Gender analysis on sexual and reproductive health

Niger - Maradi

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Cover photo: Photo of a woman in a Fulani camp in the intervention area.

Image: Aicha Douroussa

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Abbreviations

ACF	Action Against Hunger
IGR	Income generating activity
ECOWAS	Economic Community of West African States
ICPD	International Conference on Population and Development
NPC	Prenatal consultation
CS	Health hut (Case de santé)
IHC	Integrated health centre
EDSN/MICS	Multiple Indicator Cluster Survey
IFAD	International Fund for Agricultural Development
UNFPA	United Nations Population Fund
NIS	National Institute of Statistics
STI	Sexually transmitted infection
IPPF	International Planned Parenthood Federation
PDES	Economic and social development plan (Plan de développement économique et social)
FP	Family planning
RGP	General Population Census
RGPH	General Census of Population and Housing
RISE	Resilience in the Sahel Enhanced
SRHR	Sexual and Reproductive Health and Rights
SRH	Sexual and reproductive health
GBV	Gender-based violence
TFR	Total Fertility Rate

Introduction

The aim of this analysis is to provide recommendations for the design of project activities to ensure that the intervention is 'Do no harm', and takes into account the deeper reasons for and influences on people's behaviour and choices.

The project consortium represents a pioneering partnership that will test innovative, sustainable and scalable approaches to reaching some of the world's most marginalised groups with comprehensive sexual and reproductive health and rights (SRHR) services. In the face of continuing shocks to vulnerable groups in fragile and climate change-affected settings, this comprehensive approach of the ASPIRE project is based on a resilience framework. As the developing world is increasingly affected by climate change and humanitarian crises, building resilience becomes a key priority to enable vulnerable groups to adapt and lead healthy and fulfilling lives, of which access to quality sexual and reproductive health (SRH) services is an essential component.

The specific issues that the consortium (led by MSI Reproductive Choices, of which CARE is a partner) is seeking to understand in the new multi-country project in Niger, Uganda and Madagascar are

1. The social, cultural, financial/economic, logistical and behavioural dynamics that influence access to sexual and reproductive health rights - in particular social norms for people of all genders;

2. Opportunities to support the sharing of information, services and materials accessible to people of different genders and ages to meet their sexual and reproductive health needs;

3. Whether and how SRH norms interact with social and gender norms and attitudes that impact on the ability of people of all genders to build resilience (e.g. access to land and resources, economic decision-making, paid and unpaid work, etc.)

After two years of co-creation, the launch phase of the programme runs from October 2020 to June 2021. To inform the key decisions in the project design, CARE will conduct a gender analysis to understand the gender dynamics around sexual and reproductive health, including barriers to accessing sexual and reproductive health services, and then present the findings to the consortium.

Methodology

This qualitative research is being conducted to assess the role played by social norms on agency in creating development opportunities for men and women, and in access to SRH services and contraceptive use in the Maradi region.

This work will examine the following questions: (1) To what extent and how do women exercise their *agency* in areas such as control over freedom of movement, decision-making about marital formation, family planning, and the right to a voice in society, etc. and (2) Does this freedom of decision vary by age, gender, household status, ethnicity, capacity for resilience, etc.?

The study also seeks to understand the relationship between gender role norms and freedom of decision making or *agency* by highlighting the extent to which these norms limit men's and women's aspirations and achievements. Women's *agency* can be attributed to their ability to make strategic decisions about their lives (Kabeer 1999).

The fieldwork should provide a better understanding of the barriers and obstacles and clarify how people make decisions about marriage, having children and accessing sexual and reproductive health services.

The objective of this study is to gain a better understanding of the context to better understand the gender dynamics around sexual and reproductive health, including barriers to accessing sexual and reproductive health services. Three areas of work, as specified in the terms of reference, guide this analysis.

- Social, cultural, financial, logistical and behavioural barriers to accessing SRH, including power dynamics
- Social and gender norms and behaviours that influence access to and use of SRH information, services and products.
- Factors that facilitate women's and men's access to SRH information, services and products, or that could facilitate access in the future.

The approach adopted for this study is participatory and required the active participation of CARE Niger staff and its local partners in i) the validation of the design of the tools; ii) the collection in the field including the interpretation and processing of qualitative data. The gender analysis was shared with the staff who participated in the study process. Thus, the project staff and its partners are closely involved in the field surveys in order to create a knowledge base, carried by all project stakeholders.

The collection tools are interview guides for women, men and young men and girls from the communities jointly selected in focus groups. Individual interviews with male and female leaders, poor men and poor women, poor and discriminated (caste, etc.) men and women were also carried out on the basis of two guides addressed to women and men. These tools were all tested in the village of Bamo before being validated for the actual collection.

Four communities were selected on the basis of their isolation, their proximity to health centres, their capacity to support the process in terms of free expression in the face of the project, and their geographical diversity: they are spread over three communes in the two intervention departments:

- Mai Janguéro located at 2 km from a CSI (Tchadoua commune) and Dan Kada located at (Aguié commune) in the Aguié department;

- Kaguirka, which is the most isolated site and the furthest from a health facility; and Rafa, which has a health centre, both in the commune of Gazaoua (Gazaoua department).

The data collection and analysis was based on the analysis matrix[1] proposed by CARE on gender adaptive capacity in the face of demographic and SRH challenges in the Maradi region. It is a tool that has 8 horizontal and 3 vertical domains that are interrelated; the intersection of these domains as variables constitute the axes of analysis.

The **team** is composed of the consultant and 10 full-time project staff who worked for more than 10 days in the field to collect information on the following areas of the grid: division of labour, household decision-making, control over assets, access to services and public spaces, participation in public decision-making, control over the body and relationships, gender-based violence, aspirations and self-esteem.

TABLE 1: SAMPLE OF INDIVIDUAL SURVEYS

	Gender		
Village	**Woman**	**Male**	**Total**
Dan kada	8	7	15
Kaguirka	8	8	16
Mai janguero	8	8	16
Rafa	8	8	16
Grand total	**32**	**31**	**63**

In addition to the 63 individual interviews, 10 focus groups were conducted per community with vulnerable men and women, heads of households, but also single girls (aged 12 to 15) and boys (aged 18 to 20), leaders, community relays (community health workers), and marginalised people. The choice of people (men, women, girls and boys) to participate in the focus groups also respected this categorisation based on vulnerability as indicated above. The other categories were chosen for the roles they play in the communities in terms of SRH and/or their relationship with SRH issues.

In sum, this study focused on the most vulnerable households in individual and focus group interviews. These qualitative interviews made it possible to collect information that sometimes went beyond the expectations of the guides, resulting in a very rich data collection. The analysis was facilitated by the participation of project staff, many of whom have extensive experience of SRH in rural areas, having worked there in the past. Regular exchanges with the data collection teams facilitated the processing of qualitative data.

[1] See annex

Findings

1. Presentation of the villages surveyed

Presentation of the study framework

The geographical framework of this study covers four villages in the Maradi region, namely Kaguirka and Rafa in the department of Aguié and Dan Kada and Mai Janguéro in the department of Aguié. They are all administratively attached to Maradi, which is a real crossroads for trade between Niamey, the capital, to the west, the Zinder region to the east, the Tahoua region to the north and Nigeria to the south.

The four villages are located in the agricultural area, at fairly similar and related geographical scales and ecological zones.

1.1. The village of Rafa

The population is large, with over 1,500 heads of households with an average of 6 children, (450 heads of household[2]), and is estimated at over 5,000 inhabitants. The population in 2012 was 2236 (1071 males and 1165 females) with 314 households of which 274 were agricultural at the last census in 2012. The largest households have more than 40 people.

This accelerated demographic growth makes access to land very difficult, with the emergence of landless peasants for more than 10 years now.

Rafa is located in the agricultural zone 25 km from Nigeria. The fields are highly fragmented following successive inheritance divisions since 1973. The level of fertility of the soils, often sandy, is worrying given their overexploitation. Women here have the right to inheritance, which takes into account pregnancies

"We leave two shares for the unborn child. If it's a girl, we give her one share and the other share is given to her to share again" (Focus group men from Rafa)

1.2. The village of Kaguirka

In 2012, Kaguirka was populated by 1037 inhabitants (535 men and 502 women) and 110 households, 108 of which were agricultural households. Today, the village chief reports 102 family books, with an average of 5 households per book; according to this count the average household would have about 8 people.

Youth migration is very developed, with more than 200 young people already having left. The youngest boys, who are not enrolled in school, go to the Koranic school and leave the village with their marabout for more clement regions to beg, work to feed themselves and study Islam at the same time.

Inheritance, purchase, pledge and lease are the modes of access to land.

[2] The heads of households have family booklets, in which their married sons are registered as heads of households together with the members of their households. 450 heads of extended families and 1500 heads of households from these extended families.

1.3. The village of Dan Kada

The village is composed of two entities Dan Kada I which is landlocked and Dan Kada II at the edge of the road (RN1), the chief residing in Dan Kada I. Dan Kada I is formally recognised as the first village to be settled, even though it is landlocked and has a smaller population. The populations of the two villages live together peacefully and maintain social relations (marriage, baptism, etc.)

In 2012, Dan Kada I had 438 inhabitants (201 men and 237 women) and 42 households, all of them agricultural; Dan Kada II had 458 inhabitants (199 men and 259 women) and 57 households, all agricultural. The village has 110 families, of which 200 households can be counted. This village has dune and clay soils; and with the classified forest of Dan Kada land is available (land convention for plots of 0.25 ha for 3 years with a fee of 11,000F). This mode of access is now in the majority, even if it is inaccessible to about 50% of the population. Women who have lost access to the *gamana* (plot of land given to the woman or young single men of the family), for a very long time, inherit and sign land conventions with the environmental service.

1.4. The village of Mai Janguero

In 2012, the village, which is located along the RN, was inhabited by 2,250[3] people, of whom 1,099 were men and 1,151 were women, divided into 278 households, of which 221 were agricultural. Today the number of households exceeds 500 with some large households of up to 25 members. It is located less than 5 km from the chief town of Tchadoua, of which it is a part, and 30 km from Dankama on the border with Nigeria.

It has a primary school and a standpipe (connected to the Tchadoua mini drinking water supply) and a well.

Since 1984, following the ecological crisis, land fragmentation has begun, as has the sale of land for migration. The sale of land is a practice that continues; it is bought by civil servants, traders from Tchadoua and wealthy people from the village. The practice of lending land no longer exists, but renting (25,000 francs per hectare) and pledging are developing. "*Many households of 20 people have one hectare or less, and the food deficit is chronic in these households, which are very vulnerable"* (Focus group male leaders of Mai Janguéro)

At least 30 heads of household are landless, and 20 of them rent and pledge agricultural plots.

1.5. Elements of conclusion on the 4 villages

1.5.1. In the ecological aspect of climate change

The four villages are in the same agro-ecological band. The focus groups report **a shortening of the rainy season with a late onset of rains in June-July and the end of the rainy season in September-October as visible elements of climate change.**

Another visible feature is the vegetation, which has a predominance of acacia trees. The presence of rare tamarind trees is observed in Rafa.

1.5.2. In terms of agricultural land

[3] Source: General Census of Population and Housing, 2012.

New land transactions have replaced gifts and loans, which have almost disappeared. Pledging of land began with young landowners who pledged their fields to migrate to Mali (gold panning) or Libya; but the pledging operations made it impossible for the pledger to repay the money, and the field was sold after 4 or 5 years. Land rental is also developing**.**

Women have progressively lost access to agricultural land; their *gamana (plot of agricultural land lent to the woman by her husband)* are passed on to married sons. Today, women aged 30 no longer know how to farm because they did not learn from their mothers' fields. Older women who farm rent and pledge fields. Women do not inherit agricultural land in practice. The land conventions (classified forest of Dan Kada about 6000 hectares) granted by the environmental service for 1 hectare at 11000 for 3 years allow the inhabitants (men, and women to a lesser extent) of Mai Janguéro and Dan Kada to have additional land. **Poor access to land increases female poverty in rural areas and decreases household resilience.**

1.5.3. In terms of family and community solidarity

Self-help work in the fields no longer exists and has been replaced by wage labour, which pays the most vulnerable who have no fields or small areas. In Rafa the vulnerable have to go to Nigeria to sell their labour to earn money. This situation is explained by the fragmentation of farms, the monetarisation of the economy, and **the dislocation of inter-family and community solidarity**. The only form of mutual aid that persists is the *mayda haywa* organised by the son-in-law to weed his parents-in-law's field and mutual aid during the construction of a newlywed's house. At the community level, men use mutual aid work to make bricks and build community infrastructure (mosques, classrooms, etc.). The collection of crops by women, who used to organise mutual aid work, is now done by men. **The erosion of family and community solidarity weakens the social capital that is the basis of the resilience of poor households.**

1.5.4. In terms of economic activities

All these villages grow rainfed crops that are very sensitive to climate change, such as millet, sorghum, cowpeas, groundnuts, sesame, souchet (sweet peas), voandzou (groundnuts), and sorrel; they also grow market garden crops (onions, tomatoes, cassava, squash, etc.). "Groundnuts, which were the main cash and export crop, saw a drop in production from 1989. **The drought of 1972 had already diverted farmers to food production in order to ensure food security; thus cowpea gradually replaced groundnuts"** (Diarra Marthe, 2001).

The main economic activities of these villages remain, of course, agriculture and livestock rearing, to which are added various commercial activities (trade with Nigeria, Gazaoua, Aguié, Tchadoua and Maradi) and handicrafts (mat weaving, rope making, blacksmithing), **almost all of which are sensitive to the risks of climate change, thus reinforcing the vulnerability of households.**

1.5.5. Social and political

Islam has been introduced into these villages, which had an animist tradition for about sixty years, and now affects the entire population. **The religion has a strong hold on young migrants, especially those who migrate to Nigeria and Libya. With Islamisation, polygamy has become widespread in all the sites, with more than 65% of polygamous households according to the focus groups.**

At the level of local politics, decentralisation has led to political pluralism (13 political parties present in Mai Janguéro, one of whose councillors has held the post of mayor of the commune of Tchadoua). The strong involvement of the traditional chieftainship has enabled it to recover this new form of power

through local and legislative elections. This is true for Mai Janguéro; the other villages have no nationals in the communal council. Women have little presence in the political arena. The development of women's leadership beyond the communities is necessary so that they can integrate decision-making bodies and take charge of their own development.

2. Obstacles to SRG, including power dynamics

2.1. Social and cultural factors as barriers to SRG

2.1.1. Participation of women and men in power dynamics

2.1.1.1. Patriarchal and gerontocratic power

In the various village committees, women are poorly represented except in the women's structures which they manage themselves. Everywhere else, community power is exercised by men; in short, they decide on issues that concern them, but also on issues that concern youth and women in all areas of community life.

Women have a low capacity to participate in community decision-making; this raises the issue of social inequality through the low representation of women in decision-making bodies, including decisions concerning their own lives.

Most of the committees mentioned during the focus groups are managed and address needs expressed by men: *"The farmers' committee helps us to have seeds and fertilisers and makes us aware of the threat of rain and the problem between farmers and herders; it helps elderly men and women.* (Focus young men of Kaguirka). Young women, because of their poor access to farmland and their dependence on heads of households, do not participate in and are not directly supported by this committee. The same applies to young girls, who are absent from all the village dynamics because they are not perceived as full players at community level**.**

Older women are integrated into the water management committees, the sanitation committee and are very active in hygiene and sweeping, which are considered their responsibility.

Girls everywhere say that the health committee does not include them in its activities.

"This health committee sensitises us through home visits on FP, ANC and NC" (Women of May Janguéro)

"This health committee does not help us, the young girls of the village" (Focus group girls of Mai Janguéro).

"The excluded are girls and boys, because we are considered as little girls and boys" (Focus group girls from Rafa).

The influence of women leaders of associations is limited to the level of women members of the said associations and women leaders of political parties exert their influence on the women of their political party and organise mobilisation activities. The influence of traditional women leaders is limited to a relay role between the community sphere of men and women.

"They pass on information and ensure the mobilisation of women in times of need; they are seen as brave women." (Focus group young men from Dan Kada).

Young girls meet in informal female youth groups, where they gather to ensure that they are well organised for their wedding. Young men, on the other hand, meet in unstructured spaces of exchange and leisure (fadas).

The public space seems to be taken over by men. The older ones are in the forefront. The same is true for older women who participate to represent other women. **The patriarchal and gerontocratic power is a major obstacle to the participation of women and young people in public affairs, and the practical needs and strategic interests of these vulnerable groups are likely to be ignored.**

2.1.1.2. Women from MMD groups emerge in the public arena

Women's associations organised around tontines are emerging and integrating community life through credit granted to non-members, through activities such as cereal bank management, capacity building in nutrition, etc. These spaces also provide goods (cereals, ruminants, etc.) and knowledge depending on the projects with which the women members have relationships. These spaces also provide goods (cereals, ruminants, etc.) and knowledge according to the projects with which the women members maintain relations.

In villages where MMD groups exist, women are invited to community meetings and participate in decision making, arguing their position even though the final decision is taken by the most influential men.

At the level of networks (MMD group clusters), women can claim their interests, when needed. MMD groups and networks constitute solidarity groups and networks that impact the community in terms of sharing benefits such as the credit they provide to non-members through members for economic needs and social emergencies (health, baptisms etc.).

The structuring of women's MMD has opened up a new collective space for women in which they participate fully and decide for themselves as members. This women's space could be developed and opened up to men in terms of benefit sharing (e.g. cereal banks, sharing of specific knowledge/skills related to areas of competence that are recognised to women such as nutrition, good management, etc.).

An entry of the ASPIRE project through the MMD groups would be favourable for activities related to communication. But all the spaces of young girls and young men and women are spaces of free exchange which can be used as framework of animation and capacity building including in the field of SRH.

Older men and women have a strong influence on the community's value system. Their support can be crucial for young men and especially for young women to better understand their sexual and reproductive health and rights, and to access contraceptives and other sexual and reproductive health services.

2.1.2. Social construction of success potential, based on children

One of the factors of social ascension declared by all, men and women, is the number of children. A high number of children is achieved through polygamy. The majority of households in the target sites have two wives. Young people finance their own marriages with the income from migration to the gold sites. "*Young people who go to the gold sites get married when they return. There are young people under 25 who are married with 3 wives; it is competition between them*. (Focus men Dan Kada, Mai Janguéro, Focus women Rafa). The wives are usually very young, aged between 14 and 16 (Dan Kada). The marital age range of married girls in Dan Kada demonstrates the persistence of harmful traditional practices and consequently the problem of the girl's deschooling and/or withdrawal from the system in view of the gender role

Social success in the context of the communities visited is extremely important. It is based first of all on the social weight, in terms of social representativeness and capacity to take community decisions, offered to such a head of household. **The number of children guarantees a success that allows the head of the household to rub shoulders with traditional power and to have a social capital that is very useful in exchanges and in strengthening resilience**.

For women, fertility is proof of femininity and commands the respect of the husband who seeks the blessings of his children: it is an object of rivalry between wives *"the one who has many children is more respected by the husband"* (focus group women In Kada, Rafa, etc). This race to procreate between co-wives reflects ignorance of RH rights and of the consequences of multiple motherhood, sometimes too close together, on maternal and child health (MMI, malnutrition, etc.). In addition, children, especially sons, are an insurance policy for their mothers in old age, as they are the ones who house their elderly mother and provide her with daily food. "*The daughters also contribute a lot through clothing and other small specific care*" for their elderly mother. To this end, the Spotlight Initiative (programme with EU funding, 2018) confirms that "menopausal women are discriminated against because they are now part of a dynamic of marital disutility". **The menopausal woman is no longer 'visited' or cared for by her husband. She is taken care of by her children, and therefore the more children she has, the more secure she feels.**

The *bikis* or naming ceremonies or marriages of sons and daughters is an important moment in the lives of women that demonstrates their capacity for social mobilisation. It is the day when they accumulate the most financial resources and goods (gifts). Many women want to organise these naming ceremonies at reasonable intervals so as not to lose out on the mutual exchanges with the other women in the network (gifts are given in single or double amounts in return) *'If the woman to whom you have given a gift gives birth once or even twice before you do, then you lose out on the exchanges; ideally you should give birth one after the other'* (Focus group women Mai Janguéro). The income from these exchanges is invested in IGAs, household food and other needs. **Awareness-raising activities on FP should target young women who maintain a pronatalist dynamic through these practices.**

The postponement of these festivities to the post-harvest period, due to household vulnerability, is almost universal (more than 27 baptisms postponed in Mai Janguéro) in poor households. In Rafa, however, a two-week postponement is observed to give the couple time to organise the naming ceremony.

The wedding is also an opportunity for the household to get a wedding trousseau and a stock of food for the couple (*gara)* that can last from 3 to 12 months depending on the economic situation of the girl's parents and their ability to mobilise gifts through their social network.

The festivities constitute periods of expenditure, certainly, but above all of capitalisation of goods for the household that organises the baptism and marriage ceremonies. These festivities are also factors that make it possible to measure the capacity to mobilise family networks and friends (of the wife, husband, sons and daughters of the family-in-law and friends). A large mobilisation reflects the social importance of the person organising the celebration.

This also partly explains the importance of having a large family.

Advocacy issues on FP should be more targeted at young men who develop and maintain a pro-natalist dynamic for social, resilience-building reasons based on internal social factors and external factors such as son migration.

2.1.3. High fertility and building household resilience

The high number of children is seen as a survival strategy for building household resilience. Indeed, the resilience of families in the past was built on the number of children to carry out the agricultural work on large family farms. Today, the fragmentation of farms as a result of ecological crises has led to a sometimes drastic reduction in the size of family farm plots, which no longer require a large agricultural workforce (high number of children). **However, the social pattern has not changed with the collective belief that "*it is the sons and daughters who take care of the elderly later on*". The social reality is that they are still the ones who take care of the families through migration, begging for the youngest, IGAs for the daughters etc**.

The success sought is also economic because a high number of children is also the hope of finding among the siblings the prodigy, **the** "**blessed child**", who will definitively eradicate poverty from the family.

The quest for resilience is always perceived as collective in the social logic that governs the sites surveyed: the larger the household, the more strategies there are and the greater the resilience. Migration does not yet seem to have reversed this view among young people who are engaged in a competitive dynamic of polygamy. **The needs of women and heads of households are greater and dictate a maximum number of children wanted by both men and women**.

2.1.3.1. The woman's contribution to the household income

Women's contribution to food is increasingly important. The social norm tends to make women responsible for feeding their children and taking care of themselves when the head of the household cannot do so. This situation can last for several months if he has no profitable economic activity; even in exodus his contribution is far from satisfying the household's food needs. In Dan Kada, Mai Janguéro, the majority of young women ensure their food needs with the support of their parents during the husband's absence. Cases of begging by these women were mentioned during the focus groups at all the sites, and of sex work only at Dan Kada. This state of affairs poses the problem of gender-based violence against and exposes women to sexually transmitted diseases. And this also leads to men begging; this was reported in all four sites.

Mothers, older married women, widows and divorced women, travel to buy and sell from market to market. More affluent women go to Katsina in Nigeria to buy products and sell them there. "*Older married women go as far as Kano in Nigeria to buy their daughter's wedding trousseau*" (focus group men from Mai Janguéro). The poorest women also do the pounding, winnowing and other domestic chores for the more affluent women (focus group women from Rafa).

Non-agricultural, non-pastoral activities increasingly ensure the family's food supply throughout the lean season, which begins from January to March, depending on the vulnerability of the household. During the lean season: selling wood, begging, grain aid collected from the family network (friends and relatives and wealthy people such as village chiefs), cash loans (interest-free everywhere) from wealthier people, are also strategies developed by both male and older female households. Men and young men are leaving the country, but this is not yet the case for women, except in Rafa where unmarried women go to work in Nigeria as agricultural workers, domestic servants or do other IGAs.

The increasing contribution of women to household income may also encourage the development of polygamy. On the other hand, older women and unmarried women have more freedom of action in economic activities with greater mobility. They have the freedom to decide on their economic activities. Married women must have the permission of their husbands, who give them the freedom to operate within the scope of what is feasible, as defined by the norms in terms of possible activities and conditions. Younger married women can also, with the agreement of their husbands, carry out activities

that do not require mobility, i.e. inside their homes, such as preparing pancakes, selling condiments, selling hijabs (women's veils), etc. The vast majority of them carry out these activities during the summer months. In the vast majority of cases, they carry out agricultural activities for the household and/or for themselves during the rainy season (on rented or leased land, or rarely on their own inherited or purchased land). The older women combine their dry season and rainy season activities. **Women's access to income-generating activities contributes to their economic and social empowerment. The development of this relative financial empowerment of women is in favour of their access to SRH.**

2.1.3.2. Life stages: contribution of sons and daughters

The expected contribution is multiple and depends on the gender and age of the children. The focus groups revealed several life stages: the newborn (up to 6 months); then childhood with generally three sub-stages (7 months to 3 years; 3 years to 7 years; and 8 years to 14 years) which end at 14 or 15 years, depending on the focus groups. This division is based on the types of relationship maintained with the child:

- The newborn: total dependence on the mother for care.
- From the age of 7 months, the child can be looked after by a third party, such as the grandmother, usually on the father's side, who lives in the same home;
- After 3 years, they can be with his mother and older siblings. They need less attention.
- From the age of 7 and even a little earlier, until 14, the child begins to contribute to the household: both boys and girls help in domestic activities. Boys do not cook or pound. But they do the dishes, the laundry, the water supply, the wood supply, the cleaning of the house; the older ones also take care of the animals. The girls are involved in all domestic activities. They start cooking and pounding from the age of 10. It is those in this age group who also contribute to the productive activities of the household: the boys work in the fields with their fathers, the girls with their mothers, and they also help with the care of younger brothers and sisters.

The young boys (from 7 to 14 years old) leave with their marabout[4] during the lean season. This Koranic education, always coupled with begging to learn humility, is now an opportunity for these talibés (Koranic school pupils) to work as domestic servants in their free time. This allows them to send money from their income (begging and work) to families left behind in the village. The older boys among them also save up to prepare for a more profitable migration to Nigeria or the north of the country at the age of 15; and later to Mali or Libya if possible.

Young unmarried women and girls are developing more economic strategies, combined with begging and asking for support from relatives and friends; these young women are increasingly resorting to migration to the nearest communal towns of Aguié, but also to Nigeria; for example, those in Dan Kada spoke of migrating to nearby towns such as Aguié to work as domestic servants[5]. Women also use loans to engage in IGAs.

The youngest ones work as street vendors for their mother or another woman in exchange for cash, which they give to their mother (Rafa). They are married from the age of 15 and leave their parental

[4] Koranic school teacher who travels from the village to the town for religious services, teaching at the same time the children who are required to beg (learning humility) and work to survive. Usually they leave after the harvest and return just before the work in the fields.
[5] Mai Janguéro is the site where the cost of the dowry is the highest because of the overbidding by the gold panners. Girls no longer manage to get married before the age of 16. The impact on girls who are in school is that many of them go to college.

family. If they do not marry after 18, they migrate to Nigeria to work as domestic servants or in market gardening (Rafa).

Support for domestic activities is seen as a priority for the young woman, who must focus on these activities to the detriment of productive ones. The youngest boys participate in collecting and selling straw, gathering fruit, and making and selling bricks; the girl helps with domestic activities, which are very difficult given the number of young children in the household.

Overall, the roles played by offspring go beyond food security and are involved in all areas of household livelihood security.

"One of my children fell ill and needed urgent intervention in Maradi for the sum of 100,000F. Two others in migration contributed 80,000F, and I added 20,000F. If I didn't have many children how was I going to do it? That sick child was going to die.

"It is certain that the household suffers a lot to support several children during their childhood, but after this stage, it is the benefits that flow to us parents and to the care of the younger ones...". (Interview Dan Kada).

The young men are the family's workforce for all construction and maintenance work (houses, sheds, granaries, etc.) and economic activities. For this reason, not all of them migrate, the youngest stay to support their parents in various tasks.

2.1.3.3. The contribution of the head of household

The primary role of the head of household is to organise and carry out agricultural work. He also ensures the daily supervision of the field (crop pests, work to be scheduled), and the management of the household goods entrusted to him. Increasingly, each member of the household manages his or her own property and is directly involved in the management of collective needs such as food. The woman head of the household plays the same role if her sons are still young. And when they grow up they become the heads of the farm.

When the head of the household is present in the village, he is responsible for preparing his own meal and for the sub-household in which he finds himself. *The* husband takes full charge of the household, i.e. all his wives and their children, only during the harvest period.

Women heads of household make a great contribution to their households. The other women interviewed see them as courageous and fighting women, while opinions are very divided among the men, who also see them as "*irresponsible for the upkeep of the household or incapable of bringing up their children*". All admit that they are a vulnerable group who resort to begging, and for the youngest to the sex trade for the survival of young children.

2.1.3.4. Multiple strategies for household resilience

TABLE 2: STRATEGIES USED FOR HOUSEHOLD RESILIENCE

Men	Strategies for resilience						
Village	Agriculture	Rural exodus	Small business	Agricultural wage earners	Begging	Motorbike taxi	Grand total
Dan Kada	0%	14%	43%	29%	0%	14%	100%
Kaguirka	25%	13%	38%	0%	25%	0%	100%
May Janguéro	0%	25%	38%	38%	0%	0%	100%
Rafa	0%	25%	38%	13%	25%	0%	100%
Average	**6%**	**19%**	**39%**	**19%**	**13%**	**3%**	**100%**

The head of the household, like the women and children, also engages in petty trade such as the sale of wood, straw, income-generating activities (IGAs), migration, domestic wage labour (collecting water, wood, pounding etc.) or farming, etc. Begging is also mentioned as an activity - it is no longer only practised by people living with disabilities, but by migrant wives, vulnerable heads of households in neighbouring villages, in Nigeria etc. This demonstrates the lack of options for people living with disabilities to beg for money. This shows the lack of options to meet the needs of their families."

In the rainy season, in order to feed the family, the head of the household or the grandsons work every other day as farm labourers on another field (in Nigeria, as farms here no longer require hired labour) in order to ensure that the household is fed during the busy farming season. Households are no longer able to build up a stock of grain to ensure food during the farming season. This destabilisation has been going on for a long time: "the shock of the drought (1974) seems to have been a determining factor in triggering the food shortage. However, the movement continued even after a more normal rainfall pattern was restored. This suggests the existence of deeper and more lasting causes, including a chronic mismatch between the level of agricultural production and household needs..." (GREGOIRE Emmanuel and RAYMAN). (GREGOIRE Emmanuel and RAYNAUT Claude, 1980). This mismatch has continued to grow since the first major ecological crisis (1974), to the detriment of the needs of rural households, through the reduction in agricultural land per household and the increase in the number of household members.

2.1.4. Decision-making: family composition and marriage of sons and daughters

TABLE 3: REPRODUCTIVE DECISION-MAKING

Who decides to have children	According to the women	According to the men
Both	50%	14,81%
The men	30%	77,77%
Women	20%	7,42%

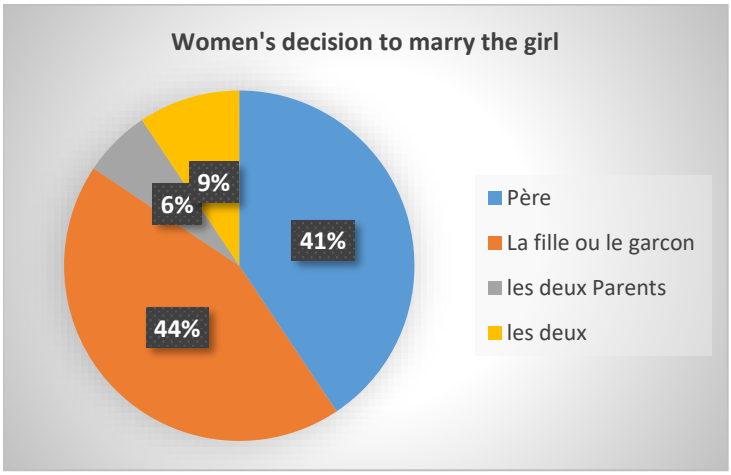
Women have a more favourable view of their participation in decision-making about their fertility, while 20% of them declare that they decide alone, men estimate that only 7.42% make this decision alone. 77.77% of men feel that they are the sole decision-makers and only 30% of women feel that men make decisions alone. Women report 50% joint decision making compared to 14.81% of men.

Women talk about negotiating for access to SRH services, and particularly for FP. This increases their perception of greater participation in decision-making. On the other hand, the low level of decision-making by single women (see table above) undoubtedly indicates a low capacity to access health services due to

women's relative financial autonomy or access to contraceptives without the knowledge of their husbands; *"if the husband refuses, the woman goes to the centre without his knowledge and can take the injection"* (Dan Kada women's focus group).

Table 3 shows a manifestation of male power with regard to the control of reproduction (77.77%) in contrast to the **view of women that this decision should be taken by both of them, hence the need for dialogue within the couple on sexual and reproductive issues**.

2.1.4.1. Early marriage



It is generally the father who decides on the marriage of the children. Girls and boys feel that they choose their spouse, although cases of forced marriage persist and are reported by girls (28.12% of the sample); the father decides to whom to give his daughter in marriage.

The young men also recognise the practice of giving them a choice of 3 to 4 girls from the community who are offered to them by their parents.

The young men believe that 61% of the decision is made by the girl's father; the mother intervenes in 6% of cases, both parents in 13%, and in only 19% of cases do the young people decide themselves.

Resistance from either the girl or the boy can lead in most cases to family conflicts and even the removal from the family home. Almost all women prefer and aspire to change with more choice of spouse left to the daughter, but 68% agree with the practice of leaving the choice to the parents, because "*these are the cultural norms and they have always existed*"; the same is true for young men (67%): *"Yes, this is my experience, my father made the choice for my two wives, I would like to impose on my children too".* (Dan Kada). Even younger men who are single find the practice normal, because it is the custom.

The average age at first marriage of girls is 13.09 and varies by site (reported by individual interviews) and the woman resides with her husband after marriage. According to the men and women consulted in the focus groups, the age of girls at first marriage is as follows:

- From 12 to 20 years for Dan Kada
- From 10 to 25 years old in Mai Janguéro
- From 13 to 18 years for Kaguirka
- And from 12 to 18 years old in Rafa

Mai Janguéro has the youngest daughter given in marriage (10 years old), and the oldest married girls and boys (first marriage 25 years for a boy, 20 years for a girl).

In view of the above, there is gender inequity and inequality and violation of human rights, especially the right to participation of young girls and boys. Indeed, the age of young men at first marriage is around 20 years and can be as late as 30 years:

- Dan Kada: 18 to 30 years old
- May Janguéro: from 18 to 30 years old
- Kaguirka: from 16 to 25 years old
- Rafa: from 18 to 25 years old for boys

Early marriage still persists everywhere; *"between the ages of 14 and 16, it is very common to marry girls in our community; but in Mai Janguéro, where the cost of marriage is rising because of the gold miners who have increased the amount of the dowry, girls stay in school longer because other young men have to work longer to accumulate the necessary amount of the dowry; many girls go to secondary school located less than 5 km away".* (Focus group Women of Dan Kada). Schooling is indeed a factor that has an effect on delaying the age of first marriage. But refusing to enrol the girl in school is an option that still exists and allows them to be married off even at the age of 10, as was always mentioned in Mai Janguéro.

Once in secondary school, some girls drop out themselves, choosing to marry like the others; they explain that they also drop out because of a lack of financial support for various school-related expenses that parents cannot afford; *"Some girls also choose to leave school because their friends have married and because they are afraid of becoming an old maid; there is currently a case here of a girl who stopped going to school because she prefers to get married"* (Rafa Women's Focus).

On the whole, young men and women marry fairly early, with girls marrying earlier than boys.

The increase in dowry for young men is a factor that discourages marriages. The decrease in dowry is socially used to encourage youth marriages, as in the survey test site (Bamo village). Early marriage is still very present in village communities. Sometimes schoolgirls marry and continue their studies. This is one of the alternatives found locally.

Polygamy

The focus groups reported fairly high levels of polygamy:

- In Mai Janguéro: 75% of households are polygamous; 50% with two wives, 20% with 3 wives and 5% with 4 wives.
- In Dan Kada: 60% with two wives, 5% have 3 wives and only 1, the village chief has 4.
- Rafa: 60% of households have 2 wives, 20% have 3 wives and 5% have 4 wives
- Kaguirka: 60% have 2 wives; only 3 men married to 3 women, and no households with 4 wives

"Monogamous households are headed by vulnerable men, if not a man who is comfortable must be able to take several wives in marriage"
(Focus Rafa, Dan Kada, and Mai Janguéro)

Cloistering[6] is practised in Rafa in the marabout district and to a lesser extent in Dan Kada by young people returning from Nigeria.

"A monogamous man at 35 is very vulnerable, i.e. he has not found the means to take a second wife; otherwise there are polygamists here aged 25 with 3 wives among the young migrants" (Focus group May Janguéro).

[6] Claustration, isolation of the wife in the marital home at the request or demand of the husband. This reduction in mobility means that she can only leave the house with the permission of her husband. The woman's situation is known in the community; men, including the woman's brothers, are forbidden to enter a house where the woman is cloistered.

About sixty years ago, the celebration of marriages was rational because they were organised by the head of the family who ensured that each member got his first marriage first. "In the last twenty years, polygamous households have become more numerous; young migrants were married to one or more women first. The women were taken care of, clothed and fed by the men and in return they worked a lot in the fields as family labour; this polygamy was also economic and the women were considered as companions for the worst *abukkan wahala.*" (Marthe Diarra, 2001).

The focus groups now report a high level of polygamy, with households with three and four wives on the increase compared to the 2000s. The number of wives is certainly a strategy for seeking to enlarge the family; it is also a strategy for strengthening the resilience of households with the arrival of new dynamic wives carrying out economic activities. These strategies are less promising economically, but socially more sustainable in the rural context and support existing strategies. **This multiplication of life and survival strategies indicates their precariousness and low effectiveness in the face of the many challenges of large households.**

The choice of spouse by parents, the marriage of young girls at an early age (15 years), and the increasing practice of polygamy are all socio-cultural obstacles to women's access to autonomy and SRHR in Maradi. The ability to make decisions for oneself and one's household is thus diminished. Respect for norms, for women, runs counter to the development of personal values related to decision making.

Power and persistence of the pro-natalist view

TABLE 4: SIZE OF HOUSEHOLDS SURVEYED

Village	Number of people in the household
Dan Kada	7
Kaguirka	6
May janguéro	9
Rafa	9
Overall average	**8**

The high number of children used to be in line with a rather extensive agricultural production system and allowed the clearing of large areas and the achievement of economic success and social value. This valorising vision of maximalist production still remains in the peasant logic, but the factors that contribute to its realisation are increasingly lacking (lack of agricultural land).

Social norms seem to change little, as having many children is still a perennial practice reinforced by social norms that are nowadays based on religion. However, studies had confirmed a trend towards a desire to control birth, on the part of young people[7]and particularly young women. This implies that the will to change exists at the level of some, who are younger and who seem to have little prospect with the dwindling agricultural land (parcelling out of land due to inheritance)

The use of contraceptive methods seems to be accepted[8] among young women and men, despite religious arguments against it. Mai Janguéro and Rafa have larger households and health centres. Kaguirka and Dan Kada have smaller households and do not even have a health centre. This is probably the effect of easier access to health care for women and children, which increases the number of healthy,

[7] Landless Women, Landless Women, 2006
[8] Findings from several IHCs and health huts on the use of contraceptives and the availability of oral contraceptives and condoms at the level of "pharmacies on the ground" and in rural markets.

living children. Contraceptives and FP animations do not seem to have had a direct effect on FP in terms of reducing the number of children per woman. Indeed, the lived realities, in terms of pressure on resources, and the actual care of parents by young people, are even more compelling.

Numerous constraints emerged from the focus groups and reflect what the communities are experiencing:

- Increasing pressure on natural resources
- Growing food insecurity
- Lack of drinking water resources
- The problem of unemployment, especially among young men
- The lack of financial means inhibits investment and aspirations for well-being and encourages men, young men and boys to migrate;
- Insufficient arable land forcing landless young men to migrate;
- The overload of the family, for example, a father with 30 children who does not even have an income of 500 francs a day to take care of their needs or even their education;
- Soil infertility, the crop pests that lead to crop failure;
- The remoteness of health centres, which prevents most pregnant women from using the maternal and child health service;

Generally, men and women see having four wives and many children as an asset, as it means better access to free family labour for farming, domestic work and earning money through economic activities (including migration as a household resilience strategy).

But the lack of agricultural land (a direct effect of population growth) and crops has led to a change in the number and quality of meals per day despite the strategies developed. The number of meals decreased (from three meals to two per day) during the lean season, with a predominance of porridge or diluted *foura*, *atchi a sharuwa* (sorrel prepared with groundnut cake) and the preparation of *tuwo* (sorghum paste meal, no longer millet paste). The arrival of new foods (such as rice, pasta) in the vulnerable households covered by this analysis was not reported. The men's focus groups also noted that "women and young children eat the least because they only eat at home. Men go out and eat something else". The direct consequence is the development of malnutrition for people with reduced mobility such as young married women and their children.

A new trend that contradicts social norms does not emerge as an option within households. **But some young people are taking a new view that reflects the awareness of the above-mentioned difficulties in their more favourable SRH behaviour. These young people experience an influence on the composition of their households from their parents.**

TABLE 5: NUMBER OF CHILDREN DESIRED IN FOCUS GROUPS

Villages	Young men	Older men	Young women	Older women
May Janguéro	10	14	8	10
Dan Kada	8	15	6	10
Rafa	10	20	14	17
Kaguirka	5	14	8	15

The desired number of children is still high in general. The standards do not seem to have changed, especially in Rafa, which has better structural living conditions. But the youngest children want fewer children in the other sites, which are relatively more vulnerable than Rafa.

The higher ideal number of children for men, and beyond the reproductive capacity of a single woman, is what drives them to have at least two wives:

- It is 9.02 for women; those who want more than 10 children are mostly over 35. About 60% of young women aspire to have smaller households;
- This average ideal number is 13 children for men: the same trend is observed among young men (over 60%) in the individual interviews.

It is important to note that the focus groups and questionnaires revealed a strong preference among parents for having boys, because it is the sons who go on the exodus to work and send the necessities to family members who have remained in the village.

Migration is for the majority the main alternative in this context of climate change where agricultural and pastoral activities are very precarious.

TABLE 6: SURVEY VIEWS ON THE MOST PROMISING OPPORTUNITIES FOR DEALING WITH THE CONSEQUENCES OF CLIMATE CHANGE

Opportunities seen as more promising	
Exodus	42%
Animals	8.3%
No agricultural opportunities: rains are not abundant	8.3%
No opportunity: Lack of water	8.3%
NGOs	8.3%
no opportunity	8.3%
Small business	8.3%
Available land for cultivation	8.3%
Grand total	**100%**

It would be important for another study to address the issue of SRH of migrants and the consequences upon their return (STDs, contagion of wives, reduced productivity, mortality of returning migrants, family and even community rejection).

In conclusion, it emerges that the ideal number of children is above the number of children per woman (total fertility rate of 7.6 children per woman (at the last population census). Indeed, at the national level, the EDNS 2012 mentions a diversity of behaviour with regard to reproduction: "We also note that the TFR shows very significant differences according to women's level of education, varying from 4.9 children, on average, per woman among those with secondary education or more to 8.0 children among those without education. Finally, there is also a significant gap between women living in households classified in the highest quintile and those whose households are classified in the lowest quintile (TFR of 6.1 versus 8.2). At the level of the communities covered by this study, this conclusion is partially confirmed. Age is beginning to be a variable that deserves a specific look at.

In Maradi region, the 2012 EDSN-MICS[9] also mentions that nearly 40% of the population is classified in the two lowest quintiles (18.3 and 19.9), with the better-off populations concentrated

[9] Multiple Indicator Cluster Survey 2012 (last survey conducted)

in urban areas. The same study reports that 75.8% of the female population of Maradi do not attend formal school and that 19.6% have an incomplete primary level, 1.4% with a complete primary level. The gender parity index at primary level is 0.71 and is the lowest in the country. This implies that the low level of girls' enrolment in this region does not work in favour of FP.

2.2. Social perception of SRH products and their use

From traditional to modern contraceptives, then back to traditional. The availability of products is satisfactory at the level of the health centres; this is explained by the low demand for contraceptive products; indeed the contraceptive prevalence rate is 12% (UNFPA, 2016). Product levels in the health centres are adequate and few stocks need to be replaced. The products most in demand are injectables, implants, oral contraceptives and condoms.

The focus groups revealed concerns about implants that move around in the body: *"I am afraid of implants, because they get lost in the body and you don't know where they are; then you have to travel to Maradi to have them removed. I prefer injectable products,"* said a woman from Dan Kada. This anecdote is plausible because of the lack of mastery of the technique by health workers: *"some workers did not know how to place the implants under the skin, but in the flesh"* (a health worker). **This implies that it is necessary to retrain the health workers in the health centres concerned by the project and to monitor the quality of the services provided by these health workers in order to satisfy the population and to ensure the active participation of women and men in going en masse to the health centres.**

The bleeding caused by injectable products was also mentioned during the interviews, causing great concern among users. **This is due to misinformation of women; capacity building of community relays (CR) in terms of awareness raising is necessary to target the different social groups present according to their needs.** It is important to have two CR per community, one man and one woman (preferably married and who have attended school). The consequence of these situations was to abandon the new use of modern contraceptives and return to traditional methods that had not been completely abandoned. Periodic use of the latter was mentioned in the Dan Kada focus groups during the rainy season when women have neither the time nor the means to go to the IHC (located 10km away). In addition, a more favourable perception of traditional contraceptives can still be observed, certainly due to the greater freedom of access to these products (amulets, herbal products, taken from marabouts and traditional practitioners). Indeed, one study reports that since contraception was not provided for, as it was necessary to take all the children that came along, women traditionally resorted to it without the husband's opinion. The arrival of modern contraceptives has introduced the need to seek the consent of the spouse, as these products are prescribed at the health centre. Access to the centre should be done with the husband's consent for the care of the various family members, including FP.

Oral contraceptives are less in demand because of the requirement to take the tablets daily and on time, the risk of missed doses is high and women prefer less restrictive contraceptives such as injectables which they find in health facilities. Oral contraceptives and condoms are also available in rural markets.

2.2.1. Women's social capacity to access SRH

In addition to the need to have the husband's permission for married women, other social pressures exerted by the community should be noted. Norms are strong and govern the behaviour of all, including leaders, men and women, including community or religious leaders, community relays, etc. The strength of norms requires the State to comply with them. The strength of the norms requires the State to comply with them.

2.2.1.1. Women's mobility and access to SRH services

Women in villages close to the health centres say that their access to SRH services does not change during the year; the young women of Dan Kada, on the other hand, feel that during the lean season access is less because of the cost of travelling to the Débi IHC, which is more than 10 km away: transport for prenatal, postnatal and FP consultations costs 600 francs (a little more than 1 dollar). A period of high demand for contraceptives is the month of Lent in order to be able to fast the whole month without menstruation.

During periods of agricultural work, agricultural investment and grain shortages and migrant returns with greater pressure on grain demand, health care is sacrificed for household food security. During the period of agricultural work, when women do not have time to go to the health centre, they use the traditional method or self-medication with oral contraceptives because they are available from drug dealers (street vendors, rural markets, etc.). Delivery is also done at home because of the distance from the health centre in Dan Kada and Kaguirka. Prenatal and post-natal consultations are less common.

Social, religious or other social constraints were not mentioned in the focus groups. Specific cultural barriers to accessing services do not exist once the husband's permission has been obtained, or the accompaniment by the mother for young girls or the mother-in-law for young married women has been acquired etc.

2.2.1.2. Barriers to accessing SRH

This study has identified several social, cultural, financial, logistical and attitudinal barriers - including power dynamics - to women's and men's access to SRH, including

- Women's time, financial availability and geographical accessibility affect attendance at reproductive health services and the use of contraceptive products; this explains the more frequent use of implants, which require less travel from the village to the health centre.
- The authorisation of the husband for married women, the authorisation of mothers or mothers-in-law who accompany their daughters and daughters-in-law are all barriers to access to SRH.
- Lack of progress on the average age at first marriage, which remains extremely low, especially for girls (15 years), and which increases the risk of early or unwanted pregnancy, and high fertility.
- The development and generalisation of polygamy, which is becoming a norm and not an option, exacerbating fertility competition between co-wives.
- The number of children desired, especially among men (from 10 to 25 children, even among community health workers), far above the current national average, which is already very high.
- The lack of lessons learned from land fragmentation, linked to fertility, but fertility is seen as a response through off-farm activities (such as migration), and the benefit of *bikis.*
- Begging as a social activity of the poor is no longer considered a shame, as are begging talibés as a source of income for the family.
- The failure of "modern" schooling, which is expensive and no longer leads to jobs, which in the long run constitutes a plea for traditional Koranic schools (following the marabout) and against formal schooling.
- The schooling of older girls is not progressing, or progressing very slowly, and is not a safe bet, even for them, in terms of marriage.

- The increasing restriction of women's mobility, especially young women, and the denial of the existence of sex trade to feed children.
- Widespread migration of young men, with increasingly uncertain economic results and aggravated risks, decapitalisation to finance it (sale of fields) compromising return, etc.
- The socialisation of women to their 'natural' gender inferiority, and thus submission to men (fathers, husbands, male relatives) and older women, always excludes them from the decisions that primarily concern them: their sexual life, their fertility, their economic mobility. It is not surprising then that women who are denied any value other than their fertility are not motivated to restrict the number of children they have and to run the risk of divorce.
- Technical and financial: treatment by providers, lack of training of providers, lack of transport costs and means, cost of health services for the mother,
- The personality of the health worker in terms of reception is important for the women and men we met. The competence of the health workers in providing quality care is an important criterion (misplaced implants). The health workers receive young men. Married girls and young women are always accompanied by their mothers, or mothers-in-law for those who are married. Similarly, the social relations maintained with the community relay facilitate access to information and products by men and women.

Recommendations

However, there are some hopeful signs. Young men and women want fewer children. **A positive approach should be put in place which advocates for "better children" (as opposed to “more children”)**: children educated, cared for, protected; school allowances, free health care, totally free contraception, whatever the method, provision of dispensers wherever possible (toilets in schools, markets, etc.). **To plead for "fewer children" would be inadmissible in the Niger context**.

In addition, there is a need to develop informed debates, with the right information, both religious and economic, on the costs and benefits of "many children" and on the notion of “better children”, etc.

The need for IEC/BCC programmes, incentives such as safe spaces for girls and teenagers, future husbands’ clubs for young boys to contribute to capturing the demographic dividend is explicit here.

3. The influences of social norms and behaviours on access to and use of SRG

According to the analysis of the data collected, there is very little change in social norms. The division of labour is stagnating in the sharing of tasks. The numerous reproductive tasks performed weigh heavily on women as the population increases. The use of child labour is carried out in accordance with the social division of labour. In young households where women are locked up and do not go out (Rafa and Dan Kada), a transfer of responsibility for water supply from the woman to the head of the household is noted. The acceptance of this situation by all is proof that this fact is not seen as a transgression of social values, but as a marginal fact. "*Yes, there is a novelty in the division of domestic tasks, like men fetching water for their wives. The community does not react because it is their choice"* (Focus group Dan Kada). This fact does not call into question the sharing of tasks, or rather the allocation of these tasks to women, which is explained by the men as a social norm that protects the rule assuming the supremacy of the man and determines household tasks, even those recognised as important by all, as degrading; *"the reason is based on the gender issue: men have always been superior to women and this is becoming a*

culture" (Focus group Dan Kada). The norm is not challenged by this behaviour, which is based on a religious interpretation and does not provoke any social reaction.

In terms of productive activities in Kaguirka, the young women mentioned a new activity that they are carrying out: *'Yes, there are exceptions, such as the women who cut down the tree. The community looks at them with both pity and admiration for their bravery"* (focus group woman from Kaguirka).

Women's access to a male economic domain does not worry the norms, and is perceived as a contribution to the household to the burdens of the household heads. The sharing of this responsibility for food security has begun, first with widowed or divorced women, and then with the wives of migrants. Women's migration is not cited as a new activity in the sites where it is observed. It is also accepted

The focus groups point out that the difference is that women carry out domestic activities and that the decision-making space belongs to men. Older men and women are in line with the stability of this norm, whereas young women have identified transgressions of norms relating to their level of submission and their capacity to decide:

- In Dan Kada: *"Women before were obedient and accepted everything their husbands said; today many women say yes and do otherwise. For example, when the husband decides against FP, she still goes to the centre and opts for the injectable product... We have seen cases where women have put the implant in and returned to remove it the next day under pressure from the husband who threatens to divorce the woman. It is better to use an injectable in this case".*
- In Rafa: The young women mentioned households where women decide: *"There are exceptions in the few cases of households where women decide. These women are frowned upon and the community does not appreciate them";* and at the same time the respondents propose a better involvement of women in decision making so that they do not feel left out because they are also heads of household.

These two very similar types of norm transgressions show that young women are seeking new directions in terms of social values. Women are engaging in decision-making despite being 'frowned upon' and are becoming role models for young women who aspire to do the same because they see themselves as heads of households, as they invest the areas of responsibility of 'headship' through their multiple contributions, in the absence of the migrating husband for example. This foreshadows the gender-biased consequences of women's increasing contributions to the household. Will the woman who is used to making decisions and managing her household alone give up this privilege automatically when her husband returns?

However, normative discourses remain intact in all groups and convey the absolute power of men to decide: *"Women are below men, it is normal that they decide for them from the religious and cultural point of view"* (Kaguirka men focus group). In Rafa the women say that *"the reason is religious because Islam advises women to obey their husbands, they are the decision-makers... The reason is that men are the heads of the family so it is normal that they should also make the decisions"*. The reason is that men are the heads of the family, so it is normal that the decisions are made by them as well". The women of Mai Janguéro add *"Yes, there is a difference between us and them, because it is the men who order and we women who execute"*. The situation is as if at the household level men decide on all decisions. **Women and men everywhere report a change in the way they consult each other. "***Women are increasingly consulted but their opinions are not always taken into account, even for the most important decisions"*. These more important decisions in which they participate include: child marriage, child education, health, prenatal consultations, FP, sale of livestock and house building.

Norms are threatened by practices, but in theory and discourse they remain unchanging and in a vision that is traditionalist and respectful of cultural and religious values.

3.1. Social perception and use of SRG

3.1.1. Standards governing the collection and use of SRH products

Traditional society had no norms for FP and the field was unregulated: "*We take the children that God gives us*". This message is still very present in the communities. However, women have always wanted to regulate births and used traditional methods without the advice of their husbands. They would go to the traditional practitioner or marabout to seek solutions adapted to their expectations in accordance with the norms governing this field. Indeed, standards of SRH practices govern the use of traditional and modern SRH products.

A mother and daughter cannot give birth at the same time; the mother has to rest and let her daughter or daughter-in-law take over: "*It is shameful to have a son who is the same age or younger than the grandson"*. A study in the Zinder region reports the same situation: "No woman wants to have children of the same age or younger than her grandchildren; this is a source of mockery from relatives, friends and neighbours. It is disrespectful to oneself to consider oneself of the same generation as one's daughter". This practice affirms the existence of a social duration of fertility or period of conception in which rural Hausa women often find themselves. This period does not begin at the menopause but well before, with the marriage of the daughter or eldest son with the arrival of the old age stage (mentioned above, which occurs at 35). The woman enters a social menopause at the first marriage of her son or daughter. This practice, combined with the need to have many children as a strategy for building household resilience, tends to reduce or maintain the inter-generational space, as it is necessary to have as many children as possible before the daughter or daughter-in-law begins her series. **Insufficient increase in the age at first marriage of girls may, in this case, promote higher fertility for the mother. Raising the age at first marriage beyond twenty, closer to the menopause, would result in fewer children for the woman**. This implies that the current measures with the current use of products will not be able to act on the fertility decline. The fertility rate of 7.6 children corresponds to marriage at the average age of 15 years (for mother and daughter) and 15 years for reproduction. If the age at first marriage is raised to 18, under the same conditions (for the mother and the daughter), this implies 18 years for reproduction and about 8 to 9 children per woman, and then the social menopause would occur later still during the woman's fertility period.

A breastfeeding woman should not carry a pregnancy; this reflects the concept of close pregnancies as defined in the communities surveyed. "*The perception of such a woman is negative: she has no time to care for her youngest child and others; her children are dirty, she herself is unclean and her house unkempt..."* Women's Focus group by Dan Kada. Multiple practices exist for weaning in the case of close pregnancies. Generally, a pregnant breastfeeding woman stops breastfeeding three months before giving birth, because from that moment onwards the milk (colostrum) is considered to be that of the foetus. Some women, however, stop breastfeeding as soon as they realise they are pregnant and others stop breastfeeding only after the birth.

One interviewer also reports that 'from a psychological point of view, *nasunya* (women who have pregnancies close together) are also subjected in a thinly veiled way to the mockery of their fellow women, who castigate them extensively. Thus, **popular semiology is full of expressions and proverbs stigmatising women who do not space their births.** This same local popular semiology covers several aspects of procreation. While some expressions glorify a large number of offspring, regardless of the conditions in which they are produced, others condemn procreation based on close pregnancies. The

spacing of births being successive births respecting the weaning period (17 months for boys and 18 months for girls). Generally, the inter-genital interval observed is about 2 years. Islam recommends breastfeeding for 22 months.

When a woman has had successive abortions or births of malformed children, custom dictates that she should stop gestating, take a period of rest and recuperation, usually at least a year, but not too long so as not to reach the social menopause

Pregnancies outside marriage are a tragedy for the woman and her family. "*Usually she cannot find a man to marry her because she is considered a sex worker"*.

Family planning is widely used to avoid pregnancy during the social menopause and while breastfeeding, and to avoid pregnancies outside marriage more and more. "*Traditionally, once a girl reaches puberty, it is her mother or grandmother who goes to the traditional practitioners to get a product to prevent the arrival of a child out of wedlock"* (Dan Kada leader). Today, mothers also accompany their daughters to the health centre for the same reason. It is difficult to estimate the proportion of mothers who do this, but the practice is reported in Kaguirka, Dan Kada and Mai Janguéro. These new behaviours and new users could lead to an increase in the demand for FP products in the health centres.

3.1.2. Categories of people, socially permitted and not permitted

The socially permissible categories of people are those who enjoy reproductive freedom which is acquired through marriage with, of course, marital permission to access reproductive health care. For these communities there is no reproduction outside marriage or in the absence of the husband. This representation clearly defines the category of those who have social permission to access reproductive health care. **As the care (prenatal consultations, postnatal consultations up to 5 years, contraceptives) is free, the costs are not a barrier for vulnerable households**.

In all the sites, the focus groups state that it is the man in majority who decides whether or not to go to the health centres to access any care. This decision is often linked to the ability to cover the costs of transport and the purchase of medicines if necessary.

Unmarried women, i.e. widows, divorcees and young girls are not allowed by norms to go to the health centre and have to do so in secret for fear of any kind of stigmatisation. But this norm is not always respected as discussed in the focus groups.

TABLE 7: RESPONDENTS' ASPIRATIONS

Aspirations of village respondents	Dan Kada	Kaguirka	May Jan Guéro	Rafa	Average
Learning about and going through puberty	0%	0%	0%	7%	2%
Learning about sex and having your first sexual encounter	8%	0%	0%	0%	2%
Learn how to avoid pregnancy and sexually transmitted diseases	0%	0%	0%	27%	7%
Starting to earn money	15%	14%	29%	33%	23%
becoming a head of household	8%	0%	0%	0%	2%
Being pregnant / having children	8%	43%	21%	13%	21%
Finishing school	15%	0%	0%	0%	4%
earn money	0%	14%	21%	0%	9%
Seeing your children get married	8%	7%	14%	7%	9%
The wedding	38%	21%	14%	13%	21%
Grand total	100%	100%	100%	100%	100%

Sexual relations are obviously hidden as an aspiration by almost all the respondents. Table 7 also shows the importance of marital issues such as marriage (Dan Kada), having children (Kaguirka) and earning money (Rafa).

Table 8 below shows that the onset of sexual relations among girls corresponds to the age at first marriage.

TABLE 8: AGE OF FIRST SEXUAL INTERCOURSE FOR GIRLS

Age group	Proportion of girls having their first sexual intercourse in each age group
15 à 16	50%
13 à 14	16%
16 à 17	13%
12 à 13	6%
17 à 18	3%
20 à 22	3%
10 à 11	3%
10 à 11	3%
14 à 15	3%
Grand total	**100%**

93% of respondents report using condoms for contraception against unwanted pregnancies and sexual diseases and 3% report using injectable contraceptives for young girls. 3% say they do not use any contraceptive method for unwanted pregnancies and sexual diseases.

TABLE 9: WAYS IN WHICH MEN, WOMEN, YOUNG MEN AND GIRLS AVOID PREGNANCY AND SEXUAL DISEASE

Men's responses	
here people do not use condoms for unwanted pregnancies	3%
Depo provera (injectable contraceptive)	3%
Condoms	94%
Grand total	**100%**

Qualitative data collected from women report that *"when the girl does not stay still, her mother can take her to the health centre for the injection, in order to avoid an unwanted pregnancy"* (focus women of Dan Kada).

TABLE 10: PLACES WHERE MEN, WOMEN, YOUNG MEN AND GIRLS CAN GET INFORMATION ON CONTRACEPTIVE METHODS AND PRODUCTS

Locations	%
Health Centre	55%
Radios	26%
at the community relays	10%
at the parents' home	3%
through awareness campaigns	3%
among health workers	3%
Grand total	**100%**

The health centre or health agents are the main information channels for accessing information on contraceptive methods and products. Community radios also play a role that is even more important than that of the community relays in the community.

TABLE 11: PLACES WHERE MEN AND WOMEN ACCESS SEXUAL AND REPRODUCTIVE HEALTH PRODUCTS

Locations	Where can they find these products?
At the market and access is very easy	16%
At the health centre	84%
Grand total	**100%**

A large majority of the men and women surveyed assume that access to SRH products is to be done through the health centre. The market is also an option that some describe as easier. Oral contraceptives and condoms are mainly available on the market. This supply channel deserves technical support to improve the quality of their service in terms of selling quality products - including conservation. Pharmacies cannot be found in the sites surveyed.

3.1.3. Decision-making on the use of SRH services and products

TABLE 12: DECISION-MAKING REGARDING THE USE OF MEASURES TO PREVENT PREGNANCY AND SEXUALLY TRANSMITTED DISEASES

Decision-making by men				
Village	**Woman**	**Male**	**both**	**Grand total**
Dan kada	14%	29%	57%	100%
Kaguir ka	0%	50%	50%	100%
Mai janguero	13%	63%	25%	100%
Rafa	0%	50%	50%	100%
Average	**6%**	**48%**	**45%**	**100%**

Public awareness of SRH services has led to a trend towards greater use of health centres by women and men. According to social norms, all decisions are supposed to be taken by men, including those concerning the use of FP, ANC and the attendance of health centres in general. The initiative or the need to go to the health centre always comes from the woman, but it is the man who decides and takes charge of the health-related costs; in his absence, the responsibility falls to the in-laws and, failing that, to community leaders. This situation reflects the violation of women's reproductive health rights despite the existence of texts and laws in favour of SRH (SRH law and its implementing decree, the constitution of the 7th^{ème}Republic, etc.), even though 45% of the interviewees think that the decision should be made by men and women**. This indicates the need to develop dialogue within the couple**.

TABLE 13: DECISION-MAKER TO GO TO A HEALTH CENTRE

Men	**Who makes the decisions to go to the health centre or not?**		
Village	**Men**	**both**	**Grand total**
Dan Kada	86%	14%	100%
Kaguirka	100%	0%	100%
Mai Janguero	88%	12%	100%
Rafa	100%	0%	100%
Average	**94%**	**6%**	**100%**

The in-laws (parents of the husband) play an important role in the decision-making process according to the young women's focus. *The man always takes the opinion of his parents before deciding* (Kaguirka). The women feel that it is their business and that they have a great deal of influence on decision-making because they are the first to be affected. Young men think that it is a couple's business and that the

decision is taken jointly with their wives. But older men and women, parents of the couples, influence these decisions a lot because it concerns them.

In conclusion, norms are threatened by practices, but in theory and in discourse they remain unchanged in a vision that wants to be traditionalist. A glimmer of hope is seen in the young people, who want to make the decision together. SRH is still seen as a family and religious matter, not entirely the exclusive decision of the couple; sexuality and reproduction are a matter of the social order, and the reproduction of that social order, not of direct actors such as the young man and woman, the husband and wife.

Fertility is the surest and shortest way to social recognition for girls. It opens the door to tontines, *bikis* and collective activities, especially in rural areas; **and older women are just as much guardians of the norms as men (their social fulfilment as mothers-in-law requires the submission of their daughters-in-law to the same constraints that they once faced).** And the prevailing virilocality cuts married daughters off from their mothers who might want them to have a different fate. The question of *agency* here is therefore to be put into perspective within family hierarchies, particularly among co-wives.

Recommendations

The entry through the collective is unavoidable. We should cultivate the provision of new examples, new models, successful alternatives, such as: smaller families whose children succeed and help their parents; daughters who help their elderly parents as well as their brothers; contraceptives being allowed to be delivered at the IHC to minors, to women without permission from the husband, and vice versa.

The support of religious leaders is essential. The approach should be collective through women's groups (MMD) and youth groups (fadas). Members of the husband's schools can work directly with the fadas. Young couples are also needed to develop dialogue and to value the joint decision; target young people with young messages, delivered by young people (peer to peer spirit). **Quality information, use of ICTs, mobile phones, video messages with WhatsApp chats could be developed and used for young women and men for learning beyond the norm.**

4. Factors facilitating access to SRH information, services and products

4.1. Enabling factors and opportunities

The concept of family planning or *houtou* (Hausa meaning rest, pause) is recent in the communities visited. But its practice is ancient through prolonged breastfeeding and other traditional practices to which women still resort: amulets, gris-gris (*kiri*), plant decoctions, Koranic writings (*rouboutou*). The fact that an old practice exists opens up the possibility of a new practice.

Regarding modern contraceptive methods, all men know of at least one contraceptive method, and women know of more than two methods (oral contraceptives, injectables and implants). Information on these contraceptives exists and is accessible to men and women through health centres and community relays; radio stations were also mentioned during the focus groups. Other modern channels are not mentioned (NICTs, mobile phones, Nollywood, etc.) which could help in the context of wider information.

4.1.1. Community agents/relays: roles and influences

The sample for this study includes 8 community relays (CRs), [10]4 of whom are women and 4 men.

TABLE 14: INFORMATION ON COMMUNITY RELAYS

N°	Age	Gender	Number of children	Number of children desired	Years of marriage	Age at marriage	Age of first child	Average spacing between children
A	42	M	6	25	27	15	13	2
B	38	M	8	20	18	20	16	1,8
C	43	M	5	10	25	18	20	2,8
D	43	M	11	25	21	22	18	1,6
E	27	F	3	6	9	18	8	3
F	23	F	3	6	15	8	8	2
G	27	F	3	8	10	17	9	2
H	24	F	2	8	9	15	4	2

The RC women surveyed are relatively young and want a lower number of children from 6 to 8 children close to the national average (lower than the average of Maradi) while **the male community relays want a high number of children ranging from 10 to 25 for reasons of strengthening household resilience and taking charge later. Therefore, the community relay does not constitute a specific FP model for young people who want to join FP**.

Inter-generational spacing under 2 years is noted among men, probably due to polygamy. Cases of children of the same age were noted in the questionnaires.

In terms of female behaviour, they wait until weaning (17 months for the boy and 18 months for the girl, according to the norms) to have another pregnancy. This explains the inter-generational intervals of two years on average. Weaning is traditionally the boundary between the non-conception and conception periods for married women.

TABLE 15: OPINIONS OF COMMUNITY RELAYS

N°	Age	Gender	Opinion on forced marriage	Years of marriage	Access PF information for young people	Should young people use contraceptives?
A	42	M	Favourable	27	At the IHC or health centre or school	No
B	38	M	Unfavourable	18	CSI and community relay	No
C	43	M	Unfavourable	25	CSI and community relay	No
D	43	M	Unfavourable	21	CSI and community relay	No
E	27	F	Unfavourable	9	Health centre, community radio relay	Yes implants and injectables for brides

[10] Community relays are volunteers from the communities who are responsible for supporting the IHCs in the promotion of essential and family practices; they carry out awareness-raising and follow-up (home visits) in the area of FP/RHSS at the local level.

N°	Age	Gender	Opinion on forced marriage	Years of marriage	Access PF information for young people	Should young people use contraceptives?
F	23	F	Unfavourable	15	Health centre	Yes if married
G	27	F	Favourable	10	Centre de santé relais	Yes if married
H	24	F	Unfavourable	9	Centre de santé relais	Yes if married

The majority are against early marriage. But all of them believe that only young married people have the right to information on contraceptives. Abstinence is the most recommended method for this category, according to social norms.

A reflection should be conducted on the redefinition of the roles of community relays and/or the definition of criteria for choosing community relays, integrating the adherence to the various services offered by health centres.

For other information concerning the mother's health, 10% of men receive it from community relays. Health centres are also the places where they find information.

TABLE 16: PLACES WHERE MEN CAN FIND INFORMATION ON WOMEN'S HEALTH DURING AND AFTER PREGNANCY

Village	Centre Health	at the parents' home	during awareness-raising events	Radio	RC	Grand total
Dan Kada	57%	14%	0%	29%	0%	100%
Kaguirka	75%	0%	0%	0%	25%	100%
May Janguéro	75%	0%	13%	13%	0%	100%
Rafa	63%	0%	0%	25%	13%	100%
Average	**68%**	**3%**	**3%**	**16%**	**10%**	**100%**

Proximity to health centres is a favourable factor for access to SRH services and products. Home deliveries are almost non-existent in communities with an IHC or health hut.

TABLE 17: MEN'S RESPONSE TO THE QUESTION "IN GENERAL, DO PEOPLE GO TO A HEALTH CENTRE FOR BIRTH?

Village	No	Yes	Grand total
Dan kada	14%	86%	100%
Kaguirka	0%	100%	100%
May Janguéro	0%	100%	100%
Rafa	0%	100%	100%
Average	**3%**	**97%**	**100%**

In Dan Kada and Kaguirka, which do not have a health centre, the people interviewed said that the health centres are regularly used for deliveries. At the focus group level, it was found that home deliveries still exist at these sites. The relays are working hard in this area and the practice is accepted by all.

26% of men prefer to have female health workers to serve their wives. But the vast majority are looking for quality care. Reception is probably satisfactory, as it is only mentioned as a wish by 19% of the sample.

TABLE 18: MEN'S RESPONSES TO THE QUESTION "WHAT DO MEN AND WOMEN LIKE ABOUT THE HEALTH CENTRES AND THE CARE THEY RECEIVE THERE?

Village	they give birth at home, because of the distance from the health centre	women like the assistance of a woman and not a man in the health centre	quality care	a good receptio n	Grand total
Dan Kada	0%	14%	57%	29%	100%
Kaguirka	13%	50%	25%	13%	100%
May Janguéro	0%	13%	63%	25%	100%
Rafa	0%	25%	63%	13%	100%
Average	**3%**	**26%**	**52%**	**19%**	**-**

TABLE 19: WOMEN'S RESPONSES TO THE QUESTION "WHO VISITS THE HEALTH CENTRES MOST? "

Village	both	women	Grand total
Dan kada	13%	88%	100%
Kaguir ka	13%	88%	100%
Mai janguero	25%	75%	100%
Rafa	43%	57%	100%
Average	**23%**	**77%**	**100%**

Women are the ones who frequent the health centres the most for SRH and even for all health care as accompanying adults for children. However, in Rafa, it was found that men accompany women more than in the other sites, probably because of the distance. It is important to check and ensure good CR coverage in the sites concerned

TABLE 20: WOMEN'S PRACTICES AFTER BIRTH

Women Village	NPC	ANC and postnatal	Matronly delivery	Exclusive breastfeeding	Grand total
Dan Kada	14%	0%	0%	86%	100%
Kaguirka	0%	0%	0%	100%	100%
Mai Janguero	0%	12%	13%	75%	100%
Rafa	0%	0%	0%	100%	100%
Average	**3%**	**3%**	**3%**	**90%**	**100%**

With regard to women's childbirth practices, exclusive breastfeeding is widely mentioned, by 90% of respondents. Other practices are not mentioned much, including good nutrition, which is linked to household resilience and is a central issue.

TABLE 21: SOURCES OF INFORMATION ON MENSTRUAL MANAGEMENT

Source	Proportion
health workers	3%
friends	13%
mothers	81%
the parents	3%

During puberty, mothers are the ones who teach their daughters about the changes in their bodies. Health workers do not intervene much in this area. For boys, friends are the source of information in this area. There is a need for more knowledge about SRH for men, women, girls and boys. The girls and

young women interviewed in this research said that it is their mothers who inform them about how to manage menstruation. They mostly use old pieces of cloth which are washed and reused regularly; four women mentioned sanitary towels (3 from Mai Janguéro and 1 from Rafa). In Dan Kada the use of sponge (like a tampon) was mentioned. Those who use pads use them alternately with pieces of loincloth because they are expensive, when they are available at the rural markets.

The term "menstruating" literally means "being *washed*". Women believe that *it is bad luck to throw blood into a loincloth that has not been washed first*. Washing a sanitary napkin is very plausible in this context and would be much less convenient than washing a piece of loincloth. But a preference for sanitary towels is noted. **Socially a girl who starts menstruating "must be married immediately" as she is ready for reproduction. This explains the practice of marriage from the age of 13. "***The rumour circulates in the village that such a girl has started menstruating"* (A woman from Rafa).

The community relay does not carry all these issues at the community level. In the framework of the ASPIRE project, a distribution for the transfer of these competences to other competent persons or structures is necessary.

Mothers (through MMD groups) are important targets for passing on SRH knowledge to girls. Similarly, Fadas and husbands' schools are also learning spaces for men.

4.2. Adverse factors and challenges

The distance from health centres does not facilitate access to services "*7 women gave birth at home last week. Often they give birth in the absence of their husbands who have left on migration*" (Kaguirga community relay). Wherever women are close to health centres, they give birth there

The mutual aid system built around naming and marriage ceremonies (Biki and Gara) encourages childbirth and marriage respectively to collect gifts and to receive food stocks, etc. Supporting household resilience through these practices is a reality.

Social menopause has negative effects on FP practice. After the first birth, the woman must have as many children as possible. Especially if the eldest child is a girl, she has only about 15 years to have the desired number of children (assuming that the eldest girl marries at 15). If the eldest is a boy, she has more time. This is one of the reasons why women start FP after the sixth or seventh child; it corresponds to the concept of "*hutu*" or rest put forward by the state discourse to promote the use of contraceptive products. "*One does not start using contraceptives when one does not have enough children. Those who manage to space their births naturally by breastfeeding do not need to use contraceptives; it is those who have pregnancies while breastfeeding who need to take contraceptives to avoid this shame. And this makes the breastfeeding child sick. These women have a duty to protect the health of the child by taking contraceptives until weaning*" (Focus group women of Dan Kada, Kaguika, Janguéro).

4.2.1. Information on contraceptive methods

Religious leaders, traditional practitioners are tacitly more supportive of the traditional methods that fall within their scope. Modern methods, confused with health care, are being accepted.

The results of this analysis suggest that attempts by the state to shift the age of marriage for girls are not the most effective and sustainable solutions, as they combine school attendance with marriage. The effects of high levels of education and information for girls and boys are more important in reducing the number of children per woman than raising the age at first marriage for girls. The successful use of contraceptives depends on their ability to break with norms in the pursuit of 'wellness'.

Recommendations

If the old obstacles remain, new ones have appeared, particularly with the rise (over the last twenty years) of a radicalised Islam interpreted and conveyed by people with little or no training, uncontrolled, and who maintain local or national patriarchal dynamics to the detriment of women and young people. This requires a global approach, a real commitment from the State and Islamic scholars, beyond that of development projects. The law on the schooling of girls and boys only concerns those who are in school.

Information to communities about the accessibility of SRH services and products and the availability of contraceptives has triggered their use by married women with the permission of their husbands. Other categories aspire to SRH products and use them in secret for fear of stigma. Access to services is limited by geographical distance and financial barrier for women.

More committed community relays will undoubtedly facilitate access to SRH products for all. Their basic training will have to be adapted to a policy that is also less restrictive.

Pro-RHSS preaching through the involvement of religious leaders in relation to household resilience and the responsibility of household heads will help to address remaining socio-religious fears.

Conclusion

Niger is far from approaching the demographic transition, and from reaping the benefits. For more than 20 years, the country has seen its population growth rate stagnate or even increase, to become the highest in the world. At the same time, Niger remains one of the poorest countries in the world. Fertility and poverty are closely correlated, and in Niger fertility remains the primary wealth of the poor, the primary source of social value for both men and women. It is the offspring, essentially male, which constitutes the life insurance, the large family, a universally recognised value.

This context maintains a "spiral of the worst" correlating numerous descendants, polygamy, early marriage of girls, a still limited school life expectancy for girls and still overwhelming female illiteracy, patriarchal and gerontocratic power dynamics reinforced by custom and religion - and even political systems - in the absence of convincing alternatives. It is difficult to believe that messages aimed at limiting births or facilitating access to quality contraceptives will be enough to reduce population growth, even though this was openly advocated by Niger as early as 1984; but since then, Niger has tripled its population (from 7 million to 21 million). The SRH approach is holistic (State through the Ministry of Health and the Ministry of Population, decentralised services, communes, etc.) and based on better communication by the State beyond the concept of birth spacing (*rouroutsa*) and rest (*houtou)*, the search for a better life and well-being for children.

Further studies to assess the level of poverty in large and small households are needed to provide more detailed information and data on the issue to better convince Nigerien households. Similarly, a better understanding of the relationship between men and women in communities and traditional contraceptives is needed. It will also serve to identify and better understand traditional contraceptives in their diversity.

However, there is a positive element regarding FP: a small proportion of young people who aspire to fewer children emerge in communities, and these cite better resilience as the reason.

The programmatic tracks identified in the next section summarise the proposals arising from this study for the implementation of the ASPIRE project.

Programmatic recommendations for ASPIRE

Areas	Main findings	Programmatic courses of action
Social cultural behavioural barriers	Rigidity of socio-cultural positions reinforced by rural poverty and the vulnerability of families to the lack of reliable opportunities that could justify a change in behaviour Blocking reactions to risks: Restricted mobility of young women for IGAs and including access to SRH services	Strengthening of actions in favour of the resilience of vulnerable families, in particular women's IGAs; creation of economic opportunities for young people (MMDs for girls and young women), with travel costs covered (motorbike taxi) if attendance at the ISC is essential.
	Still low decision-making capacity of young women and to a lesser extent young men // marriage and fertility: the interest of the large family takes precedence over that of the individual General valuation of fertility more than ever a refuge value in a context of widespread poverty	Organisation of informed debates on vulnerability - fertility, more children versus more children, family issues, local and national; supported by an active association of religious and opinion leaders
	Social perception of each of the SRH products and their use: distrust and stigmatisation persist, especially among men, due to the loss of control it entails, misinformation, unsuitable or poor quality products (pharmacy on the floor); Return to traditional products after bleeding observed with injections: professional deficiency of the CS in the SRH; insufficient consideration of traditional methods of contraception, often more effective in behaviour than in the products themselves. discouragement with misplaced implants: social acceptability was not sufficiently taken into account	Mobile SRH services with regular rounds in villages, at least for information; Continue education/awareness-raising work, particularly through women's groups (MMD) and youth fadas, Informed debates, videos, see national debate, national priority on fertility control (in national languages) Quality information, use of ICT, mobile phones, video messages with discussion; Entry by young couples with emphasis on joint decision making; targeting young people with young messages, delivered by young people (peer to peer spirit) Improved quality and control of SRH products and training of SC staff

Areas	Main findings	Programmatic courses of action
		Informed discussions with traditional practitioners and religious leaders: rehabilitating certain traditional practices by proposing improvements to the existing ones Diversify contraceptive supply and improve techniques and training
Power dynamics	Other social pressure from the community (community or religious leaders, etc. or relatives and friends): sensitive in the competition for the number of children and polygamy Demographic weight as a refuge for the poor, or a self-perpetuating cycle of vulnerability	Organise informed debates with the various categories of actors without stigmatisation; could we work on polygamy: agreement between co-wives rather than competition?
Financial barriers	No consideration of the cost-benefit of schooling for older girls, and also for older boys vs. migration, begging by talibés, leaving the girl in marriage No insurance - old age or accidents - other than the appeal to children - who must therefore be quite numerous Baptismal bikis are an important source of income for women and the gift-giving system encourages births	Advocacy for social aid: scholarships for schooling, work on insurance, social mutuals, etc. (see MMD) Reflection to be conducted with MMD women's groups, fadas and husband's schools on social capital, IGA financing
Technical & logistical barriers in SRH services	The geographical location of the health centre limits access by certain categories of people The distance from the health centre has an impact on the attendance of women and/or men: costs/availability of products, transport, time lost/waiting The personality of the health worker or community outreach worker: male or female, foreign or community, his or her position on SRH, his or her attitude towards young people;	National population policy advocacy Mobile, deconcentrated and decentralised services Open SRH issues in schools and colleges Training of health workers; More precise recruitment criteria: no pro-natalists recruited Training in welcoming and listening to young people
	Improbable quality of services, especially for the pause of implants at the level of health centres and lack of reliable information on	information and quality control

Areas	Main findings	Programmatic courses of action
	reversibility, side effects: mistrust created, source of rejection of products	Free and supportive follow-up of treated women
Social perception of the SRG	SRH is still seen as a family and religious matter, not entirely a decision of the couple - father and mother: sexuality, reproduction are a matter of the social order, and of the reproduction of this social order; not of direct actors such as the young man and the young woman, the husband and wife	Informed debates: taking the issues beyond the family circle: community, village and even region
Categories of authorised persons according to the standards	The norms have not changed much: the taboo of extramarital relationships remains absolute, especially for girls, but it is frowned upon for young men as well;	Do not stigmatize, work on the short, medium and long term, with realistic and motivating markers: schooling of girls, role of women in the community, sharing of parental responsibility or of the head of the family (cf. the Moudawana in Morocco),
Normal conditions or cases of use of SRH products	For girls, the obligatory passage to adulthood and respectability is motherhood; this recognition is desired as soon as possible. Early marriage goes hand in hand with early pregnancy: SRH is not used by couples to delay the first pregnancy, unless the future mother is still a child under the age of 12 Women must have proven their fertility and exhausted their fertility time capital before they have free access to FP: constraints of social menopause (15 to 30/35 years), competition between co-wives SRH products are widely used not to circumvent/transform social norms but to respect them and avoid shame: inter-genestial gap to be respected (breastfeeding duration), social menopause ...	Women's position (MMD) Religious leaders Reflection and discussion: what alternatives do women see?

Areas	Main findings	Programmatic courses of action
	Discretion and concealment sometimes with respect to the husband or old relatives - hence the preference for discreet products (injections) Pills complicated to use for illiterate people and not very discreet in case of bypassing husband's permission The unauthorised are unmarried young people, young women who have not reached their fertility quota (6-8 children or more) This proves that the decision-makers are not always the first ones concerned: the husband, the parents, the Imam have a strong influence on the couple's decision making, especially at a young age SRH products sometimes have a bad reputation: use of more socially accepted traditional methods, but problem of effectiveness?	Adaptation to the request, without forcing: listening and quality response Strong entry by young people: young men, young couples, older men and women, leaders, influencers
Information on accessibility	Familiar and accepted concept of *hutu* (rest) based on ancient and traditional practices rooted in cultures (abstinence, prolonged breastfeeding, stigmatized non-respect of inter-generational spaces, etc) Information on modern contraception circulated (everyone knows at least one product) but: quality of information?	Popularisation of the national population policy Dedicate the SRG, and demonstrate progress: talks, visits, education; even the possibility of involving schoolteachers and teachers, religious leaders, etc. Community preaching
Self-sufficiency in the SRH	Rising interest of young couples and demand for decision making by themselves and not by the family gerontocracy Girls' schooling levels improving, but strong competition from early marriage and the weight of the "social menopause Taking advantage of the new knowledge and behaviour of young migrants, their desire for comfort and a better life, in a context of the	Husband's schools integrating training of community relays but also importance of schooling for girls and boys, etc. Structuring of young girls with a training guide including the following themes: schooling, information on puberty, essential practices, FP,

Areas	Main findings	Programmatic courses of action
	break-up of the large family, urbanisation, and non-agricultural lifestyles The distance from the SRH centre is a major handicap, as is the loss of time, the poor quality of the reception and services provided in the health huts Existence of pharmacies on the ground in the markets. How to control the quality of products, how to associate them (often young people) Traditional contraception is preferred by men and religious leaders and traditional practitioners who maintain control; But the desired number of children remains very high, including among male community health workers, less so among women and young people	Establishment of MMD groups as a space for awareness raising, but also support for economic empowerment (better access to health centre) Involving and supporting pharmacies: supply support Support for more visibility of traditional contraception, for acceptance of modern contraception
Support for health centres	Technical training or refresher training for implants for health hut workers	Strong training in communication, listening and diversification of the offer according to the profile of the interested parties
Improving the environment for SRG	Taking into account the life plans and visions of young couples	Conduct specific local studies on: The number of children desired, the children actually born, the reasons for the discrepancies, etc.; report the results, share, discuss concretely.

In conclusion, the approach should include the following activities:

- Training and refresher courses for health workers on the use of implants
- Training of health workers to welcome and listen to young people, both men and women, and young couples, to combat their ignorance of SRH
- Training of community relays in awareness-raising on appropriate themes (better coverage per site)
- Strengthen the approach with the use of fairground outings (deconcentrated technical services) and activities/safe spaces
- Capacity building of SRH structures of husbands' schools, MMD groups, peer educators (girls and boys).
- Working with innovation platforms as a gateway
- Work with religious leaders by doing preaching on polygamy, biki, PF resilience and head of household responsibility, etc.
- Use community radios; open debates to telephone calls from listeners
- Capitalising on the experiences of projects such as; Imagine (focus on influencers.)
- The use of ICTs is important with the arrival of mobile phones in the village. Messages: video and audio WhatsApp, mini-series made by/with youth, on SRH issues; popularise examples of other Muslim countries that do not have 8 children per woman (like Morocco, and even Saudi Arabia) etc.
- Participatory monitoring of certain constraints such as effective birth spacing
- Study on modern contraception: social perceptions, strengths and weaknesses
- Undertake activities that support household resilience in line with respondents' aspirations
- Information on family and intensive farming with RECA including irrigated farming (cereals)
- Farming as a basis for nutritional security (mothers and children)
- Education being perceived as a determining factor, the establishment of literacy and education centres for young women and men is necessary (SMS and better use of mobile phones)
- Clean water to improve hygiene and sanitation
- Breeding of small ruminants and poultry under the supervision of the health committee and the livestock committee to make it sustainable (nutritional and economic security)
- IGA training for women
- Study on the resilience of large and small households in the project area

Bibliography

Bejing + 5, "*Women in Decision-Making*", Gender Equality, Development and Peace for the 21st Century^{ème}, Fact Sheet Number 7, New York, 2000

ECOWAS and UNFPA, Regional Consultations with Religious Denominations on SRH and the Demographic Dividend, October 2015

Diarra Marthe Long-term changes in social and economic organisation (gender relations) in the Maradi region, Dry Lands Research / University of Cambridge - Working Paper 26; Niger - Nigeria series; June 2001

Diarra Marthe, "*Gender analysis with mainstreaming of cross-cutting protection-ACF*", in the regions of Maradi and Tahoua (Niger) 2020

Diarra Marthe, Monimart Marie, *Etude genre et adaptation à base communautaire en région de Maradi* (Dakoro), Care international, July 2014),

Diarra Marthe and Monimart Marie, *Femmes sans terres, femmes sans repères* in Zones Arides Bulletin IIED, dossier n° 143, November 2006

Diarra Marthe, Madougou D and Diouf A, *Food crises, gender and resilience in the Sahel: Lessons learned from the 2012 crisis in Burkina Faso, Mali and Niger*, in Oxfam Research Report, June 2014

INS-Niger, *Thematic report on "Natality and Fertility" of the fourth (4th) general population and housing census (RGP/H) 2012*, 81 p. 2015

INS-Niger, *Rapport final de l'Enquête démographique et de santé et à indicateurs multiples du Niger* (EDS-MICS, III), 465p; 2006.

INS-Niger, *Final Report of the Niger Demographic and Health Survey with Multiple Indicators* (EDS-MICS, IV), 486p, 2012.

IPPF, *Sexual and reproductive health and rights: the key to gender equality and women's empowerment*, *vision 2020*

Kabeer, Naila. *Resources, Agency, Achievements: Reflections on the Measurement of women's Empowerment. Development and Change* 30: 435-64, 1999.

Masquelier Adeline, Jane Owens and Marthe Diarra, *About men and women on social norms in Niger*, World Bank, June 2014.

Moulaye Hassane, *Study on vulnerability and resilience factors of communities to Boko Haram in Diffa*, Mercy Corps, 2017

NICOLAS Guy, DOUMESCHE Hubert, DAN MOUCHE Maman, *socio-economic study of two Hausa villages: survey in view of a hydro-agricultural development, Maradi valley, Niger,* IFAN NIGER, CNRS PARIS, Etudes Nigériennes n °22, 257 pages + annexes 35 pages

UN Women, *Islamic Case for the Promotion of Women's and Children's Rights in Niger*, 30 pages, 2011.

Save the Children, *Ending Child Marriage in West Africa: Improving Policy Implementation and the Budgeting Process, Focus on Sierra Leone and Niger*, 2020,

TANGO, "*Final evaluation of the Rise II project activities on household resilience in relation to the advent of the COVID-19 pandemic", in Maradi, Tillabéri and Zinder regions* (Niger), 2020.

Annex - Gender Analysis Framework

AREAS OF INQUIRY	AGENCY	STRUCTURE	RELATIONSHIPS
Division of labour	• Freedom of decision in relation to work • Time available beyond work (time poverty)	• Roles: Productive / Reproductive, community work • Working conditions and remuneration	
Household decision making	• Ability to make decisions for self, family, household • Personal values related to decision making	• Standards in decision making • External policies or doctrines that impose power over decision-making for different groups	• Dynamics of negotiation and influence • Cooperative decision making
Control over assets	• Self-confidence and negotiating power • Control over assets	• Access to work, livelihood • Distribution of resources: assets, income and distribution of material aid. • Standards and laws surrounding paid work and inheritance rights	• Decision-making dynamics at the household level • Negotiation dynamics around paid work
Access to services and public spaces	• Mobility related to control of one's body and relationships	• Access to health and hygiene (SRHR, WASH, health, psychosocial support) • Access to housing • Access to education	• Mutual aid and collective support/care
Participation in public decision-making	• Voice and leadership in initiatives and services, by different groups, ages and genders.	• Decisions and budget in services and initiatives, including various groups impacted by emergencies/crisis	• Solidarity networks among those impacted by emergencies/crises claim their interests, positions and needs
Control of the body and relationships	• Knowledge and capacity to absorb and anticipate shocks, adapt and transform risk factors • **Freedom of decision in relation to the SRG** • **Power to decide if/when/whom to marry and the conditions of the marriage** • Knowledge of reproductive health and rights	• **Ideas about what it means to be "a woman" or "a man** • Freedom to stay, freedom to travel, freedom to return (mobility, travel and right to return) • Family and refugee laws • **Dynamics of if and when to have children** • **Quality and accessible health services**	• **Marriage practices (early or forced marriage, polygamy, patriarchy)** • **Wedding transaction: bride price, dowry** • Forced conscription
Gender-based violence	• Freedom of decision for survivors after harm • Accountability of perpetrators of violence	• Survivor-centred responses and support • Norms, conditions and laws that perpetuate harm (oppression, norms, harmful practices) that perpetuate harm • Mortality rates by gender/group identity and causes	• Partner and domestic violence, including genital mutilation • Community relations and empowerment to avoid, stop and respond to violence • Violence in public spaces
Aspirations and self-esteem	• Insurance • Vacuum cleaners • Emotional well-being • Knowledge and skills	• Social norms and statuses that bind or isolate certain people, or elevate or despise certain people	• Emotional and social support

AREAS OF INQUIRY	AGENCY	STRUCTURE	RELATIONSHIPS
	• Experiences		

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