



Healthy Timing and Spacing of Pregnancy

Research Brief 2: Advanced Maternal Age and High-Parity Pregnancy – The Role of Culture and Community Support in Family Planning in Togo and Niger

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About this Research Brief

In 2015, the Health Communication Capacity Collaborative (HC3) conducted research to better understand the knowledge, attitudes, practices and socio-cultural factors in Togo and Niger that lead women to continue having children later in life and after they have already had many births. Focusing solely on women age 35 and older and women having five or more births, HC3 analyzed Togo and Niger Demographic and Health Survey data, as well as data (n=760) from a larger [2014 Camber Collective family planning study](#), referred to here as the *AMA/HP Niger Women Insights Research*. HC3 also conducted qualitative research in Niger and Togo (n=285) with women, male partners, healthcare providers and community leaders. The research ultimately informed the HC3 Healthy Timing and Spacing of Pregnancy (HTSP) Advanced Maternal Age and High-Parity Pregnancy Implementation Kit.

This brief is one of a series of three, and presents findings from this research. The full report is available here: <http://healthcommcapacity.org/hc3resources/qualitative-research-advanced-maternal-age-ama-high-parity-hp-pregnancies-west-africa/>



Discussing AMA and HP pregnancy in Togo, © 2016 Carol Hooks. All rights reserved.

Introduction

A woman is considered to be of advanced maternal age (AMA) when she is age 35 or older, and she is considered high parity (HP) when she has had five¹ or more pregnancies. Research shows that such pregnancies carry elevated risks for the mother and the baby. These risks can include maternal hypertensive disorders, pre-term delivery, abnormal infant birth weight and maternal and fetal mortality.

Having many children is a prevalent, if not expected, reproductive norm in Niger and Togo,² but socio-cultural

Summary of Key Findings

- A fatalistic attitude and a refusal to interfere with God's plans by limiting pregnancies was a prevalent theme. This default to religious beliefs was more common in Niger than Togo, and more tied to Islam than Christianity or other beliefs.
- Normative factors – such as gender roles around FP decision-making, polygamy and desired family size – facilitated or hindered the use of FP.
- Using FP methods to have smaller families was more accepted in urban Togo than any of the other sites, and was least common in Niger, where the concept of limiting remains “forbidden” or taboo.

¹ At the start of this activity, HC3 defined HP as five or more births; USAID has since revised the definition to include women having four or more births.

² Niger has the highest total fertility rate in the world at 7.6 children per woman, and Togo's, though declining in recent years, remains elevated at 4.8 children per woman (Niger DHS, 2012; Togo DHS, 2013).

norms around large families vary slightly according to context. In urban Togo, for example, a transition to lower fertility desires has begun.

This brief presents qualitative research findings around the role cultural and community norms play in women's and couple's family planning (FP) decisions.

Key Findings

In both Niger and Togo, the research showed that social norms, religion and other cultural values directly contribute to and perpetuate AMA and HP pregnancy in rural and urban communities by encouraging large families and constraining modern FP method use.

Unfavorable Norms toward Limiting Births

In both countries, male and female participants reported unfavorable social and cultural attitudes around limiting births. These beliefs were evident in rural Togo, but were most prominent in Niger. This opposition extended beyond individual preference, and was reinforced at the community level. Though participants feared maternal or child death in any pregnancy,³ limiting the number of children a woman had was rarely an accepted safeguard. Particularly in Niger and rural Togo, a woman's reproductive life often continued until menopause, regardless of her age, parity or desired family size. Interviews with couples in these areas showed women and male partners equally rejected the idea of limiting births, and this opinion was not influenced by female respondents' educational level.

Participants in Togo spoke specifically about the differing family size norms between urban and rural settings. In urban Togo, participants explained social norms were shifting to be more favorable toward limiting births, and

“Really it is not good to limit births to three, four or five children; it is not our culture. So those of us who have four wives – and if we only want four children? So every woman will stop after a single child? (hum!) In any case, we would like every woman to have 16 children (Oh yes!). Really it is not normal, [and] not just in Niger.”

– Man, partner of women not using FP, urban Niger

“They [women who have more than five children] are poorly perceived by the community; they are sometimes made fun of. In general, they are dirty, even the kids as well because they lack the means to look after them. We often advise them to stop this because nowadays people are not having as many children.”

– Woman, community leader, urban Togo



A woman in Niger, © 2016, Carol Hooks. All rights reserved.

large families were decreasingly desirable or “à la mode.” Rural settings, where large families were more accepted and common, were sometimes seen as archaic and stigmatized by urban participants, who viewed the city as more modern and evolved.

Religion and the Fear of Interfering with “God’s Plan”

Perceived religious mandates to have many children were prominent among Muslim participants in both countries. Most participants – particularly in Niger – believed Islam forbade any interference with reproduction. Participants in both countries believed they must have and accept the number of children “God gave them,” regardless of their desired family size. This fatalistic perspective surpassed any personal views. Even in cases where women felt “embarrassed” to be pregnant as an older woman, they still chose to leave it up to God.

“Personally, five children is good. But if God arranged for us to have more, that would not be a problem.”

– Man, partner of high-parity woman, urban Niger

Regardless of education levels, perceived religious constraints prevented FP use among Niger participants. One college-educated woman said she did not use modern FP methods because they were considered illicit by Islam. Many participants in Niger, including some religious leaders, explained that while Islam forbids birth limiting, it has for centuries encouraged birth spacing. These participants did not say Islam condoned modern FP method use, though spacing through exclusively breastfeeding was largely accepted. Similar religious constraints, while not as prevalent, existed in Togo and were linked almost exclusively to Islam.

³ See series HTSP Research Brief 1: Perceived Risks and Associated Provider Communication Barriers at <https://healthcommcapacity.org/http-research-brief-1>.

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Yes, I have heard about these methods, only I don't know whether these methods will be good for me or create problems for me. The midwives have explained [them] to me but because of my religion (Islam), I cannot take them. In our house, if people are against the fact that you do FP and you persist, you could even die by doing it, that is why I did not do it.”

– Woman, AMA and HP woman, rural Togo

Favorable Norms towards Large Family and Strategic Interest

Some participants valued large families because of their perceived benefits. These beliefs were more pronounced in Niger, but some participants in urban and rural Togo also felt children enhanced social status in several ways, including 1) being positively perceived in their community, 2) being seen as blessed by God, 3) adding to the family's monetary wealth and 4) ensuring parents would be cared for in their old age.

The desire to have a large family was also linked to infant mortality fears. The perceived frequency of infant deaths⁴ led couples to develop a prevention strategy: have many children in the hope of always having some should others succumb to illness and death.

Polygamy

Polygamy was more common in Niger than in Togo, and interviews showed being in a polygamous relationship impacted when and how many children a woman had.



Woman in the market, © 2006, Richard Nyberg, courtesy of Photoshare.

Participants explained that having children was often a strategy to 1) prevent the husband from taking another wife or 2) compete with co-wives for her husband's attention, resources or inheritance. In this way, polygamy resulted in a race to have more children, regardless of the risks⁵ each pregnancy carried.

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If the woman has a co-wife, she always wants to have children. She doesn't want to stop because the other one will give birth and reach the number she has. We, as healthcare providers, we cannot manage this aspect. In a situation of polygamy, women are no longer prepared to listen to us regarding limiting births.”

– Midwife, urban Niger

Established Community Norms on Family Planning

In Niger, participants generally supported FP, so long as it was used for spacing instead of limiting. In Togo, FP use was somewhat less taboo for both spacing and limiting births. However, these positive attitudes did not necessarily translate into FP use. Participants in both countries reported they would be more likely to accept contraceptive use if they believed it had become a norm in their community and was accepted by other women. A provider in rural Niger explained that women often needed to see others close to them using a FP method, and then they were more likely to mimic that behavior and accept FP for themselves.

Conclusions and Recommendations

Participants identified many socially and culturally significant factors contributing to AMA and HP pregnancy in Niger and Togo, but the fatalistic attitude and a refusal to interfere with God's plans by spacing and limiting births was a key theme. This default to religious beliefs was more common in Niger than Togo, and more tied to Islam than Christianity or other faiths. Normative factors – such as polygamy, religion, desired family size and community acceptance of FP – facilitated or hindered FP use. These factors were slightly less influential in urban areas, particularly in urban Togo, where norms have begun to move toward smaller families and acceptance of limiting births. A lack of understanding that AMA and HP pregnancies are higher risk also contributes to these pregnancies' prevalence.

In both countries, a strong strategic communication strategy that aligns closely held cultural values, FP use and preventing AMA and HP pregnancies is needed at the national, district and community levels. Under this strategy, the following actions should be considered:

⁴ DHS reports show the infant mortality rate decreased from 123 deaths per 1,000 live births in 1998 to 81 deaths in 2006 and 51 in 2012 in Niger, and from 80 infant deaths per 1,000 live births in 1998 to 49 deaths in 2014-2014 in Togo.

⁵ Perceptions of AMA and HP pregnancy risks are discussed in Brief 1 at <https://healthcommcapacity.org/htsp-research-brief-1>.



AMA and HP discussion group in Togo, © 2016 Carol Hooks. All rights reserved.

- Use evidence-based communication strategies to shift harmful maternal health and FP norms.** It is important to work with local organizations and structures to develop holistic, community-centered programs that address harmful norms – specifically those encouraging large families, mistrust of FP methods and services, competition between co-wives in polygamous relationships and male-dominated decision making – to reduce AMA and HP pregnancy prevalence. Advocating for national attention to age- and parity-related pregnancy risks, corresponding communication strategies and supportive policies (e.g., those facilitating FP use by couples and a woman's right to adopt her chosen FP method without the permission of her husband) would further strengthen this effort.
- Capitalize on community leaders' willingness to support initiatives.** Prevention efforts should take advantage of community and religious leaders' insights in designing and disseminating AMA and HP pregnancy prevention and management messages. These leaders can be key sources of information and encourage community members to use FP, accept or plan smaller family sizes, communicate with their partner about FP and promote women's agency in making FP decisions.

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