EXTENDED ABSTRACT (2-4 pages)

Title: Women's decision-making, agency and gender norms related to sexual and reproductive health services in Niger

Authors: Hidayatou Mohamadou[1], Sarah Smith[2], Angela Odiachi[1], Balki Agali[3], Michèle Signe[1], Emma Kefiye[1], Metti Temesghen[4], Shamsi Kazimbaya[5], Jonh Cleland[6], Jean-Christophe Fotso

[1] EVIHDAF, [2] GEH-UCSD, [3] GRADE Africa, [4] Save The Children, [5] Equimundo, 6 London School of Hygiene and Tropical Medicine

Introduction/context

Women's empowerment is a fundamental element of achieving gender equality. It includes strengthening a woman's sense of self-worth, her decision-making power, her access to opportunities and resources, her power and control over her own life inside and outside the home, and her ability to effect change[1]. Women's empowerment often strengthens agency and decision-making power regarding contraceptive use and fertility reduction worldwide. It includes a woman's right to decide whether and when to have children, and her ability to safely bear children[2]. The Republic of Niger's constitution makes provision for gender equality regardless of social, religious, or ethnic origin. However, it needs to improve the gender inequality index[5]. According to Some et al., culturally defined values and norms, which contribute to women's limited agency, decision-making power and access to resources in Niger hinder positive sexual and reproductive health behaviors related to contraceptive use[6]. Previous studies showed that men generally disapproved of family planning (FP) use often because of norms around having many children, rumours and prejudices regarding modern contraceptives[7]. Nevertheless, a qualitative study in Niger revealed that contraceptive use was usually discussed between spouses[8]. This study highlighted that women played a significant role in the decision to use FP because they "suffered most" from pregnancy, childbirth, and child rearing[8].

While studies have evaluated the levels of health decision-making among couples, there is little exploration of the woman's agency and her freedom to make decisions regarding contraception. Furthermore, previous studies did not collect information from the extended family such as mothers-in-law, brothers, or friends, although community members as reference groups influence decisions regarding contraception[8,9]. This qualitative research paper presents data collected as part of a formative research study conducted by Agency for All consortium partners[1], and from which findings will be used to design and implement a gender-transformative adaptation of "Husband's Schools," an initiative in Niger, to better leverage existing benefits while shifting entrenched gender norms and inequities to support agency related to RMNCH and nutrition outcomes as part of the Wadata program. This presentation explores women's decision-making, agency and gender norms related to seeking and utilizing FP in Zinder, Niger.

Methods

The mixed-methods study took place in two departments in the Zinder region of Niger: Damagaran Takaya (DTK) and Magaria and involved conducting focus group discussions (FGDs) and in-depth interviews (IDIs), and then quantifying social network data elicited during these interviews. For FGDs, we developed semi-structured interview guides that captured perceptions of gender roles and social norms, women's and men's agency and decision-making, and relationship dynamics and gender equity as related to family and couples' relationships and sexual and reproductive health. Semi-structured IDI

[1] EVIHDAF, GRADE Africa, UCSD/GEH, Save the Children, Equimundo, Matchboxology

guides elicited patterns across social networks, including types of respondents, demographics of social contacts, and whether social contacts are decision makers, influencers or both on key SRH outcomes. FGDs were organized using a factorial design, divided by department, gender, and age, wherein we conducted 8 FGDs with married men, 8 FGDs with married women and 4 FGDs with mothers-in-law. Participants were eligible to participate if they met the following criteria: being married and having any experience with the "Husbands Schools" initiative. Meanwhile, a total of 12 men and women, referred to as primary respondents, were selected to participate in IDIs using the following inclusion criteria: being married and having at least one child. One network partner identified by each of these individuals as highly influential was then interviewed as a secondary respondent. Interviews were audio-recorded in either French, Hausa or Kanuri or, then transcribed to French.

Thematic analysis, including a combination of inductive and deductive coding approaches, was conducted using Nvivo software. Quantitative social network analyses were conducted in R and used to triangulate qualitative findings. The study was approved by the University of California, San Diego and the National Ethics Committee for Health Research in Niger (Comité National d'Ethique pour la Recherche en Santé; CNERS).

Results

Description of study participants. Two-thirds of all IDI respondents at each of the two study sites were male. (Respondents in Damagaran Takaya were slightly older (median age: 44.5 years) compared to those in Magaria (median age: 33 years). All eight female respondents had some education, while 80% of the male respondents did not report any schooling. About one third of both male and female respondents (37.5% of men and women) were in polygamous unions (**Table 1**). Each of the 20 focus groups comprised 8 to 10 participants. Male participants from FGD were all married and were separated in two groups of 26-35 years old and more than 35 years old. Female participants were married and broken down in three groups of 18-24, 25-35 years old and mothers-in-law (**Table 2**).

Women's decision-making. Women's decision-making was explored through four themes: (a) the woman's intention to use a contraceptive method; (b) couple dialogue and consultation about seeking sexual and reproductive health and family planning services together; (c) the wife's raising awareness of the importance of birth spacing; (d) husband's authorization and power over decision-making. In most IDIs, women indicated that their husbands are usually the only ones to make decisions related to their contraceptive use, and that they cannot refuse their husbands' decisions: "*It's my husband. He's the one who can decide,* if and when I will have children, and whether or not I will use modern contraceptives. " Female, 21 years old. Any deviation from the injunction to inform the husband is sanctioned by the husband and the community, and can lead to discord within the couple, even divorce. A 18–24-year-old female respondent asserted: "the wife must inform her husband, it's really obligatory, otherwise he won't like it, and it will result in a divorce".

Women's Agency. One factor that encourages women to exercise their agency in regard to contraception is the fact that many have roles as community health workers, having income revenues, knowledge of contraceptive methods and their effectiveness and within the couple. Most FGD female respondents expressed that women make their own decisions without informing their husbands about the use of FP although, in theory, the husband's authorisation is absolutely required in such situations. Factors that motivate them to exercise their agency **by adopting contraception without their husbands' consent are:**

- **Religious norms**. Women secretly use contraceptives because *"some men say that if their wives take the birth spacing drug it is a sin. and if the problem arises, it is the woman who*

suffers, that is why women use it in secret » Mother-in-law, aged +35 years old. In Zinder, a woman must have her husband's consent before considering using SRH/FP services, otherwise, it is "*haram*" (committing a sin).

- **Women's health concerns**. Women want to safeguard their health and avoid closely spaced births because it directly impacts their health and no one will find out if she adopts contraception. "*It's a secret between women and health workers because they don't report to anyone, and the woman also doesn't let her husband find out*. » Mother-in-law, aged +35 years
- **Fear of the husband's refusal**. Women may make their own decisions without informing their husbands about the use of FP because they are afraid of their husband's opposition or refusal. "*In my opinion, she's afraid to tell him because she knows he'll oppose her. If she knew she'd get his approval, she wouldn't hesitate to discuss it with him*." Female, under 25 years
- **Influence and decision-making power of reference groups.** According to the norm, family-in-laws are potentially powerful decision makers. "*Women sometimes decide with her friends and avoid discussing these decisions with her in-laws given that they may criticize her choices.*" Mothers-in-law aged +35 years. Even in health centers, health personnel commonly ask whether the woman has informed her husband of her decision to use FP.

Conclusions and implications

In conclusion, decisions and agency about women's sexual and reproductive health are conditioned by descriptive, religious, and injunctive norms. Women's level of decision-making typically involves secret circumvention of strong norms, either because it directly concerns their health, fear of their husbands' opposition or refusal, or in avoidance of potential sanctions from influential social contacts within their reference groups. While the Husband's Schools intervention already engage men and has been successful in influencing SRH outcomes, a gender-transformative adaptation of this initiative will better understand and address the root causes of gender inequality, foster enabling environment for women to make their own decision and enjoying their sexual and reproductive rights.

References

1. Global Issues: Gender Equality and Women's Empowerment. https://www.peacecorps.govhttps://www.peacecorps.gov/educators/resources/global-issues-gender-equality-and-womens-empowerment/.
2. Bank, I. A. D. Gender in Maternal and Reproductive Health: Synopsis. (2014).
3. Institut National de la Statistique, Niger. Enquête démographique et de santé et à indicateurs multiples. (2006).
4. 2022 Core Indicator Fact Sheets - Family Planning 2030. https://www.fp2030.org/news/2022-core-indicator-fact-sheets/.
5. Nations U. Gender Inequality Index [Internet]. Human Development Reports.
6. Some, B. Resilience in the sahel enhanced (rise) ii gender analysis. USAID; 2018. (2018).
7. Institute for Reproductive Health. Study of the effects of Husbands' School intervention on gender dynamics to improve Family Planning and Reproductive Health in Niger. August 2019. Washington, D.C.: Institute for Reproductive Health, Georgetown University, for the United States Agency for International Development (USAID).
8. Chace Dwyer, S., Mathur, S., Kirk, K., Dadi, C. & Dougherty, L. "When you live in good health with your husband, then your children are in good health …." A qualitative exploration of how

households make healthcare decisions in Maradi and Zinder Regions, Niger. *BMC Public Health* **22**, 1350 (2022).
9. Study of the Effects of the Husbands' School Intervention on Gender Dynamics to Improve Reproductive Health in Niger, PASSAGES PROJECT. (2019).

Table 1. Socio-demographic characteristics of IDI respondents

	Total (N=24)	Department		Gender	
		Damagaram (N=12)	Magaria (N=12)	Male (N=16)	Female (N=8)
Type					
Ego	12 (50.0%)	6 (50.0%)	6 (50.0%)	6 (37.5%)	6 (75.0%)
Alter	12 (50.0%)	6 (50.0%)	6 (50.0%)	10 (62.5%)	2 (25.0%)
Department					
Damagaram	12 (50.0%)	NA	NA	8 (50.0%)	4 (50.0%)
Magaria	12 (50.0%)	NA	NA	8 (50.0%)	4 (50.0%)
Sex					
Male	16 (66.7%)	8 (66.7%)	8 (66.7%)	NA	NA
Female	8 (33.3%)	4 (33.3%)	4 (33.3%)	NA	NA
Age (years)					
Mean	41.2	46.8	35.7	46.2	31.2
Median [Min, Max]	35.0 [21.0, 90.0]	44.5 [32.0, 90.0]	33.0 [21.0, 62.0]	44.5 [32.0, 90.0]	34.0 [21.0, 35.0]
Education					
No schooling	13 (54.2%)	8 (66.7%)	5 (41.7%)	13 (81.2%)	0 (0.0%)
Koranic school	1 (4.2%)	1 (8.3%)	0 (0.0%)	0 (0.0%)	1 (12.5%)
Primary school	6 (25.0%)	1 (8.3%)	5 (41.7%)	1 (6.2%)	5 (62.5%)
Secondary school	4 (16.7%)	2 (16.7%)	2 (16.7%)	2 (12.5%)	2 (25.0%)
Polygamous union					
No	15 (62.5%)	9 (75.0%)	6 (50.0%)	10 (62.5%)	5 (62.5%)
Yes	9 (37.5%)	3 (25.0%)	6 (50.0%)	6 (37.5%)	3 (37.5%)

Table 2: FGD's participants stratified by Age and Site

	Younger respondents (18- 24 years)		Middle aged respondents (26 – 35 years for women, 24-35 for men)		Older respondents (36-60) Women respondents will be mothers-in-law		Total
Study site	Magaria	Damagaran Takaya	Magaria	Damagaran	Magaria	Damagaran	
Married Men	0	0	2	2	2	2	8
Married Women	2	2	2	2	0		8
Mothers In Law	0	0	0	0	2	2	4
Total	**4**		**8**		**8**		**20**
Total # of Participants	**32-40 participants**		**64-80 participants**		**64-80 participants**		