Title: Filling the Void: Addressing AMA and HP Pregnancy Through Research and Social and Behavior Change Communication

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Key Message:

Gender roles, religion, cultural and other beliefs continue to perpetuate pregnancies in older and high-parity women in low- and middle-income countries such as Niger and Togo, endangering women’s and babies’ lives. However, family planning programs in low- and middle-income countries generally do not address pregnancy and birth risks associated with a mother’s age and parity. It is crucial that governments, communities, service providers, women and couples come to terms with the risks of these pregnancies, and implement health communication strategies to increase awareness, challenge enabling norms, and reduce the occurrence of advanced maternal age and high-parity pregnancies.

ABSTRACT

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 rural and urban locations of two USAID family planning (FP) priority countries – Niger and Togo. HC3 supplemented this research with secondary analyses of DHS data and data from a 2014 Niger study\(^1\) referred to here as the *AMA/HP Niger Women’s Insights Research.*

The study showed that urban locations had less restrictive cultural norms preventing FP method use compared to rural locations, and urban Togolese participants demonstrated more knowledge about AMA and HP pregnancy risks than Nigerian participants as a whole. We found 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,

\(^1\) Hope Consulting (now Camber Collective), called the *Customer Insights Research for Family Planning Demand Generation in Niger*
were key fears among men and women in both countries. The study provided important insights needed to address AMA/HP pregnancies through culturally appropriate health communication interventions.

HC3 used these findings to create an Implementation Kit (I-Kit) for FP and maternal and child health program managers. While the I-Kit provides guidance on addressing AMA and HP through social and behavior change communication in Niger and Togo specifically, the resource is designed to be adapted for use in the broader Sub-Saharan Africa region. The I-Kit includes ready-to-use health communication tools for engaging women, decision-makers, communities, healthcare providers, journalists and others. In 2016 and 2017, one organization each in Niger and Togo piloted the I-Kit, integrating selected I-Kit tools into their unique programs and documenting their experiences. Both organizations credit the I-Kit with expanding the scope of topics their programs now address to include AMA and HP pregnancy, and provided concrete suggestions for adapting the materials according to activity and intended audience.

INTRODUCTION AND LITERATURE REVIEW

Family planning (FP) remains a key aspect of the global health agenda. Despite a decline in global funding in the late 2000s, FP regained momentum and international attention in later years (Schiffman & Quissell, 2012). This funding resurgence has been coupled with renewed governmental commitments and global advocacy. For example, building from the 2012 London Family Planning Summit, the Family Planning 2020 (FP2020) movement was established to champion global advocacy and drive country level support for FP, and while Goal 3 of the Sustainable Development Goals includes a specific target to “ensure universal access to sexual and reproductive health services, including for family planning” (UN, n.d.), the argument has also been made that investing in FP will accelerate achievement across all five SDG themes (Starbird, Norton and Marcus, 2016).

While these efforts have increased FP programs in developing countries, there remain distinct, neglected needs, risk factors and population segments. For example, while much attention has been given to
preventing pregnancy in women before age 18, increasing FP uptake and establishing healthy spacing intervals between pregnancies, little to nothing has been done to address pregnancies among women of advanced maternal age (AMA, 35 years or older) or high parity (HP, having had five or more births) – even though these pregnancies are high-risk and linked to maternal and infant mortality.

AMA and HP pregnancies are prevalent in Sub-Saharan African (SSA) countries where parity rates are high and childbearing often continues until menopause (HC3, 2014a). A 29-country study found that AMA pregnancies led to a “maternal near miss (MNM), maternal death (MD), and severe maternal outcome (SMO), and perinatal outcomes” (Laopaiboon, 2014). “Maternal near miss” refers to cases “in which women present potentially fatal complications during pregnancy, delivery or during the puerperium, and who survive merely by chance or by good hospital care” (Souza et al., 2007). HP complications include anemia in the mother, postpartum hemorrhage and fetal malpresentation.

A review of the literature shows that while AMA- and HP-specific research exists, much is from high-income settings in the West. Only a few studies from SSA exist (Ngowa et al., 2013; Hoque, 2012), and most of this work focuses on establishing risks with little to no research on knowledge, attitudes and behaviors around AMA and HP pregnancy (HC3, 2014b). Understanding how a country’s culture and context impact individuals’, communities’ and a country’s beliefs and practices around these pregnancies is also crucial in developing effective interventions to address them.

Given the risks and evident region-specific information gaps, HC3 conducted formative research and created and piloted an HTSP AMA and HP Implementation Kit (I-Kit) to help program managers address these high-risk pregnancies in their programs using social and behavior change communication.

**RESEARCH GOALS AND OBJECTIVES**

To understand what drives AMA and HP pregnancy, we looked at two countries with considerable AMA and HP rates: Niger and Togo. The overall goals of the study were to 1) understand the knowledge,
attitudes and behaviors that contribute to AMA and HP pregnancy incidence/prevalence, and 2) understand how the findings could be used to improve maternal and child health and family planning programs through a pilot intervention.

HC3’s study focused on Niger and Togo for several reasons:

1. For more than a decade, Niger has led the world in fertility rates with a total fertility rate (TFR) of 7.6 (Niger DHS). On average, women in urban Niger think having 7.4 children is ideal while their rural counterparts see 9.6 children as ideal. Although lower than Niger, Togo’s national TFR implies HP risk for women at 4.8, especially in rural areas; women have on average 3.7 children in urban areas and 5.7 in rural locations. Women in both urban and rural areas say their ideal number of children is fewer at 3.6 and 4.9, respectively (DHS Togo, 2013-2014). Per each country’s most recent DHS, 43 percent and 22 percent of women had five or more births in Niger and Togo, respectively (see Table 1).

2. Both countries have critical needs for family planning. Contraceptive use is relatively low in both Niger (14 percent of married women; DHS, 2012) and Togo (20 percent of married women; DHS, 2013). 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.

3. Both countries have NGOs and government support for family planning programs. In addition to being FP2020 focus countries, both Niger and Togo are members of the Ouagadougou Partnership, whose objective is “to reach at least 2.2 million additional family planning methods users in the nine countries by 2020.”
METHODS

The qualitative research took place in one urban and two rural locations each in Niger and Togo (Table 2).

We conducted focus group discussions, case studies and in-depth interviews with 285 (174 female, 111 male) healthcare service providers, AMA and HP women, male partners and community leaders. We supplemented this qualitative research with the *Niger AMA/HP Women Insights Research* survey data, which included 760 AMA and HP female participants. Additionally, we performed secondary analyses on select indicators from Demographic and Health Surveys (DHS) from Niger (2012) and Togo (2013-2014).

The research protocol was approved by the Johns Hopkins University Institutional Review Board and by the ethics committees in Niger and Togo. We recorded all interviews and focus groups and transcribed them in French. A resource person (often the main facilitator who spoke the language in which the interview was conducted) checked and evaluated the transcripts. Finally, we conducted a content analysis using Microsoft Word.

<table>
<thead>
<tr>
<th></th>
<th>Niger</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urban Population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of population living in urban areas</td>
<td>18%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Polygamy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of married women in polygamous marriage</td>
<td>36%</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Total Fertility Rate (TFR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>7.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Rural</td>
<td>5.6</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>AMA:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of all women aged 35-49 who had a child at 35 years or older</td>
<td>60%</td>
<td>46%</td>
</tr>
<tr>
<td><strong>HP:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of all women who had five or more births</td>
<td>43%</td>
<td>22%</td>
</tr>
</tbody>
</table>

*Source: DHS Niger (2012); DHS Togo (2013-2014)*
Table 2: Number of participants by methodology and location (# of groups in parentheses)

<table>
<thead>
<tr>
<th></th>
<th>Niger</th>
<th>Togo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Niamey (urban)</td>
<td>Koygoro (rural)</td>
<td>Mokko (rural)</td>
</tr>
<tr>
<td>FGD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Women</td>
<td>36 (4)</td>
<td>8 (1)</td>
<td>8 (1)</td>
</tr>
<tr>
<td>• Male Partners</td>
<td>24 (3)</td>
<td>8 (1)</td>
<td>8 (1)</td>
</tr>
<tr>
<td>• Mixed:</td>
<td>8 (1)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Men and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CASE STUDY</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IDI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Service</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Couples</td>
<td>8 (4)</td>
<td>4 (2)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>• Leaders</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
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</tbody>
</table>

RESEARCH FINDINGS

We list our main research findings below, organized by key themes and AMA/HP contributing factors:

- **AMA Prevalence**: Participants in both rural and urban Niger believed AMA pregnancies were common in their communities. In Togo, responses were mixed; while most viewed AMA as a “rural problem” others reported such pregnancies were also prevalent in cities.

  “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

- **HP Prevalence**: In Niger, most participants reported HP was “common” in both urban and rural settings. The *Niger AMA/HP Women Insights Research*
confirms, showing 42 percent of women between the ages of 15 to 49 in a relationship at the
time of the survey were in an HP situation. Among these, 71 percent said they wanted more
children. In Togo, participants generally acknowledged the high number of HP pregnancies in
Togo, but were divided about HP pregnancy frequency in urban areas.

• **AMA and HP Risk Perception:** In Niger, participants saw pregnancy itself as a perilous situation for
women, but did not perceive age or parity to compound the risk. Those who did associate dangers
with AMA and HP pregnancies did so generally, and referred mostly to the death of the mother
and, secondarily, to that of the baby. These two risks were perceived as the most common and
the most serious. Togo participants were somewhat more aware of age- and parity-related risks,
and were also concerned about AMA and HP women dying as a result of pregnancies. They
mentioned infant mortality, the likelihood of genetic defects and even social consequences of
AMA and HP pregnancies.

• **Religion and AMA/HP:** We found religion contributed to AMA and HP pregnancy, particularly
among Muslim participants, and particularly in Niger. Many believed Islam forbids any
interference with reproduction, and mandated that women have the number of children “God
gave them,” regardless of their desired fertility. Religion was scarcely mentioned as a factor
among non-Muslim participants.

• **Cultural Norms Against Limiting Pregnancies:** In both
countries, male and female participants reported an
unfavorable cultural norm toward limiting births, or did not
feel it was their place to prevent births. These norms were
stronger in Niger, where one participant explained limiting
was “not our culture,” and rural Togo.

> “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
• **Favorable Norms Towards Large Families:** In Niger, and to a lesser extent in Togo, participants expressed a desire for large families because of perceived benefits, including: 1) being positively perceived in the 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. Also, participants in both countries favored large families because of perceived infant mortality rates: Having many children in the hope of always having some, should some succumb to illness and death. However, we should note that particularly in urban Togo, we saw evidence of norms shifting towards acceptance of and desire for using FP to have smaller families.

• **Polygamy:** More common in Niger than in Togo, our research revealed women in polygamous situations feared real consequences if they had too few children – fears which some men confirmed. Having many children therefore served to: 1) prevent the husband from attempting to take a second wife or 2) compete with co-wives for the husband’s attention, resources, and eventual social status and inheritance should the husband die.

> “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

• **Early Marriages and Maternal Instability:** In both countries, early entry into a relationship increased the number of children a woman had when limiting births was not allowed. Once married, women lacked acceptable grounds to delay childbearing. 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 provide children to their new spouse.

• **Healthcare Provider Practices around AMA and HP Pregnancy:** Interviews with maternal and infant healthcare professionals in both countries revealed inconsistent and unstructured
communication with clients about AMA and HP pregnancy risks. Providers had low or very general knowledge about age and parity related complications, though knowledge levels were acceptable among midwives compared to community health workers and other lower cadre providers, who demonstrated a poor understanding of AMA and HP pregnancy risks. Further, providers reported no guidelines existed on when or how to discuss AMA and HP pregnancy with clients, and lamented a lack of materials to support such counseling. Finally, providers seemed to lack critical skills to communicate risk in culturally appropriate ways, which sometimes led clients to fear or mistrust

DISCUSSION AND PROGRAMMATIC IMPLICATIONS

Overall, the study showed that urban locations had less restrictive cultural norms that prevent FP method use compared to rural locations, and that urban Togo participants demonstrated more knowledge about AMA and HP pregnancy risks than Niger participants as a whole. We found AMA and HP pregnancies were generally seen as part of the reproductive norms and limiting is forbidden in contexts where fertility rates remain exceptionally high, such as in Niger. In some urban settings, however, particularly in Togo, 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. Pregnancy risks, such as the mother’s or child’s death, 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. However, these risks were inconsistently or poorly communicated at the service-delivery level.

Health communication is an indispensable tool for increasing awareness of AMA and HP pregnancy prevalence and risks, and key to catalyzing improved behaviors and strengthening existing family planning programs. The study findings suggest clear opportunities to:

“I know a health center here that women did not want to [visit] . . . 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 . . . wait for this misfortune to actually happen.”

-- Service provider, interview, rural Togo
• Advocate prioritizing AMA and HP pregnancy on national agendas, and develop a comprehensive communication strategy accordingly.

• Increase healthcare provider capacity to communicate AMA and HP pregnancy risks by improving communication and clinical skills during pre- and in-service trainings.

• Include AMA and HP pregnancy information in maternal, newborn and child health, and family planning programs, including postpartum family planning (PPFP) programs and child health and immunization visits.

• Work with local organizations and structures – including religious leaders – to develop community-centered programs that address social, religious and cultural norms that perpetuate AMA and HP pregnancy through proven communication strategies.

• Engage male partners to understand AMA and HP pregnancy risks and help prevent AMA and HP pregnancies in their households, where strict gender roles elevate men as FP decision-makers.

• Develop AMA and HP pregnancy-specific health communication tools for women’s health gatekeepers to promote awareness, correct knowledge and life-saving behavior change among key audiences.

TURNING RESEARCH INTO PRACTICE

With these implications in mind, HC3 created the Healthy Timing and Spacing of Pregnancy Implementation Kit (HTSP I-Kit), focused exclusively on addressing AMA and HP pregnancy risks. The I-Kit is adaptable; HC3 shares I-Kit source files (in Microsoft Word, InDesign, etc.) with requesting organizations. It is designed to save program managers the time and money from creating
AMA/HP materials from scratch, and to enable them to expand their projects’ breadth and impact by including AMA and HP pregnancy in their existing FP/MCH work. The I-Kit is grounded in HC3’s research findings, and comprises the following elements:

1. **A Guide for Program Managers**, which outlines AMA and HP risk information, key messages and calls to action, and how to adeptly integrate such information into existing, relevant projects using social and behavior change communication (SBCC) theories and processes.

2. **A collection of ready-to-use or adapt health communication tools**, including:
   - **Client brochures** presenting AMA/HP information tailored to less and more conservative audiences;
   - **A Guide for Working with Community-Based Groups** to catalyze community mobilization and challenging harmful norms around AMA and HP pregnancy;
   - **Counseling and Assessment Guides** for providers and community health workers to encourage structured, client-centered counseling;
   - **A Provider Reminder Poster** summarizing the counseling guides’ key steps;
   - **A Guide for Researchers** to explore AMA/HP drivers in a given context;
   - **A Guide for Journalists** for reporting on AMA/HP on TV, radio or print media;
   - **An Infographic for Health Priority Decision-Makers** to highlight the urgency of addressing these pregnancy risk categories.

The I-Kit, available in English and French, was pre-tested in Niger and Togo in 2015 before being revised and finalized in 2016. Later that year, HC3 contracted with Marie Stopes International (MSI) in Niger and the Association Togolaise pour le Bien-Être Familiale (ATBEF) in Togo to pilot selected I-Kit elements and tools and identify opportunities to adapt the I-Kit’s materials based on on-the-ground use.
For context, MSI has been active in Niger since 2013, provides quality reproductive health services in and around Niamey, Tillaberi and Maradi. MSI operates primarily through its Niamey clinic and a series of mobile outreach workers, including mobile clinic teams, social mobilization agents, and community-based promoters. ATBEF is an International Planned Parenthood Federation member, and has been delivering sexual and reproductive health services throughout Togo since 1975. ATBEF operates through five clinics, two mobile teams and cadre of community health workers.

To prepare for the pilot, each organization reviewed the entire I-Kit and chose specific tools to incorporate into existing project activities to share AMA and HP information with their clients and communities. Table 3 outlines each organization’s selections and their implementation periods, which ranged from four to seven months based on each organization’s staff availability and activity schedules. HC3 provided modest financial support, and delivered technical assistance (TA) via phone, Skype and email. The TA culminated with one in-person country visit each. Time and financial resources allowed each organization to print, organize trainings, and disseminate the I-Kit materials as-is, and HC3 asked that MSI-Niger and ATBEF follow each material’s use closely, documenting successes and challenges along the way.

Both MSI and ATBEF initiated the pilot by holding a staff and stakeholder workshop to review the program manager guide, and orient their teams on AMA and HP pregnancy, why it should be a priority, and how to address it through SBCC. SBCC was somewhat new to both organizations, arguably more so to ATBEF. Despite this initial challenge – surmounted through virtual technical support sessions and HC3 providing additional French-language SBCC references, each organization successfully employed the I-Kit tools in their work. How each tool was used is detailed in Tables 4 and 5.
### Table 3: HTSP I-Kit Elements Implemented by Pilot Partner Organizations

<table>
<thead>
<tr>
<th>MSI-Niger</th>
<th>ATBEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>July to October, 2016</td>
<td>September 2016 to March 2017</td>
</tr>
<tr>
<td>Implementation manual for program managers</td>
<td>Implementation manual for program managers</td>
</tr>
<tr>
<td>Client brochure for more conservative audiences</td>
<td>Client brochure for less conservative audiences</td>
</tr>
<tr>
<td>Counseling and assessment guide for providers</td>
<td>Counseling and assessment guide for providers</td>
</tr>
<tr>
<td>Counseling and assessment guide for community health workers</td>
<td>Counseling and assessment guide for community health workers</td>
</tr>
<tr>
<td>Reminder poster for facility-based providers</td>
<td>Reminder poster for facility-based providers</td>
</tr>
<tr>
<td>Journalist guide</td>
<td>Infographics for policy and decision-makers</td>
</tr>
</tbody>
</table>

### Table 4: I-Kit Tool Use, MSI-Niger

<table>
<thead>
<tr>
<th>HTSP I-Kit Tool</th>
<th>Used by</th>
<th>Used for</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation manual for program managers</td>
<td>Leadership team and SMO</td>
<td>Staff orientation</td>
</tr>
<tr>
<td>2. Client brochure for more conservative audiences</td>
<td>Mobile Teams, AMS, MOH MCH providers</td>
<td>Client education, assessment, and reminder</td>
</tr>
<tr>
<td>3. Counseling and assessment guide for providers</td>
<td>Mobile Team FP Providers, MOH</td>
<td>Counseling, assessment, education</td>
</tr>
<tr>
<td>4. Counseling and assessment guide for community health workers</td>
<td>AMS</td>
<td>Community sensitization, individual pre-counseling</td>
</tr>
<tr>
<td>5. Reminder poster for facility-based providers</td>
<td>Mobile Team FP Providers, MOH</td>
<td>Client counseling and assessment</td>
</tr>
<tr>
<td>6. Journalist guide</td>
<td>- Social Mobilization Officer</td>
<td>- Orienting radio, TV, print, online journalists</td>
</tr>
<tr>
<td></td>
<td>- Journalists</td>
<td>- Reporting</td>
</tr>
</tbody>
</table>

### Table 5: I-Kit Tool Use, ATBEF

<table>
<thead>
<tr>
<th>HTSP I-Kit Tool</th>
<th>Used by</th>
<th>Used for</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation manual for program managers</td>
<td>Project Coordinator</td>
<td>Managers, Ministry of Health</td>
</tr>
<tr>
<td>2. Client brochure for less conservative audiences</td>
<td>Providers and CHWs</td>
<td>Client reminder (post-visit)</td>
</tr>
<tr>
<td>3. Counseling and assessment guide for providers</td>
<td>Facility-based providers</td>
<td>Client counseling, assessment, education</td>
</tr>
<tr>
<td>4. Counseling and assessment guide for community health workers</td>
<td>CHWs</td>
<td>Community education/sensitization</td>
</tr>
<tr>
<td>5. Reminder poster for facility-based providers</td>
<td>Facility-based providers</td>
<td>Client counseling and assessment</td>
</tr>
<tr>
<td>6. Infographics for policy and decision-makers</td>
<td>Project Coordinator and CHWs</td>
<td>Community education sessions</td>
</tr>
</tbody>
</table>
Overall, MSI reached 12,757 women and men with the pilot activities, and ATBEF reached 3,337 individuals. These numbers are impressive both considering the short implementation period, but particularly when considering that for most, if not all, beneficiaries, this was the first time receiving complete and correct information about AMA and HP pregnancy risks.

Specific achievements in Niger included two news stories, one each on local television and print outlets, spurred by a workshop with radio, TV and print journalists on reporting on bringing AMA and HP into focus in Niger. Other participants also expressed interest reporting on the topic, noting AMA and HP presented a new avenue for inquiry and mass sensitization. The I-Kit also helped MSI expand the topics they discuss with their clients. Because of the pilot, MSI reports they now integrate AMA and HP into their provider and outreach trainings and daily outreach activities, and are able to better tailor their RH counseling to their at-risk clients. MSI mobile health agents and community-based health workers now inform their communities about AMA and HP pregnancy risks and how to avoid or address them. The organization also shared the I-Kit with public-sector MCH providers to use and distribute.

In Togo, ATBEF providers found the poster particularly salient, and found even the infographic to be useful in their community and group education sessions. ATBEF community health workers regularly rotate their discussion topics in community conversations, and because of the I-Kit they now include AMA and HP pregnancy risks in that rotation. They found discussing the risks has led women to share their personal experience with pregnancy or birth complications, realizing for the first time that age or parity may have played a role. Communities have been so receptive to the information and messages that ATBEF now includes AMA and HP pregnancy avoidance in all of its CHW trainings. Beneficiaries even suggested that AMA and HP information be shared in all communities and health facilities.

The pilot did highlight useful lessons learned and recommendations on how MSI, ATBEF and other, similar organizations might adapt and prepare to use the I-Kit moving forward. Among them:
• Create more image-centered materials for low-literacy clients. While literacy is often higher in urban areas, rates are lower in smaller villages where AMA and HP might be more prevalent. Replacing text with pictures of AMA and HP complications would help non-literate clients to better retain necessary information.

• Develop materials for delivering messages to large groups. I-Kit materials, such as the counseling guides, infographics and client brochures, were developed with one-to-one interactions in mind. Because much of MSI’s and ATBEF’s work involves community outreach and education sessions, they had a difficult time converting the counseling guides into a less personal, group discussion format. Creating a flip chart from these materials could be a worthwhile effort for organizations with similar portfolios.

• Emphasize managing AMA and HP risks, rather than solely avoiding AMA and HP pregnancy. Participants in Niger especially questioned that five children was too many, and participants in both countries had difficulty accepting 35 as a stopping point for having children. While the current I-Kit materials include information on the importance of seeking ANC and attended delivery for AMA and HP pregnancy, they also encourage women to plan to avoid these high-risk pregnancies. Limiting is rejected in Niger, and women in urban Togo expressed desires to intentionally delay children until later to pursue career and education goals. In such cases, adapted materials could more strongly emphasize recognizing and managing AMA and HP pregnancy risks over outright pregnancy avoidance.

• Allow time for practice using new materials. Both MSI and ATBEF implementers found the counseling guides replete with new or technical information, which was difficult to remember and assimilate at first. However, with practice, this information can become second nature. Both organizations appreciated the need to truly take the time to internalize the guides and practice with them to allow better-tailored counseling for clients.
• **Develop materials for men, and revise terminology.** Especially in Niger, it was recommended that men and religious leaders be brought more into conversations about AMA and HP pregnancy and FP use. The I-Kit’s brochures and counseling guides include men as secondary audiences, and the Guide for Working with Community-Based Groups highlights the importance of working with religious leaders. However, because these two groups are often FP influencers or decision-makers in pro-natalist and conservative contexts such as Niger, developing modified counseling guides and brochures could more effectively engage them in conversation, implicate them in changing harmful norms, and catalyze individual and community behavior change.

**CONCLUSION**

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 Niger and Togo. This study illustrated that family planning programs do not sufficiently address the critical risks associated with pregnancies among women 35 years and older or those with five or more births. In the context of deeply held cultural and religious beliefs, the risks associated with these pregnancies may be misunderstood or minimized to conform to social pressures and expectations in countries such as Niger and Togo. It is crucial that governments, communities, service providers, women and couples come to terms with the avoidable risks of these pregnancies, and develop health communication strategies to increase knowledge, address harmful norms, and reduce the occurrence of advanced maternal age and high-parity pregnancies. In this spirit and to turn research into practice HC3 created the HTSP I-Kit to facilitate the process of designing AMA/HP health communication materials. Piloting the I-Kit in Niger and Togo provide additional lessons to further engage communities and create even more appropriate materials.
REFERENCES


