

The ‘Four Too’ in The Malinke of Odienne (North West of Cote d’Ivoire) Procreative Behaviours

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Abstract

This paper aims at understanding the reasons for the existence of the “four too” as the level of motherhood risk in the Health District of Odienné. In that respect, quantitative tools (questionnaire, review of records) as well as qualitative tools (semi-structured interview, focus groups, literature and desk research) were resorted to.

This range of methodological tool has enabled to underscore that the “too young”, “too old”, “too large” and “too close” motherhood, is a dominant practice in Odienné. This fact exposing women and girls to various health risks, is motivated by some socio-cultural logics. These socio-cultural beliefs about Motherhood, are out of step with the health recommendations.

Keywords: Risky motherhood, mothers, socio-cultural logics, epidemiological and institutional logics, Odienné

Introduction

Risky motherhood is a major concern in developing countries, both as a public health and development problem (Family Care International 1995 Preface). In response to this “alarming” situation, various efforts have been made both internationally and nationally. Among these, include the Safe Motherhood Initiative (SMI). This Initiative has been implemented by the United Nations Population Fund (UNFPA), in collaboration with other partners: World Health Organization (WHO), United Nations International Children’s Emergency Fund (UNICEF), etc.) in 1987 in Nairobi (Kenya) (UNFPA:2000). This alliance of international and non-governmental organisations works for : improving sensitisation, setting priorities, stimulating research, mobilising resources, providing technical support and sharing information (Ransom and Yinger 2002:10). The initial goal was to halve maternal mortality until 2000. Many other initiatives ensued, including the International Conference on Population and Development (ICPD) in

1994 in Cairo (Egypt) which more broadly, called for the “*right to access to appropriate health care to enable women to have a safe pregnancy and delivery.*”(Ransom and Yinger: *ibid.*).

Despite all these efforts aiming at ensuring women, girls and children health and well-being, the situation of the Maternal and Child Health is still worrying in Côte d’Ivoire. Indeed, maternal² (614 per 100,000 living births), neonatal³(38 per 1,000), post-neonatal⁴ (30 per 1,000), infantile⁵ (68 per 1,000), juvenile⁶ (43 per 1,000) as well as infant and juvenile⁷ mortality rate (108 per 1,000) (HDS⁸ 2011-2012) remain among the highest in the world.

In the north-western area (which includes the District of Odienné), motherhood is still at high risk. During the exploratory survey in January 2015, managers of health establishment and health workers emphasized that the Malinké women are moving very little to health services for the monitoring of their pregnancies, deliveries and after deliveries.

Moreover, interviews with health workers as well as with community leaders helped knowing that the “early”, “late”, “large” and “close” motherhood is a dominant practice in Malinké people daily life. Some cultural logics underlie this practice perpetuation and seem to promote it. From this point of view, Prual (1999:169), argued “*The famous sentence*” “*too many children, too early, too late and too close*” *underpins the cultural factors that govern the terms of reproduction in a developing society and which are causal factors of maternal deaths* ”. This situation exposes more women and their families to enormous difficulties in the context of their reproductive life.

This contribution therefore aims at understanding the reasons for the “four too” existence in the Malinké reproductive culture. In addition, it analyses the contrasts between epidemiological and cultural logic in maternal health. This study is based on Bourdieu’s (1980) theory of ‘habitus’.

²Maternal mortality: death of women during pregnancy or during the 42 days following the end of the pregnancy whatever the reason of this death is.

³ Neonatal mortality: the probability during birth to die before exactly one month.

⁴ Post-neonatal mortality: the probability for children under exactly one month to die before the first birthday.

⁵ Infantile mortality: the probability during birth to die before the first birthday (12 months exactly).

⁶ Juvenile mortality: the probability for children of precisely one year to die before reaching the fifth birthday (60 months exactly).

⁷ Infantile and juvenile mortality: the probability during birth to die before reaching the fifth birthday.

⁸ HDS : Health and Demographic Survey

Methodology

The study was conducted in three areas of Odienné District: Kôroblala (city center) and two villages (Gbahanla, located at 10 km from the city (axis Odienné - borders Mali-Guinea) and Kahanso (diametrically opposite axis Odienné -Touba). The study is mixed (quantitative and qualitative). Thus, under five children's mothers are the main targets of the study (quantitative component). To these, *counsellors women*⁹ called *kōnōmā laliri bagá*, men or husbands, the Chief of Odienné Civil Town Hall, an Imam and health workers (qualitative component) are added. Data were collected using the questionnaire, review of the Health District's records, the focus group and semi-structured interview from February to July 2015. A preliminary literature search to better understand the study object. Quantitative data have been processed using Epi Info 3.4.5 software and Excel. The qualitative data processing have been made possible through content analysis.

The quantitative sample consisted of 206 under five children's mothers as in the table below.

Table 1: Distribution of under five children mothers per locality

Places	Population of mother with children from 0 to 5 years in Odienné Health District in 2015	Mothers participating in the survey
Kôroblala	1082	184
Kahanso	79	13
Gbahanla	50	9
Total	1211	206

Source : Survey 2015

The calculation of the simple sample size randomly selected was based on the following formula (Chauvat and Reau 20

$$n = z^2 \times \frac{p \times q}{i^2}$$

- n = sample size
- z = parameter related to the risk of error. The value 1.96 is used for the risk of error set at 5%
- p = 50% (expected level of knowledge)
- q = 1 – p
- i = Desired accuracy : 5%.

For p = 0.5 and i = 0.05, the sample size is estimated at 196. Taking into account the non-respondent estimated at 10%, the sample size was estimated at 206.

The qualitative sample consists of fifty-one distributed as follows.

⁹ *Counsellors women* : this term refers to women generally aged between 45 years and more, who give piece of advice to the youngest women in diverse domains of social life, namely concerning their reproductive life.

Table 2: Distribution of the qualitative sample

Places	Targets	Types of Interviews	Number of Interviews	Number of Participants
Kôroblala	Head Midwife	Semi- Structured interview	01	01
Kôroblala	Men	Focus group	01	06
Kôroblala	Counsellor women	Focus group	01	11
Subtotal			03	18
Kôroblala				
Kahanso	Nursing Officer	Semi-structured interview	01	01
Kahanso	Men	Focus group	01	09
Kahanso	Counsellors women	Focus group	01	06
Subtotal			03	16
Kahanso				
Gbahanla	Men	Focus group	01	08
Gbahanla	Counsellors women	Focus group	01	07
Gbahanla	Imam	Semi-structured Interview	01	01
Subtotal			03	16
Gbahanla				
Odienné-city	Chief of Odienné's Civil state Town Hall	Semi-structured interview	01	01
Grand Total			10	51

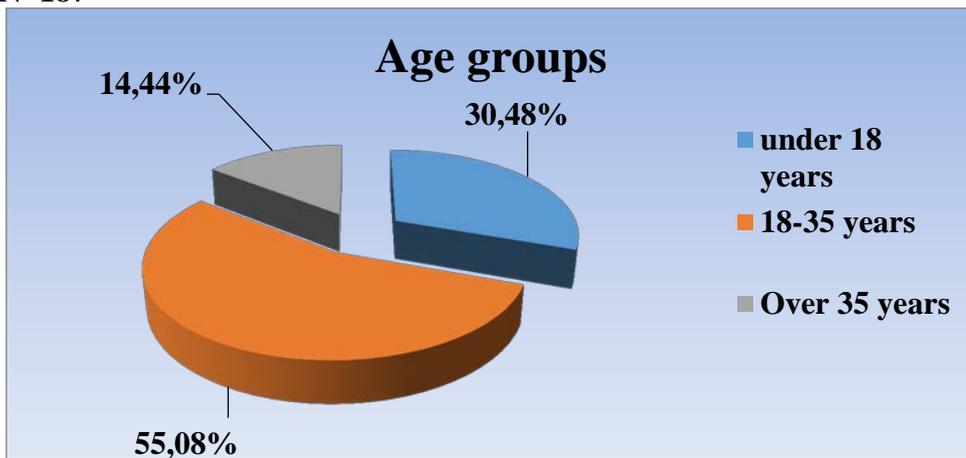
Source: Survey 2015

Results

“Too young” and “too old”: age of the mothers

The survey found that many people, especially among the female population, were not able to accurately determine their age. Taking this situation into account, we had a meeting with Odienné's Chief of the Civil Town Hall. This official said that the non-registration of births has always been a crucial concern for her service. This fact has got several consequences including the failure to obtain administrative documents (birth certificate, court judgment, etc.) and the difficulties or impossibility for some people to know their age.

This has been proven in the study, although the majority of mothers succeeded in determining their age. The table below is related to the age group of mothers.

Age groups**N=187**

Graph1: Age group of mothers

One hundred and eighty seven (187) out of the two hundred and six (206) mothers investigated were able to determine their age, that represents 90.78 percent of respondents. Those participants were divided into three age groups: under eighteen mothers (30.48 percent), those whose age ranges are between eighteen and thirty-five years (55.08 percent) and over thirty five years mothers (14.44 percent). It is found that almost half of respondents are either “too young” (under eighteen) or “too old” (over thirty five years).

These data indicate that early and late pregnancies make part of Odienné’s people daily realities. These two kinds of pregnancy can be differently accounted for. Thus, to better understand the early pregnancy, one must refer to the age of women at marriage and their age at first pregnancy. As for late pregnancies, they are justified by the duration in reproductive life, which is evidently noticed in the number of children.

Age at marriage

Interviews with groups of participants have shown that the most common forms of marriage among the Malinké are generally speaking, the customary marriages *lāda fu:ru:* and religious marriages *dinā Fu:ru:*. Religious marriage, commonly called “cola attachment” is the phase during which men get more involved. It is usually done without the future married couple. These ones are represented by their respective parents and witnesses. The ceremony is attended by religious leaders (Imam, muezzin, etc.).

As far as customary marriage is concerned, it does not imply men. These latter are represented by their sisters, aunts and other female relatives. The bride, which is called ‘*kōgñō*’, is kept in a room. This ritual is called the *kōgñō siri*, which literally means “to make the bride sit”.

Civil marriage, called “town hall wedding” or “White people wedding” *tu: babu Fu: ru:*, if it is not ignored by the actors, would not be a prerequisite for the reproductive life. That is why this type of marriage, although the only one recognized by the Ivorian legislation¹⁰, is not necessarily taken into account in this study.

The table below shows the distribution of the participants regarding their matrimonial status.

Table 3: Participants distribution according to the age at marriage

Variables	Age at marriage				Total	
	Under 18 years		18 years and more		AV	RV (%)
	AV ¹¹	RV ¹² (%)	AV	RV (%)		
Married	103	66.88	37	24.02	140	90.91
Unmarried	10	6.49	4	2.60	14	9.09
Total	113	73.37	41	26.62	154	100

Source : Survey 2015

Of the 206 interviewed mothers, one quarter (25.26 per cent) did not succeed in determining their age at marriage. Of the 154 women who were able to give an answer, 140, or that is to say 90.91 percent, are married. The majority said they were under eighteen (66.88 percent) while getting married. Early marriages have thus, a very high level in the pregnant women sample. Unmarried respondents represent a very small proportion (6.45 percent).

Interviews with participants corroborate the quantitative data:

“[...] in our customs, we can say that a woman is adult when she has her periods. She can be married. Thus, it will permit her to avoid out of marriage pregnancy somewhere. The girl should inform her mother or her elder sister. (Counsellors women of Kôrôblala)

“[...] a girl can be married when she is very young to someone we like or to someone we have great respect for his family. When she grows up a little bit, we organise the marriage and then she goes to live with her husband. That's what prevents the girl from a disordered sexual life.” (Counsellors women of Kahanso)

“[...] here, if you're with your wife, and then she dies, you marry her sister.” (Men of Kôrôblala).

It emerges from these different interviews that many factors can explain the early marriage in Malinké of Odienné tradition, among which there are the concept of majority with women, the promise of marriage *koffô furula* and the sororate *worosiri*.

¹⁰ The article 19 of the law 11 of October, 7th 1964 modified by the law n°83-800 of August 2nd 1983 states: “only a marriage celebrated by an elected civil officer is legal”.

¹¹ AV: Absolute Value

¹² RV: Relative Value

As far as the women age to get married is concerned, it is not regarded from a legal perspective, but from a physiological and social one. Indeed, the appearance of menses *ha bro dodɔi ho* is the most decisive indicator of adulthood. Before that time, girls are considered to be “children”. At the onset of their menses, they are regarded as “adult”. Consequently, the idea of majority gives those girls social responsibilities as well as entry into a married life where they should have children.

In addition, the promise of marriage for a family consists in “reserving” a girl for a subsequent marriage. In that respect, a thread is attached to her wrist. In return, the family who has “reserved” her, should take care of the girl until puberty.

This situation is supposed to allow girls to avoid a “disorderly” sexual and reproductive life. Indeed, in Malinké tradition, when a woman contracts a pregnancy before marriage, her attitude is supposed to arouse the opprobrium and outrage among her family. The semantic field of this feeling of shame can vary: “somewhere”, “disordered sexual life”, etc.

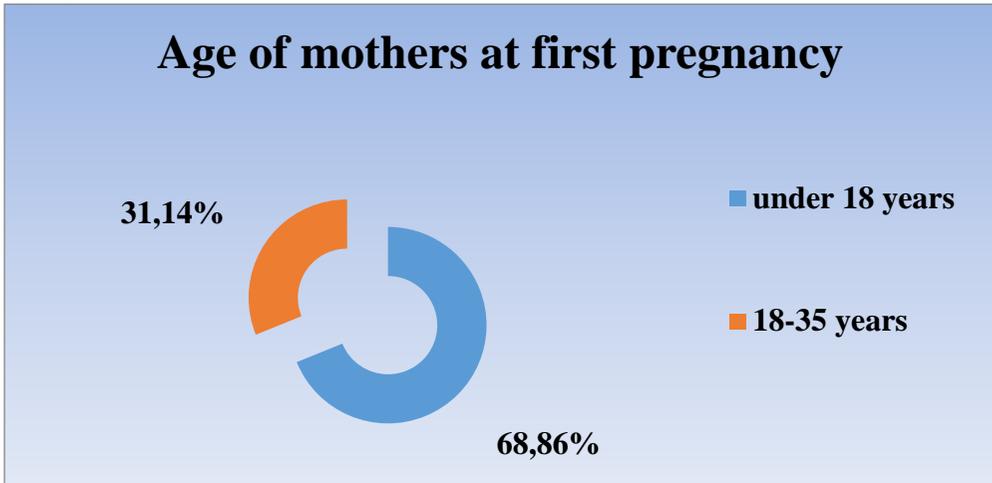
“*Somewhere*” is an adverb meaning “anywhere”. The underlying idea is that of an unknown place (by the family); resulting in a lack of control. It’s a negative value which means all that is contrary to the habits and customs. Therefore, doing what is not allowed, is synonymous with breaking the social and cultural norms. It also supposes a “loss of ways” or even a detachment of educational principles.

The noun phrase “disordered sexual life” is constituted of the adjectives ‘disordered and sexual’ and of the common noun ‘life’. This phrase is opposed to the following: “ordered sexual life”. In Malinké tradition, this latter is perceived with women, among others, through their virginity till marriage. The disordered sexual life characterises, in that logic, the state of women who had sexual contacts or had children before her first marriage. This fact is regarded as a dishonour for the woman and her family.

That is why, the child born of an illegitimate union contracted in such circumstances is frowned upon by parents as well as members of the community. The pejorative terms used to call him, include *gñãmɔkɔdé*, literally meaning “bastard” (illegitimate child).

Finally, the sororate is one of the Malinké cultural practice. It consists in the fact that a widower gets married with the sister of his late wife. If this woman is under-age (under eighteen years) during the marriage celebration, this marriage is said to be early.

Age of mothers at first pregnancy
N=167

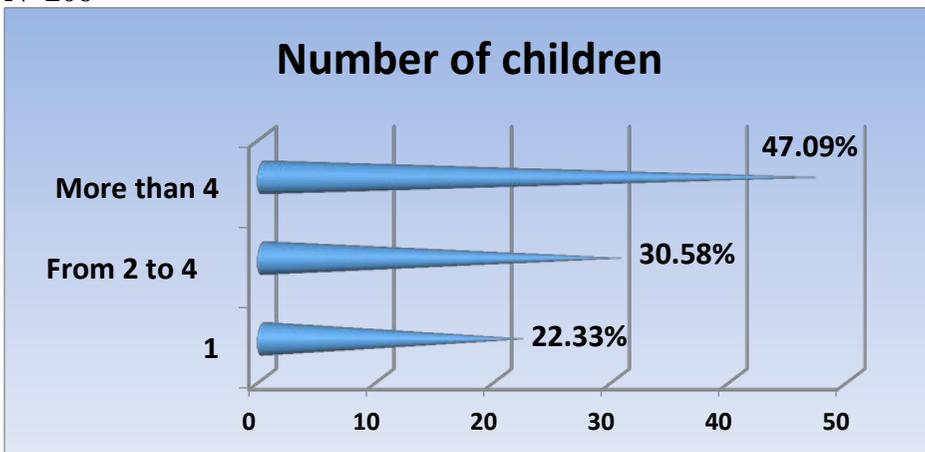


Graph2: Age of mothers at first pregnancy

Concerning the question of women age at their first pregnancy, 167 mothers gave their opinion in the survey. That is 81.07 percent of the sample. Among this total number, the majority claimed to have contracted her first pregnancy before the age of eighteen (68.86 percent). From the findings, we can say that the women age range varies from thirteen to seventeen years old. A small proportion of mothers' age was over or equal to eighteen years old when she was primiparous (31.14 percent). The early pregnancies are therefore predominant.

“Too Numerous”

N=206



Graph 3 : Number of children

The number of children possessed by each woman brings out three categories of respondents: the primiparous (women having their first child) (22.33 percent), the multiparous (women with a number of children between two and four children) (30.58 percent) and the high multiparous (women having more than four children) (47.09 percent). The high multiparous constitute almost half of the women sample. This latter case concerns the “large maternity”.

The respondents enable to better understand the reason for large maternity option:

“Here, in our tradition, when you have many children, you are better considered. Everyone has respect for you. When you have many children, they will anyway help you. If one day you die, people will say: that's her children going there.

When you don't have kids, it's not at all good. People laugh at you. They say you're not woman. Because of this, your husband may leave you or take another wife. You suffer too much. If you have only one or two children, people will think that in your marital life, you had a problem in your body later preventing you from having more children”. (Counsellors women of Gbahanla)

“[...] Here then, women don't make decision concerning children. What the man wants, that's what he did. When he gets married with you, the number of children he wants, that's what you will have”. (Counsellors women of Kahanso).

According to the participants, the fertile woman *dewolomuso* or *muso dewolobali* seems to be more valued than the one infertile. Indeed, fertility seems to be a “good thing” or *fī G̃umā* or *kog̃umā*. The child is a source of happiness *herē*, of joy *nusɔɖar*, wealth *nāfolo* and respect *bog̃ñã*. Under these conditions, the large maternity seems to arouse admiration.

“Too close”

Table 4: Birth interval of respondents

Age group of the mothers	Number of months from the previous birth				Total	
	Under 24 months		24 months and more		AV	RV (%)
	AV	RV (%)	AV	RV (%)		
Under 18years	21	40.38	31	59.62	52	32.50
18-35years	18	21.69	65	78.31	83	51.87
Over 35years	8	32	17	68	25	15.63
Total	47	29.37	113	70.63	160	100

Source: 2015 Survey

The birth interval is the period of time between two births. That is why this question has been addressed only to women who have at least two children. These latter are 160 of them. The previous table shows that in general, the duration of the birth interval is over twenty-four months (70.63

percent). However, among over a quarter of women, this period is under twenty-four months (29.37 percent).

When taking into account the age groups, we note that the duration of birth interval is shorter (under twenty-four months) among the least old mothers (40.38 percent). Conversely, the eighteen to thirty-five-years-old mothers are the most numerous to have a longer duration of birth interval (78.31 percent).

“[...] when he [your husband] wants to have child, it's not your problem. You woman, you're there to give birth to child for him. In our tradition, it is said “i nāni hole kāmā”; it means that you come here for that. [...] We have been brought up like this since we were kids. When a girl has to go to her husband, her mother tells her: “You’ve seen me with your dad, right? Go and do like me! Respect your husband. In our tradition, it's what's good [it's is a sign of good education]. If she [the daughter] goes and does something else, it means that she is not well bred.”(Counsellors women of Gbahanla)

“It is Allah [God] who gives child. We men, we cannot say when he [child] is going to come or when we are going to stop. Everything God gives, we take. It is God who knows what is good for people. So, when his time comes, he gives.” (Men of Kôrôblala)”

These two viewpoints reveal two complementary situations. On the one hand, motherhood would be one of the fundamental “duties” of Malinké women. In that respect, they should be submissive to men. The decisions about the number and interval of children then would not depend on women. On the other hand, child is considered as a gift of God *Allah ya sebaga ya*. Therefore, men to whom women refer, would be themselves “passive” in the act of procreation. This does not mean that the human contribution (coupling) is underestimated, but it is a reference to God in this reproductive process. This divine will *Allah ka sababu* is present in Islam and is strongly adopted by the Malinké people of Odienné. According to this religious conception, it is *Allah the Creator* who allows procreation. In that respect, the Imam of Gbahanla quotes Surah 23 of the *Holy Koran* entitled “Believers”, from verse 12 to verse 14 :

“Certainly we’ve created man from an extract of clay, then we placed him as a drop in a secure receptacle. Then we’ve made of the sperm an adhesion; and from the adhesion, we have created an embryo. Then, from that embryo we’ve created bones and we’ve covered them with flesh. Then we’ve transformed it into any creation. Glory to Allah the Best of creators!” .

According to the Imam of Gbahanla, it is the work of Allah’s creation which is perpetuated through human reproduction. In these circumstances,

procreation would not be possible without the will or the “authorisation” of Allah. That is why fertility is perceived as a blessing from Allah and child, a “gift of God”. From this point of view, having many children for a couple means abundance of blessings.

Moreover, the non-existence of interval between births and non-limitation of births are due to the weakness of the contraceptive prevalence. The table below illustrates this.

Table 5: contraceptive prevalence of Odienné Health District in 2014

Year	2014
Women protected according to the type of contraception	
Women protected by pill	285
Women protected by injection for 2 months	222
Women protected by injection for 3 months	2232
Women protected by implant	248
Women protected by intrauterine device	3
Total number of women protected	2990
Proportion of childbearing age protected by contraceptives of Health District	4.78%

Source: Health District of Odienné

It emerges from Table 5 that contraceptive prevalence is very low in the Health District (4.78 percent); the national rate being 18.2 percent (HDS 2011-2012). According to this same study, the northwest region of Côte d’Ivoire is the one where contraceptive prevalence is the lowest in Côte d’Ivoire (8.6 percent).

Although this weakness of the contraceptive prevalence in Odienné, some respondents have indicated that under the reluctance of men, they discreetly resort to contraceptive methods, mainly to the injectable one.

These information have been confirmed by health workers, particularly by the head midwife in charge of the Maternal and Infantile Protection (MIP) in Odienné:

“As they are frightened of their husbands, when they often come to the market, at a certain time, they entrust their goods to their neighbours. And then they do as if they go to shopping or for other needs. They hide for coming to see us. Most often, it is for the injectable contraceptive. As soon as we finish, they put the card under their loincloths and then they return to the market as if nothing had happened. [...] When we do that, they can rest a bit and maintain their health. “(Head Midwife of the maternal and infantile protection of Odienné)”.

These different results call for a deep thinking about the contrast between institutional (legal and health) and cultural logics in the reproductive domain.

Results discussion

Controversies related to the precociousness of motherhood

Early motherhood is the one that occurs before the age of eighteen (Population Report 1994:6). Indeed, people under eighteen are considered as children, as stipulated in the Article 1 of the International Children Rights Convention (UNCRC) of November 20th 1989 : *“According to the hereby Convention, a child means every under eighteen years human being unless the age of majority is attained earlier by virtue of the law applicable to that”*. The UNCRC convention has been ratified by Côte d'Ivoire on February 4th 1991.

The African Charter of the Child Rights and Welfare, adopted on July 1990 and comes into force since November 29th 1999 is in the same framework. Article 2 of this Charter specifies: *“In the conclusion of the hereby Charter, by “child” we mean every human being under18 years.”* The “Charter” has been ratified by Côte d'Ivoire on February 27th 2004.

These texts are part of the legal and institutional mechanisms for child protection and Maternal and Childhood Health improvement. From health perspective, some risks may arise from the “young” age. In a study made in Madagascar, Binet et al. (2010:261) have analysed the impact of the early fertility on maternal and childhood health: *“Young women are victimised of high risk of pregnancy complications or difficult birth because of their age [...] it appears that the young age of a woman is an additional risk to the survival of woman and child”*.

As far as Berrewaerts and Noirhomme-Renard are concerned (2006:2), they based on Faucher and state: *“If the teenager pregnancy is not a new phenomenon in itself, recent social and cultural changes have contributed to make it statistically marginal and to emerge it as a new social problem.”*

This “marginal” perception of early pregnancy has been confirmed by Alvin (2006), according to whom:

“When a pregnancy occurs with a young teenager, the family, school or institutional environment simultaneously receives three bad news: the first, “she has a sexual life”; the second, “she is pregnant”; finally, the third and a no mean new: “... and what about the fact that she desired it ? Today, the pregnant teenager is first found guilty of failing to manage her “contraceptive duty”. Then she remains more or less morally culpable for having made a stupidity that is to say, for exposing her life to risk, for not having succeeding in resisting the pressure or to the urge to go to the end”. (Alvin:2006, in Berrewaerts and Noirhomme-Renard (ibid.)).

By the same token, Lucile (2010:8) specifies: *“the teenager pregnancy disturbs the society, the families of these young as well as the medical profession”*.

Unlike these western, legal and epidemiological considerations, in Malinké culture, the girl is considered as “adult” from puberty, characterized among others, by the onset of menses. It means that before this stage of life, they are considered to be children. Menses, physiological phenomenon, endow girls with social responsibilities, especially in the domain of marriage and motherhood.

Marriage and early pregnancy would allow girls avoiding pregnancy out of marriage as revealed CEPED (1994:1) “[...] *For Muslims, sexual relations before marriage are condemned, families are favourable to very early marriage to avoid any pregnancy out of marriage*”.

While it is true that girls can be promised for marriage at the tender age, the actual marriage, takes place only after puberty. Procreation is considered as one of the essential aims of marriage, as mentioned CEPED (ibid.) : “*An early pregnancy, when it occurs within marriage is rarely identified as a “problem”. It is on the contrary, desired for the bride regardless her age, as evidence of her fertility*”.

The pregnancy precocity has been studied in several communities. This is the case of the Baoulé-Dohoun people of Bendèkouassikro (District of Bouaké). Kouadio (2015) points out that in this community, the washing rite of young girls *behunzi*, is the sign of their maturity and their entry into reproductive life. Any pregnancy occurring before this stage of life arouses shame on the girl as well as her family.

Children’s marriage is presented as a major fundamental rights violation that can have many negative effects on the well-being and physical, mental and social health of girls (CFR: 2013; UNFPA:2012a; Walker:2012; ICRW:2007), in UNICEF-Regional Office for west Africa and from the centre of UNICEF (2015:11). Furthermore, this organisation specifies that children’s marriage is the key factor of a sexual activity and of early pregnancy, as well as greatly contributing to the high rate of maternal and post-infantile mortality in this region.

A “hyper-pro-birth” culture contrasting with very high health risks (“too old”, “too many”, and “too close”)

Malinké people are a pro-birth community; we can even say they are “hyper-pro-birth”. In fact, it is in the northwest that the Total Fertility Rate is the highest in Côte d'Ivoire (6.8 for HDS 2011-2012). This high birth is rooted in sociocultural beliefs. These include spiritual considerations associated with motherhood, child’s social representations and women low power in decision-making.

Bourdieu’s (1980) theory of ‘habitus’ allows explaining these different socio-cultural considerations. According to this author:

“The ‘habitus’ is a set of sustainable acquired dispositions, consisting of categories of assessment and judgment and generates social practices adapted to social positions. Acquired during early education and early social experiences, it also reflects the trajectory and subsequent experience: ‘habitus’ results from progressive incorporation of social structures. This is what explains that, living in similar conditions, the agents have the same worldview, the same idea of what is authorised and what is not, the same criteria for selecting their hobbies and friends, the same dress or aesthetic tastes. They also share a same number of living rules (the sense of upper classes distinction, the middle classes’ cultural willingness, the choice of what is necessary by working classes) permit to account for a variety of practices in very different domains”(Bourdieu 1980 in Wagner 2012).

The ‘habitus’ theory highlights the social structures and hierarchies permanence conditions. In Malinké traditions, women are generally regarded as housewives and mothers. Their social and cultural environment limits them in such duties. During wedding, mothers emphasize the importance of submission to man. Reproductive live of women (period of birth, decision related to the number of children, etc.) does not depend on them. In other words, it is clearly stated to women that they “came [*born*] for this [*procreation*].” Procreation is for them to meet some social obligations. This increase in value of fertility has been shown by Delaunay, Adjamagbo and Lalou (2006:34) following a study in rural areas in Senegal: “*Within the framework of marriage, fertility remains widely valued*”.

The weakness of Malinké women decision making has been confirmed by HDS 2011-2012. According to this survey, in Côte d'Ivoire, only 10 percent of women freely decide regarding their own health care. Men decide alone regarding their own health care in 69 percent of cases and 64 percent decide alone for the cares of their partner. In the northwest, almost three quarters of women are not involved in decision makings regarding their health care (73.1 percent). This weakness of women's decision-making power has been studied by Brahima (2013:23) for whom the place of decision-making is the immediate social environment of women, in which man (spouse) holds a key place. This author insists that, with regard to maternal and neonatal health, it is the entire authority of the man as head of family which is also challenged. Sometimes his wife discusses directly with him or do it through her mother-in-law.

Besides, social conceptions related to the child are favourable to “large” motherhood especially since, it is a source of “wealth”, “joy” and “happiness.”

Yannick (2012:20) has analysed this conception in Mandingo's tradition of Mali where laudatory terms are associated with fertility, “*the child is the happiness of the house*” (*du da:mu je deŋje*); “[...] *it is the child who makes of man a real one*” (*məgɔwolodeŋ bɛ məgɔ kɛməgɔ je*)”.

A child's importance has also got a spiritual dimension. At this level, the child is considered as a “gift of God”. This spiritual dimension seems to underestimate human ability in the act of procreation. This reference to God was seen by Yannick (*ibid.*):

“likewise, child is present in many blessings, especially during weddings:” allah ka deŋ [amã di ahu mã] (may God gives you lots of children); or “Allah ma seŋ ni bolohu bora a lá” (may God allow children from this union).”

Apart from God, other supernatural beings are present in the African reproductive thinking. Bonnet (1988:21) reports it in his study in Mossi traditions (Burkina Faso). In this community, procreation is the result of the entrance of a spirit called *Kinkirga* (pl. *Kinkirse*) in the womb of the woman when she has sexual intercourse with her husband. For the author, “*The Human Fertility value seems to be removed and entrusted to the spirit that only grants its fertility during the sexual contact of man.*” (Bonnet *op. cit.*:25).

Sociocultural beliefs justify specific reproductive behaviours: “too large”, “too close” and “too late” motherhood. The results of the study underscore that 14.44 percent of mothers are over thirty-five years. In the meantime, the proportion of mothers with more than four children is significant (47.09 percent). Eventually, the birth interval is less than twenty-four months for 29.37 percent of mothers.

All these reproductive practices involve numerous health risks. This is what Coulibaly (2009:18) specifies:

“Many authors consider women who have got at least five, six, seven or eight pregnancies beyond the twenty-second week of amenorrhea and who has given birth for the fourth, fifth, sixth, seventh time or more as high multiparous and quote parity as factor of poor prognosis in gynaecological pathology and especially obstetric”.

As far as Diarra (2006:30-31) is concerned, he focuses on the health risks linked to the high age of pregnant women:

“It is generally assumed that women who are thirty-five years and more have an increased risk of complications during pregnancy. [...] The usual complications of pregnancy after thirty-five years are diabetes, hypertension, cardiovascular diseases, trophoblastic diseases, placental abnormalities, uterine abnormalities and multiple pregnancies with a high rate of dizygotic twins”.

Zongo (1993: 3), agreeing with Diarra (2006) writes:

“[...] In Africa, where society is pro-birth, women from puberty to menopause do not stop childbearing. This exposes them to unfavourable conditions of development of the pregnancy, to difficult childbirth, morbidity and maternal sources and appalling infantile mortality”.

The birth interval, combined with other factors, are risk factors of early neonatal mortality. In this logic, Ravaoarisoa et al. (2014) have found a relationship between the profile of mothers and new-born deaths. These authors note that among the elements constituting the profile of mothers, the monitoring of antenatal care, birth interval and occupation are significantly associated with early neonatal mortality. Mothers with a birth interval of less than two years and women who stay at home have a larger proportion of new-borns died early.

Mainly, the “four too” constitute serious threats to children life and health. From this perspective, UNICEF (2014:39) finds that the ratio of infant deaths in the high single risk category is at 1.10 ; that is to say for pregnancies “too early”, “too close”, “too late” and “too many.” This risk is 1.65 when these factors are combined together.

Conclusion

The study permitted knowing that with the Malinké people of Odienné (northwest of Côte d'Ivoire), the risks to reproductive behaviour are diverse. In this case, the focus has been on four types of maternity: the “early” motherhood (with women under eighteen years), the “late” motherhood (with women over thirty-five years), the “large” motherhood (beyond four children) and the “close” motherhood (less than two years between births). These indicators are grouped under the term “four too”. The different reproductive practices of Malinké people are rooted in socio-cultural beliefs that are spiritual considerations associated with motherhood, the social representations of children and women low decision-making power. If these cultural logics are explained by Bourdieu’s theory of habitus, they are in contradiction with the epidemiological and institutional logic of Maternal Health and Infantile improvement (MHI) or Safe Motherhood (SM).

Moreover, the study of the “four too” permits to understand the perpetuation of maternal risk in the Health District of Odienné. This remains a current issue nationwide. Indeed, maternal mortality, fails in reaching a three quarters decrease, between 2000 and 2015 (in accordance with the Millennium Development Goals) but has rather increased in Côte d'Ivoire. From 597 per 100,000 living births in 1994, the maternal mortality rate has reached 614 per 100,000 living births in 2011-2012. The Sustainable Development Goals (SDGs) (2015-2030) also address this issue of MHI,

through the one of the whole population health (Objective 3: “*Ensuring a healthy life and promote well-being for all at any ages*”). Accordingly, the extent of risky reproductive practices of Malinké people calls for the need and necessity to undertake Communication Activities for Behaviour Change (CABC) in order to contribute to the achievement of the objectives.

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