Gender context, women's autonomy in union and fertility in rural Cameroon

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Long summary

In Cameroon, fertility levels remain high, although a downward trend has been observed over the last decade. Indeed, the total fertility rate (TFR) has varied very little, rising from 5.0 children per woman in 2004 to 5.1 in 2011 and 4.8 children per woman in 2018 (INS, 2018). In rural areas, the TFR is particularly high, rising from 6.1 children per woman in 2004 to 6.4 in 2011 and 6.0 in 2018. The TFR in urban areas for the corresponding years is 4.0, 4.0 and 3.8. At the same time, the total fertility rate remains higher than the desired fertility rate, whatever the area of residence. In rural areas, it is 6.4 children per woman versus 5.1 in 2011 and 6.0 versus 5.5 in 2018, while in urban areas, the corresponding statistics are 4.0 children per woman versus 3.2 in 2011 and 3.8 versus 3.4 in 2018 (INS, 2018). These observed discrepancies between the actual and desired number of children per woman suggest that women have more children than they desire. They can be explained by obstacles that women face in their environment, in their communities, and in society among which, unequal relationships within the couple to the woman's disadvantage regarding decision-making in the household.

Indeed, most women in Cameroon still face social restrictions on their ability to make decisions about various aspects of their lives. In 2018, women in union participated in household decision-making in more than 50% of cases (INS, 2018). Whatever the decision to be made, women reported that their spouse was the main decision-maker. Thus, 45.4%of women stated that it is their spouse who decides when it comes to their healthcare, 42.5% when it comes to important household purchases, and 34.6% for visits to their family (INS, 2018). Decisions are made jointly by the woman and her spouse in 45% of cases for decisions concerning the woman's healthcare, 45.2% of cases for major purchases, and 51% for visits to the woman's family. It's when it comes to her own health care that the woman participates least frequently in decision-making: in only 9.2% of cases, it's mainly the woman who decides, and in 45.0% of cases, it's the woman with her partner.

The distinction according to area of residence shows low participation in household decision-making by women residing in rural areas compared to those in urban areas, with 46.1% versus 62.9% for decision-making about their own healthcare, 48.6% versus 65.9% for major household purchases, and 54.8% versus 71.7% for visits to their families. On the other hand, in 2018, less than one in two women (47%) participated in making all three decisions,

and 31% were not involved. In rural areas, these statistics are 39.1% and 39.0% respectively, compared with 54.9% and 21.8% in urban areas.

These results show that in Cameroon, and particularly in rural areas, women face a problem of decision-making autonomy concerning various aspects of their lives, including their sexual and reproductive health. Women's demand for children in Africa, and in Cameroon in particular, is conditioned above all by the desires of their spouses. Although women have been able to internalize the value placed on fertility, which confers on them one of the only statuses recognized to them, it has to be said that in Africa and Cameroon in particular, the man's will takes precedence in the couple (Ezeh, 1993). As the man is generally the guarantor of tradition, the one who must perpetuate the family, his option largely determines the couple's effective demand and even realized fertility (Gubry, 1988). Thus, when a woman, for one reason or another, wishes to stop childbearing temporarily or permanently, she cannot legally do so without her spouse's consent. As a result, a woman's ability to take part in decision-making is essential to her empowerment. It enables her to negotiate the spacing or limitation of births with her partner. But factors such as a woman's young age, low level of education, economic vulnerability and lack of knowledge and skills intensify the imbalance of power within the couple. This psychological, social and economic vulnerability is also fostered by patriarchal systems that convey social norms and harmful practices that are detrimental to women's well-being and emancipation.

However, while the relationship between female autonomy and fertility has been the subject of some work in the literature (Abadian, 1996; Larsen and Hollos, 2003; Al Riyami et al., 2004; Acharya et al., 2010; Patrikar et al., 2014; Musonera et al., 2016; Millogo et al., 2018), little is known about the direction of influence of autonomy on fertility. Indeed, in some contexts, results have shown that a woman's autonomy is inversely related to her fertility. The more autonomous the woman, the fewer children she has (Abadian, 1996; Millogo et al., 2018). In other studies, we observe a rather positive relationship between the influence of a woman's autonomy and her fertility. The more autonomous the woman, the more numerous her offspring (Musonera et al., 2016; Acharya et al., 2010). On the other hand, the results of certain studies (Upadhyay et al., 2014) have shown that there is no relationship between a woman's autonomy and her fertility. Under these conditions, research to better understand the meaning of the relationship between women's autonomy and fertility remains relevant and topical. Thus, this paper seeks to identify the relationship between the gender context, women's autonomy in union and fertility in rural Cameroon. Specifically, it aims to (i) describe the socio-economic and demographic variations in the relationship between the autonomy of women in union and fertility in rural Cameroon, (ii) identify the profile of these women according to their levels of autonomy and fertility, (iii) identify the explanatory factors at individual and contextual levels of the relationship between the autonomy of women in union and fertility, and (iv) identify their mechanism of action.

The data used in this study are from the fifth Demographic and Health Survey of 2018 (EDS, 2018) carried out by the Institut National de la Statistique. They are collected from the head of household or another member able to provide the essential information on all household members. The fertility component concerns women aged between 15 and 49, and covers the number of live-born children they have had, their survival status, etc. The variable of interest "number of children per woman or parity achieved" relates to fertility. Women's autonomy was apprehended through the variable relating to decision-making power in the household. This variable has four modalities: the decision is taken by the woman alone, with her spouse, by her spouse, or by someone else. The analysis methods used are both descriptive and explanatory. From the descriptive point of view, the bivariate analysis of variance will cross-tabulate the parity variable with contextual variables and individual characteristics of women in union. The profile of women in union will be identified using a Multiple Correspondence Analysis. The explanatory analysis will be based on a multiple linear regression model to identify the factors explaining the relationship between the autonomy of women in union and fertility. The implementation of this regression will be based on a multilevel approach. Two levels of analysis will be retained: the dependent variable and the explanatory variables relating to the individual characteristics of women in union will be located at the first level, and the contextual explanatory variables at the second level. Articulating these data collected at different levels in the same model enables us to correctly distinguish the effect of individual characteristics from the effect of contextual characteristics, as well as from a random effect specific to each level (Golaz and Bringe, 2017). This model can lead to results that are both more consistent and richer.