法としてCERPAAで開発されたものである。

例えば、「子供を産む」という行動を分析する際には、個人としての女性を分析単位として調査するDHS方式では把握しきれない場合があり、個人が所属する地域社会を単位として、その価値、規範、または社会内部での男性と女性の地位や関係を調査することが重要である。このような場合には人類学的なカテゴリーや変数を用いた調査が有効となる。

また、1990年～1994年にブルンジ、セネガル、カメルーンで実施されたエイズに関する調査においては、「病気としてのエイズ」に対する人々の見方や理解と、「ジェンダー」の視点からのエイズ感染に関する態度の両面から調査を行った。この調査結果から、エイズ予防を目的とするIEC（Information, Education, and Communication）キャンペーンの戦略に関して極めて重要な示唆が得られた。

特定の遺伝子によって引き起こされる鎌形赤血球の研究においても、部族社会の婚姻が同族内でのみ行われているという慣習を見つけて理解することができれば、病気の分布がランダムに発生せず、ある村に鎌形赤血球をもつ人が一人もいないという事態の理由が明らかになる。

このようなマルチ・ディシプリナリーな手法は、事前調査、プロジェクト・デザインだけでなくプロジェクト評価においても極めて有効な手法である。「プロジェクトが所期の目的を達成しているかどうか、当初のデザインどおりに機能しているかどうか、また、もし機能していないならその理由はなにか」といった問いに答えるために

も人口学と社会学・人類学をあわせた手法が有効である。

セネガルで実施したvillage monographの手法による家族計画クリニックの評価においては、クリニックの患者データから、ターゲットである村落部の女性の60％から80％は教育を受けた経験が全くないにもかかわらず、クリニック利用者の60％が中等以上の教育を受けた（市街部に住む）女性であることから、このクリニックは当初の目的を達成していないと評価した。このような定量的な評価に加えて、クリニックのでの参加観察（participant observation ）や患者、ヘルスワーカーへのインタビューを通じて、クリニックのサービスや家族計画、ＳＴＤ（性感染症）サービスへの各人の態度を調査し、村落部の人々の低い利用率の原因を調査した。多民族が混合して居住する地域や村落の場合には、「村の地図」を作成して、異なるグループに属する人々の居住パターンやヘルスポストの位置等を確認することも有効である。

モーリシャスの家族計画プログラム評価調査では、シテ地区という貧困層居住区での家族計画実施率が低い理由を、（男性を対象とした）フォーカス・グループ・ディスカッション等の手法を交えて調査した。需要サイドにおける経済的要因（貧困、居住環境等）、分化的要因（親子同居の習慣）、宗教的要因（カトリックの教え）、ジェンダー上の問題（不安定な結婚）等に加えて、供給サイドでは提供される避妊薬の品質・副作用という問題が指摘された。

Village Monograph 手法で得られた調査結果（基本的には小規模の地域社会における調査）の敷衍・一般化可能性ということについては、シテ地区の家族計画実施率に関するいくつかの要因は国家のレベルに敷衍することは困難であると考えられる。従ってＤＨＳのような国家レベルの人口調査の必要性については疑問の余地はない。しかし、Village Monograph 手法は、こうした定量的調査を補完し、貴重な定性的データを提供しうる手法である。

Village Monograph を実施するためには、優れたフィールドワーク・チームが必要である。パリ大学アフリカ・アジア人口研究所では、こうした優れたフィールドワークを行う専門家を教育する方法として、セネガルやサン・ルイ大学やカメルーンのヤウンデ大学と提携して、共同で教育・訓練を行う大学院レベルの教育を行っている。

New Methodologies in Population Problems in Africa
- Population, Health and Family Planning Programs -

Yves Charbit
Professor of Demography
Universite Rene Descartes-Paris V
Director of CERPAA

Moderator: 本日はパリ第５大学アフリカ・アジア人口研究センターの所長、イヴ・シャルビ先生をお招きいたしまして、アフリカにおける人口問題への新しいアプローチということでお話しをいただきます。シャルビ先生はイギリスのオックスフォード大学で経済学、社会学、政治学等を収められまして、その後人口学で博士号をお取りになりました。１９８９年にパリ大学の人口研究所の設立に際して所長に就任され、現在に至っております。これまでにアフリカ諸国やインドシナ諸国におきまして、国連人口基金、ユニセフ、USAID等の国際援助機関の仕事にも多く携わっておられます。本日は先生の数々のご経験のなかから、特にアフリカをとりあげていただきまして、アフリカにおける人口問題へのアプローチ、その調査手法、実施手法、評価手法等を実例を交えながらお話ししていただくことになっております。

Dr. Charbit: Thank you very much, indeed. I am very honored and happy to be invited to give some feedback on our experience, my personal experience as a researcher and as a professor of demography, but also of my research institute, which is very much applied research oriented. I believe that it's important to be technically sound, to be scientifically unreproachable, but with the major issues with which we are confronted with, which is population growth and AIDS, it's absolutely essential that we, as scientists, never lose sight of the urgent needs of the populations.

As you know, when the World Fertility Survey (WFS) program was undertaken in the 1970' s, there was absolutely no data available apart from censuses and vital statistics which proved, when analyzed, that they were basically faulty; wrong declarations, omissions of people, very low coverage of birth, death, and even marriages was the common fate of these sources. And therefore, it was a very important undertaking in 1970's under the auspices of

UNFPA, and I was very happy to take part in that program, especially in Guadalupe and Martinique in the Caribbean. And then, I took part in Africa, in Senegal, and then in other countries of Africa. WFS and the Demographic and Health Survey, DHS brought a wealth of data which was undreamt of a decade ago. And it allowed real progress in the integration of demographic variables into development planning and programs. With the International Conference on Development and Population (ICDP) in Cairo, this conference confirmed that progress in the so-called population and development approach would only be possible if demography opened itself to other disciplines like, anthropology and sociology or economics and, of course, gender issues. The research implications are worth stressing for a few minutes.

First of all, there is a shift from national data, such as DHS, to regional or local data. What we must study is communities. Second, there is a shift or an enrichment from pure quantitative measurement to integration of qualitative data, qualitative analysis, qualitative resources. And third, the major shift for the future, I think, from the point of view of research is regarding the unit of study. As you know, in the DHS it's always a woman who is interviewed; it's a sample of women. It's very important now to shift from an approach based purely on women or men, individuals, to other units; the units measured being the family, or in Africa, the compound, which is a large family, the extended family, but also the village as a society. This is why you have what are called "community modules variables."

I created a research unit in CERPAA, which is Centre d'études et de recherches sur les populations africaines et asiatiques, which means Center for Studies and Research on African and Asian Populations, in 1988 when I was a lecturer at the Sorbonne. The idea was to design a methodology which could be multi-disciplinary. It was important in my view to propose something new, which would not strictly confine itself to population and demography. All our research projects are characterized by a constant endeavor to reconcile scientific research and programs as I said before, and also to answer to the needs of people immediately confronted with problems. Our experience in Senegal, for instance, was talking all the time to the regional chief medical officers, to nurses, trying to find out what they need, how we can help them, and this is part of the things which I will expose and explain today.

The first characteristic of our approach was to design a conceptual and analytical framework which could be scientifically sound, but which would also be flexible enough to be adjusted or to be implemented when different issues are addressed; whether it is family planning, whether it is AIDS. So the idea, table 1 which you have, describes the general strategy of research. You can see that our basic hypothesis is that we can no longer confine ourselves to the idea that you can explain behaviors like having children at the sole level of the individual. We believe that the individual behavior, which is what I call hypothesis 1, is in fact the result of the interactions of the persons with two other levels. First, people belong to a village or an urban area, and in this village you have values and norms which are very important for fertility choices. Second, it's very important to take into account gender variables such as the roles and statuses of men and women. Why? Because a woman is not the only person who decides about children. She has to bargain with the husband. Third, the individual is important, but in a village, in a small social structure, all individuals do not have the same weight. You get leader opinions who are very important persons in shaping the peasant's attitudes. So we believe that it's very important to take into account these three inter-individual levels; the village, gender, or let us say, men/women relationships, and last, the individual itself, once again, taking into account that all persons do not have the same social weight in a village.

The second is that we must study something like fertility behavior at the community level regarding the village as a unit. This is usually forgotten by demographers who stick to a sample of individuals. Sociologists and anthropologists would rather study the village as a milieu. So the phrase states that the village is a social and economic unit which influences individual behavior. How do we operationalize this hypothesis?

First of all, we must take into account housing patterns, because as I said, it is an indicator of social heterogeneity and of segregation. For instance, especially in Africa, you can work in multi-ethnic villages. It's very important to take that into account; are there, for instance, interactions between different ethnic groups or not. Second, it's very important to study, of course, families, the demographic structure of households, because the family is a unit which is very important when the status of women is low. The family is the unit where

decisions are taken. And of course, a village is not a closed unit. A village benefits from NGOs, from development projects, and these are factors of modernization. So it's very important, as the anthropologists do, to take into account the village as a unit, but the village is not a closed unit. It has external influences. And community equipment are absolutely essential in promoting new ideas. And of course, another form of opening the villages to the external world is, of course, out-migration. This is extremely important in bringing in new values.

I would just like to take one example to show how important it is not to stick to the woman as a unit, but to try to take the other analytical levels into account. We did a research project in Senegal at the demand of the Senegalese government to study the social factors which might hinder the extension of the family planning project, which up to then was limited to the urban milieu. The project was to be extended to the peasant milieu. Apparently, there was not a single feasibility study, nothing at all. Nobody knew what the peasants thought, whether they were reluctant or favorable to implementing family planning. So we were asked by the Senegalese government to study a few villages. This is why I called this methodology, village monographs, in order to provide a comprehensive understanding of the situation. So what we did was to interview women. What we do in the villages is that we do a DHS-type survey. That means we interview all eligible women, eligible meaning women of child bearing age, 15 to 40; women able to bear children.

I would like to point out the difference between a strictly demographic approach and a mixed approach. If you act as a demographer, if you think in demographic terms, what you do is to compare the ideal family size declared by the woman. The woman says I want eight children, right? And you discover that she has twelve pregnancies. Therefore, you decide that between achieved fertility, i.e. the number of children she had, and desired fertility, there is a gap. This gap is called the "unmet need" for family planning, that is the difference between achieved and desired fertility. And therefore, a woman who has twelve pregnancies and eight children is described as a potential user of contraception. This is a classical approach which you will find in all scientific journals.

We happened, in one of the villages in 1990, to ask one of the women, and she said she had had 19 pregnancies and eight desired fertility. Clearly, from a purely quantitative and demographic approach, this is a typical potential user

of family planning. That was the demographic survey. Then we undertook the qualitative sociological survey. During the qualitative interview, this woman revealed a completely different reality from what could be drawn from the questionnaire. She said, yes, I have 19 pregnancies, but I am sorry for none of them. I am very happy that I had all the pregnancies. We said, but why? She said, "my motivation is that I have a co-wife. You know, in Senegal, there is a very high prevalence of polygamy. And also I have a sister, and my co-wife is sterile; she cannot bear children. I also have a sister who has one child." And she said, "in fact, I am very happy because I will be able to give a child to my co-wife who suffers from sterility and a child to my sister who has one child."

If you think in terms of demographic risk and interaction between fertility and mortality, what this woman was telling us is that she would, therefore, relieve her sister from the catastrophe which represents the death of the only child. And also the co-wife had no children, therefore, she ran the risk of being repudiated by the husband. In other words, the lesson from this example is that, the fertility of the woman is not her fertility. It is the fertility of the couple, understood globally, which means a man and his wives, but also the fertility of the family because of the sister. So you see that it is very clear from this example that it's very important to improve pure quantitative data by adding qualitative data or approach.

Question: Out of the 19 pregnancies, how many survived?
Dr. Charbit: I think she had still 12 or 13 surviving, something like that. But you are right. It's a very interesting question, because that meant that she also could have quite a large number of children in reserve, so to speak. This is called the theory of replacement birth. You know, that in a country with high mortality rates, it's very important to have many children so that a few survive until the parents become old.

Using a mixed approach, demography, anthropology, sociology, raises a fundamental issue. Is it compatible to mix demography and anthropology? Indeed, the anthropologist would say the qualitative work you are doing is not proper anthropology. They say if you want to correctly understand what is going on in the field, you must spend six months, one year, two years, you must learn

the language, and you must go deep into the social values and social norms and so forth. We do not pretend to do anthropological work. What we want to do is borrow anthropological categories, and we do not analyze them from a purely anthropological point of view, but from a demographic point of view. The best example is gender.

Gender is a typically anthropological category or variable. We do not go deep into the rationale for gender. But we think it's important to understand and to use gender to explain behaviors. Another typical anthropological category is age, age hierarchy, which is very important in Africa. We do not go deep into the relationship between the older and younger men of the community, but we try to understand how it affects demographic behavior. So to my anthropological colleagues I always tell "I am not going to invade your field."

I would like to show how important it is to recognize that anthropology can make a crucial contribution to program design, implementation, monitoring and evaluation, I mean anthropology combined with demography.

I would like to mention an international research project which we carried out in Senegal, Cameroon and Burundi between 1990 and 1994, which ended up into a very good Ph.D. thesis. The basic research strategy was the assumption that the individual perception of AIDS, I mean, attitudes, representations, knowledge of AIDS, should be analyzed along two lines of interpretation. AIDS, first of all, is a disease, like many diseases from which peasants suffer. We also did that in villages. However, AIDS is a new disease, and it's a new disease which sometimes is regarded as being imported by Westerners. Therefore, there is no traditional nosology. That means to describe malaria you get many, many terms to describe it, but with AIDS, there are very few terms except that it's a "white disease."

Nevertheless, some of the symptoms, like losing weight, is very clear and has a very specific social significance. When people say, "oh this one is losing weight," that means he is suffering from AIDS. Therefore, there is some sort of stigma attached to the person. So AIDS is clearly a health issue, but AIDS should also be analyzed from a gender perspective. For instance, in our study, men and women were declared by our respondents, the peasants which we interviewed, as being unequal sexual partners, and therefore, they were unequally considered responsible for contamination. And of course, this thing which was

said by the people leads to something very important, which is the notion of high risk groups. The peasants clearly identified two high risk groups; unfaithful males and prostitutes.

You can see clearly that you get two paradigms, two ways, two lines of interpretation, one is health, the other one is gender. Both are very important from the point of view of information, what is called IEC (information, education, communication), and also from the implementation of prevention programs. For instance, if you base yourself on the health approach, it is very clear that the posters and the information talks you are going to organize, should sensitize people on losing weight. Because losing weight is what has been said by the people, therefore we should use it as a means to promote prevention. However, it is also important to take into account the notion of high risk groups, because then you must target information campaigns at high risk groups.

However, one should be very careful about what I call the perverse effects, the unintended effects. It has been shown in Africa, not in our study, but in Central Africa, that because campaigns were targeted at prostitutes, a woman, perfectly moral in her behavior, would be regarded as a potential prostitute if she wanted a partner to use a condom. Second, if the woman wanted to use the condom, that means she would imply that her partner was unfaithful. So there is a very dramatic problem in Africa. We say that there is a trap in which women are trapped by the prevention campaigns. They simply cannot use condoms and impose the use of condoms on their partners.

The other tragic consequence as you know in Africa is that because of the knowledge that sexually active women run a high risk of being infected by AIDS, adult males tend to have young women as sexual partners, because they feel they would avoid contamination. And the result is transferring the epidemic from the adult generation to the new generation, which is a catastrophe.

So you see, it's very important when you take into account broad anthropological and sociological approach, it helps with gender or with health, to refine the information campaigns or programs. So clearly enough, anthropology, in our methodology, which is village monographs, can be very helpful in going further than simply collecting data. It's very important also from the point of view of sampling. I will take an example. We do not do what is called statistical samples, because we don't think it's very useful. What is important is to do

a survey or sample which is really targeted, and to that extent what is called purposive sampling is very essential. Purposive sampling, as you know, is to pick up a few villages without taking too much care of statistical representativeness, but simply to decide which are the best adjusted villages from the point of view for our sample.

I take a simple example. To come back to Senegal, what we do is to study resistance to implementing family planning programs, right? So in fact, what we have to make as a choice is to pick up villages according to a criterion which is very important, which is whether villages are modern or traditional. So the criterion is modernity versus traditional social structure. Also if we believe that the ethnic criteria and the values are important, we should pick up villages one from the Tere ethnic group, and the other one from the Wolof ethnic group, which are the two dominant groups. And then you cross-tabulate the two criteria and you take the Wolof and modern, Wolof and traditional, Tere and modern, Tere and traditional, and therefore, you can identify the pure effect of modernization, or the pure effect of ethnicity. This is a simple demographic mixture.

I would like to stress that it's very important to take into account sociological and anthropological factors also during data collection. The first was design and strategy of research with AIDS, second was sampling procedures, and third is data collection.

We did a very important survey on the demographic determinants of what is called, sickle-cell anemia, which is a specific genetic disease of the blood, in Mali, where we interviewed 24,000 persons. We conducted 1,000 interviews, we built up 1,400 genealogies, and we did 4,000 blood tests. We found that the identification of the members of the households suffered from a very interesting bias. It was impossible to know whether people were dead or alive. I should explain.

In the Dogon community, one of the African ethnic groups, if somebody dies, and if a specific ceremony has not been performed called dama, his soul is still regarded as haunting the household. Therefore, when you talk to the head of household saying how many people live here, he would mention people who died one or two years ago, because of course the ceremony, which is a very important ceremony, takes place every two years. Therefore, from the point of view of counting people, it's a very serious bias. So this is a typical example showing

why it's very important to take into account sociological factors.

I would like to take another example. When you take a genetic model, normally you expect that the distribution of the disease is random. It should be transmitted through marriage to the children. However, we found that in some villages there was no genetic disease. Why was it so? Because in some villages, the total population belonged to a single caste, and the caste was that of the shoemakers, and the other one, of ironsmith, a specific craft. But you should know that these crafts are those which are practiced by former slaves, and as former slaves, they are outcast, outlaws. Therefore, there is a strong endogenous marriage, and therefore protected themselves from the epidemic. So you can see that from the point of view of data collection it's very important to keep in mind such very important anthropological information.

I have finished with the first two parts of my expose, the first one being the conceptual framework. You can see that what I described in table 1 is very important, and can be applied in the methodological implications, which is part 2, with using anthropology, sampling issues and data collection. I would now come to the third point which is, evaluation of reproductive health programs and I will deal with three different issues. The first one is regionalizing the national program. This is what happened in Senegal. There was the desire to avoid excessive centralization in the health project and trying to be efficient and decentralize at the regional level. The second item I will talk about is the evaluation of staff performance. And then I will deal with a very interesting survey in Mauritius on population programs addressed to disadvantaged social groups.

I would therefore once again stress the need to adopt a multi-disciplinary approach when evaluating programs. And a multi-disciplinary evaluation of programs may address different objectives. First objective is simple; does the program correctly address its objectives from both a qualitative and quantitative point of view? In other words, is the program doing its work, what it's meant for? Second, supposing that the evaluation reveals that the program is not functioning well, can we investigate the causes of failure? Why is the program not fulfilling what it has been designed for, and therefore, can we propose corrective solutions and improvements? In particular, one of the key issues in program evaluation is staff performance. So from this point of view, we believe

that mixing demography, sociology and anthropology is very essential to evaluate programs.

I would also like to state that one of the major importance of village monographs. If you are familiar with this terminology, what has been called RAP procedures, which is rapid assessment procedures. This is why I attended the meeting in New York at the headquarters of UNFPA last December, the fact that when you undertake a DHS, it's very good, but it's a very heavy undertaking. In fact, you get results one year or two years afterwards. That's the first problem. Second, when you have a national survey, it's not always representative at the local level, because you have a sample of 4,000 persons. It's all right if you divide by rural and urban. It's all right if you divide by major regional areas. But when your come down to the village or to the small district, then the DHS is useless. So UNFPA and especially Mrs. Nafis Sadik, the executive director, is more than willing to promote new methodologies which would allow quick assessment of programs; evaluation, functioning, monitoring. And village monographs, the methodology which we invented, is very close. In fact, when we met experts from Australia, and from the United States, we found that our methodology was very comparable to what is called RAP, rapid assessment procedures.

So we believe that even a local focused methodology can bring information for what I call the national program, especially if it aims at being regionalized. In Senegal, government policy began to stress in the late 90's the need for regional planning and for increased decentralization. Therefore, regional family planning centers were set up. But these centers dealt with family planning and STDs, sexually transmitted diseases. And they were set up as a pivotal structure, as the key structure, to implement the national health policy. That was very clear. There was a very clear national policy. We found when we undertook our village monographs, that it might be useful to do what is called the situation analysis. Situation analysis is a methodology which has been developed by the Population Council, which does it strictly from the point of view of efficiency from a quantitative point of view. What we do is to do a quantitative and qualitative analysis of the functioning of these regional centers.

We therefore, did a study of three regional centers located in two regions of Senegal. These centers were, this is very important, potential providers of

family planning services for the surrounding villages. Since we are going to study villages, we might as well study the regional center to see the interaction between the regional center which is supposed to help family planning in the village, and see whether there were or no relationships within the villages and the regional center, which is very essential in the view of the government. What we did was, first of all, to study the characteristic of family planning clients through the analysis of existing files. So what we did was literary to go through the files and did some data computing, and analyzing the characteristics of the clients. We did the quantitative study but we also did the qualitative study.

You have here, Table 2, which tells you the proportion of women who had never attended school in four of the eight villages. The name of the villages does not matter. "N" is the number of eligible women, which means all women of reproductive age. There is the same table for Thies region and also for the Fatick region. Due to space, I just gave you the information of the four villages. We studied eight villages, but the results are practically the same in the other regions.

You can see that between 60 and 80 percent of the women never attended school. We are in a situation which is characteristic of rural Senegal, which is completely an under-developed country with very, very low school attendance. Women do not know how to read nor to write.

Then we went to the files of the regional center, and we analyzed the educational level of clients. And we found that 60 percent of clients had attended secondary or higher levels of education. It is very clear that the clients in view of the educational level, are not the peasants. So by simply comparing a very basic data, which you can find in any client's files, i.e. level of education or age, very basic data, you can immediately answer the question. It's very clear that the centers do not fulfill the task which the government wanted them to fulfill. Therefore, they did not draw their clients from the surrounding villages. Far from it. It was, strictly speaking, urban clients. We did another study two years later, and we found that nine of ten clients again came from the very town in which the center was located. So from that point of view, from the point of evaluation of the program, it is very clear that it's a failure.

This is for the quantitative evaluation. Let's go now to the qualitative evaluation. What we did was to do participant observation. So we posted one

of our colleagues, and just spent time in the centers. It very soon appeared that many women tended to adopt rather elusive behavior. In fact, for instance, women suffering from STDs, from sexually transmitted diseases, never mentioned them, and they remained extremely vague about the symptoms. They say, oh I have pain; I have a disease. This is so vague that no doctor can ever work on this basis. Second, prostitutes, who came for condoms never admitted that they worked as prostitutes. Never mentioned that. Third, young men came also to the STD consulting sessions, and they were clearly embarrassed to ask for condoms. So what they did was simply to shortcut the waiting queue and go directly and ask, and we even observed one young man who came with a piece of paper and said, "I want a condom," and didn't dare ask for it.

So it's clear that married women, or women suffering from an incidental infection, prostitutes, young men, all persons were embarrassed at being in this waiting queue. In fact, it's very interesting, because the idea was very good. The idea was to take health as a global behavior, and to deal with AIDS, to deal with family planning, and to deal with STDs. But by mixing the three sorts of clients, the Senegalese government got a very negative effect, and people coming for family planning were suspected of coming for STDs, and therefore, having very loose sexual behavior. So the idea was very good to have an integrated health policy, but it proved out to have very negative effects.

Then we did not only do a qualitative analysis of the behavior of the client, but we also interviewed the staff. And we found that when we interviewed the staff, we discovered very simple reasons why these centers did not perform their task, which was to draw clients from the villages. Normally, people drive motorbikes, and there was simply no gas. Therefore, they could not go to the villages and tour in the villages to talk to the clients. So that was a typical block factor of inefficiency which could be solved very easily. But that had to be reported in a survey. And that clearly enough, is not a quantitative approach. It has to do with interviewing staff, therefore, qualitative.

This study of the regional centers was confirmed on an examination of the sources of information on family planning in the villages. This is Table 3 on page 5. We asked women, what were their sources of information. They quoted radio, friends, family, husband, paramedics, rural development workers, women's association, and other or not specified. And you find that the health personnel,

especially paramedics, provided a very limited amount of information. Most of the information on family planning was provided by what we called the first social circle, which is friends and husbands. And radio is also very important, at least in one of the villages. In other words, the role of supplying family planning information is not efficiently performed by the Ministry of Health, which in Senegal is the ministry which has the responsibility for family planning.

I have mentioned the ambiguous meaning of the concept of potential demand with this woman who had so many pregnancies, etc. I recognized that it's a very ambiguous concept. However, you can see from Table 4 that no less than 30 percent of the women were willing to use family planning in the future. Looking at the last line of the table, 48, 66, 37, and 30 percent of women were willing to use contraception in the future.

Let's come back to Table 4, and to the reasons for not using family planning services. I must tell you some personal experience from the field. When I worked in Senegal in 1992 for the first time, I always encountered the same argument. Even staff from the family planning association, argued that it's impossible to promote family planning, because Islam, the religion, is unfavorable and hostile to family planning. And we thought that that was an excuse for doing nothing. It's very simple to say God refuses, therefore, men just have to obey. USAID did something very clever. They gathered in Cairo, several religious leaders. They had them sit together, and tell the truth, at least as seen by the Koran. And they decided that the Koran said that it was perfectly legitimate to use family planning inside the couple, but it was out of the question to practice abortion, and it was out of the question to give contraceptive pills to an unmarried young women. Immediately, attitudes changed, because the possibility to use family planning was legitimized by the religious authorities. That was in 1985. It happened in Cairo. And I have seen my Senegalese colleagues, demographers, changing their behavior immediately. One of them took another wife, but the others started using contraception.

If you look at the reasons for not using contraception, you can find an extraordinarily low proportion of people quoting religion. It's extraordinary. You find 1%, 2%, 3%, 15%. But you must know that Touba-toul is a village where there is a very important religious chief. But you must keep in mind, in a very remote set of villages, where 80 percent of the women are illiterate, and at least

50 percent of the men are illiterate, in such remote villages an incredibly low proportion quotes religion. You would expect illiteracy to go along with high respect for religion. You can see clearly enough, that even in the rural milieu there is simply no religious factor preventing the expansion of contraception. And I must say that I worked in Bourkina Faso in1986, and I observed the same results. It's very clear that contrary to what is generally said, men and religious authorities are not against family planning as is usually believed.

The key reason for not using family planning, as you can see, is; "not informed," 7, 20, and 11 percent, and also something very interesting, which is "no spacing problem." Women regard their spacing rhythm between births as perfectly suitable. They have three years or four years, and they consider that as perfectly alright. Therefore, they do not see why they should use contraception. So really campaigns should promote the idea that spacing more than three years, five years or six years, would be beneficial to mothers, for instance, by allowing better health and better personal development.

I must say that another survey conducted in 1992, an NGO which was running a family planning center was even obliged to organize information sessions at the request of the villages. This is why there is a very strong need for family planning simply for very important reasons which is not within the demographic, anthropological, sociological explanations. It's a crisis. As you know, Africa is suffering from a very serious economic crisis, poverty is spreading very fast, and peasants are as responsible as you and me, and they are perfectly aware of the cost of children. Therefore, the growing crisis is certainly one of our best hopes for the future. Faced with the economic difficulty to raise children, there will be a sort of built-in process which will favor the use of family planning.

You've seen in these tables a very strong discrepancy between supply and demand for family planning services. Therefore, this leads me to the question of staff performance. I am totally dissatisfied with something which is a sort of credo, a credo meaning something which is said as a prayer. It's a sentence which is believed to be a self-fulfilling prophecy. I should explain myself more clearly.

When you read some of the literature, you find the idea that health post or school or what I called community facilities, for example a health post in the village, is a sufficient condition for development. I cannot, scientifically speaking,

accept such a generalization. We have to be much more careful about what really is at stake. A health post can be a very important contribution to development, or its effect can be absolutely nil and ineffective. To go further than simply stating such very optimistic phrases like, let's implement health posts and everything will be all right, we found that we had to design a special methodology to assess reality. So what we did was to design a four-dimensional evaluative framework. We asked four questions. First question is, what are the institutional objectives of the health posts? Second, are the means available? It's all right if you have a health post, but if you do not have aspirin or antibiotics, if the means are not there, the health post is totally inefficient. Third, how do the paramedics perceive the population they are supposed to help? Are they willing to help? And fourth, what is the attitude of the population towards the paramedics? Do they accept them in the village?

I will come to the first question, which is the institutional means. One of the possibilities to promote family planning, advocacy, propaganda, information, is to use the school teachers. After all, education should include sexual education. But we immediately found that parents were very strongly against using the school as a place to inform children, because the thing which was very often said was, "if you implement biology courses, information about physiology of reproduction, what will happen is that our girls will have sexual misconduct. Therefore, we will weaken traditional values." School is school to teach and to learn. It is not to learn about sexuality. You can see that the institutional aims is very essential. We should not implement programs in institutions which are not designed for that.

Now the availability of means, which is the second item. We found that it's a very serious problem in the public sector. And very often, we observed at least in several countries, there is a very unequal competition between the public and the private sector. By sector, I mean, a health center run publicly or a health center funded by an NGO like the International Planned Parenthood Federation. We studied, for instance, in one of the regions in 1995, it was very clear just by looking at the building, by looking at the shelves, that the private center was run very well, and that the public center suffered from a very low motivation from the staff. There was absenteeism. There was no effort to draw clients to the public health post.

One of the ways to evaluate staff performance is to precisely gather data which are, as I said, "sleeping beauties." Very often, when we go into the villages, we do a survey of vaccination coverage; how many children received full coverage, partial coverage; how many women received prenatal care; how many women received delivery assistance. We also provide information on fertility preferences, on contraceptive preferences; how many women use contraception. These tables, by the way, are drawn from a book which I offered to JICA a few months ago, and you will get not only information on contraception but also family planning degree of use in the villages. You can see that by doing village monographs, which is going into the village for six weeks, it's very simple. We can in six weeks provide very solid information about the percentage of children coverage, vaccination coverage, percentage of mothers who use contraception, and so forth. This is a very simple way of evaluating staff performance. So this is one of the contributions to evaluation of staff performance.

I would like to come back to the third criterion, which is the perception of the population by the paramedics. In one of the villages which we surveyed, we found that all the staff paramedics were living in lodgings which were literally at the outskirts of the village. When the weekend arrived, they immediately ran away from the village to go back to the capital which is Dakar.

You expect the health post to be located in the center. If these people remain at the bounds of the village for a start, there is very little interaction, because in a Senegalese village, there is a place where people meet to talk. If you are located outside or even in a remote area, that means you do not want to communicate with the villagers. So that was the first point. This is why in the village monographs we talk about the village map. You can see on page 1. We study the social and cultural topography of the village, and we draw a village map. Second part is this; housing patterns as an indicator of social heterogeneity, segregation, etc. So we do what you call the social and cultural topography of the village, and we draw a village map. Of course, this village map is very useful to decide whether both ethnic groups are mixed or separate. But it is also very useful when you study the behavior of the paramedics.

So in this village, they lived outside. Second thing, they immediately went to Dakar, the town, because in fact, being posted in a village implies a very low social status to the paramedics. They all want promotion in the town, possibly

in the ministry. This is a classic problem of having staff go down to the villages. So you can see that, clearly enough, these paramedics did not want to interact with the villagers.

Last, we studied the attitudes of some of them, and we found a very ambivalent attitude, especially, the male nurses who were supposed to promote family planning. This was the mandate, the mandate given by the government. They tended to give negative messages about family planning. And they expressed very positive opinions about the legitimacy and the efficiency of traditional methods. Traditional methods of family planning is putting around your arm a special ring, which perhaps helps blood pressure, but certainly not family planning. Of course, one should not generalize. All paramedics did not have such negative attitudes towards family planning. But there is a very interesting contrast between the paramedics and the traditional religious leaders. And this is why, coming back to Hypothesis 1, we found that the opinions of the individual, it's very important to study opinion leaders. And opinion leaders, you get the modern leaders like nurses, school teachers, and you get the traditional leaders like chief of the village or religious authority, religious chief. So the question is why should we meet negative attitudes among modern staff, and why should we find very neutral or even positive attitudes among traditional leaders? This is a very interesting and very surprising result. Why is it so?

In fact, you must understand that a paramedic, a man which I will call Mr. X, belongs to a culture and has a job. All of us, belong to a culture, we have values and we have jobs. In France, I'm educated, have a job, and I teach. There is no conflict between my personal culture and my job. But if you are a man, a paramedic, who has received training to promote family planning, this man perhaps belongs to the village or to the same ethnic group. And he will find himself promoting values which can be completely contrary to his own culture. In Africa, fertility is highly valued for reasons which I can explain later. Clearly enough, if you have a job which says high fertility is a bad thing, it's very clear that there is a conflict between his culture and his job.

Now, if you take Mr. Y, who is a religious leader, his job is perfectly consistent with his culture. This man behaves in everyday life in a rather peaceful state of mind and therefore, he can be very generous and positive about family planning because that does not put him into question. He is not personally questioned

by that. So this is something very simple, when you think in terms of the structure of personality. But it is very important to take it into account, into programs. And this sort of qualitative thing is simply forgotten. And you can see that as a demographer, I am far away from demography.

So this is what we learned from the evaluation of the regionalization of a program. As I said, regional centers were inefficient, did not fulfill their tasks. Staff did not perform properly. There was inadequate supply. There was no religious barrier to family planning as shown by the interviews of the villagers. And there is a basic problem of staff performance due to conflicting roles.

I would like to talk now about the third example on the evaluation of the reproductive health and population programs, which is the case of Mauritius. Here again, that turned into a Ph.D. thesis for somebody who is now a professor at the university in New Zealand, at the University of Waikato in Hamilton. As you can see as a teacher, it's very important for me to train my students so that they can be very practically oriented. I think it's very important for their future that they can contribute immediately to population issues. You must know and you surely know that the national family planning program of Mauritius has been recognized as one of the most successful in the 1970's. You know that Mauritius received the national UNFPA gold medal, I think, in 1984.

However, when you study recent trends in contraceptive prevalence, in client enrollments, in contraceptive dropout, and in the use of non-supplied method which is not the Pill, not IUD, but traditional methods like withdrawl, you find that recent trends are very alarming. In this country, where things went very well, there are signs of rather negative trends in family planning use.

So we undertook in 1991-93, a survey with the agreement of the Ministry of Health. And we studied what is called cité. A cité is in fact blocks of houses which were built after the hurricanes and typhoons of the 1960s. These cités were sort of emergency housing where people were put together. And we established very low contraceptive use. The idea was to try to understand why these cités suffered from low contraceptive use whereas in the rest of the country, everything seemed to go well.

You can see that you get two major possibilities. The Cités are the forerunners of a national problem. In other words, what is observed in these small villages can be important from the point of view of the country, first hypothesis. Or,

second hypothesis, factors explaining low contraceptive use are specific to the villages, and therefore we cannot draw conclusions on the basis of what has been observed in the cité. Alright? It's a research strategy. So you can see that even a small focused survey can be very useful as a contribution to national trends.

So what we did was to try to understand what were these factors. And we found that the problem in the cités was a combination of supply and demand factors. First of all, we investigated the demographic characteristics in the villages. You have three levels, you have a cité which is a block of housing, you have a district, and you have the nation, Mauritius. So what we did was to take the characteristics of the people of the cités, and to compare them to the districts in which the cités are located, and then to compare them to Mauritius. So we used the census, various surveys, plus our specific village monograph. And we found that the people in the cité suffered from very poor housing, low education, low jobs, and a high fertility level. There was a cumulation of factors which can be illustrated by the following. I will just give you an example of cumulation of factors.

These women live in very poor lodgings. Since they are very poor, they cannot pay electricity, so they use charcoal, and charcoal is very untidy. They spend their time cleaning all the time. Moreover, they have no access to water. So you can see that the day of labor of the women is overburdened by such tasks as tidying, cleaning, getting water, and just lighting fires. First factor.

Second, there is a specific social behavior which consists in a family like that, you get father plus mother plus one son. If the son gets married, normally he should start a new household; a new lodging. In fact, the son brings his wife in, and they remain in the household. Therefore, very soon you get one family, and the second family; the son plus his wife. You can imagine if they have three sons, you get an incredible overburden.

So women, not only find themselves stuck with charcoal, tidying, and getting water, but they live in overcrowded households. And the result is that they said, I have no time to go to the family planning clinic. But the family planning clinic was located a two minute walk from the cité.. No time. Maybe true, maybe wrong. So we explored other factors. We interviewed men. We did focus group interviews. We gathered a group of men, and we interviewed them. When we

first interviewed the men, they said, Oh, excellent. Family planning is good, because it alleviates poverty. It reduces poverty by reducing fertility. When you hear that as a sociologist, you say, "you are not going to fool me." This is the message you've learned by heart, right? So we went further into the interviews. And we certainly discovered that men said, "hmm, you know the Pill, I'm not too much in favor of it, because my woman has nausea and is overweight. Because she has nausea, she has headaches, and she cannot perform her duties as a housewife."

That was a much more relevant, and a much more authentic reason. So in fact, you can of course say that that was wrong because women were suffering from malnutrition or poor nutrition. Overweight was due to a very unbalanced diet, and the side effect of the Pill was far more marginal than the actual diet problem. But that is what men believed. So first, family planning is good. Second, family planning is bad due to duties which should be performed. And then, as the interview went on, they went further and they said, "Ah! What we miss is the star woman. We want our wives to look like what we call a star woman." What is a star woman? And they said, "Oh you know. Dallas."

So you imagine yourself, miles away from Hollywood, in a small village where there is no electricity, but nevertheless you get TVs. In TV they look as Joan Collins and all the rest, J.R. and so forth, and they said, "ah, this is what my wife should look like." So you get a very interesting component of men's attitudes. This is a typical gender relationship. It is not specific to Mauritius, alright? After all, men always complain about their women not to be the ideal, etc.

But then, there is a specific factor. And this specific factor is mating patterns, which is unstable nuptiality. There is a high rate of turnover of partners in this region, and I have studied that in my doctoral thesis. It's the same thing in the Caribbean. What happens is that in a social milieu which is characterized by high turnover of partners, a man changes partners, very often he tends to drop the woman when she becomes pregnant to go to a younger woman. The problem is that women knew of the risk of being dropped by men. And as a result, because men expressed family planning is bad, immediately they adopted the men's opinion, and they refused to use contraception for fear of losing their partners. Do yo understand the mechanics? Because nuptiality is unstable, they are always at risk of being abandoned by their partners. Now they know

that their partners prefer the star woman. They believe that the Pill makes them grow fat, and they know that men reproach family planning for them not being proper housewives. So the immediate result is that rather than losing their partner, they prefer not to use family planning.

It's very interesting, because you get here the complete set of factors, pure economic factors; housing. Cultural factors of families remaining together in the same household. You get also the gender issue. And you also get the specific cultural factor of this community. So this is the demand factors.

Now what about the supply? And the supply was also another problem. Women said that there were very important side effects, like for instance, they could feel that the IUD was going up in their belly, and they actually felt it in their belly. And when we said, "but how big is the area?" and they said, "THAT big," which was the size of the belly. Or they would think that the condom would get lost in the vagina. And you get a complete set of rumors whether it is the Pill, the IUD, or the condom. All of them, the side effects were so to speak over-exaggerated. And it was clear that they were over-exaggerated because of all the sociocultural factors.

Now what about the supply? We found that indeed the problem was that the government was using one brand of the Pill, and this pill was over-dosed. It was too strong, and indeed, it had side effects. But side effects were clearly exaggerated by the people. But if people exaggerate, it's not an exaggeration, it's a fact. And that's a block to the program.

There was another reason for the failure of contraceptive use in the cité. First of all, women worked in the tourist resorts. They worked as maids, as employees in the hotels; the tourist areas. And then they got information from the tourists. Second, they worked as maids in rich families. In these families, the housewives gave them information about other pills than the one proposed by the ministry. And third, they heard through TV about the methods which were used in neighboring island of Réunion. You know there is Madagascar, Mauritius, and Réunion, and Réunion is a French Overseas Department. And in Réunion, there is a very large supply of various methods. Therefore, these women, they knew what was the market, and they knew that they had just one share of the market, which was one method, one brand of Pill, and that this pill, they knew, had side effects, and they found that there were other possibilities,

other offers.

I would like to stress the last factor which is the indication of religion. These women are Catholic. Being Catholic, the method which is promoted by the Church is the traditional Ogino method, which is an abstinence method. Clearly enough, when the propaganda by the Church, the local religious Catholic association NGO says, this method is good, because it enhances, it favors communication within the couple, because you must contribute you and your husband to family planning, you must talk about it, you must think about it, and you must use that method, which is the rhythm method, all the time. But it is very clear that this works if there is couple communication. In this milieu, where you get unstable nuptiality, it's impossible to build a couple strategy of contraception, because the men change. So how can you talk together about contraception if you run the risk of your husband going away?

So in fact these women were caught in a contradiction. They felt guilty because they could not use the traditional method. Therefore, they were against the Pill, because that was not agreed by the Catholic authority. And they were totally unable to use the traditional method, because this implied a stable couple which precisely was not the case. So you can see that whether it was supplied by the Catholic church or supplied by UNFPA and the government, it was totally unadjusted to the needs of this population. So there were supply problems plus demand problems So this is why we observed factors here which were specifically negative, and to that extent, these data cannot be extrapolated to the national level.

I will just finish by stating that...I will not go onto the dissemination and internalization of results, which is very simple. It really goes along the fact that we must respect some ethics about handing back results to the people. It's very important. We have a strategy which has three levels, we must inform. In terms of information, we must work at the national level. When we implement a population program, applied research, we must always inform the national authorities. It's essential. After all, it's a sovereign state, and we are not allowed to undertake research without asking permission. We must work at the regional level. For instance, the chief medical officer should be informed. And we also must make a feedback to the local population. For instance, for the study of sickle-cell anemia, we had a computer list of those having the genetic disease,

and if they wanted it, if they wanted to know, but only if they wanted to know, we gave them the results, and what they should do to get proper treatment. So we always respect national authorities. We try to involve as much as possible the regional authorities, and we do as much as possible, local feedback.

I will not talk about training of trainees. But I would just like to conclude that we believe that DHS surveys, major surveys, are absolutely essential. These kind of surveys are one of the best ways of knowing what is going in the world as far as population is concerned. However, we believe that we can certainly provide valuable information, and complementary information to that brought by a quantitative approach, and we believe that a multi-disciplinary approach is very important as I hope to have shown to you.

As far as program design, program monitoring, and program evaluation is concerned, the only problem with this methodology is that you need excellent field work teams. You cannot use a census enumerator agent. You cannot use a classical standard survey employee. Normally you need people with at least A level, which is the beginning of post-graduate studies. To that extent, it's very interesting, because what we did in order to do these surveys, all those which I have mentioned, we used students from Paris V, and students from the University of Saint-Louis in Senegal, and also from the University of Yaounde in Cameroon. To that extent it's very important, because it gives students a very important opportunity to get professional training.

Moderator: Thank you, Professor Charbit. それではご質問等をいただきたいと思いますが、その前にお話しの中で用語等で説明をしていただきたいという用語... 今日は専門用語などがだいぶ出てきておりますので、もしなにかそういう物がございましたらご質問ください。特にありませんでしょうか。今日のお話しの中で何回も出てきましたDHS (デモグラフィック・アンド・ヘルスサーベイ) というのがありまして、先生には、DHSのような人口学的な、統計学的な人口調査の手法にたいしてよりクオリテイティブな、リージョナルな調査の手法ということでお話しいただきました。DHSは主にUSAIDの資金によって世界４０カ国ぐらいで行われている大規模な人口調査でして、今JICAやその他の国際機関などで女性一人当りの子供の数（トータル・ファーティリティー・レート）ですとか、乳児死亡率（インファント・モータリティー・レート）というような人口統計の数値を使用する時に大変よく引用されている調査です。世界中で使われていて、その意義が認められているんですけれども、今

日は先生はそれを一つの人口統計学的な調査のモデルとして比較しながら、先生のチームで行っておられるビレッジモノグラフという別の手法について、大変に豊富な事例をアフリカでのご経験等から引きながらお話しいただきました。

I would like to invite questions, comments, anything from the participants.

Question 1.: I have a couple of questions. The first one is concerned with your approach. You said that you used the focus group interview in Mauritius, but you didn't seem to use that approach in Senegal. So I was wondering about the consistency of your methodology. It doesn't always include focus group interview, or depending on the societal context, or for whatever reason? Please clarify after this.

Second one is not directly concerned with your talk, but according to a study in this book on the evaluation of population programs, published in France, there is a study on the evaluation of health project in Senegal village, and according to that result, at least for the reduction of infant mortality, the village health post was to some extent effective. Since you just talked about the effectiveness in terms of STD prevention and family planning, I was not really sure about the effectiveness of village health posts in your study. This is the second question.

Third one is not a question but a kind of comment. You wrote down Ogino. It's a name of a Japanese medical doctor. I know French often use Ogino, and they pronounce it "Ojino," but it's actually Dr. Ogino from Japan. Thank you.

Moderator: Could you answer with a little bit of explanation about the methodology of focus groups, please?

Dr. Charbit: Mr. Kojima, thank you very much for your very interesting questions. Indeed, we used focus groups practically in all of our village monographs whether in Senegal, whether in Mali for when we studied migration and the problem of sickle cell anemia, and in Mauritius. I just quoted that in Mauritius because I thought it was very relevant, but we used that all the time. I must say that I am not sure, I mean, a lot has been said about the focus group methodology being a revolution. I think it's not quite relevant. We did try to assess the differences between opinions expressed personally on a face-to-face basis or in the focus groups, because I thought there would be a problem of

conformism in answers. Miss Mishima went into some of the villages, but I don't think there is something really important which would be discovered in focus groups as opposed to face-to-face interviews.

Maybe I should say that we believe that focus group is important, perhaps from the strategy of data collection. I should explain myself. If in a village, you take the time to explain to the villagers that we want to interview people according to the structure of their society, that means you talk to older women who are called "les grandes seures", which is the eldest sisters. You talk to old men, and you talk to young men. You talk to old women and you talk to young women. You talk to women belonging to a cooperative group for production, like fisherman, for instance, in the village. Not all of them belong to the cooperative groups. Therefore, I think it's important to do that from the point of view of expressing the fact that you respect social structure. I am a bit skeptical about the fact that, as I said before, you discover extraordinary things through focus groups, but it is the place where people talk freely, because they are between themselves, so to speak. It's a group of peers. So it's important to respect that from the point of view of methodology. As I said, we have done that systematically in Mali, and Senegal, and in Mauritius, but I just mentioned it about Mauritius.

The other question was very interesting about this survey of health posts and their effectiveness. It is true that there is this study which shows that finally it did not work that bad. I must say that results we produced were based on eight villages. So we do not pretend to give a complete overview of the actual efficiency of the national health program. We cannot pretend to extrapolate from a few villages. What we want to do is rather to draw from a limited amount of villages, an exhaustive identification of the factors at play. So to that extent, we might find villages where the health officer is a nuisance, and in one way plays very positive role to promote family planning methods. About STDs, for instance, you must remember that I talked about regional centers which are not villages. It's slightly different.

And the third question was about...?

Comment: It was not a question, just a comment about Ogino.

Dr. Charbit: It's called the rhythmic method or sympto-rhythmic method. It's very complicated.

Question 2: I am an engineer and architect planner working for development planning. My question concerns the summary on Table 4, page 6, for instance, religious customs, probably chief or whoever. My question is, how many sampling numbers, minimum numbers, which you can avoid a skew Thank you very much.
Dr. Charbit: This is a very interesting and a very important question. There is something which I should have made more clear before. When we go in the village, we interview ALL women. There is no sampling, because that is precisely the advantage of working in a very small village. We take all eligible women. Therefore, you do not get into the problem of threshold of confidence, because we get everybody. I take another example. If in a census you get 0.002 percent of persons who say we believe that anything but lemons are better than oranges, anything. It's all right. It's a very small number, but it's a true number. It's not a sample problem. So it's exactly the same logic. That's precisely the point of working in small villages.

Then, the question is the above level. Then the question is the choice of villages. This is why it's not a random sample of villages, but a purposive sample. I mentioned it in the paper, but I didn't have time to mention that. So I think that is the answer to your question. It's a very important question, and I would like to make it more clear.

It's important to get levels of family planning use, but it's even more important to understand the factors behind it. And to that level, very precise statistical rigor is not essential. So what we do is we take all women, and then we take villages which are representative in a purposive sense, that means by the criterion of modernization, or ethnicity. Yes, that's about the answer, I think.

Question 2 continued: There is nearly 100 something... confidential.
Dr. Charbit: No, no. But there were a hundred women in the village. There were 100 women in the village. That's the point. There were no others to interview. But maybe I should ask something. It's very important question which was raised. The question is that if you think in terms of the village as a unit, then the real problem is people who are not in the village, which are migrants. Because then you get very important factor of trends, change of modernization. For instance, in Senegal, you get young girls who leave the village to go to work to the town to constitute the dowry, and then they come back to

the village when they become rich. Clearly enough, these women, age 15 to 20, will have very different attitudes from the villagers. So we have a problem of estimating the attitudes of all the members of the village, ignoring people who were not there. But this is a typical problem of demography. If you work on a sample, those who not here are not here. It's like that. It's representative of the people who are there. What would be a catastrophe is to have among those resident in the village having lost or forgotten or having systematic refusal from a part of those resident with a strong bias; all educated, all Muslims, all Catholics. That will be a very serious problem. But as I said, we have everybody residing in the village.

Question 3: I have two questions regarding the activities of your Institute, actually how you carry out your activities. The first question is that your research works, I believe, have been conducted in close contact with international organizations, or USAID, etc., and I am just wondering whether you work with the French government, French bilateral ODA. That is the first question.

And the second question is that I was wondering of you could briefly explain your research works in Asia.

Dr. Charbit: First of all, we receive grants from a large number of international agencies; UNFPA, USAID, WHO, and the French. In the case of the French, we receive two different support. One was research grant by the Institut de l'enfance et de la famille, which is specialized on family issues. It's a national demographic institute. Of course, I do not count my salary, which is paid by the French government. But the other grant was very interesting. It's called CAMPUS, like a campus. It's a campus program, and it's a grant which binds together two universities to do research and training. And this is a part of the program in which I had the pleasure of having Miss Mishima. We could put to the field, so to speak, students from the University of Saint-Louis and from Youande on the family planning and AIDS. And I would just like to mention that in Saint-Louis is a very recent university. The old university is Dakar, and Saint Louis was recently created. In that university, one of my very good colleagues has just created a specialization on the sociology of the family. He had ten students. And I was very happy because we could take the ten students and give them that opportunity to do practical research. So all of this cohorts,

so to speak, were trained, and immediately after that, I think three of them got jobs with UNICEF. And as a result, I think, this program was very good, because from my point of view as a trainer, it's very important to identify students who are able to do field work and work in population and development. If you put them six weeks in very hard conditions in the field, then you know, those who are good and those who are not good. And also they can use data to write their MA dissertation. So for my Paris students, they would work all year before on questionnaires, bibliography and so forth. Then, they would go to the field. And you know it would be very, very hard. Miss Mishima is a survivor from that experience. It's more than 40°C during day with wind storms, or sand storms and so forth. It's pretty tough. Then, they would come back to Paris let's say, by January, do all the data computing, write the dissertation, dissertation is sometimes more than 100 pages, and take other exams as well. As one of my colleagues said, if they survive that, they are very good students. Some of them finally ended up...the girl I mentioned in Mauritius is now a professor, two others have been hired by the national research institute, and so forth. It's an excellent training and research package.

Now to come back to our activities in Southeast Asia. We received a very generous grant from UNFPA, 500,000 U.S. dollars, to do the training of professors at the National Economic University of Hanoi on a four-year program. And I am very pleased, because France added up 400,000 dollars in scholarships, which is a lot of money. And we trained eight people, all of them younger teachers. Out of eight of them, just one dropped, seven received MA degrees. As I said, one dropped. He was non-French, not fluent in French, was a pure mathematician, and was completely lost in a sociological program, and I understand him. So the six [sic] others, they all got their first year of Ph.D., three are currently writing their Ph.Ds., and the three others, they just want to carry on. France gave money for linguistic support, scholarships, and UNFPA created a documentation center. We improved the computer facilities. We sent people to Australian National University, one in Mahidol University in Thailand. And that was a lot of work for four years. I think we are likely to have a new project in Vietnam, a new four year program. The Vietnamese colleagues are very willing to have it. We'll see if there is money for that. That's one thing.

Now the other program, in Vietnam, is one of my students with a French

scholarship is writing her Ph.D. on a village monograph in a region near Hanoi, in a small region near Hanoi. So that's research in Vietnam. Of course, I can also consider as research, the Ph.D. being written on national census data, or sample data. I will talk about Cambodia after.

In CERPAA, we believe it's a very important strategic attitude or stand which we have taken. There is an extraordinary vicious circle in Africa, especially, and if you work in Africa, you know that. There is a lot of money which has been poured into data collection, because, as you know, data collection allows to pay for gas, for typing facilities, for telephone, and employment of people. But then when you get a country which works well like Senegal with political stability, you are so happy, that you reinvest money. This is exactly what UNFPA is doing, what USAID is doing, what the French are doing, and I think Japan is also doing, and the European community.

But then you are in an extraordinary vicious circle. You get a lot of money invested. People kill themselves. My Senegalese colleague just work until four o'clock a.m. in the office. They don't sleep at home, and they go to the field, and immediately after the DHS is finished, then they take the census. When the census is finished, they get The World Bank Priority Survey. And when the World Bank Priority Survey is over, they do the DHSII. When the DHSII is finished they do another survey. And you get flight forward, as we say in French. And it's a disaster, because you pile up a lot of money, and nothing gets out. I remember clearly a survey which they produced that cost something like 500,000 dollars. It's ridiculous.

So my idea was that we get excellent professionals, right? Generally speaking, they are heads of the statistical division, population division within the GSO, the General Statistical Office. These people are the best experts. The government gets nothing from the survey in terms of monitoring of national planning and so forth. And of course, the result is not quite happy, and you are JICA, because what is the output of that? So I found that one of the solutions to put everybody in agreement would be to have this man who is the national technical director of the survey write his Ph.D. on the data. He knows them perfectly.

Now normally the topic of the survey is national priority. It will be fertility, infant mortality, and so forth. So in fact, it can be perfectly justified to write

a Ph.D. on fertility regulation, on infant mortality, right? In fact, he can put, writing of his Ph.D., inside his scope of work.
(Ms. Mishima: 職場での仕事をしている中でできるということですね。)

The outcome is very good, because this man certainly jumps in terms of salary from 3,000 francs to 15,000 francs. He is very happy with that. He gets a Ph.D. first. Now the nation gets at last, fertility trends, vaccination coverage at the national level, and education dropouts, and so forth. And the donor is very happy, because something comes out from the data.

Now the key for that is that in the French system, there is no long term expatriation. You can write a Ph.D. simply not coming to France. So what I do with the contribution of the French is to have study tours paid in Paris. But study tours means not going to the shops, to the Gallerie Lafayette, major shops. (laughter) I closely watch them when they are in Paris. And we pay one month's salary when they hand back a paper. And this paper can be a chapter of the thesis. So what normally I plan to do with...what I try to do when I can get funding is to have a package which would include valorization of data, training component, and publication of a book. I think this is very important. And the book which I was very happy to offer to JICA brings in data from various sources; World Bank Survey, village monographs, DHS analysis of data, and so forth. So I talked a lot about village monographs, but the other strategy is reinforcing human resources on the basis of valorization of national data. To me, it's very important as a contribution to the strengthening human resources.

Now come back to the last item. I just arrived from Cambodia. In Cambodia, the situation is a catastrophe. Because of the Pol Pot regime, people literally vanished. It's a disaster. So you have to organize training at very low level, literally root level, on demography. We implemented intensive training for students and for trainers, for professors. So we brought professors from the various faculties. It's something of a very interesting task to train students and professors at the same time. So you must always give professors one train [sic] ahead, right? They must be always ahead of students. So it's very complicated to organize, but I think we succeeded. And I got scholarships from France for one of the professors to get a Ph.D. And I think at least in Cambodia, it's absolutely crucial to invest money into training professors, because without human resources, we shall go nowhere in Cambodia. It's really heartbreaking.

Moderator: Are there any last questions or comments? Thank you, Professor Charbit, for giving us a very extensive, detailed, and elaborate explanation of your research methodology and field works. Thank you very much.

Dr. Charbit: Thank you very much for welcoming me.

配布資料

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NEW METHODOLOGIES IN POPULATION, HEALTH, AND FAMILY PLANNING PROGRAMMES

CONFERENCE DELIVERED BY

Yves CHARBIT
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SUMMARY

When the World Fertility Survey programme was undertaken in the 1970's, demographic data on fertility and its proxy determinants were badly needed. Censuses and deficient vital registration systems were the only available sources, if one excepts the KAP surveys which addressed the specific issue of family planning.

With the World Fertility Survey and the Demographic and Health Survey programmes, the scientific community but also decision makers and national planners benefited from a wealth of data undreamed of three decades ago.

A major consequence, a part from progress in the knowledge of the dynamics of population of developing countries, was a signifiant contribution to the integration of demographic variables into development planning and programmes.

The INTERNATIONAL CAIRO POPULATION CONFERENCE (ICPD), and its emphasis on issue which are not strictly speaking demographic (such as the condition of women), confirmed the progress in the so-called "population and development" approach appeared to increasingly depend upon the taking into account of social and cultural factors. This implied to open demography to other social sciences especially sociology and anthropology when looking for explanations of what was measured (fertility, union patterns, uses of family planning). The resarch implications, as witnessed by papers published in scientific journals a shift -albeit partial- from data collection and analysis at the national level to the regional or local levels, an increasing use of qualitative methods such as focus groups and the analysis of other units than the individual females, such as the husbands, or the family, which can be viewed as an attempt to study networks which contribute for instance to shape fertility decisions.

CERPAA, since its creation in 1989, devoted most of its activity as a research unit to design and implement a methodology which would be multidisciplinary and in particular link closely quantitative and qualitative methods, in order to contribute to the explicative analysis of demographic behaviour. Its research projects were also characterized by a constant endeavour to reconcile scientific research and concern with programme requirements without ending in "quick and dirty" research. It is believed that interest in to theorical issues is not incompatible with the capacity to respond to immediate needs of those confronted with programme management : how design a programme, how to monitor and evaluate its process, how to analyse and disseminate its output.

CERPAA's methodology, based on "village monographs" has been designed so that it could be suited to a great diversity of cultural and national contents, of population issues and of stages of programme implementation. This is only possible if a conceptual and analytical framework is built up, which is sufficently flexible to fulfill the above

requirements, while retaining its basic principles and structure, so that methodological tools only need adjustement but no complete rethinking when a new issue is addressed. After a presentation of CERPAA's framework (part 1), part 2 describes some methodological implications. Part 3 concentrates on evaluation issues. Part 4 addresses the problems of dissemination and internalization of the results of research by health or population staffs. This leads to the question of training of trainers : how analysis of data should be organized ?

For each part, concrete examples are drawn from CERPAA's research in Senegal, Cameroun, Burundi, Mali or Mauritius. Research projects were focused on fertility attitudes on family planning and reproductive health, on failure to use contraception in socially deprived social groups, on attitudes on AIDS, and on international migrations.

1. CONCEPTUAL AND ANALYTICAL FRAMEWORK

The methodology of "village monographs" is based on two main hypotheses which imply specific field operations and methodological instruments. The methodology, both quantitative and qualitative, was first designed to study fertility and family planning in rural Senegal. Table 1 describes each component of field work corresponding to the subdivisions of the two central hypotheses, and the methodological tools which have been developped in this context by CERPAA.

TABLE 1 : VILLAGE MONGRAPHS.
HYPOTHESES, TYPE OF RESEARCH, RESEARCH TOOLS

HYPOTHESIS 1 **(The inter-individual level)** "The individual's behaviour is the result of his /her interactions with other members of the community"	**TYPE OF RESEARCH**	**RESEARCH TOOLS**
1. The village as a milieu shaping values and norms	Socio-cultural definition of a *village* Purposive sample of villages (ethnic, religious criteria, etc.)	Review of litterature. Interviews of regional or national informants
2. Gender variables (roles and statuses of men and women)	Socio-anthropological survey Interviews of men and women	Interview grids for men and for women
4. The individual and his/her own opinions and behaviour (including opinion leaders)	Socio-demographic survey	Demographic questionnaire
HYPOTHESIS 2 **(The community level)** "The village as a social and economic unit influences the individual's behaviour"	**TYPE OF RESEARCH**	**RESEARCH TOOLS**
1. Housing patterns (as an indicator of social heterogeneity, segregation, etc.)	Social and cultural topography of the village	Village map
2. Demographic structure of households (the family as a unit influencing the individual)	Household demographic survey	Demographic questionnaire (Questions on household composition)
3. Community equipments and development projects (as factors of modernization)	Sociological survey	Community grid (identifying FP, health ,education services)
4. Outmigration as a factor of modernization (introducing different values and financial resources)	Socio-demographic survey	Household and individual questionnaires (Questions on past and current migrations)

2. METHODOLOGICAL IMPLICATIONS

2.1 Using anthropology in population, health and family planning programmes

2.3 Sampling issues

2.2 Data collection

3. EVALUATION OF REPRODUCTIVE HEALTH PROGRAMMES

3.1 Regionalizing a national programme

TABLE 2. PROPORTION OF WOMEN WHO HAD NEVER ATTENDED SCHOOL (RURAL SENEGAL 1990)

	Thiès region			
	Keur Saïb N=86	Baback N=102	Ngound. N=100	Touba-toul N=101
% of women	59	81	80	76

TABLEAU 3. SOURCE OF INFORMATION ON FAMILY PLANNING (RURAL SENEGAL 1990)

Sources of information	Thiès region			
	Keur Saïb	Baback	Ngound. Peye	Touba-toul
	N=86	N=102	N=100	N=101
Radio	6	12	21	29
Friends	34	10	24	13
Family, husband	28	55	17	30
Paramedics	7	20	6	11
Rural development workers.	17	1	8	10
Women's association				
Other, not specified	8	2	24	7
Total	100	100	100	100

TABLE 4. REASON FOR NOT USING AND FUTURE USE OF FAMILY PLANNING (RURAL SENEGAL 1990)

	Thiès region			
Reason for not using and future of FP	Keur Saïb	Baback	Ngound, Peye	Touba-toul
	N=86	N=102	N=100	N=101
currently breastfeeding	-	16	-	1
sterile, menopaused	6	10	12	8
desire a child	3	14	16	17
not informed	-	7	20	11
access difficult	-	2	-	-
husband opposed to FP	5	1	-	4
religion, customs	1	2	3	15
side effects	3	1	-	3
still unmarried	15	10	8	-
husband away, wid, div.	1	2	2	5
no spacing problem	60	14	35	8
other (pregnant)	6	21	4	28
Total	100	100	100	100
Will use in the future	48	66	37	30

3.2 Evaluation of staff performance

3.3 National Population Programmes and disadvantaged social groups : the case of Mauritius.

4. DISSEMINATION, INTERNALIZATION AND INSTITUTIONALIZATION

4.1 Dissemination and internalization of results

4.2 Training of trainers

5 CONCLUSION

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"VILLAGE MONOGRAPHS"

USING CERPAA'S METHODOLOGY IN POPULATION, HEALTH, AND FAMILY PLANNING PROGRAMMES

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"VILLAGE MONOGRAPHS" USING CERPAA'S METHODOLOGY IN POPULATION, HEALTH, AND FAMILY PLANNING PROGRAMMES

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In the 1960's, demographic data on fertility and its proximate determinants were badly needed. Apart from the KAP surveys, which addressed the specific issue of family planning, censuses and deficient vital registration systems were the only available sources. With the World Fertility Survey and the Demographic and Health Survey programmes, the scientific community, but also decision makers and national planners, benefited from a wealth of data undreamed of twenty years ago. A major consequence of this change, apart from increasing our knowledge of population dynamics in developing countries, has been the significant contribution to the integration of demographic variables into development planning and programmes.

The ICPD, in so far as it emphasized issues which are not strictly speaking demographic (such as the condition of women), confirmed that progress in the "population and development" approach would increasingly depend upon taking into account social and cultural factors. This has engendered the need for demography to broaden its approach by integrating other social sciences, in particular sociology and anthropology, when looking for causal explanations of what was measured (fertility, union patterns, use of family planning). The research implications, as witnessed by papers published in scientific journals, have been numerous. They included a shift -albeit partial- from data collection and analysis at the national level to the regional or local levels, an increasing use of qualitative methods, such as focus groups, and the analysis of units other than the individual females, such as their husbands, or the family, indicating the need to study the impacts of networks on fertility decisions, nuptiality choices, or migrations.

CEPAA [5] since its creation in 1989, devoted most of its activity as a research unit to design and implement a multidisciplinary methodology, termed here as "village

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monographs" which would in particular link closely quantitative and qualitative methods, in order to contribute to a really explicative analysis of demographic behaviour. To that extent, village monographs are different from the purely qualitative rapid assesment procedures (RAP) as defined for instance by Manderson et Aaby (1992b : 46; also 1992a : 844-845. For an overview of related methodologies, see Manderson et Aaby (1992a). Our research projects are also characterized by a constant endeavour to reconcile scientific research and concern with programme requirements, whilst avoiding the outcome of "quick and dirty" research. It is believed that interest in theoretical issues is not incompatible with the capacity to respond to immediate needs of programme management, such as how to design a programme, how to monitor and evaluate its process, how to analyse and disseminate its output (on the relationships between theory, method and action, see Ndolamb, 1995 : 502-503. Also Manderson et Aaby, 1992b).

CERPAA's methodology of "village monographs" is designed to be applied in diverse cultural and national contents, encompasses numerous population issues,whilst remaining adaptable to various stages of programme implementation. This is possible only if conceptual and analytical frameworks are built up, which are sufficiently flexible to fulfill the above requirements whilst retaining their basic principles and structure. The methodological tools only need adjustement, but not complete rethinking when a new issue is addressed. After a presentation of CERPAA's framework in part one, part two describes methodological implications. Part 3 concentrates on evaluation issues. Part four addresses the problems of dissemination and internalization of the results of research by health or population staffs, an issue which in turn leads to the question of training.

For each part, concrete examples are drawn from CERPAA's research in Senegal, Cameroun, Burundi, Mali and Mauritius. Research projects were focused on fertility attitudes, on family planning and reproductive health, on failure to use contraception in socially deprived social groups, attitudes towards AIDS, and migrations.

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1. CONCEPTUAL AND ANALYTICAL FRAMEWORK

The methodology of "village monographs" is based on two main hypotheses which imply specific field operations and methodological instruments. The methodology, both quantitative and qualitative, was first designed to study fertility and family planning in rural Senegal. Table 1 describes each component of field work corresponding to the subdivisions of the two central hypotheses, and the methodological tools which have been developped in this context by CERPAA.

TABLE 1 : VILLAGE MONOGRAPHS.
HYPOTHESES, TYPE OF RESEARCH, RESEARCH TOOLS

HYPOTHESIS 1 **(The inter-individual level)** "The individual's behaviour is the result of his /her interactions with other members of the community"	**TYPE OF RESEARCH**	**RESEARCH TOOLS**
1. The village as a milieu shaping values and norms	Socio-cultural definition of a *village* Purposive sample of villages (ethnic, religious criteria, etc.)	Review of litterature. Interviews of regional or national informants
2. Gender variables (roles and statuses of men and women)	Socio-anthropological survey Interviews of men and women	Interview grids for men and for women
4. The individual and his/her own opinions and behaviour (Including opinion leaders)	Socio-demographic survey	Demographic questionnaire
HYPOTHESIS 2 **(The community level)** "The village as a social and economic unit influences the individual's behaviour"	**TYPE OF RESEARCH**	**RESEARCH TOOLS**
1. Housing patterns (as an indicator of social heterogeneity, segregation, etc.)	Social and cultural topography of the village	Village map
2. Demographic structure of households (the family as a unit influencing the individual)	Household demographic survey	Demographic questionnaire (Questions on household composition)
3. Community equipments and development projects (as factors of modernization)	Sociological survey	Community grid (identifying FP, health ,education services)
4. Outmigration as a factor of modernization (introducing different values and financial resources)	Socio-demographic survey	Household and individual questionnaires (Questions on past and current migrations)

According to the first hypothesis, childbearing and the woman's attitude towards fertility regulation must be regarded not only as her own choice, but as the result of her interactions with community members. Five dimensions are thus explored :

- the village of residence, as a milieu which defines cultural and social norms vis-à-vis fertility,
- gender and the roles and statuses of men and women,
- reference and peer groups (in Africa these would be age groups),
- the social hierarchy and the influence of traditional or modern leaders on individual decision-making
- the individual herself and her own opinions, attitudes and behaviour, keeping in mind that the members of the community are not socially "equal" : influence based on leadership should not be forgotten.

Beyond this inter-individual level, a second hypothesis states that the village as a social and economic unit influences a woman's decision with regard fertility or other demographic behaviours (marriage, migration). Four further sociological elements are studied :

- the topography of the village (whether lodgings are spatially scattered or concentrated),
- the patterns of family structure (nuclear or extented, with female or male-headed households, etc.),
- community associations (such as women's cooperatives) and facilities which contribute to local development,
- links with the external world, such as development projects implemented in the village by NGOs, and out-migration, whether to cities or abroad.

We hold that this approach is more far-reaching than the classic KAP (on KAP see Manderson et Aaby, 1992a) approach which, because it only addresses the individual, is based on a sociological fallacy : the social structure is not merely the sum of individuals. We advocate that networks, whether familial or social, gender, leadership, but also economic factors, whether at the community level (facilities, such as running water) or at the household level (agricultural or monetary resources brought by outmigrants) should be taken into account.

To illustrate the importance of this holistic approach,two examples are drawn from a research project carried out in Senegal (1989-1993) to investigate the social and cultural factors influencing, whether positively or negatively, fertility and attitudes on family planning in the rural milieu. The Senegalese government required such an assessment before extending its Family Health and Population Project, which up until then (1985-1992) had been imited to the urban milieu.

Our first example illustrates the first hypothesis. To measure the "total desired fertility" the ideal number of live births quoted by a woman is usually compared to her achieved fertility. If the number of live births is higher than the ideal family size, she is classified as a "potential user" of family planning services, because of an "unmet need" for contraception. In 1990, during the demographic survey of women of childbearing age, one of them declared 19 pregnancies but quoted 8 as her ideal number of children. Her potential demand for family planning, as estimated through a strictly quantitative methodology, would thus appear very high. However, during a qualitative interview, the same woman declared that she regretted none of her 19 pregnancies. The reason she offered was that her co-wife (she was married to a polygamous husband) was sterile, and that her sister had only one child. She said she could "give" some of her children to her co-wive, thus helping her to avoid the malediction of sterility, and to her sister, who could therefore have a kind of insurance against the disaster which would result from the death of her only child. This woman, who was not at all thinking in terms of her own fertility control, and regarded her pregnancies as substitutes to the sub-fecundity of the other women, is a clear example of the misleading nature of the concept of potential demand for family planning. It ignores the fact that children are viewed as not "belonging" to a woman alone, nor even to the couple, but to the lineage (Charbit, Mané and Ndiaye, 1994 : 275).

The second example refers to the meso-sociological level, dealt with by the second hypothesis. In 1989, the analysis of the economic ressources of village households led to a surprising result. According to the theory of modernization, nuclear families are more likely than extended ones to adopt fertility regulation, because they allow the couples to build and express "modern" attitudes. They are confronted with less pressure from their parents, because they do not share the same household, as would be the case if they lived in an extended family. It is also argued that couples, since they cannot rely on the economic support of the extended family, have to balance the costs and benefits of having additional children. In our study, a typology of households was set up, on the basis of their agricultural output and of the proportion of their members who had migrated and lived in towns at the time of the survey. The attitudes and behaviour of the women towards fertility, family planning and reproductive health (antenatal care, vaccination coverage of their children) were analysed according to the type of household to which they belonged. It was found that those living in the wealthier households (which also included the highest percentage of migrants) had higher levels of shooling, and had the most modern attitudes and pratices (more complete vaccination coverage, more favourable attitudes to fertility control). This result is not, in itself, surprising, but its theorical implications are worth stressing. The richest households were also the largest

ones and displayed the most complex family structure, with several family units living together. Thus, contrary to the theory of modernization, the extended family, far from hindering the adoption of modern attitudes and behaviours, was, in this particular case, favourable to them. The explanation is not cultural, but economic. Because family size is large, the extended households can afford to export part of their labour force without endangering survival. In turn, migrants bring back financial resources to the household, thus allowing the household to spend some money on the health and education of its members. Another study, conducted in a different region of Senegal with a different methodology, confirmed that the size of the farms was a significant factor (Mané, 1994 : 565-574).

2. METHODOLOGICAL IMPLICATIONS

2.1 Using anthropology in population, health and family planning programmes

Using qualitative methods in research on population issues raises a fundamental problem of multidisciplinary research, the compatibility between demography and anthropology. From the point of view of applied research such as that imbedded in RAP or related methodologies, two questions must be answered. First, can the qualitative work done be regarded as properly anthropological ? Second, what is the contribution of anthropology to the understanding of population issues, as they are dealt with by micro-local methodologies ? Anthropologists often object that without language competence and long-term residence in the field, not much can be understood. This is certainly a valid objection. However, neither village monographs nor RAP pretend to understand the inner logic of social structure. They borrow anthropological analytical categories, using them not from an anthropological point of view, but as amean sof highlighting certain population issues, such as gender, reference groups (in Africa : age groups), cultural values (for instance when does a girl become a woman socially recognized as such ?). Within these limits, anthropology can make a crucial contribution to programme design, implementation monitoring and evaluation.

This is evidenced by CERPAA's international research project on knowledge, attitudes and opinions on AIDS carried out in 9 villages in Senegal, Cameroun and Burundi (1990-1994) (Loenzien, Wade, Charbit, Mboup, 1994. Loenzien, 1995). The project was based on the assumption that the individual perceptions of AIDS could and should be analysed in accordance with two lines of interpretation. AIDS was perceived by our rural samples as one of the diseases from which they suffered. However, because AIDS is a

"new" disease, which is regarded as "imported" by Westerners, there is no traditional nosology. Nevertheless, its symptoms, as reported during fieldwork, especially "losing weight", have undoubtely a social signifiance. Second, AIDS must be studied and analyzed from a gender perspective (Loenzien, Parizot, 1995). Men and women were described by our respondents as being "unequal sexual partners", and considered as unequally responsible for contamination. This line of interpretation leads to the notion of high risk groups : our respondents indeed mentioned unfaithful promiscuous males and females prostitutes. Identifying which paradigm (health or gender) is relevant in a given population is clearly of the highest importance for programming IEC campaigns, for instance. (On this point, see Vlassoff and Tanner, 1992 : 5). In the first case, how should the health system sensitize populations to such symptoms as "losing weight" ? In the second case, although campaigns must be targetted at high risk groups, they should also take into account possible unintended negative effects. If information campaigns are focused on prostitutes, a woman wishing to use condoms runs the risk of being suspected of being a prostitute, or, in the African context, of receiving money rewards and "presents" for sex.

Taking into account the anthropological dimension of reproductive health not only influences the overall strategy of research, it leads to choices concerning teh various steps of research, especially sampling and data collection.

2.2 Sampling issues

For the epidemiologist, sampling precision is of the highest importance (for instance Anker, 1995 on segmented cluster sampling. Also Tucker, 1995). CERPAA's sampling choices in the Senegal and Mauritius projects were radically different, because research aimed at fulfulling different needs. As noted above, we aimed at identifying the socio-cultural factors which might hinder in Senegal the extension of the family planning programme in the rural milieu. To do this, a random sample was not really needed, a purposive sampling procedure being more appropriate (on the question of the "high precision" of sampling, see Vlassoff and Tanner, 1992 : 4. Also Manderson et Aaby, 1992a : 846). Then the key issue was that of criteria used to select the villages and communities under observation. Two were defined : first, the ethnic group, which was needed to identify the social and anthropological systems of values which shaped the individuals' attitudes and behaviour with regard to family planning. Second, villages were selected according to their degree of modernization (existence of a health post, of a school, of NGO projects, availability of tap water, etc.). Next a household survey was

conducted, and all egible women were interviewed. By combining the two criteria (ethnicity and modernization), we were able to define typical situations.
Such a purposive sampling is also justified by the fact that we did not only look into actual levels of contraceptive prevalence, but also aimed at identifying differential patterns. Identifying patterns has a major advantage for programme oriented research. These micro-local differences are more important than measuring levels, since they help understand why a programme works in a given village and not in another by taking into account the cultural factors and the existing degree of modernization.

2.3 Data collection

We described in the first part of this paper the ambiguities of the concept of potential demand for family planning. Another example can be provided from CERPAA's research on demographic determinants of sickle-cell anemia in Mali (1991-1995). Our hypothesis was that nuptiality and migration induced a genetic selection process. Both variables were studied through a classic demographic survey (24 652 persons were enumerated, 1 088 men and women were interviewed), 1 450 genealogies were reconstructed, and 4 982 persons were blood tested. We shall come back to the problem of sensitization, but we would like to mention here that during field work, it was found that the mere identification of the members of the households had entailed a cultural bias : deceased community members were regarded as currently present in the households, because in the Dogon cosmogony, the soul of a dead member haunts the household and can harm the living until a specific ceremony, called *dama*, is performed by the older men for all the village dead. To overcome this difficulty, it was decided to check the year of the last and next ceremony, and to control by consulting with the elder males men, the names of the defuncts concerned (Petit, 1995).
Collecting anthropological data, such as caste-belonging also proves a valuable source of data at the later stage of analysis, as it may provide a key to understand unexpected results. For instance, the fact that the distribution of sickle-cell anemia among the population of the villages was not random was due to caste barriers to marriages : blacksmiths and shoemakers who were restricted to strict endogamic mating, were less likely to carry the gene.

3. EVALUATION OF REPRODUCTIVE HEALTH PROGRAMMES

Multidisciplinary evaluation of programmes may addresss different objectives. First, does the programme correctly address its objectives from both a qualitative and a quantitative point of view ? Second, supposing this is not the case, does a multidisciplinary approach contribute significantly to an investigation into the causes of programme failures and propose corrective solutions and improvements? In particular, can poor staff performance be attributed to cultural and anthropological factors influencing their work ?

3.1 Regionalizing a national programme

In Senegal; government policy began to stress in the late 1980's the need for regional planning and for increased decentralization. Regional Centers for family planning and sexually transmitted diseases were se up and used as a pivotal structure to implement the national health policy. In 1990 , during the completion of its village monographs, CERPAA also undertook a situation anlysis of three regional centers located in the regions of Thies and Fatick, all of them potential providers of family planning services for the population of the eight surveyed surrounding villages. The characteristics of clients were analyzed through data processing of existing files and a qualitative analysis of their functioning was also carried out.

It was found that 61% of the women currently using IUDs or the pill had attended school, and among them, 57% had reached the secondary or higher level of education (Loenzien, 1994 : 264-265). In striking contrast, less than 25% of the women had attended school in six of the eight villages surveyed (Charbit, Mané and Ndiaye, 1994 : 296) (Table 2)

It is clear that the three centers did not draw their clients from the surrounding villages, and did not fulfill their regional mission. Further research confirmed this finding. In the region of Louga, which was surveyed in 1995, among the 1202 clients attending the family planning center in 1992 and 1993, more than 9 out of 10 lived in the town in which the center was located.

TABLE 2. PERCENTAGE OF WOMEN WHO HAD NEVER ATTENDED SCHOOL (RURAL SENEGAL 1990)

Thiès region				
	Keur Saïb N=86	Baback N=102	Ngound. N=100	Touba-toul N=101
% of women	59	81	80	76

Fatick region				
	Fimela N=130	Mbadatte N=90	Bangadji N=103	Ngohe N. N=118
% of women	49	94	99	82

Participant observation revealed another aspect of the dysfonctioning of these centers. Many women tended to adopt a rather ellusive behaviour, which corresponded to different profiles. Persons suffering from STDs did not dare mention this, remained rather vague about them, and mentioned "pains" or a "I have a disease". Prostitutes, known as such by the staff, did not admit their activities. Young men, clearly embarrased to ask for condoms, came in when there was no waiting line, or did not take turns. We noted a student in his early twenties, who had written the word "condom" on a piece of paper to avoid asking openly for its supply. The fact that family planning and STDs services were provided in the same building created a negative or at least an uncomfortable attitude among potential clients. Interviews with staff revealed a further problem. For lack of petrol, they could not even reach the surrounding villages and sensitize their population. Therefore they limited their activities to the towns where the centers were located (Loenzien, 1994 : 255).

Adequate supply of family planning services appears to be a major matter of concern given the observed demand for family planning in the villages. As table 3 shows, the health system in general, and the paramedics in particular were seldom quoted as sources of information on contraception (Charbit, Mané and Ndiaye, 1994 : 307).

TABLEAU 3. SOURCE OF INFORMATION ON FAMILY PLANNING (RURAL SENEGAL 1990)

Sources of information	Thiès region			
	Keur Saïb	Baback	Ngound. Peye	Touba-toul
	N=86	N=102	N=100	N=101
Radio	6	12	21	29
Friends	34	10	24	13
Family, husband	28	55	17	30
Paramedics	7	20	6	11
Rural development workers, Women's association	17	1	8	10
Other, not specified	8	2	24	7
Total	100	100	100	100

Sources of information	Fatick region			
	Fimela	Mbadatte	Bangadji	Ngohe Ndoff.
	N=130	N=90	N=103	N=118
Radio	9	20	23	22
Friends	48	15	39	38
Family, husband	26	48	5	23
Paramedics	4	1	10	4
Rural development workers, Women's association	1	-	-	-
Other, not specified	12	16	23	13
Total	100	100	100	100

Even granting the ambiguous meaning of the concept of potential demand, as shown by table 4, no less than 30% and up to two-thirds of the women we interviewed said that they were willing to use contraception in the future, except in the particularly isolated village of Bangadji, where this proportion was nevertheless 13%. Moreover, cultural factors, such as "religion", or "opposition of the husband", were by no means regarded as prominent reasons for non-use of contraception. Lack of information, but also the fact that they had encountered no difficulty in spacing their pregnancies (no "nef" in the wolof language), were far more frequently quoted by the interviewed women (Charbit, Mané and Ndiaye, 1994 : 310-311). In one of the villages surveyed in 1992, an NGO running a family planning center even organized information sessions at the request of the villagers (Lacides, 1995).

TABLE 4. REASON FOR NOT USING AND OPINION ON FUTURE USE OF FAMILY PLANNING (RURAL SENEGAL 1990)

Reason for not using FP	Thiès region			
	Keur Saib	Baback	Ngound. Peye	Touba-toul
	N=86	N=102	N=100	N=101
currently breastfeeding	-	16	-	1
sterile, menopaused	6	10	12	8
desire a child	3	14	16	17
not informed	-	7	20	11
access difficult	-	2	-	-
husband opposed to FP	5	1	-	4
religion, customs	1	2	3	15
side effects	3	1	-	3
not sexually active	15	10	8	-
husband away, wid, div.	1	2	2	5
no spacing problem	60	14	35	8
other (pregnant)	6	21	4	28
Total	100	100	100	100
Will use in the future	48	66	37	30

Fatick region				
Reason for not using FP	Fimela	Mbadatte	Baugadji	Ngohe Ndoff.
	N=130	N=90	N=103	N=118
currently breastfeeding	9	4	9	1
sterile, menopaused	4	14	16	6
desire a child	9	19	9	15
not informed	11	24	30	49
access difficult	3	1	1	3
husband opposed to FP	2	1	1	1
religion, customs	2	6	10	8
side effects	2	-	1	1
not sexually active	18	2	6	3
husband away, wid, div.	3	15	5	-
no spacing problem	20	12	3	5
other (pregnant)	17	2	9	8
Will use in the future	58	39	13	51

The discrepancy between the demand and the supply of family planning services leads to the question of the evaluation of staff performance.

3.2 Evaluation of staff performance

CERPAA's research project in Senegal also aimed at reconsidering the too widely accepted generalization that community facilities such as schools and health posts necessarily contribute in a decisive manner to development. We designed a four-dimensional evaluative framework. What are the institutional objectives of the health post ? To achieve its goals, are the means available ? How are the paramedics perceived by the population of which they are meant to improve the health status ? Reciprocally, how do the paramedics perceive the population among which they live ? An accurate assessment of the contribution of the health post to the well-being of the community depends on a careful examination of these four criteria.

The *availability of means* is of course a prerequisite to efficiency. It is a too often serious problem in the public sector, resulting in unequal and hopeless competition with the private sector. A qualitative situation analysis of two neighbouring centers located in the town of Louga revealed in 1995 that the private center, through to international funding by IPPF, fared much better than the public one. The building was nicer and more welcoming, and the center did not suffer from running out of of contraceptive means. Staff, which was well paid and adequately trained, was evidently motivated : there was no absenteism, and constant efforts were made to transform a latent demand for family planning into actual client participation (Lacides, 1995).

For each village monograph conducted between 1989 and 1994, a team of two researchers and of two translators were able, in a period of six weeks (from the begining of field work to the dissemination of results in a regional seminar) to provide data of vaccination coverage of children under five, and proportion of women having received prenatal care and delivery assistance, not to mention number of children everborn, fertility preferences, and contraceptive prevalence. These quantitiative data are, of course, sound indicators of the work performed by the health post and family planning services providers.

In one of the villages surveyed in 1989, we also discovered, through qualitative investigation and observant participation, that the paramedics lived in lodgings topographically and qualitatively distinct from the rest of the village population. They almost systematically left the village during the week-end to go back to Dakar (often for good reasons such as family obligations), expressing their feeling of estrangement whilst occupying an insignifcant administrative post.

In some villages, interviews with health personnel revealed an ambivalent attitude : they were reluctant to promote family planning, because they thought it was contrary to their folk culture, and to the ethics of Islam. Hence, negative messages about modern family planning (such as side-effects), while expessing positive opinions about the legimacy and efficiency of traditional methods. Of course, not all paramedics had this questionable professional behaviour, but it should be noted that it sharply contrasted with the rather favourable opinions on family planning expressed by some of the traditional leaders. The socio-anthropological interpretation here is that contrary to traditional leaders, health workers were confronted with a contradiction between their social and professional roles on the one hand, and their cultural identity on the other (Petit, 1994 : 330-340).

3.3. National Family Planning Services: access to services for the socio-economically deprived. Community-based studies in Mauritius.

The National Family Planning Programme of Mauritius has been recognised as one of the most successful of its type in the 1970's and 1980's. However, recent trends indicate fluctuations in levels of contraceptive prevalence, client enrolments, contraceptive drop-out rates and the increased use of non-supplied methods (Hillcoat-Nalletamby, 1995).

CERPAA, with the agreement of the Ministry of Health undertook over the period 1991-1993, a multidisciplinary survey of selected "Cites", groups of households built after the cyclones of the 1960's (Charbit and Hillcoat, 1992). This research demonstrated that the low contraceptive prevalence rates observed in these two particular communities, along with a significant proportion of women exposed to the risk of conception but using non-

supplied contraception (withdrawal), could be explained by the association of a series of factors relating to both the supply and demand aspects of contraceptive practice.

First, the socio-demographic characteristics were significantly different from those of the surrounding village and district populations (in terms of housing and living conditions, educational achievements, employment categories, religious groups, fertility levels). The cumulation of unfavourable factors on the demand side can be illustred by the following. In these poor lodgings, women used charcoal or wood, which is very untidy, and they did not have easy access to water. Moreover, for lack of money and space, children remained with their parents after marriage, which increased overcrowding and burdened the housewives. All these reasons explain why interviewed women claimed to have no time to attend the Family Planning Center, although it was located within a two minute walk from one of the Cités.

Focus groups of men revealed a further factor of tension related to gender. They first developped conformist opinions, such as "family planning is good, because it allows child spacing and helps avoid poverty". Careful interviewing revealed another picture. Men objected that the pill was harmful to the women's health, quoting the same rumors as women. Further, according to men, the described side effects on women, such as overweight (although it was probably due to malnutrition) and nauseas, preventing them from performing their duties as housewives. Men finally quoted "the star women", who they identified as characters in series such as "Dallas", which their wives should look like. This might be a classic feature of gender relationships. However, interviews with women revealed that in a context of instable nuptiality, they had internalized men's criticisms and feared to losing their partners due to overweight attributed to the pill. This explains their reluctance to use the pill and an overall low contraceptive rate.

Qualitative interviews with women residing in the two Cites and personnel of the family planning units, coupled with in-depth quantiative questions on the nature of contraceptive side-effects indicated the prevalence of knowledge of such effects, and their impact upon the individual's decision to discontinue their practice. The proliferation of what may be considered as 'rumours' concerning contraceptive use and female health was further exacerbated by women's poor understanding of their physiology and anatomy.

A discrepancy between the need for family planning services and the objectives and professional pratice of the family planning services providers was observed. Again, in-depth qualitative interviews with catholic women indicated that despite an interest in the natural family planning methods offered by one of the private sector organisations, their use was not necessarily sought. In a context of unstable nuptialityt the requirement of collaboration within the couple for the practice ofthese methods was considered impossible for many of the women interviewed. Added to this, their present

or previous use of supplied methods was mentioned as being a discriminating factor in relation to their faith as Catholics. Some women were thus obliged to renounce use of, or potential interest in use of, these methods.

Although all major supplied methods of contraception were available free of charge in both centres in each village, lack of choice of brand of the pill was frequently cited by users inteviewed as a major reason for discontinuity of practice. The study revealed that the particular brand being made available at the time of study had provoked for many users, side effects.

Compared to what was observed in Senegal, Mauritius Cités offer a clear example of the combination of unfavourable supply and demand factors, resulting into a failure to adopt modern methods of contraception. But this echoes a feeling of being a destitute and marginal group, subject to criticisms from the rest of the population, which in turn tends to block their capacity to change their behaviour or even simply to communicate with service providers and express their needs. This raises the issue of IEC campaigns (on RAP and IEC, see Cohen, 1995), which must not neglect the hidden factors of resistance to contraceptive use.

4. DISSEMINATION, INTERNALIZATION AND INSTITUTIONALIZATION

Like RAP, village monographs allow for a quick and cost-effective process of data collection and analysis However, this does not ensure against the ensuing problem of slow implementation of the results in the population programmes What then is the advantage of focusing research at the micro-local level, rather than relying upon national-level generated sample survey data? This question in turn raises the problem of the dissemination and internalization of such applied research procedures, which should be a first step towards their institutionalization Two cases must be distinguished If a particular research undertaking is conducted by a foreign executive agency, what is the appropriate level of dissemination? This situation is not fundamentaly

However, this situation is not fundamentaly different from that faced by national researchers vis-à-vis their choice of a region, a district or a local level of dissemination, especially in a pluri-etnic state. More generally, in order to implement applied research from the early stage of design to final analysis, in a communnity or at the broader administrative or geographical levels, it is necessary to define a strategy to enhance internalization of results.

We shall first discuss the possible geographical levels of internalization, before turning to one of the possible components of such a strategy, but a crucial one, the *training of trainers.*

4.1 Dissemination and internalization of results

We hold that dissemination at the national level is a necessary, but not a sufficient step. It is necessary because, contrary to the 1960's, population and reproductive health programmes are now almost always official national programmes and national sovereignty is at stake. Any research initiative, especially, but not only, if promoted by foreigners, must therefore conform to national regulations. Thanks to WHO, the ethics of research on drugs experimentation have been clarified, but this should also be the case of socio-anthropological research. It must be accepted and so to speak legitimized by national authorities, even if it is a time consuming stage, for a research procedure which intends to be rapid. The national level is not, however, a sufficent step. As we observed in some francophone African countries, decentralization is not yet effective, due to a traditionaly centralized administration, a lack of political commitment to decentralization, and last, but not least, a shortage of qualified regional staff.

And yet, the regional and local levels really matter for the success of a national programme, because the rural populations are numerically more important than the urban ones, their needs remain unmet, due to the classic concentration of health services in

towns. Regional health officers and local paramedics are indeed those who badly need results of applied research. How may we make results accessible to professionnal staff sometimes unfamiliar with statistical data ?

Let us suppose that field work has been completed. Assuming that the target population to sensitize is the regional staff, how do we organize the analysis strategy in order to maximize the contribution of the results of applied research to the population programme? Quantitative data are of course essential, because regional staff sometimes have no clear idea about what is a "modal" versus a "marginal" behaviour. Second, it may encourage them to use data. A client file is a "sleeping beauty" : how do you wake her up ? Qualitative results are no less useful : by presenting them in a straightforward manner, regional staff will recognize the relevance of the research data : "Yes, it gives a fair account of what I experience every day in the family planning center", was often heard in the regional seminars which CERPAA organized immediatly after completion of field work.

Consistent with the analytical framework described in Part 1 of this paper, at the village level, all persons, groups or institutions influential in the community, because of their knowledge, their economic power, their prestige, or their networks, and whether they are active in the project or likely to be in the future, must be sensitized : community leaders, whether modern or traditional (religious leaders, paramedics, midwives and healers, teachers, etc.), women's and men's associations, and the NGOs active in the village.

During field work, the feed-back between the research team and the population should be rapid, direct and constant to improve the villagers' capacity to make correct choices concerning their own health or eliminate erroneous health practices. This supposes that a very careful sensitization has been undertaken before field work. As was said above, blood tests were taken to identify persons carrying the anormal hemoglobins in the 26 villages of the Sangha district, covered by the CERPAA study on sickle-cell anemia in Mali.-Before starting this sensitive data collection, meetings were held in each village, district paramedics and doctors being systematically invited to participate in information meetings. During these meetings, we carefully informed the population of the objectives of the study, how we wished to work with the village population, and the short- and long-term consequences of the research on the health of the community as a whole and more specifically of target groups (children, women, sick persons). We explained at length why we wanted to undertake a serological survey, and why questions about migration, nuptiality, child mortality and health care were to be asked. When data collection was completed, we returned to the villages and presented our preliminary results. If, and only if the villagers requested, we provided the names of sick people. In fact, almost everybody wanted to be informed, and the local health post was handed a

computer listing of those affected by the disease and specific recommendations were made about drugs which had to be avoided (Petit, 1995 ; Petit, Vandewalle, 1991).

4.2 Training of trainers

As noted above, theinstitutionalization of applied research procedures implies a mid-term strategy of training of trainers if national resources and know-how are lacking. UNFPA country staff or country support teams could contribute to this training. Parts 1, 2, and 3 of this paper gave examples of the major stages of training : defining an analytical framework, making the proper methodological choices, evaluating a programme from both a quantitative and qualitative point of view. A few simple guidelines of analysis are sketched here. Needless to say, they will require adaptation to each national or regional context.

First, and as a general principle, analysis should always be clearly linked to the objectives of the population programme, and avoid lenghty developments and chapters which "go nowhere" (on this point see Vlassoff and Tanner, 1992 : 2). Second, quantitative data should be presented in a standardized form, to allow for the construction of comparable series : this implies providing standard indicators (such as contraceptive prevalence rates), as well as tables or series formated in a manner which makes them comparable to other existing sources or to later rounds of data collection. As for qualitative data, they should be analysed with the specific needs of the target populations in mind, careful atention being paid to identifying the socio-cultural factors influencing observed behaviour, which will help in the focusing of IEC campaigns. To avoid the rejection of the data as being "quick and dirty", the report should provide solid and substantiated information on the analytical framework (specifiying clearly research objectives, hypotheses) and on the methodology used (size of samples, composition of focus groups, interview grids and questionnaires). Finally, recommendations should propose steps to be taken consistent with the identified needs.

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To conclude, we believe that parallel to sample surveys, a solid contribution to programmes design, monitoring and internalization implies a multidisciplinary approach, focused on data collection at the micro-local level, since at the national level DHS type data are now available. Analysis should consider the individual's behaviour from a

contextual perspective. Supply and demand should be dealt with as separate factors, but their possible interactions should not be forgotten.

Clearly a lot depends on the ability of researchers to intuitively perceive in a short period of time what is important in the field they explore, and to scientifically and rigorously analyse it. This implies openness to both quantitative and qualitative methodologies. Interviewers such as those employed in censuses or sample surveys do not usually have such a profile. Village monographs, like all RAP procedures, do not require numerous research teams, but a small number of well-selected and carefully trained researchers. Postgraduate students, with a mixed socio-anthropological and demographic background, constitute a possible pool for recruitment, provided they receive specific training for the research project during a full academic year. All the above examples were drawn from Master's or Ph.D dissertations written by students affiliated to CERPAA. We would like to add that field research on the Senegalese project on family planning was done by mixed teams of students from CERPAA and the Universities of Saint-Louis and Dakar. Students from IFORD (University of Yaounde) and from the University of Bujumbura in Burundi, contributed with CERPAA students to the project on AIDS in Cameroun and Burundi. African students also used the data to complete national degrees. To that extent also, CERPAA contributed to institutional building and the strenghtening of human resources.

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