



**Niger Family Planning Demand Analysis:
Qualitative Research Brief**
February 21, 2014

Executive Summary

Project Overview

Camber Collective (then Hope Consulting) was engaged by the William & Flora Hewlett Foundation to develop a national demand analysis for family planning in Niger. The demand analysis was designed to:

- Provide a baseline understanding of family planning dynamics in Niger that can be used by any family planning partner (government, donor, or NGO) to inform its strategy and programming
- Identify the most significant opportunities—related to demand for and supply of contraceptives—to drive an increase in women’s modern contraceptive use in Niger
- Describe how the stakeholders to this project and their implementing partners might adjust their grant-making and programming in Niger to address these opportunities

This project’s stakeholders include the Hewlett Foundation, the Bill & Melinda Gates Foundation, the US Agency for International Development (USAID), and the Nigerien Ministry of Health, as well as these stakeholders’ implementing partners, including EngenderHealth, Pathfinder International, Population Services International (MSI), and Marie Stopes International (MSI).

The national demand analysis will be developed in three phases, from September 2013 to July 2014: phase 1, qualitative customer research; phase 2, quantitative customer research (nationwide survey of women age 15 – 49, segmentation of women according to their willingness to use modern contraceptives); and phase 3, analysis of supply-related barriers to use and strategy development.

This document synthesizes the project’s first phase of work. The objectives of Phase 1 were to identify dynamics or inputs to test in the national survey in Phase 2, and to identify strategic communications concepts that family planning actors in Niger can translate into communications campaigns or educational materials. The knowledge created in this phase can also be used by family planning actors in Niger to inform the design of family planning programs, or family planning funding decisions. Phase 1 included background research (literature review and commentator interview) and primary qualitative research (focus groups and healthcare provider observation and interview).

Background Research

The background research was intended to guide the primary research, by shedding light on topics that could be explored further in Niger or that did not need to be explored further because a definitive view on those topics already existed. We structured the background research around modern and traditional

contraceptive use, and any issues with use; determinants of modern contraceptive use; and segments of women most willing to use modern contraceptives.

In the course of the background research, we found that very little information on **modern and traditional method use**, in Niger or in West Africa more broadly. Nigerien women appear to take steps to regulate their fertility, as Niger's total fertility rate (TFR) of 7.6 is roughly half the theoretical maximum of 15 children per woman.¹ While 11% of women report using a modern contraceptive method,² a TFR of greater than 7.3 appears to be inconsistent with modern contraceptive use.³ In other words, there is a strong possibility that modern method use is ineffective.

However, there is very little literature on how women use modern and traditional methods in Niger, what issues women might have with these methods, or where opportunities to increase women's use of effective contraceptive methods might exist. This information is typically needed to develop strong family planning programs; it provides any implementing organizations with a strong understanding of the behavior they are trying to change.

The background research did indicate several possible **determinants of modern contraceptive use**. Understanding determinants of use is important, as determinants of use provide an initial indication of where programmatic resources can be targeted to best drive change.

We split determinants of use into three categories: i) barriers to use, or discrete factors that limit use today and that can be lifted; ii) influences on use, or factors that influence one's reproductive health and contraceptive use without being a direct obstacle to it; and iii) factors associated with use. Factors associated with use cannot be changed through family planning programming, but they can be used to target women who are likely to use contraceptives or may do so already.

Likely *barriers to use* include method availability, medical barriers (especially the quality of interaction with healthcare providers), and side effects represent important barriers to use today. Geography may be a significant barrier to care, but the data from Niger is mixed.

Possible *influences on use* included religion, the desire to maintain one's own (reproductive) freedom, and husband's approval. Other influences on use that might be important include Nigeriens' sense of time, expectations around child mortality, lack of privacy, the need for children as a workforce, lack of value attached to education, especially for women, and limited sense of personal agency.

Relying primarily on Niger's 2012 DHS, *factors associated with use* included age, education, geography, marital status, number of children, socioeconomic status, and potentially husband's education, the woman's labor force participation, and rainfall.

¹ Frank. 1987.

² République du Niger, ICF International. 2012.

³ Curtis and Diamond. 1995; Macro DHS. 2000.

Finally, the background research sought to discover establish whether strong **segmentations** of women based on their willingness to use modern contraceptives existed and could be used to inform the planned segmentation in Niger.

Segmentation indicates the segments, or groups, in a population that are most likely to change their behavior, and what they require in terms of programs, products, or services in order to adopt behavior change. Segmentations are an invaluable tool in resource-constrained settings, because they enable organizations to target only those that are likely to change their behavior, and to offer only those products, services, or messages that are likely to drive behavior change.

We did not find any examples of robust segmentations in reproductive health. As a result, we did not come into the primary research with a baseline segmentation to test or refine in Niger.

In sum, the background research indicated several gaps in knowledge about family planning and reproductive health in Niger, which we planned to explore further in the primary research. These gaps in knowledge included:

- A better understanding of traditional and modern contraceptive use
- Reasons for use of modern contraceptives being very low in Niger
- Relative importance of different factors in driving the use decision, to inform an initial view of segmentation parameters that might be the most important in Niger

Primary Qualitative Research

The primary qualitative research sought to generate observations and insights about how men and women think about family planning and issues related to it in Niger. Similar to the background research, the primary qualitative research was structured around child spacing, family planning, and ideal family size; how traditional and modern contraceptives are used, and any issues with use; and determinants of use, including barriers, influences on use, and factors associated with use.

The primary qualitative research was run in November 2013. Focus groups and healthcare provider interview and observation were done in and around Niamey, Zinder, and Tahoua (travel more than an hour from each city was not possible due to security concerns). There were 18 focus groups, 13 of which women and 5 of which men, married and unmarried, ranging in age from 15 to 35+. There were 21 healthcare provider interviews, and 84 family planning consultations observed.

General Learnings

In the qualitative, we learned that **child spacing** is widely practiced and accepted in Niger. It is an indigenous practice, consistent with existing religious and cultural mores. Spacing was overwhelmingly practiced to allow mothers to rest between births. **Family planning** was seen as a foreign concept, but not necessarily a negative one. Family planning was primarily considered to be the same as child spacing, but in some cases, family planning was considered to be effective household management.

Most men and women provided a range of the **ideal number of children** that they wanted, with women typically wanting fewer children than men, and young women wanting fewer children than older women. Some people refused to cite a number of children desired, as they saw this as contradicting the will of Allah. All participants said that, ultimately, the number of children they had was up to Allah.

However, some participants introduced a nuance: they said that if God wanted them to have children, they would become pregnant or impregnate their wives even if the wife used modern contraceptives. This provided one way to use modern contraceptives while allowing the will of Allah to prevail. Other participants argued that Allah says that one must be able to care for the children that one has. This introduced a window of opportunity for couples to proactively manage their fertility in order to have fewer children, again without contradicting the will of Allah.

With a very few exceptions, there was little hostility to **modern contraceptive use**. Women did perceive some methods to be inappropriate for them, including the condom and the female condom (both not appropriate for married couples), tubal ligation, and abortion. Men were more likely to be opposed to modern contraceptive use than were women.

Women's **fear of side effects** was the leading reason that women reported not wanting to use modern contraceptives or discontinuing use. The side effects feared were a mix of established biomedical side effects, side effects that may occur due to incorrect use, or fears based on a lack of understanding of a woman's reproductive health system (i.e., an IUD may float away into the abdomen).

In addition, men and women were very focused on the conflict that they perceived between modern method use and Islam's teachings. This finding suggests that there is an opportunity to provide an alternate narrative that would enable men and women to reconcile modern method use with Islam's teachings. Islam is often interpreted to support family planning and does not prohibit the use of modern contraceptives—but focus group participants were largely unaware of this interpretation.

Traditional contraceptive methods were never discussed in formal healthcare settings, but were a prominent feature in most women's fertility management. Women use a wide range of traditional methods in birth spacing, including abstinence, withdrawal, traditional drinks, and amulets (*gris gris*). Traditional methods appear to be used when better options are not available, not because traditional methods are seen as particularly effective.

Traditional methods for abortion are widely used, as abortion is illegal in Niger but fairly common, according to focus group participants. Participants were very engaged in discussion of traditional abortion methods, as traditional approaches to ending pregnancy typically did not work and women did not have access to safe, effective abortifacients. Women were also more supportive of abortion than were healthcare providers, who were overwhelmingly opposed to abortion on moral grounds or for health reasons (abortion is illegal in Niger, and therefore dangerous).

Determinants of Modern Contraceptive Use

The **barriers to use** that focus group participants reported were not strikingly different from those identified in the background research. They included the limited number of methods available, and women's preconceptions about which methods were appropriate to their circumstance; medical barriers, and specifically formal care criteria (abortion is not legal in Niger), healthcare provider bias, healthcare provider motivation or lack thereof, and content covered in counseling sessions; modern contraceptives' perceived side effects; lack of fertility awareness; and lack of contraceptive knowledge.

Influences on use weighed heavily on the use decision, for women and for men. Religion appears to be the most important influence on modern contraceptive use today. Islam was interpreted by a large portion of focus group participants to not support modern contraceptive use. Therefore, contraceptive use was rationalized, forgiveness for using contraceptives was requested from God, or contraceptive use was hidden from those who might judge a woman for her use decision, including her husband. Other influences on use included:

- The desire to maintain control over one's own reproduction, or that of one's spouse. In some cases, we believed that women cited religious or spousal objections to use when in fact the objection was the woman's own, to using a product she did not understand and did not trust.
- The woman's husband or boyfriend. While not as subservient as we anticipated coming into the field research, women were counseled, guided, or controlled by their partners. This power dynamic is important, because men were both more knowledgeable about modern contraceptives and more opposed to their use than were women.
- The lack of economic opportunity in Niger and the cultural expectation that women should get married and have children. Many young, unmarried women idealized family and children, and saw little reason to interrupt their progress towards this vision by using modern contraceptives. Those who were willing to use contraceptives had specific education or professional goals.
- Woman's sense of personal agency. The greater the personal agency, the more likely women seemed to be to use modern contraceptives, all other things equal.

The **factors associated with use** were consistent with what was found in Niger's DHS 2012. The primary field research offered some color around these factors. Marital status appeared to influence contraceptive use, as unmarried women and girls had more difficulty accessing care and were more conflicted about sex than were married women. This made unmarried women and girls less likely to use contraceptives than married women and girls. Women with at least one child were strikingly more likely to use modern contraceptives than women without children, and women with 3 – 4 children appeared still more likely to use modern contraceptives, as they were tired by childbearing and child-raising. Age seemed to influence contraceptive use, with women under age 30 (roughly) being more likely to use modern contraceptives.

Surprising Findings

The primary qualitative research in Niger accomplished exactly what it was supposed to, in terms of surfacing insights to inform the framing of family planning and identifying family planning dynamics to test in the nationwide survey in Phase 2. However, a set of findings struck us as surprising or counterintuitive, and we wanted to share them here.

- Premarital sex appeared to be more common than we would have expected. Girls left school relatively often to get married, sometimes because they were pregnant, and boys and girls talked about having sex. However, girls often said that other girls had sex not because they wanted to, but because boys had put a spell on them. It was not clear whether boys forced girls to have non-consensual sex, or whether girls were embarrassed to have consensual sex and used black magic to explain it.
- The consequences of unwanted, premarital pregnancy were severe—social sanction, which could result in girls taking drastic measures to end their pregnancies and/or kill their newborn child. However, most girls did not express a strong desire to use contraceptives, potentially because contraceptive use is a conscious admission of having sex while risk of unwanted pregnancy is uncertain. Programs targeting unmarried adolescents will likely need to address girls’ feelings of conflict about sex in order to create an environment in which girls feel more comfortable using contraceptives.
- A few women mentioned their desire to use modern contraceptives immediately after marriage, to see if the marriage would last before having children. There may be opportunity for a campaign to “take your hubby for a test drive,” or some other tongue-in-cheek play on the uncertainty of some new marriages.
- Women began to space births after the birth of their first child, not after they had already had a few children. Several women said that they “could not get to the health center fast enough” to pick up a modern contraceptive. Contrary to what we believed coming into the qualitative – that women would need to be persuaded to begin to space after the birth of their first child – women appeared ready to do so.
- Women expressed many fears of side effects of modern contraceptives, but they generally did not reject modern contraceptive use directly, as we would have expected. They were even favorably predisposed towards methods that they believed to have negative side effects: although they believed Depo Provera could cause break-through bleeding or infertility, women still saw it as “my friend for life,” “my shield,” a cement house in town, a sedan, or an airplane, rich and aspirational.
- Divorce rates are reportedly relatively high (participants reported many women having 2 – 3 marriages in their lifetimes), and women lose custody of their children at ~age 7 to the children’s father. This creates a dynamic in which women who divorce will start their families over, often

having fewer children than in previous marriages but children nevertheless. This dynamic leads to a status quo of more women per children.

- Focus group participants were surprised to learn that women in Niger have more children than anywhere else in the world. Most participants had relatively few sources of information from outside Niger. They appeared somewhat discomfited by the knowledge that they were not in line with other countries, especially other countries in the Sahel, in terms of fertility levels.
- Women were not as subservient to their husbands or partners as we anticipated coming into the primary qualitative research. While men consistently reported being the decision-makers in their families, many women took the action that they wanted to take, whether that action was seeking out modern contraceptives or participating in a focus group without her husband's consent.

Emerging Observations

The primary qualitative research has led us to an initial perspective about opportunities to increase contraceptive use in Niger.

1. Contraceptive use can be increased to some degree by lowering key barriers to use. On the supply side, key barriers to address appear to include method availability, counseling quality, and potentially geographic proximity to points of care. On the demand side, key barriers appear to be low fertility awareness and low contraceptive knowledge, both of which drive fear of side effects.
2. These barriers are likely best addressed by a mix of infrastructure-strengthening and quality-improving activities. It is tempting to focus on infrastructure-strengthening activities with tangible inputs and outputs (i.e., increasing the number of points of care). However, critical barriers to use—like poor counseling quality and lower user knowledge of reproductive health and contraceptives—cannot be addressed through infrastructure-strengthening activities alone.
3. Addressing barriers to use alone will not achieve the Government's desired increase in contraceptive use. A sub-set of Nigerien women will increase modern contraceptive use if barriers to use are addressed—for example, if points of care are brought closer to their homes or if healthcare providers are trained to offer higher quality family planning counseling. However, our current view is that many Nigerien women have a conflict with modern contraceptive use that artificially depresses use. Contraceptive use will not increase as much as it could until key conflicts (religion, reproductive freedom, spousal disagreement about use, or social prohibitions against premarital sex) are addressed. This project's segmentation will indicate how important these issues are, and to which segments of Nigerien women.
4. To drive use, intelligent communications strategies will need to enable Nigerien women to use contraceptives within their existing belief and value systems. Communications should encourage a shift towards agency or taking action within Islam's parameters. Thriving, alleviating burden, or

discerning the will of Allah for one's self can be trialed as concepts underlying communications collateral or education materials.

5. Driving change will be hard, because family in Niger is defined as a large and vibrant family. This view of family is central to life in Niger, reinforced by religion, culture, and economy. As a result, while some people express a desire for smaller families than in the past, Nigeriens still default to larger family size at almost every point at which a decision about family size is made.
6. However, there is strong evidence of “narrative instability” in Niger, or shifting thinking about long-standing cultural norms. There was increasing openness to girls attending school (longer), marrying later, having children later, and having smaller families than in the past. These suggest an opportunity to introduce a new cultural narrative or narratives in Niger, as existing narratives are shifting and have not yet settled into a “new normal.” These narratives can frame family planning in a manner that is acceptable to Nigeriens, or to sub-segments of Nigeriens who are ready to manage their fertility more pro-actively and/or use modern contraceptives.

Strategic Communications Concepts

One of the two objectives of this project's first phase was to develop strategic communications concepts that can be used to engage and influence target audiences. We share these concepts here. They can be used in any type of communication, from 1:1 family planning counseling to mass communications.

These concepts do not stand alone. They should be translated into creative messaging and piloted with target populations before wide-scale roll-out. In addition, family planning actors may want to wait until we have developed the segmentation of women according to their willingness to use contraceptives in Phase 2, and then refine these concepts to more effectively influence high-priority segments.

Communications Themes. These themes represent areas for further development in messaging, marketing, product and program development. These appear to have the most potential for engaging people in ways that they really think, feel, and live, while inviting them to evolve and expand their narrative around family planning:

- Thriving and Organized. For every Nigerien mother and child, the first challenge is thriving, or “growing up,” which is to make it past the first 40 days of life and then to the 2 year mark. In adult life, the concept of being organized is closely related to thriving insofar as it creates the conditions to thrive: food, shelter, healthcare, and education. We suggest that expanding the definition of thriving to these hallmarks of adult maturity. Done well, themes around thriving and organization (“being on top of it”) will not contradict Islam and may even leverage it.
- Responsibility and Contribution. This theme focuses on making conscious choices to maximize and extend the contribution of each person. It is not about quantity of people required to live well,

but the quality of each person’s contribution to living well. With a responsibility/contribution theme, parents can become responsible for providing more than subsistence care and minimal education to their children. They can aspire to provide longer and better education, more personal presence, an emotional life, and a sense of choice and plans for the future to their children.

- Longer Spacing and a Shorter Childbearing Timeframe. Children and family are central to Nigeriens’ lives. Choosing to not have children, radically limit the number of children one has, or cease having children as a lifestyle choice is a non-starter. However, it is possible that rising health expectations and a liberal interpretation of Islam (either officially or at the grassroots) may add time between births. In addition, women may choose to make a health-based argument to stop having children at a particular pre-menopausal age. Having a shorter timeframe in which to bear children and longer spacing between children seems like a reasonable goal, and it plants the cultural seeds for greater change.
- Stronger Family and Community. Closely related to thriving and adjusting the timeframe for birth is the idea of building stronger families and community. Historically, a child – any child – could help to provide manual labor in agriculture or around the homestead. Today, more families appear to seek children with specific capabilities. There are benefits to having a French speaker in the family, someone with knowledge of Nigerien bureaucracy, or someone with aptitude as an entrepreneur. Perhaps three capable, thriving adult children are a greater asset than eight children of lesser knowledge and skill. Supported by policies and programs to increase children’s likelihood of success, messaging around this theme become a persuasive argument for smaller but more prosperous families.
- Partnership with Allah. Allah stands alone as a god defined by sovereignty. The Western god is omnipotent, but Islam translates literally as “submission.” Islam has what is known in academic religious studies as a low theological anthropology, which is to say a huge difference and distance between Allah and humanity, and very little power or independence for humanity. However, Allah does expect humanity to use its reason and free will to discern and act upon the best path forward in specific circumstances even as it walks in a life determined by Allah. By framing change in terms of partnering with Allah, conflict between modern and traditional agendas can be diffused.
- Living Islam. Religious and political traditions can ossify, grow reactionary, and become belligerent as they feel threatened by rapid change and creative forces more powerful than themselves. Soviet communism and Christian and Islamic fundamentalist extremism are good examples of this phenomenon. However, a thriving tradition is a *living* tradition. In Islam, there is room for a variety of voices and opinions about family planning. A powerful foundation for more family planning may be provided by a solid yet adaptive vision of Islam, driven by respected thinkers and activists in the local and international Muslim community. Encouraging or facilitating dialogue,

communication, and action around how one “lives Islam” is a key strategic communications opportunity.

Campaign Directions. We offer a set of campaign directions that can be used in strategic communications and education. These directions are designed to reflect the reality, cultural priorities, and dominant yet evolving narrative in Niger. Each of the directions is aimed at: a) increasing average spacing between children to above its current 31 months;⁴ b) delaying first birth beyond the current median age of 19;⁵ and c) accelerating the decline in fertility as women approach menopause. They are meant to be read as the core concept or idea that education or outreach is meant to capture. Some themes have been abridged; their full text can be found in the Strategic Communications Directions section.

- Thrive! “Thriving is more than merely living for 40 days. It means living the Islamic values of increasing prosperity, reducing burdens, raising health standards and expectations, increasing living conditions, maximizing education, doing duty to your family, using the gift of reason, seeking knowledge, overcoming ignorance, and actively participating in Allah’s plan for his people. Thriving is being a good Muslim.”
- We’re All in This Together. “We work with each other and with Allah, to take responsibility for creating the conditions of our life, including our family life. The best way to do our duty and submit to Allah is to, as the classic story says, ‘Tie your camel, then rely upon Allah.’ We should use our own reason and resources to take good care of ourselves, in the situation we find ourselves in and together, as a community.”
- Let’s Be Honest. “Real life is complex, full of decisions and daily challenges. Sometimes, to do what’s best for our families, we have to stretch or even break the rules. But we do what we think is right, and what is good in the moment, and sometimes we just have to ask for forgiveness for what we’ve done. Sometimes these choices are complex, hard, or even funny. But, in the end, we know that Allah wants us to be happy, healthy, and thriving, not suffering. *Let’s be honest*, life as a Muslim is about peace, not about suffering. And getting to peace sometimes means that we need to stretch the rules a bit: by starting to have children a little later, spacing a little longer, and even stopping having kids a little earlier. *Let’s be honest*, sometimes even the cleric’s wife has to hide her pills!”
- The Choice is Mine [Youth Focused]. “Young people today understand that they can own more of their choices. Better education, open attitudes, less ignorance, new opportunities, new jobs, and frank chat with friends and family make us aware of what is possible. We make decisions each day about how we will live. The choice is ours. And this applies to when we marry, who we marry, how

⁴ République du Niger, ICF International. 2012.

⁵ République du Niger, ICF International. 2012.

many and when we have our children, how we raise them, and what we want for them. It's our responsibility, it's our choice."

Communications Practices. In Niger today, much pressure is placed on healthcare providers to be the near-only source of information about family planning and contraceptives. Instead, there is much potential to use informal communication channels and astute ways of communicating to ensure that family planning messages reach and influence target audiences. Key communications practices are:

Reimagining media. As a largely illiterate country, radio and phones are the obvious media of choice in Niger. But we recommend maximizing the power of other crucial media: health workers, imams, and chit chat. We recommend initiating messaging in cities, suburbs, and large villages/regional centers, where population density makes messages more likely to "go viral," and supporting these messages with national media. A map can be developed of conversation content for each target group (healthcare providers, imams, women, men, couples). Don't be afraid to use radical honesty and occasional cheeky humor to engage these audiences.

Use powerful words. Powerful words are those that come up often in discussion, and can be used to engage target audiences and to create messages, programs, or products that they will accept. Powerful words bring the weight of culture, they create bonds of understanding, and they offer permission to engage. In this study, powerful and prevalent words include: suffer; patience: forbearance, acceptance; burden (bearing it, limiting it); rest; peace; peaceable advice; organized (males: enabling men to provide); education; courage (to act while trusting Allah); reliance upon Allah; grown up (able to thrive); community; togetherness; health; living conditions; contribution, usefulness; permission (from husband, Allah, cleric); mature (age 18, not at puberty); agency.

Consider radical honesty and humor, another key communications practice. Nigeriens laugh easily and often, have a knowing glint, and are open to even taboo topics. They seem to enjoy radical honesty, occasionally poking fun at sacred cows as long as the narrative frame permits it. In developed countries, a medium risk-high reward strategy that has had great success in advertising has been to lead with humor and bracing honesty. However, this humor is not shallow or gratuitous. Cheeky humor and radical honesty may be something to leverage in family planning education or communications.

Survey Inputs: Hypotheses and Factors to Test

Phase 1's second objective was to provide inputs to the nationwide survey of women age 15 – 49, planned for this project's Phase 2. The survey will evaluate women's demand for modern contraceptives in Niger. It will do so by identifying the segments of Nigerien women most willing to increase their modern contraceptives; defining the "offer" required to increase their contraceptive use; and modeling the impact that providing this offer to the target segments will have on Niger's contraceptive use rate.

To develop a strong segmentation, it is very important to understand the range of factors that may influence women's use decision, as well as to identify how women describe these factors, so that we can ask women about them in a way that they understand. This was achieved in the primary qualitative research.

Hypotheses. Based on initial analysis of Niger's 2012 DHS, we know that the women who are more likely to use modern contraceptives today are: over age 20, highly educated, located in urban areas and especially in Niamey, are married, have 1 or more children, have high socioeconomic status, and are able to make decisions within their household.

By contrast, we do not know which segments of women are the most willing to use contraceptives in the future. Based on the Phase 1 findings, we hypothesize that the segments of women most willing to use contraceptives will include women who: want to space their children more than they are able to space today; demonstrate agency or self-determination; have a low tolerance for their own suffering or those of their children; are conflicted about modern contraceptive use due to their perception that it conflicts with Islam; and have medium to high fertility awareness, making them less likely to have non-religious concerns about modern contraceptive use.

We also believe that there may be a window of opportunity to introduce use after major changes in life status (i.e., onset of sexual activity, marriage, first child). Of these, we believe that the birth of one's first child is the most significant opportunity to introduce contraceptive use, but that this change alone will not have a major impact on modern contraceptive use in Niger.

Factors to Test. To test these hypotheses, we will test a set of demographic, behavioral, and attitudinal factors associated with willingness to modern contraceptives. An initial set of factors to test is provided in this report's last section, on Survey Inputs.

We will also test the contraceptives or contraceptive characteristics most appropriate to each segment of women. These characteristics include the ability to follow a regimen, desired discretion, the ability to re-supply, fertility awareness, desired speed of return to fertility, periodic or sustained hunger, existing prejudices about specific methods, and conflict with religion.

Next Steps

There are three next steps coming out of Phase 1. First, we will share this document and the accompanying "Qualitative Insights and Strategic Narrative in Niger" with this project's stakeholders and others interested in a discussion of Phase 1 results. The goal of these discussions is to provide information and feedback that can help these actors in their funding and programming decisions in Niger. Second, any family planning actor in Niger may take the strategic communications ideas presented here and translate them into communications campaigns or educational materials.



Third, and finally we will begin this project's Phase 2, to test women's demand for modern contraceptives. The survey instrument and methodology will be developed in February 2014. We expect to submit the survey for review by Niger's National Ethics Committee in March 2014, and to field the survey in late April to early May. Initial survey results are expected to be presented in June 2014.

FULL QUALITATIVE RESEARCH BRIEF

Context

Background

Recent shifts in the family planning landscape in Niger have created new momentum to address family planning issues there. Specifically, Niger's preliminary 2012 Demographic and Health Survey (DHS) found that Niger's fertility rate is the highest in the world and has increased since 2006, from 7.1 to 7.6 children per woman. Moreover, the 2006 DHS found that Nigerien men and women's ideal number of children was higher than this fertility rate, at 11.0 children for men and 8.8 children for women.

These findings—and the increased fertility finding in particular—have galvanized the Niger Ministry of Health (MOH) and non-governmental actors in Niger to take decisive action to increase women's use of modern contraceptives. As these actors scale up their programming and support to family planning, the William and Flora Hewlett Foundation has chosen to fund a national demand analysis in Niger, and Camber has been engaged to drive this analysis.

The Ministry of Health of Niger, the Bill & Melinda Gates Foundation, and the US Agency for International Development (USAID) are the project's stakeholders. The project will also work closely with these stakeholders' implementing partners, including EngenderHealth, Pathfinder International, Population Services International (MSI), and Marie Stopes International (MSI).

Focus and Structure of the National Demand Analysis

The national demand analysis is designed to provide these and other family planning actors in Niger with a common evidence base from which to make decisions, allowing them to scale up their family planning funding and interventions in Niger in a thoughtful, evidence-based manner. It also means that each group should not have to do its own research and analysis independently.

Currently, little is known about women's needs, attitudes, and behaviors around family planning and contraceptive use in Niger. What is known is not systematically codified in published literature, is not comparable, and is not translated into actionable insights that the Ministry of Health and other major family planning actors in Niger can use to inform their funding and programming.

This national demand analysis is intended to address these gaps. Specifically, it will:

- Provide a baseline understanding of family planning dynamics in Niger that can be used by any family planning partner (government, donor, or NGO) to inform its strategy and programming
- Identify the most significant opportunities—related to demand for and supply of contraceptives—to drive an increase in women's modern contraceptive use in Niger
- Describe how the stakeholders to this project and their implementing partners might adjust their grant-making and programming in Niger to address these opportunities

The demand analysis is being developed in 3 phases: phase 1, qualitative customer research, designed to provide insights into family planning behavior in Niger, to inform strategic communications concepts and inputs to test in Phase 2's nationwide survey; phase 2, quantitative customer research, centered around

a national survey designed to establish the segments of women who are most likely to use modern contraceptives, and what they need in order to increase contraceptive use; and phase 3, supply-side analysis and strategy development, designed to evaluate supply-related barriers to use and to identify the most significant opportunities—related to supply and demand—to increase use of modern contraceptives in Niger.

This Document's Focus

This document synthesizes this project's first phase. The objectives of Phase 1 were to identify dynamics or inputs to test in the national survey in Phase 2, and to identify strategic communications concepts that family planning actors in Niger can translate into communications campaigns or education. The knowledge and insights created in this phase can also be used by family planning actors in Niger to inform funding or programming decisions.

This project's Phase 1 ran from September 2013 to January 2014. Phases 2 and 3 will run in parallel from February to July 2014. This document provides a report-out from Phase 1, as follows:

- I. Synthesis of background research
- II. Insights from the primary qualitative research
- III. Strategic communications concepts
- IV. Survey inputs: Hypotheses, factors to test
- V. Next steps

I. Synthesis of Background Research

Here, we provide an overview of existing literature on family planning (FP) and contraceptive choice from Niger, Africa, and countries with cultural or religious similarities to Niger. We reviewed literature from Africa, with an emphasis on West Africa, from other moderate Islamic countries (i.e., Bangladesh), and from Niger itself. We reviewed formal and grey literature, from public health and, where practicable, from anthropology. We also interviewed a set of commentators who could provide perspective on society, religion, and cultural in Niger, and how those factors might influence family planning choices.

It is important to note the objective of the background research. It was intended to guide this engagement's primary research, by shedding light on topics in family, family planning, and contraceptive use that could be explored further in the primary research in Niger or that did not need to be explored further because a definitive view on those topics already existed. Background research was not intended to provide a definitive view on family, family planning, and contraceptive use in Niger or in the Sahel.

A list of commentator interviews is provided in annex. A full literature review can be provided upon request.

We have structured this synthesis of the background research around 3 main topics:

- A. Use of modern and traditional methods, and any issues with use
- B. Determinants of modern contraceptive use
- C. Segments of women most willing to use modern contraceptives

A. Use of modern and traditional methods, any issues with use

To change behavior, we first try to understand how a population behaves today, issues/problems they currently have around that behavior or experience, and their willingness to switch to a superior solution. We then try to identify what that “superior solution” looks like. However, doing so without a baseline understanding of behaviors and pain points today is nearly impossible.

For example, while consumers in the pre-Henry Ford era did not know that they wanted a car, they likely complained about their best transportation option at the time – the horse. Henry Ford was able to design the car to respond to the many shortcomings of a horse, including slow speed, maintenance cost, tendency to get tired out, limited power, and mess left by horses in city streets.

Unlike the horse, there is a relatively limited understanding of which methods women currently use in Niger to manage their fertility, what the shortcomings of those methods are, and which segments of women would be most likely to trial the new innovation, the modern contraceptive. In our background research and interview, we discovered that:

- **The framework for high fertility is strong:** Nigerien women marry young (median age of marriage = 15.8), have first sex at 15.9 years old, and have their first child by 18.6 years. Median duration between births is 30.9 months, and women tend to continue bearing children until menopause. Within these parameters, it is easy to understand how a TFR of 7.6 children per woman is achieved.
- **There are few alternatives to marriage and childbirth:** Women’s primary role is as wife and mother, but in many cases they have no choice: 86% of women are illiterate, and only 29% have worked for cash outside the home in the past year, compared with 66% of women in Africa overall.⁶
- **Fertility management is practiced:** Nigerien women are taking measures to space their births. Total fertility rates (TFR) of 6 or 7 children are less than half the theoretical maximum fertility level of 15 children per woman,⁷ suggesting that women take measures to auto-regulate their fertility.
- **Traditional and modern contraceptive use is low:** 6% of women use the pill, 4% use the lactational amenorrhea method (LAM), 2% use the injection (i.e., Depo-Provera), and 2% of women reportedly use all traditional methods combined.⁸

⁶ République du Niger, ICF International. 2012.

⁷ Frank. 1987.

⁸ République du Niger, ICF International. 2012.

- **Modern contraceptive use appears to have little impact on the TFR:** Some literature suggests that fertility rates of 7.3 and above are consistent with little to no contraceptive use.⁹ In other words, there is a strong likelihood that, although some women report using modern contraceptives, actual use is ineffective or not nearly as effective as it could be. TFRs of 7.4 to 7.6 suggest auto-regulation of fertility, rather than modern contraceptive use.
- **Traditional method use is poorly understood:** In the 2012 DHS, only 2% of women report using any traditional contraceptive method, and nearly all of that use is categorized as “other” (i.e., not LAM (considered a modern method), the rhythm method, or withdrawal). Very little is understood about fertility management strategies which decrease the TFR from the theoretical maximum of 15 to today’s 7.6. Small-scale, localized studies in Ghana and Nigeria suggest that periodic abstinence (an umbrella term for all rhythm, calendar and cycle-based methods) and post-partum abstinence are common traditional methods in West Africa, used by 18 – 25% of women in the populations studied.¹⁰ In Niger, a 1994 study found that amulets/*gris gris* were the most commonly cited method of contraception (cited by 66% of women surveyed), but there has been no published research quantifying amulet use since then.¹¹
- **Modern or traditional, contraceptives are likely not used correctly:** A 2013 study of breast-feeding found that the method is not being properly used by most Nigerien women, and that practice must be improved if LAM is to have an impact on Nigerien fertility rates.¹² Only 20% of Nigerien women know when they are likely to be fertile,¹³ making it difficult to use calendar-based methods effectively. While research on the correct use of all methods has not been done, it is likely that many modern and traditional methods are not being used correctly, given Niger’s TFR of 7.6.
- **Existing, in-depth research has not focused on how to shift fertility rates:** While much excellent ethnography has examined women’s fertility management in Niger and in other West African countries, this body of work tends to examine fertility management as an expression of social dynamics (power, politics, gender, etc.),¹⁴ rather than studying why women choose between different traditional or modern contraceptive methods and where opportunities might exist to increase contraceptive use.

In sum, there are significant gaps in the current body of knowledge about how women use modern and traditional contraceptive methods in Niger, what issues women have with these methods, and where opportunities might exist to enable women to use their existing contraceptive methods more effectively

⁹ Curtis and Diamond. 1995; Blanc and Grey. 2000.

¹⁰ Abdul-Rahman et al. 2011; Audu et al., 2006 ; Orji et al., 2005; Ugboaja et al., 2011.

¹¹ Remez. 1994.

¹² Sipsma et al. 2013.

¹³ République du Niger, ICF International. 2012.

¹⁴ See, for example, Moussa, H. (2012) and Bledsoe, C. (2002).

or to switch to more effective methods. These gaps must be bridged in order to develop effective funding and programming strategies.

B. Determinants of modern contraceptive use

There is an extensive literature on key determinants of contraceptive use in Africa, especially as regards modern contraceptives. This is important, because family planning actors need to understand a) what the most significant drivers of fertility are, and b) which drivers they can address in programming.

We have built on Campbell et al.'s framework of barriers to contraceptive use,¹⁵ to provide a way to characterize the levers that this project's stakeholders and other family planning actors in Niger can pull to increase women's use of modern contraceptives.

Campbell argues that barriers to use – or “constraining factors standing between women and the realistic availability of the technologies and correct information they need to in order to decide whether and when to have a child” – current limit women's use of contraceptives and, if lifted, will result in an increase in modern contraceptive use.

This is likely true, but changes to contraceptive supply alone will probably not be sufficient to increase contraceptive use, or to increase use across the entire population. As Jennifer Hirsch establishes in her 2008 examination of Mexican women's contraceptive strategies within the context of Catholicism, religious and social influences may limit use, even where barriers are relatively low.¹⁶ As a result, we have expanded Campbell's framework to classify existing literature on contraceptive use as follows:

- **Barriers to modern contraceptive use:** Discrete factors that limit use today. Barriers can be “lifted” and directly addressed through supply-side interventions (i.e., bring access points closer to the population) and education (i.e., increase women's fertility awareness)
- **Influences on modern contraceptive use:** Factors that influence one's reproductive health and contraceptive choices. Influences on use are often shifted through demand-side interventions (i.e., marketing campaigns). Addressing them directly may or may not be effective
- **Factors associated with modern contraceptive use:** Unlike barriers to and influences on use, these factors cannot be changed by reproductive health programming, but they can be used to target women who are likely to use contraceptives or may do so already

Barriers to modern contraceptive use. Barriers to modern contraceptive use include geography, number of methods available and awareness of those methods, method cost, medical barriers (including provider bias), side effects or misinformation about side effects, and fertility and method awareness. The current literature suggests that the following may be important barriers to use in Niger:

¹⁵ Campbell et al. 2006.

¹⁶ Hirsch. 2008.

- **Geography:** About half of Nigerien women live within 5 km of a public health center.¹⁷ However, in the 2006 DHS, 51% of women cited distance as a major barrier to healthcare. A 2013 study in Zinder suggests that distance is a particular issue for those seeking multiple contraceptive methods.¹⁸ Distance may be a particular issue in rural areas and/or where regular re-supply is required.
- **Method availability:** While product stock-outs appear to be low at the central and regional levels, with 100% of these facilities reporting no stock-outs in 2009 and 99% in 2010, stock-outs appear to occur frequently at specific health facilities, for maternal and child healthcare in general and for contraceptive methods in particular.¹⁹
- **Number of methods available:** According to UNFPA, 81% of standard delivery points in Niger offered 3 or more contraceptive methods in 2010.²⁰ Much family planning literature has established a relationship between increasing the number of contraceptive methods and increasing use.²¹ Increasing the contraceptive methods available in each health center could increase contraceptive use (this basket of methods could include the pill, injection, implant, IUD, and the condom, with LAM and rhythm methods available as back-up or alternate methods). However, the point at which adding one more method no longer increases contraceptive use, and may even decrease it by adding too many choices,²² is not known.
- **Method awareness:** While awareness of contraceptive methods may not drive use, it is a prerequisite for use to occur. Awareness levels in Niger suggest a solid foundation from which to drive use, and that increasing awareness need not be a focus of educational efforts in Niger. Awareness of modern contraceptive methods in Niger has increased from a relatively low 68% of women knowing at least one method in the 2006 DHS to nearly ~88% in 2012. This is compared to 74% in Mali and near universal awareness of at least 1 method in Kenya (95%), Ethiopia (97%), Burkina Faso (96%), and Swaziland (100%).²³
- **Medical barriers:** The quality of medical care in Niger, and the interaction with healthcare providers in particular, may limit access to appropriate contraceptives. Considerable research has been done in Niger on healthcare provider quality and interaction with patients, particularly by the well-regarded Niamey based qualitative research organization LASDEL and the London School of Tropical Medicine.²⁴ This body of research indicates that healthcare providers tend to judge their clients, to let their clients

¹⁷ DSME. 2013.

¹⁸ Afrik Consulting. 2013.

¹⁹ Diarra, 2012. Afrik Consulting. 2013.

²⁰ UNFPA. 2010.

²¹ Magadi and Curtis. 2003; Freedman and Berelson. 1976; Philips et al. 1988, as cited in Jain, 1989:6-7.

²² This is known as the “paradox of choice.” See the readable coverage of this phenomenon in “[You Choose: The Tyranny of Choice](#),” published by *The Economist* in 2010.

²³ DHS Studies: Burkina Faso 2010, Ethiopia 2011, Kenya 2008-09, Mali 2006, Niger 2012, Swaziland 2006-07.

²⁴ The London School of Tropical Medicine is undertaking a series of studies around healthcare provider quality, particular regarding the quality of interaction with adolescents and youth around family planning counseling.

know that they're judging them, and to fail to maintain patient confidentiality. However, this research was typically not focused on family planning counseling.

- Older research (1994 – 2004) suggests that healthcare workers may be indifferent to women seeking family planning counseling, may communicate ineffectively with patients, and may not be motivated to refer patients due to a potential loss of prestige.²⁵ In addition, healthcare facilities may be affected by favoritism, short staffing, and corruption, all of which potentially limit the quality of care.²⁶
- **Side effects:** Less than 3% of women in Niger's 2006 DHS survey reported side effects as the leading reason they do not use modern contraceptives. However, qualitative research from Niger and other African countries suggests that side effects or fear of side effects may be a major reason for lack or discontinuation of contraceptive use, even if it is not the leading reason.
- Side effects reported or feared in Niger include: irregular bleeding, weight gain, heart problems, hypertension, and cancer, for oral contraceptives;²⁷ sterility, for the injection and for hormonal methods more broadly,^{28, 29} and infection, for the IUD.³⁰ Nigerien women may also share the fears or experiences of women elsewhere in Africa. These include weight fluctuations,³¹ temporary or permanent infertility,³² and the perception that oral contraceptives may fill up the womb, gradually and irreversibly, leaving no room to gestate a fetus.³³
- These side effects represent a mix of actual side effects of correctly used contraceptive methods, side effects occurring due to incorrect use, and side effects that do not exist but are perpetuated by hearsay due to women's relatively limited experience with contraceptive methods and low fertility awareness. All types of side effects can be addressed through outreach and education.

Influences on modern contraceptive use. Several factors appear to influence women's desire to use modern contraceptives, and men's and women's desire to space or reduce births. Important influences appear to include:

- **Religion:** The literature suggests that religion provides an overarching framework for reproductive choice. It is not clear whether it has a measurable influence on modern contraceptive use. In Nigerien Islam, reproduction is often stressed as the will of God.³⁴ Similarly, religious women in West Africa

²⁵ Bossyns et al. 2002; Bossyns & Van Lerberghe. 2004; Jaffre and Paul. 1994; de Sardan et al. 2001; Souley. 2001.

²⁶ Alou. 2001 ; Hahonou. 2002.

²⁷ Moussa, H. 2012.

²⁸ Moussa, H. 2012.

²⁹ Castle, S. 2003.

³⁰ Moussa, H. 2012.

³¹ Chipeta et al. 2010.

³² Williamson et al. 2009.

³³ Castle. 2003.

³⁴ Moussa. 2012.

may opt not to use birth control because they believe that pregnancies are the will of God,³⁵ and to use contraceptives to prevent pregnancy is to defy God.

- Just 6% of women in Niger’s 2006 DHS reported not using modern contraceptives for religious reasons.³⁶ However, this finding does not mean that religion has no impact on modern contraceptive use, but rather that it is not the leading reason that women may not use contraceptives (the DHS did not provide a rank-ordering of the various reasons a woman might not use contraceptives, and therefore only the main reason is provided).
- Similarly, a survey of 6 African countries found that modern contraceptive use and religion were weakly associated.³⁷ However, this study measured only one’s religious affiliation (Catholic, Protestant, Muslim, Other) rather than the strengths of one’s religious belief. In her 2008 ethnography of Mexican Catholics, Jennifer Hirsch found that religiosity heavily influenced women’s willingness to use modern contraceptives, as women were very reluctant to go against the teachings of the church.³⁸
- **Resistance to state power:** Hirsch that women may decline to use contraceptives because they have not bought into externally imposed views that smaller family sizes are better, or that the state should have anything to say about one’s reproductive choices at all.³⁹ To develop the wrong message in this context is to invite resistance.
- **Husband’s approval of contraceptive use:** In a study across the Côte d’Ivoire, Ghana, Burkina Faso, Kenya, Malawi, and Tanzania, husbands’ approval of contraception was the factor most strongly associated with contraceptive use.⁴⁰ Similarly, an analysis of family planning programs in Madagascar found that women who perceive that their family members support the use of modern contraceptives are more likely to use them compared to those who do not have that perception.⁴¹
- In Niger, husbands’ approval of contraceptive use may not play as strong a role in actual use as in the decision process around contraceptive use. 2013 research in the Zinder area found that husbands were not a major obstacle to use of modern contraceptives. Rather, they were generally supportive of their wives.⁴² However, 2002 research found that many women (19%) did not accept a contraceptive method during a health center visit because they wanted to ask their husband’s permission to use the method first, and 6% declined a method because they assumed that their husbands would not allow them to use the method.⁴³

³⁵ Jaffre. 2013.

³⁶ DHS and Institut National de la Statistique. 2007.

³⁷ Stephenson et al. 2007.

³⁸ Hirsch. 2008.

³⁹ Hirsch. 2008.

⁴⁰ Stephenson et al. 2007.

⁴¹ Population Services International. 2011.

⁴² Afrik Consulting. 2013.

⁴³ Bossyns et al. 2002.

- **Locus of control / sense of agency:** In Niger, it appears that women’s sense of agency may make her more likely to actively manage her fertility. The 2012 DHS indicates that women who make at least one household decision each month are 33% more likely to use modern contraceptives, and 78% more likely to use modern and traditional methods combined. A similar trend is observed in the number of reasons that a woman can cite that would justify her refusal to have sex with her husband.
- **Additional influences on use, from commentator interviews:** Our commentator interviews suggest a few more factors that may influence women’s likelihood of using modern contraceptives. These include an “in the present” **sense of time** (living in the present may result in a lower propensity to plan, which in turn may lead to lower contraceptive use); **expectations around child mortality** (an expectation of high mortality drives a perceived need to have more children, which in turn drives low modern contraceptive use); and **lack of privacy**. The lack of privacy may drive a lack of participation in family planning, or a culture of secrecy and subversion around use of modern contraceptives.
- Several cultural drivers of high fertility may also exist, again from commentator interview. These include the **status one gets from children** (wealth or role fulfillment), to **children as a workforce or commodity**, to **downward pressure on the value of education**, particularly for females and usually beyond a young age. There is also a perception that **little sense of personal agency** exists. While the data appears to suggest that women who do have agency are more likely to use modern contraceptives, expert interviews asserted that a sense of personal agency was widespread.
- **Community approval:** Based on the current literature, we do *not* believe that community approval is likely to have a major impact on use. Community approval has a mixed effect on contraceptive use across Africa, increasing use in Kenya, Malawi, Tanzania, and Ghana, while having no statistically significant effect on use in Côte d’Ivoire and Burkina Faso. Côte d’Ivoire and Burkina are the most culturally similar to Niger of the countries studied.⁴⁴

Factors associated with modern contraceptive use. While factors associated with contraceptive use cannot be changed within reproductive health programming, they can be used to target women more effectively. From the 2012 DHS, factors that are associated with contraceptive use include:

- **Age:** Nigerien women over age 20 are much more likely to use modern contraceptives than women under age 20. 4% of women age 15-19 use a modern contraception method, vs 12% of women age 20 – 24, 16% of women age 25 – 29, 14% of women age 30 – 34, 15% of women age 35 – 39, 8% of women age 40 – 44, and 3% of women age 45 – 49.

⁴⁴ Stephenson et al. 2007.

- **Education:** Use of a modern contraceptive method in Niger is 30% for women with some secondary school education or higher, 18% for those with some primary school education, and 10% for those with no formal education.
- **Geography:** Modern contraceptive use is overwhelmingly an urban phenomenon, with 27% of urban women using modern contraceptives vs. 10% of women living in rural areas. Contraceptive use also varies considerably by region, from a high of 32% modern contraceptive use in Niamey, followed by modest levels of contraceptives use (12 – 18%) in Agadez, Diffa, Dosso, Tillaberi, and Zinder, and low levels of modern contraceptive use in Maradi (7%) and Tahoua (6%). We have no ready explanation for the wide variances in use across Niger’s regions.
- **Marital status:** Married women, or those who are co-habiting, are slightly more likely to use modern contraception than unmarried women (12% vs 11%). However, this effect is pronounced for women under 20: married girls age 15 – 19 are 59% more likely to use contraceptives than unmarried girls of the same age. Marital status has *less* effect on modern contraceptive use than age: modern contraceptive use increases from 4 – 6% for girls age 15 – 19 to 12 – 13% for women age 20 – 24, or an increase of >200%.
- **Number of children:** Modern contraceptive use rises sharply with children, from 1% use among women without children to 13 – 14% use in women with 1+ children.
- **Socioeconomic status:** Modern contraceptive use is sharply associated with socioeconomic status: Niger’s 3 bottom quintiles have modern and total contraceptive use rates of under 10%, while the 4th quintile has modest rates of contraceptive use (13% use modern methods, 15% any method), and 5th quintile has the highest rate of use (24% use modern methods, 26% any method).

Drawing from commentator interviews and other literature, including development economics, we believe that the following factors are also likely to be correlated with modern contraceptive use:

- **Husband’s education:** It stands to reason that husband’s educational levels may correlate with use, given husbands’ reported influence on women’s contraceptive use decision. While there is no data on the relationship between men’s education and women’s modern contraceptive use, awareness of at least 1 contraceptive method does rise with education (90% awareness for men with no formal education, 96% with some primary education, and 99% with some secondary education or higher).⁴⁵
- **Labor Force Participation:** No available literature documents a relationship between women’s work outside the home and her likely contraceptive use. However, Niger’s DHS data should be analyzed in order to understand any relationship here. We would expect that earning money outside the home

⁴⁵ République du Niger, ICF International. 2012.

could provide women with greater control and may be able to be used as a proxy for a woman's power or sense of agency, as described in the previous section.

- **Rainfall:** Commentator interview and some literature suggest that rainfall may be positively associated with greater contraceptive use in Kenya.⁴⁶ This effect seems odd, but may make perfect sense: lower rainfall results in lower harvests, which in turn lead to hunger or famine. Hormonal contraceptive methods may spur the appetite, and therefore may not be well-suited to people who are regularly hungry, as is likely the often or at least seasonally in Niger. It is worth noting that significant weight gain associated with the pill is not medically established, but some women may nevertheless experience this side effect.

In sum, our assessment of the determinants of modern contraceptive use provided us with several possible drivers of contraceptive use in Niger:

- Likely barriers to use include method availability, medical barriers (especially the quality of interaction with healthcare providers), and side effects represent important barriers to use today. Geography may be a significant barrier to care, but the data is mixed
- Influences on use that seem to be important included religion, the desire to maintain one's own (reproductive) freedom, and husband's approval. Influences that might be important include Nigeriens' sense of time, expectations around child mortality, lack of privacy, the need for children as a workforce, lack of value attached to education, especially for women, and limited sense of personal agency
- Factors associated with use include age, education, geography, marital status, number of children, socioeconomic status, and potentially husband's education, women's labor force participation, and rainfall

We planned to use the primary research to better understand some of these dynamics. Particular areas of focus included the healthcare provider interaction: would the same provider biases apply to family planning counseling? They also included side effects: would fears of side effects seen elsewhere in Africa, such as a woman's womb filling up with pills and rendering her infertile, also exist in Niger?

In addition, we wanted to understand the relative importance of these factors in driving women's contraceptive choices. Without doing any quantitative exercises, just listening, what were we likely to come away believing were the most important reasons that women do or do not use contraceptives in Niger today, and what were initial implications for funding and programming in Niger?

C. Segments of women most willing to use modern contraceptives

⁴⁶ Stephenson et al. 2007.

Overview of customer segmentation. Customer segmentation is used to identify homogenous groups within a given population that have distinct likelihoods of using a given product or service. Segmentation can be based on demographics (gender, income, education, geography) or psychographics (attitudes, values, interests, lifestyles). However, the segmentations that tend to do the best job of predicting how humans are likely to behave in the future are based on past behavior or current unmet needs. These are referred to as behavioral or needs-based segmentations.

Potential for segmentation in global reproductive health. Segmentation is an invaluable tool in resource-constrained settings, where it can help to ensure that scarce dollars are used as efficiently as possible. Segmentation allows family planning partners to target the population segments most willing to change their behavior and to provide them with the “offer,” or elements of family planning services, that is most likely to drive that behavior change.

The potential for segmentation to improve the delivery of reproductive health services in developing countries is considerable. Imagine a country like Niger, where per capita reproductive health spending is relatively low. A segmentation of women according to their willingness to use modern contraceptives allowing family planning actors to identify which segments of the population are most likely to adopt contraceptive use, to target resource delivery to those segments, and to emphasize delivery of services that are likely to increase women’s use of contraceptives.

Limited use of segmentation today. The power of segmentation is gradually being recognized in reproductive health. USAID and the Reproductive Health Supplies Coalition describe market segmentation as “a tool to help governments and private sector suppliers better coordinate their efforts, leading to more sustainable programs and a rational use of resources.”⁴⁷

In practice, segmentation is not yet widely used in global reproductive health strategy or programming. Where it does exist, it does not yet represent best-in-class segmentation in the commercial market context. Existing segmentations⁴⁸ tend to share the following shortcomings:

- Segmentations are based on demographics or attitudes, neither of which are good predictors of likely behavior change
- Some segmentations rely on populations’ “stated preferences,” or what people say is important to them, rather than testing “revealed preferences,” or how they are likely to behave in real life
- Segmentations are typically cross-tabulated, not derived. As such, we don’t know whether each segment’s parameters are predictive of use or just associated with it. If we pull this lever, will it contraceptive use increase?

⁴⁷ USAID and Reproductive Health Supplies Coalition. 2009.

⁴⁸ A table of existing segmentations in global reproductive health can be found in the complete literature review accompanying this paper and available upon request.

- Segmentations do not derive importance-weighted factors that are most and least critical to each segment’s contraceptive use. Knowing what these factors are is critical to effective programming and marketing, as it provides a guide to where to invest (and not to invest) resources to increase contraceptive use
- The increase in contraceptive use or in uptake of other reproductive health services associated with meeting a given segment’s needs is not calculated. Therefore, we do not know which segments to target to drive maximum increase in contraceptive use

Coming into the primary research, existing segmentations provided us with some ideas about factors that might drive contraceptive use—including one’s education, where one lived, one’s religious belief, one’s income, one’s agency, and the number of children one has. Yet we did not have a rich set of potential segments that we could test in Niger, developed elsewhere in Africa or the developing world and based on women’s unmet needs, attitudes, and behaviors.

II. Insights from the Primary Qualitative Research

A. Primary Research Structure

The primary research was run in Niger in November 2013. The primary research included focus groups and healthcare provider observation and interview.

Eighteen focus groups were held in and around Niamey, Zinder, and Tahoua. Nine focus groups were urban, and 9 were peri-urban or rural (we were unable to travel more than an hour from each city due to security concerns). Thirteen focus groups were women, and 5 were men, married and unmarried, ranging in age from 15 to 35+. ⁴⁹

Twenty-one healthcare providers were interviewed: 10 in Niamey, 6 in Tahoua, and 5 in Zinder. Eighty-four family planning consultations were observed: 72 in Niamey, 9 in Tahoua, and 3 in Zinder.

It’s important to note what primary qualitative research is and is not intended to do. Primary qualitative research is intended to identify patterns and possibilities, and provide observations and insights. It surfaces directions that may be pursued in communications and outreach efforts, and points to specific dynamics to be tested—or to be discarded from testing—in quantitative primary research.

Primary qualitative research is not intended to serve as “poor man’s quantitative.” It does not provide definitive answers to specific questions (“Are young people more likely to use contraceptives than older

⁴⁹ Focus group composition broke down as follows: unmarried women, age 15 – 24 (4 groups); married women, age 15 – 24 (5 groups); married women, age 25+ (4 groups); unmarried men, age 15 – 24 (2 groups); married men, age 15 – 24 (1 group); married men, age 25 – 34 (1 group); and married men, age 35+ (1 group).

people?") and cannot reliably be used to count, measure, or speak to the exact proportions of different population segments that say or do different things.

In this section, we provide an overview of major topics explored in the qualitative primary research in Niger. These include child spacing, family planning, and ideal family size; how contraceptives are used, and any issues with use; and determinants of contraceptive use, including barriers to use, influences that shape use, and factors associated with use. The section closes with a synthesis of learnings and insights from the qualitative primary research.

For a deeper exploration of family planning dynamics in Niger, we highly recommend our qualitative insights report, "Qualitative Insights and Strategic Narratives in Niger: A Report of Findings, Insights, and Ideas." That report accompanies this document.

B. Child spacing, family planning, and ideal family size

In any country, needs, attitudes, and behavior vis-à-vis family, family size, and fertility management heavily influence women's desire to use contraceptive methods. If one does not want to space births nor limit family size, why would one use contraceptives? This section provides an overview of directly relevant focus group findings on these topics.

Child spacing. Child spacing is widely practiced and accepted in Niger—a point that we cannot emphasize enough. Child spacing is seen as congruent with religious and cultural mores. While it is not acceptable to limit births, which would get in the way of Allah's divine vision to have a large and happy family, it is perfectly acceptable to space in order to allow mother and child (or children) to thrive.

Spacing is practiced in order to allow the mother to rest and, to a lesser degree, to allow the child to grow up. Spacing is also practiced to allow families to accumulate sufficient resources for more children, to see if a marriage will take after the wedding, and to allow time for marital conflicts to be resolved before having another child. Interestingly, the high risk of maternal mortality was never cited as a reason for women to space her children, by men, women, or healthcare providers.

Spacing begins after one's first child, with 40 days' of rest at the mother's parents, and continues throughout the mother's child-bearing years. Women are expected to continue to space for as long as they are able to have children; ending fertility is not well viewed. However, while women didn't feel right about permanently ending their fertility, they believed that being pregnant as an older woman was not a good idea: "If you have your first daughter, and she's pregnant, you shouldn't be pregnant, too."

Family planning. In some countries, child spacing is considered or promoted as a means of family planning. This is not the case in Niger. Child spacing is a dominant cultural practice; family planning is seen as a new introduction, sometimes of the West. Family planning is seen as foreign more than bad. Focus group

participants saw family planning as child spacing or as household / family management, but never as limiting births.

Ideal number of children. Coming into the qualitative research, we believed that Nigeriens would have an ideal number of children in mind and would practice spacing in order to achieve that ideal number. This was not the case. Many focus group participants gave a range of the number of children they wanted, but virtually all participants said that the number of children they had was ultimately up to Allah. As Bill Wilkie, our insights expert writes:

“The ‘Allah decides’ narrative is so strong that conversations around real limits in resources to provide for children, even when backed up by facts about birthrate and poverty and development in Niger, simply fall flat. These thoughts either don’t exist or are taboo. The conversation never goes farther than, “We pray we get the number we can take care of.” Therefore, we believe this topic [having an ideal number of children] is too far outside the narrative framework to gain traction and consideration.”⁵⁰

Men were more likely to want more children than women. Like most women, most men believed that Allah would provide for however many children they had. As one man said, “Whatever number of children Allah gives you, he’ll help you to take care of them. I want 40 children. If I’m healthy, I’ll take a lot of wives, so that I can have 40 kids.”

Some participants believed that it was important to be able to care for one’s children, invoking Islam to support their argument. A man asserted, “In heaven, you’ll be asked how you took care of your family. Even if you took care of yourself, you have duties to fulfill for your children.”

Men were more likely than women to believe that specifying the number of children was a sin. As one man said, “Religion doesn’t advise discussing the number of children to have. Sit down and ask how many kids to have? No. When Allah decides that a woman will be pregnant, she’ll be pregnant. I’ll pray so that my wife makes it through her pregnancy in good health.”

Most participants believed that there are more advantages than disadvantages to having many children:

“The advantages to having many children are emotional and practical, and include pride, support, help at home, on the farm, and in business, help with younger children, and help when you are old. In short, help.

“Disadvantages include looking older than your years (and inviting the possibility of a new wife or abandonment) and, in the case of having children too close together, health

⁵⁰ See Camber’s “Qualitative Insights and Strategic Narratives in Niger” report.

problems, malnutrition, unfriendly gossip, being ‘filthy,’ and ‘having two children that look like twins.’⁵¹

Similarly, having more children than participants wanted was seen as tiring and sub-par (“You could have a heart attack, having to talk to all your children and telling them, ‘Do this, do that.’”), but it was a familiar circumstance. Having too few children was sad and high risk: those children could die, leaving participants with few to no children.

We did observe a trend in young people (<20 years) towards smaller family size, typically 4 – 6 children. However, when asked to choose between having 2 children or 8 children, all participants chose 8 children—underscoring the riskiness of having too few children when there is a high probability that they will die, or will fail to thrive and provide for their parents or family when they are adults.

A similar dynamic applies around divorce, which participants reported as relatively common. In divorce, custody goes to the father, so women often need to start their family over if they get divorced. If women could be guaranteed that they’d hold onto their children after divorce, they would have fewer children. But when forced to choose between no children and more children, women opt for more children.

Taken together, these dynamics suggest that a growing number of Nigeriens want smaller families, but larger families are still the *de facto* option for most.

C. How contraceptives are used, and any issues with use

As mentioned in the literature review, to drive behavior change, we typically try to understand how a population behaves today, issues/problems they currently have around that behavior or experience, and their willingness to switch to a superior solution. We also try to understand whether the desired behavior change is congruent or incongruent with existing cultural and religious mores. Will changing behavior create conflict with one’s over-arching beliefs and values, and therefore be untenable?

Modern contraceptives. Nigeriens are trying to reconcile modern contraceptive use with their religious beliefs and/or with their efforts to retain control of their lives or at least their fertility (this is discussed in the “influences on use” section below). However, and surprisingly, there was not wide hostility towards modern contraceptive methods.

Method use. A higher than expected share of women used modern methods, although this may have been due to the urban and peri-urban composition of our focus groups and their relative affluence. Women tended to use the pill, the injection, and the implant, in descending order of frequency. Women also breast-fed, but reported that breastfeeding did not always work. This was an issue, as there was a strong cultural norm against becoming pregnant while still breastfeeding a child. Other modern methods

⁵¹ See Camber’s “Qualitative Insights and Strategic Narratives in Niger” report.

were not used (i.e., the IUD) and/or were not discussed (i.e., using oral contraceptives as emergency contraception).

Perceptions of modern methods. Perceptions of methods influenced the number of methods that women were willing to use or that healthcare providers were willing to offer. Condoms were seen as viable for unmarried men and women, not married couples. Female condoms weren't widely known, but younger participants (<20) had sometimes heard of them. Like male condoms, they weren't seen as a viable option for married couples. Tubal ligation was not seen as acceptable, because it would permanently limit one's number of children. Abortion was condoned by women, but not by healthcare providers. Abortion is illegal in Niger. Moreover, 17 of 21 healthcare providers interviewed opposed terminating pregnancy for religious reasons or due to perceived medical risks.

Some perceptions of modern contraceptives point to opportunities to increase their use. In projective exercises, the pill was described as "my friend." The injection was as "my friend for life" or "my shield"; like a cement house located in a town, a sedan car, or an aircraft; and as rich, wealthy, aspirational. Women's positive views of the injection are particularly interesting. The pill is used more frequently and reportedly has fewer side effects than the injection, but the injection was seen as a superior method in these projective exercises.

Side effects. Side effects, or fear of side effects, were the most significant factor that participants *said* influenced contraceptive use (specific side effects are discussed in greater detail in the "Barriers" section, below).

Fear of side effects was a more important driver of women's decision-making than method cost (methods are free in public health clinics in Niger), distance to a care facility, or quality of care. Because focus group participants were urban or peri-urban and relatively well-off, we would expect some of these barriers to be more important to randomly sampled women.

With this said, the level of concern and frequency of discussion of side effects suggests a need to provide education around fertility and around specific contraceptive methods, so that side effects in and of themselves are no longer considered nor used as a reason not to use modern contraceptives.

Traditional contraceptives. Traditional methods were never discussed in a formal care setting, but were a prominent feature in most women's fertility management.

Traditional methods in contraception. Women use a wide range of traditional methods in birth spacing, including post-partum abstinence, withdrawal, traditional drinks, and amulets (*gris gris*). Post-partum abstinence is still widely used, but other methods appear to be used less frequently and in some cases have been abandoned entirely. As one participant put it, "I was wearing a *gris gris* around my hips. Then I got pregnant. And right away I realized that the *gris gris* didn't work."

Traditional method use appears to occur when better options are not available, not because traditional methods are seen as particularly effective. Women appear to use traditional methods when they're not satisfied with modern methods, when they haven't reconciled modern method use with Islam,⁵² or when they believe that modern method use means yielding hard-won degrees of freedom to government or other entities that are targeting them with contraceptive or family planning messaging.

These findings point to two opportunities. The first is to provide a narrative (storyline) that enables women to reconcile modern contraceptive use with Islam and with her own right to make decisions for herself. The second is to provide more effective education, to enable women to use traditional methods like post-partum abstinence and cycle-based methods with greater success and to use them as back-up contraceptive methods as needed.

Traditional methods in abortion. Traditional methods are widely used in abortion, as abortion is illegal in Niger. Women turned to a range of methods to end unwanted pregnancies, including leaf infusions (neem leaves, cacedra leaves, sour leaves); other drinks (henna, mixing crushed glass with liquid and drinking it); and methods assisted by clerics, which included clerics writing verses on a blackboard, washing the blackboard, and having the woman drink the water.

When we raised unwanted pregnancy and abortion, participants were very engaged in discussion. Participants believed that traditional approaches to ending pregnancy did not work, and they did not have access to any reliable, safe abortifacients.

D. Determinants of use

As mentioned in the background research section, there are likely two sets of factors that affect women's contraceptive use: *barriers* that act as obstacles to her use, and *influences* that affect women's willingness to use contraceptives. There are also a set of *factors associated with use* that can be used to target women who may not be using contraceptives today but who would be willing to do so if the barriers of use important to them were addressed.

Barriers to use. The leading barriers to use appear to be the quality of provider counseling, fear of side effects, and knowledge of women's fertility and of different contraceptive methods. Perceptions about side effects, knowledge of fertility, and knowledge of contraceptives are all driven by the lack of quality of education, of which provider counseling is a part. Therefore, based on our focus groups, *lack of education* appeared to be the most important over-arching barrier to use.

⁵² This is similar to some Mexican Catholics' reluctance to not use modern contraceptive methods, as profiled in Jennifer Hirsch's insightful (2008) "Catholics Using Contraceptives: Religion, Family Planning, and Interpretive Agency in Rural Mexico": "A key reason for their preference for non-technological methods was their discomfort with using methods prohibited by the Church."

We do note that the focus groups were disproportionately urban or peri-urban (rural areas chosen for the focus groups were within an hour's drive of urban areas for security reasons). In Niger's more rural areas, geography and method availability or breadth of methods available may be more important barriers to use. Here is an overview of specific barriers to use:

- **Geography** did not appear to be a major factor limiting use. This may be due to focus group composition or because, as noted in the literature review, about half of Nigerien women live within 5 km of a health center.⁵³ Some participants complained about transportation cost, suggesting that geography may act as a barrier to use for those further from points of care, for poorer participants, or for those needing frequent contraceptive re-supply.
- **Number of methods** available was somewhat of a barrier to use, in two senses. First, only a limited number of methods were typically available in health centers (pill, injection, the implant (brand name: Jadelle). Second, women's perception that some modern methods are not suitable limits use of these methods. For example, women's lack of knowledge about their reproductive systems currently precludes use of IUDs (women believe that IUDs will disappear into the abdomen, and therefore refuse to use them).
- **Method cost** was not an issue for focus group participants, as modern contraceptives are now free in public health centers under Niger's *gratuité de soins* policy, and public health centers are the most common place that women seek contraceptive methods. When products were stocked out at public health centers, some women went to the market or to pharmacies to purchase contraceptives. A slim minority of women didn't like the wait or the healthcare provider interaction at public health centers, and would go directly to pharmacies to seek products. The cost of contraceptives at the market or at pharmacies was not mentioned as a major source of concern.
- **Medical barriers** are significant obstacles to contraceptive use. Counseling quality was the most notable medically-related barrier to use, and appears to be a significant issue (Interestingly, focus group participants did not recognize it as such. This may be because women have not had quality counseling, so they do not know what "good" looks like, or because many dimensions of life in Niger are hard or sub-optimal, and interaction with the medical system may not feel much different from interaction with other systems or structure there). Specific medical barriers to use include:
 - *Formal care criteria*, which limits access to some modes of fertility management (i.e., abortion is illegal in Niger and therefore not formally available).
 - *Counseling quality* is made up of three parts: *healthcare provider bias*, *healthcare provider motivation*, and *content covered in counseling sessions*. On *healthcare provider bias*, the most important way that bias manifests itself is in arbitrary care criteria, which limit women's access to the contraceptive methods that might be most appropriate for them. For example, healthcare

⁵³ DHS and Institut National de la Statistique. 2007.

providers refuse to offer longer-acting methods if women are recently married or do not yet have 4 or more children. But women often find that shorter-term methods are not effective for them, and abandon modern contraceptive use altogether. Focus group participants also reported provider reluctance to offer care when girls or women fell outside consultation norms. As one focus group participant said, “We can’t talk to any health worker about this, because we’re girls. People will start bothering us.”

- *Healthcare provider motivation* may act as a second barrier to use. Based on focus group participants’ reports as well as healthcare provider observation and interview, we did not find healthcare providers to be as dispirited or hostile as previous research suggests. Providers nevertheless had work-related issues that likely affect the quality of care they provide. Some providers are posted at a long distance from their regions of origin and would prefer to return to their native regions. This may make them less likely to offer high quality care at their current posts. Potentially more importantly, providers seemed tired by women’s misperceptions about contraceptive methods (i.e., shots will make you sterile, pills will give you cancer, IUDs will disappear into your abdomen). They also feel undervalued or underappreciated. Many women come to family planning consultations and request a contraceptive method without asking the provider’s opinion, despite the provider’s deeper knowledge of contraceptive methods. These dynamics could lead providers to offer sub-optimal care.
- *Counseling content* was also sub-par. Healthcare providers typically covered the major contraceptive methods (pill, injection, implant), but did not cover all methods available in Niger, including the IUD and the condom. Counseling often focused solely on how a method was used and its side effects, rather than seeking to understand client needs and client’s position on trade-offs between effectiveness and other attributes desired in use (i.e., ease of resupply, method’s discretion, speed of return to fertility), recommending a suitable method, and helping the client to understand how to use the method in order to achieve maximum effectiveness. Counseling was typically not provided in an integrated care facility, making it difficult for women to combined family planning consultations with well-baby visits or other medical consultations. Finally, confidentiality was not always maintained in the consultation. Other healthcare providers, trainees, or waiting patients were able to hear consultations in many – but not all – cases.
- Modern contraceptives’ **side effects** were a major topic of conversation in women’s focus group discussions. Side effects were the most common reason that participants reported not using contraceptives or discontinuing use. Common side effects reported by participants included breakthrough bleeding (the injection), frequent periods (the pill), failure to work (the pill), method disappearing into the arm if one is overweight (the implant) or into the abdomen (IUD), a long return to fertility or complete sterility (the injection, the IUD), cancer (Depo, implant, IUD), and hunger (“If a woman is hungry, she shouldn’t take any method except maybe the condom. It can kill her.”)

- Side effects represented a mix of documented biomedical side effects of different contraceptives (i.e., a slow return to fertility with Depo-Provera), misperceptions (i.e., IUDs cause sterility or can float into the abdomen), and side effects that may exist but have not been well-documented (i.e., pills make women hungry and therefore may not be a good option for women who experience hunger, as do many women in Niger).
- Many perceived side effects were based on low fertility awareness, incorrect method use, and rumor, as many women had not had experience with modern contraceptives themselves. This makes accurate, viral education very important to counteract incorrect rumors around use, and correct, well-designed training on how to use methods very important.
- **Fertility awareness** (of when one can get pregnant, and of one’s reproductive system) was extremely low. For example, in one indicative focus group, women reported that they could get pregnant just before their menses, just after their menses, and 7 or 8 days after their menses. The lack of awareness of the female reproductive system makes allaying fears about IUD use and potentially other methods difficult (i.e., women believe IUDs can disappear into the abdomen). Women’s lack of understanding of when they are likely to become pregnant makes use of traditional, cycle-based methods less effective. While existing fertility management practices in Niger (i.e., break of 40 days after childbirth, breastfeeding) enable fertility management without an accurate understanding of fertility, women’s lack of understanding about their fertility makes these practices less successful than they could be (i.e., women aren’t able to time when to have or not to have sex, women do not practice exclusive breastfeeding to ensure continued lactational amenorrhea). Women’s lack of fertility awareness also makes “the will of Allah” appear to be a leading explanation of why women do or do not become pregnant.
- Finally, **knowledge of modern contraceptives** was low and was unequal between men and women. More focus group participants knew about modern contraceptives than was reported in Niger’s 2012 DHS, but very few women had accurate knowledge about them. Men had more contraceptive knowledge, but it was still poor. Low contraceptive awareness is not inherently problematic: if the quality of contraceptive counseling is high and provider bias low, women can receive a method appropriate to them without having complete understanding of their own fertility or the contraceptive methods available to them. However, the quality of counseling is not high and provider bias is significant in Niger, making it important that women are “educated consumers” of family planning counseling. In addition, couples tend to decide at home which contraceptive methods the wife should use. The wife, almost always without her husband, will ask for (and typically will receive) that method at the health center. This method may not be suited to the woman’s contraceptive needs. Moreover, this mode of interaction—the preferred contraceptive method dictated to the healthcare provider after having been decided by the man and woman—is likely demoralizing to the healthcare provider and perpetuates an unequal gender dynamic, as men and women agree on a contraceptive method at home, and women do not feel at liberty to modify that decision once at a healthcare facility.

Influences on use. There are a series of influences on use that appear to condition women's willingness to use modern contraceptives, or their ability to use them consistently and correctly:

- **Religion** appears to be *the most important influence* on modern contraceptive use today. Religion was the main reason that women reported that they would not use modern contraceptives, and the only reason that men stated they would not support modern contraceptive use. Men and women continually tried to adapt Islam to meet their needs, and asked for forgiveness when they felt that they went against the teachings of Islam. There was also an overwhelming tendency to explain that decisions or life circumstances were the "will of Allah." This demonstrated one's piety; signaled to the Allah that participants knew they did not have the final word and were not trying to "tempt the gods;" and enabled participants to not take responsibility for their actions.
- We interpreted these findings in two ways. First, many Nigeriens feel genuine conflict between the teachings of Islam and modern contraceptive use, and are trying to reconcile that conflict by explaining their actions in the context of Islam and in asking for forgiveness when they cannot reconcile Islam and modern contraceptive use. "It's a sin to take the pill, because it kills your eggs and you piss them out." Followed by: "But, if you do take the pill, you can pray that Allah forgives you." And: "If you go to remote villages, out of 3 women, 2 are taking pills."
- Second, many Nigeriens feel that decisions about family planning and contraceptive choice are their decisions to make, and they do not want the state or other third-parties to make these decisions for them. "If you bring medicine and tell me, 'This is medicine,' and to just take it, this won't work. But if you tell me to read the Koran, I will read it. If you tell me to do something, I will ask you to tell me why. If you cannot convince me, then I will reject it."
- A woman's **relationship with her spouse** is also a significant influence on her willingness to use modern contraceptives. While not as subservient as we anticipated coming into the qualitative research, women were counseled, guided, or controlled by their husbands. Similarly, in unmarried adolescent relationships, boys' viewpoints had influence on girls' behavior. Consistent with this power dynamic, men's' or boys' views on contraceptives influenced and, less frequently, dictated women's or girls' contraceptive use.
- This pattern of influence is important, because men were both more knowledgeable about modern contraceptives and more opposed to their use than were women. However, while men postured around being able to control their wives' behavior ("We decide"), women and men acknowledged that women were likely to seek out contraceptives if they wanted to use them, even if their husbands had forbidden use. In all, women were much more likely to successfully seek out contraceptives when they wanted to use them than we had anticipated coming into the qualitative research, but were nevertheless strongly influenced by their husbands' or boyfriends' wishes about their contraceptive use.

- A third influence on use appears to be the **lack of economic opportunity** in Niger and **cultural expectation** that women should get married and have children. This appears to be especially true for unmarried or newly married women. They are expected to marry and have children (“Because God made me a woman, whether I like it or not, I’m going to get married.”) They often have an idealized vision of what the family should look like (“I would love it if I could see my many grandchildren in front of me.”). They see little reason that they would interrupt their progress towards realizing this vision with modern contraceptive use, which represents a clear, proactive attempt to avoid having children. This is not to say that some young people do not want to access contraceptives, but rather than the dominant cultural narrative and lack of better alternatives for women are likely to suppress women’s and girls’ desire to use modern contraceptives.
- Another factor that we believe weighs heavily on likely contraceptive use is a woman’s **sense of personal agency**, or lack thereof. As Bill Wilkie writes: “In Niger, personal agency and responsibility are minimal. Allah takes the credit or blame for nearly everything. All outcomes are written, planned, and affected by Allah. In addition to Allah, authority figures (parents, elders, clerics, men) have agency. After that, it’s black magic. Women’s choice comes in last.”⁵⁴
- We do see evidence that women’s agency is increasing. Women are increasingly subverting their husbands (“I told my husband that I was going to the health center, but I’m here.”), being feisty, threatening or actually divorcing their mates, “playing dead,” or simply being “difficult women.” Women who do demonstrate agency appear more likely to seek or demand modern contraceptive use.
- Like a lack of agency, we believe that a **cyclical sense of time** slows progress in Niger, towards contraceptive use or otherwise. On a day to day basis, “Niger does not experience the individual or collective narrative of progress, achieved goals, realized plans, and dramatic change. Instead, cyclical seasonal duties and feasts, being socialized into expected roles, inherited wisdom and consistency with past generations and the overall way of live are normative and defining. Life is ritualized, travel is minimal and pragmatic, friends are for life, and much is quantified on the calendar, including 40 days of post-partum abstinence, 2 years of breastfeeding, 2 – 3 years for spacing, a 4 month limit on celibacy, a test in 10th grade, being marriageable at 18, etc.”⁵⁵
- However, and importantly, there is evidence of narrative instability in Niger. Very young marriage (<age 15) is increasingly seen as unacceptable, girls’ education is increasingly acceptable and sometimes desired (“My daughter can study from middle school, to secondary school, to university, and go to America to study if she wants.”), waiting until one is old enough to “have nothing more your parents can teach you” before having children is seen as a good idea, and ideal family sizes are

⁵⁴ See Camber’s “Qualitative Insights and Strategic Narratives in Niger” report.

⁵⁵ See Camber’s “Qualitative Insights and Strategic Narratives in Niger” report.

shrinking somewhat. This suggests that there may be an opportunity for change in Niger, particularly around family planning and reproductive choice.

Factors associated with use. Qualitative research is not well suited to understanding measurable factors associated with contraceptive use, as it does not pretend to weigh the magnitude of different effects on the use choice. With this said, we are able to make several initial observations:

- Some demographic factors appeared to be associated with modern contraceptive use. **Education**, Western or Koranic, mapped to increased openness to use. High school education or greater was a strong indicator of contraceptive use or stated intent to use. **Age** appeared to influence contraceptive use, with women under age 30 (roughly) being more likely to use contraceptives.
- **Number of children:** women with at least one child appeared to be more likely to use contraceptives than those without children, whether married or unmarried. Women with 3 – 4 children, tired by childbearing and child raising, appeared very likely to use modern contraceptives. **Marital status** also appeared to influence contraceptive use, with unmarried women or girls both having more difficulty accessing care and feeling conflicted about sex – and therefore contraceptive use – before marriage. The presence of **co-wives** did not seem to drive major changes in one’s desire to have children, but this dynamic would likely have required a deeper and more focused inquiry.
- **Earning money** also appeared to be associated with use. Those who did petty trade seemed more likely than other women to use contraceptives. Earning money outside one’s home may be a proxy for agency, or the degree to which a woman believes that she has control over her life circumstance.
- Some factors that have been correlated with use in other research were not observable in the focus group format. These include income, household wealth, and geography.

E. Emerging Observations

Taken as a whole, the primary qualitative research in Niger offers a wealth of ideas about how to increase modern contraceptive use. This engagement’s upcoming quantitative primary research (Phase 2) will distill these opportunities into a set of testable factors, and will measure their potential impact on modern contraceptive use in Niger. However, we’d like to share our emerging view of where opportunities to increase contraceptive use in Niger may exist:

1. Contraceptive use can be increased to some degree by lowering key barriers to use. On the supply side, key barriers to address appear to include method availability, counseling quality, and potentially geographic proximity to points of care. On the demand side, key barriers appear to be low fertility awareness and low contraceptive knowledge, both of which drive fear of side effects.

2. These barriers are likely best addressed by a mix of infrastructure-strengthening and quality-improving activities. It is tempting to focus on infrastructure-strengthening activities with tangible inputs and outputs (i.e., increasing the number of points of care). However, critical barriers to use—like poor counseling quality and lower user knowledge of reproductive health and contraceptives—cannot be addressed through infrastructure-strengthening activities alone.
3. Addressing barriers to use alone will not achieve the Government’s desired increase in contraceptive use. A sub-set of Nigerien women will increase modern contraceptive use if barriers to use are addressed—for example, if points of care are brought closer to their homes or if healthcare providers are trained to offer higher quality family planning counseling. However, our current view is that many Nigerien women have a conflict with modern contraceptive use that artificially depresses use. Contraceptive use will not increase as much as it could until key conflicts (religion, reproductive freedom, spousal disagreement about use, or social prohibitions against premarital sex) are addressed. This project’s segmentation will indicate how important these issues are, and to which segments of Nigerien women.
4. To drive use, intelligent communications strategies will need to enable Nigerien women to use contraceptives within their existing belief and value systems. Communications should encourage a shift towards agency or taking action within Islam’s parameters. Thriving, alleviating burden, or discerning the will of Allah for one’s self can be trialed as concepts underlying communications collateral or education materials.
5. Driving change will be hard, because family in Niger is defined as a large and vibrant family. This view of family is central to life in Niger, reinforced by religion, culture, and economy. As a result, while some people express a desire for smaller families than in the past, Nigeriens still default to larger family size at almost every point at which a decision about family size is made.
6. However, there is strong evidence of “narrative instability” in Niger, or shifting thinking about long-standing cultural norms. There was increasing openness to girls attending school (longer), marrying later, having children later, and having smaller families than in the past. These suggest an opportunity to introduce a new cultural narrative or narratives in Niger, as existing narratives are shifting and have not yet settled into a “new normal.” These narratives can frame family planning in a manner that is acceptable to Nigeriens, or to sub-segments of Nigeriens who are ready to manage their fertility more pro-actively and/or use modern contraceptives.

III. Strategic Communications Concepts

The primary qualitative research leads us in two directions. The first direction is strategic communications: what themes are most important to message around, to increase women’s likelihood of using modern contraceptives? To whom must we message, via what media?

The second direction is the planned nationwide survey of women age 15 – 49: which segments of women are going to be most likely to adopt modern contraceptive use, what are the major levers that we can pull in order to enable that use, and how can we test these things in a survey?

This section’s focus is on strategic communications. We will explore themes that can be used to underpin marketing or communications campaigns; specific campaign concepts; and considerations for the best communications channels for conveying accurate and persuasive messaging around family planning and contraceptive choice.

This section was developed by Bill Wilkie, our insights expert. Those involved in strategic communications, and those thinking deeply about behavior change in Niger, will find rich additional material in the “Qualitative Insights and Strategic Narratives in Niger.” That report that accompanies this document.

A. Themes

These themes represent areas for further development in messaging, marketing, product and program development. These appear to have the most potential for engaging people in ways that they really think, feel, and live, while also inviting them to evolve and expand their narrative. All of these have direct implications for and applicability to family planning:

Thriving and Organized. For every Nigerien mother and child, the first challenge is thriving, or “growing up,” which is to make it past the first 40 days of life and then to the 2 year mark. This is deeply embedded and ingrained in experience and culture. In adult life, the concept of being organized is closely related to thriving insofar as it creates the conditions to thrive: food, shelter, healthcare, and education. We suggest that expanding the definition of thriving to include progress, prosperity, opportunity, options, and self-determination in adult life, or “maturity.” Done well, themes around thriving and organization (“being on top of it”) will not contradict Islam and may even leverage it. After all, in its golden age, Islam thrived to a very great degree.

Responsibility and Contribution. This theme focuses on making conscious choices to maximize and extend the contribution of each person. It is not about quantity of people required to live well, but the quality of each person’s contribution. And as jobs increasingly become urban, less manual labor is needed in agriculture. With a responsibility/contribution theme, it becomes possible to increase focus on the responsibility of parents to provide something more than subsistence care and minimal education to their children. Parents can thrive to provide longer and better education, more personal presence, an emotional life, and a sense of choice and plans for the future to their children. Responsibility and contribution allow each person to think about contribution in a way that may start to feel like progress and linear time, rather than stasis and cyclical time or lack of progress.

Longer Spacing and a Shorter Childbearing Timeframe. Children and family are central to Nigeriens’ lives. Choosing to not have children, radically limit the amount of children one has, or cease having children as

a lifestyle choice is a non-starter. The only legitimate reason not to have many children in Niger is one's own health or that of one's children. However, it is possible that rising health expectations and a liberal interpretation of Islam (either officially or at the grassroots) may add time between births. In addition, women may choose to make a health-based argument to stop having children at a particular pre-menopausal age. Lastly, there is evidence of a willingness to break with tradition in order to finish school or test the marriage, thereby having one's first child after 2 or 3 years after marriage rather than the traditional 1 year. For example, if a woman marries at 20, has her first child at 22, has 1 child every 4 years, and stops having children at 40, she will have 5 children rather than today's national average of 7.6 children per woman (Note: This number of children may be lower due to miscarriages and child mortality, but both should decrease as health standards improve). If Niger's economy modernizes, this fertility rate is likely to fall further in future generations. For the foreseeable future, however, having a shorter timeframe in which to bear children and longer spacing between children seems like a reasonable goal, and it plants the cultural seeds for greater change.

Stronger Family and Community. Closely related to thriving and adjusting the timeframe for birth is the idea of building stronger families and community. Historically, a child – any child – could help to provide manual labor in agriculture or around the homestead. Today, more families appear to seek children with specific capabilities. There are benefits to having a French speaker in the family, someone with knowledge of Nigerien bureaucracy, or someone with aptitude as an entrepreneur. Perhaps 3 capable, thriving adult children are a greater asset than 8 children of lesser knowledge and skill. This applies not only to families, but to entire communities and to the nation. Supported by policies and programs to increase children's likelihood of success, messaging around this theme become a persuasive argument for smaller but more prosperous families.

Partnership with Allah. Allah stands alone as a god defined by sovereignty. The Western god is omnipotent, but Islam translates literally as "submission." Islam has what is known in academic religious studies as a low theological anthropology, which is to say a huge difference and distance between Allah and humanity, and very little power or independence for humanity. However, Allah does expect humanity to use its reason and free will to discern and act upon the best path forward in specific circumstances even as it walks in a life determined by Allah. In this way, humanity can partner with Allah by taking on the responsibility to forward their shared agenda, starting with thriving, wellness, prosperity, and learning. In this context, blessings might be understood to expand from being blessed by one's static life circumstance (one is blessed to have what one has in life), to include notions of greater thriving and progress. In this regard, Nigeriens have much stepping up to do: there is no theological reason they must be as passive or accepting of their life circumstance as they appear to be. By framing change in terms of partnering with Allah, conflict between modern and traditional agendas is diffused.

Living Islam. Religious and political traditions can ossify, grow reactionary, and become belligerent as they feel threatened by rapid change and creative forces more powerful than themselves. Soviet communism and Christian and Islamic fundamentalist extremism are good examples of this phenomenon. However, a thriving tradition is a *living* tradition. It reframes itself and re-appropriates key emphases, values, and

teachings to address each new time and context. In the area of family planning, Islam has a broad consensus, but it is not monolithic. There is room for a variety of voices and opinions. A powerful foundation for more family planning and falling birth rates may be provided by a solid yet adaptive vision of Islam, driven by respected thinkers and activists in the local and international Muslim community. Something as simple as redefining a women’s maturity from the onset of menses to 18 years old is evidence of the kind of adaptive flexibility required to live within a changing world: maturity remains the abiding issue, and it is merely reframed. As the classic story affirms, sometimes the better part of wisdom is to move from one will of Allah to another more important will of Allah through greater discernment. Encouraging or facilitating dialogue, communication, and action around how one “lives Islam” is a key strategic communications opportunity.

B. Campaign Directions

This section offers campaign directions that can be used in strategic communications. These concepts are designed to reflect the reality, cultural priorities, and dominant yet evolving narrative in Niger. Each of the concepts is aimed at: a) increasing average spacing between children to above its current 31 months;⁵⁶ b) delaying first birth beyond the current median age of 19;⁵⁷ and c) accelerating the decline in fertility as women approach menopause.

These campaign directions do not stand alone: they should be developed creatively, piloted, and executed in education, outreach, and communication campaigns. They are meant to be read as the core concept or idea that education or outreach is meant to capture.

Thrive! “Thriving is more than merely living for 40 days. It means living the Islamic values of increasing prosperity, reducing burdens, raising health standards and expectations, increasing living conditions, maximizing education, doing duty to your family, using the gift of reason, seeking knowledge, overcoming ignorance, and actively participating in Allah’s plan for his people. Thriving is being a good Muslim.”

We’re All in This Together. “We work with each other and with Allah, to take responsibility for creating the conditions of our life, including our family life. The best way to do our duty and submit to Allah is to, as the classic story says, ‘Tie your camel, then rely upon Allah.’ We should use our own reason and resources to take good care of ourselves, in the situation we find ourselves in. When it comes to our families, it is important to make sure that we understand what Allah wants for our children’s well-being. Sometimes the answers are surprising. Sometimes these answers take us to new ideas and practices in birth spacing, birth limiting, and when to start and stop having children.”

Let’s Be Honest. “Real life is complex, full of decisions and daily challenges. Sometimes, to do what’s best for our families, we have to stretch or even break the rules. But we do what we think is right, and what is good in the moment, and sometimes we just have to ask for forgiveness for what we’ve done. Sometimes

⁵⁶ République du Niger, ICF International. 2012.

⁵⁷ République du Niger, ICF International. 2012.

these choices are complex, hard, or even funny. But, in the end, we know that Allah wants us to be happy, healthy, and thriving, not suffering. *Let's be honest*, life as a Muslim is about peace, not about suffering. And getting to peace sometimes means that we need to stretch the rules a bit: by starting to have children a little later, spacing a little longer, and even stopping having kids a little earlier. *Let's be honest*, sometimes even the cleric's wife has to hide her pills!"

The Choice is Mine [Youth Focused]. "Young people today understand that they can own more of their choices. Better education, open attitudes, less ignorance, new opportunities, new jobs, and frank chat with friends and family make us aware of what is possible. We make decisions each day about how we will live. The choice is ours. And this applies to when we marry, who we marry, how many and when we have our children, how we raise them, and what we want for them. It's our responsibility, it's our choice."

C. Practices

We place much pressure on healthcare providers to be the leading source of information about family planning and contraceptive use in Niger. While their role is critical, family planning actors can use a range of communication channels and astute ways of communicating to ensure that family planning messages reach and influence target audiences. Three ways to do so include re-imagining what we consider media to be; using powerful words; and employing radical honesty and humor.

Reimagine Media. As a largely illiterate country, radio and phones are the obvious media of choice in Niger. But we recommend maximizing the power of other crucial media: health workers, imams, and chit chat. Health workers are uniquely knowledgeable and trustworthy sources of relevant information, imams are the powerful keepers of an expanding or contracting vision of Islam; and chit chat is the primary medium of sharing and discernment. These are media. We recommend initiating messaging in cities, suburbs, and large villages/regional centers, where population density makes messages more likely to "go viral," and supporting these messages in national media. A map can be developed of conversation content for each target group (healthcare providers, imams, women, men, couples). Don't be afraid to use radical honesty and occasional cheeky humor.

Use Powerful Words. We find it useful in any narrative inquiry to pay particular attention to words and concepts that come up often in discussion, and to highlight those words which may be leveraged to better understand our audience and find successful ways to engage them. We recommend that all communications, products, and programs take these powerful words into account.

In this study, powerful and prevalent words include: suffer; patience: forbearance, acceptance; burden (bearing it, limiting it); rest; peace; peaceable advice; organized (males: enabling men to provide); education; courage (to act while trusting Allah); reliance upon Allah; grown up (able to thrive); community; togetherness; health; living conditions; contribution, usefulness; permission (from husband, Allah, cleric); mature (age 18, not at puberty); agency.

These words carry loaded meaning. They bring the weight of culture, they create bonds of understanding, and they offer permission to engage. They should be used wisely and well in communications channels and initiatives. Using powerful words will turbo-charge connection and create the preconditions for understanding and change.

Consider Radical Honesty and Humor. Nigeriens laugh easily and often, have a knowing glint, and are open to even taboo topics. They seem to enjoy radical honesty, occasionally poking fun at sacred cows as long as the narrative frame permits it. In developed countries, a medium risk-high reward strategy that has had great success in advertising has been to lead with humor and bracing honesty. However, this humor is not shallow or gratuitous. Rather, it pointedly expresses a discovered truth, and gets attention through its radical honesty. The best humor rings true and runs against accepted convention. The jester is often the prophet. The best humor is never disrespectful, because it respects truth. Cheeky humor and radical honesty may be something to leverage. As one person in Niger said about laughing, “It’s better than crying.” And a tragic-comic perspective certainly beats a tragic mindset.

D. Using This Section’s Content

This section and its accompanying report, “Qualitative Insights and Strategic Narratives in Niger,” provide rich material for communications strategy, execution (creative), and media (channel). There are several ways in which this project’s stakeholders could help this content to be used by the Niger family planning community and/or translated into communications in Niger. These include:

- **Digestion:** Another working session or working sessions with this project’s stakeholders, to discuss and understand these findings more deeply. This will likely enable better thinking about how this content could be used
- **Dissemination:** Niger’s national ethics committee recommended that the results of this Phase 1 be shared in a national workshop in Niger. We believe that this would be best done after further digestion by near-in collaborators (as above), but would help to socialize results in Niger
- **Piloting and iteration:** The strategic concepts could be handed off to a third party, which could test the concepts with Nigeriens, translate winning strategic concepts into creative concepts, test those concepts with Nigeriens, and use winning creative concepts to design a campaign
- **Pro bono resources:** We believe that a set of global ad agencies would be willing to provide pro bono services to develop this material into a campaign. An ad agency could be engaged to develop the campaign or, better yet, work in partnership with a local agency to do so. This approach would not be “free,” in the sense that considerable translation would be required, but it could be a way to engage a new set of enthusiastic, skilled actors in family planning in Niger

IV. Survey Inputs: Hypotheses, Factors to Test

A. Hypotheses and Factors to Test

Survey Background. In the project’s next phase, we will seek to establish the greatest demand-side opportunities to increase modern contraceptive use in Niger. To do so, we will develop a statistical segmentation of Nigerien women. We will define the segments of women that are most willing to switch to modern contraceptive use, and what each segment requires in order to do so. Each segment may need different reproductive health services or communications in order to embrace modern contraceptive use.

The segmentation will be based on a nationwide survey of women age 15 – 49. The survey will be a 20 – 30 minutes, in-person, and will target 2,000 participants. The sample will be nationally representative by geography, education, marital status, and income or socioeconomic group, to the degree these can be identified. The survey will test women’s needs, attitudes, and behaviors around contraceptive use. It may also test other factors that are thought to influence contraceptive use, such as attitudes towards marriage, family, or education.

Hypotheses. Based on initial analysis of Niger’s 2012 DHS, we know that the women who are more likely to use modern contraceptives today are: over age 20, highly educated, located in urban areas and especially in Niamey, are married, have 1 or more children, have high socioeconomic status, and are able to make decisions within their household.

By contrast, we do not know which segments of women do not use modern contraceptives today, but are the most willing to do so in the future. Similarly, we do not know whether demographics are likely to be the strongest predictors of willingness to use modern contraceptives. However, based on the primary qualitative research, we hypothesize that target segments will be those that:

1. Want to space their children more than they are able to space today
2. Demonstrate agency or self-determination
3. Have a low tolerance for their own suffering or those of their children
4. Are currently conflicted about modern contraceptive use due to its perceived conflict with Islam
5. Have medium to high fertility awareness, making them less likely to have non-religious concerns about modern contraceptive use

We also believe that there may be a window of opportunity to introduce use after major changes in life status (i.e., onset of sexual activity, marriage, first child). Of these, we believe that the birth of one’s first child is the most significant opportunity to introduce contraceptive use, but that this change alone will not have a major impact on modern contraceptive use in Niger.

Factors to Test. To test these hypotheses, we will test a set of demographic, behavioral, and attitudinal factors associated with willingness to modern contraceptives. These are included in the table below.

Demographic Variables (Hypotheses)	Behavioral or Attitudinal Variables (Hypotheses)
Age (>20 = + use)	Importance of religion (- important = + use)
Education (+ education = + use)	Conflict with religion (+ conflict = - use)
Socioeconomic status (+ status = + use)	Agency (+ agency = - use)

Geography (+ urban = + use)	Desire to maintain repro. choice (+ desire = - use)
Region (specific regions = + use)	Interest in personal health (+ interest = + use)
# Children (- kids = + use, shows desire to space)	Fear of social judgment (+ fear = - use)
# Children died (+ death = - use)	Fear of side effects, general (+ fear = - use)
# Siblings (- siblings = + use, parents used FP)	Fear of side effects, sterility (+ fear = - use)
Proximity to point of care (+ proximity = + use)	Fertility awareness (+ awareness = + use)
Method availability (+ available = + use)	Tolerance for suffering (- tolerance = + use)
# of methods available (+ methods = + use)	Opinion of birth spacing (+ favorable = + use)
# of months since marriage (- months = - use)	Satisfaction with current spacing (- = + use)
# of months since marriage (- months = - use)	Satisfaction with traditional methods (+ = - use)
	Satisfaction with modern methods (- = - use)
	Importance of educ. for self/kids (+ imp = + use)
	Concern about STIs (+ concern = + use)
	Importance of edu for self/kids (+ imp = + use)
	Ideal age to marry (older = + use)
	Relationship with husband (better = + use)
	Living in the present (+ = - use)

To identify the contraceptives or contraceptive characteristics most appropriate to each segment of women, we will test:

Contraceptive Characteristics
Ability to follow a regimen (+ ability = + ST methods)
Desired discretion (+ discretion = + LT methods)
Ability to resupply (- ability = + LT methods)
Fertility awareness (+ awareness = + IUD)
Desired speed of return to fertility (+ speed = less Depo Provera, + condom or IUD)
Periodic or continued hunger (+ hunger = - hormone-based methods)
Existing prejudices about contraceptive methods (+ prejudices = fewer viable options)
Conflict with religion (+ conflict = + LT method)

In addition to product-specific characteristics, we will also test sales channels and dimensions of the provider experience that are most important to each woman.

V. Next Steps & Conclusion

Next Steps. There are three next steps coming out of Phase 1. First, we will share this document and the accompanying “Qualitative Insights and Strategic Narrative in Niger” with this project’s stakeholders and others interested in a discussion of Phase 1 results. Second, any family planning actor in Niger may take the strategic communications ideas presented here and translate them into communications campaigns

or educational materials. Third, and finally, we will begin this project's Phase 2, to test women's demand for modern contraceptives. The survey instrument and methodology will be developed in February 2014. We expect to submit the survey for review by the national ethics committee in mid-March, 2014, and to field the survey in late April to early May.

Conclusion. It has been a pleasure to engage on this work in Niger thus far, and we expect our enthusiasm to continue throughout the course of this project. This engagement's intent is to provide useful information, insights, and strategic considerations for Niger's family planning community. If you see ways in which we might do so more effectively, please do not hesitate to let us know.

Annex A | Niger Commentator Interviews

We thank the following individuals for taking the time to speak with us about their observations about Nigerien culture, economy, religion – and family planning.

Name	Title	Organization	Interview Type	Date
Ismael Barmou	General Manager	Societe de Transformation Alimentaire	Practitioner	10/10/2013
Jane Bertrand	Chair, Global Health Systems and Development	Tulane University	Academic	10/9/2013
Sarah Burgess	Indendent Consultant, Global Health	Independent	Researcher	10/9/2013
Barbara Cooper	Professor of History	Rutgers University	Academic	10/9/2013
Aissa Diarra	Researcher, Medicine and Antrhopology	LASDEL	Researcher	10/9/2013
Rob Eiger	Advisor	Animas-Sutura	Practitioner	10/14/2013
Alison Heller	PhD Candidate, Sociocultural Anthropology	Washington University	Academic	10/7/2013
Alice Kang	Assistant Professor, Political Science	U of Nebraska, Lincoln	Academic	10/7/2013
Nathalie Maulet	PhD Candidate, Research Assistant	Universite Catholique de Louvain	Academic	9/25/2013
Ellen Thomas	Vice President, Corporate Communications	WomenCare Global	Practitioner	10/4/2013
Mustafa Umar	Director of Education and Outreach	Islamic Institute of Orange County	Religious Scholar	10/11/2013

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The following bibliography provides references for our full literature review. If you would like a copy of the full literature review, please email jessica@cambercollective.com.

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