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## QUALITATIVE RESEARCH ON ADVANCED MATERNAL AGE AND HIGH PARITY PREGNANCIES IN WEST AFRICA

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## ACRONYMS

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<b>AMA</b>	Advanced Maternal Age
<b>CHW</b>	Community Health Worker
<b>CPNs</b>	Conseil Pre-Natal (prenatal exams)
<b>CPONs</b>	Conseil Post-Natal (postnatal exams)
<b>DHS</b>	Demographic and Health Survey
<b>FGD</b>	Focus Group Discussions
<b>FP</b>	Family Planning
<b>HC3</b>	Health Communication Capacity Collaborative
<b>HP</b>	High Parity
<b>HTSP</b>	Healthy Timing and Spacing of Pregnancies
<b>IDI</b>	In-Depth Interviews
<b>MNCH</b>	Maternal, Newborn and Child Health
<b>NN</b>	Neonatal Mortality Rate
<b>PNN</b>	Postneonatal Mortality Rate
<b>PPFP</b>	Postpartum Family Planning
<b>SBCC</b>	Social and Behavior Change Communication
<b>TFR</b>	Total Fertility Rate
<b>USAID</b>	United States Agency for International Development

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## EXECUTIVE SUMMARY

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In January and March 2015, the USAID-funded Health Communication Capacity Collaborative (HC3) conducted qualitative research in Togo and Niger on the knowledge, attitudes, behaviors and contributing factors around advanced maternal age (AMA) and high parity (HP) pregnancies. The research also sought to understand barriers and facilitators to AMA and HP women's modern family planning (FP) method use. Advanced maternal age is defined as 35 years or older, and high parity is defined as having five or more births, including stillbirths.

The qualitative research took place in one urban and two rural locations in each country. Data was collected through focus group discussions, case studies and in-depth interviews with 285 healthcare service providers, AMA and HP women, male partners and community leaders. The qualitative research was supplemented with the *Niger AMA/HP Women Insights Research* survey data collected with 760 AMA and HP women by Camber Collective in 2014. Additional context was provided by examination of data from Demographic and Health Surveys (DHS) from Niger (2012) and Togo (2013-2014).

The results of these studies yielded the following conclusions:

- HP pregnancies are common in Niger, in both rural and urban areas. In Togo, however, the prevalence of HP pregnancies is more common in rural areas. In both Niger and Togo, the contribution of AMA women to the fertility rate remains high.
- Attitudes regarding AMA and HP pregnancies differ and vary depending on the context. Perceived as a reproductive norm in Niger and accepted as such, HP pregnancies are only tolerated in rural areas of Togo and perceived poorly in cities where a transition to lower fertility desires has begun. As for AMA pregnancies, how they are viewed continues to be contingent upon the mother's age and parity in both Togo and Niger. While tolerated for low-parity women, they are considered less acceptable for HP women and for women with older children.
- Participants provided many reasons for the prevalence of AMA and HP pregnancies, but the fatalistic attitude and a refusal to interfere with God's plans by 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 beliefs.
- Normative factors – such as gender roles around FP decision-making, polygamy and desired family size – facilitated or hindered the use of FP.
- A lack of understanding around associated risks, particularly in Niger, contributed to AMA and HP pregnancy prevalence. Inadequate AMA and HP knowledge was not limited to lay populations as health care providers also lacked the training and materials to properly counsel their patients. Also, a level of mistrust between clients and providers was evident. Pregnant clients thought providers wished them ill if providers spoke to them about the risks of their situation.

- The interviews with various maternal and infant healthcare professionals in both countries revealed that communication about AMA and HP pregnancies was very limited or even nonexistent. The bulk of the communication about the risks of pregnancies in general was done during Conseil Pre-Natal (CPNs – prenatal exams) and Conseil Post Natal (CPONs – postnatal exams) and in FP services counseling. Furthermore, the topics addressed during these various sessions did not necessarily incorporate aspects related to AMA and HP pregnancies.
- The interviews did not reveal any significant differences between male and female participants' AMA/HP knowledge and perceptions of risks. Slight differences of opinions about FP decision-making were noted.

Recommendations to provide guidance on developing and implementing an effective social and behavior change communication (SBCC) strategy targeting AMA and HP pregnancies are to:

- Advocate prioritizing AMA and HP pregnancy prevention activities in maternal, newborn and child health (MNCH)/FP programs (e.g., through postpartum family planning (PPFP) programs and child health and immunization visits), and to promote development of coordinated AMA/HP communication strategies.
- Work with local organizations and structures to develop community-centered programs that address harmful social and cultural norms that perpetuate AMA and HP pregnancy – such as those encouraging large family size and limiting women's decision-making – through proven communication strategies.
- Strengthen service providers' capacity to communicate the risks and counsel women with AMA and HP pregnancies and their partners to recognize danger signs during pregnancy and delivery, and develop birth plans. Ensure sensitive and non-threatening communication, especially when providers are counseling a woman who is already pregnant.
- Where strict gender roles elevate men as FP decision-makers, engage male partners to understand AMA and HP pregnancy risks and help prevent AMA and HP pregnancies in their households.
- Capitalize on community leaders' willingness to support AMA/HP pregnancy prevention efforts by asking them to lead or participate in risk communication, knowledge dissemination and other community mobilization activities.
- Develop effective communication tools to support clients', providers' and community members' understanding of AMA and HP pregnancy risks, and how these risks can be managed or prevented (e.g., client brochures, provider counseling materials, community mobilization tools, advocacy resources for community leaders, decision-makers and others).



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## INTRODUCTION

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Early, frequent and late pregnancies pose significant dangers to maternal, neonatal and child health (MNCH) especially in countries where women have limited access to quality healthcare services (HC3, 2014a). Pregnancies among women of advanced maternal age (AMA, 35 years or older) or among women of high parity (HP, having had five or more births) are linked to maternal and infant mortality.

To better understand the context in which AMA and HP pregnancies occur, the USAID-funded Health Communication Capacity Collaborative (HC3) project conducted qualitative research on the perception and determinants of such pregnancies in two USAID family planning priority countries: Togo and Niger. Francophone Sub-Saharan Africa was identified as an area where very little research has been conducted on this topic. Togo and Niger were selected within the region due to their high rates of AMA and HP pregnancy, and also because the topic aligned with each country's USAID Mission priorities. The research was designed to inform the development of a series of adaptable tools for promoting healthy timing and spacing of pregnancies (HTSP), with particular focus on AMA and HP pregnancies, for use by FP and maternal and child health (MCH) program managers working in Sub-Saharan Africa.

This document includes the findings from the qualitative research conducted in Togo and Niger, and supplemental findings from the analysis of survey data from AMA and HP women in Niger.

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## OBJECTIVES

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The overall goal of the study was to identify factors encouraging or preventing modern FP method use among AMA or HP women.

The five specific objectives of the study were to:

1. Identify the cultural factors contributing to AMA and HP pregnancies
2. Understand AMA and HP women's perceptions and attitudes, as well as those of their partners, about the risks of AMA and HP pregnancies
3. Identify factors facilitating or preventing AMA and HP women's FP method use
4. Document healthcare provider practices on communicating about AMA and HP pregnancies with clients
5. Explore ideas, messages or approaches to inform women about AMA and HP pregnancy risks that would encourage modern FP method use among AMA and HP women and their partners

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## METHODOLOGY

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This report includes a summary of both quantitative and qualitative data.

### QUANTITATIVE

HC3 began with a review of the secondary data, including Demographic and Health Surveys (DHS) in Togo (2013-2014) and Niger (2012). *Customer Insights Research for Family Planning Demand Generation in Niger*, a nationwide survey of 2,000 women between the ages of 15 to 49, was conducted in 2014 by Hope Consulting.<sup>1</sup> HC3 analyzed a subset of this survey data, the responses of the AMA and HP women (n=760), to examine specific knowledge, attitudes and behaviors related to AMA and HP pregnancies. This subset analysis will be referred to as the *Niger AMA/HP Women Insights Research* in this report.

### QUALITATIVE

The qualitative study was conducted between January 21 and March 2, 2015 in Niger and Togo and included focus group discussions (FGDs), case studies and in-depth interviews (IDIs). A total of 285 individuals participated in this study – 174 were recorded as female, 111 as male. Table 1 displays each methodology and number of participants by location. In each study site:

- **FGDs** were conducted with AMA and/or HP women and with male partners of AMA and/or HP women to gather data about collective perceptions and attitudes that influence choices about reproduction, particularly AMA and/or HP pregnancies.
- **Case studies** were conducted with AMA and/or HP women who had difficult pregnancies or deliveries. These histories highlighted the level of knowledge these women had about AMA and/or HP pregnancy risks and how this impacted their pregnancies and deliveries.
- **IDIs** were conducted with:
  - **AMA and HP couples** to understand how marriage and gender dynamics impacted fertility desires and reproductive health decision-making. The couples also gave insight into how cultural, economic or other factors influence reproductive behaviors around AMA and HP pregnancies. Each partner was also interviewed separately to understand the personal factors that affected their decision to have or not to have children.
  - **Maternal and infant health service providers** to understand their perception and knowledge of AMA and HP pregnancies, and whether they communicated with their clients about AMA and/or HP pregnancies.
  - **Community leaders** to understand their maternal health and family planning perspectives, as well as their view of AMA and/or HP pregnancies.

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<sup>1</sup> Hope Consulting merged with SwitchPoint to form Camber Collective in July 2015.

**Table 1: Number of Participants by Methodology and Location**

	Niger			Togo			Total
	Niamey (urban)	Koygoro (rural)	Mokko (rural)	Lomé (urban)	Aouda (rural)	Adjengre (rural)	
<b>FGD (Number of groups shown in parentheses)</b>							
• Women	36 (4)	8 (1)	8 (1)	31 (4)	19 (2)	25 (2)	<b>127 (14)</b>
• Male Partners	24 (3)	8 (1)	8 (1)	25 (3)	8 (1)	9 (1)	<b>82 (10)</b>
• Mixed: Men and Women	8 (1)	--	--	8 (1)	--	--	<b>16 (2)</b>
<b>CASE STUDY</b>	2	1	1	2	1	1	<b>8</b>
<b>IDI (Number of couples shown in parentheses)</b>							
• Service Providers	3	2	1	3	2	2	<b>13</b>
• Couples	8 (4)	4 (2)	4 (2)	4 (2)	4 (2)	4 (2)	<b>28 (14)</b>
• Leaders	2	2	1	2	2	2	<b>11</b>

**LOCATION**

Research was conducted in one urban site and two rural sites in Niger and Togo. Data collection in the field took place from January 21 to February 10, 2015, in Niger, and from February 11 to March 2, 2015, in Togo. The selection of study sites was based on several factors including fertility rate, prevalence of AMA pregnancies, cultural diversity and level of contraceptive use as well as their accessibility from the capital. In Niger, the sites were Niamey (urban), Koygoro and Mokko (rural) in the Dosso region, about 130 km from the capital Niamey. The study was conducted in villages in the north of this region as safety concerns prevented the team from going any further. In Togo, the three sites were Lomé (urban), Aouda and Adjengre (rural) in the Plateaux region, located 169 km from the capital Lomé. This region was chosen because of its mix of religion (Muslim, Christian and traditional religions).

**RECRUITMENT AND CHALLENGES**

Participants for the study were recruited at local health centers, through maternal and infant health (MIH) providers and by canvassing study towns. Health providers aided in recruiting colleagues and a snowball technique was used to invite additional participants in each study town. Recruitment for the study presented some challenges, including:

- **Willingness to Participate:** In Niger, while women were generally open to participate, some were anxious about their spouses' reaction and canceled their interviews.
- **Political Climate:** In Togo, the data collection was impacted by strikes in health care facilities and schools.
- **Recruitment of AMA and HP Pregnant Women:** Several AMA and HP pregnant women were inadvertently recruited for the focus groups or the couples' interviews. Since the recruitment forms did not include pregnancy status, the research team learned of pregnancy when the

woman or couple arrived for the interview. To avoid causing undue stress to these pregnant women, the team reimbursed them for travel expenses and did not complete the interview.

The research protocol was approved by the Johns Hopkins University Institutional Review Board and by the ethics committees in Niger and Togo. All members of the research team were trained in confidentiality standards. Study participation was voluntary, anonymous and non-discriminatory. Each participant was provided a consent form that indicated the study's purpose and the confidential nature of the data collection and use.

### **LANGUAGE**

Interviews in Niger were conducted in Hausa and Zarma languages. In Togo, most of the interviews were conducted in Mina language with a few in Kabiye. All interviews and focus groups were recorded and transcribed in French.

### **DATA ANALYSIS PLAN**

The transcripts were checked and evaluated by a resource person (often the main facilitator) who spoke the language in which the interview was conducted. The transcribed data were entered into Microsoft Word for content analysis. Participant responses were organized into main thematic areas or topics, and according to participant profile attributes (e.g., AMA and/or HP status, gender, FP users or non-users, rural or urban).

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## OVERVIEW OF THE CONTEXT OF AMA AND HP PREGNANCIES IN NIGER AND TOGO

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To provide context for the qualitative findings, this section utilizes the quantitative data to provide highlights of the countries regarding fertility, contraceptive use and unmet need, and AMA and HP risk factors.

### COUNTRY CONTEXT

Niger is located in Western Africa with an estimated population of 18 million, of which approximately one million live in the capital Niamey. Eighteen percent of the population lives in urban areas. Eighty percent of the population is Muslim and 20 percent practice other religions (including Christianity and indigenous religions). Literacy levels, where those aged 15 and older can read and write, are much higher for males (27 percent) than females (11 percent) (CIA, 2015). Among married women in Niger, 36 percent are in polygamous unions. Nearly half (47 percent) of polygamous unions are among women 45 to 49 years old. The proportion of women in polygamous relationships decreases as a woman's education level increases. Polygamy is slightly more common in rural compared to urban settings – in 2012, 37 percent of rural married women versus 31 percent of urban married women were in polygamous unions (DHS Niger, 2012).

Togo is also in the western part of Africa with a population of 7.5 million, with approximately one million living in the capital Lomé. Forty percent of the population lives in urban areas. Twenty-nine percent of the population are Christian, 20 percent are Muslim and 51 percent practice indigenous religions. Literacy levels in Togo are nearly triple those in Niger but the rate is still higher for males (78 percent) than females (55 percent) (CIA, 2015). Thirty-two percent of married women in Togo are in polygamous relationships. Very similar to Niger, nearly half (46 percent) of polygamous unions are among women 45 to 49 years old, and polygamy is more common among women with no or low education and among women in rural compared to urban environments. Thirty-nine percent of married rural women are in polygamous unions compared to 22 percent of married urban women (DHS Togo, 2013-2014).

### FERTILITY

In Niger, the total fertility rate (TFR – the average number of children per woman) is 7.6. In rural areas, the fertility rate is relatively higher (8.1) than in urban areas (5.6) as shown in Table 2. DHS data also revealed that almost half (43 percent) of Nigerien women between the ages of 15 to 49 were in a HP situation (they had five or more children, see Table 3). It is important to note that education was a considerable factor as women who did not have any formal education had on average 3.1 children more than women with secondary or higher education.

**Table 2: Fertility Indicators by Area of Residence and Age**

Age group	Fertility rates by age (per 1000 women)					
	NIGER			TOGO		
	Urban	Rural	Together	Urban	Rural	Together
15-19	112	231	206	50	118	85
20-24	250	359	338	155	257	205
25-29	279	336	326	191	264	230
30-34	225	300	287	186	223	207
35-39	165	234	221	98	157	133
40-44	55	111	100	38	87	68
45-49	32	52	49	16	36	29
Other fertility indicators						
TFR (Total Fertility Rate)	5.6	8.1	7.6	3.7	5.7	4.8

Sources: NDHS [Niger Demographic and Health Survey]-MIS [Multiple Indicator Survey] IV, 2012 and DHS Togo, 2013

**Table 3: AMA and HP Pregnancies**

	Niger	Togo
<b>AMA:</b> Percent of all women aged 35-49 who had a child at 35 years or older	60%	46%
<b>HP:</b> Percent of all women who had five or more births	43%	22%

Source: DHS Niger (2012); DHS Togo (2013-2014)

In Togo, the average number of children per woman is 4.8, which is lower than in Niger but still high (DHS Togo, 2013-2014). Similar to Niger, fertility rates among rural Togolese women are higher with a TFR of 5.7 children compared to 3.7 among urban women (see Table 2). Almost one-fourth (22 percent) of Togolese women between the ages of 15 and 49 had five or more children. Similar to Niger, education also played a role in Togo, as women who did not have any formal education had on average 2.6 children more than women with a secondary or higher education.

### CONTRACEPTIVE USE AND UNMET NEED

Contraceptive use is relatively low in both Niger and Togo. According to the 2012 Niger DHS data, the contraceptive use rate among married women for all methods was 14 percent and for modern methods was around 12 percent.

In Togo, women’s contraceptive use also remains low. According to DHS data, in 2013, married women’s use of any contraceptive method was 20 percent and the modern method contraceptive prevalence rate (CPR) was 17 percent.

In both countries, contraceptive use was much higher among urban women than among rural women. Education also plays a role in contraceptive use. In both countries, women with secondary education had the highest rates of use.

As reported in Table 4, both countries still face substantial unmet need for family planning – that is, women who wish to delay or prevent pregnancy but are not using contraception.

**Table 4: Unmet Need for Family Planning by Age for Women in Relationship**

<i>Age group</i>	<i>Unmet Need for Family Planning by Age for Women in Relationship (%)</i>					
	<b>NIGER</b>			<b>TOGO</b>		
	Birth Spacing	Birth Limiting	Together	Birth Spacing	Birth Limiting	Together
15-19	12.9	0.2	13.1	40.5	1.1	41.6
20-24	18.1	0.2	18.4	37.5	2.1	39.5
25-29	16.0	0.4	16.4	29.7	5.6	35.3
30-34	14.6	1.6	16.2	24.4	10.7	35.1
35-39	9.6	4.0	13.6	15.0	20.7	35.7
40-44	8.1	10.8	18.9	6.6	21.7	28.3
45-49	4.7	9.3	14.1	2.1	16.6	18.7
Sub-total of 35 – 49 age group	22.4	24.1	46.6	23.7	59	82.7

Source: DHS Niger, 2012; DHS Togo, 2013-2014

Unmet need is particularly important for AMA women. According to each country’s most recent DHS, 60 percent of women in Niger and 46 percent of women in Togo had a child at age 35 or older. About half of AMA women in Niger (47 percent) and over three-fourths of AMA women in Togo (83 percent) reported unmet need for FP and were not using FP to space or limit pregnancies.

### **MATERNAL, NEONATAL AND INFANT MORTALITY AND AMA AND HP RISK FACTORS**

The maternal mortality rate (MMR) among women between the ages of 15 to 49 in Niger (39 percent) is more than twice as high as Togo (14 percent, see Table 5). Neonatal mortality rates are higher in rural than urban areas in Niger (33 rural vs. 21 urban) and Togo (30 rural vs. 28 urban).

**Table 5: Maternal and Neonatal Mortality Rates**

	<i>Niger</i>		<i>Togo</i>	
MMR (Maternal Mortality Rate) % of 15-49 yrs.	39		14	
	Urban	Rural	Urban	Rural
NMR (Neonatal Mortality Rate)	21	33	28	30

Sources: DHS Niger, 2012 and DHS Togo, 2013

A child's birth order has a significant impact on the risk of infant mortality. The DHS data in Table 6 illustrates this risk in Niger and Togo. In both countries infant mortality rates are higher for both the first and seventh or higher child.

**Table 6: Infant Mortality Rate According to One-Year Birth Order**

<i>Child's Birth Order</i>	<i>Infant Mortality Rate</i>					
	<i>Niger</i>			<i>Togo</i>		
	<i>Neonatal (NN) Mortality<sup>2</sup></i>	<i>Post-neonatal (PNN) Mortality<sup>3</sup></i>	<i>Infant Mortality</i>	<i>Neonatal (NN) Mortality</i>	<i>Post-neonatal (PNN) Mortality</i>	<i>Infant Mortality</i>
1	49	37	85	32	22	55
2-3	26	30	56	24	22	47
4-6	25	33	58	28	28	56
7+	37	37	74	44	17	61

Sources: DHS Niger, 2012 and DHS Togo, 2013

Other AMA pregnancy complications include intra-uterine fetal death, fetal distress and maternal mortality. Additional HP complications include anemia in the mother, postpartum hemorrhage and fetal malpresentation. Both AMA and HP pregnancies also increase the risk of hypertension, irregular infant birth weight and need for Caesarean delivery (HC3, 2014b). In spite of these significant risks, the literature shows that little to no research has been done on knowledge, attitudes and behaviors around AMA and HP (HC3, 2014a), and anecdotal evidence suggests that many HTSP programs focus on birth spacing and delaying or preventing early pregnancies and do not sufficiently address pregnancies and births among AMA or HP women.

<sup>2</sup> Neonatal Mortality (NN) rate is the risk of a child dying before reaching 28 days of age.

<sup>3</sup> Post-neonatal Mortality (PNN) rate is the risk of a child dying during the period of the first month to the first year.



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## KEY FINDINGS

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Reported perceptions about AMA and HP pregnancies differed between Togo and Niger and between rural and urban settings. However, some common themes also emerged. Overall, the HC3 research study showed that urban locations had less restrictive cultural norms preventing FP method use compared to rural locations, and urban Togo participants demonstrated more knowledge about AMA and HP pregnancy risks than Niger participants as a whole. Such location-specific differences and similarities are discussed by thematic category in this section.

### AMA AND HP PREVALENCE

As previously stated, DHS data shows that fertility rates in Niger and Togo are high. This trend was confirmed by the *Niger AMA/HP Women Insights Research*. The research revealed that 42 percent of women between the ages of 15 to 49, who were in a relationship at the time of the survey, were women in a HP situation. Of these, 71 percent said they wanted more children. Results from the qualitative study confirmed AMA and HP prevalence.

### AMA IN NIGER AND TOGO

Participants in both rural and urban Niger believed that AMA pregnancies were common in their communities. They shared examples of women they knew (or had heard about) who had AMA pregnancies. Healthcare providers also echoed this sentiment. As one midwife explained:

*“Yes, women who are 35 years old still seek pregnancy. They come here to get contraception and after two years of spacing, they come back to tell us that they want to stop in order to get pregnant again.”* (Midwife, interview, urban Niger)

Participants in Togo were mixed about the prevalence of AMA pregnancies in their country. While most viewed them as a “rural problem” others reported that they were also prevalent in cities.

### HP IN NIGER AND TOGO

In Niger, most participants reported that HP was “common” in both urban and rural settings. Findings were not as consistent in Togo. Although the high number of HP pregnancies in rural areas was generally acknowledged, participants were divided with regard to HP pregnancy frequency in urban areas. While some perceived HP pregnancies to still be common, others thought their frequency was reduced due to contraceptive use among women. One participant rejected the perception that HP was just a “rural issue” in Togo when she stated:

*“Yes, I think the perception is that [it is a village problem] but unfortunately this also happens in the city. . . I can even give an example of a woman who is a retailer and her dockworker husband in Port Autonome [Port Authority of Lomé]. They currently have five children and the oldest is in CM2 [5th grade].”* (Woman, FP non-user FGD, urban Togo)

## **CULTURAL FACTORS CONTRIBUTING TO AMA AND HP PREGNANCIES**

A key theme emerging from the FGDs, IDIs and case studies is the importance of cultural factors contributing to AMA and HP pregnancies. In both countries, it was clear that attitudes and norms about AMA and HP pregnancies were deeply rooted in cultural and contextual factors. Participants in both countries reported a range of factors contributing to these pregnancies including norms, religion and other cultural factors. These sub-themes are discussed next.

### **“NO, WE ARE NOT ALLOWED”: UNFAVORABLE NORM TOWARDS LIMITING BIRTHS**

In both countries, male and female participants reported an unfavorable norm toward limiting births. Specifically, they did not feel it was their decision to prevent births. These norms seemed to be stronger in Niger and rural Togo. One participant from Niger noted:

*“Really it's not good to limit births to three, four or five children. It's 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's not normal, [and] not just in Niger.”* (Man, FP non-user FGD, urban Niger)

The idea that limiting births was “not part of our culture” and “not just in Niger” is important to consider as it reveals that participants’ views on AMA and HP were not a matter of individual preference but rather a community norm. In both countries, AMA and HP pregnancies were generally seen as more acceptable than the alternative of limiting the number of children. This perspective was shared by couples. Interviews with AMA and HP couples showed women and their male partners equally rejected the idea of limiting pregnancies. Even in HP situations, couples had a hard time entertaining the idea of stopping reproduction. A 36-year-old man with nine children illustrated this point when he explained:

*“It's better to seek to ease the suffering by spacing out the births rather than taking measures to not have any more children. To stop having children is an offense.”* (Man, mixed FGD, urban Niger)

It is important to note that this unwillingness to limit births seemed to be more prominent in Niger than Togo. Some participants in Togo did report that the norms were changing to be more favorable towards limiting births, especially in urban areas. A male partner with six children who participated in the couple interview explained:

*“The desire for children, any man who eats well must reproduce. But having many children is no longer fashionable. It's no longer fashionable to have many children.”*  
(Man, HP couple, FP non-user, interview, rural Niger)

Further, in urban areas especially, large families were no longer seen as desirable or “à la mode.” As one community leader put it:

*“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 interview, urban Togo)

A review of the respondents’ socio-demographic characteristics revealed that a woman's refusal to limit births was not influenced by her level of education in either AMA or HP couples. However, some participants – especially in Togo – did perceive differing large family acceptability norms between urban and rural settings. Rural settings were sometimes seen as archaic, and in a way were stigmatized by urban participants who viewed the city as more modern and evolved.

### **RELIGION AND THE FEAR OF INTERFERING WITH “GOD’S PLAN”**

Many participants, particularly in Niger, believed that religion forbade any interference with reproduction. Participants in both countries believed that they must have the number of children “God gave them,” and regardless of their desired number of children, they had to accept what they were given. A husband and father of five illustrated this point when he stated:

*“Personally, five children is good. But if God arranged for us to have more, that would not be a problem.”* (Man, HP couple interview, urban Niger)

A focus group participant added:

*“I’m going to give the example of my own brother. His wife always says that the Bible says to go multiply and fill the earth so she will have children until menopause, which means that they have many children and all the time it is arguments ... at home. The man complains each time that he has no money, yet he must pay for the woman's prenatal exam costs.”* (Man, FGD, urban Togo)

It is important to note that this fatalistic perspective surpassed any personal views. Even in cases where women felt “embarrassed” by their AMA pregnancy, they still chose to resign to God. A 42-year-old AMA participant with seven children shared her story:

*“My daughter said to me, ‘Mom, really, this time you have to stop. Hey Mom, I give birth, you give birth; it's not good.’ It's because she cannot say to her husband that her mother gave birth. And her husband cannot come congratulate me. What can I do? It's really embarrassing and it's awkward. But if God so decides, we must ensure that no one can stop it.”* (Woman, FP user FGD, urban Niger)

### **FAVORABLE NORM TOWARDS LARGE FAMILY AND STRATEGIC INTEREST**

Some participants had a favorable perception of large families because of perceived benefits. This favorable norm was more pronounced in Niger, but some participants in Togo did share the view that 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 that parents would be cared for in old age. Participants in Niger also perceived a functional advantage of having large families. A rural woman detailed the perceived daily life advantages this way:

*“This woman lives better with her six children, because she has three grown children, the two grown daughters can do the manual labor, the boy, who is enrolled in school, can study and be useful knowing that his brothers are not suffering. He can even go to the field with his little brothers. The grown daughter can crush/grind [grain] and her sister can bring water and the youngest can be sent by their mom. Like this, it is well structured.”* (Woman, FP user FGD, rural Niger)

Finally, in both countries, the desire to have a large family was linked to perceived infant mortality rates. The perceived frequency of infant deaths lead couples to develop a prevention strategy: Having many children in the hope of always having some, in case the others succumb to illness and death. As one participant in Togo explained:

*“It's true that I always wanted three children, so I was lucky to have three. If I had lost one of them, and my wife was already 40 years old or she was menopausal, what could I do? Should I go marry another? No. I must just pray that this doesn't happen.”* (Man, AMA couple interview, urban Togo)

### **POLYGAMY**

The practice of polygamy was more common among participants in Niger than in Togo. The interviews suggested women's fears regarding polygamy remained strong and having more children was a strategic choice. It served to: 1) prevent the husband from attempting to take a second wife or 2) compete with co-wives. In this way, polygamy resulted in a race to have more children, often to the detriment of preventing risky pregnancies. One man explained:

*“If you do not want to raise your hands to implore God because your husband wants to take another wife, you must agree to lift your legs. Yes, if the woman wants to close her legs instead of providing all the children she can have, the man will want to take a second wife. If she doesn't want him to take a second wife, she is forced to open her legs. That's why instead of raised hands 'alolédji', it's instead lifted legs 'afolédji' you see”?* (Man, FGD, urban Togo).

A midwife further noted:

*“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 can't manage this aspect. In a situation of polygamy, women are no longer prepared to listen to us regarding limiting births.”* (Woman, interview, urban Niger).

Finally, concerns about money, inheritance and social status provided another motivation for women in polygamist marriages to have more children. Children were seen in this case as a way “to amass all of the man's wealth,” a woman from urban Togo explained.

### **EARLY MARRIAGES AND MATERNAL INSTABILITY**

The *Niger AMA/HP Women Insights Research* indicated that early marriages were prevalent: 70 percent of the AMA women in a relationship polled were married before the age of 18. In Togo, however, early marriages had significantly declined in urban areas. In fact, their impact on HP pregnancies was not

often cited. However, in rural areas the interviews revealed that girls still married young and, in the absence of contraceptive use, many rural women ended up in HP situations. This early entry into a relationship positively influenced the number of children a woman had in a context where limiting births was not allowed. Once married, women lacked acceptable grounds not to start having children.

In addition to early marriages, participants reported that divorces and remarriages also put women in circumstances where, regardless of age or parity, they had to give children to their new spouse. A service provider interviewed in Togo recounted one of these cases:

*“I had a case, a woman who had already had eight children with a teacher and since they no longer live together, she remarried. She was taking a [FP] method with the former husband, the new husband requires that she also give him children. I informed her of the risks associated with her age and her history of pregnancy, and she agreed and she left. She came back after to tell me that she wants to stop the method regardless of the cost. I reminded her of the risks associated with additional pregnancies, and she left again. But, she came back once to tell us that her husband beat her because of her refusal to drop the method and so we were required to remove the implants. She gave birth later but the child died. I invite her to come do the planning again but she is reluctant.”* (Service provider, interview, rural Togo).

### **AMA AND HP WOMEN’S AND PARTNERS’ PERCEPTIONS AND ATTITUDES ABOUT AMA AND HP PREGNANCY RISKS**

In Niger, participants saw pregnancy itself as a perilous situation for women, but this did not translate into knowledge of the specific risks associated with AMA and HP pregnancies. A woman from rural Niger explained:

*“When you get pregnant, you're never sure to pull through. When you are going through pregnancy, you are a dead person with a suspended sentence. Each day, you pray that God will show you the next day and when the sun rises expect to live until the evening. You're never sure to pull through and carry your child on your back. Only God knows. You are a dead person with a suspended sentence and it is after giving birth that you will feel better.”* (Woman, FP non-user FGD, rural Niger)

The risks that women and men associated with AMA and HP pregnancies were general, and referred first to the death of the mother and then to that of the baby. These two risks were perceived to be the most common and the most serious. Additional concern was expressed around childbirth itself, particularly for the need for a Caesarean section. However, while these consequences were reported by both men and women during the various FGDs, they were not seen as being specific to AMA and/or HP pregnancies. Instead, they were considered to be part of the risks associated with all pregnancies, regardless of the parity reached or the woman's age.

Risks associated with AMA and HP pregnancies were better understood in Togo, especially in urban areas. Participants reported that the risks were related to either age or parity, or both factors at once. An AMA couple interviewed used a metaphor to explain the physical risk of having too many children, the husband shared:

*“Yes, there are risks for this pregnancy compared to the others because she is already old and her organs are already tired and some of their cords/strings are cut so they cannot properly fulfill their roles. It's just like the engine of a car or motorcycle, once the car or motorcycle is old, it can't function properly and you have to sell it. If such a women gets pregnant, she will have a lot of problems.”* (Man, FGD, urban Togo)

Togo participants were also concerned about AMA/HP women dying as a result of pregnancies, mentioning infant mortality, the likelihood of genetic defects and even social consequences of AMA and HP pregnancies. Male focus group participants in urban Togo were specifically concerned that children resulting from (unplanned) AMA or HP pregnancies, or orphaned by such pregnancies, would not do well in school, or could have “intellectual” and other behavioral problems.

While maternal mortality was a chief distress in both Niger and Togo, this fear was not limited to the loss of the woman’s life alone, but often participants relayed the perceived social impact of such loss. This suggests that women were more valued through their children, not necessarily as individuals. Their potential loss was seen as primarily the loss of the children’s caregiver. As discussed later in the report, allowing space between pregnancies was seen as a way to help preserve the mother’s health and as a way to rest, but using a modern FP method to do so was not universally accepted. Protecting the mother’s health by limiting the number of births she has in her lifetime was also not as favorably accepted between the two countries.

### **DETERMINANTS AND MOTIVATIONS OF FP METHOD USE AMONG AMA AND HP WOMEN**

AMA and/or HP couples that used a modern FP method were asked about their FP use. The interviews revealed several determinants and motivating factors of FP method use, each of which are explained in the following sub-sections. These factors are listed in Table 7.

**Table 7: Determinants and Motivations of FP Method Use among AMA and HP Women**

<b>Determinants</b>	<b>Motivations</b>
Attitudes towards FP	Preserving the woman’s health
Religious beliefs	Ensuring the child’s well-being
Correct knowledge about FP methods	Feeling supported by community norms
Women’s agency and decision-making power	Women’s income generation
	Pleasing husband/to have a better sexual life

### **DETERMINANTS**

Interviews with couples highlighted four implicit factors, or determinants, of modern FP method use: 1) attitudes towards FP, 2) religious beliefs, 3) correct knowledge about FP methods and 4) women’s agency and decision-making power.

#### **ATTITUDES TOWARDS FP**

In Niger, attitudes were generally positive toward FP so long as it was used for spacing instead of limiting. The *Niger AMA/HP Women Insights Research* suggested that most women were in favor of FP use for birth spacing, and supported government FP 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). This finding was important as it expressed the women's adherence to the birth spacing concept. Furthermore, more than half (57 percent) of the women thought that a husband would be displeased if his wife became pregnant again if their last child was still young enough to be carried on the back. This finding underscores the social consequences and disapproval of births that are too close together. Support for FP to space births was echoed in the qualitative study. One male participant explained that his reluctance for his wife to use FP subsided with more understanding about its use for birth spacing, he stated:

*“I personally experienced this with my wife, [a] lack of understanding. It's because I didn't understand that I was refusing for her to take contraception. And then I understood. She asked me for permission to take pills and I agreed so that she could rest too.”* (Man, partner of FP user FGD, urban Niger)

However, half (51 percent) of AMA women in the *Niger AMA/HP Women Insights Research* thought that a woman should no longer get pregnant if her oldest daughter were pregnant. In relation to FP, these results indicate a mixed attitude towards limiting births for AMA women. The qualitative results on this were more absolute: Niger participants reported that they believed women could use FP “to rest,” meaning to space births, but not to limit. A 33-year-old woman with five children stressed this point saying:

*“Not having any more children, that's what I can't understand, I can advise women to space out births, but never advise them to limit. ...If you can space out we can understand, but wanting to stop, it's as if you kill the rest of the children that you bear within you.”* (Woman, FP user FGD, urban Niger)

Qualitative study participants in Togo also had an overall favorable attitude toward family planning. However, the clear distinction between using FP for spacing versus limiting births was not as pronounced compared to Niger. As mentioned earlier, Togo participants demonstrated a better understanding of AMA and HP pregnancy risks, which partly explains their favorable FP attitude and openness to limiting pregnancies. On the other hand, in Niger, the limited approval of FP for birth spacing was not necessarily related to an accurate understanding of risk but rather to a perceived religious/cultural approval. Women and their partners realized that closely spaced and too many pregnancies could be harmful to their health. One AMA woman interviewed recounted her experience sharing the benefit of FP with a neighbor:

*“Almost everyone agrees that family planning is a good thing. For example, one day, I learned that they offer planning services to women at the hospital in Bè. I spoke about it with a woman in my part of town who, like me, already had five children. I told her that they offer Norplant free of charge. Run quickly; take SORTRAL (Intra-urban Transit Agency). She went and upon her return she came to thank me. I asked her if she had informed her husband. She said no; that if he hears about this he would never agree to it. I told her go cover your arm. You did it, it's done, it's done. Nowadays everyone accepts family planning.”* (Woman, FP user FGD, urban Togo)

In sum, favorable attitudes towards FP existed in both countries but differences existed in whether it was acceptable to use FP for spacing or limiting. It is important to note that in both countries, favorable attitudes toward FP did not necessarily lead to systematic FP use. Furthermore, as illustrated in the last quote, a disconnect remains between partners about the use of FP.

## RELIGIOUS BELIEFS

Factoring into supportive attitudes around FP were religious beliefs. Some participants, especially in Niger, had favorable attitudes toward FP because their interpretation of their religion – Islam – did not prohibit birth spacing. It is important to note that these participants were clear in stating that Islam encourages birth spacing but they did not overtly state that the religion encouraged use of modern FP. One religious leader provided a historical perspective:

*“Islam is not against planning births, but there has to be a good explanation. Birth spacing has existed in Islam since the fourth century.”* (Religious leader, interview, urban Niger)

A male participant added:

*“The problem is with the men who impose too many things on their wives... Even the Muslim religion recommended putting an interval of 30 months between births.”* (Man, FP non-user FGD, urban Niger)

Similarly, perceived religious constraints were strong deterrents for participants not using FP in Niger. These were often expressed in categorical terms and did not leave room for flexibility. A father of five children declared:

*“My status as a true Muslim believer does not allow me to offend God the Almighty. We leave it to God, any time that a pregnancy occurs, we accept it.”* (Man, HP couple interview, urban Niger)

Higher levels of education did not override the beliefs of participants with conservative perspectives. For example, a college-educated participant in Niger indicated that she did not use modern FP methods because they were considered illicit by Islam. She preferred to follow the prescriptions of the Koran, which support breastfeeding and postpartum abstinence as a means of FP. Religious and cultural values were central and at times more powerful than education levels to FP decision-making in Niger.

In Togo, religious constraints did not seem to be as strong as in Niger, but they did exist and were tied to Islam more directly than to Christianity or other faiths. For some participants, the perceived constraint was sufficient grounds for rejecting modern methods of contraception. Because these methods were considered illicit by Islam, they refused to use them. A mother of six children, age 36, in rural Togo stated:

*“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 can't 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's why I didn't do it.” (Woman, AMA and HP case study, rural Togo)*

### **CORRECT KNOWLEDGE ABOUT FP METHODS**

According to the *Niger AMA/HP Women Insights Research*, access to information was a factor that positively influenced contraceptive use among AMA and HP women. It seemed that among women who used modern contraception, almost all (94.6 percent) tried to learn about how to use different methods, the cost of procuring them and the adverse effects. About three-fourths (76.3 percent) visited a health center at least once to have a consultation on family planning. These results indicated that learning about how to use the methods was the main factor that positively influenced their use. The qualitative interviews showed that access to quality information continued to be one of the essential conditions for contraceptive use by AMA and/or HP women in both Niger and Togo. A FP user in Togo stated:

*“If this AMA woman got pregnant at 41, it's because she didn't have information on family planning. What kills us is the lack of information and the fear of seeking information.” (Woman, FP user FGD, urban Togo)*

A mother of seven children added:

*“I think some women don't expect to get pregnant. That happened to me seeing as I was in the village and I didn't know anything about FP. It's because I came to Lomé that I was informed by the radio [and] that I changed my behavior. So if...women follow the news on the radio then they will change.” (Woman, mixed FGD, urban Togo)*

The *Niger AMA/HP Women Insights Research* also showed that a fear of side effects and a lack of information were two of the leading reasons (37.5 percent and 13.9 percent, respectively) AMA and HP women had never considered using a modern FP method. The qualitative research suggests a relationship between these two factors, as the perceived types and gravity of method side effects were seemingly based on misconceptions. For example, a woman from a couple in urban Niger explained she feared that using the pills would lead to “future problems,” and as shown by the first quote in the following section, men also thought FP methods would cause illness in their female partners.

### **WOMEN'S AGENCY AND DECISION MAKING POWER**

According to the *Niger AMA/HP Women Insights Research*, 23.6 percent of AMA and HP women reported that their husband's refusal prevented them from considering a modern FP method. The qualitative research confirmed this to be a powerful determinant in FP use in both rural and urban settings in Niger and Togo. A woman who does not use a modern FP method in urban Togo recounted:

*“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're afraid to disobey him you'll do nothing but spawn children.” (Woman, FP non-user FGD, urban Togo)*

A service provider in Niger also echoed this sentiment:

*“One thing that's certain is that there are husbands who refuse to let their wives do FP because they want the wife to have many children. There are husbands who refuse. The husband can refuse. That's the case of the parturient in trouble that I was just referring to this morning. I had brought the husband in well before this pregnancy. Not only did he not come, but he categorically refused to let his wife take MMC [modern methods of contraception].”* (Service Provider, interview, rural Niger)

FGDs provided some insights into the men’s refusal. Male partners who participated were more likely to refuse FP use because they feared being deceived by their wives. Women in both urban and rural Togo confirmed that experience. An urban woman stated:

*“If you ask your husband for permission, in response he'll turn the question back on you by asking you if you want to become a prostitute.”* (Woman, FP non-user FGD, urban Togo)

A rural woman who does not use a modern method of contraception added:

*“The service providers do their work because when you give birth, they give you a lot of advice and it's up to you to choose from among the products. The problem continues to be with our husbands. When they learn this, they say that the service providers are leading us to debauchery. So whether we have many children depends on our husbands because they refuse FP.”* (Woman, FP non-user FGD, rural Togo)

Similarly, the *Niger AMA/HP Women Insights Research* showed that less than half (48 percent) of women reported that they could make decisions regarding their own health. This indicates the limited decision-making power women experience regarding the use of contraception. In addition, a majority of AMA and HP women (67 percent) said they were not in favor of a woman using contraception without her husband's knowledge. Most women sought the husband's approval before using contraception. Finally, nearly one-third (28.3 percent) of surveyed AMA women saw using contraception as a source of indiscretion in one's sex life. This theme was supported by qualitative findings in Niger as well.

In Togo, however, the qualitative results suggested that 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 point is further explained as a motivating factor in the next section.

## **MOTIVATING FACTORS**

The qualitative research revealed additional motivations for women to use modern FP methods. Among them were: 1) preserving the woman’s health 2) ensuring the children’s well-being, 3) feeling supported by community norms, 4) women’s income generation and 5) pleasing the husband and/or to have a better sexual life.

### **PRESERVING THE WOMAN'S HEALTH**

In AMA and HP couples that had adopted a FP method, preserving the woman's health was often cited as an important motivation for using contraception. This finding was prevalent among FP users in both countries and it was reflected in both rural and urban areas. One of the women with five children interviewed explained that FP was necessary to help the uterus rest to endure future pregnancies:

*"I think that birth spacing is the less risky method, because with this method the women will rest before having another pregnancy. Having children very quickly makes the woman weak and her body will be open to all illnesses."* (Woman, HP couple interview, urban Niger)

This concern was not limited to women as illustrated by the male participant with eight children who believed FP was valuable for his wife's health:

*"The ones I'm familiar with are the pill and the injections. My wife already used both. She currently does both. Often if she [learns] at the [health] center that the injections are not available, she takes the pills. I don't see any problem with that because it's for my wife's good health."* (Man, AMA couple interview, rural Niger)

### **ENSURING THE CHILDREN'S WELL-BEING**

Ensuring children's well-being by having the means to take care of them was an important motivation for FP use. Participants in urban areas spoke about the cost of having large families and the challenges one could face taking care of such a family. A mother of five children, age 37, explained:

*"My husband and I decided that since the children go to school now, we're going to stop ... so that we can take care of the ones we already have so that they can move forward."* (Woman FP user, AMA couple interview, rural Togo)

### **FEELING SUPPORTED BY COMMUNITY NORMS**

Participants reported that they were more likely to accept contraceptive use when they believed that FP use had become a norm and was accepted by other women. Knowing another women using FP was a motivating factor. An FP user explained the influence of peers:

*"Now, everyone understands the importance of FP. Every woman tries to do as her friend and you have to follow. If you follow the instructions, you'll be like this woman."* (Woman, FP user FGD, urban Niger)

A service provider added:

*"You know not every women accepts [FP]. Some accept [FP] and others don't. Yes, some women don't understand, they have to see the cases. For example if they notice that someone close to them is taking contraception, then they can accept. Here, there is a lot of mimicry among women with regard to using the methods. For some it is others who encourage them to do contraception. Those who use tell the others: You see how I am? So do contraception like me and rest."* (Service provider, interview, rural Niger)

## **WOMEN'S INCOME GENERATION**

Concerns with employment and generating an income was a motivation for using FP. Participants in Togo spoke more about this as a consideration for FP use than women in Niger. Carrying out a professional activity seemed to be sufficient motivation to support the use of contraception among HP and AMA women. One participant linked employment to a woman's decision-making power when she said:

*"I would say we can no longer find women like Esse [female character in video shown during focus group] in Lomé because it's 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)

## **PLEASING THE HUSBAND/HAVE A BETTER SEXUAL LIFE**

Although not as common as other factors, the desire to please the husband and/or to enjoy a fulfilling sexual life was yet another motivation for using FP, particularly in Niger. Among women, it represented a new motivation for using contraception. In the study sites, it was not favorable for women to overtly discuss sexual pleasure, so this motivation was expressed in other forms including making other arrangements to please the husband. A woman who used a modern method of contraception explained:

*"Nowadays, if you give birth a lot, your husband may hate you because it's a real mess you're making. When the husband returns, the children are lying everywhere, and on top of that he has to bear the smell of pee and poop. With that he'll hate you 'walahi' (I swear to God)."* (Woman, FP user FGD, urban Niger)

Men were more forthcoming with the motivation to use FP for pleasure. As one father of five stated:

*"I said that using the pill is better for both of us than a condom. Yes, and even for pleasure during sex. I think that it's much better than a condom."* (Man, HP couple interview, urban Niger)

## **PROVIDER PRACTICES ON COMMUNICATING WITH CLIENTS ABOUT AMA AND HP PREGNANCIES**

In addition to generally low knowledge about AMA and HP pregnancy risks by men and women in communities, conversations with service providers – who normally would be frontline sources of health information – also revealed significant gaps in FP service delivery.

### **LITTLE OR NO COMMUNICATION ABOUT AMA AND HP**

The interviews with various maternal and infant healthcare professionals in both countries showed that communication about AMA and HP pregnancies with their clients was very limited or even nonexistent. The bulk of the communication about the risks of pregnancies in general was done during CPNs, CPONs and in FP services counseling. Furthermore, the topics addressed during these various sessions did not necessarily incorporate aspects related to AMA and HP pregnancies. These interviews indicated that the topics most often addressed were:

#### During Prenatal Exams

- Protection against HIV/AIDS
- The couple's life

- Nutrition for the pregnant woman
- Breastfeeding
- Complications during childbirth
- Different signs of risk

#### During Postnatal Exams

- Breastfeeding
- Newborn hygiene
- Nutrition for the breastfeeding woman
- Unwanted pregnancies

#### During FP consultations

- The benefits of FP
- Birth spacing
- Different methods of contraception
- Unwanted pregnancies
- Closely spaced pregnancies

While AMA and HP were not on the official lists of topics discussed with clients, service providers reported that they did bring them up in their discussion. One service provider from Togo detailed how these topics are addressed:

*“Awareness sessions cover topics on family planning, birth spacing, the benefits of newborn vaccination, vaccination against tetanus for pregnant women, feeding the newborn and infant, nutrition for pregnant women, body and food hygiene, awareness about changes in behavior, managing and protecting against malaria, preventing and managing HIV in pregnant women, caring for the HIV-positive pregnant woman and caring for the newborn.”* (Service provider, interview, rural Togo)

Based on statements from other providers, it still seemed there was some communication about managing the risks of AMA and HP pregnancies. However, in most cases, the discussion was general and it did not necessarily target the needs of HP or AMA women. A midwife from rural Niger explained:

*“This may happen individually, but instructions are given as a group. It's in the Hall [waiting area] there that everything first starts and once the woman enters the exam room, we resume giving her the explanations individually . . . For example, if the woman is at an advanced age and she has had many pregnancies, she is made to understand the risks she runs.”* (Midwife, interview, rural Niger)

Nevertheless, the service providers' experience in communicating about AMA and HP pregnancies remained limited. This communication usually rested on the personal initiatives of the service provider and there were no predefined guidelines. Furthermore, the practice of only discussing AMA and HP in prenatal consultations (after a woman is already pregnant) did not allow for a proactive prevention approach.

## **DIFFICULTY FINDING CULTURALLY AND CONTEXTUALLY APPROPRIATE WAYS OF COMMUNICATING RISK**

Beyond limited communication, providers' interactions were marred by a lack of skills in communicating risk in a culturally and contextually appropriate fashion in both Niger and Togo. These shortcomings sometimes led to misunderstandings between providers and patients as these patients felt like victims of a malicious assessment. One service provider from rural Togo recounted a colleague's experience:

*"We have problems here, especially with HP women. If we try to tell them not to have any more children because they may have risks, they are frustrated. There is one to whom we provided awareness. Arriving at home, she told her mother-in-law that we offended her. Her mother-in-law saw my colleague at the market and made malicious comments to her along the lines of: Are you the one who feeds my grandchildren?"*  
(Service provider, interview, rural Togo)

Additionally, health providers ran the risk of being stigmatized when communicating the risk in communities that place a high value on the supernatural. Often in these situations, presenting risk could be seen as wishing misfortune. Health providers could be stigmatized if "the misfortune" came true. Some health workers had been suspected of witchcraft for having pointed out these risks. A service provider in rural Togo explained that:

*"I know a health center here that women did not want to [visit]. Because they say that there is a midwife there, and when she tells you that a misfortune is going to happen to you during the pregnancy, you have to wait for this misfortune to actually happen."*  
(Service provider, interview, rural Togo)

Such observations suggest that women may not be receptive to messages about AMA and HP pregnancies as they were presented. They reflect significant challenges in terms of communication about AMA and HP pregnancies. These challenges involve two major issues: content (actual risk information provided) and form (approach and style in communicating these messages). Providers may unintentionally blame or shame the women without taking into account the strong norms that limit a client's decision-making and encourage large families. This underlines a need to build providers' skills to counsel their patients in a productive and positive manner and engage the male partner, who often has the decision-making power.

## **LIMITED PROVIDER KNOWLEDGE ABOUT HP AND AMA RISKS**

Service providers had limited/superficial knowledge about HP and AMA risks. The risks mentioned most often referred to the World Health Organization's (WHO's) guidelines on managing pregnancies and childbirth. These included uterine rupture, hemorrhaging during delivery and the death of the mother or baby. A service provider from urban Togo explained:

*"AMA and HP women all run the same risks, the same risks. A woman who has more than five children can die giving birth too, she can rupture her uterus too, after childbirth have hemorrhaging all that, bleeding after childbirth can lead to a death too, all that, she can have stillborn [babies] or retained placentas."* (Service provider, interview, urban Togo)

Knowledge levels differed between midwives and the community health workers (CHWs) who assisted them in both countries. The midwives' knowledge of the risks for pregnancies was overall acceptable. However, among CHWs ("filles de salles" [women who assist the midwife], case nurses and others) the interviews revealed a clear lack of understanding of the risks related to AMA and HP pregnancies.

#### **NO SPECIFIC AMA AND HP MATERIALS**

Health care providers also noted the lack of communication materials on the risks associated with AMA and HP pregnancies. To support communication, service providers used materials that were not intended for this use, including any material that had the family planning logo or any relevant family planning images. The providers did recognize that the lack of materials was a major challenge. A midwife from rural Niger highlighted the importance of getting adequate materials:

*"Right now we certainly need tools to make the demonstrations more attractive in order to have more confidence in them."* (Midwife, interview, rural Niger)

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## CONCLUSION

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HC3's qualitative research and the *Niger AMA/HP Women Insights Research* revealed that AMA and HP pregnancies are linked to strong contextual and cultural factors in both Togo and Niger. Deeply rooted in religious beliefs and community norms, the decision to use FP was complex in the communities studied. While the fertility rate was exceptionally high in Niger, Togo seemed to have begun a transition to a lower rate. The study also revealed that shifting norms in urban settings, most pronounced in urban Togo, contrasted with strong beliefs about large families and not using FP in rural settings, especially in Niger.

Participants provided many reasons for the prevalence of AMA and HP pregnancies, but the fatalistic attitude and a refusal to interfere with God's plans by spacing and limiting birth 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 beliefs. Normative factors – such as gender roles around FP decision-making, polygamy and desired family size – facilitated or hindered the use of FP in both countries. These factors were slightly less influential in urban areas, however, particularly in urban Togo.

Also, a lack of understanding around the associated risks, especially in Niger, contributed to AMA and HP pregnancy prevalence. Inadequate AMA and HP knowledge was not limited to lay populations as health providers in both countries also lacked the training and materials to properly counsel their patients. Though midwives indicated a higher knowledge level around AMA and HP pregnancy risks than did other providers, communicating these risks to clients remained difficult. Finally, a level of mistrust between clients and providers was evident, particularly in Togo. Pregnant clients thought providers wished them ill if providers spoke to them about the risks of their situation, and this sometimes discouraged clients from seeking services.

All of these findings provide key insights for designing SBCC AMA and HP pregnancy prevention programs and materials for audiences in Togo and Niger, as well as other, similar country contexts. These program implications and recommendations are described below in broad, rather than country-specific, terms.



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## OPPORTUNITIES AND RECOMMENDATIONS

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AMA and HP pregnancy communication continues to face major challenges but also presents major opportunities. For example, the study showed that AMA and HP pregnancies were generally seen as part of the reproductive norms in situations where fertility rates remain exceptionally high, such as in Niger. However, pregnancy risks, such as loss of the mother or child's life, were key fears among men and women in both countries. In Togo, these were already understood by some to be elevated risks in AMA and HP pregnancy. Positive attitudes around FP unfortunately did not always lead to FP adoption, but factors like FP acceptance according to religious and community norms did increase these positive perceptions and, sometimes, FP adoption among AMA women and couples in both countries. In most study sites, especially rural areas in both countries, large families continued to be culturally valued, but in some urban settings these norms were shifting as some "positive deviant" men and women were recognizing the social, health and economic value of planning pregnancies and having smaller family sizes.

The lack of a consistent and integrated AMA and HP pregnancy communication strategy that balances these challenges and opportunities contributed to shortcomings at the service delivery level. In both countries, service providers often lacked the knowledge, skills and resources to adequately engage their clients and their male partners. A strong strategic communication strategy that aligns FP use and preventing risky AMA and HP pregnancies with closely held cultural values is needed at the national, district and community level – not just in Togo and Niger, but in the countless similar contexts in Sub-Saharan Africa and other regions. Under this strategy, the following actions should be considered:

- **Advocate prioritizing AMA and HP pregnancy prevention in MNCH/FP programs, including PFPF and child immunization initiatives.** MNCH and FP are often recognized issues on health and population priority lists. However, AMA and HP pregnancies rarely gain attention at the decision-maker level, despite their elevated risks. Not having a communication strategy or relevant guidance means AMA and HP pregnancies are perpetuated. Advocacy is needed to reverse this trend and to make resources available to systematically address and prevent AMA and HP pregnancy. This includes identifying opportunities where AMA and HP messages fit within existing MNCH/FP programs, such as life events where women are already thinking about their children's health or before their next pregnancy (e.g., during child immunization visits and postpartum visits).
- **Use evidence-based communication strategies to shift harmful maternal health and FP norms.** Social and cultural norms around maternal health – specifically those encouraging large families, competition between co-wives in polygamous relationships, male-dominated decision-making and mistrust of FP methods and related services – directly contribute to AMA/HP pregnancy prevalence. It is important to go beyond individual-level efforts and work with local organizations and structures to develop holistic, community-centered programs that address harmful norms head-on to create an enabling environment for preventing AMA and HP pregnancy.
- **Strengthen service providers' capacity to communicate the risks of AMA and HP pregnancies.** One of the most significant weaknesses that can hinder AMA and HP pregnancy communication is limited service provider skills. Providers' AMA and HP knowledge should not be limited to clinical

information. It should also include building skills to communicate in contextually and culturally appropriate ways about health risks and strategies to mitigate risk to women and their male partners. Counseling should include client reassurance from the provider to build trust, and should also highlight culturally relevant client priorities and concerns, such as how preventing AMA and HP pregnancy also protects the health of a mother.

- **Engage male partners in efforts to prevent AMA/HP pregnancies.** Male partners are often key decision makers given strict gender roles. Programs should target men to inform them about the risks of HP and AMA pregnancies and encourage them to make changes in their own families.
- **Capitalize on community leaders' willingness to support initiatives.** Community leaders who participated in the study generally supported FP efforts and were willing to support efforts to prevent AMA and HP pregnancies. Religious and community leaders are important sources of information and can encourage members of their communities to use FP, accept or plan smaller family sizes, communicate with their partner about FP and promote women's agency in making FP decisions. Program managers should take advantage of these leaders' insights in designing and disseminating messages, and championing AMA and HP prevention initiatives. Leaders must be supported with tools to lead community dialogue around the drivers of AMA and HP.
- **Develop effective tools to support AMA and HP communication.** Service providers, community leaders and women themselves play frontline roles in AMA and HP pregnancy education and behavior change for prevention. Yet providers reported they do not have communication resources specific to AMA and HP, and community members in this study showed generally low knowledge of AMA and HP risks. Culturally adequate materials for these audiences that address AMA and HP pregnancy risks should be developed for integration into HTSP, FP and maternal health programs. These materials should include interpersonal verbal and visual tools to accommodate intervention areas with lower literacy levels, and should look to others who can help spread AMA and HP pregnancy risk information, such as journalists and individuals who set health priorities and agendas. Materials might include client brochures, provider counseling materials, community mobilization tools, advocacy resources for community leaders, decision-makers and others.

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