Healthy Timing and Spacing of Pregnancy

Research Brief 1: Advanced Maternal Age and High-Parity Pregnancy – Perceived Risks and Associated Provider Communication Barriers in Togo and Niger

January 2017

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/

A high-parity woman in West Africa with her six children, © 2014, Dieneba Ouedraogo. 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 five[1] 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.

Summary of Key Findings

- AMA and HP pregnancies are frequent in Niger and Togo, and are often not perceived to be high risk.
- Age- and parity-related pregnancy risks were better understood in Togo than Niger, and were most understood in urban Togo.
- Clinic- and community-based providers in both countries lack the skills, training and tools needed to adequately and appropriately communicate AMA and HP pregnancy risks.

[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.

In Niger and Togo, these pregnancies are common,[2] but are not perceived as any more dangerous than pregnancy in general. Religious and cultural beliefs and social norms often constrain modern family planning (FP) method use and encourage large families, and inadequate provider training and a lack of resources prevent providers from discussing relevant pregnancy risks with their clients.

This brief presents research findings around perceived AMA and HP pregnancy risks, and how healthcare providers discuss these risks with their clients.

Key Findings

Risk Perception

During focus group discussions (FGDs) and interviews, men and women in Niger described pregnancy itself as dangerous for women. The most commonly feared pregnancy risks were the death of the mother and of the baby. Additional concern was expressed around childbirth itself, particularly the need for a Caesarean section. However, participants did not associate older age or HP with any increased danger to the mother or baby.

> "*When you get pregnant, you are never sure to pull through. . . each day, you pray that God will show you the next day and when the sun rises expect to live until the evening. . . only God knows. You are a dead person with a suspended sentence and it is after giving birth that you will feel better.*"
>
> – Woman, not using family planning, rural Niger

Pregnancy risks associated with age and parity were somewhat better understood in Togo, especially in urban areas. Participants said when a woman was older, her organs "cannot properly fulfill their roles," which would lead to problems during pregnancy, and also cited concerns around genetic defects, infant mortality and maternal mortality. Male participants in urban Togo also worried that children resulting from AMA or HP pregnancies, or orphaned by such pregnancies, would not do well in school or could have "intellectual" and other behavioral problems.

Maternal mortality was a main concern in both Niger and Togo. Participants feared both the loss of life and its social impact on the child and family. This suggests women are valued through their children first, as their death was seen primarily as the loss of a child's caregiver.

Healthcare provider in Niger, © 2016, Carol Hooks. All rights reserved.

> "*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, urban Togo

Healthcare Provider Communication Barriers

Limited Provider Knowledge

Providers demonstrated limited and superficial knowledge about HP and AMA pregnancy dangers. Common risks mentioned referred to the World Health Organization's general guidelines on managing pregnancies and childbirth, including uterine rupture, hemorrhaging during delivery and the death of the mother or baby.

Knowledge levels differed between categories of healthcare providers. For example, midwives' knowledge of pregnancy risks for women age 35 or older or for women who had already had many births was general but accurate. CHWs, however, demonstrated poor understanding of the risks related to such pregnancies.

Little or No Risk Communication

Interviews with maternal and infant health professionals revealed that communication about the dangers of having too many births or having children after a certain age was limited or nonexistent. Providers most frequently discussed pregnancy risks with their clients during prenatal and postnatal exams and in FP services counseling. As official guidelines for these

[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).

consultations did not include AMA or HP pregnancy prevention or management messages, providers did not regularly include these themes in their counseling. Also, addressing these risks during prenatal exams did not allow for proactive, preventive behaviors (as the client was already pregnant), and instead contributed to clients' mistrust of providers.

Overall, providers' communication about pregnancy with AMA or HP women remained limited and unguided, and varied according to a provider's personal initiative and level of knowledge.

Challenges Discussing Risk with Clients

Providers often lacked the skills needed to discuss AMA and HP pregnancy risks in ways that were acceptable to their clients. This led clients to misinterpret providers' intentions as malicious; providers said their colleagues were sometimes stigmatized or suspected of witchcraft for explaining pregnancy risks to their AMA or HP clients, particularly if "the misfortune" came true.

These results also suggest that providers may unintentionally blame or shame female clients and overlook the circumstances fueling AMA and HP pregnancies. Factors such as family or spousal pressure to have many children and competition between co-wives[3] encourage large families and can limit a woman's independent decision making. It is important for providers to be able to counsel patients in a productive and positive manner, taking such factors into account, and to engage male partners in particular, as men often have final decision-making power.

No Specific Risk Communication Materials

Healthcare providers also noted the lack of AMA- and HP-specific communication materials, and acknowledged this was a major challenge. To support their counseling, providers often adapted other FP materials they already had.

> "*Right now we certainly need tools to make the demonstrations more attractive in order to for clients to have more confidence in them.*"
>
> – Midwife, rural Niger

Conclusion and Recommendations

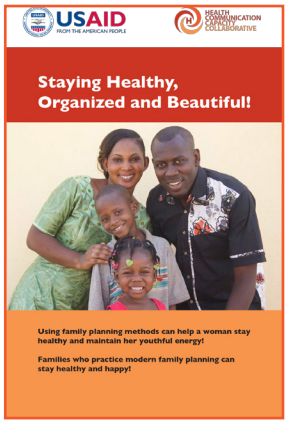
HC3's qualitative research and the *AMA/HP Niger Women Insights Research* revealed an overall lack of understanding of AMA and HP pregnancy risks, particularly in Niger. This, combined with social and cultural norms that encourage large families, pressures women to continue having children, regardless of age and previous births. Though midwives had higher knowledge levels about pregnancy risks associated with age and parity, communicating these dangers to clients remained difficult and fostered mistrust between clients and providers. Providers also lack the training and materials to properly counsel clients about these pregnancies.

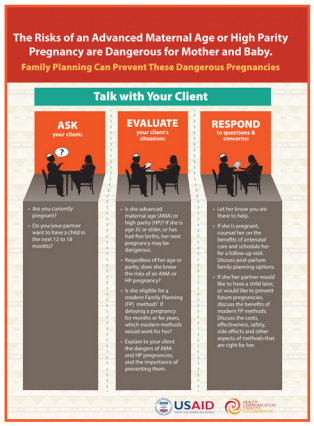
HC3 recommends that Togo and Niger – and other contextually similar countries – develop an integrated AMA and HP pregnancy communication strategy at national, district and community levels. The strategy must integrate specific messages about maternal age and parity into existing maternal, newborn and child health (MNCH) and FP programs, and align FP use and preventing these risky pregnancies with closely held cultural values. In developing a strategy, the following actions should be considered:

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

- **Advocate prioritizing AMA and HP pregnancy on national agendas.** MNCH and FP programs – including child immunization and post-partum FP programs – are often priorities on health and population agendas. However, age- and parity-related pregnancy risks scarcely gain decision makers' attention, despite AMA and HP pregnancy prevalence and the associated health risks. Advocacy is needed to identify intervention opportunities, make resources available to systematically address and prevent such high-risk pregnancies.

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





Examples of HC3 provider and client AMA and HP communication materials

- **Include AMA and HP pregnancy information in MNCH and FP programs.** Awareness about age- and parity- related pregnancy risks is low. Program implementers can integrate key AMA and HP messages into existing MNCH and FP programs and activities. Identify opportunities to reach women when they are already thinking about their child's health or a next pregnancy, such as during child immunization or post-partum visits.
- **Strengthen healthcare providers' capacity to communicate the risks of AMA and HP pregnancies to clients.** Providers need correct clinical knowledge and strong communication skills to discuss the dangers of having children when a woman is 35 or older, or has already had many births. Providers must understand the pressures female clients may be under to have children, and the importance of also engaging male partners in the conversation. Counseling should include client reassurance to build trust, and be structured around relevant client priorities and concerns, such as protecting the mother's health. These skills can be introduced and re-visited during pre- and in-service trainings.
- **Develop effective tools to support AMA and HP communication at the service delivery level.** Culturally appropriate materials addressing age- and parity-specific pregnancy risks are needed. Verbal and visual tools are crucial in intervention sites where literacy levels are low, and materials should incorporate imagery, messages and language that priority audiences will understand and appreciate. Materials might include counseling guides and wall posters for providers, and take-home brochures for clients.

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.