Healthy Timing and Spacing of Pregnancy

Research Brief 3: The Impact of Gender on Advanced Maternal Age and High-Parity Pregnancy in Niger and Togo

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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/

Men in Togo, © 2016 Carol Hooks. All rights reserved.

Introduction

In Niger and Togo, traditional gender roles directly impact women's reproductive health. While women are charged nearly exclusively with caring for children, men generally make the decisions about contraceptive use and family size. These circumstances strongly contribute to the prevalence of advanced maternal age (AMA) and high parity (HP) pregnancies.

A woman is considered to be AMA when she is age 35 or older, and she is considered HP when she has had five[1] or more pregnancies. Research shows that such pregnancies carry

Summary of Key Findings

- Factors like polygamy, early marriage, remarriage and religion – particularly Islamic beliefs – contribute to AMA and HP pregnancies.
- Male partners' refusal of family planning or limiting pregnancies is a primary barrier to women accessing, using and continuing family planning methods.
- While men made final decisions on family planning use, women were often blamed when they had too many children or their pregnancies were too closely spaced.

[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.

elevated risks for the mother and baby. These risks can include maternal hypertensive disorders, pre-term delivery, abnormal infant birth weight and maternal and fetal mortality.

This brief presents research findings on how gender norms specifically drive women to continue having children, even when her age and parity makes pregnancy and delivery dangerous.

Key Findings

The *AMA/HP Niger Women Insights Research* results showed that women in Niger supported family planning (FP) use for birth spacing and supported government initiatives to help families in this way. Over two-thirds (70.5 percent) of surveyed women said they agree a woman should not get pregnant "if she still has a child on her back" (i.e., has a child under two years old). Furthermore, more than half (57 percent) of the women thought a husband would be displeased if his wife became pregnant again while their last child was still under two years old. This finding underscores the social consequences and disapproval of births that are too close together.

HC3's qualitative research also showed favorable attitudes toward FP in Niger and Togo. In Niger, Muslim religious beliefs[2] condoned FP use exclusively for spacing births, while participants in Togo were more open to using FP to space or limit births, particularly in urban areas. Favorable attitudes, however, did not always lead to systematic FP use or agreement about use between partners in either country. Both the quantitative and qualitative data showed that, while FP use and method choice decisions were primarily made by men, the woman was often blamed if she had too many children or if children were too closely spaced. Some of the more salient gender and relationship dynamics impacting FP use in each country are detailed in the following sections.

Lack of Decision-Making Power

The *AMA/HP Niger Women Insights Research* revealed that less than half (48 percent) of women reported they could make decisions about their health. A majority (67 percent) of AMA and HP women thought a woman should not use contraception without her husband's knowledge, and most women said they sought their husband's approval before using contraception. The Niger qualitative research validated these findings, and little difference in gender dynamics was noted between urban and rural locations.

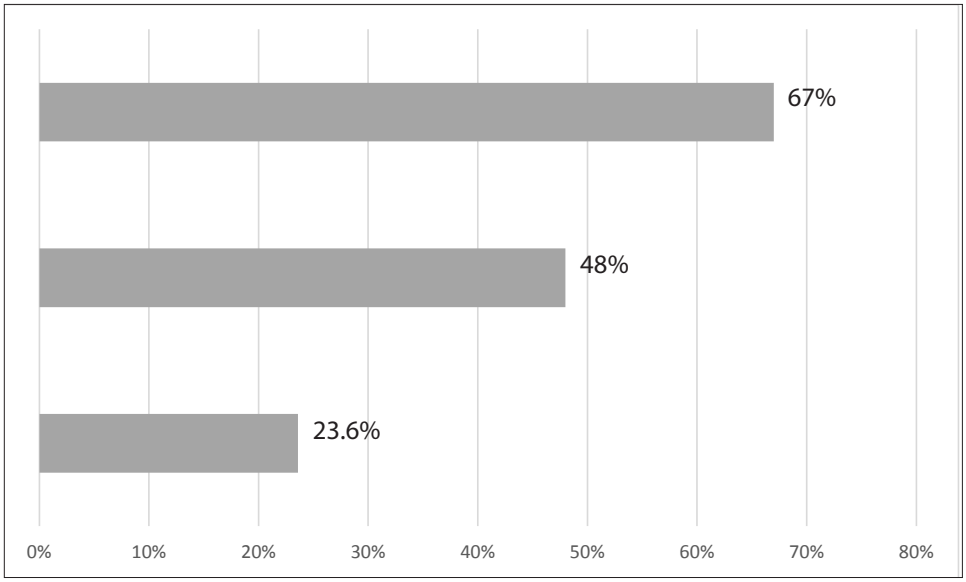
In Togo, however, the qualitative results suggested women had more agency than in Niger, and were less dependent on their male partners, particularly if they were engaged in income-generating activities. This is explained more under this brief's Women's Agency section. Gender norms seemed slightly more fluid in urban Togo, where rates of early marriage have declined over the years, and some participants described making FP decisions themselves or with their husband.

Husband's Refusal

While women had favorable attitudes toward FP, gender roles dictated FP use. The *AMA/HP Niger Women Insights Research* showed that 23.6 percent of participants reported their husband's refusal prevented them from considering a modern FP method. The qualitative research confirmed this barrier throughout Togo and Niger; women in both countries reported not using FP because their husband/partner refused to allow it.

Women and providers gave examples of how difficult it was to engage men in discussions about FP methods. One provider in rural Niger described a client's husband, who rejected her request to come in to discuss FP, and then "categorically refused" to let his wife use modern FP methods. Women and providers explained that men rejected FP use because

AMA and HP Womens' Views in Niger



Source: *AMA/HP Niger Women Insights Research*; n=760

[2] The role of culture and religion in FP is discussed in Brief 2 of this series, available at https://healthcommcapacity.org/htsp-research-brief-2.

Community members in Togo, © 2016, Carol Hooks. All rights reserved.

they feared their wife being unfaithful, they did not trust the methods' safety, or they simply wanted their female partner to have many children.

> "*When we go to a prenatal or pediatric exam, they advise us about FP methods for spacing the births . . . at home, when we tell our husbands, they refuse under the pretext that these methods create illnesses that will still be their responsibility, when you return to inform the midwives they will tell you to bring your husband in, but he always refuses. There is no other way, you are condemned not to do it because he threatened you at home, because you are afraid to disobey him you will do nothing but spawn children.*"
>
> – Woman, not using FP, urban Togo

Polygamy

As discussed in Research Brief 2[3] in this series, polygamy was more common among participants in Niger than in Togo. The interviews suggested women in polygamous unions often chose to have more children as a strategy to 1) prevent the husband from seeking a second wife or 2) compete with co-wives. Polygamy resulted in a race to have more children, regardless of the risks[4] each pregnancy carried.

> "*If the woman has a co-wife, she always wants to have children. She does not 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, FGD, urban Niger

Early Marriages and Marital Instability

The quantitative data indicated early marriage was prevalent in Niger: 70 percent of the women in a relationship surveyed were married before age 18. In Togo, however, early marriages have declined, and their impact on HP pregnancies was not often cited in urban areas. Interviews in rural Togo, however, showed that girls still married young. This early entry into a relationship positively influenced the number of children a woman had in a context where limiting births was taboo or not allowed. Once married, women lacked acceptable grounds to further delay having children, and many found themselves having more children than they expected. Participants also explained that divorces and remarriages put women in circumstances where, regardless of age or parity, they were obligated to give children to their new spouse.

Woman's Agency

> "*I think some women do not expect to get pregnant. That happened to me seeing as I was in the village and I did not know anything about FP. It is because I came to Lomé and I was informed by the radio that I changed my behavior. So if . . . women follow the news on the radio, then they will change.*"
>
> – Woman, mixed FGD, urban Togo

Although not as commonly discussed by participants, women who 1) had access to FP information, 2) held FP decision-making power and 3) were employed were more motivated to use FP.

According to the *AMA/HP Niger Women Insights Research*, access to information positively influenced contraceptive use by AMA and HP women. Among women FP users, almost all (95 percent) sought information on different methods' use, cost and associated adverse effects. Three-fourths (76 percent) visited a healthcare center at least once for an FP consultation. The qualitative interviews also showed access to quality information was an essential condition for contraceptive use by AMA and/or HP women in both Niger and Togo. Finally, employment and income generation motivated women to use FP, although participants in Togo spoke more about this than women in Niger.

> "*I would say we can no longer find women like Esse [female character in video shown during FGD] in Lomé because it is trade that women of Lomé are concerned with nowadays so you can only find women like Esse in the villages.*"
>
> – Woman, Mixed FGD, urban Togo

[3] Cultural norms that contribute to AMA/HP pregnancy are discussed in HTSP Research Brief 2 at https://healthcommcapacity.org/htsp-research-brief-2.

[4] Perceptions of AMA and HP pregnancy risks are discussed in Brief 1 at https://healthcommcapacity.org/htsp-research-brief-1.

Discussion group in Togo, © 2016, Carol Hooks. All rights reserved.

Conclusions and Recommendations

While women's attitudes are generally positive toward FP in both Togo and Niger, male partners are often a barrier to women spacing births and/or using modern FP methods. Gender roles in both countries disempower women in matters of their own reproductive lives and health. Early marriage, remarriage, polygamy and strong religious beliefs all contribute to AMA and HP pregnancy prevalence in Togo and Niger. To address these harmful norms, it is recommended that countries with similar barriers to FP use consider the following recommendations:

- **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, gender-transformative (e.g., those that facilitate gender equity and address imbalanced gender norms) and community-centered programs that address harmful norms – specifically those encouraging large families, male-dominated decision-making, competition between co-wives in polygamous relationships and mistrust of FP methods and services – head on to reduce AMA and HP pregnancy prevalence.
- **Engage male partners in efforts to prevent AMA/HP pregnancies.** Programs should involve men, inform them about pregnancy risks associated with AMA and HP and engage them to make changes in their own families.
- **Capitalize on community leaders' willingness to support AMA/HP prevention initiatives.** Religious and community leaders are important sources of information and influence. These gatekeepers can model and promote more equitable gender norms, encourage community members to use and accept FP, accept or plan smaller family sizes, communicate with their partners about FP use and promote women's agency in making FP decisions. Work with these groups should also highlight the harmful effects of early marriage and polygamy, particularly as it relates to reproductive health decision making and the health of women and children.
- **Develop effective tools to support AMA and HP communication at the service delivery level.** FP healthcare providers play a frontline role in educating women and couples about age- and parity-related pregnancy risks, and in facilitating behavior change for pregnancy risk management and prevention. Culturally appropriate materials that include guidance on structured couples counseling is key to ensure men understand the benefits of birth spacing and FP and are supportive of their partner's use of these approaches.

References

Camber Collective. (2014). *Customer Insights Research for Family Planning Demand Generation in Niger*. Retrieved from http://www.cambercollective.com/fpniger/.

National Statistics Institute and ICF International. (2013). Demographic and Health Survey (DHS) Program. *Niger Demographic and Health Survey, 2012*. Calverton, Maryland, USA: ICF International. Niamey, Niger: National Statistics Institute, Ministry of Finance. Retrieved from http://dhsprogram.com/What-We-Do/survey/survey-display-407.cfm.

Ministry of Territory Planning, Development and Organization (MPDAT), Ministry of Health (MOH), and ICF International. (2015). *The Demographic and Health Survey (DHS) Program Togo Demographic and Health Survey, 2013-2014*. Lome, Togo: MPDAT MOH. Rockville, Maryland, USA: ICF International. Retrieved from http://dhsprogram.com/what-we-do/survey/survey-display-328.cfm.