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Speeches by health providers on family planning in Matamèye, Niger

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Abstract

Purpose: To explore health workers' perceptions of their role in promoting family planning in Matamèye, as well as the barriers and facilitators to the acceptance and use of modern contraceptive methods.

Materials and Methods: An inductive qualitative study was conducted using semi-structured interviews with three health professionals. Thematic analysis, supported by the social ecology model, identified the individual, social, and institutional dynamics at work.

Findings: The interviewed workers demonstrate a strong commitment to family planning. They note growing acceptance among women, but face persistent obstacles: family opposition, rumors, religious pressure, shortages, and work overload. Facilitating factors include the continued availability of services and greater awareness of the risks of closely spaced pregnancies. Professionals recommend free services, better listening to women, ongoing staff training, and the involvement of community leaders.

Unique Contribution to Theory, Practice and Policy: The findings suggest that improving access and acceptability requires a multi-pronged approach: investing in continuous training and recruitment of health staff, ensuring consistent supply of contraceptives, and removing financial barriers through free services. Moreover, the involvement of men, community leaders, and religious authorities is essential to counter rumors and resistance. By integrating these actors and adapting strategies to the local sociocultural context, reproductive health policies can achieve greater effectiveness and sustainability in promoting family planning in Niger.

Keywords: *Family planning, Health workers, Professional perceptions, sociocultural barriers, Contraceptive acceptability, Modern contraceptive methods.*

JEL Classification Codes : I18, J13, O15, Z13

INTRODUCTION

The use of family planning is crucial for optimizing reproductive health, reducing maternal and child mortality rates, and boosting socioeconomic progress in communities, especially in low-income nations. In Niger, a country with one of the highest birth rates in the world (approximately 6.2 children per woman in 2022), access to contraception remains a critical public health challenge (UNFPA, 2023). Despite the government's implementation of various policies to promote modern contraception, the adoption rate is low, with only 18.1% of women using a modern contraceptive method in 2022. (DHS Niger, 2022).

In this context, health workers play a crucial role, both as providers of contraceptive services and as intermediaries between government policies and local sociocultural norms. Access, acceptance, and the quality of family planning services greatly influence their perceptions, attitudes, and habits (Schwandt et al., 2017; Tumlinson et al., 2015). It is therefore possible to more precisely understand the dynamics of implementing reproductive health services by understanding their discourse, especially in rural areas where obstacles are numerous.

Matamèye, a department in the Zinder region of eastern Niger, is a perfect example of these challenges. This rural region is characterized by a strong reliance on religious and traditional norms, significant economic dependence on women, and a still precarious health infrastructure (Ministry of Public Health of Niger, 2021). In this context, health professionals must constantly find a balance between technical directives from reproductive health policies and the demands of local communities. Thus, their proposals are not objective; they highlight both the structural challenges and the institutional restrictions and sociocultural situations they face. (Kane et al., 2016).

Their role has been widely highlighted in the literature. Various studies conducted in sub-Saharan Africa have demonstrated how the personal attitudes of health professionals, their level of education, their religious or ethnic beliefs, and their vision of female behavior imply their willingness to offer certain forms of contraception (Solo & Festin, 2019; Sidze et al., 2014). Sometimes, prejudices regarding single women or adolescent girls may have access to modern methods, despite official recommendations (Wood & Jewkes, 2006; Chandra-Mouli et al., 2014). Other studies have shown how the lack of resources (stock shortages, lack of qualified personnel, work overload) negatively affects the quality of advice and the availability of services (Tumlinson et al., 2013).

However, there is a lack of studies that focus on the providers' own narratives in specific contexts such as Matamèye, where family planning is still largely considered an external approach, sometimes at odds with local norms. The qualitative method used in this research offers the opportunity to record these narratives, not only as professional testimonies, but also as results of a complex social, institutional and moral environment. It seeks to answer the following question: what is the perception of health workers regarding their role in promoting family planning in Matamèye? and what are, from their point of view, the main obstacles and facilitators in terms of acceptability and use?

This work is carried out from a socio-anthropological perspective, drawing on the social ecology model (Bronfenbrenner, 1979), which facilitates the examination of interactions between individual, relational, community and institutional levels in the context of health practices. This study, carried out through interviews with health professionals active in health facilities in Matamèye, examines the tensions, adaptation methods and room for maneuver used by these front-line workers. It therefore helps to deepen knowledge of the dynamics of adoption

or refusal of family planning services in Sahelian environments, and to fuel discussions on training, reproductive health policies and strategies taking into account local contexts.

Most recent DHS (EDSN-MICS IV 2012): Among women in union, 12% were using a modern contraceptive method. Pills (6%), LAM/MAMA (4%) and injectables (2%) dominated the mix; modern use was 27% urban vs. 10% rural.

Next national population survey after DHS (National Survey on Fertility and Infant Mortality 2021): 10% modern contraceptive prevalence among women in union a decline from 2012, after a peak around 18.1% in 2017 seen in medically assisted procreation rounds. The brief attributes the 2021 dip partly to the COVID-19 context and method mix shifts (greater use of implants/IUDs, less pill use).

Most existing studies on family on family planning in Niger and the Sahel have focused on the demand side, especially the perspectives of adolescents and young women regarding contraceptive knowledge, fears, and cultural constraints. Other research has examined married women's decision-making and the role of men, policymakers, or community leaders in shaping contraceptive uptake. These works have highlighted issues such as spousal refusal, religious norms, and rumors surrounding modern methods. However, the supply side particularly the lived experiences and perceptions of frontline health providers remains comparatively underexplored. Yet, providers are the critical interface between health systems and communities: they ensure availability, deliver counseling, and mediate sociocultural tensions during service provision. In rural districts like Matamèye, where contraceptive prevalence remains below national averages, understanding providers' narratives is essential to uncovering structural and cultural bottlenecks that are often invisible in demand-side research. By foregrounding their voices, this study addresses a significant gap in the literature and offers insights for both policy and practice.

Theoretical Framing

This study draws on the social ecological model to situate health providers' narratives within multiple, interacting layers of influence. Providers' testimonies are not analyzed solely as individual opinions, but as reflections of broader social, cultural, and institutional dynamics. Four ecological levels are mobilized:

- **Individual level:** Providers' own beliefs, attitudes, and professional experiences regarding family planning (e.g., years of service, personal convictions about contraceptive safety). This level captures how knowledge, motivation, and confidence shape counseling practices.
- **Interpersonal level**: Providers' daily interactions with women, husbands, and families. Testimonies at this layer reveal how marital opposition, rumor circulation, or family pressures influence service delivery and providers' capacity to negotiate sensitive situations.
- **Community level:** Wider norms, values, and expectations embedded in the local social fabric of Matamèye, including the influence of religious leaders, elders, and peer networks. Providers' accounts highlight how these collective dynamics can either reinforce resistance or create openings for acceptance of family planning.
- **Institutional / Policy level**: The health system environment, encompassing supply chains, facility resources, training directives, and national family planning strategies. Providers' testimonies illuminate how structural factors stockouts, workload, lack of supervision, or programmatic priorities condition the scope of their practice.

By mapping providers' narratives across these levels, the study captures the multi-layered barriers and facilitators that shape family planning delivery in rural Niger. This framing makes visible the intersection of personal beliefs, sociocultural pressures, and institutional constraints, providing a holistic understanding that demand-side research alone cannot achieve.

West African scholarship underscores the centrality of providers in shaping contraceptive choice and access. Beyond classic "gatekeeping," newer analyses document both restrictive and steering forms of provider bias, with counseling dynamics influencing autonomy and method fit (Solo & Festin, 2019; Jain et al., 2023). Concurrently, evaluations of community-embedded strategies including gender-synchronized and faith-leader engagement demonstrate promising shifts in norms and FP uptake in the region, from rural Niger's RMA intervention to faith-leader initiatives in Nigeria and Ghana (Riley et al., 2023; Apanga et al., 2023). Programmatic syntheses in implementation science further show that sustained gains depend on health-system enablers reliable commodities, adequate staffing, and provider behavior change linking institutional arrangements to counseling quality (Frontiers, 2022; Breakthrough ACTION, 2020). Anchored in the social-ecological model, our focus on providers' testimonies in Matamèye therefore addresses an underexplored interface where individual beliefs, community norms, and institutional directives converge.

Problem Statement

Niger continues to record one of the highest fertility rates in the world, alongside low contraceptive prevalence. According to the Demographic and Health Survey (DHS), modern contraceptive use among married women rose only modestly from 12% in 2012 to 14% in 2022, reflecting slow progress despite decades of family planning (FP) initiatives. This limited increase highlights persistent barriers that undermine FP adoption, especially in rural districts such as Matamèye.

Much of the existing scholarship in Niger and West Africa has focused on the demand side of FP examining adolescents' needs, women's reproductive choices, and the influence of men, religious leaders, and cultural norms. While these studies have generated valuable insights into user perspectives and sociocultural constraints, they leave an important gap: the voices of frontline providers**.** Health workers are key gatekeepers in FP delivery, tasked with counseling, ensuring commodity availability, and negotiating community sensitivities. Yet, their perceptions, challenges, and coping strategies remain underexplored in the literature**.**

This study addresses that gap by systematically examining the narratives of FP providers in Matamèye, using an ecological lens that connects individual beliefs, interpersonal dynamics, community norms, and institutional directives. In doing so, the research highlights how providers themselves interpret the barriers to FP access, how they respond to sociocultural resistance, and what systemic factors shape their service delivery practices.

The findings are expected to benefit several groups:

- **Policymakers and program managers**, by generating evidence on how national FP policies translate into realities at the facility level.
- **Health system managers**, by identifying areas of provider support, training, and structural improvement.
- **Local communities and women**, who indirectly benefit from services that are more culturally sensitive, provider-informed, and better aligned with their reproductive health needs.

MATERIALS AND METHODS

Type of Study and Methodological Approach

This research is based on a descriptive qualitative method, the objective of which is to examine the perspectives, behaviors, and experiences of health professionals regarding family planning in Matameye, Niger. It is part of an inductive approach, meaning that the study was developed based on field data, without any pre-established hypotheses. This process is particularly suited to analyzing complex phenomena rooted in specific social and cultural environments.

The theoretical framework of social ecology (Bronfenbrenner, 1979) also guides this research, considering that human behaviors, especially related to reproductive health, are the result of diverse interactions between individual, relational, community, and institutional levels. This context helps us understand how health professionals, as intermediaries, navigate social norms, health policies, patient demands, and their personal beliefs.

Study Setting

The survey was conducted in the Matameye health district, located in the Zinder region, in eastern Niger. This rural setting is characterized by a strong influence of traditional and religious norms, limited use of modern contraceptive methods, and sometimes inadequate availability of care. Despite their existence, local health facilities face material and human barriers to achieving quality and access to family planning services.

Study Population and Sampling

The survey focused on health care providers involved in the delivery of family planning services at the primary level (health district and the Matameye Integrated Health Center). This included, among others, nurses and midwives.

Selective (or targeted) sampling was used to ensure a variety of profiles: gender, seniority, type of structure, geographical location (rural or semi-urban). The sample size was decided on the basis of the concept of data saturation, that is, until the interviews no longer provided new information. In total, three semi-structured interviews were conducted.

Data Collection

We collected information using a semi-structured interview guide, designed based on existing documentation and modified following a pre-test conducted on two health workers. This guide included open-ended questions that allowed for the discussion of various topics:

- Providers' personal perceptions of family planning;
- Obstacles encountered in daily practice (social, institutional, logistical);
- Strategies used to counsel women;
- The influence of social and religious norms on their work.

Interviews were conducted in French, or Hausa, depending on the participants' preference, between [October 29 and November 11, 2024] in locations that guaranteed confidentiality. All interviews lasted 30 to 60 minutes and were documented with the participants' verbal and written consent.

Data Analysis

An inductive thematic approach was used to conduct the data analysis. Following multiple analyses of the transcripts, open coding was implemented to identify relevant units of meaning. These codings were then classified into categories and then into main themes, highlighting the salient aspects of the healthcare professionals' discourse. The data coding and organization process was facilitated through the use of NVivo 14 software (QSR International).

The analysis was conducted iteratively, constantly oscillating between the raw data, emerging categories, and the theoretical framework. This approach highlighted tensions, paradoxes, and adjustment tactics in the providers' actions and words.

Ethical Considerations

The study was conducted in accordance with the ethical principles of qualitative research. All participants provided informed consent, being informed of the study's aims, their right to withdraw at any time, and the confidentiality of the information obtained. Interviews were anonymized, and data were stored securely. The research was approved by the Committee of the Institute of Life and Earth Sciences of the Pan African University**.**

FINDINGS

Thematic Analysis Table – Health Workers' Perspectives on Family Planning in Matamèye

Category / Theme	Key idea or observation	Illustrative quotation	Source
1. Professional experience and role	Workers with long experience in family planning services	*"I've been working in family planning for 8 years."*	Health worker, 8 years
	Active staff available even outside standard hours	*"We provide family planning services even at night."*	Health worker, 8 years
	Commitment to listening and welcoming women	*"We are here to serve women. We welcome them properly."*	Health worker, 12 years
2. Perceptions of family planning	Increased use, better information among women	*"Before, they didn't know the importance. Now, they use family planning a lot."*	Health worker, 17 years
	Growing but incomplete acceptance	*"It's still not fully accepted, due to the husband's or family's refusal."*	Health worker, 12 years
3. Barriers to access	Rumors, family opposition (husband, co-wife, extended family)	*"The men, the surroundings, the rumors."*	Health worker, 8 years
	Women's lack of punctuality and patience	*"Women must come on time."*	Health worker, 12 years
4. Facilitating factors	Awareness of risks related to closely spaced births	*"Closely spaced births are not good."*	Health worker, 8 years
	Continuous availability of services	*"We respond to women's needs at any time."*	Health worker, 12 years
5. Service evaluation	Overall positive assessment of service quality	*"Everything is fine. The methods are available."*	Health worker, 17 years

Category / Theme	Key idea or observation	Illustrative quotation	Source
	Need for continuous training to avoid mistakes	*"We need qualified health workers for family planning."*	Health worker, 17 years
6. Suggestions for improvement	Free services, listening to women, adapting to their needs	*"Everything should be free. Listen to women, provide methods based on their needs."*	Health workers, 8 and 12 yrs
	Hiring more staff and avoiding stockouts	*"The state must recruit more health workers and avoid shortages."*	Health worker, 12 years
7. Existing initiatives	Sensitization during services, including antenatal and postnatal consultations	*"Raise awareness during antenatal consultation, after delivery..."*	Health worker, 17 years
	Reaching accompanying women	*"Even when a woman accompanies another, she can be sensitized."*	Health worker, 17 years
8. Proposed strategies	Mobile caravans, outreach, local sensitization in neighborhoods and villages	*"We should organize caravans in villages where marabouts are resistant."*	Health worker, 12 years
9. Role of men and community leaders	Men and leaders must help counter rumors and promote family planning	*"Marabouts must be sensitized and should sensitize one another."*	Health worker, 12 years
	Collaboration with local leaders and elected officials	*"We need to involve local leaders and elected officials in awareness campaigns."*	Health worker, 12 years

Health workers interviewed in Matamèye demonstrated strong commitment to family planning (FP), ensuring continuous availability and attentive care. They observed growing acceptance of FP among women, though still hindered by resistance from husbands, families, and prevailing rumors.

The main barriers are sociocultural but also organizational, such as women's lack of punctuality and stock shortages. Nevertheless, the agents identified facilitating factors like awareness of the risks of closely spaced births and the constant accessibility of services. They proposed concrete improvements: free services, active listening to women, better training, and recruitment of new staff. Existing strategies such as sensitization during consultations—are seen as useful but insufficient.

Agents suggested more targeted actions: outreach caravans, interventions in resistant villages, and involvement of marabouts. The role of men and community leaders is considered crucial. Altogether, these perspectives highlight complex dynamics between progress and persistent barriers. These testimonies offer concrete recommendations for adapting reproductive health policies to the local context.

CONCLUSION AND RECOMMENDATIONS

Conclusion

The testimonies of health workers in Matamèye reveal the tensions between family planning policies and local sociocultural realities. Although highly committed, these professionals face social resistance, material constraints, and a lack of resources. Their role goes beyond simply enforcing guidelines: they negotiate between community norms and institutional requirements. Strengthening training, adapting awareness-raising strategies to the local context, and involving community leaders appear to be essential levers for improving the acceptability and effectiveness of family planning services in rural Niger.

Policy Recommendations

Findings from this study highlight several areas where policy and programmatic action can strengthen family planning (FP) uptake in Matamèye and comparable rural settings in Niger.

- **Strengthen provider capacity through targeted training**
    - Develop continuous professional development modules focusing on culturally sensitive counseling**,** enabling providers to address misconceptions and navigate opposition from spouses or community elders without alienating users.
    - Integrate specific training on adolescent access to FP**,** equipping providers to manage confidentiality, stigma, and ethical dilemmas while aligning with national adolescent health strategies.
    - Reinforce skills in managing side effects and method switching, ensuring that women receive responsive follow-up care that sustains trust in the health system.
- **Engage key community stakeholders to build acceptance**
    - Actively involve religious leaders (imams, marabouts) in sensitization campaigns, framing FP within culturally and spiritually acceptable narratives.
    - Collaborate with traditional chiefs and village leaders, who hold authority to legitimize FP as part of community well-being and development.
    - Strengthen partnerships with women's associations and youth groups, leveraging them as trusted intermediaries for peer education, rumor management, and grassroots mobilization.
- **Institutionalize supportive supervision and resource provision**
    - Establish structured supervisory visits to provide providers with feedback, mentorship, and emotional support in handling sociocultural pressures.
    - Ensure reliable supply chains for contraceptives and informational materials to reduce service delivery disruptions that undermine provider credibility.
- **Promote multi-level dialogue**
    - Facilitate regular forums between providers, policymakers, and community leaders to ensure alignment of national FP directives with local realities, reinforcing mutual accountability.

This study extends Sahelian family planning (FP) literature by shifting the focus from users to frontline health providers, capturing their lived experiences, strategies, and negotiations in delivering FP services. While most research emphasizes women's knowledge, attitudes, and

sociocultural constraints, this study documents how providers navigate family opposition, religious pressures, rumors, and institutional limitations such as stockouts or workload. By foregrounding provider narratives, it reveals the adaptive practices they use counseling, engaging community leaders, and tailoring services to bridge the gap between national FP policies and local sociocultural realities. This perspective enriches the literature by highlighting the provider–community interface, showing that improving FP uptake requires attention not only to women's choices but also to how providers mediate, negotiate, and facilitate access in complex rural Sahelian contexts.

This study is qualitative and based on three in-depth interviews with health providers in Matamèye, which allows for a detailed understanding of local experiences and practices but limits the generalizability of the findings to other districts or regions in Niger or the broader Sahel. Additionally, because participants were aware that the study focused on their professional practices, their responses may reflect social desirability or professional self-presentation, introducing potential response bias. Despite these limitations, the study provides valuable insights into provider strategies, negotiations, and the sociocultural dynamics shaping family planning delivery in a rural Sahelian context.

To build on these findings, future research could adopt mixed-methods designs, combining qualitative insights from providers with quantitative measures of contraceptive uptake, service quality, or community attitudes. Comparative studies across different districts or regions in Niger and the Sahel could also help identify context-specific versus generalizable patterns in provider negotiations and sociocultural barriers. Such approaches would strengthen the evidence base for designing interventions that are both locally sensitive and scalable, bridging the gap between provider practices, user experiences, and health system outcomes.

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