Providing Reproductive Health Services to Young Married Women and First-time Parents in West Africa

A Supplemental Training Module for
Facility-based
Health Care Providers

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Contents

Acronyms and Abbreviations

DHS	Demographic and Health Survey
FTP	First-time parent
HTSP	Healthy timing and spacing of pregnancy
IUD	Intrauterine device
SRH	Sexual and reproductive health
WHO	World Health Organization

Notes for Organizers and Trainers

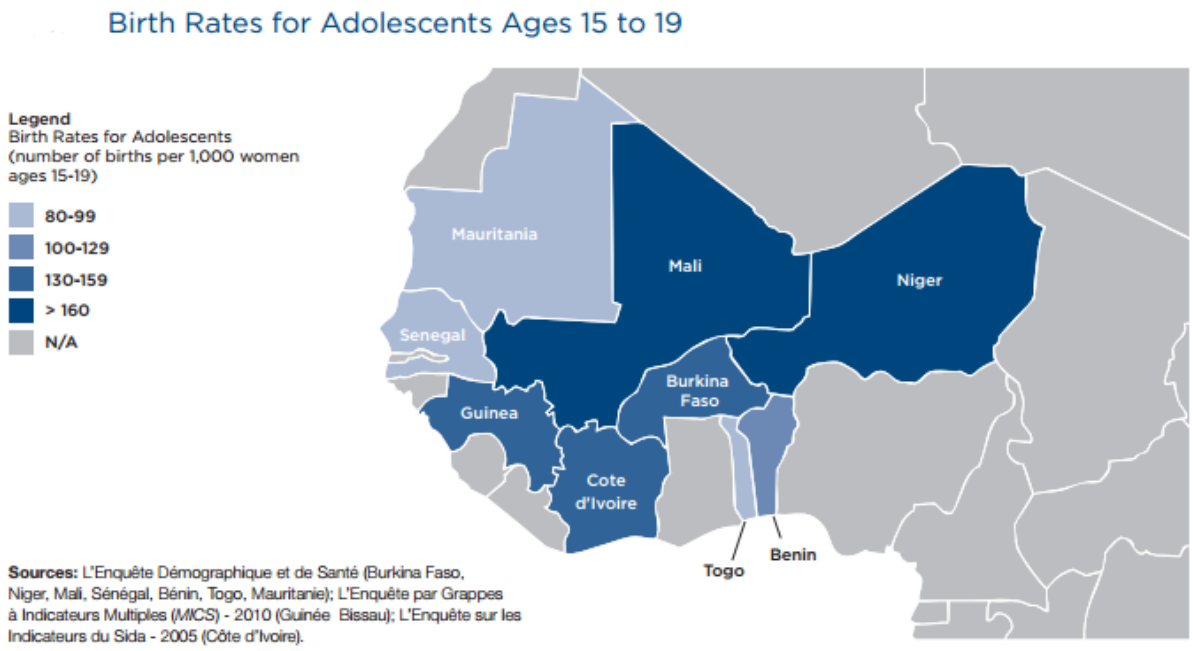
Background

In much of francophone West Africa, a significant proportion of adolescent girls aged 15–19 and young women aged 20–24 are married or living in union. For most young women, sexual debut and childbearing occur within the context of marriage (formal and informal unions in which a man and a woman are living together). Use of modern contraceptives is low among young married women and adolescents and childbearing usually begins soon after marriage. See the table below for a selection of data on marriage, childbearing, and contraceptive use in several countries.

	Minimum age of marriage for girls	% adolescent girls aged 15-19 who are married/in union	% women aged 20-24 who are married/in union	% women 20-24 who gave birth by 18	% women 20-24 who gave birth by 20	% married adolescents 15-19 using a modern method
Burkina Faso (DHS 2010)	15	31.5%	81%	28%	57%	6%
Guinea (DHS 2012)	17	35%	76%	40%	59.6%	2.6%
Cameroon (DHS 2011)	15	24.2%	61.8%	29.9%	49.4%	12.2%
Niger (DHS 2012)	15	70%	90.5%	48.2%	73.9%	5.9%
DRC (DHS 2007)	15	22.5%	65.3%	23.3%	48.3%	16.1%
Côte d'Ivoire (DHS 2011-12)	18	20.7%	56%	31%	50.2%	6.9%
Senegal (DHS 2012-13)	16	22.6%	56.7%	17.7%	34.3%	2.8%
Mali (DHS 2012-13)	16	43.1%	84.5%	46.2%	68.2%	6.5%
Benin (DHS 2011-12)	18	13.8%	61.4%	23.3%	41.6%	4.2%

First-time parents (FTPs) may be married or unmarried, are either pregnant with or have had their first child, and are 10–24 years of age (although the male partner may be much older in certain contexts). The map below gives an overview of birth rates among adolescent girls aged 15–19 in a number of francophone West African countries.[1]

[1] Map source: Ouagadougou Partnership, *Family Planning: Francophone West Africa on the Move – A Call to Action* (2012). Available at: http://www.prb.org/Publications/Reports/2012/ouagadougou-partnership-en.aspx



Young married women and first-time parents face a unique set of challenges to living healthy sexual and reproductive lives—challenges that are different to those faced by unmarried adolescents, older married women or older parents. When they get married, young women quickly become isolated, with household responsibilities and limitations on their mobility keeping them at home without supportive social networks or access to health information and services. Furthermore, the choice of whether or not to use contraception to plan when and if they want to have children is rarely their own. Their husbands/partners, co-wives, community and family elders, in-laws, and religious leaders have most of the decision-making power (or influence) related to sexual and reproductive health (SRH) and they also often decide how resources within the household are used.[2] These unequal power dynamics and gender inequalities place young married women at particular risk of gender-based violence, gender-based household maltreatment, pressure to bear children before they are ready, and prevention of pregnancy spacing. As a result of these dynamics and other factors (including sociocultural preferences around fertility and provider bias), many young in-union or married women become parents during their youth and young mothers have closely spaced pregnancies, compromising their health and that of their newborns. Significant evidence posits that both mother and baby are healthier if at least 24 months passes between pregnancies. [3,4,5,6]

[2] S. Engebretsen and G. Kabore, *Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso* (Population Council, May 2011). Accessed June 25, 2013 at: http://www.popcouncil.org/pdfs/TABriefs/09_BurkinaFaso.pdf.

[3] S. Engebretsen and G. Kabore, *Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso* (Population Council, May 2011). Accessed June 25, 2013 at: http://www.popcouncil.org/pdfs/TABriefs/09_BurkinaFaso.pdf.

[4] UNFPA, *How Universal is Access to Reproductive Health? A Review of the Evidence* (UNFPA, 2010). Accessed Dec. 3, 2014 at: http://www.unfpa.org/sites/default/files/pub-pdf/universal_rh.pdf.

[5] A. Conde-Agudelo and A. Rosas-Bermudez, "Effects of Birth Spacing on Maternal, Perinatal, Infant and child Health: A Systematic Review of Causal Mechanisms" *Studies in Family Planning* (2012) 43[2]: 93–114.

[6] J. Cleland, et al. "Contraception and health" *The Lancet* (2012) 380: 149-156.

Despite the need for health services and community-based programming to address gender and other social norms, few programmatic efforts intentionally address the needs and rights of young married women and first-time parents. Educating health providers about the needs of married adolescents has been shown to increase both provision and utilization of antenatal and SRH services aimed at young married women and first-time parents.[7]

Intended audience

This training is intended for health care providers (e.g., doctors, nurses, midwives). Only health care providers who have previously been trained in the SRH of adolescents and youth are eligible to participate in this supplemental training.

The training is designed for 15–20 participants. If there are more than 20 participants, the trainer will need to modify some of the activities.

Purpose

This supplemental 1-day training is designed to be added to any full training program on adolescent and youth sexual and reproductive health. The goal of the supplemental training module is to improve health care providers' ability to offer high-quality, nonjudgmental services to young married women and/or first-time parents.

For the purposes of this training, the term **young married women** refers to young women (aged 10–24) in formal and informal unions, in which they are cohabitating (living) with a partner. This group includes both those with and those without children. The term **first-time parents** refers to any young person aged 10–24 who is pregnant with or has had a child for the first time (parity of 1), regardless of marital status.

Learning objectives

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

1. Describe the unique challenges young married women and first-time parents face in living healthy reproductive lives.
2. Explain the three main messages of healthy timing and spacing of pregnancies (HTSP).
3. Demonstrate appropriate, nonjudgmental, and comprehensive counseling for young married women and first-time parents regarding their reproductive health.

Components of the module

This supplemental module includes the trainer's guide (this document), participant handouts (see Annex 1 of this document), and a PowerPoint Presentation that can be used if the trainer so desires (available electronically from Pathfinder International's website).

[7] The ACQUIRE Project, "Mobilizing married youth in Nepal to improve reproductive health: The Reproductive Health for Married Adolescent Couples Project, Nepal, 2005–2007," *E&R Report No. 12* (New York: EngenderHealth/The ACQUIRE Project, 2008).

Overview of training

Sessions	Duration	Supporting resources
Session 1: Introduction to the Module	15 minutes	Slide 1-1 Participant Handout 1
Session 2: Understanding the needs and challenges of young married women and FTPs	1 hour	Slide 2-1 Participant Handout 2
Session 3: Attitudes and values related to young married women and FTPs regarding fertility and contraception	1 hour	Agree/Disagree signs for each participant
Session 4: Healthy timing and spacing of pregnancy	1.5 hours	Slide 4-1 and Review Game Slides Participant Handout 3 Small prize 3 colored sheets of paper
Session 5: Counseling young married women and FTPs	2 hours	Slides 5-1, 5-2, 5-3 Participant Handouts 4 and 5
Session 6: Review and Conclusion	30 minutes	–
Total time	**6 hours 15 minutes** (375 minutes)	

Adapting this training

This training was originally developed for working in Burkina Faso and Guinea. However, it can be relatively easily adapted to fit contexts in other francophone West African countries, or—with a little more effort—countries outside that region. There are several specific places where adaptation may be needed, depending on the country and context:

Country-specific information: When introducing the training, you can share statistics from your specific country or setting. You can draw on the information in the table in the Background section, which shares relevant statistics on early marriage, childbearing, and contraceptive use in various countries.

Case studies and role plays: You may want to change the names that are used in the case studies and role plays ("Fatimata" in Session 2, Activity 2-2; "Salimatou and Mariam" in Activity 5-1). Depending on the typical age of marriage in the community you are working in, you may want to change the ages of these characters. Depending on the religion(s) of your target community, you may also want to change the references to Islam and Muslim religious leaders. Similarly, if polygamy is not common in your target community, you may want to change those details in both of the above activities as well as in the counseling scenarios in Activity 5-2.

Illustrative training schedule

This supplemental module can be used in different ways. The trainer should develop the schedule based on the needs of the participants and the time constraints. The supplemental module can be completed in one day, and an illustrative schedule for a one-day training can be found below. However, if trainers are able to use the module over a two-day period, it will allow more time for in-depth discussion and reflection, which will enhance the learning process. In addition, a trainer may decide to use each session by integrating the content into a full training program on adolescent and youth sexual and reproductive health, rather than keeping this module as an addition to the training.

Illustrative 1-day Training Schedule

Time	Sessions
9:00-9:15	Session 1: Introduction to the Module
9:15-10:15	Session 2: Understanding the needs and challenges of young married women and FTPs
10:15-10:30	Break
10:30-11:30	Session 3: Attitudes and values related to young married women and FTPs regarding fertility and contraception
11:30-1:00	Session 4: Healthy timing and spacing of pregnancy
1:00-2:00	Lunch
2:00-2:45	Session 5: Counseling young married women and FTPs Activity 5-1
2:45-3:00	Break
3:00-4:15	Session 5 Continued Activity 5-2
4:15-4:45	Session 6: Review and Conclusion

Session 1: Introduction to the Module

Objective of the session:

1. Introduce participants to the supplemental training module.

Before the training, the trainer should:

- Review the training content and familiarize him/herself with the material and methodologies.
- Prepare **Slide 1-1**.
- Adapt the training content and schedule so that it meets your project's specific needs.
- Make enough copies of **Participant Handout 1: Training Schedule** for all participants.

Total session time: 15 minutes

Activity 1-1: Introduce the participants to the supplemental training module on young married women and first-time parents (FTPs)

Time: 15 minutes

Methodology: Trainer presentation

The trainer should:

1. **Introduce the session by reading aloud the content below to the participants.** (You may want to add country-specific data, drawing from the table in the Background section.)

In much of francophone West Africa, a significant proportion of adolescent girls aged 15–19 and young women aged 20–24 are married or living in union. For most young women, sexual debut and childbearing occur within the context of marriage (formal and informal unions in which a man and a woman are living together). Use of modern contraceptives is low among young married women, and childbearing usually begins soon after marriage. For the purposes of this training, the term **young married women** refers to young women (aged 10–24) in formal and informal unions, in which they are living with a partner. This group includes both those with and those without children. The term **first-time parents** refers to any young person aged 10–24 who is pregnant with or has had a child for the first time, regardless of marital status.

Gender and socioeconomic inequalities render this group of young people particularly vulnerable, and this module will provide an opportunity for further exploration of the specific challenges that young married women and first-time parents face to living healthy reproductive lives.

2. **Present Slide 1-1 (session 1, slide 1) and present the content below:**

The module builds on the training that you have had on adolescent and youth sexual and reproductive health by adding an additional focus on young married women and first-time parents. At the end of this 1-day supplemental training, participants will be able to:

1. Describe the unique challenges young married women and first-time parents (FTPs) face to living healthy reproductive lives.
2. Explain the three main messages of healthy timing and spacing of pregnancies (HTSP).
3. Demonstrate appropriate, nonjudgmental, and comprehensive counseling for young married women and first-time parents regarding their sexual and reproductive health.

3. **Ask participants if there are any questions**

4. **Pass out and review Participant Handout 1: Training Schedule.**

Session 2: Understanding the Needs and Challenges of Young Married Women and FTPs

Objectives of the session:

1. Increase participants' awareness and understanding of the needs of young married women and first-time parents and the challenges that they face to living healthy reproductive lives.
2. Describe why it is important to provide young married women and FTPs with comprehensive, nonjudgmental reproductive health counseling and services.

Before the training, the trainer should:

- Review the training content and add any country-specific data that you think will be useful.
- Prepare **Slide 2-1.**
- Make enough copies of **Participant Handout 2: Case Study - Fatimata** for all participants.

Total session time: 1 hour

Activity 2-1: Understand the challenges young married women and FTPs face when seeking reproductive health services

Time: 40 minutes

Methodology: Case study and discussion

The trainer should:

1. **Read the following to participants:**

   Let's discuss the barriers that young married women and FTPs face when trying to seek reproductive health services. I will read a case study about a young woman named Fatimata to you. As I read the case study, please write down each of the barriers that Fatimata faces while trying to access contraceptive services. The barriers can be within her home, her community, and at the health facility.

2. **Pass out Participant Handout 2: Fatimata Case Study and read the case study about Fatimata (also found below) out loud to participants.**

3. **After reading the case study, give participants a few minutes to reread the case study themselves and make additional notes, if necessary. Then ask them to share some of the challenges that they wrote down.**

4. **After participants have shared, lead a discussion with the participants, using the following questions. Ask each question aloud and allow the group to discuss their answers to the questions.**

   - Could the story in this case apply to young married women and first-time mothers in your community? Why or why not?
   - What do you think Fatimata is thinking and feeling during this experience?
   - Who might be pressuring Fatimata or influencing the decisions that Fatimata and her husband are making?
   - What might be some of the health needs of Fatimata and other young married women in your community?
   - What support would be useful to Fatimata and other young married women and first-time parents in your community?

5. **Conclude the activity by reading the following out loud:**

When a young woman enters a marriage or has a child, 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, a new relationship can create challenges for which they may not be prepared. As we discussed in the case study, young women and their

husbands/partners often experience pressures and influences that are different from those affecting unmarried young people or older married women, particularly around childbearing. As a health care provider in West Africa, it is important to understand these pressures and provide supportive counseling for young women and their partners, so they can navigate the various challenges they face in order to live healthy reproductive and sexual lives.

Case study: Fatimata (also Participant Handout 2)

My name is Fatimata. I am 17 years old. I have a baby girl who is 1 year old. I have been married to my husband for two years. I am the youngest of my husband's three wives. I love my baby girl, but I worry about her a lot because it seems like she is always sick. My husband's mother is always asking when we will have our next child. She says that the baby will start running everywhere soon, so it is time.

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 get a shot to avoid having a baby for three months, but I don't know anything about it. There are some community health workers working in my community, but they are older women who are friends with my mother-in-law, and I know my husband and mother-in-law would disapprove if they knew I wanted to learn more about the medicine to prevent pregnancy. I don't have any friends to talk to about this. I hardly even leave the compound. All my friends from school are also married and live far away.

I was scared, but 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 husband and mother-in-law 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 an 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 two hours 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 my mother-in-law and asked me why I was there since the family planning services are for older women who are ready to stop having children, not a young woman like myself who should have another child while I'm still young.

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 hadn't told him why I was coming. The nurse told me that I had better not use family planning since my husband was certain to find another wife if I didn't have another baby soon, especially since my first baby was a girl. She said I should have all my babies now while I'm young.

I explained that my baby was sickly and it wouldn't be good for us to have another child so soon. The nurse finally said that it is ok for me to use a method and said I should use the three-month injectable, she didn't mention any other method options. I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Fatimata, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including that friend of my mother-in-law. I got my injection and left the clinic very embarrassed and worried.

Activity 2-2: Describe why it is important to offer comprehensive, nonjudgmental services to young married women and FTPs

Time: 20 minutes

Methodology: Brainstorm and trainer presentation

The trainer should:

1. **Brainstorm: Ask participants why they think it is important to offer young married women and FTPs in West Africa comprehensive, nonjudgmental SRH counseling and services.**

2. **After participants have answered, supplement their responses by showing Slide 2-1 and reading aloud the content below.** (The trainer may wish to add country-specific data to the content regarding: percent of women aged 10–24 who are married and modern contraceptive use by age cohort [15–19-year-olds; 25–29-year-olds; 30–34-year-olds].)

Content: Reasons why it is important to offer young married women and first-time parents comprehensive, nonjudgmental SRH counseling and services

- Young women who are married experience pressures from community, family, and husbands to bear children immediately. First-time parents are often under a lot of pressure to have more children quickly, and do not practice healthy timing and spacing of pregnancy.
- Young women often have very little power to:
    - Negotiate use of health services;
    - Decide when and if to have children;
    - Decide when and if to use contraception in their relationships.
- Young people who are married are often ignored by other programs designed for youth because they are not in school or in community-based youth groups. Traditional youth-friendly services are also often geared toward unmarried adolescent boys and girls, or those who do not yet have children.
- Young married women and their partners are just beginning their relationships and reproductive lives together, so this is an opportunity to develop lifelong healthy sexual and reproductive practices and to promote better communication and joint decision making among couples.
- Promoting delay of the first birth and spacing of the second and subsequent births, in addition to joint decision making and communication between young women and their partners, can result in an increase in contraceptive use, lower lifetime fertility, reduced maternal mortality, and increased ability for young women to participate in educational and economic opportunities.

Session 3: Attitudes and Values Related to Young Married Women and FTPs Regarding Fertility and Contraception

Objective of the session:

1. Reflect on attitudes and values related to fertility, contraception, and decision making among young married women and their partners and first-time parents.

Before the training, the trainer should:

- Review the training content.
- Make pieces of paper that are blank on one side, and say either 'Agree' or 'Disagree' on the other. Make enough so that each participant has one card that says Agree, and one that says Disagree.

Total session time: 1 hour

Activity 3-1: Reflecting on views and beliefs related to young married women and first-time parents, fertility, and contraception

Time: 1 hour

Methodology: Game

The trainer should:

1. **Explain to the participants that this activity is designed to provide a time to reflect on their own and each other's values and attitudes about the reproductive health issues facing young married women, first-time mothers, and their partners. It is designed to challenge some of the current thinking about the issues facing young married women, couples, and FTPs, and to help them clarify how they feel about certain issues. Remind participants that this is a safe space for open discussion and that everyone has a right to his or her own opinion. Everyone's opinions should be respected, even if there is disagreement.**

2. **Ask the participants to sit in a circle. Give each participant one piece of paper that says "Agree" and one that says "Disagree."**

3. **Read aloud the first statement from the list of statements found below.**

4. **Give participants a few seconds to think about whether they agree or disagree with this statement (repeat the statement, if necessary). Once everyone has had time to make a decision, say "1, 2, 3." When you say "3," each participant should hold up a card. If they agree with the statement, they should hold up the "Agree" card. If they disagree, they should hold up the "Disagree" card.**

5. **Ask for two volunteers (preferably one "agree" and one "disagree") to explain why they chose their answer. Discuss the distribution of answers—did most people pick "agree" or "disagree"? Do the participants think that this reflects the range of opinions within their community?**

6. **Repeat Steps 3 to 5 with the next statement. Continue with each of the statements below.**

   Statements

   - There are many contraceptive methods that are dangerous for adolescents and youth to use.
   - It is acceptable for a young woman to use contraception before she has had her first child.
   - Husbands should make the decision about whether or not a couple should use contraception.
   - If a married young woman does not have a child in the first two years following her marriage, it is acceptable for her husband to leave her or to seek an additional wife.

- Married young people should not use contraception until they have completed their family size.
- It is acceptable for a health care provider to provide SRH advice and care to a young married woman without her husband's permission or knowledge.
- Many contraceptive methods have a long-term effect on fertility.
- It is sometimes appropriate for health care workers to tell a young married woman's family about her sexual or reproductive health choices.

7. After all of the statements have been read, lead the participants in a discussion using the following questions:

- Are there any statements that you found challenging to agree or disagree with? If so, which ones and why?
- How do you think other people in your community might feel about these statements? Would they agree or disagree with you? How do you think your attitudes might affect your interactions with young married women and first-time parents?

8. Conclude by reading the following out loud:

As health care providers it is important to understand the pressures that young women face from society to have children, and the challenges they might have in communicating about fertility with their partners, their mothers-in-law, and other influencers. It is also essential that you, as health care providers, reflect on the way your own biases might influence how you provide services to young people. Health care providers must reconcile those beliefs with the reality of young women's lives in order to guarantee the right of the young people to receive SRH counseling and services. Remember, young women can use any contraceptive method, though permanent methods are not always the best choice. They can begin using a method before having a child or any time in their reproductive lives. It is healthy for a young woman to delay her first birth until at least age 18 and space subsequent pregnancies by at least two years. We can have healthier communities and healthier women and children if young married women and their partners are supported to delay and space their pregnancies by using contraception.

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 3: HTSP 101** for all participants.
- Review **Slide 4-1** and **Review Game Slides**.
- 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: 90 minutes (1 hour and 30 minutes)

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

Time: 45 minutes

Methodology: Trainer presentation

The trainer should:

1. Present the content below and show Slide 4-1.

Content: Healthy timing and spacing of pregnancy

Healthy timing and spacing of pregnancy (HTSP) is an approach to family planning service delivery that helps women and couples make an informed decision about delaying the first pregnancy, and timing (spacing or limiting) subsequent pregnancies to ensure the healthiest outcomes for mother and baby. There are three key messages associated with HTSP. These are based on 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 two years before trying to become pregnant.
    - Consider 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 six months before trying to become pregnant again.
    - Consider 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.

When counseling young married women and first-time parents, use the HTSP messages as a guide. Ask young women about when and if they would like to have a child, and talk to first-time parents about when and if they would like have subsequent children. Seek to understand what pressures women might be facing related to their fertility, explain the key HTSP messages, and provide them with options to achieve their fertility goals. This would include guidance on contraceptive options, as well as advice regarding joint decision making within couples, and responding to external influences on reproductive choice.

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

- How long a couple should wait before trying to become pregnant again after a live birth?
    - *Answer: Two years*
- After what age is it healthiest 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.*

- How long should a couple wait before trying to become pregnant again after a miscarriage or abortion?
  - *Answer: Space pregnancy by at least six months after a spontaneous or induced abortion.*

3. **Ask participants to brainstorm what some of the benefits of practicing HTSP are for women, adolescents, and newborns.** The research has shown a considerable reduction in maternal and infant mortality when HTSP is practiced. Following the brainstorm, present **Slide 4-2** and read the content below aloud to participants.

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

For families:

- More financial security
- Potential for women to continue education or work

4. **Pass out Participant Handout 3: HTSP 101 as a reminder sheet**

5. **Present the content below:**

Most healthy young women can use any method of contraception to practice HTSP. It is the role of the health care provider to inform, educate, and counsel women and couples on the options that are available to them. It is important to reiterate, however, that 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 young woman has had a child, during antenatal and postnatal care, and even during child health visits.

6. **Ask participants if they have any questions.**

Activity 4-2: Review contraceptive options, HTSP, and counseling for young married women and FTPs

Time: 45 minutes

Methodology: Game

The trainer should:

1. **Divide participants into 2–3 teams.**

2. **Give each team a different colored piece of paper. This piece of paper will be used by the team leader to signal that their team has an answer.**

3. **Ask each of the questions below, one at a time using the eight Review Game Slides. Each team should talk amongst themselves to come up with their answer and *come to an agreement about their collective answer*. When the team has reached consensus about 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 do not get it right, then 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 (e.g., candy).**

5. **When the game is over, the trainer should review the questions once again, this time going into more detail about the answers using the content below.**

Content: Contraception for young women and FTPs and their partners review game

Question 1: **Which contraceptive methods are contraindicated for young women under age 25 who have *not* had children?**

Answer 1: Nearly all contraceptive methods are safe for women of all ages. This includes 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. ***All clients should be told that only male or female condoms alone or condoms used with another method (dual method use) offer protection from both unintended pregnancy and STIs, including HIV.***

Question 2: **Which contraceptive methods can be used while a woman is breastfeeding?**

Answer 2: A woman is only preventing pregnancy through breastfeeding if the baby is less than 6 months old, the baby is exclusively breastfed (no other food or liquid is given to the baby, not even water), and the woman's monthly bleeding has not returned. A woman/couple can use the mini-pill (progestin-only pills), implants, IUDs, and male and female condoms during the postpartum period and while breastfeeding. The IUD can be inserted within 48 hours postpartum. After the 48 hour postpartum window, delay insertion until 4 weeks postpartum.

Progestin-only pills and implants can be used immediately postpartum in breastfeeding women. Injectable contraceptives can be used by breastfeeding women from 6 weeks after childbirth. Providers can consult the World Health Organization's (WHO) Medical Eligibility Criteria for more information.[8]

Question 3: **Give 3 examples of times when a provider can discuss contraception and HTSP with a young married woman or first-time parent.**

Answer 3**:**

- During prenatal consultations
- During postnatal consultations
- During visits to monitor infant health

Counseling on the importance of spacing births should begin during prenatal consultations. If a woman wants to space her next pregnancy, she can select a contraceptive method at this time to begin using during the postpartum period. Postpartum checks and child health visits are also a good opportunity to provide counseling on HTSP and contraception.

Question 4: **Give 3 examples of ways in which confidentiality can be maintained during a consultation with a young married woman or first-time parent.**

Answer 4: Any 3 of the following:

- Carry out the consultation in a separate or partitioned room.
- Make sure no one other than members of staff required for the consultation are present.
- Keep any notes regarding the consultation in a locked place.
- Do not call out the client's full name or the reason for her visit in the waiting area.
- Do not discuss the consultation with anyone, including the woman's husband/partner or family-in-law.

Young married women often experience significant pressure to conceive, particularly if they have not yet had a child. Equally, first-time mothers may be expected to have another child very quickly, and may therefore experience stigma when seeking contraceptive services. It is therefore very important to maintain confidentiality when counseling and treating young married women and first-time parents, to ensure that they are able to make the decisions that are best for their health and lives.

[8] WHO and JHU-CCP, *Family Planning: A Global Handbook for Providers* (Geneva: WHO, 2011): https://www.fphandbook.org/language/french; WHO, *Medical Eligibility Criteria for Contraceptive Use* (Geneva: WHO, 2010): http://www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/

Session 5: Counseling Young Married Women and FTPs

Objectives of the session:

1. Identify the key principles of counseling young married women and first-time parents.
2. Practice counseling young married women and first-time parents on HTSP and contraception.

Before the training, the trainer should:

- Review the training material.
- Review **Slides 5-1, 5-2, 5-3**.
- Make enough copies of **Participant Handouts 4 and 5** for all participants.

Total session time: 2 hours

Activity 5-1: Identify the key approaches for counseling young married women and FTPs

Time: 45 minutes

Methodology: Case study and group discussion

The trainer should:

1. **Introduce the session by reading out loud the content below:**

As a health care provider trained to work with adolescents and youth, it is important to consider how to best provide SRH counseling to young married women, FTPs, and their partners (if they accompany the young women to the clinic). The way you communicate with people impacts what they are willing and able to learn from you. If you are speaking to a young woman and you do not think she should be using contraception, this will come across in your actions, in your tone of voice, and in your body language. The counseling skills and principles you have learned in previous adolescent sexual and reproductive health training are all relevant to young married women and FTPs. Building on what you learned in that training, we will now consider a counseling scenario.

2. **Read aloud the following story. Tell participants to write down what Salimatou does well and what she doesn't do very well.**

Salimatou is a family planning nurse at the health center. Mariam is 19 years old and has been married to Karim for one and a half years. They have a 6-month-old baby and Mariam is a first-time mother. Mariam is planning to introduce solid foods to her baby and once she does that, she knows that breastfeeding will not protect her from becoming pregnant anymore. She does not want another child right away, but does not have much knowledge about contraception. Mariam goes to find out more at the nearest health center. After waiting 3 hours, it is Mariam's turn to see Salimatou (the family planning nurse). Being careful to protect Mariam's privacy, Salimatou calls Mariam to the consultation room quietly and makes sure the door is closed. Salimatou sits in front of Mariam and looks at her very kindly. She asks Mariam questions about her health and the health of the baby. Then she asks Mariam why she came to the family planning room. Mariam tells her that she knows that breastfeeding will no longer protect her from pregnancy and she wants to wait to have another baby and she had heard that there was some medicine that could prevent pregnancies. Salimatou starts to look angry. She asks: "Mariam, does Karim know you are here?" Mariam says that she told him she had to come to the clinic to have the child seen by the nurse. Salimatou says that Mariam does not need to be using contraception now, she only needs to wait 6 months between having a baby and becoming pregnant again, and that it is a perfect time to begin trying to have a baby. Even if she wanted contraception, Salimatou does not feel comfortable giving it to her without Karim's permission. Salimatou is friends with Karim's mother and knows that his mother would not approve.

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

What did Salimatou, the nurse, do well?

Possible answers might include:

- Salimatou closed the door to make sure there was privacy.
- Salimatou greeted Mariam warmly.
- Salimatou sat in front of Mariam, at eye-level (not above her).
- Salimatou asked Mariam open-ended question about her health and the health of her child.

What did Salimatou do poorly?

Possible answers might include:

- Salimatou scolded Mariam for wanting to use contraception.
- Salimatou told Mariam incorrect information about the healthiest spacing of pregnancies.
- Salimatou should not require Karim's permission to give Mariam contraception.
- Salimatou should respect Mariam's privacy and should not let her friendship with Karim's mother affect her advice to Mariam.
- Salimatou should have provided Mariam thorough contraceptive counseling and the contraceptive method of her choice.

4. Present the content below:

As health care providers who are going to be counseling young married women and first-time parents, it is important to learn from the mistakes that Salimatou 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. It is also important to note that if a husband or a male partner accompanies a young woman to the clinic and the young woman is comfortable with him joining them in the counseling session, the health care provider should be welcoming and invite the man to join the consultation.

5. Ask participants to brainstorm a list of the good counseling techniques that they know. After they have finished brainstorming, supplement their answers with the suggestions below and show Slides 5-1, 5-2, 5-3.

Supplemental answers for considerations for good contraceptive counseling:

- Protect the client's privacy and confidentiality. Ensure that counseling is done in a room where others cannot see or hear. Do not announce to the waiting area what services the client is at the clinic for.
- Sit at eye-level with the client.
- Welcome the client warmly.
- Ask open-ended questions about her wellbeing and the wellbeing if her child/children (if she has any).

- Do not do all the talking.
- Show respect for the relationship between the couple, by asking about the woman's relationships with her partner/husband (e.g., how are decisions made in the household) and the partner/husbands' fertility desires and perspective on the use of contraception. Under no circumstances should a woman be denied contraception because her husband has not approved.
- Emphasize the importance of HTSP to the health of the family, and the other benefits of HTSP, such as greater economic stability and improved nutrition.
- 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 the client 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 5-2: Practice counseling young married women and FTPs

Time: 1 hour and 15 minutes

The trainer should:

1. **Introduce the role play exercise.**

2. **Distribute Participant Handout 4: Scenarios for Counseling Role Plays and Participant Handout 5: Observation Checklist for Counseling Role Plays.**

3. **Review both handouts with the group, orienting them on the three scenarios in Participant Handout 4 and the observation checklist in Participant Handout 5.**

4. **Ask participants to form groups of three people. For each set of three, ask participants to decide who will be the provider, who will be the client, and who will be the observer for the first role play.**

5. **Ask each set of participants to select one of the three scenarios in Participant Handout 4.**

6. **Ask participants to act out the scenarios using the counseling skills we've discussed. One person should act as the provider, another as the client, and the third as the observer. After they have acted out the first scenario, the observer should provide his/her feedback using Participant Handout 5 to guide his/her observations.**

   Note to trainer: You may circulate and observe the role plays. If the "provider" needs assistance, you may use the suggestions included below under each scenario as prompts ("Topics that the provider can cover in the counseling").

7. **Now ask the participants to select another scenario and rotate roles so that the person who was the provider is now the client, the person who was the client is now the observer, and the person who was the observer is now the provider. Repeat step 6.**

8. **Then ask the participants to select a third scenario and switch roles so that each member plays the role they have not played yet. 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 client role, what behaviors did you notice that were not comforting? What behaviors were comforting?
   - When you were in the provider role, what behaviors did you find came naturally to you? What behaviors were not as natural or were more difficult?
   - 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 Young Married Women and FTPs (also Handout 4)

Scenario 1: The client is a young woman of 16. She is recently married and has not had a child yet. She came in because her sister, who is older, told her that if she used this thing called family planning then she might be able to prevent pregnancy and go back to school. Her mother-in-law and the sisters of the husband are already talking about how she must be sterile since she is not yet pregnant and it has been 5 months since she married.

Topics that the provider can cover in the counseling: Importance of delaying the first birth until she is at least 18 years old for the health of the mother and the baby; methods of contraception she could use to delay the first birth; use of different methods; characteristics of different contraceptive methods; opportunities she might have for school or work if she delays becoming pregnant; strategies to deal with the pressure she is facing from her husband, mother in-law or sisters-in-law; strategies to talk to her husband about her desire to delay a pregnancy.

Scenario 2: The client is a 19-year-old young woman. She just gave birth to her first child. She will be leaving the maternity ward to go home later in the day. She is nervous. Her labor was very difficult, and she does not want to become pregnant again right away. She mentions her concerns to the maternity nurse and says she would not like to become pregnant again too quickly. She does not know how long she should wait to become pregnant and she has not heard much about family planning.

Topics that the provider can cover in the counseling: importance of waiting at least 2 years before becoming pregnant again 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; different contraceptive methods available; characteristics of different contraceptive methods; strategies to talk to her husband about her desire to space her next pregnancy; strategies to deal with co-wives and other pressures she might feel to have a child very soon.

Scenario 3: The client is a 22-year-old young woman. She came to the health facility with her three children because one them is sick. The nurse who saw her sick child, sent the young mother to the family planning room for counseling. The nurse in the child health room said to the young woman that her babies were all malnourished and that she should not be having another one so soon. The young woman is confused. She does not know what family planning is, but she wants to do something to keep herself and her babies healthy. Since she has three girl children, her husband is demanding a boy child.

Topics that the provider can cover in the counseling: Importance of waiting at least 2 years before trying to become pregnant again; why spacing is important for the health of mother and baby; why spacing the next pregnancy will help with the wellbeing of her children; methods of contraception she could use to space the next pregnancy; different contraceptive methods available; characteristics of different contraceptive methods; strategies to talk to her husband about her desire to space her next pregnancy; strategies to deal with the mother-in-law and other pressures she might feel to have a child very soon.

Session 6: Review and Conclusion

Objective of the session:

1. Review key learnings from the training module.

Before the training, the trainer should:

- Review the material.

Total session time: 30 minutes

Activity 6-1: Review Circle

Time: 30 minutes

Methodology: Brainstorm

The trainer should:

1. **Ask participants to form a circle.**
2. **Ask participants to spend five minutes thinking about the entire training day and come up with one thing that they have learned.**
3. **Go around the circle and ask each participant to share one thing they learned. The participants cannot repeat anything that any other participant has already said.**
4. **Thank participants for their participation in the session, ask for any remaining questions, and close the day.**

Annex 1: Participant Handouts

Participant Handout 1: Training Schedule

Illustrative 1 Day Training Schedule: Supplemental Training for Providing Reproductive Health Services to Young Married Women (ages 10-24)

Time	Sessions
9:00-9:15	Session 1: Introduction to the Module
9:15-10:15	Session 2: Understanding the needs and challenges of young married women and FTPs
10:15-10:30	Break
10:30-11:30	Session 3: Attitudes and values related to young married women and FTPs regarding fertility and contraception
11:30-1:00	Session 4: Healthy timing and spacing of pregnancy
1:00-2:00	Lunch
2:00-2:45	Session 5: Counseling young married women and FTPs Activity 5-1
2:45-3:00	Break
3:00-4:15	Session 5 Continued Activity 5-2
4:15-4:45	Session 6: Review and Conclusion

Participant Handout 2: Case Study Fatimata

My name is Fatimata. I am 17 years old. I have a baby girl who is 1 year old. I have been married to my husband for two years. I am the youngest of my husband's three wives. I love my baby girl, but I worry about her a lot because it seems like she is always sick. My husband's mother is always asking when we will have our next child. She says that the baby will start running everywhere soon, so it is time.

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 get a shot to avoid having a baby for three months, but I don't know anything about it. There are some community health workers working in my community, but they are older women who are friends with my mother-in-law, and I know my husband and mother-in-law would disapprove if they knew I wanted to learn more about the medicine to prevent pregnancy. I don't have any friends to talk to about this. I hardly even leave the compound. All my friends from school are also married and live far away.

I was scared, but 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 husband and mother-in-law 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 an 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 two hours 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 my mother-in-law and asked me why I was there since the family planning services are for older women who are ready to stop having children, not a young woman like myself who should have another child while I'm still young.

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 hadn't told him why I was coming. The nurse told me that I had better not use family planning since my husband was certain to find another wife if I didn't have another baby soon, especially since my first baby was a girl. She said I should have all my babies now while I'm young.

I explained that my baby was sickly and it wouldn't be good for us to have another child so soon. The nurse finally said that it is ok for me to use a method and said I should use the three-month injectable, she didn't mention any other method options. I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Fatimata, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including that friend of my mother-in-law. I got my injection and left the clinic very embarrassed and worried.

Participant Handout 3: HTSP 101

The handout begins on the following page and is available online in French and English:

https://www.k4health.org/toolkits/htsp/htsp-101-everything-you-want-know-about-healthy-timing-and-spacing-pregnancy

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 recommendations* to the WHO, which are included in a report and policy brief[1]:

- *<u>After a live birth</u>, 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.*
- *<u>After a miscarriage or induced abortion</u>, 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 make an informed decision about the delay of first pregnancy and the spacing or limiting of subsequent pregnancies to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed contraceptive choice**,** taking into account fertility intentions and desired family size, as well as the social and cultural contexts.

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)

*WHO 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.

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.
- 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

[*]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, 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 review[10] 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 knowledge using a tracking matrix. ESD is also developing a list of common HTSP indicators.

[†]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.

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.

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Participant Handout 4: Scenarios for Counseling Role Plays

Scenario 1: The client is a young woman of 16. She is recently married and has not had a child yet. She came in because her sister, who is older, told her that if she used this thing called family planning then she might be able to prevent pregnancy and go back to school. Her mother-in-law and the sisters of the husband are already talking about how she must be sterile since she is not yet pregnant and it has been 5 months since she married.

Scenario 2: The client is a 19-year-old young woman. She just gave birth to her first child. She will be leaving the maternity ward to go home later in the day. She is nervous. Her labor was very difficult, and she does not want to become pregnant again right away. She mentions her concerns to the maternity nurse and says she would not like to become pregnant again too quickly. She does not know how long she should wait to become pregnant and she has not heard much about family planning.

Scenario 3: The client is a 22-year-old young woman. She came to the health facility with her three children because one them is sick. The nurse who saw her sick child, sent the young mother to the family planning room for counseling. The nurse in the child health room said to the young woman that her babies were all malnourished and that she should not be having another one so soon. The young woman is confused. She does not know what family planning is, but she wants to do something to keep herself and her babies healthy. Since she has three girl children, her husband is demanding a boy child.

Participant Handout 5: 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 client can understand?			
Counsels the client using the HTSP messages?			
Asks the client about pressures she may be feeling at home 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., does not 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 (i.e. reassure the client if she seems nervous)?			
Is non-directive (i.e., does not tell the client what to do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			

Please record any additional observations/comments for feedback for the provider:

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