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Conducting Home Visits and Providing Counseling and Contraceptive Services to Young Women, Including First-Time Mothers in Akwa Ibom, Nigeria

A Supplemental Training Module for

COMMUNITY HEALTH EXTENSION WORKERS



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Acronyms and Abbreviations

DHS	Demographic and Health Survey
FTP	First-time parent
HTSP	Healthy timing and spacing of pregnancy
SRH	Sexual and reproductive health

Notes for Organizers and Trainers

Background

Nigeria is the most populous country in sub-Saharan Africa. The majority of Nigerians are below the age of 25 years, with 22 percent of the country's population between the ages of 10-19 years. At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality.¹ Globally, adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child. These international findings have been confirmed by studies conducted in Nigeria.² In addition, childbearing during adolescence frequently has adverse social consequences for young mothers, particularly regarding educational attainment, as well as social exclusion. Across Nigeria, 23 percent of adolescent girls aged 15-19 have begun childbearing. In Akwa Ibom, 17.9 percent of adolescent girls have started childbearing.³ Data show that the average age at sexual debut among adolescent mothers in Nigeria is 15 years of age.⁴ Contraceptive prevalence rates among adolescents and young women in Nigeria remains low. Only 1.2 percent of married adolescent girls (15–19) and 6.2 percent of married young women (20-24) currently use a modern method of contraception – much lower than the contraceptive prevalence among older married women. For unmarried sexually active adolescents (15-19) and young women (20-24), 49.7 percent and 63.5 percent, respectively, currently use a modern method of contraception.⁵ Unmet need for contraceptive among adolescents and young women (15-24 yrs.) is also important to note: 19.8 percent of married young women and 33.2 percent of sexually active unmarried young women in Nigeria have an unmet need for contraception.⁶

In addition, Nigeria's population is highly affected by HIV, with an estimated 3.4 million people living with HIV.⁷ The HIV prevalence rate of 6.5% in Akwa Ibom far exceeds the national prevalence rate of 3.5 percent.⁸ Socio-demographic differences in the HIV prevalence are observable across Nigeria with women, youths, and people with low level of formal education being worst affected by the epidemic. NARHS plus 2012 showed an increase from 1.7 percent in 2007 to 2.9% in 2012 in the 15-19 years age group while the prevalence for the age category (20-24) for both years remain the

¹ NPC (National Population Commission [Nigeria]) and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

World Bank. Trends in maternal mortality: 1990-2010. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. 2012 <http://data.worldbank.org/indicator/SH.STA.MMRT>. Accessed 25 October, 2015.

² Loto O.M, et al. 2004. "Poor Obstetric Performance of Teenagers: is it Age- or Quality of Care-related?" *J Obstet Gynaecol*, 24(4):395-8

³ NPC (National Population Commission [Nigeria]) and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

⁴ NPC (National Population Commission [Nigeria]) and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

⁵ NPC (National Population Commission [Nigeria]) and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

⁶ NPC (National Population Commission [Nigeria]) and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

⁷ UNAIDS. 2014. HIV and AIDS estimates (2014). <http://www.unaids.org/en/regionscountries/countries/nigeria> Accessed 25 October, 2015.

⁸ National Agency for the Control of AIDS (NACA). 2015. Global AIDS Response: Country Progress Report Nigeria GARPR 2015. Abuja: NACA.

same with a value of 3.2 percent.⁹ Gender inequality is an important driver for HIV among young people in Nigeria. The HIV prevalence rates among adolescent girls and young women until age 34 are higher than their male counterparts.

Within this context, first-time mothers, defined as young women below the age of 25 with one child or who are pregnant for the first time, face a unique set of challenges to living healthy sexual and reproductive lives. Most of these challenges are different from older women who have multiple children. First-time mothers often lack sufficient and accurate information about their sexual and reproductive health, as well as maternal and child health. They are also less likely to access maternal health care, specifically antenatal and postnatal care, as well as skilled birth attendance.¹⁰ As noted above, contraceptive prevalence among adolescents and young women remains low in Nigeria. First-time mothers are also less likely to use contraception than those who have three or more children.¹¹

The limited use of sexual and reproductive health services among first-time mothers, including contraceptive services, is partly due to the fact that many young women do not have control over decision-making about their sexual and reproductive health. Often key influencers, such as parents, husbands or male partners, in-laws, co-wives, community and family elders and religious leaders drive household decision-making, including those related to sexual and reproductive health (SRH) and contraceptive use. In addition, unmarried first-time mothers often face additional stigma and discrimination, which further prevents them from accessing important sexual and reproductive health information and services. These unequal power dynamics and gender inequalities place young women and girls in Nigeria at particular risk of gender-based violence and HIV, as well as early or closely spaced pregnancies and child-bearing—all of which increase the risk of maternal mortality and morbidity for young women and increase of the risk of infant mortality for their children.¹² Furthermore, first-time mothers—both married and unmarried - can quickly become isolated, with household responsibilities and limitations on their mobility, keeping them at home and away from health information and services and from supportive social networks.

Investing in the human capital of young women, including their health, is important for boosting Nigeria's long-term development prosperity. This requires a focus on adolescent sexual and reproductive health, including for first-time mothers.

⁹ National Agency for the Control of AIDS (NACA). 2015. Global AIDS Response: Country Progress Report Nigeria GARPR 2015. Abuja: NACA.

¹⁰ Suleiman Adamu, H. 2011. Utilization of Maternal Health Care Services in Nigeria: An Analysis of Regional Differences in the Patterns and Determinants of Maternal Health Care Use. Dissertation. April 2011. University of Liverpool, United Kingdom

¹¹ National Agency for the Control of AIDS (NACA). 2015. Global AIDS Response: Country Progress Report Nigeria GARPR 2015. Abuja: NACA.

¹² Extending Service Delivery Project. Healthy Timing and Spacing 101 Brief (see Handout 4-1). Washington, DC

Purpose

The goal of the supplemental training module is two-fold:

1. Improve Community Health Extension Workers' capacity to offer high-quality, non-judgmental sexual and reproductive health/family planning (SRH/FP) counseling and contraceptive services to young women (10-24), in particular first-time mothers, through home visits.
2. Improve Community Health Extension Workers' capacity to provide SRH/FP information and counseling to the key influencers (including husbands/male partners, in-laws, parents and other influential household members) who influence young women's decision-making about SRH/FP through home visits and community activities.

For the purposes of this training module, "first-time mothers" refers to young women under 25 years old who have one child or are pregnant for the first time. The term "first-time parents" refers to first-time mothers and their male partners.

This supplemental one-day training is designed for Community Health Extension Workers who have already been trained in family planning, reproductive health, and client counseling. The module can be used as part of a comprehensive SRH training or it can be used as a one-day refresher training.

Learning objectives

At the end of this one-day supplemental training, participants will be able to:

1. Describe the specific challenges first-time mothers face in living healthy reproductive lives.
2. Identify people who influence young women, including first-time mothers' reproductive health decision-making (referred to as "key influencers").
3. Explain the three main messages of healthy timing and spacing of pregnancies (HTSP).
4. Explain at least three characteristics and three competencies for youth-friendly service delivery.
5. Demonstrate skills for age- and life-stage-appropriate and nonjudgmental counseling and contraceptive services for young women, including first-time mothers.
6. Demonstrate skills to counsel key influencers about HTSP and family planning (e.g., husbands/partners, mothers-in-law, and others).

Components of the module

This supplemental module includes the trainer's guide (this document), participant handouts (see Annex I of this document), and a PowerPoint Presentation that can be used if the trainer so desires.

The activities in this supplemental module should be contextually adapted to meet the specific needs of the each group of participants. The module includes an illustrative training schedule, which can also be adapted according to participants' needs.

This training module was designed for 15-25 participants. If there are more than 25 participants, the trainer will need to modify some of the activities.

Overview of sessions

Session and activities	Duration	Supporting resources
Session 1: Introduction to the Module	30 minutes	Slide S1-1 Participant Handout 1-1
Session 2: Understanding the needs and challenges of young women	75 minutes	Participant Handout 2 Slide S2-2
Session 3: Attitudes and values towards first-time mothers, fertility, and contraception	60 minutes	
Session 4: Healthy Timing and Spacing of Pregnancy	90 minutes	Slide S4-1a, S4-1b Participant Handout 4-1
Session 5: Youth-friendly services characteristics and core competencies	60 minutes	Slides S5-1a, S5-1b, S5-1c
Session 6: Counseling first-time mothers and key influencers	90 minutes	Participant Handout 6-2a, 6-2b, 6-2c
Session 7: Reflection and Conclusion	15 minutes	
Total time	420 minutes (7 hours)	

Illustrative training schedule

This supplemental module is designed to be used with Community Health Extension Workers who have already been trained in family planning, reproductive health, and counseling skills. This one-day module can be used as part of a comprehensive reproductive health training, or it can be used as a one-day refresher training. The schedule below is illustrative and can be modified by the trainers to fit the circumstances of the training.

Illustrative Training Schedule

Time	Session and activities
8:00-8:30	Session 1: Introduction to the Module
8:30 – 9:45	Session 2: Understanding the needs and challenges of first-time mothers Activity 2-1
9:45 – 10:45	Session 3: Attitudes and values towards first-time mothers, fertility, and contraception
10:45 – 11:00	Break
11:30-13:00	Session 4: Health Timing and Spacing of Pregnancy
1:00-2:00	Lunch
2:00-3:00	Session 5: Youth-friendly services characteristics and core competencies
3:00 – 4:30	Session 6: Counseling first-time mothers and key influencers
4:30-5:00	Session 7: Reflection and Conclusion

Session I: Introduction to the Module

Objective of the session:

- I. Introduce participants to the supplemental training module.

Before the training, the trainer should:

- Review the training content and familiarize yourself with the material and methodologies.
- Adapt introduction [Slide I-1](#) as necessary.
- Print [Participant Handout I-1: Training Schedule](#) for all participants.

Total session time: 30 minutes

Activity 1-1: Introduce the participants to the supplemental training module

Time: 20 minutes

Methodology: Trainer presentation

The trainer should:

I. Introduce the session by reading aloud this content to the participants:

The majority of Nigerians are below the age of 25 years, with 22 percent of the country's population between the ages of 10-19 years. At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality. Globally, adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child. These global findings have been confirmed by studies conducted in Nigeria. In addition, childbearing during adolescence frequently has adverse social consequences, particularly regarding educational attainment, as well as social exclusion.

Across Nigeria, 23 percent of adolescent girls aged 15-19 have begun childbearing. In Akwa Ibom, 17.9 percent of adolescent girls have started childbearing. Data show that the average age at sexual debut among adolescent mothers in Nigeria is 15 years of age. Contraceptive prevalence rates among adolescents and young women in Nigeria remains low. Only 1.2 percent of married adolescent girls (15-19) and 6.2 percent of married young women (20-24) currently use a modern method of contraception – much lower than the contraceptive prevalence among older married women. For unmarried sexually active adolescents (15-19) and young women (20-24), 49.7 percent and 63.5 percent, respectively, currently use a modern method of contraception. Unmet need for contraceptive among adolescents and young women (15 -24 yrs.) is also important to note – 19.8 percent of married young women and 33.2 percent of sexually active unmarried young women in Nigeria have an unmet need for contraception.

In addition, Nigeria's population is highly affected by HIV, with an estimated 3.4 million people living with HIV. The HIV prevalence rate of 6.5 percent in Akwa Ibom far exceeds the national prevalence rate of 3.5 percent. Socio-demographic differences in the HIV prevalence are observable across Nigeria with women, youths, and people with low level of formal education being worst affected by the epidemic. NARHS plus 2012 showed an increase from 1.7 percent in 2007 to 2.9% in 2012 in the 15-19 years age group while the prevalence for the age category (20-24) for both years remain the same with a value of 3.2 percent. Gender inequality is an important driver for HIV among young people in Nigeria. The HIV prevalence rates among adolescent girls and young women until age 34 are higher than their male counterparts.

In your role as a Community Health Extension Worker with this project, you will be asked to conduct home visits to young women, with a focus on first-time mothers, to counsel them on family planning and provide contraceptive services to those who choose to use a method. You may also be asked to conduct group counseling and education sessions with husbands/partners, mothers-in-law, and other household influencers. This module will provide an opportunity for further exploration of the specific challenges that young women, particularly first-time mothers, face in living healthy reproductive lives. The module also aims to equip you with the skills needed to provide counseling

and contraceptive services to first-time mothers, as well as encourage behaviors that lead to the healthy timing and spacing of pregnancies.

1. Display Slide SI-1 (Session 1, Slide 1) and explain the training objectives using the content below:

At the end of this 2-day supplemental training, you will be able to:

1. Describe the specific challenges first-time mothers face in living healthy reproductive lives.
2. Identify the key influencers that influence young women including first-time mothers' reproductive health decision-making.
3. Explain the three main messages of healthy timing and spacing of pregnancies.
4. Explain at least three characteristics and three competencies for youth-friendly service delivery.
5. Demonstrate skills for age- and life-stage-appropriate and nonjudgmental counseling and contraceptive services for young women, including first-time mothers.
6. Demonstrate skills to counsel key influencers about healthy timing and spacing of pregnancies and family planning (e.g., husbands/partners, mothers-in-law, and others).

2. Ask participants if there are any questions.

3. Pass out and review: [Participant Handout I-1: Training Schedule](#).

Session 2: Understanding the Needs and Challenges of First-Time Mothers

Objectives of the session:

1. Understand the ways that community norms and different types of people influence the decisions of first-time mothers and their husbands or partners.
2. Increase awareness and understanding of the needs and challenges first-time mothers face in living healthy reproductive lives.
3. Describe why it is important to provide first-time mothers with comprehensive, non-judgmental reproductive health counseling and services.

Before the training, the trainer should:

- Review the training content.
- Prepare the following materials:
 - Flipchart paper
 - Masking tape
 - Chalk or something else that you can use to mark/draw on the floor
- Print **Participant Handout 2-1: Anna's Case Study**
- Prepare **Slide S2-2**.

Total session time: 75 minutes

- Activity 2-1: 45 minutes
- Activity 2-2: 30 minutes

Activity 2-1: Understand the challenges that young women, including first-time mothers, face in seeking reproductive health services in Akwa Ibom

Time: 45 minutes

Methodology: Case study and discussion

The trainer should:

1. Introduce the session by reading this content to the participants:

Let us now examine the kinds of pressures young women, including first-time mothers, face regarding child-bearing and explore the barriers that they face when trying to seek health services. I will read a case study about a young woman named Anna. As I read the case study, please write down each of the people who hold influence over Anna and the barriers that she faces while trying to access family planning services. The barriers can be within her home, her community, and at the health facility.

1. Pass out **Participant Handout 2-1: Anna's Case Study** and read the case study (found below) to participants. You can also ask different participants to take turns reading the case study aloud.
2. After reading the case study, ask participants to share some of the challenges they wrote down.
3. After participants have shared, lead a discussion with the participants and the people who influence Anna and Jonathan about their decisions related to fertility and contraception. Ask participants the following questions:

All around us are circles of influence: family and friends, community members, and society. People at each of these level influence a young woman's ability to make choices about when and if to have children. As a Community Health Extension Worker, it is your role to understand the different pressures a young woman might feel and offer counseling to help her navigate those different pressures.

- In the case study, how is Anna influenced or pressured by people around her?
 - Are there other people who were not mentioned in the case study who might have influence over Anna's decisions? (For example what kind of pressure might come from Jonathan's parents, Anna's friends, religious leaders, etc.)?
 - How might Jonathan be influenced or pressured by people around him? (For example what kind of pressure might come from Anna's parents, Jonathan's parents, Jonathan's friends, community leaders, etc.)?
4. After discussing the circles of influence around the young couple, lead a discussion with participants using the following questions:
 - Does this story reflect the realities of young women in Akwa Ibom? Why or why not?
 - What are some of the specific health needs of first-time mothers like Anna in Akwa Ibom?

- What do you think the Community Health Extension Worker in Anna's community could have done differently to prevent Anna from having this negative experience
- What support would be useful to Anna and other first-time mothers in Akwa Ibom at the community level?

5. Conclude the activity by reading this aloud:

When a young woman becomes a mother for the first time, her life and the life of her partner can change both positively and negatively. Depending on the person's support structure, culture, economic situation, and personal relationships, having a child can create challenges for which they may not be prepared. As we demonstrated with the first exercise and as we discussed in this case study, first-time mothers and their male partners often experience different pressures and influences compared to older couples, particularly around childbearing. As a Community Health Extension Worker, it is important to understand these pressures and provide supportive counseling for first-time mothers in order for them to live healthy reproductive and sexual lives.

Anna's Case Study (see also Participant Handout 2-1)

My name is Anna. I am seventeen years old. I have a baby girl who is one year old. Jonathan is my baby's father. We were dating and I got pregnant by accident. He has stayed with me and helps as much as he can with our daughter, but we're not married.

I love my baby girl, but I worry about her a lot since it seems like she is always sick. My mother keeps asking when we will have our next child. She says that it might convince Jonathan to marry me. She also says that my baby will start running everywhere soon, so it is time for a second child. I know I need to have another baby, especially because my first baby is a girl. But, I know that having another baby soon will be very hard for me and my little girl, since she has been so sick. It will mean that I will have to make the small amount of food we have stretch even further.

I heard you could take get a shot to avoid having a baby for 3 months, but I don't know anything about it. There are some Community Health Extension Workers in my community, but they are older women who are friends with my mother and I know she would disapprove if she knew I wanted to learn more about the medicine to prevent pregnancy. Jonathan might also disapprove, because he will think that I could be unfaithful to him if I get the shot.

I decided to try to go to the nearest health center. I hoped that I wouldn't see people I knew there. I told my mother that the baby was sick and walked the 10 km to the nearest health center. I went to the health center early in the morning because I needed to go back home and do household chores before it became too late in the day. When I arrived, there were several women waiting outside with many children. They kept looking at me.

The health center staff was late to arrive. I waited for one hour. When the facility opened, I got up enough courage to speak to the woman behind the table with a sign saying "Reception". She asked me why I was at the clinic when my baby wasn't sick. When I explained that I wanted to talk with the nurse about family planning, she made a disapproving face and just pointed to the consultation waiting area.

I waited for 2 hour near the family planning room. I hadn't eaten anything and my baby started to cry. I felt that all the older women were staring at me. One of the women recognized me. She is a friend of a my mothers and asked me why I was there since the family planning services are for married, older women who are ready to stop having children, not a young woman like myself.

I was finally called in to speak with one of the nurses. When I went into the consultation room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant so soon after my last baby and I had heard there was some kind of shot I could get. She asked if my

husband had given me permission to be there. I looked down and told her that I wasn't actually married and that I hadn't told Jonathan why I was here. The nurse scolded me for having a child before being married. She said "Why didn't you think about all of this before you decided to have sex outside of marriage? You made bad choices and now you have to deal with the consequences". I explained that my baby was sickly and it wouldn't be good for us to have another child so soon.

The nurse finally says that it is ok for me to use a method and says I should use the 3 month injectable, she didn't mention any other method options. I asked to have the injection right away, but she said that I would have to wait for it since the pharmacy at the clinic wasn't open. I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Anna, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including my mother's friend. I got my injection and left the clinic very embarrassed and worried.

Activity 2-2: Describe why it is important to offer comprehensive, non-judgmental services to first-time mothers

Time: 30 minutes

Methodology: Brainstorm and trainer presentation

The trainer should:

1. **Read the following to participants and as they brainstorm write their answers on flipchart paper.**

Now that we have discussed the different challenges first-time mothers face, let us brainstorm some reasons why it is important for Community Health Extension Workers to specifically offer first-time mothers in Akwa Ibom comprehensive, non-judgmental SRH counseling and support.

A first-time mother is a young woman under the age of 25 years who has one child or is pregnant for the first time. First-time mothers include both married and unmarried young women. Please share some ideas of why it is important to offer SRH counseling and services to this group of young women.

2. **After participants have answered, supplement their responses by showing [Slide S2-2](#) and reading this aloud:**

Reasons why it is important to offer young women and first-time mothers in Akwa Ibom comprehensive, non-judgmental SRH counseling and services:

- Young women who are married experience pressures from community, family, and husbands to bear children immediately and often and don't practice healthy timing and spacing of pregnancy.
- Unmarried young women who are pregnant or have a child often face stigma and discrimination, which limits their access to sexual and reproductive health information and services.
- First-time mothers often have very little power to negotiate use of health services, when and if to have children, use of contraception in their relationships. This is due to both gender inequality and age inequality.
- Young people who are married or in union and first-time parents are often ignored by other programs for youth, because they are often not in school and are less likely to be involved in community-based youth groups. Traditional adolescent and youth sexual and reproductive health programs are often geared toward unmarried adolescent boys and girls who do not have children and focus on pregnancy and HIV prevention.
- 23 percent of adolescent girls aged 15 – 19 in Nigeria have begun childbearing. In Akwa Ibom, 17.9 percent of adolescent girls have started childbearing.

- Data show that the average age at sexual debut among adolescent mothers in Nigeria is 15 years of age. Contraceptive prevalence rates among adolescents and young women in Nigeria remains low. Only 1.2 percent of married adolescent girls (15 – 19) and 6.2 percent of married young women (20 – 24) currently use a modern method of contraception – much lower than the contraceptive prevalence among older married women. For unmarried sexually active adolescents (15 – 19) and young women (20 – 24), 49.7 percent and 63.5 percent, respectively, currently use a modern method of contraception.
- Unmet need for contraceptive among adolescents and young women (15 -24 yrs.) is also important to note – 19.8 percent of married young women and 33.2 percent of sexually active unmarried young women in Nigeria have an unmet need for contraception.
- Young women and their husbands or partners are just beginning their relationships and reproductive lives together and this is an opportunity to develop lifelong healthy sexual and reproductive practices and better communication among couples.
- Promoting the delay of first births to age 18 and spacing of the second and subsequent births, in addition to joint decision-making and communication among first-time mothers and their male partners, can result in increased contraceptive use, lower lifetime fertility, reduced maternal mortality, and increased ability for first-time mothers to participate in education and economic opportunities.

Session 3: Attitudes and values towards first-time mothers, fertility, and contraception

Objective of the session:

1. Reflect on attitudes and values related to fertility, contraception, and decision making among first-time mothers and their husbands or partners.

Before the training, the trainer should:

- Review the training content.
- Make two signs for Activity 3-1 on flipchart paper. One sign that says “Agree” and one sign that says “Disagree.” Hang the signs on opposite sides of the room.

Total session time: 1 hour (60 minutes)

Activity 3-1: Exercise to reflect on views and beliefs related to first-time mothers, fertility, and contraception

Time: 60 minutes

Methodology: Game

The trainer should:

1. Explain to the following to participants:

This activity is designed to provide a time to reflect on your own and one another's values and attitudes about the reproductive health issues that young people, including first-time mothers and their partners, face. It is designed to challenge some of the current thinking about these issues and to help you examine how you feel about certain issues. Please remember that everyone has a right to his or her own opinion, and everyone's opinions should be respected. The group must respect one another's responses even if there is disagreement.

2. Identify two spots in the room opposite one another and hang one sign that says "Agree" on one wall and hang another sign that says "Disagree" on the other wall.
3. Explain that you will read out some statements, and participants should take a stand on the imaginary line somewhere between "Agree" and "Disagree" according to their response/opinion to this statement.
4. Read aloud the first statement from the statements below. Ask participants to stand near the spot that best reflects what they think about the statement – Do they agree or disagree? After the participants have moved to their spot, ask for one or two people in each spot to explain why they either chose agree or disagree.
5. Repeat Step 2 with the next statement. Continue with each of the statements from below. After all the statements have been read, ask the participants return to their seats.

Statements

1. Only married young people and sexually active young people should have access to information about family planning.
2. All sexually active young women should have access to family planning methods, regardless of their age or marital status.
3. A married young woman should not use contraception until she has had a child.
4. Husbands or partners should make the decision about whether or not the couple should use family planning.
5. Most modern contraceptive methods are safe for adolescents and young women to use.
6. Only older married women with multiple children should have access to injectables and long-acting reversible contraceptive methods (implants and IUDs).
7. Young women living with HIV should not have children.
8. If a married young woman does not have a child in two years after marriage, her husband should have the right to leave her or find an additional wife.
9. Married young people should be counseled on the use of family planning to help them achieved their desired family size.
10. Young women who use contraception are mischievous and unfaithful to their partners.

6. After all the participants have returned to their seats, lead the participants in a discussion using the following questions:

- Which statements, did you find challenging? Why?
- How do you think attitudes might affect your interactions with young clients (young women and young men), including first-time parents?

7. Conclude by reading the content:

As Community Health Extension Workers, it is important to understand the pressures that young women, including first-time mothers, face from society regarding sexuality and fertility. They also often face challenges in communicating about fertility with their husbands or partners, their mothers-in-law, their own family members and other influencers.

It is also important to reflect on the way in which your own opinions, values and attitudes might influence how you provide counseling and contraceptive services to young women, including first-time mothers. As Community Health Extension Workers, it is important to reconcile your personal beliefs with the health needs of first-time mothers', in order to guarantee the right of all young people to receive non-judgmental SRH counseling and services.

Remember, all contraceptive methods should be made available to young women and first-time mothers, including long-acting reversible contraceptive methods. Permanent methods, however, are not always the best choice. Young women can begin using contraception before having a child or any time in their reproductive lives. It is healthy for a young woman to delay her first birth until age 18 and space subsequent pregnancies by at least 2 years. We can have healthier communities and healthier women and children if young women, including first-time mothers, are supported to delay and space their pregnancies by using contraception; and this, with the full support of their husbands or partners.

Session 4: Healthy Timing and Spacing of Pregnancy

Objectives of the session:

1. Describe the three key messages of health timing and spacing of pregnancies (HTSP).
2. Summarize the range of contraceptive options for young people.

Before the training, the trainer should:

- Review the training content.
- Make enough copies of **Participant Handout 4-1: HTSP 101** for all participants.
- Obtain a small prize (e.g., candy) for the winning team in Activity 4-2.
- Prepare three colored pieces of paper for the game in Activity 4-2.

Total session time: 1 hour and 30 minutes (90 minutes)

- Activity 4-1: 45 minutes
- Activity 4-2: 45 minutes

Activity 4-1: Understand healthy timing and spacing of pregnancy

Time: 45 minutes

Methodology: Trainer presentation and discussion

The trainer should:

1. Explain to participants that this session will focus on the healthy timing and spacing of pregnancies. Read the following aloud and show **Slide S4-1a**.

Healthy timing and spacing of pregnancies (HTSP) is an approach to family planning service delivery that helps women and couples make informed decisions to help delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

Multiple studies have shown that adverse maternal and perinatal outcomes are related to closely spaced pregnancies. Studies have also shown that early pregnancy before a woman is 18 yrs. is also associated with negative health outcomes for young women and their babies.

The HTSP approach helps women and families to understand when it is healthiest for a woman to become pregnant, in order to help them make informed decisions about fertility and contraceptive use.

There are three key messages associated with HTSP. These are based on global research that determined the healthiest time to begin childbearing and the healthiest amount of time between a birth and the next pregnancy for both the mother and the baby. The three key messages for HTSP are:

1. For couples who desire a next pregnancy after a live birth, the messages are:
 - For the health of the mother and baby, wait at least 2 years before trying to become pregnant.
 - Considering using a contraceptive method of your choice during that time.
2. For couples who desire a next pregnancy after a miscarriage or abortion, the messages are:
 - For the health of the mother and baby, wait at least 6 months before trying to become pregnant again.
 - Considering using a contraceptive method of your choice during that time.
3. For a young woman who has not had a child, the messages are:
 - For your health and the health of your future child, wait until you are at least 18 before trying to become pregnant.

Using HTSP messaging and approaches has been effective in many settings to counsel young women, especially first-time parents, on family planning. As a Community Health Extension Worker, you can use the HTSP messages when providing counseling and contraceptive services to young women, including first-time mothers. It is important to first ask a young client about when and if she would like to have a child. Then, seek to understand what pressures she might face in relation to her fertility. You can then use the HTSP messages to counsel her about options to achieve her fertility goals.

2. Review the key messages, by asking participants the following questions:

1. How long should a couple wait before trying to become pregnant again after a live birth?
(Answer: Research shows that a 2 year interval between a birth and subsequent pregnancy is ideal)
2. After what age is it healthier for a woman to begin having children?
(Answer: For the health of the mother and the baby, delay the first pregnancy to at least age 18.)
3. How long should a couple wait before trying to become pregnant again after a miscarriage or abortion?
(Answer: Research shows that spacing a pregnancy by at least six months after a spontaneous or induced abortion is ideal.)

3. Ask participants to brainstorm what some of the benefits of practicing healthy timing and spacing are for women, adolescents, and newborns. Once participants have shared their ideas, read the following aloud, while projecting Slide S4-1b.

International research has shown a considerable reduction in maternal and infant mortality when HTSP is practiced. Specific benefits include:

For women:

- Lower risk of maternal death
- Lower risk of pre-eclampsia
- Lower risk of miscarriage

For newborns:

- Lower risk of perinatal death
- Lower risk of pre-term birth
- Lower risk of low birth weight
- Lower risk of small for gestational age

4. Pass out **Participant Handout 4-1: HTSP 101** as a reminder sheet

5. Conclude the activity by reading the following:

It is the role of the Community Health Extension Workers to inform, educate, and counsel young women and couples on HTSP and on the contraceptive options that are available to them. It is important to reiterate, however, that young women and couples must understand that they can freely choose whether or not to use a contraceptive method, and that they can freely decide which method they would like to use. Counseling on HTSP can occur at many different times, including before a woman has had a child, while a woman is pregnant, after a woman has given birth, and during child health visits.

6. Ask participants if they have any additional questions.

Activity 4-2: Review contraceptive options, HTSP, and counseling for young women, including first-time mothers

Time: 45 minutes

Methodology: Game

The trainer should:

1. Divide participants into two or three teams.
2. Give each team a different colored piece of paper. They will lift the piece of paper to signal when their team has an answer.
3. Explain to participants that you will ask a series of questions. Each team should talk amongst themselves to come up with their answer. When the team has an answer, the team leader should raise the colored piece of paper. The team that raises the paper first has the opportunity to share their answer. If they don't get it right the next team to raise their paper can share their answer. The team gets one point for each correct answer.
4. The team with the most points at the end wins a small prize or candy.
5. When the game is over, the trainer should review the questions and the correct answers using the content below.
6. Questions for Contraception for young women, including first-time mothers game

Question 1: Which contraceptive methods are safe for use by young women under age 25 who have not had children?

Answer 1: Nearly all contraceptive methods are safe for women of all ages, this include pills, injectables, implants, IUDs, condoms, and more. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for most young women due to their stage in life and the permanent nature of this method. Special counseling is required for young women living with HIV and those at high risk of HIV infection.

All clients should be counseled on the importance of dual protection through the use of male or female condoms with another method to offer protection from both unintended pregnancy and STIs, including HIV.

Question 2: What contraceptive methods can be used while a young woman is breastfeeding?

Answer 2: Breastfeeding can only prevent pregnancy if: the baby is less than 6 months old, the baby is exclusively breastfed (no other food or drink is given to the baby, not even water), and the woman's monthly bleeding has not returned. All woman, including young women and first-time mothers, can use the mini-pill (progestin-only pills), implants, progestin-only injectables, IUDs, and male and female condoms during the post-partum period and while breastfeeding. The IUD can be inserted within 48 hours post-partum. After the 48 hour post-partum window, insertion should be delayed until 4 weeks post-partum. Progestin-only pills, injectables, and implants can be used starting 6 weeks after childbirth. In some cases, these methods may be

used immediately post-partum depending on clinical judgment and national guidelines, see the World Health Organization's (WHO) Medical Eligibility Criteria and the Family Planning Handbook developed by USAID and WHO for more information.

Question 3: True or False: A Community Health Extension Worker should discuss contraception and HTSP with young women, including first-time mothers, while they are pregnant and immediately after they give birth.

Answer 3: True. Counseling on the importance of spacing births should begin while a young woman is pregnant, and if a young woman wants to space her next pregnancy, she can select a contraceptive method to begin using as soon as she gives birth.

Question 4: True or False: Married or cohabitating couples shouldn't use contraception until they have finished having all the children they want to have.

Answer 4: False. Contraception enables a couple to practice health spacing of pregnancies to ensure that the mother and the baby are healthier.

Question 5: Where should a Community Health Extension Worker refer a young woman who wants to use family planning? Should the Community Health Extension Worker accompany the woman?

Answer 5: If the young woman wants a method that is available through community-based distribution (such as pills, condoms, injectables or implants), then the Community Health Extension Worker can provide the young woman with that method. If the young woman wants a different method (such as an IUD), then the Community Health Extension Worker should refer the young woman to the nearest health center. The Community Health Extension Worker should accompany the woman to the health facility, if possible.

Question 6: How should a young woman's husband or male partner be involved in decision-making about contraceptive use?

Answer 6: Ideally, a young woman's husband or partner should be involved in decision-making about contraceptive use. Family planning and contraceptive use is a shared responsibility in a couple and open dialogue about contraception between a couple should be encouraged. However, the ultimate decision about whether or not to use a contraceptive method and which method to use should remain with the young woman. It is her right to make - and act on - informed decisions about her sexual and reproductive health.

Session 5: Youth-friendly services characteristics and core competencies

Objectives of the session:

1. Increase participants' awareness and understanding of youth-friendly service characteristics.

2. Increase participants' awareness of the core competencies for health providers to offer youth-friendly SRH services.

Before the training, the trainer should:

- Review the training content.
- Prepare **Slides S5-1a, S5-1b, S5-1c.**
- M Gather information on national or state-level policies or guidelines on youth-friendly services delivery

Total session time: 5 hours

Activity 5-1: Youth-friendly service characteristics and core competencies

Time: 60 min

Methodology: Brainstorm and group work

The trainer should:

1. **Introduce the activity by explaining to participants that offering services to young people requires a specific approach, which takes into consideration their unique needs and realities. Ask participants to brainstorm what “adolescent and youth-friendly sexual and reproductive health services” refers to. Write down their answers on a flipchart.**
2. **After the group has shared their ideas, project Slide S5-1a and read the following aloud:**

The World Health Organization has established five characteristics for adolescent-friendly services¹³:

- **Equitable:** All adolescents, not just certain groups, are able to obtain the health services they need.
 - **Accessible:** Adolescents are able to obtain the services that are provided.
 - **Acceptable:** Health services are provided in ways that meet the expectations of adolescent clients.
 - **Appropriate:** The health services that adolescents need are provided.
 - **Effective:** The right health services are provided in the right way and make a positive contribution to the health of adolescents.
3. **Now divide participants into two groups.**
 - Ask group 1 to discuss how these principles apply to health providers (What types of characteristics, skills and competencies should health providers have to deliver youth-friendly services?). Ask them to write their main points on a flipchart paper.
 - Ask group 2 to discuss how these principles apply to health service delivery (What characteristics should be integrated into health service delivery approaches at facilities and in community-settings to make them youth-friendly?). Ask them to write their main points on a flipchart paper.
 4. **After the groups have had sufficient time to discuss, ask a representative from Group 1 to share a summary of their. Then ask members of Group 2 to add any questions or comments. After both groups have had sufficient time to share their ideas, project slide S5-1b and read the following aloud:**

¹³ World Health Organization, "Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services" (Geneva: WHO, 2012).

The following characteristics, skills and competencies are important for health care providers, including Community Health Extension Workers, when offering services to adolescents and young people:

- Trained in youth-friendly services (YFS), including: basic concepts in adolescent health and development, protective and risk factors; effective communication with adolescents; how to raise and discuss sensitive issues with young people; local attitudes, beliefs, and practices related to youth SRH; how gender and life-stage-related norms influence young people's SRH; reflection on how providers' beliefs and values influence the delivery of youth SRH, in addition to the delivery of clinical SRH services tailored to young people.
- Trained on providing confidential YFS. In all countries, young people emphasize the importance of ensuring privacy and confidentiality when receiving SRH services.
- Treat male and female young people with respect and demonstrate non-judgmental attitudes toward all young people.
- Aware of and apply laws and policies related to youth SRH access and choice, including those that allow young clients to receive services without the consent of their parents or spouses.
- Provide adolescents with time to understand their options and make decisions.
- Actively listen to young people and communicate in a non-judgmental way.

5. After the groups have had sufficient time to discuss, ask a representative from Group 2 to share a summary of their discussion. Then ask members of Group 1 to add any questions or comments. After both groups have had sufficient time to share their ideas, project [Slide S5-1c](#) and read the following aloud:

The following characteristics are important to integrate in service-delivery approaches when offering SRH and FP services to adolescents and young people:

- Hours are convenient for males and female youth (for home visits and facility-based and community-based services).
- Counseling and services are offered in conveniently located places so that both male and female youth can access them.
- SRH services, including contraceptives, are offered at an affordable fee for young people.
- There are short waiting times for young people to receive SRH services.
- Counseling and service provision settings guarantee privacy (auditory and visual).
- Possibly offer specific times, days or spaces are set aside for young people, so that they can avoid being seen by people they know.

6. Close the session by referring to any state-level or national policies or guidelines on youth-friendly services delivery.

Session 6: Counseling first-time mothers and key influencers

Objective of the session:

1. Identify the key principles of counseling first-time mothers.
2. Explain special considerations for confidentiality and privacy for counseling first-time mothers.

Before the training, the trainer should:

- Review the material.
- Print **Participant Handouts 6-2a, 6-2b, 6-2c.**

Total session time: 90 minutes

- Activity 6-1: 45 minutes
- Activity 6-2: 45 minutes

Activity 6-1: Identify the key approaches for counseling first-time mothers

Time: 45 minutes

Methodology: Case study and group discussion

The trainer should:

1. Introduce the session with this content:

As a Community Health Extension Worker, you will encounter many different situations when conducting home visits to young women, including first-time mothers and their families. Each time you visit a home, the context and family dynamics will be different. It will be up to you to consider the best way to approach the situation, considering the power dynamics and relationships in the home. It may be most appropriate to begin by talking with the young woman's mother-in-law, her own parents or her husband/partner and return on another visit to counsel the young woman. If a couple is closer in age, it may be appropriate to counsel a young woman and her husband/partner together, provided you can successfully navigate the gender and power dynamics. When couples have larger age gaps, it might be more effective to hold separate counseling sessions for the young woman and her older partner. There might also be different family members that you may want to counsel on SRH issues (for example in-laws, siblings, etc.).

As you discussed earlier in this FP training, the way in which you communicate with people impacts what they are willing and able to learn from you. The counseling skills and principles you learned in your previous training are all relevant to young women, including first-time mothers, their husband or partner, and other key influencers in their lives. Building on what you learned in your previous training, we will now consider one counseling scenario. Please write down what the Community Health Extension Worker does well and doesn't do well during the home visit.

2. Read aloud the following story. Tell participants to pay attention to what the main character does well and what she doesn't do very well.

Ufuoma, a Community Health Extension Worker, is visiting the home of a young woman named Mariam. Mariam is 19 years old and has been married to Abdul-Aziz for one and a half years. They have a nine-month-old baby.

When Ufuoma arrives at the home, she immediately looks for Mariam. She greets the other people she sees in the compound, but she doesn't talk to Abdul-Aziz's parents or other family members.

When Ufuoma finds Mariam, Abdul-Aziz is near her. Ufuoma asks Abdul-Aziz to leave since she needs to talk to Mariam about things that are for women only. Gideon is suspicious. Once Abdul-Aziz leaves, Ufuoma checks to make sure there is no one else around and they have privacy. She sits in front of Mariam and looks at her very kindly. She asks Mariam questions about her health and the health of the baby. Ufuoma asks Mariam questions about her desires to have another baby. When Mariam says that she thinks that it is time for her to become pregnant again, Ufuoma tells her sternly and loudly that dropping out of school so early must have made her a stupid girl. That she must wait at least 2 years after giving birth before becoming pregnant again. Mariam looks frightened, she looks

around and whispers to Ufuoma that it is Abdul-Aziz and his mother, who are saying it is coming time for her to become pregnant again. Ufuoma tells Mariam that she should just ignore those people and should use injectable contraception, because that is the best method and it is discreet.

Mariam has many concerns: how can she ignore her husband and mother-in-law? What will happen if she doesn't produce a child right away, especially since her first baby is a girl? Why is the injectable the best method? Mariam doesn't like the idea of a needle in her arm. But, Ufuoma has two more houses to visit that day and so she tells Mariam she must leave. Ufuoma leaves the compound without talking with Abdul-Aziz or his mother.

3. Ask the participants the following questions. Supplement with the answers below.

What did Ufuoma, the Community Health Extension Worker, do well?

Possible answers might include:

- Ufuoma checks to be sure they have privacy before asking Mariam sensitive questions.
- Ufuoma greeted Mariam warmly.
- Ufuoma sat in front of Mariam, eye-level – not above her.
- Ufuoma asked Mariam open-ended question about her health and the health of her child.
- Ufuoma asks Mariam about her desires to have a baby.
- Ufuoma gives Mariam accurate information about how long she should wait between a birth and pregnancy.

What did Ufuoma do poorly?

Possible answers might include:

- Ufuoma doesn't take time to talk with the other members of the family to build up a rapport and trust.
- Ufuoma doesn't explain to the family what she is doing there or ask to speak with Abdul-Aziz first.
- Ufuoma spoke very badly to Mariam when she said she wanted to have another child soon.
- Ufuoma didn't consider the importance of the pressure that Mariam faces from her mother-in-law and husband.
- Ufuoma didn't give Mariam any opportunity to discuss the pressure she feels or provide Mariam with ways to talk about fertility desires with her family.
- Ufuoma didn't spend time to talk to Mariam more about the benefits of healthy timing and spacing of pregnancies or about the different methods of contraception that she could use.
- Ufuoma didn't spend time to ask Mariam if she had any questions.
- Ufuoma didn't give Mariam clear information about how she can access contraceptive methods.
- Ufuoma didn't spend time to talk with the other members of the family before leaving.

4. Present the content below:

As Community Health Extension Workers who are going to be counseling young women, including first-time mothers, it is important to learn from the mistakes Ufuoma made and build on the good things she did. It is your obligation to protect the privacy and confidentiality of all clients and treat them with respect and dignity. However, when conducting home visits, it is very important to build trust and understanding with the husband or partner, co-wives, and the parents of the husband. This may require many visits to talk with the family before speaking with the young woman alone. You may also consider counseling the husband and wife at the same time, but this will depend first on

whether the young woman feels comfortable and agrees to it. It will also depend on your relationship with the family, the dynamics between the husband and the wife, as well as whether the husband is comfortable.

5. Ask participants to brainstorm a list of the good counseling techniques that they learned in the previous days of training. Supplement their answers with the content below.

Supplemental answers considerations for counseling:

- Use home visits to establish trust with the larger family and talk to different people about the importance of HTSP.
- When counseling the individual young woman, ensure that there is privacy – don't ask her personal questions with other people around.
- Sit at eye-level with the client.
- Welcome the client warmly.
- Maintain the confidentiality of the young woman/first-time mother. Don't tell other people about their experiences and decisions.
- Ask open-ended questions about the young woman's well-being and the well-being of her child/children (if she has them).
- Listen actively. Don't do all the talking.
- Show respect for the relationship between the couple, by asking about the husband or partner's perspectives.
- Emphasize the importance of the health of the family and the other benefits of HTSP, such as greater economic stability.
- Be aware of yourself, what you are feeling, and what you are giving to the other person. Do not let your own values and biases prevent you from counseling the young woman accurately and comprehensively.
- Provide accurate information, never give wrong information, and if you do not know something, to say you do not know (and will find out).
- Use simple words.
- Encourage people to ask questions.
- Use visual aids (e.g., a picture, flipchart) if available or show a person how to do a task as you explain.
- Listen carefully to what is said and repeat back to make sure you have understood correctly.

Activity 6-2: Practice counseling first-time mothers, husbands/partners, mothers-in-law, and other key influencers

Time: 45 minutes

Methodology: Role-play

The trainer should:

1. Introduce the role play exercise.

We are now going to practice counseling young women, including first-time mothers, and their key influencers. Community Health Extension Workers should work closely with the people who have influence and power over young women's decisions about reproductive health. In this activity, we will take turns role-playing different situations that you may encounter when conducting home visits and offering community-based contraceptive services. You can use the handout 4-1 and 6-2c as guidance for possible HTSP messaging.

2. Distribute

- a. **Participant Handout 6-2a: Scenarios for Counseling Role Plays**
- b. **Participant Handout 6-2b: Observation Checklist for Counseling Role Plays**
- c. **Participant Handout 6-2c: Benefits of HTSP vs. Risks if HTSP is Not Practiced**

3. Review both handouts with the group, orienting them on the three scenarios in **Participant Handout 6-2a: Scenarios for Counseling Role Plays** and on the observation checklist in **Participant Handout 6-2b: Observation Checklist for Counseling Role Plays**.

4. Ask participants to form groups of three people.

5. Ask each set of participants to select one of the three scenarios in **Participant Handout 6-2a**.

6. Ask participants to act out the scenarios using the counseling skills we've discussed. One person should act as the **Community Health Extension Worker**, another as the young woman or influencer, and the third as the observer. The participants can refer to **Participant Handout 4-1: HTSP 101** and **Participant Handout 6-2c: Benefits of HTSP vs. Risks if HTSP is Not Practiced** to help them develop messages during their role play.

7. After they have acted out the first scenario, the observer should provide his/her feedback using **Participant Handout 6-2b** to guide his/her observations.

8. Now ask the participants to select another scenario and rotate roles so that the person who was the **Community Health Extension Worker** is now the young woman, the person who was the young woman is now the observer, and the person who was the observer is now the **Community Health Extension Worker**. **Repeat step 6**.

9. Bring the group back together and facilitate a discussion using the questions below. Ask respondents to refer to their observation checklists to facilitate discussion.

- When you were in the role of the young woman, what behaviors of the community health extension worker were not comforting? What behaviors were comforting?
- When you were in the role of the key influencers (husband, mother-in-law), what behaviors of the community health extension worker were not comforting? What behaviors were comforting?
- When you were in the role of Community Health Extension Worker, what did you find challenging about counseling the young woman? what did you find challenging about counseling the key influencers (husband, mother-in-law)?
- When you were the observer what were some of the positive counseling skills you observed? What were some ways that the providers could improve

Scenarios: Role Plays for Counseling

Scenario 1: The Community Health Extension Worker is visiting the home of an 18 year old woman who lives with her mother and 1 year old baby. The young woman had a boyfriend when she was in secondary school, but got pregnant during her last year and had to leave to take care of her baby and now the boyfriend is no longer around. Recently the young woman has started seeing another man and the Community Health Extension Worker asks her if she is using a contraceptive method to prevent pregnancy. The young woman's mother is supportive as they are already struggling financially, but the young woman is worried that contraceptive methods will cause her to become sterile.

Topics that the Community Health Extension Worker can cover in the counseling: importance of spacing the next pregnancy by at least another year (2 years total) and why that is important for the health of the mother and the baby; methods of contraception she could use to space the next pregnancy; use of different contraceptive methods; characteristics of different contraceptive methods; dispel myths and misconceptions that contraceptives cause sterility; importance of using condoms (with a contraceptive method) for dual protection against unintended pregnancy and STIs.

Scenario 2: The Community Health Extension Worker is conducting a home visit with a 20 year old married young woman. The young woman gave birth to her first child less than a year ago. Her labor was very difficult, and she doesn't want to become pregnant again right away. She doesn't know how long she should wait to become pregnant and she hasn't heard much about family planning. Her husband is happy that the young woman's newborn baby is a boy. The young woman thinks her husband might be open to supporting her to use family planning, but she has never tried to talk to him about it.

Topics that the Community Health Extension Worker can cover in the counseling : importance of spacing the next pregnancy by at least another year (2 years total) and why that is important for the health of the mother and the baby; contraception methods she could use to space the next pregnancy; how to use different contraceptive methods; characteristics of different contraceptive methods including possible side-effects; strategies to talk to her husband about her desire to space her next pregnancy; possibility of organizing a couple's counseling session.

Scenario 3: The Community Health Extension Worker is counseling a mother-in-law of a young married woman whose first child is one year old. The mother-in-law would like her daughter-in-law to have another child soon.

Topics that the Community Health Extension Worker can cover in the counseling : importance of spacing the next pregnancy by at least another year (2 years total) and why that is important for the health of the mother and the baby; safety of different contraception methods.

Scenario 4: A small group of men are gathered with a male Community Health Extension Worker. Some of the men are married and others are single. One of the married men complains that by discussing family planning with women in the community, the Community Health Extension Worker is going to encourage women to be unfaithful. Another man says he has heard that contraceptive methods cause infertility.

Topics that the Community Health Extension Worker can cover in the counseling : characteristics of different contraceptive methods including possible side-effects; dispelling myths about contraceptive methods leading to infertility; addressing gender norms; benefits of contraceptive use for HTSP.

Session 7: Review and Conclusion

Objective of the session:

- I. Review key learnings from the training module.

Before the training, the trainer should:

- Review the material.

Total session time: 15 minutes

Activity 7-1: Review circle

Time: 15 minutes

Methodology: Game

The trainer should:

1. **Ask participants to form a circle.**
2. **Ask participants to spend a couple of minutes thinking about the entire one-day training.**
3. **Go around the circle and ask participants to share with the group one thing they found particularly interesting or useful about the training**
4. **After all participants have shared their feedback, thank everyone for their participation, ask for any remaining questions, and close the day.**

Annex I: Participant Handouts

Participant Handout I-I: Illustrative Training Schedule

Time	Session and activities
8:00-8:30	Session 1: Introduction to the Module
8:30 – 9:45	Session 2: Understanding the needs and challenges of first-time mothers Activity 2-1
9:45 – 10:45	Session 3: Attitudes and values towards first-time mothers, fertility, and contraception
10:45 – 11:00	Break
11:30-13:00	Session 4: Health Timing and Spacing of Pregnancy
1:00-2:00	Lunch
2:00-3:00	Session 5: Youth-friendly services characteristics and core competencies
3:00 – 4:30	Session 6: Counseling first-time mothers and key influencers
4:30-5:00	Session 7: Reflection and Conclusion

Participant Handout 2-1: Case Study Anna

My name is Anna. I am seventeen years old. I have a baby girl who is one year old. Jonathan is my baby's father. We were dating and I got pregnant by accident. He has stayed with me and helps as much as he can with our daughter, but we're not married.

I love my baby girl, but I worry about her a lot since it seems like she is always sick. My mother keeps asking when we will have our next child. She says that it might convince Jonathan to marry me. She also says that my baby will start running everywhere soon, so it is time for a second child. I know I need to have another baby, especially because my first baby is a girl. But, I know that having another baby soon will be very hard for me and my little girl, since she has been so sick. It will mean that I will have to make the small amount of food we have stretch even further.

I heard you could take get a shot to avoid having a baby for 3 months, but I don't know anything about it. There are some Community Health Extension Workers in my community, but they are older women who are friends with my mother and I know she would disapprove if she knew I wanted to learn more about the medicine to prevent pregnancy. Jonathan might also disapprove, because he will think that I could be unfaithful to him if I get the shot.

I decided to try to go to the nearest health center. I hoped that I wouldn't see people I knew there. I told my mother that the baby was sick and walked the 10 km to the nearest health center. I went to the health center early in the morning because I needed to go back home and do household chores before it became too late in the day. When I arrived, there were several women waiting outside with many children. They kept looking at me.

The health center staff was late to arrive. I waited for one hour. When the facility opened, I got up enough courage to speak to the woman behind the table with a sign saying "Reception". She asked me why I was at the clinic when my baby wasn't sick. When I explained that I wanted to talk with the nurse about family planning, she made a disapproving face and just pointed to the consultation waiting area.

I waited for 2 hour near the family planning room. I hadn't eaten anything and my baby started to cry. I felt that all the older women were staring at me. One of the women recognized me. She is a friend of a my mothers and asked me why I was there since the family planning services are for married, older women who are ready to stop having children, not a young woman like myself.

I was finally called in to speak with one of the nurses. When I went into the consultation room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant so soon after my last baby and I had heard there was some kind of shot I could get. She asked if my husband had given me permission to be there. I looked down and told her that I wasn't actually married and that I hadn't told Jonathan why I was here. The nurse scolded me for having a child before being married. She said "Why didn't you think about all of this before you decided to have sex outside of marriage? You made bad choices and now you have to deal with the consequences".

I explained that my baby was sickly and it wouldn't be good for us to have another child so soon. The nurse finally says that it is ok for me to use a method and says I should use the 3 month injectable, she didn't mention any other method options. I asked to have the injection right away, but she said that I would have to wait for it since the pharmacy at the clinic wasn't open.

I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Anna, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including my mother's friend. I got my injection and left the clinic very embarrassed and worried.

Participant Handout 4-1: Healthy Timing and Spacing of Pregnancy

(use HTSP 101 hand out, available here: <http://www.who.int/pmnch/topics/maternal/htsp101.pdf>)



HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

Background

Over the past few years, the United States Agency for International Development (USAID) has sponsored a series of studies on pregnancy spacing and health outcomes. The research objective was to assess, from the best available evidence, the effects of pregnancy spacing on maternal, newborn and child health outcomes. In June 2005, the World Health Organization (WHO) convened a panel of 30 technical experts to review six USAID-sponsored studies. Based on their review of the evidence, the technical experts made two recommendations¹ to the WHO, which are included in a report and policy brief¹:

- *After a live birth, the recommended minimum interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.*
- *After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.*

What is HTSP?

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention to help women and families delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

¹WHO is reviewing the technical experts' recommendations and has requested additional analyses to address questions that arose at the 2005 meeting. WHO recommendations will be issued when their review has been completed.

Qualitative studies conducted by USAID in Pakistan, India, Bolivia, and Peru showed that women and couples are interested in the healthiest time to *become pregnant* versus when to *give birth*. In this way, HTSP differs from previous birth spacing approaches that refer only to the interval after a live birth and when to give birth. HTSP also provides guidance on the healthiest age for the first pregnancy.

Thus, HTSP encompasses a broader concept of the reproductive cycle — starting from healthiest age for the first pregnancy in adolescents, to spacing subsequent pregnancies following a live birth, still birth, miscarriage or abortion — capturing *all* pregnancy-related intervals in a woman's reproductive life.



Volunteer health worker reading an HTSP Pocket Guide in Dadaab refugee camp in Kenya (Photo credit: Jennifer Mason)

Why HTSP? The Rationale

Multiple studies have shown that adverse maternal and perinatal outcomes are related to closely spaced pregnancies. As shown in Table 1, the risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage, or abortion.

Table 1. Risks of Adverse Health Outcomes After Very Short Interval Pregnancy, Compared to the Reference Group Interval Used in the Selected Study

INCREASED RISKS WHEN PREGNANCY OCCURS 6 MONTHS AFTER A LIVE BIRTH		
Adverse Outcome	Increased Risk	
Induced Abortion	650%	
Miscarriage	230%	
Newborn Death (<9 mos.)	170%	
Maternal Death	150%	
Preterm Birth	70%	
Stillborn	60%	
Low Birth Weight	60%	
INCREASED RISKS WHEN PREGNANCY OCCURS <6 MONTHS AFTER AN ABORTION OR MISCARRIAGE		
	Increased Risk with 1-2 Month Interval	With 3-5 Month Interval
Low Birth Weight	170%	140%
Maternal Anemia	160%	120%
Preterm Birth	80%	40%

Sources: Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2004; Razzaque, et al, 2005; Rutstein, 2005.

Too long intervals (>5 years) are also associated with adverse health outcomes. Thus, through the promotion of healthy timing and spacing of pregnancy, there is the potential to significantly reduce risks to both mothers and children. HTSP offers:

- *Reduced risks after a live birth:* Short birth to pregnancy intervals less than 18 months and longer than 59 months, had a greater risk for adverse perinatal outcomes, than women delivering 18 to 23 months after a live birth.²
- *Reduced risks after a miscarriage or post abortion:* Women delivering singleton infants after becoming pregnant less than six months after a previous abortion or miscarriage had a greater risk for adverse maternal and perinatal outcomes, than women delivering 18 to 23 months after a previous abortion.³

Reduced risks for adolescents: The annual global burden of disease report estimates that 14 million adolescent pregnancies happen every year. Sixty percent of married adolescents reported that their first birth was either mistimed or unintended.⁴ Compared to older women, girls in their teens are twice as likely to die from pregnancy and child birth-related causes; and their babies also face a 50 percent higher risk of dying before age 1, than babies born to women in their twenties.⁵

Considerable unmet need and demand for spacing still exist in the younger 15-29 age cohorts as well as in postpartum women, as shown in the findings below.

- *Women in younger age cohorts:* Spacing is the main reason for family planning demand among women in younger age groups (15-29). Among married women 29 years or younger who wanted family planning, FP demand for spacing ranged from 66% to over 90%.⁶ Data from developing countries also show that younger, lower parity women have the highest demand and need for spacing births. Commonly, between 90% and 100% of the demand for spacing in the 15 to 24 year age cohort, is made up of women with parity of two or less.⁷
- *Postpartum women:* Unmet need for spacing among postpartum women is very high. 95-98% of postpartum women do not want another child within two years – yet only 40% are using family planning.⁸ In short, 60% of postpartum women who want to space their pregnancy have an unmet need.

HTSP is an aspect of FP which is associated with healthy fertility and helping women and families make informed decisions about pregnancy spacing and timing to achieve healthy pregnancy outcomes. Family planning (FP) has made great progress in helping women avoid unintended pregnancies. To date, the focus of FP has mostly been on lowered fertility, rather than healthy fertility. Findings from the WHO technical panel support the role of family planning in achieving healthy fertility and healthy pregnancy outcomes.

HTSP is an effective entry point to strengthen and revitalize FP in sensitive settings because it focuses on the mother/child dyad and improved health outcomes for mother and baby. HTSP provides an opportunity to highlight family planning as a preventive intervention using the framework of healthy mothers, healthy babies, healthy families and healthy communities.

From Research to the Field

The Extending Service Delivery (ESD) project, in collaboration with USAID, is currently spearheading an activity to take the evidence from research to the field.

Specifically, ESD is developing a program approach focusing on achieving **three HTSP outcomes** – (1) healthy pregnancy spacing after a live birth; (2) healthy pregnancy spacing after a miscarriage or induced abortion; and (3) healthy timing of the first pregnancy in adolescents, to delay until age 18, for healthy mother and healthy baby.

The first two HTSP outcomes are based on the two recommendations to WHO from the panel of technical experts. The third outcome was added by USAID to address issues of pregnancy at too early an age – a significant contributor to maternal and infant mortality in many developing countries.

Towards Achieving HTSP Outcomes: The Messages

To achieve HTSP outcomes, three take-home messages have been developed – all to be discussed *in a framework of informed family planning choice, personal reproductive health goals and fertility intention.*

For couples who desire a next pregnancy after a live birth, the messages are:

- For the health of the mother and the baby,* wait at least 24 months, but not more than 5 years,† before trying to become pregnant again.

*This message encompasses perinatal, neonatal, and infant health and can be adapted to the context – for example postpartum programs would emphasize perinatal, neonatal and maternal health.

†Some technical experts at the 2005 WHO technical consultation felt it was important to note that in birth-to pregnancy intervals of five years or more, there is evidence of increased risk of adverse maternal outcome,

- Consider using a family planning method of your choice without interruption during that time.

For couples who decide to have a child after a miscarriage or abortion, the messages are:

- For the health of the mother and the baby, wait at least six months before trying to become pregnant again.
- Consider using a family planning method of your choice without interruption during that time.

For adolescents, the messages are:

- For your health and your baby’s health, wait until you are at least 18 years of age, before trying to become pregnant.
- Consider using a family planning method of your choice without interruption until you are 18 years old.

The Interventions

Key HTSP interventions include:

- Advocacy at the policy level;
- Education and counseling of women and families, and linkage to FP services at the service delivery level; and
- Monitoring and evaluation.

Advocacy.

There is significant increased risk for multiple adverse outcomes after short pregnancy intervals. Decision makers must be reached with advocacy and information about HTSP evidence and recommendations from the 2005 WHO technical consultation; DHS data on country-level burden of disease; and HTSP’s important role in contributing towards maternal, neonatal and child mortality by reducing adverse maternal and perinatal risks. Country-specific advocacy briefs, developed by ESD, are available at www.esdproj.org.

Education and counseling of women and families, and linkage to FP services.

Recent OR studies indicate that educating and counseling women and families on HTSP is

namely pre-eclampsia, and adverse perinatal outcomes, namely pre-term birth, low birth weight and small infant size for gestational age.

associated with increased knowledge and use of FP services.⁹ To ensure women and couples are informed, educated, and counseled about HTSP, programs need to use every window of opportunity. In addition to FP services, several other service delivery events represent excellent opportunities for HTSP education and counseling – pre-natal visits, post-partum care, well-baby check-ups, infant growth-monitoring sessions and immunization sessions as well as postabortion care services, and PMTCT/VCT/STI counseling sessions. Non-health activities such as youth, literacy, and agriculture are also good venues. Community leaders and religious leaders can also be trained as HTSP champions. Knowledge of service providers should also be increased so that FP plays a role not only in reproductive health, but also in maternal, newborn and child health. To that end, HTSP tools are available at: www.esdproj.org to strengthen HTSP training, education and counseling activities.

Linkage to FP services is critical to achieve HTSP outcomes. Some women and couples may not want to make a decision immediately after education and counseling. Programs need to have a mechanism in place to ensure that these women return for services, have access and choice of a wide range of contraceptive methods, including long-acting and permanent methods (LAPM), or are referred for appropriate FP services including voluntary sterilization for those who wish to limit.

HTSP training materials/curricula provide information on all methods[†], for both spacing and limiting, and on how to probe for fertility intentions, so that providers can refer women for voluntary sterilization if that is appropriate and requested.

Monitoring and evaluation. A 2004 birth spacing programmatic review¹⁰ documents that most FP or maternal-child health (MCH) programs do not formally track birth to pregnancy intervals as a statistic that helps define the overall FP/MCH program success. Over the next few years, ESD will work with the HTSP Champions' Network to monitor and track changes in HTSP trends and

[†]Includes information and training on all FP methods including LAPM, voluntary sterilization, probing for fertility intentions and referral to appropriate health facilities for sterilization as requested.

knowledge using a tracking matrix. ESD is also developing a list of common HTSP indicators.

Conclusion

USAID is working in collaboration with WHO and other organizations to integrate HTSP into health and non-health programs. For countries to reduce their burden of disease and reach their Millennium Development Goals, adding HTSP interventions to their strategies and programs should be considered a priority because of significant, multiple health benefits for women and babies.

Prepared by May Post, Extending Service Delivery Project.

Based on the ESD HTSP Strategy, available at www.esdproj.org.

Please contact esdmail@esdproj.org for more information.

¹ Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.

² Conde-Agudelo A., et al., Birth Spacing and the Risk of Adverse Perinatal Outcomes: A Meta Analysis. *Journal of the American Medical Association*, 29, April 2006.

³ Conde-Agudelo A., et al., Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.

⁴ Married Adolescents: No Place for Safety. WHO and UN Population Fund: WHO, 2006.

⁵ Shane Barbara (1997), cited in *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns*. Save the Children, 2006.

⁶ Jansen, W., Existing Demand for Birth Spacing in Developing Countries: Perspectives from Household Survey Data. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.

⁷ Jansen, W and L. Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.

⁸ Ross and Winfrey, Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives*, Vol. 27, No. 1, March 2001.

⁹ Minia Village Household Survey; Communications for Healthy Living, Egypt, 2000-2005; PRACHAR Project, Pathfinder/India, 2001-2005; Results of the Household Survey, TAHSEEN/Pathfinder, Egypt, 2003-2005; Promoting Postpartum Contraception: Possible Opportunities, Population Council, New Delhi 2007; Solo et al. (1999), Kenya. Cited in Report of the PAC Technical Advisory Panel, USAID, April 2007. Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.

¹⁰ Jansen, W. and L. Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level.

Participant Handout 6-2a: Scenarios for Counseling Role-Plays

Scenario 1: The Community Health Extension Worker is visiting the home of an 18 year old woman who lives with her mother and 1 year old baby. The young woman had a boyfriend when she was in secondary school, but got pregnant during her last year and had to leave to take care of her baby and now the boyfriend is no longer around. Recently the young woman has started seeing another man and the Community Health Extension Worker asks her if she is using a contraceptive method to prevent pregnancy. The young woman's mother is supportive as they are already struggling financially, but the young woman is worried that contraceptive methods will cause her to become sterile.

Scenario 2: The Community Health Extension Worker is conducting a home visit with a 20 year old married young woman. The young woman gave birth to her first child less than a year ago. Her labor was very difficult, and she doesn't want to become pregnant again right away. She doesn't know how long she should wait to become pregnant and she hasn't heard much about family planning. Her husband is happy that the young woman's newborn baby is a boy. The young woman thinks her husband might be open to supporting her to use family planning, but she has never tried to talk to him about it.

Scenario 3: The Community Health Extension Worker is counseling a mother-in-law of a young married woman whose first child is one year old. The mother-in-law would like her daughter-in-law to have another child soon.

Scenario 4: A small group of men are gathered with a male Community Health Extension Worker. Some of the men are married and others are single. One of the married men complains that by discussing family planning with women in the community, the Community Health Extension Worker is going to encourage women to be unfaithful. Another man says he has heard that contraceptive methods cause infertility.

Participant Handout 6-2b: Observation Checklist for Counseling Role-Play

TASK OR ACTION	YES	NO	COMMENTS
Provider assures confidentiality?			
Friendly/welcoming/smiling/respectful?			
Not judgmental or condescending?			
Listens attentively/nods head to encourage and acknowledge client's responses?			
Uses open-ended questions (i.e., not yes/no questions)?			
Uses non-technical terms and language the patient can understand?			
Counsels the client using the HTSP messages?			
Asks the client about pressures she may be feeling to have a baby and discusses how to deal with those pressures?			
Listens to client's responses closely and patiently?			
Provides encouragement and reassurance?			
Counsels the client on a full range of contraceptive methods, including long-acting methods (i.e., doesn't just offer one or two methods)?			
Prepares the client to use the method she selects effectively, including thorough discussion of side effects and what the client can expect?			
Responds to client's non-verbal communication?			
Is non-directive (i.e., doesn't tell the client what she has to do or not do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			
Provides the client with a referral to the nearest health facility and offers to accompany the client?			

Please record any additional observations/comments for feedback to the participants:

Participant Handout 6-2c: Benefits of HTSP vs. Risks if HTSP is Not Practiced¹⁴

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
For the Newborn Child	
<ul style="list-style-type: none"> • Newborns are more likely to be born strong and healthy. • Newborns may be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding. • Mother-baby bonding is enhanced by breastfeeding, which facilitates the child's overall development • Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns. 	<ul style="list-style-type: none"> • Risk of newborn and infant mortality is higher. • There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age. • When breastfeeding stops before six months, the newborn does not experience the health and nutritional benefits of breast milk, and the mother-baby bond may be diminished, which may affect the baby's development.
For the Mother	
<ul style="list-style-type: none"> • The mother has a reduced risk of complications which are associated with closely spaced pregnancies. • She may have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy. • She may breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer. • She may be more rested and well-nourished so as to support the next healthy pregnancy. • She may have more time for herself, her children, and her partner, and to participate in educational, economic and social activities • She may have more time to prepare physically, emotionally, and financially for her next pregnancy. 	<ul style="list-style-type: none"> • Women who experience closely spaced pregnancies are: <ul style="list-style-type: none"> ○ At increased risk of miscarriage ○ Are more likely to experience iron-deficiency anemia ○ Are more likely to experience pre-eclampsia ○ More likely to induce an abortion

¹⁴ ESD Project. 2010. *Healthy Timing and Spacing of Pregnancy: A Trainers' Reference Guide*. Second Edition.

For Men	
<ul style="list-style-type: none"> • His partner may find more time to be with him, which may contribute to a better relationship. • Expenses associated with a new pregnancy will not be added to the expenses of the last-born child. • More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one. • Men may feel an increased sense of satisfaction from: <ul style="list-style-type: none"> ○ Safeguarding the health and well-being of his partner and children; and ○ Supporting his partner in making healthy decisions regarding FP and HTSP. 	<ul style="list-style-type: none"> • The stress from closely spaced pregnancies may prevent couples from having a fulfilling relationship. • If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.
For the Family	
<ul style="list-style-type: none"> • Families can devote more resources to providing their children with food, clothing, housing, and education. 	<ul style="list-style-type: none"> • A new pregnancy requires money for antenatal care, better nourishment for the mother, savings for the delivery costs and costs associated with the needs of a new baby. • Illness or a need for emergency care is more likely if the woman has closely spaced pregnancies • Unanticipated expenses may lead to difficult financial circumstances or poverty.
For the Community	
<ul style="list-style-type: none"> • HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children, which can contribute to reductions in poverty and improvements in the quality of life for the community • It may relieve the economic, social and environmental pressures from rapidly growing populations 	<ul style="list-style-type: none"> • Lack of HTSP may result in a poorer quality of life for community residents • Economic growth may be slower, making it more difficult to achieve improvements in education, environmental quality, and health.



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