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Influence of Male Decision-making and Sociocultural Factors in the use of Contraceptive Methods by Women in Niger

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Abstract

Niger is one of the worldwide countries where Muslims are majorities (98.7% of Muslims and 1% of Christians in 2006. Five Ethnicity groups are also majorities. We have as follow: Djerma Songhai (25.4%); Haoussa (42.8%); Toureg (13.2%); Kanouri, (7.7%) and Peulhs (6.9%). Six main factors have a great influence in the use of contraception: We have: the age of people, the type of place of residence, the facto place of residence, the highest educational level, religion and ethnicity. In 2012, when women decided to stop the use of contraception, the reason of last discontinuation is mainly the need of pregnancy (52.3%). In Niger, population wants more children (20.4% of women and 31.4% of men in 2006) and do not use more contraception for the moment (86.4% of women and 91.2% of men in 2012). Between 2006 and 2012, a large part of people do not intend to use contraception (50.5% of women in 2012 relative to 62.2% in 2006). Then, three main reasons are relevant to explain the very highest level of Fertility in Niger: the desire of more children, the religion prohibit and the opposition of both men and women into the use of contraception.

Key words: Decision-making; Contraceptive methods; Sociocultural Factors
Introduction

In the African context, the child is seen historically as a source of wealth and metaphysically as critical density which enhances the prestige and power of parents, increasing energy and the line number of descendants (BWALWEL JP, 1998). Thus, a child, regardless of the reasons of his birth is always a joy to the entourage. Proverbs, songs including contemporary songs evoke everything about the blessing of the fertile woman and the curse of the barren woman (Lecoh, 1982).

But in the current context, characterized by economic and environmental issues, policies on population and development are favors in birth control, in the countries with high fertility, in order to control poverty and environmental problems. In this context, there is a number of families that begins to perceive the child as a burden earlier as a source of wealth (Lecoh, 1982). But birth control is a slow process that requires education and is fraught with political and cultural obstacles, even more than religious to be considered as a choice is offered to families in the area of gender equality, girls’ education and family planning.

As quoted by Henri Leridon and mentioned by Grégoire Allix in 2009, “It is not enough to put boxes of contraceptives available to people to limit population growth”. Thus, the decision on contraception generally requires that we analyze the pros and cons of different methods, weighing the pros and cons of each, depending on the situation, and see how the interpretation of each person.

Thus in some countries such as Niger, fertility remains high. The 2012 DHS-MICS report of Niger indicates that the Total Fertility Rate (TFR) index is 7.6 children per woman, against 7.1 children per woman in 2006. In addition, if adolescents aged 15-19 account for only 10% of the total fertility in urban areas, they contribute 14% of the rural fertility. The Graph 1 below shows the evolution of total fertility rate of Niger between 1950 and 2012.

**Graph 1**: Evolution of the total fertility rate in Niger between 1950 and 2012

Moreover, it often appears from studies on the Family in Africa (Ngoy Kishimba 2000; Wakam 1994; Titi, 1985; Yana, 1995) that women have roles in reproduction, the exercise of domestic chores and other non-profit work in the family. In African society, women must procreate more and as soon as possible. More children a woman has, the more it is valued socially and better their social status (Wakam, 1994). This design has many consequences both demographic and socio-economic.

From this point of view, it is important to evaluate the decision-making power of men and women, as well as socio-cultural factors in the use of contraceptive methods in Niger, although the choices of using contraceptive methods are complex, multifactorial and subject to changes, given the context applied to each company. Hence, our research question is as follow: **What are sociocultural factors that influence the men and women decision-making in the use of contraception in Niger?**

To best describe the influence of sociocultural factors in the use of contraception, we have developed the following conceptual scheme.

**Figure 1:** The Conceptual Scheme of the influence of sociocultural factors in the use of contraception

![Diagram](image)

**Source:** My own description.

The fact that the man exercises outside the household income-generating activities that allow him to have some financing capacity and power for household needs, make the power of women is limited in terms of decision about their reproductive life and the use of contraceptive methods, especially if the woman has a low level of education and that it has difficulty in entering the labor market. Thus, women's choice of contraception is often dictated or limited by direct or indirect social, economic and cultural factors.
**The sociocultural factors** can be considered as economic and environmental issues, policies on population and development, educational level, the fact of place of residence, poverty and environmental problems, political and cultural obstacles, etc.

Then, the two main hypothesis of our research are the following:

- The sociocultural factors have an influence in the men and women decision-making
- The men and women decision-making have an influence in the use of contraception

As a reminder, we have as modern methods, female sterilization and male sterilization, the pill, IUD or IUD (Device Intra Uterine), injectable, implants (Norplant), the male condom, the female condom, the diaphragm, vaginal methods (spermicides, foams and jellies) and the morning after pill. Regarding traditional methods, we can mention: breastfeeding, periodic abstinence and withdrawal. In terms of methods, called "popular" or "folk", we have: herbs, amulets, herbal teas and other methods that may fall into this category.

### 1. Methodology

#### 1.1. Data and Ethical Approval

For analysis, we will use for analysis, the 1992; 1998; 2006 and 2012 DHS-MICS data of Niger. The Demographic and Health Surveys is one of the five component activities of MEASURE (an acronym that stands for Monitoring and Evaluation to Assess and Use Results). DHS is managed within the Bureau for Global Health (GH) at USAID, and implemented under a contract with Macro International Inc. (now ICF Macro), a private company based in Calverton, Maryland. It is the main source of nationally representative and cross-nationally comparable population and health data for the Bureau and the Agency. Other donors have also contributed to the DHS, often through support for local costs.

The DHS program, which is now in its sixth contract cycle since 1984, has conducted more than 260 surveys and special studies in over 80 countries across Africa, Asia, Latin America/Caribbean, and Central Asia and Eastern Europe. One of the main objectives of the DHS is to provide useful information to decision makers in participating countries and to help them make informed policy and program choices, especially in the area of population, health and nutrition (Jacob A. Adetunji & James D. Shelton, 2011).

In the collection of data, the DHS surveys maintain high ethical standards under the DHS program: protecting survey participants, obtaining informed consent, ensuring privacy and maintaining anonymity, and reconciling differences when Western ethical standards are at odds with locally approved procedures (Jacob A. Adetunji & James D. Shelton, 2011).

Some of the information gathered from individuals is of a sensitive nature. When surveys involve the collection of biomarkers, the potential for risks is further increased. Any biomarker collection involves some risks related to potential infection, unless certain clinical procedures are carefully followed. In addition, illnesses such as HIV/AIDS may be detected through biomarker components, thereby increasing the importance of maintaining the anonymity of the participants. Identifying the “harm” that might result from participation in research, determining how to protect participants from them, and ensuring that respondents understand the potential risks is not straightforward. The Bureau of Global Health of USAID has technical staff who works closely with the contractor as well as host country agencies to help minimize the risk of any known harm. This is done by emphasizing careful planning and attention to detail, keeping up to date with the state of the art and current best practices, multiple vetting of survey protocols by Institutional Review Boards (IRB), and satisfying of US Government regulations.
1.2. Method of Analysis

For analysis, we will use the “Logistic regression”. That method best fits with our dichotomous dependent variable allows evidencing the chances of using contraception by women. Through the logistic model, we estimate the probability of occurrence of the use of contraceptive methods. The model can be written as following:

\[ Z = \text{Logit} (P) = \log \left( \frac{p}{1-p} \right) \quad \text{where} \]

\[ Z = b_0 + b_1X_1 + b_2X_2 + \cdots + b_kX_k \quad \text{and} \]

\[ P = \frac{1}{1+e^{-z}} \]

\( P \) is the probability of the occurrence of the use of contraceptive Methods. That is to say:

- \( \text{proba (Use of contraception= p)} = 1 \)
- \( \text{proba (Use of contraception= 1-p)} = 0 \)

\( Z \) is the dependent variable (the using of contraceptive Methods), the \( X_k \) are the explanatory variables and \( b_k \) are coefficients of regression.

2. Findings

2.1 Reasons of not use Contraceptive Methods

Three main reasons are relevant to explain the very highest level of Fertility in Niger. We have the desire of more children, the religion prohibit and the opposition of both men and women into the use of contraception. The following table illustrates the situation.

**Table1**: The main reasons of not use contraception.

<table>
<thead>
<tr>
<th>Main reasons of not use contraception (%)</th>
<th>1992</th>
<th>1998</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Male</td>
<td>Women</td>
</tr>
<tr>
<td>Want more children</td>
<td>43.1</td>
<td>48.2</td>
<td>28.1</td>
</tr>
<tr>
<td>Religion prohibit</td>
<td>2.6</td>
<td>7.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Subfecund/infecundity/Breastfeeding</td>
<td>4.9</td>
<td>5.8</td>
<td>8.5</td>
</tr>
<tr>
<td>Respondent opposed</td>
<td>0.7</td>
<td>0.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Know not method</td>
<td>11.5</td>
<td>6.2</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Source: The exploitation of DHS 1992; 1998; 2006 of Niger

The Graphic below shows the average of men and women who want more children between 1992 and 2006 in Niger.


2.2 Current contraception use and intention to use

The use of contraceptive methods by women aged 15-49 in union is not very high: 14 % use any contraceptive method against 11% in 2006. The level of education of women is another important differentiating factor. Among women with at least a secondary or higher education, 30% currently use a modern method, against 18 % for those with a primary level and 10 % for those with no education. In 2012, 50.5% of women do not intend to use contraceptive method. In 2006, we had 62.2% and 52.2 in 1998 (DHS 1998, 2006 and 2012). In 2012, when women decided to stop the use of contraception, the reason of last discontinuation is mainly the need of pregnancy (52.3%). For men, the main raison of not using condom at the first sexual intercourse is that they had Confidence of their Partner (74.2 %). Wherever, 99 % of women did not use condom at the last intercourse in 2012. About 60.7% of women trust to their partner, when having not protect sex intercourse. Among currently married women, 9 % said they wanted no more children (additional), against 86% of women who said they wanted a child or another child. The following Graphics show the trends in contraception use and intention to use contraceptive methods by women in Niger between 1992 and 2012.
Graphic 3: Current use and intention to use contraception for women aged 15-49 years old between 1992 and 2012.

2.3 Influence of sociocultural factors

Table 2: The main results of Logistic regression.

<table>
<thead>
<tr>
<th>Differences Factors</th>
<th>Wald statistic</th>
<th>Exp(B)</th>
<th>Differences Factors</th>
<th>Wald statistic</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 5-year groups</td>
<td></td>
<td></td>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[15-19]</td>
<td>63,837</td>
<td>0.203***</td>
<td>Muslim</td>
<td>917,076</td>
<td>1,411E7***</td>
</tr>
<tr>
<td>[20-24]</td>
<td>0,412</td>
<td>1,103</td>
<td>Christrian</td>
<td>660,902</td>
<td>1,717E7***</td>
</tr>
<tr>
<td>[25-29]</td>
<td>10,251</td>
<td>1,602***</td>
<td>Animist</td>
<td>0,000</td>
<td>1,173</td>
</tr>
<tr>
<td>[30-34]</td>
<td>12,442</td>
<td>1,709***</td>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[35-39]</td>
<td>8,147</td>
<td>1,558***</td>
<td>Arab</td>
<td>3,670</td>
<td>0.407*</td>
</tr>
<tr>
<td>[40-44]</td>
<td>1,848</td>
<td>1,254</td>
<td>Djerma/songhai</td>
<td>0,012</td>
<td>1,028</td>
</tr>
<tr>
<td>Type of place of residence</td>
<td></td>
<td></td>
<td>Gourmantché</td>
<td>3,818</td>
<td>0.320*</td>
</tr>
<tr>
<td>Urban</td>
<td>18,730</td>
<td>1,787***</td>
<td>Haoussa</td>
<td>3,789</td>
<td>0.614*</td>
</tr>
<tr>
<td>Capital, large city</td>
<td>9,120</td>
<td>0.689***</td>
<td>Peul</td>
<td>6,061</td>
<td>0.501*</td>
</tr>
<tr>
<td>Small city</td>
<td>0,390</td>
<td>0.920</td>
<td>Touareg</td>
<td>6,551</td>
<td>0.504*</td>
</tr>
<tr>
<td>Highest Educational level</td>
<td></td>
<td></td>
<td>Toubou</td>
<td>4,797</td>
<td>0,358*</td>
</tr>
<tr>
<td>No education</td>
<td>7,769</td>
<td>0,446***</td>
<td>Wealth Index</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>3,220</td>
<td>0,590**</td>
<td>Poorest</td>
<td>0,264</td>
<td>0,926</td>
</tr>
<tr>
<td>Secondary</td>
<td>4,132</td>
<td>0,546**</td>
<td>Poorer</td>
<td>2,777</td>
<td>0,774*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Middle</td>
<td>3,626</td>
<td>0,747*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Richer</td>
<td>0,743</td>
<td>0,899</td>
</tr>
</tbody>
</table>

a. The reference modality of dependent variable is: Not using
b. (*) Significant Association at 10%; (**) Significant association at 5%; (*** ) Significant association at 1%.

According to the above table, some individual and sociocultural factors influence the use of contraceptive method in Niger. We have: the age of people, the type of place of residence, the facto place of residence, the highest educational level, religion and ethnicity. We also have the standard of living but which do not really determine to the use of contraception in Niger. Hence, our two hypotheses have been verified.

The results we obtained lead us to question the performance of family planning programs. To this end, we can conclude that the campaigns to promote family planning have not achieved their objectives (7.6 children per woman in 2012 instead of 7.1 in 2006). So, perhaps we should also look in other directions than dwelling or insist on sociocultural causes related to the refusal of contraception, and to consider such a self-control of fertility, especially it had bee, demonstrated that economic development is a factor in reducing fertility, even in the absence of family planning services.

Moreover, contraception agencies are promoting hormonal methods or the IUD and generally completely unaware methods "natural". However recent (sympto-thermal method, amenorrhea method of breastfeeding and the Billings method) are also accepted in developing countries because they give women the power to control themselves, knowledge of their cycle, their phase combined male-female fertility, vis-à-vis independence of health services. Moreover, these methods are not subject to delays providers, and do not have unwanted side effects on their health. In addition, these methods strengthen the irretrievable responsibility of husband and wife together and are immediately reversible. For this purpose, the knowledge of the cycle is also important for subfertile couples, since it can recognize maximum fertility day of a given cycle. Once a woman knows diagnose fertile and infertile days of each of its cycles, she can explain to his daughters, relatives and friends. In addition, given the socio-economic context (poverty and place of residence), these "natural" methods are of a very low cost.

However, it is clear that the abandonment of the so-called "modern" methods in question could only be applied to specific methods like the IUD and implants, for which the use of health professionals or family planning is necessary because the population of Africa in general, and Niger in particular cannot abandon the methods such as sterilization permanently. To this end, if they abandon pills and barrier methods (condoms, spermicides, etc.), they will not need to make it known publicly. They will do without health and family planning professionals are aware.

In Western countries and North Americans, having been denigrated, traditional Chinese medicine (TCM), with its main axes namely food, plants, breathing Qi Gong, massage, acupressure, meditation and acupuncture, arouses more and more interest. According to clinical studies, acupuncture brings many benefits (increasing the success rate of in vitro fertilization (IVF), relief from stress related to infertility and its treatment, improving production and quality of eggs, reduced risk of miscarriage and ectopic pregnancy, normalization of the hypothalamic-pituitary-ovarian axis and the menstrual cycle, etc.).

It will be interesting to direct new research into the origins and causes of this abandonment, focusing both to people and family planning health centers through quantitative surveys and qualitative through interviews and discussions groups.
Conclusion

Niger is one of the worldwide countries where Muslims are majorities (98.7% of Muslims and 1% of Christians in 2006, according to the 2006 DHS of Niger). Five Ethnicity groups are also majorities. We have as follow: Djerma Songhai (25.4%); Haoussa (42.8%); Toureg (13.2%); Kanouri, (7.7%) and Peulhs (6.9%). Six main factors have a great influence in the use of contraception: We have: the age of people, the type of place of residence, the facto place of residence, the highest educational level, religion and ethnicity. In 2012, when women decided to stop the use of contraception, the reason of last discontinuation is mainly the need of pregnancy (52.3%). For men, the main reason of not using condom at the first sexual intercourse is that they had Confidence of their Partner (74.2%). Wherever, 99% of women did not use condom at the last intercourse in 2012. About 60.7% of women trust to their partner, when having not protect sex intercourse. In Niger, population wants more children (20.4% of women and 31.4% of men in 2006) and do not use more contraception for the moment (86.4% of women and 91.2% of men in 2012). For the moment, a large part of people do not intend to use contraception (50.5% of women in 2012 relative to 62.2% in 2006). We can resume this situation in this few words: “They want more children; they do not more use contraception and do not intend to use it more”.

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