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Original Research Article

Factors associated with decision-making on family planning use among women aged 15-49 in Guinea

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ABSTRACT

Background: In Guinea, several factors affect women's ability to make decisions about contraceptive use. The objective of this study was to identify factors associated with married women's decision-making power regarding family planning use in Guinea.
Methods: Data from the 2018 Guinea Demographic and Health Survey were used. A sample of 752 women was included in the study. Multivariate logistic regression was performed to determine the factors associated with women's decision-making power regarding the use of family planning in Guinea. The Odd ratio with 95% confidence interval was calculated for the variables in the final model.
Results: The overall prevalence of women deciding to use family planning was 65.47% [95%CI: 62.18 68.61]. Urban women had a 49% lower chance of deciding to use family planning than rural women (adjusted OR=0.61; 95% CI [0.238 0.92]). Similarly, women with secondary education were 3.53 times more likely to use family planning than those with no formal education (adjusted OR=3.53; 95% CI [1.27 9.78]).
Conclusions: This study shows the importance of several factors in women's decision-making power regarding family planning use in Guinea. Women with secondary education, those in the Kindia and Kankan regions, and those with a job had higher probability of deciding to use family planning. Findings from this study could help guide public health policies, emphasising the importance of education, employment and access to health services in improving women's decision-making power when it comes to family planning in the Republic of Guinea.

Keywords: Decision-making, Factors associated, Family planning, Guinea, Women

INTRODUCTION

Universal access to family planning has been identified as one of the Sustainable Development Goals (SDGs) with social benefits. Family planning plays an essential role in preventing unwanted pregnancies and unsafe abortions.[1,2] It is also a fundamental pillar of reproductive health, enabling couples to plan the number of children they want, which has a direct positive impact on the health of mothers.[3-5] Globally, the proportion of women of childbearing age using modern contraception methods is 77%, and was 58% in sub-Saharan Africa in 2022.[5]

Family planning use is closely correlated with women's decision-making capacity in the region. Studies conducted in Cambodia, Ethiopia and Ghana have shown that an increase in contraceptives use and, by extension, better use of maternal healthcare services can be achieved by strengthening women's decision-making power.[8-10]

In Guinea, despite the efforts of health authorities and partners' support to improve family planning use, the situation is still worrying. According to the 2018 Guinea DHS, almost one out of ten women in couple uses a modern contraceptive method (11%) and 22% of them (women in couple) have unmet need for family planning.[6] A study conducted in Guinea in 2022 reported a prevalence of unmet need for contraception of 22.6%.[7]

Women's decision-making power regarding the use of family planning services is a real problem in Guinea. Yet there are no studies examining the factors associated with this decision-making power among married women in the country, where the cost-free provision of family planning methods is not fully in place. This study was conducted to fill this research gap by identifying factors associated with women's decision-making regarding family planning use in Guinea. Findings of this study could help to design appropriate intervention measures in order to strengthen women's decision-making power with regard to family planning in Guinea.

This study aimed to identify factors associated with women's decision-making regarding family planning use in Guinea.

Guinea is a coastal country in the West African region, covering an area of 245,857 km^2, with an estimated population size of 12,907,395 in 2021, the majority of whom live in rural areas.[11] It has 33 prefectures, 38 urban communes and 304 rural communes. The socio-economic situation is marked by persistent poverty. Indeed, data from the 2012 Poverty Assessment Survey show that 55.2% of the population live below the poverty line, and according to the UNDP Human Development Index (HDI), the country ranks 182nd out of 187 countries. [12,13] The total fertility rate is estimated to 4.8 children per woman according to the 2018 DHS.[6]

METHODS

This was a secondary analysis of data from the 2018 Guinea Demographic and Health Survey.

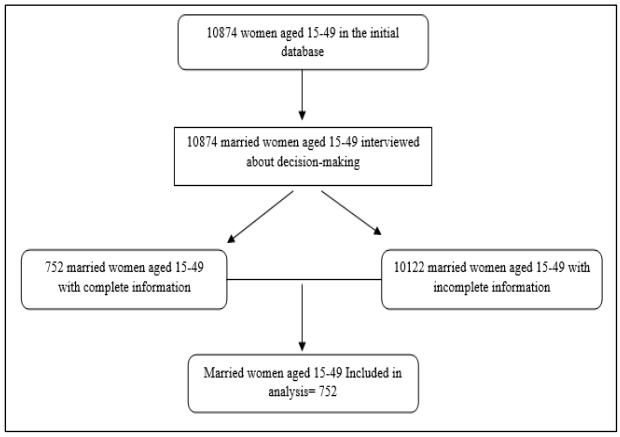

Figure 1: Flow chart of study participants.

This study used data from Guinea's most recent Demographic and Health Survey (DHS), conducted in 2018. The DHS is a nationally representative cross-sectional survey, carried out every 5 years, to provide population and health indicators at national and regional levels. Methodology for data collection as well as reports are available and accessible on the DHS programme website. For this study, data from individual women questionnaires were used as a source of information on women's decision-making and contraceptive use. Out of a total of 10874 women aged 15-49 in the initial database, 752 women meeting our criteria were included in this analysis (Figure 1).

Study variables

Variables from the individual recoding file, which corresponds to the women's data, were extracted.

Dependent variable

The dependent variable for this study is the decision-making power of married women aged 15-49 to use family planning services in Guinea. According to the 2018 Demographic and Health Survey (DHS), married women's decision-making power regarding family planning use was listed as different categories: decision-making by the women themselves, by the partner/husband and jointly (Woman and Partner/Husband). Therefore, this variable was dichotomized: yes (if women decide on their own) and no (if women do not decide on their own or decide jointly with their partner/husband to use family planning).

Independent variables

Independent variables were chosen, based on literature review. They include: age, education level, wealth index, professional status of women and their husbands, exposure to media, antenatal visits, women's fertility preference, husband's desire in terms of number of children, family planning information in the institution, women's place of residence and region of residence.

Statistical analysis

Stata software version 17.0 was used to extract, recode and analyse the data. Before performing statistical analysis, the data were weighted in order to ensure that the sample was representative and to obtain a reliable estimate and standard error. A descriptive statistical analysis was carried out. Proportions were calculated for categorical variables, whereas means and standard deviation were calculated for continuous variables. Overall prevalence of women's decision-making power with regard to family planning use and the prevalence per the sample's characteristics were calculated. Chi-square was applied to assess the association between categorical variables at a 5% significance level.

A binary logistic regression model was used to identify factors associated with women's decision-making power for family planning use. Crude and adjusted odd ratios (ORs) with 95% confidence intervals (CIs) were reported. The final model was obtained using the following method: 1) Variables to be included in the multivariate analysis were identified through a univariate analysis including the dependent variable and each of the explanatory variables. The inclusion threshold was set at 0.20. 2) For the modelling procedure, the bottom-up stepwise method was adapted: starting from the empty model, we added the significant variables to the univariate analysis one by one. When moving from one model to the next, the WALD test was used to assess the significance of the variable introduced. When a variable was significant at a 5% threshold, it was retained in the model and the next variable was added. To validate the final model, adjustment and specification tests were performed (linktest and Lroc).

A formal request for analysis of all the data was made to measure DHS via the online platform, and authorisation was granted.

RESULTS

The overall, 752 women were included in the study, a quarter of whom (25.44%) were under the age of 25 (adolescents and young people); more than two-thirds (68.71%) of them as well as their husbands (81.13%) had not attended school. Most of the respondents (55.31%) lived in rural areas (Table 1).

Of the women included in the study, more than a third (46.43%) had attended at least four antenatal clinics. More than half (52.89%) of the husbands surveyed wanted to have no more children (Table 2).

Overall, women's decision-making power regarding family planning use was 65.47% (CI: 62.18-68.61]. Decision-making power was higher among urban women than rural women (69.81% (CI95%: 52.16-67.52]; P-value=0.012). Also, women whose husbands had no job were more autonomous than those whose husbands had a job, respectively 80.42% and 64.40 with <0.002 (Table 3).

At a 20% threshold, variables associated with women's decision to use contraceptives were: age (25-29 years: crude OR=0.24; IC95% (0.12 0.47]), mother's level of education (primary: Crude OR=1.99; IC95% (1.15 3.43]; Secondary: Crude OR=1.57; IC95% (1.02 2.42]), mother's occupation (Crude OR=1.01; IC95% (0.66 1.56]), women who had received FP information at a health facility (Crude OR=0.99; IC95% (0.58 1.40] (Table 4).

Holding constant the other variables in the model, the probability of married women living in urban areas to decide for family planning use compared with those living in rural areas decreased by 49% (adjusted OR=0.61; CI95% (0.238 0.92]). Similarly, women with secondary education were 3.53 times more likely to decide to use family planning than those with no formal education (adjusted OR=3.53; 95% CI (1.27 9.78]). Lastly, women with a job were 2.96 times more likely (adjusted OR=2.96; 95% CI ((1.21 7.23]) to decide to use contraception than those without a job.

Table 1: Socio-demographic characteristics of respondents in Guinea.

Variable	Category	Weighted frequency (%)
Age in years (mean±SD)	30.49±7.99 years	
Age in years	15-19	9.24
	20-24	16.2
	25-29	22.24
	30-34	20.38
	35-39	17.54
	40-44	8.85
	45-49	5.55
Mothers' education level	None	68.71
	Primary	10.18
	Secondary	16.67
	Higher	4.44
Husband's education level	None	77.12
	Primary	4.06
	Secondary	3.21
	Higher	15.61
Women's current occupation	Has a job	85.16
	Does not have a job	14.84
Husbands' current occupation	Has a job	92.72
	Does not have a job	7.28
Wealth index	Very poor	9.10
	Moderately poor	18.74
	Poor	18.48
	Moderately rich	25.91
	Rich	27.77
Region	Boké	4.40
	Conakry	20.54
	Faranah	6.70
	Kankan	22.46
	Kindia	16.88
	Labé	3.27
	Mamou	1.97
	N'zérékoré	23.78
Residence	Urban	44.69
	Rural	55.31

However, several other individual factors (age, husband's occupation, wealth index) were not associated with FP decision-making (Table 5).

Table 2: Reproductive health characteristics of respondents in Guinea.

Variables	Category	Weighted frequency (%)
Number of antenatal visits	**1 to 3**	92.35
	≥4	7. 65
Number of living children	**<3**	39.65
	3 to 5	46.43
	>5	13.92
Fertility preference	**Yes**	73.10
	No	26.90
Information on FP in health facilities	Yes	31.91
	No	68.09
Husband's desire in terms of number of children	Same as wife	43,13
	Husband wants more children	52.89
	Husband wants fewer children	3.98

Table 3: Prevalence of women's decision-making power for family planning use, by characteristics.

Variables	Decision-making power for FP N (%)	(95% CI)	P value
Age group (year)			
15-19	64 (82.6)	(71.48-90.07)	0.003
20-24	122 (71.5)	(61.58-79.73)	
25-29	160 (5.49)	(46.54-63 .12)	
30-34	156 (65.84)	(57.36-73.41)	
35-39	134 (63.26)	(52.53-72.83)	
40-44	71 (62.53)	(49.13-74.25)	
45-49	45 (71.50)	(55.58-83.41)	
Residence			
Rural	279 (60.09)	(64.08-74.98)	0.012
Urban	216 (69.81)	(52.16-67.52)	
Region			
Conakry	56 (46.03)	(36.18-56.21)	<0.001
Boké	31 (61.98)	(44.28-76.98)	
Kindia	109 (83.23)	(72.50-90.33)	
Mamou	19 (61.67)	(25.05-88.56)	
Labé	17 (61.73)	(44.08-76.75)	
Faranah	35 (46.41)	(35.16-58.04)	
Kankan	142 (84.00)	(78.17-88.51)	
N'zérékoré	58 (58.97)	(50.86-66.62)	
Women's education level			
None	332 (65.15)	(59.57-70.34)	0.148
Primary	63 (73.92)	(63.74-82.04)	
Secondary	82 (66.19)	(55.92-75.14)	
Superior	18 (48.22)	(30.17-66.74)	
Women's occupation			
Has a job	70 (62.41)	(52.59-71.31)	0.093
Does not have a job	424 (66.29)	(61.12-71.10)	
Husband's occupation			
Has a job	451 (64.40)	(59.30-69.19)	0.016
Does not have a job	40 (80.42)	(66.64-89.41)	
Wealth index			
Very poor	48 (55.29)	(43.87-66.18)	0.002
Moderately poor	80 (65.15)	(53.97-74.88)	
Poor	88 (71.74)	(60.84-80.57)	
Rich	156 (73.80)	(66.00-80.34)	

Continued.

Variables	Decision-making power for FP N (%)	(95% CI)	P value
Richer	123 (57.06)	(48.30-65.40)	
Exposure to media			
No	312 (64.90)	(59.65-69.82)	0.915
Yes	183 (66.54)	(58.38-73.82)	
Number of antenatal visits			
1 to 3 antenatal visits	698 (66.74)	(62.07-71.11)	0.025
≥ 4 antenatal visits	54 (50.02)	(35.42-64.63)	
Number of living children			
< 3 children	193 (68.20)	(61.76-74.01)	
3 to 5 children	227(62.96)	(56.88-68.65)	0.219
>5 children	75 (66.04)	(55.17-75.45)	
Women who received information on family planning at a health facility			
No	183 (66.89)	(59.46-73.56)	0.173
Yes	89 (59.11)	(50.65-67.06)	
Taking into account husband's desire in terms of number of children			
Husband and wife want	178 (49.46)	(40.55-58.41)	
Husband wants more	258 (73.50)	(67.06-79.07)	<0.001
Husband wants less	20 (44.76)	(23.56-68.04)	
Religion			
Muslim	415 (67.81)	(62.62-73.25)	
Christian	66 (55.93)	(45.54-64.13)	0.044
Other	14 (63.64)	(53.31-71.24)	
Overall prevalence	495 (65.47)	(60.78-69.87)	

Table 4: Factors associated with women's decision-making power regarding contraceptive use (Univariate analysis).

Variables	Odd ratios Crude OR (95% CI)	P value
Age group (year)		
15-19	Ref.	
20-24	0.52 (0.25-1.08)	0.081
25-29	0.24 (0.12-0.47)	<0.001
30-34	0.38 (0.19-0.77)	0.008
35-39	0.37 (0.18-0.75)	0.006
40-44	0.37(0.17-0.82)	0.015
45-49	0.71 (0.29-1.76)	0.468
Residence		
Rural	Ref.	
Urban	0.94 (0.64-1.39)	0.792
Region		
Conakry	Ref.	
Boké	1.91 (0.92-3.95)	0.081
Kindia	5.82 (3.41-9.91)	<0.001
Mamou	1.88 (0.66-5.31)	0.230
Labé	1.89 (0.82-4.32)	0.131
Faranah	1.02 (0.55-1.85)	0.961
Kankan	6.15 (3.76-10.06)	<0.001
N'zérékoré	1.68 (1.11- 2.54)	0.013
Women's education level		
None	Ref.	
Primary	1.99 (1.15-3.43)	0.013
Secondary	1.57 (1.02-2.42)	0.040
Higher	0.68 (0.33-1.42)	0.312

Continued.

Variables	Odd ratios Crude OR (95% CI)	P value
Women's occupations		
Has a job	Ref.	
Does not have a job	1.01 (0.66-1.56)	0.941
Husband's occupation		
Has a job	Ref.	
Does not have a job	0.26 (0.13-0.53)	<0.001
Wealth index		
Very poor	Ref.	
Moderately poor	1.28 (0.70-2.32)	0.407
Poor	1.51 (0.82-2.77)	0.183
Rich	1.76 (0.97-3.20)	0.061
Richer	1.19 (0.63-1.25)	0.571
Exposure to media		
No	Ref.	
Yes	1.16 (0.82-1.65)	0.389
Number of antenatal visits		
1 to 3 antenatal visits	Ref.	
≥4 antenatal visits	0.46 (0.26-0.79)	0.006
Number of living children		
<3 children	Ref.	
3 to 5 children	0.75 (0.54-1.05)	0.096
>5 children	0.82 (0.51-1.33)	0.433
Women who received information on family planning at a health facility		
No	Ref.	
Yes	0.90 (0.58-1.40)	0.654
Taking into account husbands' desire in terms of number of children		
Husband and wife want	Ref.	
Husband wants more	2.45 (1.57-3.84)	<0.001
Husband wants less	0.97 (0.36 -2.59)	0.955

Tableau 5: Factors associated with women's decision-making power regarding contraceptives use (Multivariate analysis).

Variables	Odd ratios Adjusted OR (95% CI)	P value
Age group (year)		
15-19	Ref.	
20-24	2.02 (0.50-8.19)	0.323
25-29	0.86 (0.22-3.24)	0.825
30-34	2.53 (0.53-12.01)	0.242
35-39	2.94 (0.56-15.17)	0.203
40-44	1.61 (0.25-10.38)	0.611
45-49	4.85 (0.56-41.93)	0.151
Place of residence		
Rural	Ref.	
Urban	0.61 (0.238-0.92)	0.030**
Region		
Conakry	0.25 (0.33-4.75)	0.734
Boké	3.63 (0.76-14.71)	0.109
Kindia	14.73 (5.17-41.97)	<0.001**
Mamou	1.06 (0.13-8.13)	0.954
Labé	2.04 (0.21-19.34)	0.532
Faranah	0.71 (0.18-2.76)	0.622
Kankan	4.63 (1.68-12.77)	0.0 3**

Continued.

Variables	Odd ratios Adjusted OR (95% CI)	P value
N'Nzérékoré	Ref.	
Women's education level		
None	Ref.	
Primary	2.24 (0.63-7.90)	0.207
Secondary	3.53 (1.27-9.78)	0.015**
Higher	1.50 (0.26-8.68)	0.648
Women's occupation		
Does not have a job	Ref.	
Has a job	2.96 (1.21-7.23)	0.017**
Husband's occupation		
Has a job	Ref.	
Does not have a job	0.31 (0.40-2.46)	0.271
Wealth index		
Very poor	Ref.	
Moderately poor	1.11 (0.29-4.23)	0.879
Poor	1.12 (0.29-4.34)	0.860
Rich	1.29 (0.33-5.02)	0.711
Richer	0.61 (0.12-3.07)	0.551
Fertility preference		
No	Ref.	
Yes	1.10 (0.41-2.91)	0.839
Number of antenatal visits		
1 to 3 antenatal visits	Ref.	
≥4 antenatal visits	0.57 (0.19-1.70)	0.315
Number of living children		
<3	Ref.	
3 to 5	0.65 (0.26-1.61)	0.353
>5	0.42 (0.28-3.00)	0.220
Women who received information on family planning at a health facility		
No	Ref.	
Yes	0.70 (0.35-1.36)	0.298

DISCUSSION

Women's decision-making power is important in improving unmet need for family planning.

The study findings showed an overall prevalence of women's decision-making power regarding family planning use of 65.47% (i.e. almost two-thirds of women). This prevalence was much higher than the results of studies conducted in Senegal (26.3%), Mali (17,1%) and Kenya (21,6%) and close to the figures for Ethiopia in 2022 (52%).[14-16,9] However, a recent study carried out in Ethiopia in 2022 reported higher prevalence (71%).[17]

This diversity of research results could be due to the specific context of each country. Thus, based on data obtained from current Demographic and Health Surveys (DHS) conducted in 32 sub-Saharan African (SSA) countries, it was found that 68.66% of adolescents in SSA had the capacity to make decisions about their reproductive health. The overall prevalence of contraceptive use was 18.87%, ranging from 1.84% in Chad to 45.75% in Zimbabwe.[18]

In addition, our study showed that women's decision-making power to use family planning was influenced by several factors:

With regard to place of residence, this study reported a 54% reduction in the chance of married women living in rural areas to decide to use family planning in Guinea. This finding is in line with other studies conducted in Burkina Faso, Senegal and Ethiopia.[19,14,16,20,21] Furthermore, another study conducted in 32 sub-Saharan African countries had similar findings.[18] This difference between rural and urban women could be explained by the fact that rural women may have difficulty accessing family planning services due to geographical remoteness, lack of health centres and limited availability of services. In addition, social and cultural norms may be more restrictive in rural areas, which may limit women's ability to make autonomous decisions about family planning. Finally, rural women may be more likely to get married and start having children at an earlier age. This could limit not only their ability to pursue education and careers, but also to make independent decisions about family planning.

Similarly, our study showed an association between women's education level and their decision-making power when it came to using family planning. In fact, women with secondary education were 3.5 times more likely to decide to use family planning than those with no formal education. This finding has been corroborated by previous studies in Senegal and in Ethiopia.[15,17] This was also the case with a multi-country study carried out in Namibia, Zambia, Ghana and Uganda and with a systematic review in 29 sub-Saharan African countries.[22,23] These findings underline the importance of women's education in the use of family planning and highlight the need for policies and interventions to improve access to education for women in order to increase their decision-making power for family planning.

In terms of women's professional status, this study revealed that women with jobs would contribute to decision-making power for family planning. Findings of this study are consistent with evidence derived from previous studies conducted in Nigeria, Ethiopia and Zambia, as well as from a systematic review in 29 sub-Saharan African countries.[23-25] The findings also showed the impact of employment on women's decision-making power with regard to family planning. They suggest that women's employment could have a positive impact on their decision-making power in terms of family planning, while also taking into account other factors, such as education, access to health resources and cultural norms.

There are a few limitations to consider when interpreting these findings. Being a cross-sectional study, its design does not allow causal relationships to be established, and also data gaps remain due to their secondary nature, resulting in missing data.

CONCLUSION

This study highlighted the importance of several factors for women's decision-making power with regard to family planning use in Guinea. Married women living in rural areas, those with secondary education, those in the Kindia and Kankan regions and those with a job had higher probability of deciding to use family planning. Findings of this study could help to guide public health policies in Guinea and other sub-Saharan African countries, by emphasising the importance of education, employment and access to health services in improving women's decision-making power for family planning.

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