ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG EASTERN REGION, GHANA

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE & HIGH PARITY AS RISK FACTORS FOR MATERNAL MORTALITY IN THE SOUTH TONGU DISTRICT OF THE VOLTA REGION OF GHANA

A QUALITATIVE STUDY

By

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A Thesis submitted to the Department of Community Health in the faculty of Public Health in partial fulfillment of the requirements for the degree

MASTER OF PUBLIC HEALTH

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DECLARATION

I, **Momodou Cham** declare that this submission is my own work towards the MPH and that to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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Ag. Head of Academic Programme Signature Date

DEDICATION

I dedicate this work to my family, my teachers and my patients who have taught me all I know.

You continue to be a source of inspiration and strength as we seek to improve health.

I hope that this humble contribution will add a little to what we already know.

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DEFINITION OF TERMS

Term	Definition
Advanced Maternal Age	Women aged 35 years or older at the time of pregnancy
Direct Obstetric Cause	Causes of maternal death resulting from complications of pregnancy, labour, delivery or the post-partum period.
High Parity	Women with 5 or more children
Indirect Cause	A cause of maternal death which existed prior to pregnancy but may or may not have been aggravated by pregnancy.
Maternal Mortality Ratio	The ratio of the number of maternal deaths per 100,000 live births in a given location at a specified time.

ABBREVIATIONS/ACRONYMS

AMA -	Advanced maternal age
ANC-	Antenatal care
CHPS-	Community-based Health Planning and Services
FGD-	Focus group discussion
GFR-	General Fertility Rate
GHS-	Ghana Health Service
GSS-	Ghana Statistical Service
HC3-	Health Communication Capacity Collaborative
HP -	High Parity
JSS-	Junior Secondary School
MMR-	Maternal mortality ratio
PPAG-	Planned Parenthood Association of Ghana
SDG-	Sustainable Development Goal
TFR-	Total Fertility Rate
USAID-	United States Agency for International Development
VR-	Volta region of Ghana

WHO-	World Health Organization

ABSTRACT

Maternal mortality is high in the Volta region of Ghana. Most of the maternal deaths in the South Tongu district in recent years have been in women with Advanced Maternal Age (AMA) and/or High Parity (HP).

In the past, the perception of these risk factors has been found to be different from the health worker and women's perspectives.

This qualitative study set out to determine the community's perception of AMA and High Parity as maternal mortality risk factors.

A cross-sectional study design was used. It was descriptive and qualitative.

Fifty-four (54) participants (18 male, 36 Female) took part in Focus group discussions and key informant interviews which were audio recorded.

Experience of previous maternal deaths, perceived pregnancy risks, perceived risks of AMA and High Parity and future healthcare suggestions were the main themes of the discussions/interviews.

The perception of AMA as a risk was not widespread, and those who perceived it as such thought of women in their 50's and 60's as those at risk of maternal mortality.

High Parity was thought of as not being a risk by older women, and thought of as an economic risk rather than a medical one by younger women.

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CHAPTER 1:INTRODUCTION

1.1: Background Information

Globally, 830 women die each day from complications of pregnancy and childbirth(WHO,2015). Ninety nine (99%) percent of these deaths occur in developing countries and mostly in rural settings.

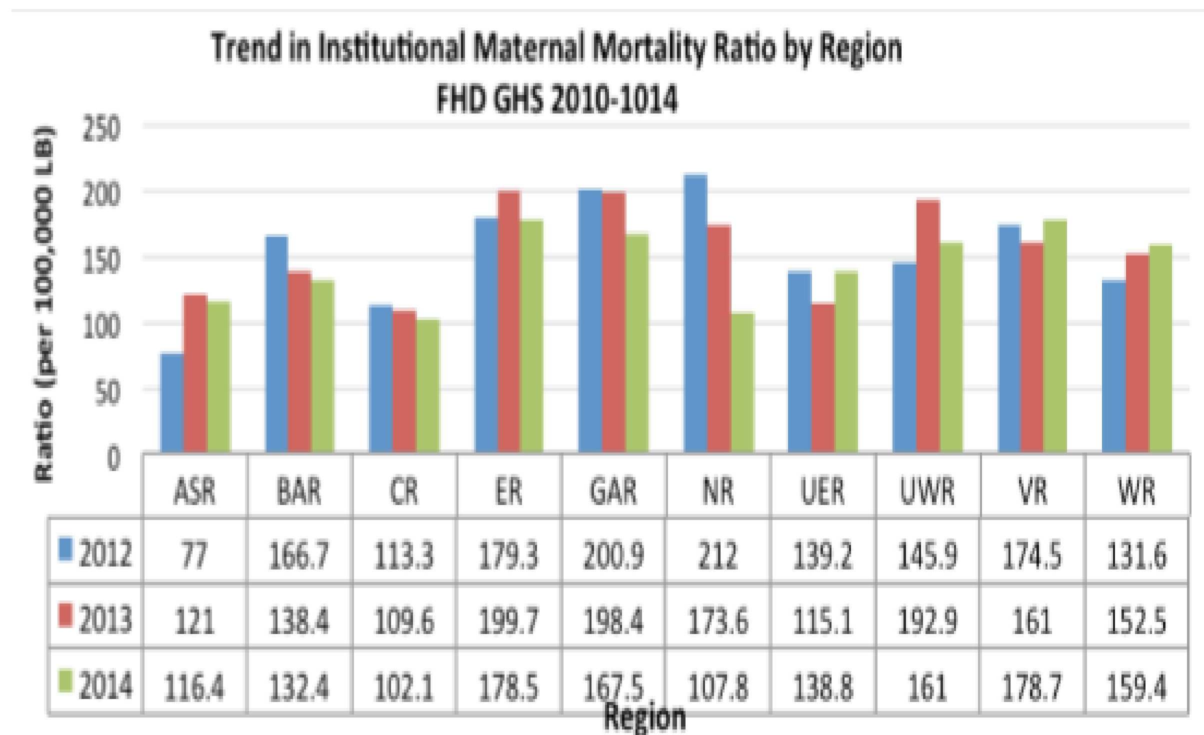
Direct obstetric causes accounted for about 86% of all maternal deaths globally in 2015, led by maternal hemorrhage, and maternal hypertensive disorders (Bill & Foundation, 2016). Hemorrhage, as cause of global maternal death peaked in women aged 35 to 39 years old. The contribution of most other causes of maternal death also increased with age, especially other direct maternal disorders and the combined category of abortion, ectopic pregnancy, and miscarriage (Bill & Foundation 2016).

About 12% of maternal deaths can be attributed to indirect causes (excluding HIV/AIDS) such as cardiovascular, endocrine, chronic respiratory disorders and cancers(Bill & Foundation, 2016). These indirect causes have been found to be more common in women above 35 years of age(Jolly et al. 2000).

Pregnant women aged 35 years and older are considered to be of Advanced Maternal Age (AMA). And those with 5 or more children are considered to be of high parity (HP). Both groups mentioned above have an increased risk of developing obstetric complications compared to their younger counterparts. These complications include hemorrhage, hypertensive disorders, gestational diabetes, stillbirths and organ failures(Jolly et al. 2000).

Contrary to the previously held view that the risk of maternal mortality is higher in adolescents, women who are 35 years or older carry the greatest risk of maternal mortality worldwide(Bill & Foundation 2016).

Figure 1: Maternal Mortality trend in Ghana by Region (Ghana Health Service, 2015)



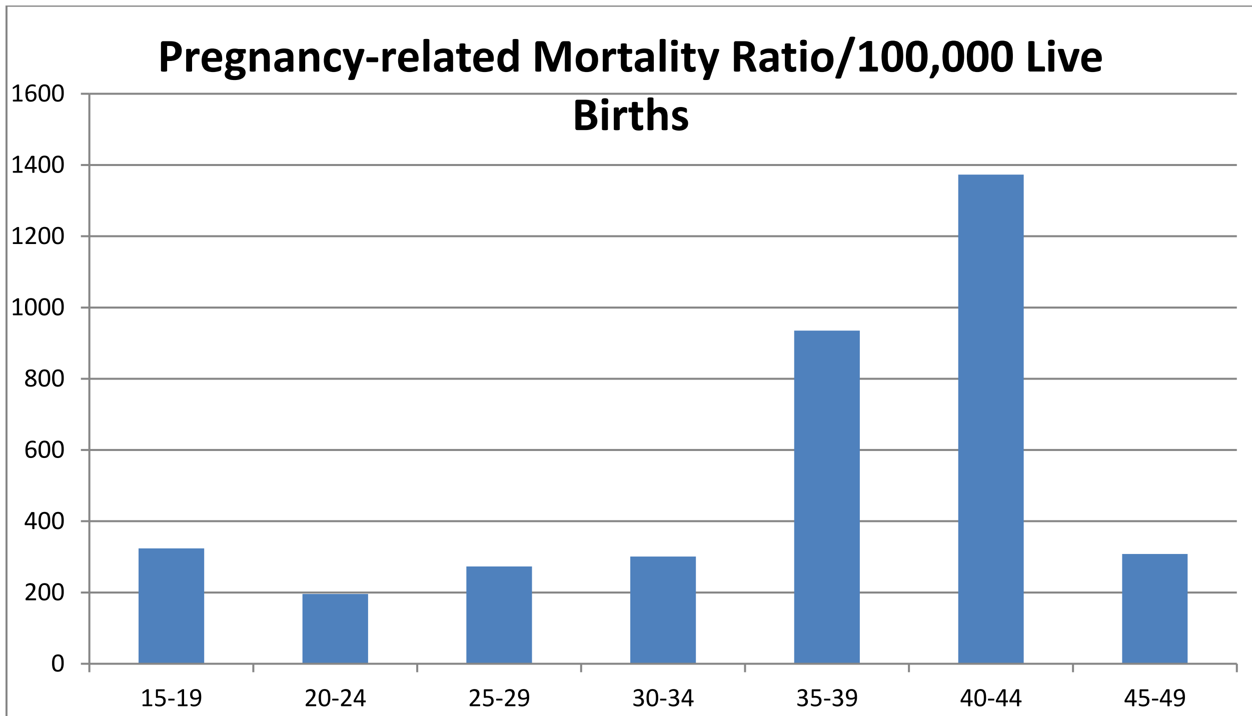
In Ghana, 29.1% of maternal deaths occurred in women aged 35 years and above, and 89.3% occurred in women with no or only basic education(Ghana HealthService & Ghana Statistical Service 2009). These women are more likely to be of high parity as well.

In 2014, the Volta Region of Ghana recorded the highest Maternal Mortality ratio (MMR) amongst the 10 regions (GHS, 2015).

Three (3) out of 4 maternal deaths in 2015 and both maternal deaths in the first 9 months of 2016 in the South Tongu District of the Volta Region occurred in women over the age of 35 years (Ghana Health Service, unpublished).

Lacks of knowledge, gender roles and fatalism have been noted to influence Advanced Maternal Age and High Parity risk perception in different communities of Sub-Saharan Africa (HC3, 2016).

Figure 2: Maternal Mortality by Age in Ghana (Ghana Maternal Health Survey 2007)



1.2: Problem Statement

The fact that the Volta region of Ghana has had a challenge with its MMR is stated above.

It is also stated above that lack of knowledge, gender roles and fatalism have been noted to influence Advanced Maternal Age

and High Parity risk perception in different communities of Sub-Saharan Africa (HC3, 2016).

The South Tongu District has been recording maternal deaths in women of Advanced Maternal Age and High Parity consistently over the past 3 years.

Three (3) out of 4 maternal deaths in 2015 and both maternal deaths in the first 9 months of 2016 in the South Tongu District of the Volta Region occurred in women over the age of 35 years (Ghana Health Service, unpublished).

Documentation of knowledge on how communities in the region perceive Advanced Maternal Age and High Parity as maternal mortality risk factors is scanty.

Knowledge about the perception in our communities of Advanced maternal age and High Parity as maternal mortality risk factors will help to develop improved approaches and strategies to reduce maternal mortality in South Tongu and nationally.

1.3: Rationale

Quantitative data from the Ghana Health Service shows that the Volta region has the high MMR of 178.8 deaths/100,000 Live Births (2015).

Concerns about Advanced Maternal Age and High Parity as potential risk factors for poor maternal health outcomes have been highlighted in Continuing Education (CE) and training programs for health workers in the region. Health workers therefore perceive these two situations as such.

However, it is unclear whether the perception held by health workers is the same as that held by community members. It is also unclear whether community members in the South Tongu District see Advanced Maternal Age and High Parity as risk factors for maternal mortality?

Only a few recent studies have explored such community perceptions in Sub-Saharan Africa (SSA) and Ghana in particular.

This study therefore, seeks to explore communities' perceptions of Advanced Maternal Age and High Parity as potential risk factors for poor maternal health outcomes.

Finding out what communities perceive as risky, leading to maternal mortality will help to attain the global MMR of 70 deaths/100,000 Live Births targeted by 2030.

1.4: Research Questions

The research questions are as follows:

1.4.1: What do community members in the South Tongu District of the Volta Region think about Advanced Maternal Age and Pregnancy?

1.4.2: What do community members in the South Tongu District of the Volta Region think about High Parity and Pregnancy?

1.4.3: Do community members in the South Tongu District of Volta Region perceive Advanced Maternal Age and High Parity as risk factors for maternal mortality?

1.4.4: What are the socioeconomic and cultural factors influencing pregnancy in women of Advanced Maternal Age and of High Parity?

1.4.4: What are the communities' perspectives and recommendations, if any, on the practice of Advanced Maternal Age and High Parity pregnancies in relation to maternal health outcomes, going forward?

1.5: General Objective

To describe maternal mortality risk perception among community members in the South Tongu District.

1.6: Specific Objectives

1.6.1: To explore and describe the communities perception of Advanced Maternal Age as a risk factor for maternal mortality.

1.6.2: To explore and describe community perception of High Parity as a maternal mortality risk factor.

1.6.3: To explore and describe community factors which facilitate or discourage Advanced Maternal Age.

1.6.4: To explore and describe community factors which facilitate or discourage High Parity.

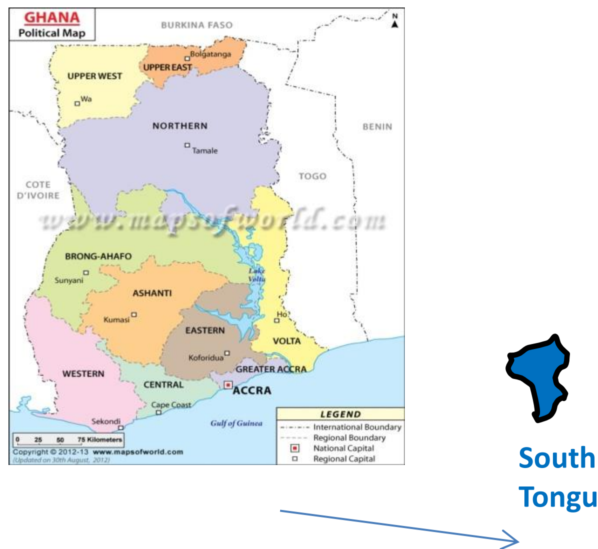
1.7: Profile of Study Area

The South Tongu District is located in the south-western part of the Volta Region. It has a population of 87,950, and is 87.1% rural. Females make up 54% of the population, and most of the community are farmers, traders or engaged in fish-related activities (GSS-2014).

The district has the following healthcare resources:

- 2 District Hospitals
- 4 Health Centers
- 13 CHPS Zones
- 1 Family Planning Facility (PPAG)
- 2 Private Healthcare Facilities

Figure 3: Location of South Tongu District.



The Total Fertility Rate (TFR) for the district is 3.6, and the General Fertility Rate (GFR) is 103.6 births per 1000 women aged 15-49 years.

Of the population aged 11 years and older, about 74% are literate (males- 85%, females- 64%).

About 70% of the district population aged 15 or older is economically active, with more males being employed than females. About half of this active population is engaged in farming, mostly rice (GSS-2014).

1.8: Scope of the Study

This study was carried out in the South Tongu District of the Volta region. It is a qualitative study designed to explore community perceptions of advanced maternal age (Advanced Maternal Age) and high parity (HP) as potential risk factors for maternal mortality.

Data was collected through focus group discussions (FGDs) and key informant (KI) interviews.

A few case studies of maternal deaths involving the key risk factors mentioned above were carried out.

A deductive approach was used in data analysis, with the results organized according to the research questions.

CHAPTER 2: LITERATURE REVIEW

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2016). The rate of maternal deaths has been accepted as a measure of the quality of healthcare in the various parts of the world and within health institutions.

The leading causes of maternal deaths are Haemorrhage, Hypertensive disorders (Global Burden of Disease 2015 Maternal Mortality Collaborators, 2016).

Other causes include infections, unsafe abortions, and delivery complications such as obstructed labour. Malaria and HIV/AIDS have also been associated with deaths during pregnancy and childbirth (WHO, 2016).

In 2015, the global Maternal Mortality Ratio (MMR) was 196/100,000 live births (LB). The figure for Ghana was 296/100,000LB(Bill & Foundation 2016). Ghana has to reduce its MMR by more than 75% in 15 years to achieve the Sustainable Development Goal (SDG) target of an MMR less than or equal to 70/100,000LB.

The risk of maternal mortality increases significantly with age above 35(Jolly et al. 2000), especially in women with lower levels of formal education(Ghana Health Service & Ghana Statistical Service 2009). But there are very few studies documenting the social and community perception of Advanced Maternal Age and High Parity as risk factors in Developing countries.

Risk perception is a key component of health behavior theories such as the Health Belief Model (Janz et al,1984), Protection Motivation Theory (Maddox et al, 1983), and the Prospect Theory (Kahneman et al,1979). Most often, informing pregnant women of a medical risk such as Advanced Maternal Age or High Parity and explaining how this can lead to pregnancy complications does not automatically lead to a perception of this risk in the mind of the pregnant woman. Perceiving this risk being communicated by the health worker has been found to depend on a number of factors.

Lifestyle choices, delayed marriage and infertility (Bayrampour et al. 2012) have been identified as the main reasons for Advanced Maternal Age amongst women in developed countries.

Bayrampour et al. (2012) found that predictability of risk affected a pregnant woman's perception of herself as high or low risk. So being told that one had Pre-eclampsia, for example, might not ring alarm bells if one's mother and siblings had it before her. It would almost be considered as "normal". Women of Advanced Maternal Age did not necessarily define pregnancy-related risks solely on the basis of health-associated factors. The women in this study considered social and personal factors as well in their assessment of pregnancy-related risks.

To some of these women, having a stable partner and income, eating healthy, not smoking or drinking alcohol carried more points than merely being aged 35 or over.

Most of the women were aware of the medical risks associated with their Advanced Maternal Age prior to getting pregnant but felt that they had some sort of control over this risk factor from either their personal lifestyle choices or socio-demographic background

People who perceived themselves as "healthy" also perceived themselves as "low risk" regardless of the identified risks simply because they believed that the "healthy diet and

lifestyle" they lived will see them through. They "felt in control". Women in this study were also less likely to perceive risks if they had other issues to deal with such as infertility. They thus concluded that pregnant women were less likely to perceive pregnancy risks if they felt healthy, believed that they could succeed, expected the pregnancy risk or had a "bigger risk" such as infertility to overcome.

Though Bayrampour et al. shed significant light on risk perception in pregnancy; their study was limited to pregnant women. The community support system of pregnant women also has its own perceptions of risk based on a lot of factors. These can also affect the woman's risk perception.

Husbands and relatives (such as in-laws, fathers) have been found to be the decision-makers in maternal referrals in SSA (Pembe et. al, 2008). Their perception of maternal risks and the need for referral is equally important in these settings. Women appear to have little influence especially in rural settings.

Cultural and religious norms have been identified as the leading cause of Advanced Maternal Age (Advanced Maternal Age)in some African settings (HC3, 2016). The notion of limiting births due to Advanced Maternal Age or high Parity (HP) in parts of the Continent appears not to be consistent with the current cultural and religious norms. Couples tend to give birth for as long as they can. Both men and women in these communities accept this practice as the norm. The women's knowledge of the medical risks of Advanced Maternal Age did not seem to affect their decision to limit child-bearing. Some societies even considered it an offence to deliberately stop child merely because of Advanced Maternal Age or High Parity. This trend was noted to be more common in rural settings. Inadequate information from health workers regarding the risks of Advanced Maternal Age also contributed to low risk perception in some instances.

An earlier study (Papiernik, E., J. Tafforeau 1997) did report a difference in risk perception in women of Advanced Maternal Age according to socio-economic status. They found that women who had completed higher levels of education were more likely to have a higher degree of concern for themselves and their children. They also found that women with a higher socio-economic index were more likely to choose to give birth in a setting with more highly qualified health professionals.

A Systemic review(Lee et al. 2012) also identified the lack of consistency in the health professionals' perception of Advanced Maternal Age as a risk factor. This had the tendency to confuse women of Advanced Maternal Age as to whether or not they were at a higher risk medically.

CHAPTER 3: METHODOLOGY

3.1 Research Design and Methods

A cross-sectional study design was used. The study was community-based, descriptive and qualitative.

A purposive sampling technique was used to select the community for the study.

The community of Fievie was chosen for the fact that its characteristics were representative of the rural nature of most of the South Tongu District. It is also easily accessible from the district capital of Sogakope.

3.2 Data Collection Techniques and Tools

Data collection was through Focus Group Discussions (FGDs) and Key Informant Interviews (KIs). The interviews and discussions were carried out using a structured interview guide with themes to guide discussions.

Community entry was done at a durbar which was initially organized to plan a funeral. The research team was introduced and given the chance to explain the purpose of the study. Confidentiality was assured for both the community and the participants.

Thereafter, community members were invited to the JSS Complex starting from the next day for the Interviews and discussions for the study.

Two (2) methods of data collection were used:

1. Focus Group Discussion (FGD).
2. Key Informant Interview (KI)

Participants were categorized into groups for ease of communication amongst peers (stratified for age and sex).

Focus Group Discussions (FGDs) were held with each of the following groups:

1. Women at least 35 years old.
2. Men at least 35 years old.
3. Women less than 35 years old.
4. Women with high parity.
5. Men with high parity.
6. Women with low parity.

The following key community stakeholders had key informant interviews conducted.

1. The Chiefs
2. Traditional Elders
3. Assemblymen
4. Head Teacher of Basic Schools
5. Traditional Birth Attendants
6. Community Health Workers

A qualitative study design was able to provide deep insight needed to appreciate the factors contributing to pregnancies at ages 35 or older and high parity. This deeper understanding is

needed to facilitate the design of interventions that will, in the long term, impact positively on the lives of women in these communities.

3.3 Study Population

The study population was Fievie community. Community entry was done at a durbar which was initially organized to plan a funeral. The research team was introduced and given the chance to explain the purpose of the study. Confidentiality was assured for both the community and the participants.

Thereafter, community members were invited to the JSS Complex starting from the next day for the FGDs and Key Informant Interviews.

3.4 Sampling

A purposive sampling technique was used in this study. Participants were stratified for sex and age to enhance free expression amongst peers.

The sample size was determined by the Principle of Saturation in qualitative methodology, referring to the point at which no new information is gathered from the interviews/FGDs. Saturation point was reached after eight (8) key informant interviews and five (5) FGDs.

3.5 Pre-testing

The thematic guide used in data collection was pre-tested amongst health workers and patients in the nearby Comboni Catholic Hospital in Sogakope. A population whose characteristics is similar to that of South Tongu.

3.6 Data Handling

Each focus group discussion and key informant interview was conducted in a private setting where the participants could freely express themselves without interference.

A thematic guide was used for the sessions. The sessions were audio-recorded and transcribed verbatim. The transcripts were then reviewed by a separate individual listening to the tapes to fill out missing details.

3.7: Data Analysis

Soft copies of the transcripts were then analyzed through content analysis with Microsoft word by converting the text into tables and forming data matrices.

3.8: Ethical Considerations

Ethical clearance was sought from the Ensign College of Public Health Ethics Review Committee.

Permission was also sought from the District Assembly and the Local Traditional Council (Fievie) and the District Health Directorate.

The chiefs and community elders were met privately, followed by a community durbar where the study team was introduced to the community.

Being a community, confidentiality and privacy was assured. Participants were informed of their anonymity. Interviews and focus group discussions were carried out in the most private settings, enabling the participants to speak freely.

The necessary cultural competencies were practiced to display the necessary respect and regard for local customs, traditional and religious beliefs.

Research team members were trained to be conscious of their non-verbal and verbal communication in order to encourage community commitment and cooperation in the short and long term.

3.9: Inclusion and Exclusion Criteria

Pregnant women were excluded from participation, with the inclusion of those who have delivered safely. This was to reduce the effect of fear and anxiety amongst those who were pregnant after the age of 35 or with high parity.

3.10: Limitations of the Study

Due to limited time and resources, other communities within the South Tongu district could not be added to the study. This restricted the sample size.

The structured nature of the interview guide left little room for exploring new perceptions outside of its scope, even though some of these did emerge during the discussions.

A deductive approach was used to analyze the data due to the structured nature of the interview guide. This approach was chosen due to limited time, resources and available knowledge from similar studies.

Using an Inductive approach would have been less biased and would have left more room for new themes to emerge.

New themes were, however, searched for extensively during data analysis and reported on in Chapter 4.

3.11: Assumptions

1. The response obtained from respondents is true and reflect their perceptions.
2. The perceptions of health workers are different from that of community members
3. The perceptions of communities are influenced by that of health workers.

CHAPTER 4: RESULTS

A total of fifty four (54) community members took part in the study. Forty six (46) took part in focus group discussions stratified for age and sex. The remaining 8 were key informants who were interviewed individually.

Table 1: Demographic characteristics of participants

RESPONDENT CHARACTERISTICS (N=54)			
Sex N (%)		Occupation N(%)	
Male	18(33.3)	Farming	22(40.7)
		Trading	14(25.9)
Female	36(66.7)	Fishing	8(14.8)
		Others	10(18.6)
Age Category N(%)		Education N(%)	
20-24	6(11.1)	None	27(50)
25-29	7(13.0)		
30-34	7(13.0)	Basic	15(27.7)
35-39	5(9.3)		
40-44	5(9.3)	Secondary	7(13.0)
45-49	3(5.6)		
50-54	5(9.3)	Tertiary	5(9.3)
55-59	8(14.8)		
60-64	6(11.1)		
65 & Above	2(3.7)		

Table 2: Focus Group Discussions and Key Informant Interviews by Participants

Participants	Below 35 years old	Above 35 years old	Without High Parity	With High Parity	Total
Women	9	7	17		33
Men		7		6	13
KEY INFORMANT INTERVIEWS					
Assemblyman	1				1
Chiefs	2				2
Community Pastor	1				1
Catechist	1				1
Health worker	1				1
Traditional Birth Attendant	2				2
TOTAL					54

The study was performed with 8 core themes in the interview guide, but two (2) relevant themes emerged from the results. The new themes were also reported on.

Table 2: Theme of Results

S/N	Theme	Type
1	Experience of Maternal Deaths	Core
2	Perception of Risk in Pregnancy	Core
3	Factors facilitating AMA and HP Pregnancies	Core
4	Perception of Age as a Maternal Mortality Risk factor	Core
5	Perception of HP as a Maternal Mortality Risk factor	Core
6	Planning of HP and AMA pregnancies	Core
7	The ANC experience of HP and AMA women	Emergent
8	Perceived Abuse of Pregnant Women by Health Workers	Emergent
9	Planning Ahead	Emergent
10	Experience of Neonatal Death	Emergent
11	Experience of Spontaneous Abortion	Emergent

4.1: Experience of Maternal and Neonatal Deaths

Most participants believed that maternal deaths were not common in the community. Only a few of them knew someone who died as a consequence of childbirth. Those who had experienced maternal deaths were mostly in the older age or high parity categories.

Participants narrated painful and sad experiences of having lost community members in the past and circumstances surrounding these deaths.

"*We used to think that it was a misfortune. One of our nieces whose house is just nearby was a victim. When it happened and we rushed her to the hospital she had an operation and unfortunately, we lost her but the baby was alive."*- A Male Participant in the High Parity FDG.

Even though the question was on maternal deaths, participants wished to share their experiences with the loss of babies as well.

"This is how it happened. At that time, there was no access road through this town so it was difficult getting vehicle to transport women in labour to the hospital. By the time we could get a vehicle to transport my wife to the Adidome hospital, the baby had died and the mother had to be operated to remove the dead baby. So we lost the baby but the mother was saved and she is still alive."- Another male Participant in the High Parity FDG.

Participants attributed these deaths to a range of issues from poor nutrition and non-attendance of antenatal clinic (ANC) to marital and financial problems. Poor road networks were also mentioned, but these were now things of the past.

Witchcraft was mentioned as a suspected cause by community members for maternal deaths that occurred a long time ago, this opinion is no longer commonly expressed.

4.2: Perception of Risk in Pregnancy

Anaemia, a poor diet and not attending ANC during pregnancy were stated as risk factors for maternal death. Social factors such as neglect by a husband, loss of a husband or close relative and refusal of a partner were also stated as factors which make pregnancies risky. Extremely hard work was mentioned as a possible source of risk for pregnant women.

“*There are others who do not go for Antenatal check-up. As a result, problems or complications that may concern the pregnancy are not detected early. Most at times, the mothers lack blood and because they do not attend antenatal, anaemia is diagnosed very late and if God does not intervene, the unexpected happens. It happened to one of our siblings; at the point of delivery, when she needed blood to enable her to give birth, we were not having money so I had to quickly donate my blood to save her.*”- A male participant (Age >35)

Beliefs were also identified as a risk; the belief by some community members that “a woman must bring forth all the children in her womb” was mentioned as a source of high parity. Seeing women with 10 or 12 children was said by participants to be common.

Religious community stakeholders were asked for their opinion on this notion. They referred to *Genesis Ch1-2* as being what most common in their communities quoted from the Bible to support the above belief. They however quoted *1st Timothy Ch 5 Vs 8* as a counter argument which indicates that not being responsible for family upkeep is worse than being an unbeliever.

Other beliefs related to culture and the community were also mentioned by participants:

“*There are women who sleep with other men during pregnancy and it is believed that, when such women are due for delivery, the elders must sprinkle grains of maize in the air before they could give birth easily and safely*”- A participant in the Below 35 years FGD

Apart from anaemia, no other medical conditions were named as possible risk factors for maternal death.

Non-compliance with medical advice and medication given at antenatal clinics was mentioned as risk factors by participants.

Poverty was mentioned, mostly by men as a risk factor for maternal death.

"*In my view, lack of money or poverty could be a serious risk to maternal mortality. Ideally, when a pregnant woman is sick she should be taken to the hospital. But where there is no money to send her to the hospital she is kept at home and treated with herbal concoctions until the conditions get critical and then the person is rushed to the hospital at which time it becomes too late. This is what I have observed to be the risk to maternal mortality.*"- A male participant in the Age > 35 FGD.

With this theme, most males listed risk factors related to lack of funds, "laziness of the women in attending ANC" and women not taking their medicines as risk factors.

The women listed risks that had to do with lack of support from their spouse, lack of acceptance of responsibility for the pregnancy and spousal neglect.

"*Refusal of your partner to accept responsibility for the pregnancy is a risk"-* A female Participant (Age >35).

4.3: Factors facilitating AMA and HP in the community

Marital instability was seen as a reason why some women ended up being pregnant above the age of 35, and also having more than 5 children. A woman may start a family at a young age with a man. They may have 3 or 4 children only for the man to "stop minding her" when she gets "older", sometimes to be with a younger woman. This "neglected" woman may seek a divorce when she finds a man who gives her the necessary attention and support. The common belief in this situation is that she must have at least 2 children for this new man to "secure" the marriage and enhance the chances of inheritance.

Teenage pregnancy was also mentioned as a cause of Advanced Maternal Age

and High Parity. Young girls get pregnant due to peer or financial pressure. These girls may have 1 or 2 children in their teens, go through a turbulent time with multiple partners and eventually find a stable partner when they are in their 30s, such women will now want to have 1 or 2 additional children for this partner to secure the marriage. This may lead to them having 5 or more children and having them after the age of 35.

4.4: Perception of Age as a risk factor in pregnancy

Most participants either did not see age as a risk factor in pregnancy, or felt that age only made pregnancy risky after 50 years. Some participants felt that age should not be considered at all because "God grants pregnancies, and one should get pregnant for as long as God grants it". A minority of participants did feel that a woman's womb became "weaker" with time, but the minimum age identified by this minority was 40 years.

Participants mentioned women who were consciously trying to have children after the age of 35 due to one reason or the other (late marriage/union, re-marriage, infertility etc). For those couples who have been married for a long time and already had children, advanced maternal age was not always planned.

"*Yes age is a risk, but because we were enjoying sex, we were not looking at the health implications of having children at that age*"- A Female Participant (Age>35).

Some participants went as far as to link advanced maternal age with bad neonatal outcomes.

"*From my experience …. my wife was forty-years and was going to give birth to the ninth child when the unfortunate happened…we lost the baby*"- Male participant (HP)

Women in the FGDs comprised of women below the age of 35 also tended to view the age of 35 and above as an age when they "lost strength" as far as childbirth was concerned. They did not want to be pregnant above the age of 35 years.

"*The former (women below 35 years of age) looks younger and more beautiful than the latter. I always say it with pride that once I attain the age of 35, I will not get pregnant again because at that age, your strength begins to deteriorate.*"- A participant female in the < 35 year FGD.

Younger women also stated that there were more operative deliveries in women above 35 years old:

"When the person gets to that stage, she loses strength so we tend to believe she would be operated on before she could give birth"- Another female participant in the <35 year FGD

A few younger women also expressed the desire for economic stability before marriage/childbearing:

"There are some who just do not want to marry early or have anything to do with men at an early stage. There are still others who would want to get rewarding jobs and have money before marrying."- A female participant in the < 35 year FGD

Some participants (mostly female participants) also believe that deciding whether or not to get pregnant after the age of 35 depended on whether or not one has a child already. The upper age limit for giving birth was mostly given as 50 or 60 by most participants who felt that age should not be a factor.

"*If a woman has not given birth before the age of 35, I believe she can still give birth even up to 50years.*"- A female participant (<35 FGD)

4.5: Perception of High Parity as a risk or Benefit

Most participants, especially women, felt that the number of children should be limited due to economic hardships. The ideal number of children mentioned ranged from 4 to 7.

Most men also echoed this sentiment that economic reasons will make them limit the number of children they have at this point in time.

Having more children was perceived as an economic risk rather than a maternal mortality risk factor by most community members.

Others were of the opinion that "God gives children, and one must bring forth all the children in one's womb".

Indeed, high parity was seen by some as a way out of economic hardship. They mentioned the need for lots of children to help in the farm so that they can fund education.

One participant said that he is funding the tertiary education of his children from the money earned through family farming activities. He is not sure if this would have been possible had he had fewer children.

"Maybe if the husband is a farmer, it could be a reason for the high number so that these children can help in the farm. I say this because that was how what I did so I had 10 children".- Key Informant

Other participants saw limitations of age and parity as a religious contravention.

"*To stop giving birth is not biblical. A woman can give birth at any age. But it is we humans who have given age limit to giving birth. For me I think there should be no age limit to giving birth. Once I am strong and I am sure I can give birth, I will give birth*"- A participant in the <35 years FGD

4.6: Planning of HP and AMA Pregnancies

With the exception of women with new husbands at Advanced Maternal Age, most of the women in the Advanced Maternal Age and High Parity groups said that their recent pregnancies were not planned. Some of them did not attend antenatal clinics as well partly because the unplanned nature of the pregnancies meant they were not prepared financially.

Community stakeholders were asked for their opinion and they also believed that more needs to be done in terms of planning of pregnancies.

"*There should be more education on family planning to the community*"- A Community stakeholder/Key Informant

The FGD participants, mostly women, spoke of the need for more Family Planning education and services within the community. Some expressed the opinion that women with high parity should be sterilized secretly.

"I think that a policy must be put in place so that when such women go to the hospital and it is observed that they have given birth to more than necessary, their wombs will be sealed secretly."

- FGD Participant < 35 years old.

All participants in the FGD for women above the age of 35 had pregnancies above the age of 35. All of them said that the pregnancies were NOT planned.

Only 2 out of 6 of these women attended ANC, citing "gossip" and scolding by health workers as their reasons for not attending ANC.

"*The young ones of today will just be gossiping about the person (who is pregnant at advanced maternal age and attending ANC).*"- A participant in the FGD (>35 years old)

Most male participants felt that they (males) needed to know more in order to consent to Family Planning. They felt that women were the ones being educated, and in some cases, they were not even aware that their wives were using one contraceptive method or the other. They also mentioned the cost of Family Planning as being a barrier.

"*I have already mentioned the hospital charges. But another one is that some doctors connive with some women and without the knowledge of their husbands take injections for family planning. This brings confusion in marriages. I will suggest that though not all men will understand issues with family planning but more education should be given in that direction.*"- A male participant in the Above 35 years FGD.

4.7: The ANC Experience of women with AMA and HP

Women with Advanced Maternal Age and High Parity complained about feeling "odd" at community ANC clinics. The said that younger women and health workers either gossip or openly tell them that they are too old or are having too many children. This is why they prefer not to attend ANC sometimes.

"*The young ones of today will just be gossiping about the person (who is pregnant at Advanced Maternal Age and attending ANC).*"- A participant in the FGD (>35 years old)

4.8: Perceived abuse of community members by hospital staff

One key emergent theme of this study was the perceived abuse of female community members at maternity wards in health facilities.

Participants narrated incidents which have traumatized them and prevented them from going to the hospitals for clinics and deliveries.

"*I have witnessed one before. The woman was in labour when she came to the hospital, so when she arrived, she was putting pressure on the nurse to attend to her but the nurse was attending to someone else so she (the nurse) got angry and said, "you old woman like this you got yourself pregnant and you are here disturbing us." That statement was a discouraging and an insulting one. So, the nurses should learn to talk to such women well*."- A participant in the <35 year FGD

"*Our nurses should have patience for us. What I am coming to say is my own experience at the hospital. I fell sick and I was admitted to the hospital. All of a sudden, I went into labour. When I called the nurse, she was far away and kept saying I should lie down for me to be injected instead of making noise. Quickly, I took my mat and rubber and went to the ward. By the time they realized, I had given birth. I got so angry and told her that I will report her but she pleaded with me not to. If that was my first time of giving birth, I would have lost the baby or myself. They did same to my earlier pregnancy and I lost that baby. This happened at ----------- hospital.*"- Another participant in the <35 year FGD.

Health workers who were consulted on these perceptions were quick to point out that these were perceptions of the women, but conceded to the need for more education on procedures and processes that the women were going through.

CHAPTER 5: DISCUSSION

The community chosen for the study has not witnessed maternal deaths for at least a decade. Members cannot recollect any recent maternal deaths. Since maternal mortality is used as a measure of the quality of healthcare available to a community, it can be inferred that the Fievie community in the South Tongu District of the Volta region is being served well by health facilities. It may also mean that the practices within the community promote maternal health.

The community is located 2km from a District Hospital (Comboni Catholic Hospital), with a first class road connecting them.

Findings from other themes in the study however, point to perceptions that need to be modified through better health education, community involvement and behavior modification.

Globally, Haemorrhage is a leading cause of maternal deaths. The community identified nutrition and anaemia as risk factors which are in line with well-known risk factors for maternal deaths and related global efforts to reduce maternal deaths.

Hypertensive disorders were not mentioned at all by community members as a risk factor, and only one person mentioned abortions and their complications as relevant.

Globally, there is a significant increase in the risk of maternal morbidity and mortality after the age of 35 (Jolly et al. 2000).

The community did not perceive age as being a risk factor for maternal death. The few community members who considered it a risk were mostly referring to ages above 50, and above 60 for some.

High parity increases the risk of haemorrhage during child birth. Community members were mostly against high parity for economic reasons and not medical risk. There appears to be a religious and cultural factor in support of high parity. This is similar to findings in other studies cited earlier (HC3, 2016) which were conducted in different sociodemographic settings.

Previous studies mentioned delayed marriage, infertility and lifestyle choices as the reason for Advanced Maternal Age. This study found that divorce/separation and re-marriage was one cause of Advanced Maternal Age in the community. The norm of having at least 2 new children for the newly married husband was cited as one of the causes of Advanced Maternal Age.

Lifestyle choices, mainly for economic reasons were the main cause of the perception that High Parity was not a practice for these times. The medical risks of High Parity were not cited by the majority of participants.

Younger women in this study in particular, perceived High Parity as something that would prevent them from financial stability. Most of the women under 35 years of age expressed the wish to have fewer children and make time for economic/academic activities. This finding is similar to what studies in high income countries found, perhaps a reflection of the shifting psyche of young women with access to education and gainful employment or entrepreneurship.

Contrary to the findings of Bayrampour et al. (2012) , most women in this study did not know the medical risks associated with Advanced Maternal Age prior to pregnancy, and did not even plan on getting pregnant at an advanced maternal age, it just happened.

Culture and religion have been found to play a part in the promotion of High Parity and Advanced Maternal Age to some extent in this study. This finding is interesting when compared to the HC3 study (2016) which was carried out in predominantly Muslim communities with similar findings.

Papiernik et al,(1997) found that women with higher education tend to limit the number of children in return for economic gains. Our study found a difference in perception of high parity between women below and above 35 years. Most of the younger women opted against High Parity, citing economic activities and the ability to improve the quality of life of their families.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1: Conclusion

The Fievie Community in the South Tongu of the Volta region has not experienced maternal deaths in at least a decade. Community members recall maternal deaths from a long time ago or from other communities. They perceived poor nutrition, non-attendance of ANC, spousal neglect and witchcraft as the causes of these deaths. Perceptions of witchcraft causing maternal deaths are less frequent than they used to be according to participants.

Anaemia and poor nutrition were perceived as maternal mortality risk factors, but medical conditions such as hypertensive disorders were not mentioned in this study as perceived risk factors or causes of previous maternal deaths.

Lack of family planning (FP) education and services, little awareness of the need for FP, cultural and religious factors as well as divorce-remarriage were perceived to increase the prevalence of High Parity and Advanced Maternal Age pregnancies in the community.

Age was largely not perceived as a maternal mortality risk factor, and those who thought it was were thinking of much older women (50’s and 60’s) as being at risk.

High parity is becoming unpopular in the community, especially amongst young women primarily for economic reasons and not medical risk.

Women with Advanced Maternal Age or High Parity fail to attend Antenatal clinics because younger women or health workers make them feel uncomfortable from their point of view.

Some women felt abused (verbally and physically) by health workers and this contributed to them not attending ANC or delivering in hospitals.

The community wants greater engagement by health workers and a health facility (CHPS compound).

6.2: Recommendations

6.2.1: Ministry of Health

A clear messaging strategy or policy on Advanced Maternal Age and High Parity Pregnancies.

6.2.2: Ghana Health Service

1. Training of health workers on appropriate technical messaging regarding Advanced Maternal Age and High Parity.
2. Training on the rendering of quality healthcare to women with Advanced Maternal Age and High Parity pregnancies.

6.2.3: Civil Society Groups

Engagement on the medical and sociocultural dimensions of Advanced Maternal Age and High parity.

6.2.4: Religious bodies

Engagement on the medical and sociocultural dimensions of Advanced Maternal Age and High parity.

6.2.5: Community leaders

Community leaders (Traditional leaders, assemblymen/women and religious leaders) should engage health officials at the local level for a collaborative effort aimed at harmonizing the approach maternal mortality reduction.

The community leaders should seek to provide the platform and support to health workers to share knowledge about maternal mortality risk factors with community members.

The leaders at community level must also be convinced of the need for behavior change, and commit to leading the community in this regard.

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APPENDIX I: CONSENT FORM

ADVANCED MATERNAL AGE AS A RISK FACTOR FOR MATERNAL MORTALITY IN THE SOUTH TONGU DISTRICT OF VOLTA REGION, GHANA

A QUALITATIVE STUDY

CONSENT FORM

I have been approached to be part of the above-titled study. The purpose and nature of the study have been explained to me as:

1. A study to gain deeper insight into the issues affecting maternal mortality.
2. My personal details shall not be used in any part of the study.
3. All opinions expressed by my person shall remain confidential and anonymous.
4. This discussion shall not affect my standing in the community or neighboring healthcare institutions.

After having understood the above points, I willingly consent to be part of a Focused Group Discussion (FGN) related to this study.

Name:

Community:

Telephone Number

House Address:

Signature/Thumb Print Date

APPENDIX II: THEMATIC GUIDE TO FOCUSED GROUP DISCUSSIONS

ADVANCED MATERNAL AGE AS A RISK FACTOR FOR MATERNAL MORTALITY IN THE SOUTH TONGU DISTRICT OF VOLTA REGION, GHANA

A QUALITATIVE STUDY

GROUP BEING INTERVIEWED	
LOCATION	
DATE	
NAME OF MODERATOR	

Section	**Guiding Questions**	**Please tick when completed**
1: Introduction	1. Allow all participants to get seated and comfortable.	
	2. Ensure adequate privacy in terms of	

	location.	
	3. Introduce the purpose of the Focus Group Discussion and ensure that all the participants understand its purpose seeking verbal confirmation and looking for non-verbal communication to the contrary. Clarify all doubts prior to continuation.	
	4. Seek verbal, then written consent from participants.	
	5. Introduce the study team, allow participants to introduce themselves.	
	6. Ask if anyone has anything to declare or get off their chest prior to the commencement of the discussion, note these concerns/opinions prior to proceeding with the discussion.	
2: Maternal Risk Perception	1. Has any participant had an experience with the maternal death of a close relative or friend?	

	a. What did they perceive to have been risky about that pregnancy which could have contributed to death?	
	2. What characteristic of pregnancy do participants see to be risky and likely lead to a maternal death?	
	3. Do they think that maternal age is a risk factor for maternal mortality? a. If yes, what is the cut off age to be considered high risk? b. If no, what are the other things that they consider to be riskier than age with respect to maternal death?	
	4. Are there any community factors that they consider to lead to high risk pregnancy?	
3: Maternal Age	1. How do participants perceive being	

Perception	pregnant above the age of 35? a. For those in favor, what are the benefits they perceive? b. For those against, what are the reasons for this?	
	2. Is there something in the community that facilitates or discourages pregnancy above the age of 35?	
	3. For those who have been pregnant above the age of 35, a. Did they feel different? b. Did they ever imagine themselves to be pregnant at this age? i. If not, what were the reasons for pregnancy at this "unimagined" time? c. Did they attend antenatal clinic, and how did it feel?	

4: Planning Ahead	Looking into the future, would participants like to see more women getting pregnant above the age of 35? a. If yes, is there anything that they would like to see done differently for such pregnant women i. By their communities? ii. By their healthcare providers? b. If no, is there anything they would like to see done to prevent them from occurring i. By their communities? ii. By their healthcare providers?	

APPENDIX III: INSTITUTIONAL REVIEW BOARD APPROVAL

ENSIGN COLLEGE OF PUBLIC HEALTH - KPONG

OUR REF: ENSIGN/IRB/M2
YOUR REF:
Tel: +233 245762229
Email: irb@ensign.edu.gh
Website: www.ensign.edu.gh

P. O. Box AK 136
Akosombo
Ghana

21st November, 2016.

INSTITUTIONAL REVIEW BOARD SECRETARIAT

Momodou Cham,
Ensign College of Public Health.

Dear Mr. Cham,

OUTCOME OF IRB REVIEW OF YOUR THESIS PROPOSAL

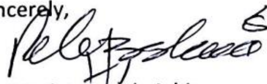
At a meeting of the INSTITUTIONAL REVIEW BOARD (IRB) of Ensign College of Public Health held on 16th and 17th November 2016, your proposal entitled "**Community Perception of Maternal Age as a Risk Factor in the South Tongu District of Ghana- A Quantitative Study**"was considered.

Your proposal has been approved for data collection in the following settings:

1. Amend the topic to include Region.
2. Provide Consent form in your proposal.

We wish you all the best.

Sincerely,



Dr (Mrs) Acquaah-Arhin

(Chairperson)

Cc. Dean of Ensign College.

Cc: Ag. Academic Registrar, Ensign College.

BOARD OF TRUSTEES:
Mrs. Lynette N. Gay – Chair, Prof. Agyeman Badu Akosa- Vice Chair, Dr. Stephen C. Alder, Lowell M. Snow, Dr. DeVon C. Hale, Dr. Kwesi Dugbatey, Prof. Tsiri Agbenyega, Prof. Samuel Ofosu Amaah , Togbe Afede XIV

APPENDIX IV: DATA TABLES

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON RESPONSES FOR EXPERIENCES OF PAST MATERNAL DEATHS

(W>35)Participant 1: I had an experience where a close friend of mine died and I think it was due to her not attending ANC.
(W>35)Participant 2: being pregnant at a location where there is no heath care facility nearby also makes the pregnancy risky
(MP>5)Participant 1: Yes
(MP>5)Participant: There are some women who do not eat nutritious food during pregnancy. There are others who also do not attend ANC to check on the health of the baby in the womb. These result in the loss of the baby or mother or both at the point of delivery.
(MP>5)Participant 2: Yes it has happened to me (LOSING BABY AND NOT MOTHER)

(MP>5)Participant 2: This is how it happened. At that time, there was no access road through this town so it was difficult getting vehicle to transport women in labour to the hospital. By the time we could get a vehicle to transport my wife to the Adidome hospital, the baby had died and the mother had to be operated to remove the dead baby. So we lost the baby but the mother was saved and she is still alive.
(MP>5)Participant 3: We used to think that it was a misfortune. One of our nieces whose house is just nearby was a victim. When it happened and we rushed her to the hospital she had an Operation and unfortunately, we lost her but the baby was alive.
(MP>5)Participant :I think it was due to delay in going to ANC.
(M>35)Participant 1: With what I know, the person was in labour and was rushed to the hospital. At the hospital, there was the need to operate her. Unfortunately, the mother died leaving the baby.
(M>35)Participant: This happened long ago so I can't recall her exact age.
(M>35)Participant: She was staying somewhere before she was brought. She had four children

and the one that was delivered was the fifth.
(M>35)Participant: I was then young so I couldn't actually get to know the cause.
(M>35)Participant: In my family, since I came to this town I have never heard that a woman was going to the hospital to be delivered of a baby and had died.
(M>35)Participant: It is same with my clan. (no maternal deaths)
(M>35)Participant: All agreed that cases of maternal mortality do not occur in recent time.
TA: Yes, 3 or 4 people.
TA: From my recalling, one or 2 of them did not visit the hospital when they were pregnant. So I have been trying to get them to go to the hospital. But they have complained that when they go to the hospitals they are not given the attention due them. So in their opinion, it is better to stay at home,
(HT)Participant: Yes
(HT)Participant: sometimes some of them don't eat proper food**.**
Some of them to don't take proper care of the women.
Some of the women do so much hard work even whiles pregnant.

(AM) Participant: No I have not had an experience but I have heard of it in some other communities.

(TAIII)Participant: Yes but that was a long time ago.

(TAIII)Participant: By then the mother of the deceased was accused to be a witch so she was blamed for being the cause of the death.

Participant (FP<5)1: I have not heard of it before but it nearly happened to me. What happed was that I went to give birth at Comboni Hospital in 2011. I bled profusely that I nearly loss my life but it took the tireless effort of doctor Cham to save me. That was what happened to me.

Moderator: Who else.

Participant 2(FP<5): I got pregnant and had a miscarriage in the sixth month. I got pregnant again and gave birth in the ninth month but unfortunately, I lost the baby after three weeks. That was my experience. In this village, maternal mortality is not common but I have seen a lot in Afram Plains.

Participant 3(FP<5): I got pregnant and gave birth on the due day. But I gave birth in the morning and in the evening, I started bleeding to the extent that I could not walk out of the washroom; I was served food and water in the washroom. When I forced myself to get out of the bathroom into the living room, I collapsed and a big clot of blood got expelled from me. I went into coma and came back to myself later. I took the medicines I was given and with the help of family members, I came back to life.

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON RESPONSES FOR PERCEPTION OF RISK IN PREGNANCY

Moderator: In your view, what can make a woman lose her life during pregnancy?
(TAIII)Participant: Lack of good nutrition which can cause anaemia. Sometimes too I think quarrels between husband and wives whiles the woman is pregnant and this will lead the woman to be worrying so I think stress from the family is also a factor.
(AM) Participant: When the pregnant woman is not attending hospital for her to be monitored well, it can put her at risk.
(HT)Participant: sometimes some of them don't eat proper food**.** Some of them to don't take proper care of the women. Some of the women do so much hard work even whiles pregnant.
TA: Yes, I have observed that some people do not pay attention to the food they eat during pregnancy. They usually say that "food is food" and so they eat anyhow during pregnancy. Some people eat and in less than 30 mins they go and sleep. Personally I think that this is not the best.

TA: Some women don’t get time to rest. They move around the whole day. They feel that when they get pregnant they have to be morning around the whole day.
(MP>5)Participant: There are others who do not go for Ante-natal check-up. As a result problems or complications that may concern the pregnancy are not detected early. Most at times, the mothers lack blood and because they do not attend anti-natal anaemia is diagnosed very late and if God does not intervene, the unexpected happens. It happened to one of our siblings; at the point of delivery, when she needed blood to enable her to give birth, we were not having money so I had to quickly donate my blood to save her.
(MP>5)Participant: Not really. But I will attribute it to laziness on the part of both the mother and father of the baby; laziness to go for check up to see if mother and baby are in good condition.
(M>35)Participant: In my view, lack of money or poverty could be a serious risk to maternal mortality. Ideally, when a pregnant woman is sick she should be taken to the hospital. But where there is no money to send her to the hospital she is kept at home and

treated with herbal concoctions until the conditions get critical and then the person is rushed to the hospital at which time it becomes too late. This is what I have observed to be the risk to maternal mortality.
(M>35)Participant: Usually every pregnant woman is supposed to attend ANC but the motivation to attend ANC is lacking in our community. In this community, it is only when the worst happens that you get assistance.
(M>35)Participant: In addition to what has been identified. Some pregnant women refuse to take medicines that are given to them at ANC. The medicines are given for the woman to take in order for the baby to grow well and healthy so refusal to take medicines can result in complications during birth.
(M>35)Participant: They do. But some pregnant women still refuse to take the medicines . It is said that one does not take medicine on behalf of a sick person.
(M>35)Participant: When women continue to defy the instruction of their husbands to

take medicines given to them at ANC, we will continue to have the risks.
(M>35)Participant: I can’t really tell.
(W>35)Participant 1: Anaemia.
(W>35)Participant 2: Not attendance to ANC.
(W>35)Participant 3: Eating non nutritious foods.
(W>35)Participant 4: Neglect by the husband.
(W>35)Participant 5: Refusal of the partner to accept responsibility for the pregnancy.
(W>35)Participant 6: Loss of your husband or a close relative whiles pregnant.
Participant(W<35): There are women who sleep with other men during pregnancy and it is believed that, when such women are due for delivery, the elders must sprinkle grains of maize in the air before they could give birth easily and safely.
Moderator(W<35): Does that mean that if the sprinkling of grain ritual is not performed the woman will die with the baby?
Participant(W<35): Yes that is the belief.
Moderator: Is the practice still existing currently and is it relevant?

Participant(W<35): I can’t really tell.
Participant(W<35): Some of the causes of maternal death can be attributed to the work of demons and evil forces. There are others that are as a result of misfortune. In this instances, it takes the grace of God for the woman to deliver safely.
Participant(W<35): There are others who do not attend ANC when they get pregnant. When you get pregnant, you must visit the hospital regularly for you to be checked so that if there are problems, they will be attended to early by health personnel. If this is not done, it then results in birth complications.
There are women who sleep with other men during pregnancy and it is believed that, when such women are due for delivery, the elders must sprinkle grains of maize in the air before they could give birth easily and safely.
Moderator(W<35): Does that mean that if the sprinkling of grain ritual is not performed the woman will die with the baby?
Participant(W<35): Yes that is the belief.
Moderator: Is the practice still existing currently and is it relevant?
Participant(W<35): I can’t really tell.
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COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AND HP AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON PLANNING OF AMA AND HP PREGNANCIES

Moderator(W<35): What do you think we can put in place in Fieve here to ensure that women do not get pregnant after 35years and also for those who have more than five children to stop giving birth.
Participant(W<35): I think that a policy must be put in place so that when such women go to the hospital and it is observed that they have given birth to more than necessary, their wombs will be sealed secretly.
Moderator: We cannot just seal the womb without the concern of your husband or relatives because in future, there could be legal implications where you will deny ever asking for the womb to be sealed or removed. So, your husband or relatives must be involved in this process.
Participant(W<35): Family planning education must be given to such women.
Moderator: What do you think health workers should do to assist women who get pregnant at the age of 35 and above in order to eliminate maternal mortality?
Participant(W<35): The health workers should assist them in family planning methods.

Moderator: Do we put up some behaviours that deter them from accessing our health facilities?
Participant(W<35): (They could not give any response).
Moderator: What do you think we can do to help you?
Participants(W<35): Nurses and other health workers should have patience for the clients who patronize the ANC. They should talk to them in an encouraging manner. Do not shout at them. Most nurses and midwives do not treat pregnant women with care. Mostly, the younger nurses and midwives are culpable of this offence. When the pregnant woman is humiliated or abused verbally, she will not return to attend ANC again. She will stay and give birth at home.
Moderator: For those who have been pregnant above the age of 35 did you feel different compared to the previous ones, did you imagine yourself to be pregnant at that time and did you attend ANC and how did you feel?
(W>35)Participant: Six of the participants answered this question of which three said their late maternal aged pregnancy was smoother than the earlier ones whiles three also said the late maternal age one they had after 35 years was more stressful with frequent visits to the health facilities. However, all three of them attended ANC and delivered at the hospital whiles the former three, two delivered at home.
(W>35)Participant: Now the entire six respondents said they did not plan on getting

pregnant at a late maternal age but it just happened
Moderator: Did you attend ANC with those pregnancies?
(W>35)Participant: Out of the six respondents, four said they attended ANC whiles two did not.
Moderator: Thank you. But moving forward, do you think that women above 35 should give birth in future. I would be those who say ''yes'' and those who say, ''no''. Both sides should give their reasons as well what is the way forward.
(M>35)Participant: A woman at that age must plan with the husband to ensure that they both do not go through unnecessary stress as a result of child birth. Both spouses must plan.
Moderator: How is this achievable?
(M>35)Participant: What we see as good in our community is usually not the case with you the health workers. No other person can advise us on health issues than our doctors and health workers so we must pay heed to their advice.
Moderator: What is it that the doctors and nurses are doing which is not encouraging women to give birth at age 35 and above?

(M>35)Participant: I have already mentioned the hospital charges. But another one is that some doctors connive with some women and without the knowledge of their husband take injections for family planning. This brings confusion in marriages. I will suggest that though not all men will understand issues with family planning but more education should be given in that direction.

(M>35)Participant: There are others who also do not take family planning education serious. They make remarks such as, ‘‘even if I give birth to many children is it the doctor who will cater for them for me?’’

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AND HP AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON PERCEPTION OF FUTURE PLANS TO IMPROVE AMA AND HP PRACTICES

(W>35)Participant 6: A CHPS compound should be opened in the community to serve as first contact and in cases of emergencies to help prevent maternal death.
Moderator: What is it that the doctors and nurses are doing which is not encouraging women to give birth at age 35 and above?
(M>35)Participant: I have already mentioned the hospital charges. But another one is that some doctors connive with some women and without the knowledge of their husband take injections for family planning. This brings confusion in marriages. I will suggest that though not all men will understand issues with family planning but more education should be given in that direction.
(M>35)Participant: There are others who also do not take family planning education serious. They make remarks such as, ‘‘even if I give birth to many children is it the

doctor who will cater for them for me?’’
(M>35)Participant: Giving birth to a lot of children can lead to early death of parents. Parents with many children would have to be thinking of how and what they will be providing for their numerous children as a result they (the parents) suffer from depression and die early. That is why I will recommend family planning.
Moderator: It means someone recommended Family Planning but another complained that it delays child birth.
(M>35)Participant: Another cause of women giving birth after age 35 is women leaving one husband to marry another.
Moderator: And what do you think is forcing the women to leave their husbands.
(M>35)Participant: Most at time the fault comes from our end. When men begin to have extra marital affairs with other women, they neglect the woman in the house. They tend to spend more on the new woman than they do their real wives. When the wife cannot bear it again, she leaves.
Moderator: Most reforms at the hospital, especially, those at the ANC were made out of

suggestions from clients like you. So feel free to make your input.
Participant(FP<5): I will strongly advocate for the construction of a health post for us.
Participant(FP<5): I suggest that some preferential treatment be given to pregnant women when they get to the hospital. This could be in the preparation of health insurance form and collection of drugs.
Moderator: Usually, the area of delay now is with the filling of the health Insurance forms but we will work on that as well. This can happen if we get more workers.
Participant(FP<5): I want to plead that a different section be created at the laboratory for pregnant women because it is another place where pregnant women waste time.
Moderator: There is always pressure on our laboratory machines so it will be a bit difficult. But we will still find a way out.
Participant : The clinic is still dear to our heart.
Moderator: We have heard your concern but for the clinic, it will all depend on your commitment as a town. You must work hard and provides the basic facilities. Thank you.

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AND HP AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON COMMUNITY PERCEPTION OF HIGH PARITY AS A MATERNAL MORTALITY RISK FACTOR

I agree it is not good.
Moderator: Why do you think it is not good?
Participant(W<35): It is not good because you can't take good care of all of them.
Participant: If you give birth to plenty, you make the children suffer.
Moderator(W<35): Then I think that you are all agreeing finally that it is not good to give birth to more than five children.
Participants(W<35): Yes.
: What are your perceptions on parity 5 and above?
Participants gave a chorus answer that it is normal for a woman to have the number of children she wants.
(W>35)Participant: "i don't see the need for giving birth to so many children in today's hardship where you cannot take proper care of them".
(W>35)Participant: in the olden days it was a pride to have more children but now there

is no benefit in it.
Moderator: Is there anything in the community that facilitates or discourages high parity?
(W>35)Participant: One participant said The response from participants was NO.
Moderator: for those with parity 5 and above did you feel any different?
Moderator: For those who did not imagine having parity 5 or above, what might be the reason for the other children?
(W>35)Participant 1: Since God has giving it to you, you cannot refuse it.
(W>35)Participant 2: For me it just happened because I was not expecting it.
(W>35)Participant 3: I have no control of the number of children to give birth to because it is God who decides.
Moderator: Did you attend ANC with your last pregnancies, for those with parity 5 and above?
(W>35)Participant 1: Yes I did.
(W>35)Participant 2: Yes I did.
(W>35)Participant 3: No all my deliveries were done at home.
Moderator: How did you feel when attending ANC?
(W>35)Participant 1: The young once of today will just be gossiping about the person.

(W>35)Participant 2: Sometimes at the hospital some comments from the staffs is that we are giving birth to too many children hence the abandonment of ANC.
(M>35)Participant: From my experience, my mother gave birth o nine of us but she was full of strength till she died but one thing I observed was that during their time they ate good food which were in their natural state with chemicals. This therefore, made them healthy. These days however, the food we eat do not enhance quality health so as to allow us live long.
Moderator: So in your looking at current trend, how many children should a woman give birth to?
(M>35)Participant: I cannot really give a specific number.
Moderator: What are the effects of having many children.
(M>35)Participants (Different): It is not good to have many children but I think six or seven children should be enough.
Moderator: Why would you advocate for a lesser number of children.

(M>35)Participant: So that both mother and children will remain healthy. The woman especially, must have the strength to cater for the children. If on the other hand the woman is not healthy the children will suffer.

Moderator: So when a woman gives birth one or two do you think it is ok?

(M>35)Participants: (**Chorus Response**): It is ok.

Moderator: Is there anything in the community that makes it easier for women to give birth to more?

Because in some communities women are given certain food or herbs that make them produce more children. Do we find such acts here?

(M>35)Participant: In our town here there is nothing that is given to women to enable them give birth to more children. But this days you will find out that the young girls are promiscuous. When it comes to having sex, hence even when they are in school, most of them start giving birth and this results in they having a lot of children; because they began early.

Moderator: In the past, there was this effort to have children so that they could assist parents on the farm. Does this apply today?

(M>35)Participant: It is no more the case today. Because children do not work on the farms again, they go to school and taking care of children in school now is very experience and the means is hard to come by.

Therefore, if you have many children in school it becomes a burden on you the parents. Because of this women nowadays give birth to a few and stop. But this must be a mutual agreement between the two spouses.

(M>35)Participant: To add to what the earlier speaker had said, catering for a larger number of children requires a lot of financial commitment which is not easy to meet. For example if you give birth to ten children and all of them are in school, it will be very difficult to fulfill all your financial commitment and other commitments towards them. That is why giving birth to many children can have a lot of negative ramifications.

It is good in some instances but it is not good in other instances.

Participant(FP<5): I think that because of education now we need to give birth to a few children; at least three or four is ok. So that they can attend school and become responsible children.

Moderator: Another person's view

Participant(FP<5): Somebody can give birth to ten but she will be able to cater for them and they will become responsible in life but there is somebody who will give birth to three but may not be able to take good care of them. So in my view, parents should give

birth to children based on their ability and financial strength. So the decision to have more or a few should vary.
it is the case with some people. But in this time and age, where education is important to parents, this nation is not applicable. It is advisable to give birth to children you can adequately take care off.
(MP>5)Participant 5: Yes it need to be the situation in the past but now, because of formal education, children are sent to school instead of farm and taking care of children in school is expensive so most parents wouldn’t want to have many children.
What about having 5 or more children put the woman at risk when she gets pregnant ageing?
(TAIII)Participant: Yes it can because she cannot be able to look after the children well.
Moderator: What about the woman herself, is there risk to the pregnant woman?
(TAIII)Participant: Yes because if you have more children and you cannot look after them well and you get pregnant again, she will be thinking about the one it the womb which can affect her.
Moderator: Is there a situation where someone would like to give birth to so many

children in order to help in the farm as we may have heard elsewhere?
(AM) Participant: No, but in the olden days yes but now because of the difficulties no one is doing that again in the community.
(HT) Participant: Yes because in those years the conditions were better than now. Taking care of the children and their schooling, so if you have 3 you would be able to cater for them.
TA: Personally I think that if you give birth more it puts you at risk. It is just like you are…. It is a journey so at some point in time there is bound to be a problem. So when you are giving birth to 5,6, and some to even 10 children. They are bound to face problems on the way.

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON RESPONSES FOR PERCEPTION OF RISK IN PREGNANCY

Moderator: In your view, what can make a woman lose her life during pregnancy?
(TAIII)Participant: Lack of good nutrition which can cause anaemia. Sometimes too I think quarrels between husband and wives whiles the woman is pregnant and this will lead the woman to be worrying so I think stress from the family is also a factor.
(AM) Participant: When the pregnant woman is not attending hospital for her to be monitored well, it can put her at risk.
(HT)Participant: sometimes some of them don't eat proper food**.** Some of them to don't take proper care of the women. Some of the women do so much hard work even whiles pregnant.
TA: Yes, I have observed that some people do not pay attention to the food they eat during pregnancy. They usually say that "food is food" and so they eat anyhow during pregnancy. Some people eat and in less than 30 mins they go and sleep. Personally I think that this is not the best.

TA: Some women don’t get time to rest. They move around the whole day. They feel that when they get pregnant they have to be morning around the whole day.
(MP>5)Participant: There are others who do not go for Ante-natal check-up. As a result problems or complications that may concern the pregnancy are not detected early. Most at times, the mothers lack blood and because they do not attend anti-natal anaemia is diagnosed very late and if God does not intervene, the unexpected happens. It happened to one of our siblings; at the point of delivery, when she needed blood to enable her to give birth, we were not having money so I had to quickly donate my blood to save her.
(MP>5)Participant: Not really. But I will attribute it to laziness on the part of both the mother and father of the baby; laziness to go for check up to see if mother and baby are in good condition.
(M>35)Participant: In my view, lack of money or poverty could be a serious risk to maternal mortality. Ideally, when a pregnant woman is sick she should be taken to the hospital. But where there is no money to send her to the hospital she is kept at home and

treated with herbal concoctions until the conditions get critical and then the person is rushed to the hospital at which time it becomes too late. This is what I have observed to be the risk to maternal mortality.
(M>35)Participant: Usually every pregnant woman is supposed to attend ANC but the motivation to attend ANC is lacking in our community. In this community, it is only when the worst happens that you get assistance.
(M>35)Participant: In addition to what has been identified. Some pregnant women refuse to take medicines that are given to them at ANC. The medicines are given for the woman to take in order for the baby to grow well and healthy so refusal to take medicines can result in complications during birth.
(M>35)Participant: They do. But some pregnant women still refuse to take the medicines . It is said that one does not take medicine on behalf of a sick person.
(M>35)Participant: When women continue to defy the instruction of their husbands to

take medicines given to them at ANC, we will continue to have the risks.
(M>35)Participant: I can’t really tell.
(W>35)Participant 1: Anaemia.
(W>35)Participant 2: Not attendance to ANC.
(W>35)Participant 3: Eating non nutritious foods.
(W>35)Participant 4: Neglect by the husband.
(W>35)Participant 5: Refusal of the partner to accept responsibility for the pregnancy.
(W>35)Participant 6: Loss of your husband or a close relative whiles pregnant.

COMMUNITY PERCEPTION OF ADVANCED MATERNAL AGE AND HP AS A MATERNAL MORTALITY RISK FACTOR IN THE SOUTH TONGU DISTRICT OF VOLTA REGION

A QUALITATIVE STUDY

DATA TABLE ON COMMUNITY PERCEPTION OF AGE AS A MATERNAL MORTALITY RISK FACTOR

(W>35)Participant 1: Maternal age cannot be a factor for maternal death
as one can give birth for as long as God grants it.
(W>35)Participant 2: Yes I think it can be a risk so I think the cut off age for child for women should be 50 years.
(W>35)Participant 3: As you are growing the womb becomes weak so by age 30 a woman should have stop child bearing but if she is not having any then she can give birth when she gets it.
(W>35)Participant 4: It won't be a risk so 50 years will be ok for a woman to cut off child birth because after that age you cannot work to look after the children well.
(W>35)Participant 5: For those who began child bearing early, should quit by age 45 as by then their body becomes weak.
(W>35)Participant 6: Yes the age a woman gets pregnant can be a risk factor because the body grows and becomes weak so I think the cut off age for child birth for women

should be between 40 and 50 years.
(W>35)Participant 7: No it is God who gives children so it does not matter, however 50 to 60 years can be set as a cut off age for child birth.
(W>35)Participant 8: Don't really have an idea on it but thinks that the cut off age should be around 40 years.
1. Maternal age perception
Moderator: How do you perceive being pregnant at age 35 and above? For those in favor what are the perceived benefits and those against what are the reasons?
(W>35)Participant: There was a common response from the participants that since it is God who gives children and so there is nothing wrong with and that it is normal
(W>35)Participant: One other participant said giving birth after the age of 35 above is bad because by that time the body is becoming weak and the womb becomes tired.
Moderator: Is there any community factor that discourages or facilitates pregnancy above the age of 35?
(W>35)Participant: General response from the participants was NO.
Moderator: For those who have been pregnant above the age of 35 did you feel different compared to the previous ones, did you imagine yourself to be pregnant at that time and did you attend ANC and how did you feel?
(W>35)Participant: Six of the participants answered this question of which three said

their late maternal aged pregnancy was smoother than the earlier ones whiles three also said the late maternal age one they had after 35 years was more stressful with frequent visits to the health facilities. However, all three of them attended ANC and delivered at the hospital whiles the former three, two delivered at home.

(W>35)Participant: Now the entire six respondents said they did not plan on getting pregnant at a late maternal age but it just happened

Moderator: Did you attend ANC with those pregnancies?

(W>35)Participant: Out of the six respondents, four said they attended ANC whiles two did not.

(M>35)Participants: All agreed that age counts.

(M>35)Participant 1: There are stages that when a woman gets to she must not get pregnant. For a example when the HB of a woman drops, she could face a lot of complications in pregnancy.

Moderator: If this is the case, then what age should a woman stop giving birth.

(M>35)Participant: In the era we are now, when the woman attains age 30 and above.

(M>35)Participant: Generally, women have a shorter life span so when they are able to give birth to three or four child, they must stop.
Moderator: Our focus is on the age.
(M>35)Participant: Yes. So a woman must stop giving birth by age 35. If you should force it, the at most by forty every woman should stop having babies. However there are others who are to carry babies beyond age 40. These women grow weak.
(M>35)Participant: From my point of view, before a man and a woman start giving birth, the woman especially should not start at age 18.
Moderator: Why?
(M>35)Participant: Because at that age, the woman may manage its associated stress. So ideally a woman should start giving birth at age 22. Yes . At this age the woman is fully grown and ready to carry pregnancy and eliminate maternal death and forty she should stop giving birth.
(MP>5)Participant: From my experience that I shared earlier my wife was forty-years and was going to give birth to the ninth child when the unfortunate happened.

Moderator: So what do you attribute the loss of the baby to?
(MP>5)Participant: I will attribute it to our inability to get to the health facility early.
Moderator: What about the age of your wife at the time? Don’t you see anything wrong with the age at which your wife was still giving birth?
(MP>5)Participant: Yes: but because we were enjoying sex, we were not looking at the health implications of having children at that age. **(MP>5)Participant 4:** Also, some mothers as they grow would want to abort unwanted pregnancies and this affect the child and the mother at birth.
(TAIII)Participant: No because the church which I attend, there are members the church of age 50 who are pregnant and are being prayed for.
Moderator: What about having 5 or more children put the woman at risk when she gets pregnant ageing?
(TAIII)Participant: Yes it can because she cannot be able to look after the children well.

Moderator: What about the woman herself, is there risk to the pregnant woman?
(TAIII)Participant: Yes because if you have more children and you cannot look after them well and you get pregnant again, she will be thinking about the one it the womb which can affect her.
(AM) Participant: A woman should start by age 18 through to 45 years.
Moderator: what is your reason for that age?
(AM) Participant: Because from that time the woman may not have the energy to carry the pregnancy well.
Moderator: Is there any community that makes it easier to get pregnant at age 35 and above.
(AM) Participant: Sometimes it is due to late marriage or re-marriage at a later age.
(HT)Participant: Yes and that is when the woman is young the risk is low but when old it gets high. But also those girls who get pregnant without knowing the man responsible for it don't get the care and support that they need making some of them do all sorts of things to the pregnancy leading to their death.
Moderator: At what age in your opinion would you say women should start giving birth and when should they stop?
(HT)Participant: Below 18 years should not get pregnant and above 35 years.
Moderator: Is there a reason for these selected age limits?

(HT)Participant: The 18 is because at that age the body has not developed well to carry a pregnancy and the 35 the person is old and may not be doing any proper work to look after the children.
TA: yes. Out of the 4 women I mentioned, 2 were below 18 years. They did not visit the hospital regularly and were rushed to hospital when it was too late. So I think that age below 21 years, especially among school girls.
MC: What about the upper limit of age. Do you have any experience of that being a risk?
TA: Yes, Another one of the pregnant women I knew who lost her life was 54 years old. She also did not visit the hospital regularly. So personally, I think that age above 55 I don't think that it will be appropriate to have kids. Looking at another aspect of it, when you give birth, definitely you are the person going to look after that person during their school days. So if you give birth at the age of 55, and you will retire at 60, how will you look after these late children that you have brought forth?