Contextual Factors, Gender Relations within the Couple and Family Planning Use in Dakar, Senegal

Mariam Ben Aya[a] and Macoumba Thiam[b]

March 2004

Paper prepared for presentation at the Annual Meeting of the Population Association of America, Boston, MA, USA, 1-3 April 2004

[a] School of Social Work – Université de Montréal, Montreal, Canada
[b] Department of Demography – Université de Montréal, Montreal, Canada

Abstract

We use qualitative data from Dakar, Senegal collected in 2001 to analyze the impact of gender relations and contextual factors on the use of modern contraception by married couples. Our findings revealed that virtually all women had to first challenge their husband's authority before resorting to contraception. Some women did so by encountering a conflict and others in a more consensual way that avoided direct confrontation with the husband. In both cases, challenging men's authority was possible mainly because of the economic plight that results into the derivation of men's economic power and the relatively new phenomenon of women participating in the household economy. However these changes did not yield a more egalitarian gender relation between the couple in many other respects since nearly all women still grant their husband the right to exert power. Women submission to their husband stems from the ingrained social and cultural norms that dictate men's powerful position.

Introduction

The demographic transition in the West has shown that the changes in reproductive behaviors are inevitable consequences of social change through two different processes that act independently: "*[t]he first involves the general influence of economic and cultural change on society and individuals; here we refer to this as socioeconomic modernization. The second involves the influence of the economic and cultural change on the status of women; we call this the female status effect of social change*." (Benefo 1995: 139-140). The debate among scholars on the relative importance of the impact of the contextual versus individual characteristics on reproductive matters in the developing world, especially in Sub-Saharan Africa, is still in progress. Some researchers argue that personal feelings are the main factors that govern fertility decision-making (Wilkinson *et al.* 1994, Binyance *et al.* 1993) while others think that cultural norms and social practices are prominent (Hull 1983). Gender relations are one of the factors that are have the greatest impact on reproductive matters. Indeed, gender relations are not a fixed reality in time. Some conditions favor emergence of new gender relations. Economic changes for example may call into question previous relations within the couple and may even lead to some balanced relations (Yana 1997).

In this paper, we use a systemic approach (Dumond 1981) that integrates the contextual factors, the couple and familial characteristics as well as the individual characteristics into the same framework to explain the decision-making process that leads to contraceptive use. We employ qualitative data gathered among married couples in the Medina area of Dakar, the capital city of Senegal.

Theoretical perspectives

Focus on women

Although women's reproductive life has been recognized "*as a lifelong process inextricably linked to the status and roles of women in their homes and societies*" (Freedman & Isaacs 1993: 18), the strategies aimed at improving women's reproduction have been curiously centered only on women, seen as the central actors to their

reproduction (Greene and Biddlecom 2000, Touré 1996). The primary focus on women is to be related to the fact that most contraceptive methods are designed for use by women (Barnett 1998a) and offered within maternal and child health centers, where men were generally excluded from (Robey and Drennan 1998). However, women in Sub-Saharan Africa were found not being the sole decision-makers about reproductive matters, especially modern contraception use (Blanc *et al.* 1996). Even the couple singled out does not operate as a decision-making unit (Bankole 1995). Decisions about reproductive matters involve many other actors such as husband, family members, in-laws, friends, health professionals or religious leaders (Blanc et *al.* 1996, Caldwell 1987, Wulf 1985). Among all these actors, men have the strongest impact on the reproductive health decision-making in Sub-Saharan Africa. Their characteristics and attitudes tremendously influence theirs wives attitudes, initiation and continuation of family planning (FP) use (Dodoo 1998, Isiugo-Abanihe 1994, Dodoo 1993), while the converse is not always true (Ezeh 1993). This stems from the women's low legal and social status vis-à-vis their husband, in-laws and own parents (Wulf 1985). Men by their own are also viewed as barriers to their wives' FP usage through their false perception that giving their wives means to control their fertility without consulting them will undermine their authority as head of the family or encourage female infidelity and promiscuity (Mistik et *al.* 2003).

Involving men

The idea that men are barrier to their wives' FP use was mainly based on women's declarations of what they perceived as their husbands' knowledge of, perceptions of and attitudes towards FP (Speizer 1999). However, due to poor interspousal communication on reproductive matters, wives' declarations about their husband's feeling about modern contraception may be misleading (Nagase et *al.* 2003, Touré 1996). For instance empirical data from six Western African countries have revealed that some wives declared that their husband oppose FP while the latter reported the contrary (Robey and Drennan 1998). Others even argue that men are not barriers to FP; rather they are more supportive to it than their stereotypes suggest (Ezeh et *al.* 1996). Recent data gathered directly from men themselves throughout the continent reveal that 1) they are more likely to be interested in, to know about and to approve of contraception than is usually

assumed and 2) few of them desire more children than their wives (Robey and Drennan 1998, Ezeh et *al.* 1996). Men are also aware of the health and economic benefits for their FP usage may bring and expect to be involved in the decision after the wives initiate discussions about contraceptive use as reported by a survey from Zimbabwe (Barnett 1998a).

The gap between men's approval of FP and usage may come from 1) their exclusion from the programs aimed at promoting FP, whereas the power of decision-making is bestowed on them (Dodoo 1998) and 2) the poor communication between partners about reproductive matters. Many studies have found that couples who discuss FP are more likely to use it (Terefe and Larson 1993). Conversely, the direction of the relation is not clearly known so far. Discussion may precede use but use may invite discussion on FP, as well as both of them may be true (Robey and Drennan 1998). It then appears that involving men and their families in order to gain their support and commitment to FP is crucial in Africa, given their elevated position in the African society (Barnett 1998a, Touré 1996). This strategy was supported by the recommendations of the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing (Mistik et *al.* 2003, FNUAP 1994). However, many obstacles prevent women to openly discuss FP. For example according to (Barnett 1998a), "*in general, some women say they are too shy or too busy to begin discussions with their husbands; others fear their husband's response or worry that their knowledge of sexual issues could be interpreted as promiscuity or infidelity*".

Going beyond the gender approach: a systemic approach

In order to improve male involvement, understanding the context within which the reproductive health decisions are made is crucial (Isiugo-Abahihe 1994). This context refers both to the gender and family relations and to the global cultural, social, economic and institutional context that shape these relations. In this paper, we will argue that not only are both levels relevant, but also the interaction between them is equally. As Dumont (1981) argued, we believe that the systemic and relational approach is the most

appropriate way to study interconnections between the global context, the gender relations and the social and sexual roles within a society.

To do so, one needs to go beyond the outcome of the decision-making process that is generally collected through quantitative demographic surveys. One needs to address the whole process and its determinants at different levels in order to better understand the complexities of the mechanisms favoring or preventing use of FP services (Andro 2000). For that reason we will employ qualitative data on modern contraception use with married couples in Senegal that were collected in an urban setting in Dakar (Senegal) during year 2001. More specifically we will describe the FP use process: motivation of use, implementation, disclosure of the use status in case of clandestine use, reaction of the husband/negotiation, and continuity of practice. We will assess the impact of gender relations on each of this steps and how contextual factors shape this impact. An understanding of these interconnections may help improve reproductive health behaviors and outcomes.

We focus on married couples that are current FP users because the prevalent approaches in the literature neglect somewhat the thorough study of the success stories of those couples that have managed to go through a negotiation process that lead them to use modern contraception. Rather, they primarily focus on couples that do not use FP and on the determinants of their failure to do it. Yet it is sound to base the recommendations to improve FP on conclusions drawn from the example of couples that, within the real life conditions, have managed to overcome all the obstacles against FP usage.

The Medina area: an original mixture of tradition and modernity

The fieldwork took place in Medina district, located in Dakar, the capital city of Senegal. Two main reasons guided our choice of the survey site. First, Medina harbors the second oldest and one of the largest FP service delivery points (SDP) in Senegal. The SDP was established in 1976 and funded by the United-States Agency for International Development (USAID) and the United Nations Fund for Population Activities (UNFPA) (Douglas et *al.* 1985). The Medina SDP is also the seat for the National Service in charge of Reproductive Health, the former National FP Program. The contraceptive prevalence

in Medina is presumably closed to the one recorded at the regional level. According to the latest Senegalese Demographic and Health Survey (DHS 1999), only 18.6% of married women in Dakar were using a modern contraceptive method at the time of the survey (Sow et *al.* 2000).

The second reason is the unique feature of Medina that mixes both traditional and modern life. Medina is an old suburb erected close to downtown Dakar in 1914 during the colonial era to quarantine local populations infected by the plague virus that broke in the region at that time[1]. One can find virtually all types of households in Medina with socioeconomic statuses ranging from the most affluent (landowners, traders), to middle class (public servants) and the lowest classes (the unemplyed). Despite of its closeness to downtown Dakar and its integration to the intensive economic activity (formal and non-formal) of the capital city, Medina is a popular area that has traditional structures that place it between modernity and traditional life. The Lebou (a subgroup of the Wolof, the largest ethnic group of Senegal) are the first inhabitants of Medina and form the majority of its population. They have a unique and hierarchical social organization based on the existence of traditional chiefs recognized by local populations and governmental authorities who rely on them in the resolution of some conflicts and in the management of natural resources (fishing, land).

Data and Method

We use qualitative data gathered in the Medina district from July through November 2001. Overall we conducted 20 in-depth semi-structured interviews with 10 women and their husbands along with two focus group discussions with respectively the husbands and the wives. The criteria for inclusion in the sample was being a married couple, living in the Medina area and being currently using a modern contraceptive method (Pills, Injection, the Norplant, Intra Uterine Device, Condom, Sterilization, or spermicidal). Each member of the couple had to first sign the informed consent form before the couple was definitely included in the sample. In a case a participant was unable to read and

[1] This official reason has been recently challenged by a scholar who argued that the idea of separating the French colonizers from the local indigenous population predates the plague epidemic (for more information, see the official website of the District of Medina: http://www.sip.sn/Medina/).

understand fluently French, he/she was asked to choose anyone in his/her family he/she trusts to translate the paper for him/her. The consent form explained that participation in the study was voluntary, that respondents had the possibility to cancel the interview at anytime, that nowhere in the research documents and materials or future publication, their name or another indication that may help identify them will appear, and then access to the data will be strictly limited.

A son of a traditional chief helped us identify and recruit the first survey participants. Later on we used the snowball sampling method to identify and recruit the rest of the sample. Two members of each couple were interviewed separately and simultaneously to avoid any communication between them and the later interviewed adjusting his/her responses to his/her partner's. The timing and the venue of the interviews were let to the respondents' disposal. After all the individual interviews were completed, we conducted two focus groups; one with the husbands and another with the wives. The focus group was aimed at validating the information gathered during the individual interviews by creating a contradictory debate from which we expected a more real picture of the reality on reproductive health behaviors will emerge.

Information gathered encompass childhood and socialization, type of household where the respondent was raised, his/her perception of his/her role as a wife or a husband within the couple, the circumstances surrounding the first time they met, their marriage process, their reproductive and various factors that facilitate or impede FP decision-making, and finally, the respondent's own experience regarding use of contraception. The interview was semi-directive, so that other issues may be gathered throughout the interview. The first author of this paper conducted the interviews and the focus group with women. She was assisted by a male interviewer who worked with the husbands. All the interviews and focus group discussions were conducted in Wolof, the Lebou's mother tongue. The information was then taped and translated into French. We resort to the *phenomenological content analysis*[2] to analyze the data. As explained by Lesler (1999), "*[t]he purpose of the phenomenological approach is to illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation*".

[2] See Lester (1999) and Fortin (1996) for an introduction to *Phenomenological Analysis*.

We define the decision-making process as a communication between a husband and his wife on reproductive health, especially the use of modern contraception. The outcome of this communication is not always certain. It may then lead to a range of interactions or even to a conflict between the spouses. The final decision will depend on power relations between the couple that are heavily culturally and socially defined, but are more and more altered by the economic change. Even if a decision happens to be taken, it may be called into question later on and a new process of negotiation starts again. The decision-making process does not necessarily end with a definite and consensual decision.

Results

Sample description

The sample is composed of 20 respondents, of which 10 consists of women and the others their husbands. With the exception of two women that belong to the Serer group, the third largest ethnic group in Senegal, all of the women are of Lebou origin. The women range in ages from 27 and 42 years old while the men are 34 to 64 years old. The wide age range of the respondents gives indication that they have different life experiences and were at different stages of their life cycle at the time of the survey. Age difference between spouses varies considerably from 3 to 23 years with husbands being typically older than their wives. This may place the wife in a more subordinate position due to him being older and the seniority associated with his masculinity (Thiriat 2000). All respondents except three women have a certain level of education, ranging from six years schooling to high school. In general, men are better educated than women, except in two cases. The gap between the spouses' level of education may render problematic their ability to openly discuss FP matters and to come to some form of agreement.

All of the men have been vocationally trained and also follow these occupations. Of the men that are employed, three are paid-employees and six are self-employed. One men is unemployed. It should be noted that none of the women possesses professionally training. Women work in the petty trade and their clients consist mainly of their own parents, in-laws, neighbors and friends. This constitutes also a social support network. Women's

financial autonomy vis-à-vis their husband and their participation in the labor market and the household expenses may cause a power conflict. Interestingly, eight out of 10 male respondents live in their extended family household and one of them in his wife's family. The men's depending on their extended family and family-in-law may eventually alter their authority as head-of-household. Living in the same household as one's in-law may also reduce considerably a woman's power to manage her own family and reproductive life. According to Barnett (1998b), parents and in-laws may discourage couples from using FP to delay pregnancy, but encourage couples to use FP to limit or space births after they have a large family.

In all the cases, the spouses belong to families that were neighbors and previously knew each other. This may presage a great deal of in-laws involvement in the couple's life when comes time to make decision about reproductive health matters or to solve conflict between the spouses. Couple formation was preceded and motivated by a premarital pregnancy in four cases out of ten. In general, the respondents were reared in extended families including the biological parents and siblings as well as cousins, aunts, uncles, grand-parents, fostered children, and so on.

All respondents are Muslim. Their socialization includes values taught at Koran schools for men and by older women for girls during early childhood that tends to impose strict control over sexuality. On the other hand, modern education acts as a disturbing influence on this religious and traditional socialization since it brings people out of the traditional norms that they have been bound too, and exposes them to modern ideas that favors gender mixture in a setting that escapes parental control (Rwenge 2000). As a result, more and more girls are exposed to delaying their first marriage and to having pre-marital affairs. However, the family remains the most prominent setting where most part of the socialization is performed. These nested levels of socialization add a level of complexity in the individual's life and may introduce great heterogeneity in the population depending on the level of socialization that has the greatest impact.

Main findings

The process leading to resort of modern contraception can be broken into six different steps: the *motivation* to use, the *implementation*, the *disclosure* of the use status in case of clandestine use, the *reaction* of the husband/*negotiation*, and *continuity* of practice. Each of these stages is determined by the global context, the both partners' individual characteristics, the characteristics of the couple and the gender relations.

- *Motivation and first use*

The decision to use modern contraception is a result of a process that does not only involve present events and situations but includes the entire life cycle. The motivation and the timing of the first contraception use seem to be directly influenced by several factors: childbearing experience before the current union, current number of children, the child and mother's health. FP has never been used before the birth of the child. In some instances, FP was used after a reproductive mishap. The economic plight (joblessness, residential promiscuity, lack of resources) and uncertainty about the future influences couples to consider limiting their family size. In nine couples, the decision to use contraception was mainly motivated, but not exclusively, by health-related reasons. However, the health argument seems to have played the crucial role in gaining men's approval of contraception. This appears from the declaration of a 27-year old woman, with six years of schooling and without job:

> "*Yes, my first child, it was hard because I was hospitalized during the pregnancy (...) with my second child, it was the same story (...) I needed again to be hospitalized and my husband was fed up of the pregnancies. He was really fed up. Finally, we have talked and I adopted family planning*".

In the majority of the surveyed couples (eight out of 10), it was the woman who initiated the use of contraception.

> "*That's me who had the idea [to use contraception] for economic reasons because my husband has no job. That's me who work. Given those conditions, if I am to become pregnant each year, I would no longer be able to work, and then we*

run the risk to having nothing to wear" (Woman, 35 years, no education, maidservant)

Some of the women have started contraception use without their husband's agreement and let him know later on while others did it clandestinely. Even if women initiate the contraceptive discussion and use, men tend to appropriate it later on, especially during the focus group discussion. These were generally men with low economic status and low level of education. On the other hand, if the initiative came from men, women accepted automatically. This reflects the traditional values that dictate women to fulfill their husband's desire, especially when he is the only household resource provider. The motivation to use contraception may also arise following a sister's advice or a health professional's recommendation. In one of the couples for instance, the wife has decided to use contraception after her sisters advised her regardless of the spouse opinion. She could ignore her husband's opposition because the man lives in her family's household. Yet when interviewed, the same man declared that the initiation to use contraception comes from him after evaluation of his poor economic condition.

The respondents, male and female together, tended frequently to deny or minimize the influence of their family environment on their decision or not to resort to modern FP. Such an attitude was more prevalent among the youngest couples. Probably this comes from their desire to preserve their intimacy and reproductive life. It is an indication that they are more willing to be emancipated from traditional rules and want to preserve their own generation's ideals. In younger couples, FP use refers to some extent to the complicity between the spouses.

To sum up, respondents can be divided into three groups depending on the motivation and the timing of their first use (the most used method is the Norplant system due to its versatility and long-lasting effectiveness):

- Couples that start their reproductive life at the same time as the formation of their current union (three couples). The use of modern contraception among this group started respectively after the birth of the first, second and third child.

- Couples where at least one of them had a child from a previous union (three couples). For these couples use of modern contraception occurs later (after the birth of a third child) and seems to be prompted by health related problems during pregnancy and/or delivery.
- Couples that were formed after a prenuptial birth (four overall). For three of these couples, FP use was motivated by health-related reasons.

- *Disclosure of the use status, reaction, negotiation and continuity*

Some of the men interviewed reported that they oppose modern methods of FP even though their wives use it. The reasons they gave include religious ones, desire of more children, misconceptions about FP, side effects, preference of natural methods. In the woman's case, she resorted to contraception before letting her husband know, different reactions have been observed depending on how the man came to know. Some men are informed after the decision has been already implemented while others discover the FP use of their wives accidentally. There was one reported case of a man whose wife has clandestinely used an IUD for six years before he discovered it during a sexual act that closely followed menstruation. Generally, the men's reactions to the disclosure of the use status by the woman did not follow immediately. Some men were angry to know and even have threatened the women to take a second wife. No woman has reported physical violence or threat.

> "*I did not react, it was her decision. What concerns me is what the health professionals told me about these methods…. Even them, they do not use them. My wife uses Norplant. From time to time she has headache, palpitation (...) I explain to her that I agree with birth spacing but I oppose the pills, Norplant and the others [modern] methods. I am also against the limitation of births. You know she is free. But as for me if the situation comes to improve, I may marry a second wife. Me too I am free.*" (Man, 46 years, vocational training, electrician self-employed).

The wife of that man has reported for her part that her husband has threatened to lodge a complaint against the health professionals who implanted the Norplant in her without his

previous consent. As for the continuity of the use of contraception, it depends on the men's collaboration in the initiation of the use or his reaction at the disclosure of the use; but it also depends on the woman's characteristics. The most traditionalist and economically dependent women are those who first sought their husband's consent before using contraception and who were ready to abandon it if their husbands asked then to do so. For example this 29-year old woman who is a maidservant, with no education and reared by her homonym in an extended and very conservative family said:

> "*If he had not accepted, I would give up and follow him in what he would like because after all, I am his wife (…). The wish of every married woman is to fulfill the desire of her husband. It is related to my education. I hear old people saying that (…) a wife who is submissive to her husband will have all her prayers granted by God. That's why I am submissive to him and I do my utmost to make him happy.*"

The other women who are more modern and economically independent reported that they intended to continue using contraception no matter what the reaction of their husband would be. This opinion is reflected by a 35-year old woman declaration. She completed 10 years of schooling, and was trained as a secretary, but worked unpaid at the time of the survey. She has two children and has decided to use contraception for economic reasons despite her husband's strong opposition:

> "*He does not approve so far. From time to time, he reacts for about two days before calming down. Later on, when the family planning hits his mind again, he starts over. Some times he goes as far as threatening me and demanding the method being removed the same day or the day after. But that's me who is stubborn.*"

The women who first seek first their husband's approval of contraception before using it tend to be more traditional and more economically dependent while the others can be depicted as modern and more capable to manage their reproductive life by their own. They are innovative in the sense they have managed to break traditional rules that devote respect and obedience to husband. However, during the focus group discussions both

types of women granted men the right and the authority to dominate the decision-making about reproductive behaviors within the couple.

Conclusion and discussion

The systemic approach we adopt here reveals interesting findings. Our main result points to a substantial impact of the gender relations on the decision-making process regarding the use of modern contraception. Virtually all women needed first to challenge their husband's authority before resorting to contraception. They did so either by encountering a conflict or in a more consensual way that avoided direct confrontation with the husband. In both cases, challenging men's authority was possible mainly because of the economic plight that results into a) the derivation of men's economic power that erode their status as head of household and b) the relatively new phenomenon of women participating in the household economy. In general, the men who were unemployed, had precarious jobs, were living in the household of their own family or of their family in-law are more opened to the idea of the wife taking the decision to use FP. However, men no longer support such a behavior in public places, as revealed by the focus group discussion. Moreover, the woman's education and economic activity and circumstances surrounding the union formation tend to bring the couple to a more balanced gender relationship. The most consistent finding is that FP is used and accepted more easily when a woman's health is being threatened. In that instance men are ready to ignore their own interest and expectations in the lieu of preserving their wives' and children's health.

However, the observed changes did not yield an egalitarian gender relation between the couple in many other respects since nearly all women still grant their husband the right to exert power. This stems from the ingrained social and cultural norms that dictate men's powerful position. Even those who challenged their husbands' authority and use FP felt somewhat guilty and tried later on to reconcile with them through an arrangement that recognizes their authority within the couple. Moreover, all women seem not to be conscious about this influence of their socialization. We also found that reproductive outcomes go beyond husband-wife interaction, but also involve extended family members of both partners. Couple discussion triggers this interaction. We thus

recommend that programs aimed at increasing FP use go beyond the gender approach and move on to a broader approach that takes into account the extended family, particularly the in-laws, and the global context. Finally, many of the women studied here can be considered as the vanguard as far as contraception is concerned. The strategies they have implemented to practice contraception despite their husbands' lack of support deserve in-depth study and can serve as a basis to create a diffusion of attitudes and behaviors favorable to contraception use.

Notes

This research was funded by Canadian International Development Agency (CIDA) through the Francophonie Scholarship Program. The authors would like to express their sincere thanks to CIDA for their financial support. They also extend their thanks to Fenna E. Bacchus for her comments on an early version of this paper.

References

Andro A. (2000). « La maîtrise de la reproduction, un enjeu majeur des rapports de genre » *in* M. Bozon et T. Locoh (sous la direction de), *Rapports de genre et questions de population I1. Genre, population et développement*, Paris, INED, Dossiers et Recherches N° 85, pp. 95-104.

Bankole A. and S. Singh (1998). "Couples' fertility and contraceptive decisionmaking in developing countries: hearing the man's". *International Family Planning Perspectives,* Vol. 24, N° 1, pp. 15–24.

Bankole A. (1995). "Desired Fertility and Fertility Behaviour among Yoruba of Nigeria: A Study of Couple Preferences and Subsequent Fertility", *Population Studies*, Vol. 49 N° 2, pp. 317-328.

Barnett B. (1998a). "Family Planning Use Often a Family Decision", *Network* Vol. 18, N° .4, http://www.fhi.org/en/RH/Pubs/Network/v18_4/NW184ch3.htm .

Barnett B. (1998b). "Strategies Needed to Involve Men, Other Family Members" *Network* Vol. 18, N° 4. http://www.fhi.org/en/RH/Pubs/Network/v18_4/nw184ch3a.htm .

Benefo K. D. (1995). "The Determinants of the Duration of Pospartum Sexual Abstinence in West Africa". *Demography*. Vol. 32, N° 2, pp. 139-157.

Binyance M., U. Cyridion, V. Ward, E. Landry and L. Behrman (1993): *Vasectomy decision-making in Rwanda*. New York, AVSC International, 44 p.

Blanc A. K., B. Wolff, A. J. Gage, A. Ezeh, S. Neema and J. Ssekamatte-Ssebuliba (1996). *Negotiating Reproductive Outcomes in Uganda*. Calverton, MD: Macro International Inc. and Institute of Statistics and Applied Economics [Uganda], 215 pages.

Caldwell J. and P. Caldwell (1987). "The cultural context of high fertility in sub-saharan Africa". *Population and Development Review.* Vol. 13, N° 3, pp. 409-437.

Dodoo F. N.-A. (1998). "Marriage Type and Reproductive Decisions: A Comparative Study in Sub-Saharan Africa". *Journal of Marriage and the Family*, Vol. 60, N° 1, pp. 232-242.

Dodo F. N. A. (1993). "A couple analysis of micro level supply/demand factors in fertility regulation". *Popultation Research and Policy Review*, N° 12, pp. 93-101.

Dumont L. (1981). *Homo Hierarchicus: The Caste System and Its Implications*, (2nd edition) Chicago, IL: University of Chicago Press.

Ezeh A. C. (1993). "The influence of spouses over each other's contraceptive attitudes in Ghana". *Studies in Family Planning*, Vol. 24, N° 3, pp. 163-174.

FNUAP (1999): *Première partie. Programme d'action de la Conférence Internationale sur la Population et le Développement.* (http://www.unfpa.org/french/icpd/icpd_poa.htm)

Fortin M.-F. (1996): *Le processus de recherche: de la conception à la réalisation*. Mont-Royal, Québec: Décarie, 379 p.

Freedman L. P. and S. L. Isaacs (1993). "Human Rights and Reproductive Choice". *Studies in Family Planning*, Vol. 24, N° 1, pp. 18-30.

Greene M. E. and A. E. Biddlecom (2000). "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles". *Population and Development and Review,* Vol. 26, N° 1, pp. 81-115.

Hull T. (1983). "Cultural influence in fertility decision styles", in R. A. Bulatao and al. (eds.) *Determinants of fertility in developing countries*, Vol. 2 : *Fertility Regulation and institutional influences*, New York, Academic Press, pp. 381-414.

Isiugo-Abahihe U. C. (1994). "Reproductive Motivation and Family-Size Preferences among Nigerian Men". *Studies in Family Planning*, Vol. 25, N° 3, pp. 149-161.

Lester S. (1999). *An introduction to phenomenological research.* http://www.devmts.demon.co.uk/resmethy.htm .

Mistik S., M. Naçar, M. Mazicioğlu and F. Çetinkaya (2003). "Married men's opinions and involvement regarding family planning in rural areas", *Contraception,* Volume 67, Issue 2, Pp 133-137.

Nagase T., O. Kunii, S. Wakai and A. Khaleel (2003). "Obstacles to modern contraceptive use among married women in southern urban Maldives", *Contraception*, N° 68, pp. 125-134.

Robey B. and M. Drennan "Male Participation in Reproductive Health" *Network* Vol. 18, N° 3. http://www.fhi.org/en/RH/Pubs/Network/v18_3/NW183ch3.htm .

Rwenge M. (2000). "Sexual Behaviors Among Young People in Bamenda, Cameroun", *International Family Planning Perspectives*, Vol. 26, N° 3, pp. 118-123 & 130.

Sow B., S. Ndiaye, A. Gaye et A. H. Sylla (2000). *Enquête Sénégalaise sur les Indicateurs de Santé (ESIS 1999)*. Ministère de la santé, SERDHA et Macro International Inc., 212 pages.

Touré L. (1996). "Male Involvement in Family Planning. A Review of the Literature and Selected Program Initiatives in Africa". http://sara.aed.org/publications/reproductive_health/family_planning/html/male.htm .

Terefe A. and C. P. Larson (1993). "Modern Contraception Use in Ethiopia: Does Involving Husbands Make a Difference?" American Journal of Public Health 83(11):1567–1576.

Thiriat M.-P. (2000). « Les pratiques matrimoniales, aux principes des systèmes de genre » *in* M. Bozon et T. Locoh (sous la direction de), *Rapports de genre et questions de population I1. Genre, population et développement*, Paris, INED, Dossiers et Recherches N° 85, pp. 81-94.

Wilkilson D., Y. Ward, E. Landry and L. Behram (1994). *Vasectomy decision-making in Kenya*. New York, AVSC International, 32 p.

Wulf D. (1985). "The Future of Family Planning in Sub-Saharan". *International Family Planning Perspectives*, Vol. 11. N° 1, pp. 1-8.

Yana, S. D. (1997). « Statuts et rôles féminins au Cameroun: réalités d'hier, images d'aujourd'hui », in Politique Africaine, N° 65, pp. 35-47.