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Influence of Social and Cultural Norms on the Sexual and Reproductive Health of Young Couples in Incharoua, Droum rural district (Zinder, Niger)

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Influence of Social and Cultural Norms on the Sexual and Reproductive Health of Young Couples in Incharoua, Droum rural district (Zinder, Niger)

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Abstract

This paper analyses the influence of social norms and cultural practices on the sexual and reproductive health (SRH) of young couples in the village of Incharoua, in the rural commune of Droum. It aims to understand how these norms shape behaviours and the use of SRH services. Adopting a mixed methodological approach (quantitative and qualitative), the research is based on a survey of 76 couples (152 individuals), supplemented by interviews, observations, documentary research and a pre-survey. The results are presented in two parts: the first describes the socio-demographic characteristics of the couples and the factors explaining the use of traditional or modern SRH practices; the second highlights the strengths, weaknesses and local perceptions of SRH. The analysis reveals that formal norms derived from modern structures, as well as traditional social norms, strongly influence the SRH of young couples. This influence can be explained in particular by women's limited decision-making power within the household and by the attachment to cultural values passed down from generation to generation.

Keywords: Sexual and Reproductive Health, Social norms, influence, cultural practices, Incharoua

Introduction

Sexual and Reproductive Health (SRH) is defined by the World Health Organization (2001) as a state of physical, mental, and social well-being in relation to sexuality and reproduction, encompassing the ability to engage in a safe and fulfilling sexual life and to freely decide on the number and spacing of children. This approach is grounded in a human rights perspective, according to which every individual should be able to exercise reproductive choices free from coercion. However, the exercise of these rights does not depend solely on the availability of health services. As recent research in public health and the social sciences has shown, social norms, cultural practices, and gender relations profoundly shape reproductive behaviors and access to SRH services (M. Chandra Mouli et al., 2017; J. Upadhyay et al., 2019). These studies highlight that access to information and quality services alone is insufficient to transform practices when these are deeply embedded in social values, religious beliefs, and cultural

traditions. In the village of Incharoua (Mirriah Department, Zinder Region), the Integrated Health Center provides a range of SRH services, including the prevention of unintended pregnancies, access to modern contraceptive methods, the management of sexually transmitted infections, and support for high-risk pregnancies. Although these services are theoretically accessible to all, they are often underutilized or bypassed in favor of traditional practices of contraception and reproductive care, many of which are based on limited or poorly understood knowledge. This observation is consistent with the findings of A. Gibbert et al. (2020), who demonstrate, across several African contexts, that local beliefs and traditional practices may persist despite the availability of modern health services. Furthermore, gender norms play a decisive role in shaping how individuals make decisions regarding SRH. Health literacy (that is, the ability to seek, understand, and use health-related information) is influenced by access to education, socioeconomic status, and family dynamics. According to S. M. Becker and R. S. Tsui (2018), in many rural settings, women have less decision-making authority over their own reproductive health, thereby limiting their use of modern SRH services and increasing their exposure to the risks associated with informal or traditional practices. Another important factor is sexuality education and intergenerational communication. The absence of open dialogue between parents and children about sexuality and reproduction is consistently identified in the literature as a major barrier to informed and safe SRH practices (E. Bankole et al., 2019). The lack of such communication contributes to the transmission of incomplete knowledge, myths, and stigma surrounding sexuality and SRH services. Thus, the persistence of traditional practices observed in Incharoua cannot be reduced to a mere arbitrary choice or lack of knowledge. Rather, it reflects the complex interplay between social norms, economic constraints, gender roles, and cultural value systems that shape reproductive behaviors. This raises the central question underlying this research: How do social norms and cultural practices influence the sexual and reproductive health of young couples in the village of Incharoua?

I. Research Methodology

✓ Study design, setting and participants

This study used a mixed-methods approach combining quantitative and qualitative methods to investigate the influence of social and cultural norms and practices on sexual and reproductive health (SRH) among young married couples in Incharoua, Droum rural district, Zinder Region, Niger. The study was conducted in Incharoua and the villages served by the Incharoua Integrated Health Centre (Centre de Santé Intégré, CSI).The study population comprised 759 projected households in Incharoua and the villages attached to the CSI. A sample representing 10% of the projected households was selected, corresponding to 76 married couples (152 participants). Eligible participants were married individuals aged 15–39 years. Participants aged 15–17 years were married adolescents considered emancipated through marriage within the social and legal context of the study. The selection of couples combined probability sampling with non-probability snowball sampling. The qualitative component involved 16 key informants, including health workers, reproductive health officers, community leaders, traditional female practitioners, magico-religious practitioners, and representatives of the Mazan Daga programme (GRADE Africa).

✓ Data collection

A preliminary survey was conducted to refine the research questions and data collection instruments. Quantitative data were collected through structured questionnaires administered directly to the selected couples. Qualitative data were obtained through semi-structured interviews, two focus group discussions (one with married young women and one with community leaders), indirect observations at the Incharoua CSI and traditional medicine outlets, and life histories and testimonies. A documentary review of books, theses, dissertations, scientific articles, and institutional reports was also conducted to inform the theoretical and methodological

framework. Data collection took place from October to December 2024. Interviews and focus group discussions were conducted under conditions designed to ensure privacy, confidentiality, and a trusting environment.

- ✓ **Data processing and analysis**

Quantitative and qualitative data were reviewed, cleaned, coded, and triangulated. Quantitative data were analysed using Sphinx and Microsoft Excel and presented using tables, graphs, and diagrams. Qualitative data were transcribed using Microsoft Word and analysed manually through content analysis. The analysis considered sex, age, educational level, marital status, social representations, and the social and cultural factors influencing SRH-related practices and behaviours.

Table 1. Summary of Data Collection Tools and Study Participants

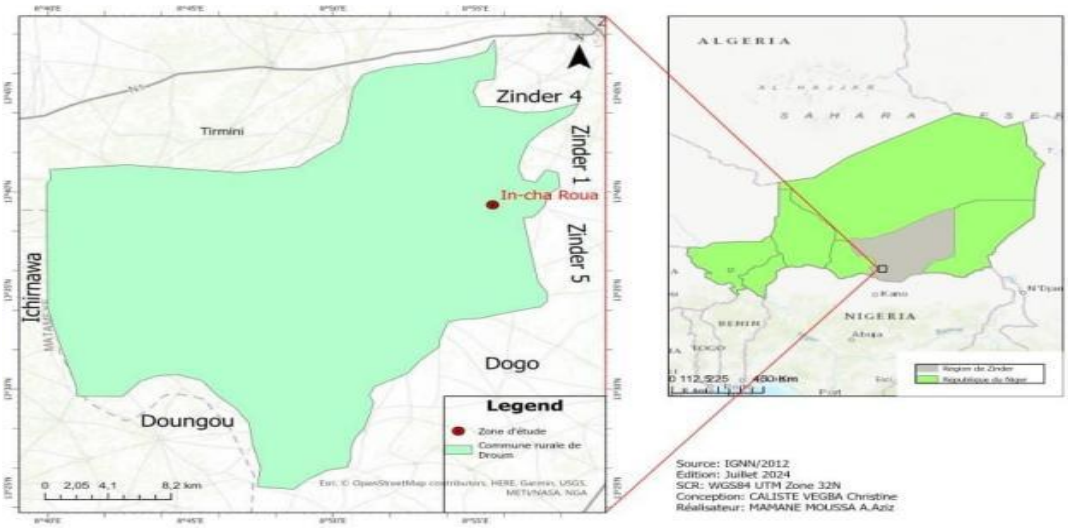
Data Collection Tools	Methodological Approach	Respondents	number
Questionnaire	Quantitative	Couples (men and women)	**76**
Guide d'entretien	Qualitative	Health workers	**3**
		Reproductive Health Officers	**2**
		Community leaders	**5**
		Traditional practitioners	**2**
		Magico-religious practitioners	**2**
		Coordinators of the Mazan Daga Program (GRADE Africa)	**2**
Total			**168**

Source : Field **research conducted in the village of Incharoua, 2024.**

II. Brief Presentation of Incharoua

The village of Incharoua, located in the rural commune of Droum, in the Department of Mirriah (Zinder Region), is known for its vast geographical extent and its central role in the socioreligious life of the region. Its origins are closely associated with Qur'anic teaching and the study of the Qur'an, and it has historically been regarded as a village of marabouts. This religious tradition has been transmitted from one generation to another, making Incharoua a well-known center for Qur'anic education. According to local residents, the name of the village is said to refer to an earlier period of water scarcity, symbolizing both past hardship and the perseverance of its inhabitants. Everyday life is strongly structured around religion, and anyone who draws water from the village well is expected to commit to in-depth Qur'anic learning. The inhabitants' livelihoods are largely connected to Qur'anic education through the *almajiranci* system, and the village is commonly referred to as *"Incharoua garin mallamai,"* emphasizing its identity as a village of scholars and its commitment to preserving traditional values. From a sociocultural perspective, conservative religiosity predominates, and modern schooling has not been established in the village, as it is perceived as a potential source of cultural acculturation. Thus, social life in Incharoua is largely structured around the transmission of Islamic knowledge and the preservation of local norms and traditions.

Map 1. Location of the Study Area



II. Research Findings

2.1. Sex and Marital Status of the Respondents

Table 2. Distribution of Respondents by Sex and Marital Status

Sex	Married (Monogamous)	Married (Polygamous)	Total	Frequency
Male	58	18	76	50%
Female	46	30	76	50%
Total	104	48	152	100%
Frequency (%)	68.42%	31.58%	100%	

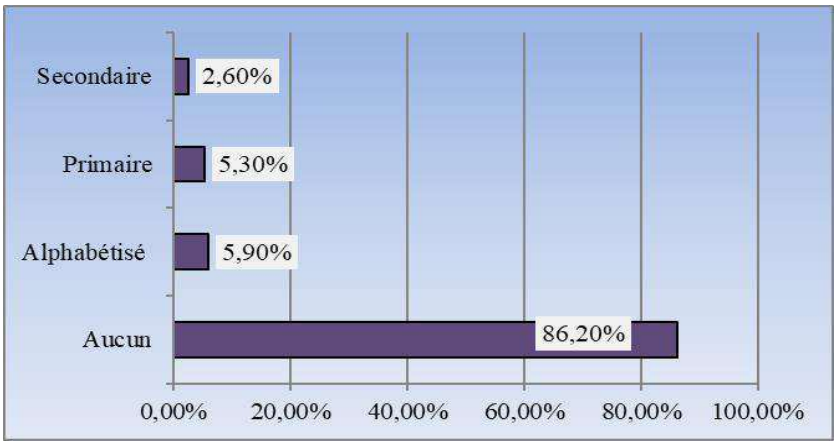
Source: Fieldwork findings, December 2024

The data show that 68.42% of the couples studied are in monogamous unions, whereas 31.58% are in polygamous unions. The majority of monogamous couples are newly married, which accounts for the prominence of this pattern within the sample. In the context of Incharoua, marriage is perceived both as a personal destiny and as an interfamily alliance, in which individual choices are strongly influenced by family decisions. The family system is based on the consanguineous family, with kinship ties structured along patrilineal or matrilineal lines and shaped by religious, economic, and political factors. Marriage, whether monogamous or polygamous, is closely connected to kinship systems and local sociocultural realities. Polygamy is often associated with the length of marriage and the expansion of families, constituting a traditional feature that reinforces family and community ties. It is also perceived as a marker of social status and is governed by socioeconomic considerations. These practices directly affect reproductive health: women in polygamous unions tend to use contraception less frequently than those in monogamous unions, which is consistent with the observations reported by Mamadou (2018) and Thérèse (1988). Polygamy may also place some women in a socially subordinate position in relation to their husbands. Thus, marital practices in Incharoua, whether monogamous

or polygamous, are crucial to understanding behaviors related to Sexual and Reproductive Health, as they incorporate cultural, religious, economic, and social dimensions.

2.2. Educational Level of the Couples Surveyed

Figure 1 : Distribution of Respondents by Educational Level

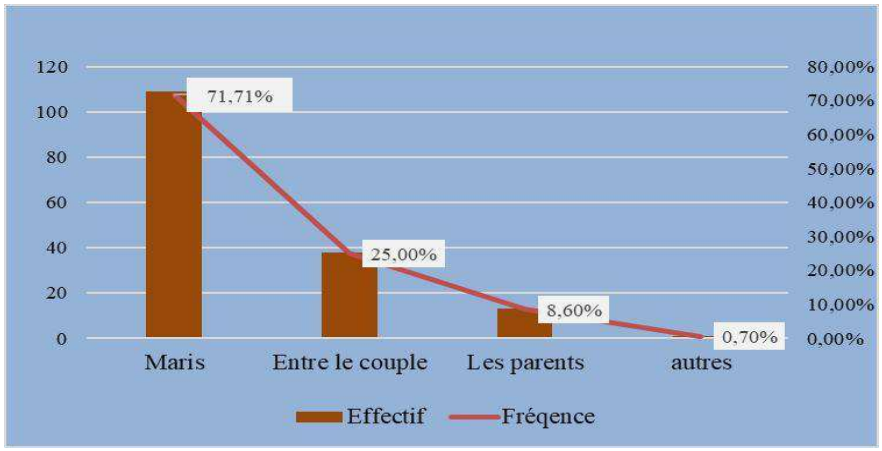


Source: Fieldwork findings, December 2024

The figure illustrates the distribution of the surveyed population according to educational level. It shows that 86.2% of men and women have no formal education, their educational experience being limited to Qur'anic instruction. Primary, secondary, and literacy education levels are highly underrepresented, accounting for 5.9%, 5.3%, and 2.6%, respectively. This situation is consistent with regional trends: in the Zinder region, 56.5% of the population has never attended school, while 22.5% attends Qur'anic schools (INS, 2012). Incharoua is distinguished by the absence of a school within the village, thereby reinforcing the predominance of traditional religious education. The educational level of couples constitutes a major factor in the adoption of modern sexual and reproductive health (SRH) practices. Respondents with secondary education or literacy skills are more likely to use modern sexual and reproductive health services, whereas those with no formal education tend to adhere more closely to traditional practices. Awareness-raising sessions and interventions by community leaders have shown that increased knowledge can promote the use of modern health services, despite the strong influence of local religious and cultural norms. Educational choices are strongly shaped by the religious system and traditional beliefs. Formal schooling is often perceived as a potential threat to local values, whereas Qur'anic education is valued as a means of preserving the village's cultural and religious identity. Traditional education also structures social relations, particularly gender relations, and directly influences behaviors related to sexual and reproductive health. Educational level, in conjunction with religious and cultural influences, is therefore a key factor for understanding sexual and reproductive health practices in Incharoua. In this context, the population places particular value on religious education, while the modernization of health-related behaviors depends largely on awareness-raising efforts and on improving the educational attainment of couples.

2.3. Decision-Making Patterns

Figure 2: Distribution of Respondents According to Decision-Making Patterns within the Couple



Source: Fieldwork findings, December 2024

An analysis of decision-making patterns within couples in Incharoua reveals limited decision-making power among women. In the majority of cases, the husband makes the decisions, accounting for 71.71% of responses. Joint decision-making between spouses and decision-making involving parents account for 25% and 8.6%, respectively, of respondents. Patriarchy and the extended family structure reinforce this male dominance, with men's authority grounded in descent, the transmission of the family name, and religious and cultural norms. In the area of health, th e husband is often the sole decision-maker, thereby influencing therapeutic choices and decisions regarding healthcare utilization. Women reported this situation as follows:

- ✓ "Regarding reproductive matters, I do not seek care at the health center because my husband has not given me permission. Consequently, I rely exclusively on traditional therapies and simply have to obey."
- ✓ "In many cases, it is the husband who decides the fate of the members of the family."
- ✓ "Regarding healthcare for household members, major household purchases, and visits to relatives, it is primarily the husband who makes the decisions."

Women's decision-making power remains constrained by social norms, tradition, and religion. Medical decisions are shaped by clinical experiences, beliefs, and consensus within the couple or the wider community. Women's autonomy is restricted, and discussions concerning sexual and reproductive well-being are uncommon, with women tending instead to share their experiences in public spaces such as the market or the water point. A religious leader explains: "*The man decides where the child should be educated. But it also depends on the woman's level of education. An educated woman can influence her husband regarding the place that is best suited [for the child].*" Thus, decision-making in Incharoua reflects a patriarchal social organization in which women's roles and capacity to exercise influence are strongly conditioned by the cultural and religious context.

2.4. Socio-Cultural, Economic, and Institutional Barriers to the Utilization of SRH Services

The decision not to use Sexual and Reproductive Health (SRH) services provided through formal health facilities in Incharoua is a multidimensional phenomenon associated with structural, socio-cultural, and individual factors. The factors identified include, in particular, forms of Gender-Based Violence (GBV), including social, physical, and psychological violence. Such forms of violence are regulated and condemned by shared social norms, some of which are explicit (such as family or community rules), while others are implicit. Violations of these norms may result in family or social sanctions. Within this traditional context, key social institutions (the family, religion, education, and the state) regulate behavior and shape patterns of healthcare utilization. The socio-economic dimension also constitutes a key factor. The costs of healthcare, transportation, and food constrain access to services. Although certain categories of healthcare are provided free of charge, particularly for children under five years of age and family-planning commodities, associated costs remain a significant barrier. Respondents reported:

- ✓ "Sexual and Reproductive Health services are costly, in addition to transportation costs, which make these services inaccessible to those of us with low incomes."
- ✓ "There are women who are sometimes referred from here when they experience health complications, but husbands do not always have sufficient means to cover not only the transportation costs but also the hospital expenses there in Damagaram."
- ✓ "In rural areas, immediately after the agricultural harvest, a man may decide not to use the household's food reserves, and this can sometimes become a source of conflict between spouses and, in some cases, even a cause of divorce."

Cultural and social factors also influence the decision not to seek formal healthcare. The utilization of modern health services is constrained by local practices, representations, and norms transmitted from one generation to another. Certain practices are regarded as legitimate only when they conform to locally established norms and are endorsed by religious leaders. Cultural and identity-related constraints thus contribute to the continuity of traditional health-seeking behaviors and to limited utilization of formal healthcare services. Access to SRH services in Incharoua is therefore constrained by a combination of poverty, cultural norms, religious influences, and gender-based violence (GBV), which collectively contribute to a greater reliance on traditional healthcare practices rather than formal health facilities.

2.5. Traditional Barriers to the Utilization of Sexual and Reproductive Health Services in Incharoua

In Incharoua, the utilization of Sexual and Reproductive Health (SRH) services is strongly influenced by cultural and traditional barriers. The predominantly patriarchal social structure assigns men and the family a central role in decision-making, thereby limiting women's autonomy, particularly with regard to decisions concerning the choice of and access to healthcare. Cultural and religious values further reinforce these barriers. The preservation of ancestral customs, the primacy accorded to Qur'anic education, and the perception of children as a gift from God contribute to the persistence of traditional contraceptive practices and constrain the use of modern contraceptive methods. Furthermore, sexuality, contraception, and abortion remain

highly sensitive and often taboo subjects. This situation generates fear of disclosure, stigmatization, and limited utilization of formal health facilities. Local therapeutic practices, including traditional, magico-religious, and family-based forms of healing, are widely accessible and frequently preferred, thereby reinforcing local forms of therapeutic autonomy and limiting adherence to biomedical healthcare. Finally, these healthcare practices are embedded within a cultural "habitus" that legitimizes traditional behaviors, values the continuity of established traditions, and shapes therapeutic choices outside formal institutional pathways. In this sense, the persistence of such practices constitutes a set of cultural and social barriers to the utilization of SRH services, illustrating how locally embedded systems of meaning, authority, and therapeutic practice continue to structure health-seeking behaviors in Incharoua.

2.6. Types of Traditional Sexual and Reproductive Health Therapies

Table 3 : Distribution of Respondents According to the Type of Therapeutic Recourse Used and the Mode of Satisfaction

Traditional Therapy Type	Very Satisfied	Satisfied	Less Satisfied	Total	Frequency
Amulets (gris-gris)	2 (40%)	3 (60%)	0	5	21.74%
Herbal remedies	4 (26.67%)	9 (60%)	2 (13.33%)	15	65.22%
Du'as / Qur'anic writings	3 (100%)	0	0	3	13.04%
Total	**9 (39.13%)**	**12 (52.17%)**	**2 (8.70%)**	**23**	**100%**

Source: Fieldwork findings, December 2024.

In the locality of Incharoua, young couples make extensive use of traditional therapies for Sexual and Reproductive Health (SRH), particularly when they do not seek care from modern health facilities. Among the 23 respondents who had not used formal health services, 65.22% preferred herbal remedies, 21.74% used gris-gris (protective amulets), and 13.04% used du'as (supplications) or Qur'anic writings, with generally high levels of reported satisfaction. These therapeutic choices are strongly influenced by local culture and the patriarchal social system, in which the family, religion, and social norms regulate individual and collective behaviors. Traditional practices are regarded as legitimate and effective, and are often transmitted from one generation to another, combining ancestral knowledge with religious knowledge. Traditional healers and magico-religious practitioners hold a high social status, and their prescriptions (herbal remedies, amulets, and du'as) are regarded as safe and appropriate. They are sometimes preferred to modern healthcare because of their accessibility and relatively low cost. However, several cultural and traditional barriers constrain the utilization of formal SRH services :

- ✓ **Cultural taboos** surrounding sexuality, contraception, and abortion prevent open discussion within couples and the wider community.
- ✓ **Religious and magico-traditional beliefs** that value ancestral practices and amulets may, in some cases, take precedence over modern medical recommendations.
- ✓ **Distrust of health facilities**, associated with concerns about confidentiality, fear of stigmatization, and previous experiences of poor service management or medication shortages.

- ✓ **Autonomy and family control:** the husband or the family exerts considerable influence over therapeutic decisions, particularly those relating to pregnancy and maternal healthcare.
- ✓ **Perceived superiority of local practices:** traditional therapies are regarded as effective, free from side effects, and financially accessible, thereby reinforcing their use despite the availability of formal health facilities.

The combination of patriarchal norms, cultural taboos, and trust in traditional healers constitutes a major barrier to young couples' utilization of modern SRH services. These factors contribute to a preference for local therapeutic practices and to the intergenerational reproduction of ancestral healthcare practices.

Photo 1 : Medicinal Plant and *Kiri* Used for Birth Spacing



Source: Fieldwork findings, December 2024.

III. Discussion of Results

The findings of this study demonstrate that social and cultural norms significantly influence the sexual and reproductive health (SRH) of young couples in Incharoua; however, this influence cannot be interpreted in a linear or deterministic manner. Rather, it is embedded within a complex interplay of religious traditions, gender relations, economic constraints, and gradual social transformations. A nuanced interpretation therefore reveals dynamics that are simultaneously constraining and adaptive. On the one hand, the findings confirm the structuring role of religious and cultural norms in reproductive behaviours. The centrality of Qur'anic education and the absence of formal schooling contribute to a system of representations in which fertility is highly valued and modern contraceptive methods may be perceived as inconsistent with local norms. This observation is consistent with the analyses of C. McDougall et al. (2020), who demonstrate that, in several rural African contexts, religious beliefs profoundly influence reproductive decision-making, irrespective of the availability of health services. Similarly, J. Askew et al. (2019) emphasize that engagement with SRH services is strongly dependent on their perceived compatibility with local cultural and religious norms. Nevertheless, it would be reductive to draw a strict opposition between tradition and modernity. The data indicate the existence of therapeutic pluralism, whereby some couples combine traditional practices with the use of modern health services. This coexistence corresponds to what A. Béhague and M. Brodbeck (2017) describe as strategic navigation between different healthcare systems, depending on available resources,

lived experiences, and the social legitimacy of particular practices. Thus, even within a strongly conservative context, biomedicine is not completely rejected but is selectively utilized, particularly in situations involving complications.

The low level of formal education (86.2%) constitutes a major explanatory factor. The findings indicate that individuals who have attained secondary education or who have benefited from literacy programmes make greater use of modern SRH services. This trend is consistent with the work of S. O. Rutstein et al. (2021), who identify female education as a key determinant of the use of modern contraception and reproductive health services. Nevertheless, education does not automatically guarantee behavioural change: some educated individuals continue to favour traditional practices, suggesting that cultural norms may persist despite the acquisition of formal knowledge.

The analysis of decision-making patterns reveals a marked predominance of male decision-making authority (71.71%), confirming the influence of patriarchal structures. This finding is consistent with the conclusions of K. Doyle et al. (2022), who demonstrate that gender relations directly shape women's access to SRH services. However, the findings also reveal spaces for intra-marital negotiation, particularly when women possess a certain degree of educational capital or have specific health-related experience. Male authority is therefore not absolute; rather, it may be moderated by relational and contextual dynamics. Economic constraints constitute another ambivalent factor. Despite the official provision of certain services free of charge, indirect costs remain a significant barrier. This situation is consistent with the analyses of S. Shiferaw et al. (2023), who demonstrate that transportation expenses and ancillary healthcare costs constrain access to SRH services in rural areas. However, these same economic constraints may also restrict access to certain traditional therapies, indicating that therapeutic choices result from pragmatic trade-offs rather than from a simple ideological attachment to traditional practices. The substantial reliance on traditional therapies, combined with a high level of satisfaction, should likewise be interpreted with caution. It reflects cultural trust and community-based validation of local practices, as highlighted by S. Van der Geest and S. R. Whyte (2019) in their research on African medical systems. Negative experiences, or experiences perceived as negative, with modern methods (particularly concerns regarding side effects or infertility) further reinforce collective representations. According to L. A. Zimmerman et al. (2020), community perceptions of contraceptive side effects strongly influence adherence to, or rejection of, modern contraceptive methods, in some cases more strongly than objective biomedical evidence. The social norms observed in Incharoua appear to be both constraining and structuring. While they restrict women's autonomy and strictly regulate reproductive decision-making, they also contribute to community cohesion and the continuity of collective identity. As D. Lupton and K. Willis (2021) argue, individuals are not merely passive recipients of social norms but are capable of developing adaptive strategies. The women interviewed in this study consequently develop subtle forms of agency through which they reconcile respect for local values with the protection of their health.

Accordingly, these findings should not be interpreted either as evidence of rigid cultural determinism or as demonstrating a binary opposition between tradition and modernity. Rather, they reveal a normative system characterized by tension, within which young couples navigate among cultural heritage, economic constraints, and a gradual openness to modern health services. The influence of social and cultural norms on SRH in Incharoua is therefore substantial, but it is

mediated by educational attainment, economic resources, individual experiences, and marital dynamics. This finding is consistent with contemporary analyses by J. T. Bertrand et al. (2022) and M. Kidane et al. (2023) concerning the gradual transformation of reproductive behaviours in rural African settings.

Conclusion

This study has demonstrated the significant influence of social and cultural norms on the sexual and reproductive health of young couples in Incharoua. Reproductive behaviours are strongly shaped by religious values, patriarchal structures, and family organization, which constrain women's autonomy in reproductive decision-making. However, the findings also indicate the existence of processes of social change, particularly among couples with higher levels of educational attainment. The use of traditional therapies, far from representing a simple rejection of modernity, is embedded within a coherent cultural and economic rationale. Financial constraints further exacerbate barriers to accessing modern SRH services. The coexistence of traditional and biomedical practices therefore reflects therapeutic pluralism rather than a direct opposition between the two systems. Thus, social norms appear to be both constraining and structuring. Improving SRH consequently requires a contextualized approach that incorporates community leaders, promotes education, and strengthens intra-marital dialogue. Any intervention should seek to reconcile respect for local values with the gradual promotion of reproductive autonomy.

Limitations of the Study

This study has some limitations. First, the sensitive nature of sexual and reproductive health may have influenced participants' responses, potentially leading to social desirability bias or underreporting of certain practices. Second, the cross-sectional design limits the ability to establish causal relationships between social and cultural norms and reproductive health behaviours. Furthermore, the assessment of traditional therapies was based on participants' reported use and satisfaction rather than clinical evaluations of their safety and effectiveness. Despite these limitations, the mixed-methods approach provides valuable insights into the social, cultural, economic, and gender-related factors influencing the sexual and reproductive health of young couples.

Funding: No funding was received for this project.

Data availability: The datasets generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Competing interests: The authors declare no competing interests.

Ethical approval: All methods were carried out in accordance with relevant ethical guidelines and regulations governing research involving human participants. The study received ethical approval from the competent ethical authority in Zinder, Niger, under approval number 1281-18, dated 24 February 2025. The ethical oversight body comprised Dr Zakari Aboubacar, Associate Professor, Faculty of Letters and Humanities (FLSH), André Salifou University of Zinder (Chair); Dr Oumarou Issoufou, Associate Professor, FLSH, André Salifou University of Zinder (Director); and Dr Ousseini Abdoulmajidou, Assistant Professor, National School of Public Health, Zinder (Assessor). All participants were informed about the study objectives, procedures, voluntary nature of participation, right to withdraw, and confidentiality measures. Informed consent was obtained from all participants before data collection. Participants aged 15–17 years

were married adolescents considered emancipated through marriage within the social and legal context of the study, and their participation followed the procedures approved by the relevant ethical authority. All data were treated confidentially and used exclusively for research purposes.

Consent for publication: The Institutional Committee lead bu Pr. Zakari Aboubacar, Univsersité André Salifou (Zinder), waived the requirement for written consent to publish due to the anonymous and minimal-risk nature of the questionnaire. Participation was voluntary, and completion of the survey implied consent for the anonymous data to be used in publication (under approval number 1281-18, dated 24 February 2025).

Guidelines and regulations: All methods were carried out in accordance with relevant guidelines and regulations.

Informed consent: Informed consent was obtained from all participants prior to completing the questionnaire. Participation in the survey was entirely voluntary, and respondents were informed that their data would remain anonymous and be used solely for research purposes. The Institutional Committee, Univsersité André Salifou (Zinder), reviewed the study and deemed that no additional written consent was necessary as the research involved minimal risk and anonymous questionnaire-based data collection under approval number 1281-18, dated 24 February 2025).

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