USAID FROM THE AMERICAN PEOPLE

esd REACHING FURTHER
extending service delivery

ESD works in partnership with local organizations across the world to promote the healthy timing and spacing of pregnancy (HTSP).
Photo Courtesy: Knowledge for Health/Photoshare

The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Mainstreaming Healthy Timing and Spacing of Pregnancy: *A Framework for Action*

Operations research and other studies show that when women, men, youth, families and communities are educated on the role family planning plays to help time and space pregnancies to improve the health of the mother and child, use of family planning increases significantly. Increasing awareness of the benefits of Healthy Timing and Spacing of Pregnancy (HTSP) among policy makers, providers and community members can contribute to efforts to increase the use of modern contraceptives.

HTSP is an approach that helps women and couples achieve the healthiest pregnancy outcomes. HTSP focuses on the healthiest time to become pregnant, rather than when to give birth. While timing refers to timing pregnancies at the best age possible, spacing refers to pregnancy spacing – the amount of time a woman should wait after a live birth, a miscarriage or abortion, before attempting to get pregnant again – for the healthiest outcomes. The recommendation for pregnancy spacing following an outcome other than a live birth (e.g. stillbirth or neonatal death) that takes into account a woman's desire to immediately replace the lost child, is still being considered. Studies show that if a preceding pregnancy results in a stillbirth, there is elevated risk that the next pregnancy will have the same outcome. [1] The interim recommendation is that special attention should be paid to these women to help them space their next pregnancy (by at least six months), and to ensure that they have access to antenatal care and skilled attendance at delivery.

BACKGROUND

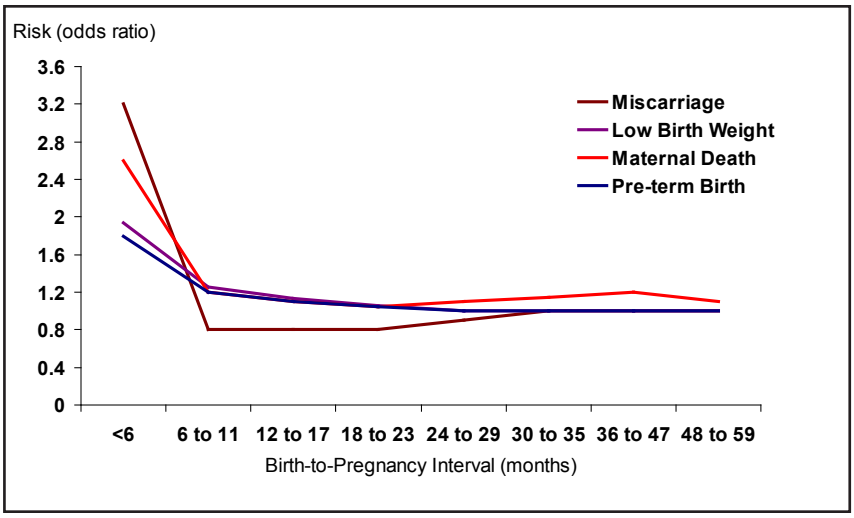
From 2000-2005, USAID sponsored a series of five meta-analysis and systematic literature reviews on pregnancy spacing and health outcomes. The primary objective of the research was to critically assess, from the best available evidence, the effects of spacing on maternal and child health outcomes. [2]

In June 2005, USAID organized a WHO technical consultation and submitted the research findings for review by a panel of 35 World Health Organization (WHO) selected international experts. After the evidence review, the technical panel concluded that short pregnancy intervals following a live birth were associated with adverse maternal outcomes – specifically, maternal mortality, induced abortion, still births and miscarriages – as well as adverse perinatal outcomes, specifically, pre-term birth, small for gestational age and low birth weight. Similarly, the panel agreed that short pregnancy intervals after a miscarriage or abortion were associated with increased risk of early rupture of membrane, maternal anemia, and increased risk of adverse perinatal outcomes, such as preterm births and low birth weights.

The consultation resulted in a Policy Brief, which included two recommendations to WHO from the panel: (1) After a live birth, the recommended interval before attempting the

[1] DaVanzo J, Hale L, Razzaque A, Rahman M. Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. *BJOG - An International Journal of Obstetrics and Gynaecology* 2007: 1-9 (5).
[2] This encompasses perinatal, infant and child health.

Figure 1: Birth to Pregnancy Intervals and Relative Risk of Adverse Maternal and Perinatal Outcomes



next pregnancy should be at least 24 months (this is equivalent to a 33 month birth-to-birth interval) to reduce the risk of adverse maternal, perinatal and infant outcomes; (2) After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy should be at least six months to reduce the risks of adverse maternal and perinatal outcomes.

Additionally, USAID incorporated a third message aimed at reaching youth, based on recommendations from WHO, UNICEF and UNFPA on early age pregnancy, to delay first pregnancy until at least 18 years of age. These three recommendations formed the basis for the key HTSP messages

WHAT'S NEW ABOUT HTSP?

In general, the focus of family planning has been mostly on lowered fertility, rather than healthy fertility. HTSP, however, represents a paradigm shift—from lowered fertility and smaller family size to healthy fertility through family planning. HTSP focuses on all pregnancy-related intervals and when to become pregnant after a live birth, still birth, miscarriage or abortion, rather than on when to give birth. The ultimate aim of HTSP is to increase family planning use to delay, space or limit pregnancies, based on a woman's reproductive health choice and fertility intention. HTSP repositions family planning as a health and social intervention that contributes to healthy mothers, babies, families and communities.

HTSP allows the mother more time to care for her baby following delivery, to breastfeed, to engage in educational, economic and social activities, and to prepare for the next pregnancy. Breastfeeding, in particular, is beneficial for the mother and the newborn; it helps to protect the mother against breast and ovarian cancer, strengthens the health of the baby, and enhances mother-baby bonding. Men also benefit from HTSP, as it gives them an ability to safeguard the health of their partners and children. Because they are not undergoing the stress associated with closely spaced pregnancies, men may find more time to ensure there are enough resources and build a healthy relationship with the family. A new pregnancy leads to new costs, including medical care for the mother and the needs of the new baby. With more resources, families spend more on food, clothing, housing and education for themselves and their children. Healthier families inevitably lead to healthier communities.

MAINSTREAMING HTSP: A FRAMEWORK FOR ACTION

ESD played an integral part in "rolling out" HTSP – i.e., taking the evidence from research to the field and putting the three recommendations into action. To do this, ESD identified a number of critical activities at the global level and at the program/field level.

Key Activities at the Global Level

At the global level, ESD:

(1) *Developed a roll-out strategy*: As a first step, ESD developed a roll-out strategy which served as a roadmap to mainstream HTSP. The strategy was also presented to organizations with a field presence, and used as an entry point to provoke collaboration and interest in HTSP and to establish an HTSP core group network.

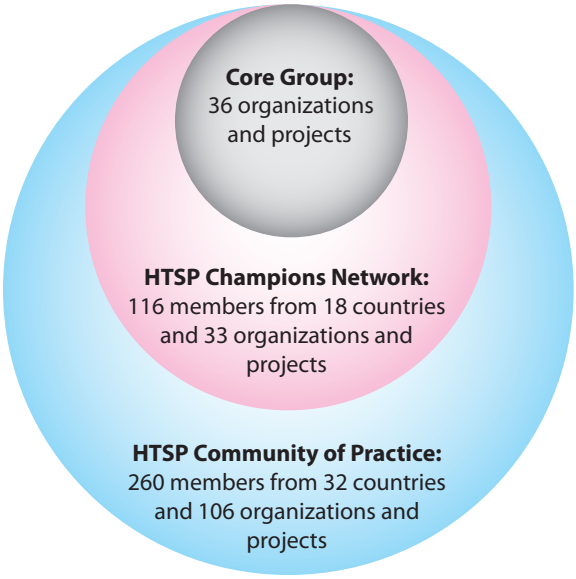
(2) *Supported research and dissemination of findings*: ESD supported research and dissemination of research findings that contributes to the role of HTSP as an aspect of family planning, which reduces maternal and infant mortality and morbidity, and the global burden of disease.

(3) *Established HTSP networks at the global and local levels:* [3]

- An HTSP core group that served as a steering committee and advocated for inclusion of HTSP in

[3] It is hoped that all established global and local HTSP networks will be sustained by local NGOs, organizations, and Ministries of Health. Countries where ESD has worked with the MOH to revise policies, guidelines and curricula to include HTSP recommendations, such as in Guinea, Nepal, and Angola, will be best prepared to maintain HTSP local networks and country-level activities.

Figure 2: HTSP Advocacy Networks



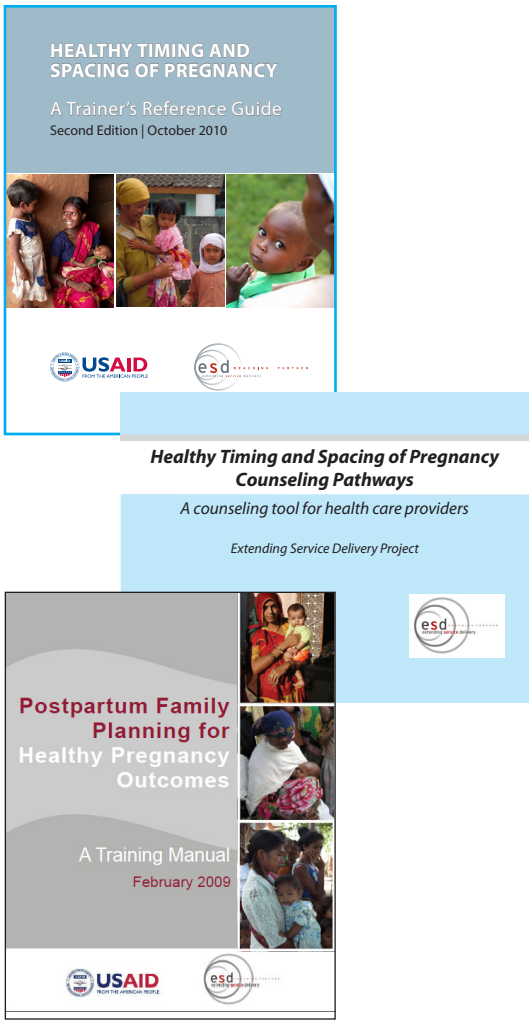
respective field programs. The core group consisted of representatives from USAID-funded, U.S.-based organizations (CAs, PVOs, NGOs).

- A Champions Network of implementers who worked at the field level to integrate HTSP into policies, guidelines and service delivery programs worldwide.
- A web-based HTSP Community of Practice (CoP) on the Implementing Best Practices website[4] which served as a repository of HTSP related tools and resources and as a platform for ESD to share HTSP updates and information. The CoP is comprised of professionals with a common interest in HTSP including members from the Champions Network.
- Country-level HTSP secretariats/advocacy networks that disseminated HTSP information updates and implemented advocacy activities related to HTSP programming.

(4) *Served as the HTSP Global Secretariat*: Any activity involving the cooperative efforts of multiple organizations needs a central point for coordination. As the HTSP Global Secretariat, ESD coordinated HTSP activities, maintained the Champions Network and the CoP, developed HTSP tools, shared HTSP information and updates, including e-newsletters, and developed an activity matrix to record and update the status of HTSP activities being implemented globally.

(5) *Developed HTSP resource materials and tools*: Research indicates that in many countries, little information is included in communication and counseling materials for providers or clients about the specific health risks and benefits associated with the timing and spacing of pregnancy. For this reason, ESD focused on developing HTSP resource materials[5], such as: training guides and manuals, counseling tools and job aids, advocacy briefs, technical briefs and information, education, and communication (IEC) materials for trainers, providers, community workers and policymakers. Two important new resources include the HTSP DVD, a training tool for family planning providers and community health workers at all levels of health care, and the HTSP Counseling Tool, a job aid for family planning counselors that provides cues for counseling women

Figure 3: Examples of ESD HTSP resource materials.



[4] Link to the Implementing Best Practices web site: www.ibpinitiative.org/

[5] HTSP 101 Technical Brief; HTSP Trainers' Reference Guide; Postpartum Family Planning Training Manual; Country Specific HTSP Advocacy Briefs; Fertility Intention Algorithm; Bayer Schering client and provider HTSP brochures and posters. All materials developed are available on the ESD website: http://www.esdproj.org/site/PageServer?pagename=HTSP_publications.

who are at risk of closely spaced pregnancies. [6] ESD also took the lead in translating the technical panel's recommendations into user-friendly take-home messages for service providers to use with clients. At the same time, ESD ensured that HTSP is addressed in materials developed for HIV, postabortion care (PAC), maternal, neonatal and child health (MNCH), child survival and gender-based violence (GBV) programs. ESD also collaborated with partner organizations to include HTSP in partner resource materials and tools, for example, the Family Planning Global Resource Package (FHI), job aids for the Lactational Amenorrhea Method (LAM) and the Standard Days Method (SDM) (Georgetown University/Institute for Reproductive Health), child survival materials (BASICS), and the reproductive health/family planning technical reference materials developed for Child Survival and Health Grants Programs (CSHGP).

(6) *Reached key stakeholders and the health community*: ESD co-hosted an international video conference[7] on HTSP; participated in online forums; provided support to country-level HTSP workshops (DRC, Nepal); and presented HTSP advocacy presentations at international and regional events wherever possible (e.g., Global Health Council (GHC), MotherNewBorNet, the African Association of Gynecology and Obstetrics (SAGO), the Medical Women's Association of Tanzania (MEWATA), Countdown to 2015: Tracking Progress in MNCH conferences, East Africa Child Health Forum and at the Bangkok Asia and Near East Technical Meeting).

Key activities at the Program/Field Level

At the program/field level, ESD:

(1) *Identified a package of interventions*: To facilitate the development and implementation of HTSP programming at the field level, ESD identified a package of interventions to mainstream HTSP into policies and guidelines, programs and services:

- **Advocacy**—bringing evidence to policy makers, increasing their understanding of FP/HTSP's role in reducing maternal and infant mortality and morbidity and reaching the Millenium Development Goals (MDGs) ; delivering information about benefits of family planning and HTSP through training, orientation and education at the community level.
- **Capacity building**—training facility-based and community-based providers to update provider knowledge on HTSP and to strengthen family planning education and counseling skills.
- **Integration**—using all windows of opportunity to link/integrate family planning into other services—health and non-health—including services to underserved populations (e.g. men and youth) and services provided by the private and corporate sector.

(2) *Operationalized HTSP*: To operationalize HTSP, ESD worked on: (1) strengthening community systems; (2) strengthening health systems; and (3) ensuring institutionalization of HTSP. Select illustrative descriptions follow.

Strengthening community systems: ESD focused on strengthening community systems and networks in information provision and community mobilization to raise awareness about benefits of HTSP and family planning. This, in turn, has contributed to community action for HTSP. Specifically, ESD worked with local non-governmental organizations (NGOs), community organizations and community leaders (including religious leaders and private networks of midwives and physicians).

- In *Kenya*, ESD ensured that HTSP was included in all training and orientation of community health workers and religious leaders, working with local partners to reach refugees in the UNHCR supported refugee camps at Kakuma and Dadaab in North East Province Kenya (NEP). By the end of the activity, approximately 4,000 refugees were reached through the mobilization activities led by trained "gender champions," trained community health workers (CHWs) working in the camps, and through collaboration with religious leaders. More recently, ESD supports orientation and education on HTSP, as part of a package of information on focused antenatal care (ANC), preventing mother to child transmission (PMTCT), safe delivery, PNC, and voluntary counseling and testing (VCT) services, for Mothers Group participants in NEP.
- In *Nepal*, ESD supported a local NGO, the Nepal Technical Assistance Group (NTAG), to train

[6] *HTSP DVD and Counseling Tool are available at www.esdproj.org/site/PageServer?pagename=HTSp_Tools*

[7] ESD co-hosted the videoconference "Motivating Families for Healthy Spacing: New Research and Programs" in December 2007, with the Health Communication Project, JHPIEGO, and the World Health Organization. The discussion included participants from Uganda, Kenya and Jordan.

Photo 1: A Mother's Group in Nepal, established by a partnership between the Nepali Technical Assistance Group (NTAG) and ESD in Kathmandu 35, learns about HTSP.

community health outreach workers and mothers' groups to reach postpartum women with HTSP information so that they would adopt family planning and better space their next pregnancy. Focus group discussions revealed that the couples' increased knowledge of HTSP was an important motivating factor for pregnancy spacing. Similarly, husbands reporting a positive attitude toward family planning use increased from 74 percent at baseline to 95 percent at endline, according to household surveys.

- In *Nigeria*, ESD worked with the Federation of Muslim Women Association of Nigeria (FOMWAN), a community organization, to address household and community barriers young married women face related to family planning use and delaying and/or spacing their pregnancies. To do this, FOMWAN reached out to husbands and mothers-in-law who often play a large role in the reproductive health decisions made by young Nigerian women. ESD also oriented religious leaders on the benefits of HTSP for the individual, family and community, resulting in HTSP messages added to sermons given by religious leaders. More than 60,000 young married women, their mothers-in-law and other influential women in the community were reached with information on HTSP and FP in the five target local government areas (LGAs).[8] Additionally, more than 60,000 community members were reached by the 30 trained imams in the five target LGAs during Friday prayers and one-on-one counseling sessions. An additional 1,000 imams were oriented to the benefits of HTSP and FP in all 45 LGAs of Kano State as part of a roll-out training initiated and organized by the original 30 trained imams and five ulamas. In June 2010, select FOMWAN members conducted a follow up community survey to determine the outcome of these interventions. From the population surveyed, FOMWAN members found that awareness of HTSP was quite high among all respondents, with 87 percent of young women aged 15- 20 and 89 percent of women aged 21- 24 having heard about HTSP. All male respondents surveyed reported having heard of HTSP. When asked where they had heard about HTSP and FP, young women were most likely to report learning from FOMWAN workers who visited their compounds (79 percent of young women aged 15 to 20; 82 percent of young women aged 21-24). Among older women aged 40 to 55, the majority of women had heard about HTSP from friends (36 percent) or at an Islamiyya school (36 percent), while 27 percent had heard about HTSP from an imam and 27 percent from their husbands.
- In *Tanzania*, ESD supported Medical Women's Association of Tanzania (MEWATA) to serve as the HTSP local secretariat, with a mandate to increase HTSP awareness among the Ministry of Health (MOH), private providers, training institutions, NGOs, and the media. MEWATA developed a three year advocacy action plan for inclusion of HTSP in national protocols and training plans. To date, HTSP is included in the national pre-service curricula for nurses as well as the medical university OB/GYN curricula and post-graduate seminars. MEWATA

[8] Lane, Cate et al. Reaching Young Married Women in Northern Nigeria with Information on Healthy Timing and Spacing of Pregnancy: Findings from a Community Survey, September 2010.

has successfully engaged its network of providers who counsel couples on HTSP in their private clinics. MEWATA members have also presented HTSP at several workshops and conferences, resulting in increased awareness of HTSP both in Tanzania and elsewhere. MEWATA presented HTSP at its official launch; at a workshop organized by the Population Reference Bureau (PRB) for journalists in Tanzania; at the Association of Gynecologists and Obstetricians in Tanzania (AGOTA) conference; and at the White Ribbon Alliance Annual General Meeting for global members held in Tanzania. The MEWATA HTSP Committee also facilitated translation of key HTSP documents, including the Bayer Schering Pharma consumer and provider booklets and poster into Swahili. Five hundred translated copies were later printed and disseminated to HTSP stakeholders in 23 regions of Tanzania.

- In the *Asia/MIddle East region* (AME), ESD supported and strengthened local organizations through sub-grants to scale up best and promising practices including HTSP. (Refer to the Legacy Series: Scaling Up Best Practices in Asia and the Middle East).

Strengthening health systems: For health systems strengthening, ESD focused on: generating knowledge by supporting research, synthesis and analysis of HTSP-related global and regional data and presenting evidence at international forums; sharing evidence to impact leadership and policies; developing training tools/guides for training and workforce building in FP/HTSP; and developing and implementing service delivery models and integrated packages in partnership with the national MOH and on-the ground partners. A few select examples follow:

- In *Angola*, ESD designed and implemented a service delivery model which used a three-pronged approach: (1) capacity building of Ministry of Health (MOH) providers; (2) integrating FP/HTSP into antenatal, postpartum and post abortion care services and MCH programs; and (3) community mobilization. Simultaneously, ESD worked with the MOH to update the national family planning curriculum and developed an addendum to supplement the curriculum, which included HTSP recommendations and benefits. Between July and September 2010, ESD and Medicus Mundi held

Photo 2: Mamans Lumières in Burundi being trained on nutrition for safe motherhood. Their curriculum also includes HTSP.

three sessions to train a total of 100 Community Agents (CAs) in RH/FP, HTSP and interpersonal communication subjects. Once trained, these CAs went on to conduct 159 community talks with a primary focus on family planning, HTSP and MCH. These forums were attended by 13, 877 people between the ages of 14-45 years of ages, composed of 8,785 women and 5,092 men. CAs also conducted a total of 986 home visits during which they provided FP, HTSP and MCH counseling for a total of 5,099 family members. A chapter on HTSP is also included in the MOH's updated RH/FP national training guidelines.

- In *Guinea*, ESD worked closely with the MOH and other national organizations to revise national RH/FP norms and procedures, policies and training curricula to include HTSP recommendations and to develop counseling guidelines for health providers, supervisors, and community-based distributors (CBD). The national CBD strategy and training curricula include HTSP recommendations and benefits. At the health facility level, in addition to training providers, supervisors were trained to

ask questions and remind service providers of the HTSP messages during follow-up visits as well as distribute brochures and posters that promote HTSP. Community health workers were also trained to sensitize clients on HTSP in facility waiting rooms. These talks were well received, and often reached up to 70 people at a time. ESD worked with the MOH to successfully launch a Secretariat in early 2011. Other plans include integrating HTSP messages into PMTCT, ANC, PNC, PAC, and EGI (vaccine) programs in four regions, as well as introducing HTSP into the curricula of training institutions.

- In *Burundi*, community health workers were trained to deliver HTSP messages during Community-Integrated Management of Childhood Illness (C-IMCI) related home visits and health education sessions. As of September 2010, a total of 1,071CHWs, TBAs and "Mamans Lumières"were trained to promote HTSP. As a result of the trainings, CHW and TBAs in Kayanza and Muyinga provinces are now responsible for the dissemination of HTSP messages at the community level. To date, at least 1,335 people (785 women and 550 men) have participated in community education events on FP/HTSP led by CHWs working with MCH project staff.
- In *Yemen*, ESD focused on training and workforce building in HTSP programming starting from the hospital level to the community level. ESD trained 667 hospital staff, including 207 doctors, 293 midwives, 129 nurses and 38 others in HTSP in ten governorates as part of clinical skills training and the scale up of best practices. At the community level, a total of 934 community health workers, 175 religious leaders, and several members of community mobilization groups have been oriented to date on HTSP messages and benefits. To support the orientation and workforce building, ESD and the Basic Health Services (BHS) Project developed a community health workers' handbook and flip chart, as well as a mother and baby care handbook for clients. The client handbook was distributed in hospitals where ESD has supported the implementation of best practices. HTSP messages and benefits were also included in five video public announcements that were broadcasted in clinic waiting rooms and counseling rooms.
- In *Nepal*, an ESD-supported local NGO, Society for Essential Natural Resources Protection and Peace (SENRPP), organized a series of seminars and advocacy workshops for parliamentarians, ministry officials, NGO partners, media and other stakeholders. The activities resulted in raised awareness about HTSP benefits in reducing maternal and neonatal mortality and morbidity. As a result of SENRPP's advocacy efforts, HTSP has been included in the Government of Nepal's Ministry of Health and Population and the Family Health Division's national training curriculum for Female Community Health Volunteers. Within the curriculum, there is a specific section that provides guidelines for counseling postpartum women on FP and HTSP. Parliamentarians have also recently signed a commitment to include HTSP recommendations in the Safe Motherhood Act, which is currently awaiting approval in the House.
- Also in *Nepal*, ESD helped NTAG conduct a community-based program to increase knowledge of HTSP and FP use and continuation among the urban poor. To evaluate the impact of the

Photo 3: West Bengali mother and children. Photo courtesy of Photoshare.

intervention model, ESD carried out academically rigorous, operational research to measure and track trends in the contraceptive behavior of women who received monthly HTSP counseling during their first six months postpartum, as one component of NTAG's family planning outreach activities also including Mothers' Groups (see bullet on page 5). The study followed postpartum women for up to 30 months, collecting information on FP use by method type, source of method, reasons for use/non-use, pregnancy status and pregnancy outcome. As of March 2010, 89 percent of postpartum clients (N= 85) are currently using a modern FP method as compared to 62 percent of (N=183) of postpartum women in control sites. The final results will show evidence of the impact this HTSP community-based intervention has on birth spacing and contraceptive use over time among an urban poor, largely displaced population. Lessons learned in applying and refining this model will be shared through ESD's broad dissemination channels and through submission to a widely read, peer reviewed journal.

- In *Pakistan* ESD's partners (Ministry of Population and Welfare, Ministry of Health, Pakistan Initiative for Mothers and Newborns, Family Advancement for Life and Health) have been working to integrate HTSP messages at multiple levels in the health care system. This was done through using ESD's HTSP Trainers' Reference Guide in the HTSP training of lady health workers and the translation of key HTSP documents, including the Bayer Schering Pharma client and provider brochures and ESD's Religious Leaders Training manual.

(3) *Ensured the Institutionalization of HTSP*: Establishing and maintaining a Champions Network[9] was a vital step in ensuring the institutionalization of HTSP. The diverse global Champions Network members representing different projects, institutions and organizations played a variety of roles and contributed to the institutionalization of HTSP as follows:

- *Global Projects*: USAID's global projects (e.g., ACCESS-FP, BASICS, FAM project, etc) were able to incorporate HTSP into their resources, publications and field-based activities.
- *Field programs*: Through its field programs in Burundi, Guinea and Angola, ESD was able to work directly with national governments to promote and integrate HTSP information into existing government programs, policies, curricula and guidelines.
- *Partner CAs*: CAs with a field presence (e.g., Intrahealth, FHI, MSH, Pathfinder, GU/IRH) implemented programs that incorporated HTSP. PVOs/NGOs/FBOs (World Vision, FlexFund partners) with an expansive reach and sustained presence reached populations in many community settings.
- *Training institutions*: Training institutions (Medical School of DRC, School of Midwifery in Tanzania) included HTSP in pre-service training as part of their student coursework.
- *Networks*: Global networks (White Ribbon Alliance), private networks of midwives/physicians (MEWATA/Tanzania) and business coalitions/corporations (Bayer Schering) played unique roles in advocating and disseminating HTSP information.

Regional programs: Working through regional programs such as AWARE II in West Africa, ESD has helped integrate HTSP in several of its focus countries:

- *Mauritania* – In Mauritania, AWARE II's policy and fund leveraging activities in the regional and country levels have produced two important PowerPoint advocacy tools – "Islam and HTSP" and "Islam and HIV" – for religious leaders. These tools have been reviewed and approved by officials at the Ministry of Health for national use, and have been produced in Arabic for easy dissemination throughout the country. In addition to these tools, AWARE II has been working to update the curriculum at the country level to integrate HTSP into Emergency obstetric and neonatal care (EmONC) guidelines.
- *Burkina Faso* – In Burkina Faso, AWARE II helped update the curriculum at the country level to integrate HTSP for the Community Based Distribution (CBD) program.
- *Sierra Leone* – In Sierra Leone, AWARE II developed a Family Planning advocacy tool stressing the benefits of HTSP to the Ministry of Health and partners. They plan to extend the use of the advocacy tool nationally and, more specifically, in the two

[9] The Network consisted of USAID global projects, field programs, CAs, PVOs/NGOs and training institutions

districts where AWARE II works. AWARE II has also developed guidelines for integrating HTSP into C-IMCI protocols which were disseminated to other partners in country.

- *Togo* – Working with a local consultant and in close collaboration with UNICEF and WHO, AWARE II has revised Togo's C-IMCI guides by integrating HTSP and focusing on ARI, Diarrhea and Malaria among children under five years. The new guidelines have also integrated illustrations, detailed pictures, and job aids for CHWs to make them easier to understand and use.

RESULTS

At project's end, the US-based HTSP Core Group, which started with 16 members, expanded to 85 members from 36 U.S.-based organizations. The HTSP Champions Network has 116 members from 33 organizations and projects in 18 countries. The web-based HTSP Community of Practice has 260 members from 32 countries and 106 organizations and projects:

Furthermore, ESD and HTSP Champions have reported[10] HTSP integrations into 396 activities worldwide (see table below):

Specifically, HTSP information was:

- incorporated into national standards, policy documents and protocols in seven countries;
- presented to MOH representatives and other government officials in 27 countries;
- included in training curricula in 12 countries; and
- disseminated in IEC/Behavior change communication (BCC) Campaigns. For example, ACCESS-FP, a HTSP Champion, reached individuals through IEC/BCC campaigns in Nigeria, Haiti, Burkina-Faso and Bangladesh. In Nigeria, these groups reached 14,825 individuals in 2007 and 2008. In Haiti, they reached 142 young mothers and community leaders. In Burkina-Faso, 651 people were reached through group discussions and 2,255 through family planning counseling. In Bangladesh, 14,950 people were reached through community mobilization. In total, 32,681 individuals were reached with HTSP messages through IEC/BCC campaigns and activities.

HTSP WORLD WIDE ACTIVITES

CATEGORY	NO.	% OF GLOBAL HTSP ACTIVITIES	ACTIVITES INCLUDING HTSP
TRAINING AND CURRICULUM DEVELOPMENT	105	27%	-POSTPARTUM COUNSELING TRAINING FOR MIDWIVES -IUD PROVIDER TRAINING -ORIENTATION OF RELIGIOUS LEADERS
IEC MATERIALS AND TOOLS	96	24%	-INSTITUTIONAL WEBSITE UPDATES -PROVIDER COUNSELING TOOLS AND JOB AIDS -NATIONAL FP AWARENESS CAMPAIGN
SERVICE DELIVERY	52	13%	-FP COUNSELING -COMMUNITY CASE MANAGEMENT OF CHILD AND NEWBORN ILLNESSES -POSTNATAL CARE FOR HIV+ WOMEN
ADVOCACY AND POLICY DEVELOPMENT; CONFERENCES AND MEETINGS	96	24%	-ADVOCACY BRIEFS FOR POLICY MAKERS -NATIONAL IMCI STRATEGY -NATIONAL COMMUNITY-BASED DISTRIBUTOR STRATEGY -POSTPARTUM FP TECHNICAL CONSULTATION MEETING -CONFERENCE OF ISLAMIC LEADERS -FEDERATION OF OB/GYN IN AFRICA CONFERENCE
RESEARCH AND EVALUATION	47	12%	-EVALUATING THE EFFECTS OF HTSP COUNSELING -HTSP INCLUDED IN MENU OF EVIDENCE-BASED PRACTICES -OPERATIONS RESEARCH

[10] Information is gathered from several sources: email updates from HTSP Champions and Community of Practice members, quarterly reported activities from ESD field support and associate award activities, and the online survey of HTSP country-based activities, administered in February 2010.

- According to a USAID Desk Review conducted in 2008, an estimated 15 training manuals, training curricula and national documents have been developed that incorporate HTSP messages. An estimated 7,611 of providers, trainers and community champions have been trained by ESD and members of the HTSP Champions Network. (See tables below for details.)

LESSONS LEARNED

Key lessons learned from ESD's framework for action to mainstream HTSP are as follows:

1. *Developing a well-defined strategy* from the beginning served as a roadmap and successfully guided the HTSP rollout from knowledge to action.

2. *Recommendations and messages based on data/evidence are influential* and are considered key in advocacy and behavior change activities.

3. *Establishing and maintaining global to local networks was* important to ensure sustainability. To maintain these networks, *consistently sharing communication and information was vital*, as was ESD's function as the HTSP Global Secretariat.

4. *Using networks* to promote best and promising practices have significant multiplier effects.

5. *Building service providers' skills in counseling and communication* is crucial for mainstreaming HTSP recommendations. Operations research studies show that when communication and counseling are provided and FP is understood as a health intervention essential for healthy mother and child outcomes, FP use increases. Pathfinder's PRACHAR project (see page 11) demonstrates the positive effects of HTSP.

6. *Investing in community systems* by building the capacity of local stakeholders (local NGOs, community organizations, community leaders, religious leaders, community members including husbands mothers-in-laws and private networks of midwives, pharmacists and physicians) improved community mobilization and outcomes of the HTSP rollout strategy.

5. *Using all windows of opportunity* to integrate HTSP counseling and information provision into health and non-health services—such as maternal care (antenatal, postpartum), post abortion care, child health services, HIV services, youth activities, religious leaders' activities gender activities and work places—is pivotal in mainstreaming HTSP.

6. *Establishing the Champions Network* and including different organizations, institutions, and MOHs in the Network broaden the base of support for HTSP and ensures sustainability.

PENDING AGENDA

Much remains to be done as the mainstreaming of HTSP goes forward. Some examples follow:

Contraceptive security: HTSP is being credited with revitalizing interest in family planning among countries or regions that had prematurely stalled in their attempt to reduce the unmet need for family planning services. While ESD's mandate does not include ensuring the availability of family planning

CHAMPIONS/LEADERS TRAINED (FY06-08)
COMMUNITY CHAMPIONS—219
YOUNG MOTHERS/COMMUNITY LEADERS—142
COMMUNITY MOBILIZERS—146
RELIGIOUS—92
MALE GENDER-BASED VIOLENCE CHAMPIONS—60
GOVERNMENT PARTNERS—30
MEDIA OFFICERS—2
CULTURAL OFFICER—1
WOMEN'S CLUB SUPERVISOR—1

PROVIDERS/TRAINERS TRAINED (FY06-08)
PROVIDERS (DOCTORS, NURSES, MIDWIVES, CLINICAL OFFICERS—5,388
COMMUNITY HEALTH WORKERS—201
COMMUNITY-BASED FP DISTRIBUTORS—245
TRAINERS—674
PHARMACISTS —300
PHARMACY STAFF—569
PEER EDUCATORS—162
MENTORS/TUTORS—72
TOTAL—7,611

Source: USAID Desk Review: HTSP Technical Priority Activities and Results, February 2009

commodities, there have been observations that if demand for family planning service is raised, clients should concurrently have access to reliable contraceptive supply. In the future, it will be critical to strengthen collaboration with programs working in contraceptive security.

Inclusion in pre-service training: ESD has generated significant momentum and interest in HTSP, and HTSP continues to be endorsed by partners. For institutionalization and sustainability of HTSP programming, HTSP needs integration into more pre-service training, alongside ongoing in-service training.

HTSP programming tools: Other important HTSP programming tools will need development, including a methodological guide to integrate HTSP recommendations into on-going activities; a supervisory checklist for providers working in HTSP integration activities; and a framework for systematic monitoring of HTSP at the country level.

Behavior change communication (BCC): Equally important will be activities focusing on BCC. BCC will help to establish and strengthen social norms in reproductive health and family planning that support a woman's choice to delay, space or limit within a framework of informed choice, fertility intentions and personal reproductive health goals.

Monitoring and Evaluation: ESD has worked with the MEASURE Project to develop a series of HTSP Indicators to include in a revised version of the Compendium of Indicators for Evaluating Reproductive Health Programs (soon to be published online). Going forward, more programs need to utilize data on spacing practices/birth intervals and related birth outcomes as a measure of overall program success. We also need to focus on other M&E activities, such as evaluating provider attitude towards HTSP; impact of provider attitude on clients' HTSP behaviors; and assessing the impact of HTSP recommendations on the use of contraceptives and family planning services.

Scaling-up

Local secretariats – ESD developed "local secretariats" for HTSP in targeted countries to promote HTSP and the adoption of HTSP messages among professional

Effect of Counseling and Communication on Contraceptive use in Bihar, India [11]

The PRACHAR project was implemented by Pathfinder International in Bihar, India, aimed to improve the health and welfare of young mothers and their children by changing social norms related to pregnancy delay and spacing. The program used a gender integrated approach which included couple communication, negotiation and joint decision making, and intensive communication and counseling. Interventions included counseling young women with (zero to one) child through monthly home visits. The newly married women were counseled on delaying first births (the median age of marriage for women in Bihar is 15.9 years, and the median age of women at first birth is 18.8 years) and women who were pregnant for the first time were counseled on spacing their next birth by at least 36 months using contraceptives. Over 33 percent of couples exposed to counseling on the benefits of delaying the first pregnancy decided to delay their first child, compared to 10 percent of couples in the comparison group; similarly 59 percent of couples signaled their intent to space their second child, compared to 22 percent of couples who were not exposed to HTSP counseling. As a result, contraceptive use among childless women deciding to delay their first birth increased from 3 to 16 percent in the intervention areas, compared to 2 to 3 percent in comparison areas. This resulted in median age at first birth over two years greater in the intervention group compared to the comparison group (age at first birth of 23.6 years vs. age at first birth of 21.5 years). The project also showed the impact of intensive communication efforts and joint decision making on delay and spacing. Nearly 60 percent of couples exposed to communication efforts and joint decision making in the intervention areas spaced their 2nd child, compared to 21.8 percent of couples in the comparison areas. Additionally, use of contraception among women with no education – generally considered the most difficult to reach – increased significantly in intervention areas, compared to little change in the non-intervention areas.

[11] Daniel, E. Elkan, Masilamani, Rekha, Rahman, Mizanur, The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive Use Among Young Married Couples in Bihar, India. International Family Planning Perspectives, 2008 34(4): 189-197. Nanda, Rema Pathfinder India, PRACHAR Program, presented at Reconvening Bangkok Best Practices Meeting, March 6-11, 2010

[12] Rutstein, Shea O. 2008. "Further Evidence of the Effects of preceding Birth Intervals on Neonatal, Infant and Under-Five-Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys." DHS Working Paper. No. 41.

[13] DaVanzo Julie, L Hale, A Razzaque and M Rahman. 2008. "The effects of pregnancy spacing on infant and child mortality in Matlab, Bangladesh: How they vary by the type of pregnancy outcome that began the interval." Population Studies. V. 62. No. 2

[14] Quoted from "The Missing Link: Leading Changes in Practices to Improve Health," by J. Dwyer and R. Jacobstein, MSH.

[13] USAID. GH Technical Assistance Project. July 2009. Extending Sevice Delivery Participatory Assessment.

organizations, service providers and the community. The first secretariat was launched in Tanzania with MEWATA. Scaling up this activity and establishing a foundation of local secretariats in priority countries will ensure that HTSP has a sustainable institutional foothold in the future.

Consumer campaigns – Continuing direct outreach to consumers with HTSP information and messages will be essential in the pending agenda. Under ESD, a consumer campaign was implemented in Tanzania in partnership with Bayer Schering Pharmaceuticals (see legacy brief: Promoting HTSP through Pharmaceutical Partnerships and Professional Associations). Under ESD, a 30-second TV public service announcement (PSA) featuring images of women, children and families from across the world was developed to promote HTSP. The PSA focuses on the "wait two years after a live birth" HTSP message and will be aired throughout West Africa by AWARE II. It is also being considered by partners in Tanzania, Nepal, India, and East Timor. It will be important to continue consumer campaigns that directly reach the general public with HTSP messages. The ultimate goal of scaling up consumer campaigns as a part of future messaging is to mainstream HTSP messages into all health service delivery, while increasing the use of family planning.

CONCLUSION

New research findings (unavailable at the 2005 WHO technical consultation) support an even stronger case for HTSP. A study looking at 52 DHS surveys from 2000 to 2005 shows an association between short birth-to-pregnancy intervals and increased risk of under five and child mortality. Specifically, the analyses showed that children conceived after an interval of less than 24 months have an increased risk (1.5 times more) of dying between their 1st and 5th birthday, compared to children conceived after an interval of 36 to 47 months.[12] Another recent study[13] shows a 37 percent increased risk of late neonatal mortality and a 23 percent increased risk of under-five mortality at short intervals, compared to longer intervals of 36 to 59 months. Based on these findings, researchers concluded that "the previously recommended birth interval of at least two years could arguably be increased to at least three years."

As Dwyer and Jacobstein wrote in The Missing Link, "Fostering change is not easy. Change does not happen just because evidence shows it is beneficial. Five factors have been identified that effect successful change—a dedicated change agent; clarity on purpose and anticipated results; motivation and ongoing support of staff; clearly assigned and accepted responsibility; and an environment that encourages change. The new idea either finds a champion/dedicated change agent, or dies." [14]

The HTSP network members have been and will continue to be these champions by continuing to show that "the HTSP roadmap is clear, readily understood and can be used across cultures with providers, community leaders, and peer health educators." [15]

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