Healthy Timing and Spacing of Pregnancy



A Trainer's Reference Guide

August 2008

USAID
FROM THE AMERICAN PEOPLE

esd
extending service delivery

What is ESD?

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.

For further information, please contact:

Director, Extending Service Delivery Project
1201 Connecticut Avenue, NW, Suite 700
Washington, D.C. 20036
Tel. 202-775-1977
Fax 202-775-1988
ESDMail@ESDProj.org

This trainer's reference guide is an updated and revised version of the Optimal Birth Spacing Interval (OBSI) Trainer's Guide prepared by the CATALYST Consortium. The update and revision were done by staff from the Extending Service Delivery Project.

Credits:

May Post
Natalie Elkan
Kamlesh Giri
Maija Kroeger
Cate Lane
Jennifer Mason
Graciela Salvador-Dávila
Ilham Siddig
Cathy Solter
Caroline Tran

This publication was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. GPO-A-00-05-00027-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

Trademarks:

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

PREFACE

It is increasingly clear that family planning (FP) helps save women's and children's lives. Family planning:

- prevents untimely and unintended pregnancies;
- reduces women's exposure to the health risks of unsafe childbirth and abortion; and
- reduces the risks associated with pregnancies that are early, closely spaced, late or high parity.

All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education, and the means to do so.

Easy access to FP information and improved provision of services must continue to be supported and integrated with efforts to promote antenatal care, encourage breastfeeding and increase use of other health services. In countries where unsafe abortion is common, access to family planning services is even more important because increased use of contraception can prevent the pregnancies that may lead to unsafe abortion[1].

As part of international efforts to achieve the Millennium Development Goals of reducing child mortality and improving maternal health, and to reduce unmet need for contraception, the Extending Service Delivery (ESD) Project, in collaboration with USAID and local partners in the field, is addressing reproductive health and family planning (RH/FP) needs at the community level. A key project activity focuses on strengthening the ability of health workers to reach women, men, and communities with information, education and counseling on the health and social benefits of Healthy Timing and Spacing of Pregnancy (HTSP) through the use of RH/FP services.

The Extending Service Delivery (ESD) project has developed *Healthy Timing and Spacing of Pregnancy: A Trainer's Reference Guide* as a resource for trainers in developing in-service training for facility-based healthcare providers and community health workers (CHWs) who already have some basic experience with and understanding of RH/FP. This is not a training manual, but a reference guide which can be used and adapted by trainers based on whether or not trainees are are facility-based or community-based. HTSP training will enable providers to disseminate up-to-date and correct information and education on the health and social benefits of HTSP as part of RH/FP counseling and other health services. This information can help women better use FP to delay, space or limit their pregnancies, within a context of informed contraceptive choice.

Data show higher rates of maternal and/or infant and perinatal mortality and morbidity when a pregnancy following a live birth is spaced by less than two years or more than five years. The data show a similar effect when a pregnancy occurs less than six months after an induced or spontaneous abortion. These data were compiled and analyzed by USAID-supported researchers Agustin Conde-Agudelo, José Belizan, Shea Rutstein, Julie DaVanzo and Bao-Ping Zhu, in addition to focus group discussions commissioned by the CATALYST Consortium[2] on pregnancy spacing. Findings were discussed by a panel of 30 technical experts in 2005, and the recommendations from this technical consultation were published in a World Health Organization (WHO) 2006 Policy Brief on Birth Spacing[3].

1 ESD does not provide nor advocate for abortion services.

2 The CATALYST Consortium (2000-2005) was a global reproductive health activity initiated in September 2000 by the Center for Population, Health, and Nutrition, Bureau for Global Programs of the U.S. Agency for International Development (USAID). The Consortium was a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.

3 World Health Organization. 2006. *Policy Brief on Birth Spacing – Report from a World Health Organization Technical Consultation.* WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.

Using this information, as well as materials produced by a number of USAID cooperating agencies, including ACCESS-FP, JHPIEGO, Family Health International (FHI), and Pathfinder International, this Reference Guide will facilitate the integration of HTSP research findings and recommendations into health programs and services, which will improve utilization of RH/FP services.

ACKNOWLEDGMENTS

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. ESD is committed to making all RH/FP products and services, including fertility awareness and long acting and permanent methods, available to all who wish to use them when they want them, and is actively working to operationalize HTSP at the policy and programmatic levels.

The *Healthy Timing and Spacing of Pregnancy Trainer's Reference Guide* builds on the work of the CATALYST Consortium. In this updated version of the Guide, ESD incorporates new research findings, as well as the recommendations of technical experts to WHO, after their review of the evidence at the 2005 WHO Technical Consultation on Birth Spacing. Their recommendations were published in a ***2006 WHO Policy Brief*** on birth spacing. WHO is now reviewing the technical experts' recommendations and has requested additional analyses to address questions that arose at the 2005 meeting. WHO's recommendations will be issued when their review has been completed. The Guide also incorporates new information from ***Family Planning: A Global Handbook for Providers***, published in 2007.

ESD would like to acknowledge the contributions of ACCESS-FP, JHPIEGO, FHI, Pathfinder International, and ORC MACRO International in using and/or adapting their material in the preparation of this Guide.

ESD made significant use of the following resources in developing this guide:

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. 2007. *Family planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO.

WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe. 2006. Policy brief on birth spacing: report from a World Health Organization technical consultation. World Health Organization (WHO), Geneva.

DaVanzo Julie, et al. 2007. The effects of birth spacing on infant and child mortality, pregnancy outcomes, and maternal morbidity and mortality in Matlab, Bangladesh. *British Journal of Obstetrics and Gynecology* 114, 9 (Sept):1079-1087.

Agustin Conde-Agudelo, et al. 2006. Birth spacing and the risk of adverse perinatal outcomes: a meta-analysis. *The Journal of the American Medical Association* 29 (19 April): 1809-1923.

Conde-Agudelo Agustin, A., J. Belizan and C. Lammers. 2005. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: cross-sectional study. *American Journal of Obstetrics and Gynecology*, Vol. 192: 3429.

"The Facts: Adolescent Maternal Mortality" is used with permission from Advocates for Youth (www.advocatesforyouth.org)

Additional resource materials can be found in the complete bibliography, which appears as Annex X

Finally, ESD thanks Dr James D. Shelton, Senior Medical Scientist, Office of Population and Reproductive Health, United States Agency for International Development (USAID), and our Cognizant Technical Officer, Dr Maureen Norton, and Technical Advisor, Dr Rushna Ravji for their ongoing support and guidance.

LIST OF ACRONYMS AND ABBREVIATIONS

ARV/ART	Anti-retrovirals/Anti-retroviral Therapy
BCC	Behavior change communication
CHW	Community health worker
COC	Combined oral contraceptive
DMPA	Depot Medroxyprogesterone Acetate (Depo-Provera)
DVT	Deep vein thrombosis
ECP	Emergency contraceptive pill
ESD	Extending Service Delivery
FHI	Family Health International
FP	Family planning
GATHER	Greet, Ask, Tell, Help, Explain, Return for Follow-Up
HIV/AIDS	Human immuno-deficiency virus/Acquired immune deficiency syndrome
HTSP	Healthy timing and spacing of pregnancy
IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
LAPM	Long acting and permanent methods
MCH	Maternal and child health
MOH	Ministry of Health
PAC	Postabortion care
PID	Pelvic inflammatory disease
PMTCT	Prevention of mother to child transmission
POP	Progestin only pills; “mini-pills”
RH	Reproductive health
STI	Sexually transmitted infection
USAID	United States Agency for International Development
WHO	World Health Organization

Section 1:
Introduction and Overview

Multiple studies have shown that adverse maternal and perinatal outcomes are associated with early, late, closely spaced, and high parity pregnancies. Improved use of family planning to ensure healthy timing and spacing of pregnancy can significantly improve the health of mothers and babies.

From *HTSP: A Reference Guide for Trainers*

1 INTRODUCTION AND OVERVIEW

Healthy Timing and Spacing of Pregnancy: Research and Recommendations

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention that:

- helps women and families delay, space or limit their pregnancies;
- helps achieve the healthiest outcomes for women, newborns, infants, and children;
- works within the context of free and informed contraceptive choice; and
- takes into account fertility intentions and desired family size.

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 an effort to consolidate research findings and to suggest a way to apply the evidence in programs and services, in June 2005, the World Health Organization (WHO) convened a panel of 30 technical experts to review six USAID-sponsored studies on timing and spacing of pregnancy. Based on their review of the evidence, the technical experts made two recommendations[4] to the WHO (below) on pregnancy spacing following a live birth as well as a spontaneous or induced abortion. The technical experts' recommendations were published by WHO in a report[5] and a 2006 Policy Brief.[6] (Note: The Policy Brief appears in the Annex of this Guide as Handout #1)

Technical Consultation Recommendations to WHO[7]

Preamble
Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences in making choices for the timing of the next pregnancy.

Recommendation for spacing after a live birth
After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.

Recommendation for spacing after a miscarriage or induced abortion
After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.

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

This information should be incorporated into health education, counseling and service delivery for women who would like to delay, space or limit their pregnancies, within the context of informed contraceptive choice, taking into account fertility intentions and desired family size as well as the the social and cultural environment.

4 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.
5 World Health Organization. 2006. *Report of a WHO Technical Consultation on Birth Spacing.* WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.
6 World Health Organization. 2006. *Policy brief on Birth Spacing – Report from a World Health Organization Technical Consultation*. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.
7 Ibid.

This edition of the HTSP Trainer's Reference Guide focuses only on the evidence of the health and social outcomes that are related to too early and too closely spaced pregnancies. ESD recognizes that other women (especially women over the age of 35, and high parity women) also face pregnancy-related health risks. USAID is currently reviewing evidence and gathering data to better document risk among these two populations. Once the review has been completed, and appropriate messages have been developed, USAID will develop and disseminate additional guidance and reference materials, as well as training tools and other resources.

In the meantime, providers can use this Trainer's Reference Guide to meet the needs of women who are over the age of 35 and/or high parity (i.e. >5) since the guide:

- Discusses all methods of family planning, including long acting and permanent methods
- Provides information on assessing fertility intentions and desired family size with all clients, including older women and/or high parity women who may be particularly interested in long-acting or permanent methods.

ESD hopes that this Trainer's Reference Guide will help trainers and instructors develop and implement successful training activities to ensure that HTSP information, education and counseling contributes to greater use of HTSP tools and models as common practice in clinics and communities which will in turn lead to the increased use of family planning

A Note on the Organization of this Manual

This Trainer's Reference Guide is not a training manual. Rather it is intended as a reference guide and a resource that trainers can use to incorporate HTSP information into current or planned training activities as part of pre-service, in-service or continuing education for health care providers working in maternal child health; reproductive health and family planning; well-baby and child health programs; cervical cancer screening programs; HIV prevention, care and treatment; immunization programs; malaria prevention programs; youth services; or men's services, among others. It can also be used by trainers and programs to build community support for and acceptance of delay of first pregnancy and improved pregnancy spacing practices through increased use of FP.

To facilitate the trainer's ability to develop training activities, each section of the manual addresses a key content area. Section 2 discusses the benefits of HTSP, Section 3 provides up-to-date information on FP methods that can be used for HTSP, and Section 4 provides information on how to improve counseling for FP and HTSP. A suggested training outline and select training tools are presented in Section 5. An Annex provides additional background information, handouts and a bibliography.

Section 2:
Healthy Timing and Spacing of Pregnancy

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.

From *HTSP: A Reference Guide for Trainers*

2 HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

What is Healthy Timing and Spacing of Pregnancy?

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention that:

- helps women and families delay, space or limit their pregnancies;
- helps achieve the healthiest outcomes for women, newborns, infants, and children;
- works within the context of free and informed contraceptive choice; and
- takes into account fertility intentions and desired family size.

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.

Research and program experience worldwide indicate that the use of family planning to time the first pregnancy to age 18, space subsequent pregnancies by at least 24 months after a live birth, and limit high parity births[8] is associated with multiple health and social benefits for women, men and their children, as outlined below in Table 2.1. (Note: This table appears in the Annex as Handout #2.)

Table 2.1 Benefits of Healthy Timing and Spacing for Infants and Mothers[9]

For newborns/infants	For all women	For adolescents
● Lower risk of stillbirth. Infants of adolescent mothers are 1.5 times more likely to die before their first birthday than infants of older mothers.	● Lower risk of maternal death,	● Adolescents aged 15 – 19 are twice as likely to die during pregnancy or childbirth as those over 20; girls below the age of 15 are five times more likely to die.
● Lower risk of neonatal death	● Lower incidence of induced abortion	● Each year, at least 2 million young women undergo unsafe abortion
● Lower risk of preterm birth	● Lower risk of pre-eclampsia	● Adolescents are more likely to experience pregnancy and delivery related complications such as pre-eclampsia and fistula
● Lower risk of low birth weight.	● Lower risk of miscarriage	● Adolescent mothers are more likely to deliver early or to deliver low birth weight babies.
● Lower risk of small for gestational age	● Lower risk of anemia	● Unmarried adolescents who give birth may be forced to marry the father, drop out of school, become a single mother or have an unsafe abortion, leading to multiple social or health consequences
● Increased benefits of extended breastfeeding	● Allows for two years of breastfeeding, which is linked with reduced risk of breast and ovarian cancer	● Delaying early childbearing saves lives.

8 The evidence on the benefits of limiting family size are being reviewed.

9 DaVanzo, Julie, Lauren Hale, Abdur Razzaque, and Mizanur Rahman, "Effects of Interpregnancy Interval and Outcome of the Preceding Pregnancy on Pregnancy Outcomes in Matlab, Bangladesh," *BJOG*, 2007.

Most healthy 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 best 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 an FP method, and that they can freely decide which method they would like to use. Furthermore, counseling on FP and HTSP should consider and respond to the particular needs of women given her age, marital status, parity and stage of life.

The following Figures (2-1, 2-2, and 2-3) summarize the major findings of HTSP research. Although effective pregnancy spacing is a key positive outcome related to the use of RH/FP services, few countries have established policies and guidelines that promote pregnancy spacing for the health of mothers and children, despite evidence that suggests significant unmet need for FP is related to women's desire to space their pregnancies.[10]

The timing of the first pregnancy in women is also of concern. The research clearly shows that young women who become pregnant before the age of 18 face a number of negative health and social outcomes, as do their children.[11] Pregnancy is the leading cause of death among young women.Young women aged 15 – 19 are twice as likely to die of pregnancy related complications as their peers who are over 20, while young women under the age of 15 are five times more likely to die. Babies born to teenage women are more likely to die than those born to women in their 20s and 30s. The infant mortality rate averages 100 deaths per 1,000 births among mothers younger than 20, compared with 72-74 deaths per 1,000 births among mothers 20-29 and 30-39.[12] Adolescent pregnancy and birth rates are influenced by the fact that young women ages 15 to 19 are less likely to use modern contraceptives than women ages 20 to 24. Lower use may reflect a lack of awareness of family planning among women who marry young, societal expectations about having a first child, and more limited access to services for adolescents. Promoting policies and implementing programs that help young women delay their first pregnancy until the age of 18 will have a significant impact on the wellbeing of young women and their babies.[13]

(Note: These graphs appear in the Annex as Handout #3.)

10 Jansen, 2005
11 McCauley and Salter 1995, Conde-Agudelo et al, 2005
12 http://www.guttmacher.org/pubs/ib_2-02.html, retrieved 3/26/08
13 UNFPA

Figure 2.1 Improved Pregnancy Spacing is Associated with Reduced Infant Deaths

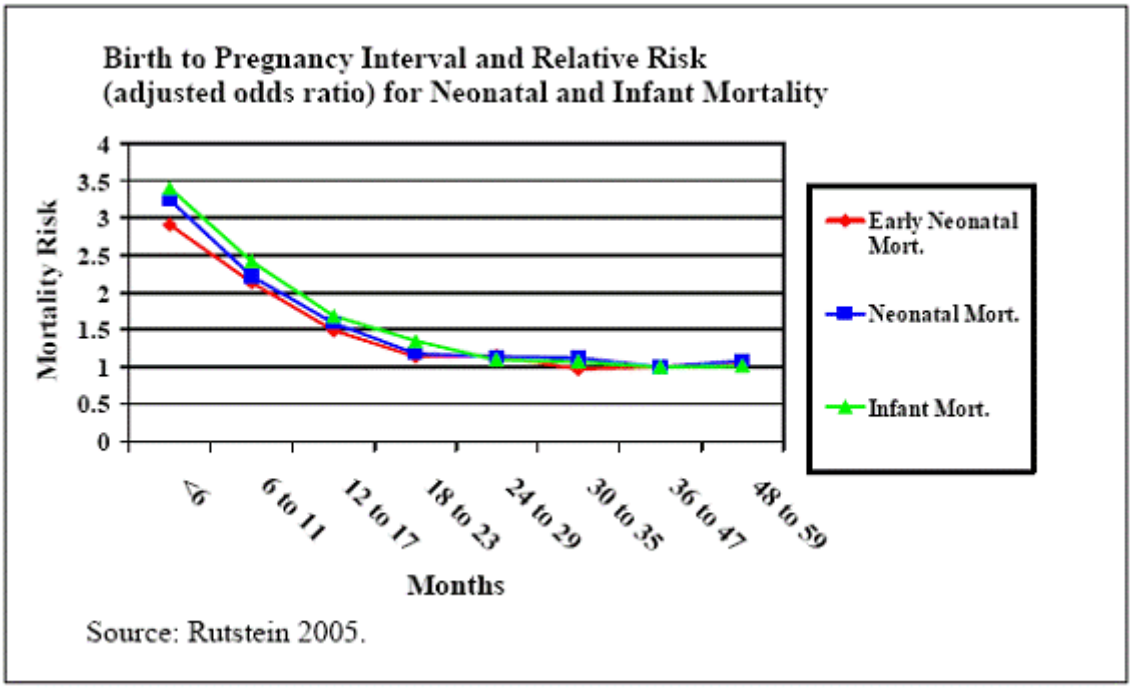
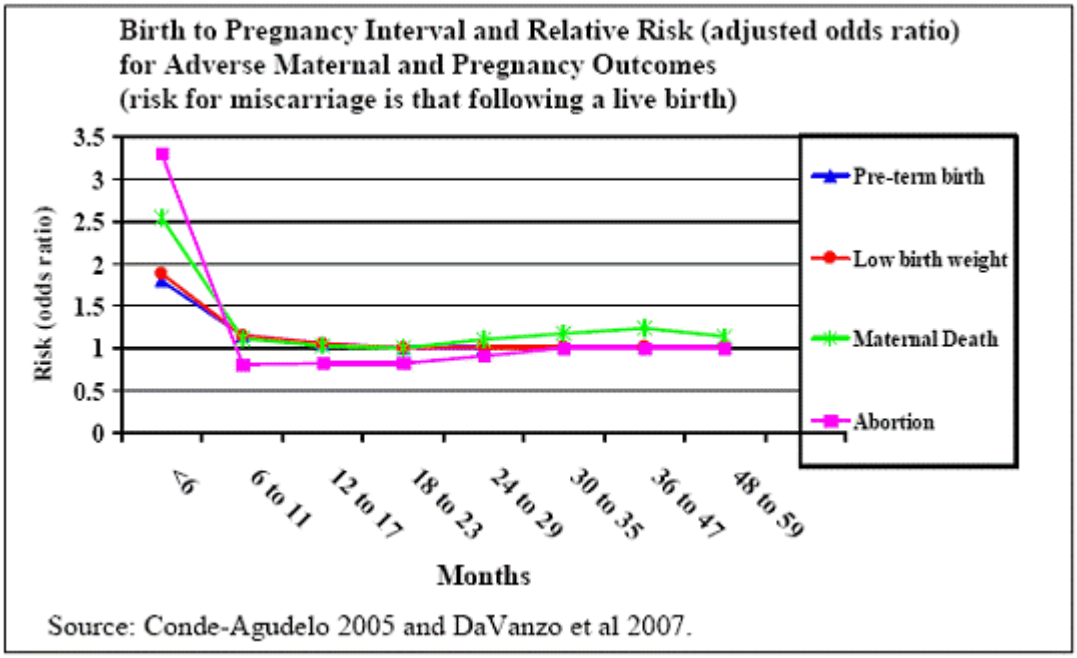
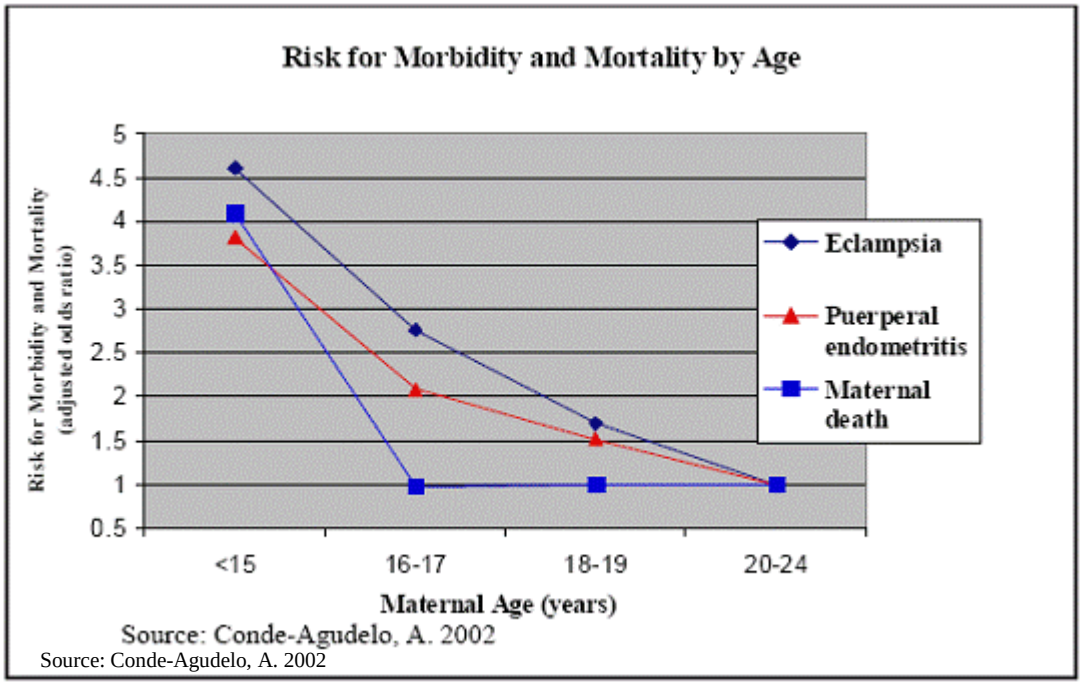


Figure 2.2 Improved Pregnancy Spacing is Associated with Reduced Maternal Mortality



A 24-month, birth-to-pregnancy interval reduces the prevalence of adverse maternal, perinatal, newborn and infant outcomes associated with too closely spaced pregnancies. Data from developing countries in Africa, Asia, Latin America, and the Middle East show a sharp decline in mortality risk for newborns and infants with increased birth-to-pregnancy intervals.

Figure 2.3 Young Women under the Age of 18 Are at Higher Risk for Morbidity and Mortality*



Source: Conde-Agudelo, A. 2002

**While first births always have higher risks, this analysis adjusts for parity.*

Adolescents aged 15-19 are twice as likely to die during pregnancy and childbirth as those over 20 and girls under age 15 are five times as likely to die. Pregnancy is the leading cause of death for young women aged 15-19.[14]

Achieving HTSP Outcomes

HTSP focuses on helping programs and services achieve three key outcomes:

(1) Healthy pregnancy spacing of at least 24 months after a live birth;
(2) Healthy pregnancy spacing of at least six months after a spontaneous or induced abortion;
(3) Healthy timing of the first pregnancy to at least age 18 in adolescents.

To help women and couples effectively practice HTSP, the following three sets of messages should be incorporated by health service providers into their information, education and counseling of clients. Providers must always keep in mind that the messages should be delivered within the context of informed contraceptive choice, fertility intention and desired family size.

14 UNFPA (2004) State of the World Population, 2004; http://www.unfpa.org/swp/2004/english/ch9/page5.htm; accessed 3/4/08

HTSP Messages

For couples who desire a next pregnancy after a live birth, the messages are:	**For couples who decide to have a child after a miscarriage or abortion, the messages are:**	**For adolescents, 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 during that time.	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 during that time.	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 until you are 18 years old.

(Note: These messages appear in the Annex as Handout #4.)

How Can Healthy Timing and Spacing of Pregnancy Contribute to Use of FP?

Family planning programs have made great progress in helping women avoid unintended pregnancies, and the focus of most family planning programs has mostly been on decreasing women's fertility. Family planning, however, can significantly contribute to helping women and couples achieve healthy fertility and healthy pregnancy outcomes by helping them to space their pregnancies, which helps to reduce maternal and infant morbidity and mortality. Equally important is the fact that family planning can help women plan the size of their families and only have the number of children that they want. An emphasis on healthy fertility may help women and families make more informed decisions and increase the overall community's support to use FP for improved timing and spacing of pregnancy for healthy pregnancy outcomes.

Women and couples want to know the safest time to become pregnant. ***When*** pregnancies occur (i.e., the timing and spacing of pregnancies) is important for healthy maternal and child outcomes. HTSP refers to the *timing* of first pregnancies and the *spacing* of subsequent ones (following a live birth or after a miscarriage or abortion), which is achieved by using an FP method of choice.

The potential benefits of HTSP, however, are yet to be fully realized within clinical service delivery and health education programs. A 2004 assessment of family planning and reproductive health services in 18 countries found that most health workers and health care managers were unaware of evidence that links poor maternal and child health outcomes with closely spaced pregnancies.[15] Health care services can do more to reduce maternal and child health risks through improving information, education, counseling and service delivery for FP that better addresses the needs of women and couples.

15 Jansen, W. and L. Cobb. 2004. USAID Birthspacing Programmatic Review: An Assessment of Country-Level Programs, Communications and Training Materials. Population Technical Assistance Project, POPTECH publication No. 2003-154-024. Washington, D.C.

Short birth-to-pregnancy intervals are common in many countries where early pregnancy is common and many second and subsequent births occur soon after (see Figure 2.3). This is especially true for women under the age of 29. Many of these young women have an unmet need for contraception (ranging from 66 to over 90%) for spacing their next pregnancy.[16]

HTSP and Engaging the Community[17]

> At times, men, religious and community leaders, and others may be resistant to FP—but are committed to ensuring the health and well-being of their families. ESD's experience has shown that when information and education on the health benefits of HTSP is provided to these gatekeepers, former skeptics become HTSP champions in their communities.
>
> The TAHSEEN project in Egypt conducted workshops with Christian and Muslim religious leaders on the benefits of HTSP for young newlyweds, women and children. Following the workshops, the religious leaders began incorporating this information into their work with their communities and followers. Community members (especially men) later reported that they were reassured by the endorsement of HTSP and FP by their religious leaders, and were better able to envision a role for themselves as protectors of their families' health.

Components of HTSP Interventions

There are many opportunities to include information on healthy timing and spacing of pregnancy and a number of health interventions naturally lend themselves to the inclusion of HTSP information. Such programs and services include child survival, malaria programs, maternal-neonatal-child health, HIV/AIDS, prevention of mother to child transmission (PMTCT) of HIV, postabortion care, youth friendly services, cervical cancer screening, and workplace health programs. There are likely to be other services in your community where HTSP can be included that are not listed here.

To successfully ensure that HTSP information, education, and counseling are made widely available to women, HTSP must be implemented as ***a comprehensive intervention*** in multiple venues and settings. For purposes of this training guide, the first step is to:

- **Train facility-based service providers and community health workers** in HTSP. This training will help providers develop skills to educate and counsel their clients on FP. Training should include the HTSP messages and the benefits of HTSP for women, their families and the community. For health care providers, training should include information and skills development on how to better assess women's fertility intentions and desired family size and how to link this information with counseling on FP.

  Where possible, training should also be conducted for community leaders to help them understand how the HTSP and FP services that are provided by health care workers can benefit the entire community, and how community leaders can facilitate the promotion of HTSP.

Once providers have been trained to provide HTSP and FP information, education and counseling, they must next:

16 www.measuredhs.com
17 *Best Practices in Egypt: Mobilizing Religious Leaders*, CATALYST Consortium, 2004.

- **Integrate HTSP and FP** into the information, education and counseling that is provided to women during antenatal visits, post-partum care, well-baby check-ups, infant growth-monitoring, immunizations, postabortion care, malaria services and PMTCT/VCT services, among others. HTSP information can also be disseminated as part of community-based health education and outreach, such as youth development, literacy, women's micro-enterprise, agricultural programs, etc.

Program managers and health care providers should also begin to:

- **Strengthen and establish linkages** within the health center as well as to community and other social services to ensure improved availability of and access to FP services. It is critical to ensure that women who are educated and counseled on HTSP have ready access to a wider range of FP methods, including long-acting and permanent methods through direct provision of a method or referral for FP services.

Resource Materials
ESD is continuing to develop resource materials, including training materials and job aids. Please visit our website, www.esdproj.org to obtain copies of relevant materials as they are published.

Finally, to ensure greater support of and the sustainability of HTSP, providers and community members must begin to:

- **Advocate for policies** that support HTSP by bringing evidence on HTSP and its association with reducing maternal and infant morbidity and mortality to the attention of Ministries of Health, policymakers, donors, technical agencies, health care providers, non-governmental organizations, program managers, and community leaders. It is important that policy makers and service providers understand that short pregnancy intervals lead to increased risk of multiple adverse outcomes, and that focused efforts to promote HTSP can improve the health of women and infants, and ultimately, communities.[18]

(Note: *HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy* is included as Handout #5 in the Annex. This technical brief was created by ESD and can be used for education, awareness and advocacy purposes. The brief provides and overview HTSP including the background, rationale research findings, and recommendations for integration into field programs and activities.)

Benefits of HTSP and Risks of Not Practicing HTSP

Providers, clients, community members and leaders need to understand the clear benefits of HTSP practices. There are many health and social benefits for women, men, children and communities that result from improved use of FP to achieve HTSP. Similarly, there are potential risks when pregnancies are closely spaced. Table 2.2 presents these benefits and risks.

(Note: Table 2.2 also appears in the Annex as Handout #6.)

18 To facilitate advocacy efforts, ESD has developed 13 advocacy briefs for countries where FP use is low, maternal, infant and child morbidity and mortality is high, and short birth intervals are common. These are available at www.esdproj.org.

Table 2.3 Benefits of HTSP vs. Risks of Not Practicing HTSP

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
For the Newborn Child	
• More likely to be born strong and healthy. • May be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding. • Mother-baby bonding is enhanced by breastfeeding, which facilitates the child's overall development • Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns.	• Risk of newborn and infant mortality is higher. • There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age. • When breastfeeding stops before six months, the newborn does not experience the health and nutritional benefits of breast milk, and the mother-baby bond may be diminished, which may affect the baby's development.
For the Mother	
• Reduced risk of complications which are associated with closely spaced pregnancies. • Have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy. • May breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer. • May be more rested and well-nourished so as to support the next healthy pregnancy. • Has more time for herself, her children, and her partner, and to participate in educational, economic and social activities • Has more time to prepare physically, emotionally, and financially for her next pregnancy.	• Women who experience closely spaced pregnancies are: o At increased risk of miscarriage o Are more likely to experience iron-deficiency anemia o Are more likely to experience pre-eclampsia o More likely to induce an abortion o • Women with birth to pregnancy intervals of five years or more A are more likely to experience pre-eclampsia

Table 2.3 (continued): Benefits of HTSP vs. Risks of Not Practicing HTSP

For Men	

• Men may feel an increased sense of satisfaction from:
  o Safeguarding the health and well-being of his partner and children; and
  o Supporting his partner in making healthy decisions regarding FP and HTSP.
• More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.
• Expenses associated with a new pregnancy will not be added to the expenses of the last-born child.
• His partner may find more time to be with him, which may contribute to a better relationship.
	• If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.
	• Men may experience stress from closely spaced pregnancies, which may prevent couples from having a fulfilling relationship.

For the Family	
• Families can devote more resources to providing their children with food, clothing, housing, and education.	• A new pregnancy requires money for antenatal care, better nourishment for the mother, savings for the delivery costs and costs associated with the needs of a new baby. • Illness or a need for emergency care is more likely if the woman has closely spaced pregnancies • Unanticipated expenses may lead to difficult financial circumstances.
For the Community	
• HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children, which can contribute to reducing the economic strain on a family and improving the quality of life for the community • It may relieve the economic, social and environmental pressures from rapidly growing populations	• Lack of HTSP may result in a poorer quality of life for community residents • Economic growth may be slower, making it more difficult to achieve improvements in education, environmental quality, and health.

Integrating HTSP Education and Counseling into Existing Services

There are many opportunities to introduce or reinforce HTSP messages in health education and counseling. HTSP can be discussed in traditional service delivery venues, including FP and MCH services, as well as HIV/AIDS prevention, care and treatment services and services that are specially targeted to youth and/or men. There are also a number of community-based activities and settings where it is appropriate to discuss HTSP. These opportunities are discussed further below.

Antenatal Care

During antenatal care visits, a woman is likely to be open to information about how she can ensure the health of the baby she is carrying. The benefits of HTSP can be described to a pregnant woman by advising her that:

- She should wait at least two years after the birth of her last child before trying to become pregnant again, (but no more than five years).
- Her child will benefit from her attention and care if she does not become pregnant again too quickly.
- If she becomes pregnant before this child is at least two, it may affect the child's health and development, especially if she has to wean the child.
- She will be able to provide the best care for her children if their births are adequately spaced.
- If she is interested in spacing her next birth, or has reached her desired family size and would like to limit, there are a number of family planning methods that she can use, including long-acting and permanent methods.

A Special Concern: Malaria, Pregnancy and HTSP[19]

Malaria is a leading cause of pregnancy complications, including miscarriage, stillbirth and premature birth, particularly in sub-Saharan Africa, and poses a special threat to the health of pregnant women and newborns. Increasingly, MCH and ante-natal programs are focusing on improving efforts to prevent and treat malaria among pregnant women and children through the use of intermittent preventive treatment (IPT) and insecticide treated bed nets (ITN). Healthy Timing and Spacing of Pregnancy (HTSP) has been recognized as a critical and essential preventive child survival intervention that effectively complements curative and other child health interventions, with additional benefits to the mother, family, men, community and the society. It is important to introduce, integrate, strengthen, and expand access to information, education and counseling on HTSP within maternal and child health services and ensure that HTSP and FP messages and services are incorporated into maternal and child health interventions, including malaria prevention and treatment efforts. This is especially important when women experience a miscarriage or infant death due to malaria, so that women can improve their chances of having a subsequent healthy pregnancy through appropriate pregnancy spacing.

Postpartum Care

The postpartum return visit or newborn checkup is a good time to provide HTSP information and counseling, because the mother is likely to be eager to hear what she can do to ensure the health of her newborn, as well as herself. All women receiving postpartum care need to be given counseling and

19 Dr Gloria Ekpo, BASICS Project, personal communication.

information to make sure they understand that they could become pregnant again **before** the return of their menses. The health worker can emphasize the benefits of HTSP by advising the client that:

- If she wants to have another child, she should wait at least two years after the birth of this child before trying to become pregnant again.
- If she spaces her pregnancies her newborn will be healthier and her next child will be less likely to be pre-term, small for gestational age and have low birth weight.
- Spacing her pregnancies will give her more time and energy to care for the newborn.
- Spacing her pregnancies will help her exclusively breastfeed for six months and continue to breastfeed for two years as recommended by WHO and UNICEF.[20] If she were to become pregnant, she would have to wean the baby. Exclusive breastfeeding for the first six months postpartum provides contraceptive protection, which is also known as the Lactational Amenorrhea Method (LAM). LAM signficiantly contributes to the abilities of postpartum mothers to better space their pregnancies (see Box 2.3)
- Explain that the chances of becoming pregnant during the postpartum period change according to breastfeeding status, intensity of breastfeeding, and length of time postpartum.
- If any one of the three criteria for LAM use is not met, pregnancy can occur even when menses has not returned.
- She will be stronger, healthier, and better nourished, which will prepare her for another healthy pregnancy, if she and her partner decide to have another baby.
- She will not have to deal with the demands of a new pregnancy while still caring for a newborn.
- She may have more time to spend with her family.
- If she is interested in spacing her next birth, or has reached her desired family size there are a number of family planning methods that she can use.[21] Women who do not want to become pregnant again because they have reached their desired family size should also be encouraged to use a contraceptive method to prevent an unwanted pregnancy. Women or couples who have reached their desired family size and are interested in limiting, may be interested in other family planning options, including long-acting and permanent methods (LAPM).

(Note: A Brief on LAPM is included in the Annex as Handout #7.)

20 World Health Organization (WHO), "Infant and Young Child Nutrition: Global Strategy on Infant and Young Child Feeding." http://www.who.int/gb/ebwha/pdf_files/WHA55/ea5515.pdf (16 Apr 2002).

21 All contraceptive methods can be used by postpartum women, although the use of each method depends on whether or not she is breastfeeding. The health worker should help the client assess the contraceptive method that best suits her and provide information and counseling regarding her chosen method. Contraceptive methods are discussed in the next section of the guide.

Special Opportunity for HTSP Education with Postpartum Women: Counseling on Lactational Amenorrhea Method

Most women are encouraged to breastfeed their children and the Lactational Amenorrhea Method (LAM) is an appropriate FP method for postpartum women for the first six months following delivery.

The three conditions for successfully practicing LAM to prevent pregnancy are:

1. The mother's menstrual periods (monthly bleeding) have not resumed; **AND**
2. The baby is exclusively breastfed frequently, day and night; **AND**
3. The baby is under six months of age.

Counseling on the importance of breastfeeding and its role in pregnancy spacing may be providing during antenatal, postpartum, child health, and/or family planning services. To prevent a closely spaced pregnancy, women may wish to adopt another method of family planning that is appropriate for breastfeeding mothers, in addition to breastfeeding, as soon as she resumes sexual relations.

When talking to mothers about breastfeeding, providers should highlight that HTSP helps women continue exclusively breastfeeding for at least six months and up to two years, while using a family planning method of her choice, to ensure that she does not become pregnant again too soon after delivery.

Postabortion Care

Women should be advised that fertility may return anywhere from 10 days to two weeks after an induced or spontaneous abortion. All women receiving postabortion care need to be given counseling and information to make sure they understand that they could become pregnant again **before** the return of their menses.

During postabortion counseling, the provider can discuss the advantages of HTSP:

- Discuss fertility intentions with client.
- Inform the client that she should wait at least six months after a spontaneous or induced abortion before trying to become pregnant again (should she wish to do so).
- If she is eager to become pregnant again, waiting six months will help to ensure that her next pregnancy is a healthy one.[22]
- Women who do not wait six months and become pregnant again may experience adverse outcomes and complications such as anemia, premature rupture of membranes, pre-term delivery, low-birth weight and small for gestational age.[23]
- To ensure that she does not become pregnant again too quickly, she should use a contraceptive method (See Box 2.4).
- If she wants to space her next pregnancy beyond six months, she should use a contraceptive method.

22 World Health Organization. 2006. *Policy brief on Birth Spacing – Report from a World Health Organization Technical Consultation*. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.

23 Agustin Conde-Agudelo, et al. "Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America." *International Journal of Obstetrics and Gynecology* 89 (April 2005): S34-S40.

- All contraceptive methods are appropriate for use after an induced or spontaneous abortion.
- If she does not wish to become pregnant again because she has reached her desired family size should also be encouraged to use a contraceptive method to prevent an unwanted pregnancy. Women who have reached their desired family size may be particularly interested in long-acting and permanent methods (LAPM).

FP Is Often Overlooked in PAC Programs[24]

"The failure of health systems to work toward reducing the incidence of abortion is nowhere more evident than in postabortion care programs. The growth of postabortion care services has been slow, and since these services are not especially difficult to establish, this is hard to understand in the post-ICPD environment. However, what is truly inexplicable is that postabortion care seldom includes family planning counseling and services. If ever there were women in need of family planning information and services, it is those in postabortion care programs. Johnson and colleagues found that two years after leaving postabortion programs that offered family planning, two percent of women had a repeat abortion; by contrast, five percent of women who were in programs without family planning services had a repeat abortion."

—Duff Gillespie

Child Health Services

Routine child health visits, well-baby care, immunizations, growth and development monitoring, and/or treatment of illness present a natural opportunity to discuss pregnancy spacing or limiting with mothers and couples, based on their reproductive goals and desired family size. During these visits, the health worker can discuss how HTSP benefits children's health. The health worker can:

- Tell the mother that she should wait at least two years after the birth of her last child before trying to become pregnant again, should she wish to have another child.
- Encourage her to adopt a method of FP (if she has not already done so) to space her next pregnancy. If she has reached her desired family size and does not want any more children, she may wish to consider using a long-acting or permanent method.
- Reinforce the health benefits for the child by pointing out that using FP for HTSP will give the mother more time to breastfeed and care for the baby, which will support the child's healthy development.
- Explain that there are a variety of family planning methods that can help the mother to space her next pregnancy or prevent an unwanted pregnancy

Immunizations: An Important Point of Contact for HTSP[25]

24 Source: Gillespie, Duff G "Whatever happened to family planning and, for that matter, reproductive health?" *International Family Planning Perspectives*, Mar 2004.

25 Rebecca Fields, IMMMUNIZATIONBasics (personal communication) and *Studies in Family Planning*, May/June 1994.

The IMMUNIZATIONBasics project suggests that immunization contacts are an important place where HTSP and FP information, services and referrals can easily be provided, especially where immunization rates are high, based on a 1994 study conducted in Togo. This study found that pairing Expanded Program in Immunization (EPI) services with simple messages for the mother on the importance of spacing her next pregnancy through the use of FP resulted in a significant increase in awareness of FP services and the use of those services by EPI clients. In Togo, the awareness of FP service availability among clients in the intervention group increased from 40 percent at baseline to 58 percent. The difference between the intervention group and control group increased from 8 percent at baseline to 22 percent after the introduction of these simple message. compared to a control group whose awareness increased from 8 percent to 22 percent.

Increase in awareness was also accompanied by an increase in the number of new FP acceptors (of oral contraceptives, injectables or the IUD). During the nine months prior to the intervention, the test group received an average of 200 new FP acceptors each month, and the control group received 144, with an average difference between the groups of 56 clients. During the intervention, the mean number of new acceptors per month in the test group increased to 307 ($p<.001$) while in the control group it increased to 167, which was not a significant increase. Overall, the difference between the two groups' mean number of new acceptors increased from 56 to 140 clients per month

Family Planning Services

Women attend FP services to learn how to delay or space pregnancies, prevent an unplanned pregnancy or limit childbearing, and FP visits are an important time to discuss the benefits of HTSP.

Effective family planning counseling takes into account women and couples' pregnancy intentions and desired family size, and includes information on healthy fertility and childbearing and the social benefits of pregnancy spacing.

In addition to counseling on the use of a method, providers should:

- discuss the benefits of using a method to practice HTSP
- the positive benefits of HTSP for women and their babies
- the risks of closely spaced pregnancies.

HTSP counseling can empower women and couples to make a more informed decision on the use of FP for effective child spacing that ensures the best possible health outcomes for mothers and infants, or to prevent unwanted pregnancy if she has reached her desired family size and is not interested in having more children. FP counseling for HTSP is addressed in greater detail in Section 4.

HIV/AIDS Services

Women may attend HIV/AIDS prevention, care and treatment services:
if they are at risk and wish to prevent the transmission of HIV;

- to improve child survival outcomes;
- to provide care for people living with HIV/AIDS; and
- to address the impact of HIV/AIDS on themselves, their families, and communities.

HIV/AIDS services usually include counseling and education, voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), and anti-retroviral therapy (ART). HTSP counseling and FP can easily be integrated into these programs and services. Recent research shows that as more women are enrolled in ART programs, unwanted pregnancy can become a significant concern, showing that women want to space and limit their pregnancies. Most FP methods can safely be used by HIV+ women, including LAM.

The Importance of FP and HTSP for HIV+ Women[26,27,28,29]

A 2005 study by researchers from the US Centers for Disease Control (CDC) in Uganda was conducted to examine the total impact of ART on reproductive attitudes and behaviors in over 700 women offered ART in rural Uganda.

What they found was disturbing: at least 85 pregnancies occurred in these women; 97% of these women did not want to have more children, and 99% of them were not planning to have more children at that time (these patterns were similar among women who did not get pregnant). 79% of those who knew said that their partners did not want more children either.

Many of the women were surprised by their pregnancies since they had not been fertile for years prior to going on ART. While ART might reduce the likelihood of transmission to the infant, the serious difficulty that an unwanted pregnancy poses a woman who is HIV positive should not be underestimated. Although her health may be improved for now, or quite possibly years, the future is still filled with uncertainty, and aside from the additional work that having an another child might put on the family, there is no guarantee that the child won't fall ill or be orphaned while still quite young.

In South Africa, where family planning services are available, unwanted pregnancies in women on ART are reported — and these were on efavirenz-based regimens. Becoming pregnant while on efavirenz-based regimens is discouraged because the drug could potentially cause birth defects. The Perinatal HIV Research Unit at Wits University has placed more than seven hundred women on efavirenz-based ART since August 2004. Fifty-three (8%) of the women were diagnosed as pregnant while in the program and only ten of these pregnancies had been planned. Women who elected to continue their pregnancies were switched to other treatment regimens.

In a survey conducted by Family Health International in Tanzania, researchers found that about one third of patients on ART want to have children at some point in the future, but very few use contraception. FHI recommends that family planning services should be provided in-house at HIV care and treatment clinics (CTC). Patients prefer to have family planning and sexuality counseling offered through their CTC, rather than to be referred elsewhere. Initially, the CTC counselors were unfamiliar and uncomfortable with providing these services, so they are receiving further training in family planning and sexuality.

When counseling an HIV+ woman on FP and HTSP, be sure to address the following:

- Assess the fertility intentions and desired family size of a woman with HIV.
- Inform her that PMTCT programs can dramatically decrease the risk of a mother passing on HIV to her baby during pregnancy and delivery.

26 Gray RH et al. Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study. *Lancet* 366(9492):1182-8, 2005.

27 Homsy et al. *Determinants of pregnancy among women receiving HAART in rural Uganda;* The 2006 HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, Abstract 98.

28 Mohohlo M et al. *Pregnancy-related events in an antiretroviral treatment program.* The 2006 HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, Abstract 113.

29 Mpangile G et al. *Sexual and child-bearing needs of people on ART: The forgotten agenda.* The 2006 HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, Abstract 116.

- Remind her that pregnancy places a heavy burden on her body and overall health, so she could be careful to limit her pregnancies, and space them adequately so she has time to recover between pregnancies.
- Advise her that it is extremely important for her health and the health of the baby that she attend ante-natal care.
- Provide her with information on breastfeeding for HIV + women

Cervical Cancer Screening Programs

Cervical cancer affects nearly 500,000 women worldwide each year, with more than 270,000 women dying from cervical cancer. Increasingly, cervical cancer screening programs are being established in hospitals and clinics, using low cost and effective technologies for detection and treatment. The Alliance for Cervical Cancer Prevention recommends that women aged 30 – 40 be screened for cervical cancer so that cancer can be detected early and treated. This is an opportune time to reach this key group of women with HTSP and FP information and services, especially those women who have reached their desired family size and are not interested in having more children.

Youth Services

Pregnancy is the leading cause of death among young women. Adolescents aged 15 – 19 are twice as likely to die during pregnancy or childbirth as those over 20, and girls under 15 are five times more likely to die.[30] While modern contraceptive use has increased somewhat among sexually active young women, in many countries, overall use remains low due to persistent barriers to their access to contraception. In addition to death, young women are at higher risk of injury and illness as a result of unsafe abortion, and complications during pregnancy and childbirth.

While many youth friendly services are targeted to unmarried adolescents, in fact, married adolescents are at greater risk of early pregnancy, and subsequent closely spaced pregnancies. They often have limited ability to discuss contraceptive use with their husbands, and are overlooked by existing youth or MCH programs. As more programs are established to meet the needs of adolescents, it is important to consider and address both married as well as unmarried young women through improved access to HTSP information, education and FP services so that young women can delay their first pregnancy till at least age 18.

"Youth friendly" health services are intended to promote the health (particularly the reproductive health and safe behaviors) of youth through health promotion, education and skills development, as well as access to high-quality health services for prevention and treatment of pregnancy, STIs and HIV. HTSP can be integrated into youth-focused health, education, and social services that provide young people with information on the importance of timing and spacing their pregnancies, especially to delay the first pregnancy until at least age 18, through improved use of abstinence and contraception.

During visits with adolescents, the health worker can:

- Ask about fertility intentions.
- Explain and discuss how delaying the first pregnancy until the age of 18 will lead to healthier mothers and babies.
- Encourage clients who are sexually active to adopt a FP method of their choice in order to prevent pregnancy until they are at least 18 years old. Reinforce the health benefits of delaying pregnancy for both mother and child.

30 Advocates for Youth, *The Facts*. "Adolescent maternal mortality: an overlooked crisis," May 2007.

- For young women who have already had at least one child, discuss the benefits for both mother and child of spacing by pointing out that using FP for HTSP will decrease the risk of experiencing problems during pregnancy and will give her more time to breastfeed and care for her baby, which will support the child's healthy development.
- Explain that there are a variety of family planning methods that she can use to prevent pregnancy until she is ready or to better space her next pregnancy.

(Note: The Facts: Adolescent Maternal Mortality appears in the Annex as Handout #9.)

Men's Health Services

Men's health services promote health and wellness in men and boys through programs that reduce their health risks and help men and boys learn new skills to live healthier lives. Including information about HTSP will help men learn how HTSP benefits men, women, and children, and how they can support their partners by using condoms or helping their partner to adopt an FP method for HTSP.

The socialization of men affects their attitudes, knowledge, and behaviors, which in turn strongly influence their own health as well as the health of women. There are an increasing number of male-focused programs that are designed to help men acquire information and develop new skills to address their reproductive health, as well as the health of their wives and partners. HTSP is a highly relevant topic to be included in such programs.

HTSP has many benefits for men, including:

- His partner may find more time to be with him, which may contribute to a better relationship.
- Expenses associated with a new pregnancy will not be added to the expenses of the last-born child.
- More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.
- Men may feel an increased sense of satisfaction from: Safeguarding the health and well-being of his partner and children; and Supporting his partner in making healthy decisions regarding FP and HTSP.

The risks of not practicing HTSP (for men):

- The stress from closely spaced pregnancies may prevent couples from having a fulfilling relationship.
- If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.

Community Outreach

Most health programs have a community outreach component which is usually implemented by community health workers (CHWs). CHWs bring health care to community members by visiting families and providing health education on a number of topics, including FP and MCH. As part of their outreach activities, CHWs can educate men, women and youth about HTSP. Importantly, CHWs are more likely to be able to interact with decision-makers of the families, including husbands, mothers-in-law or other members of the family. The CHWs can explain to these influential family members how HTSP can contribute to ensuring and even improving the health of mothers, children and families.

Section 3:
Review of Family Planning Methods

To effectively practice healthy timing and spacing of pregnancy, men, women and youth need access to quality family planning information and services.

From *HTSP: A Reference Guide for Trainers*

3 REVIEW OF FAMILY PLANNING METHODS

To effectively practice HTSP, women and men need to use a family planning method. This section reviews family planning methods and discusses which methods may be most appropriate in given circumstances, depending on a woman's age, reproductive history, fertility intentions, medical history as well as health risks and benefits based on information from *Family Planning A Global Handbook for Providers* (2007).

Short-acting pills and injectables are often the most commonly used FP methods for pregnancy spacing. Condoms are also widely used and have the additional benefit of protecting against sexually transmitted infections (STIs) and HIV/AIDS. Women who have reached their desired family size may be more interested in using long-acting and permanent methods, such as implants, IUDs or voluntary sterilization (either vasectomy or tubal ligation). Her choice of family planning method will depend on her health, her fertility intentions, her partner's wishes, and her desired family size, among other factors.

While all methods of family planning are safe for women to use, it is still important to screen women to ensure that they are not pregnant and that they can safely and consistently use the method without risk of any side effects or problems. People with STIs, HIV, AIDS, and those on anti-retroviral (ARV) therapy can start and continue to use contraceptive methods safely, with some limitations. There are key groups of women who have special FP needs that need to be considered during education and counseling. These women include post partum women, women who have experienced an abortion or a miscarriage, women over the age of 35 and adolescents (both married and unmarried).

Women do not need to be menstruating or have a pregnancy test to obtain an FP method. You can be reasonably sure a woman is not pregnant by using the pregnancy checklist presented in Table 3.1.

Table 3.2 shows the effectiveness of different contraceptive methods in preventing pregnancy. The most effective methods appear at the top of the chart. The right hand column provides additional information on how to make the method most effective.

Table 3.3 presents detailed information on many FP methods in a chart that discusses the benefits of the method and who should and should not use the method.

This checklist is a simple and low-cost way for a provider rule out pregnancy in a client, so that she may begin using a method immediately without having to wait for a return visit. This checklist eliminates the need for women to be menstruating or for blood or urine pregnancy tests.

To use the checklist, ask the client questions 1–6. As soon as the client answers "yes" to any question, stop and follow the instructions below.

Table 3.1 Pregnancy Checklist[31]

NO		YES
	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and had no monthly bleeding since then?	
	Have you abstained from sexual intercourse since your last monthly bleeding or delivery?	
	Have you had a baby in the last 4 weeks?	
	Did your last monthly bleeding start within the past 7 days (or within the past 12 days if the client is planning to use an IUD)?	
	Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if the client is planning to use an IUD)?	
	Have you been using a reliable contraceptive method consistently and correctly?	

If the client answered **"no"** to *all* questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test.

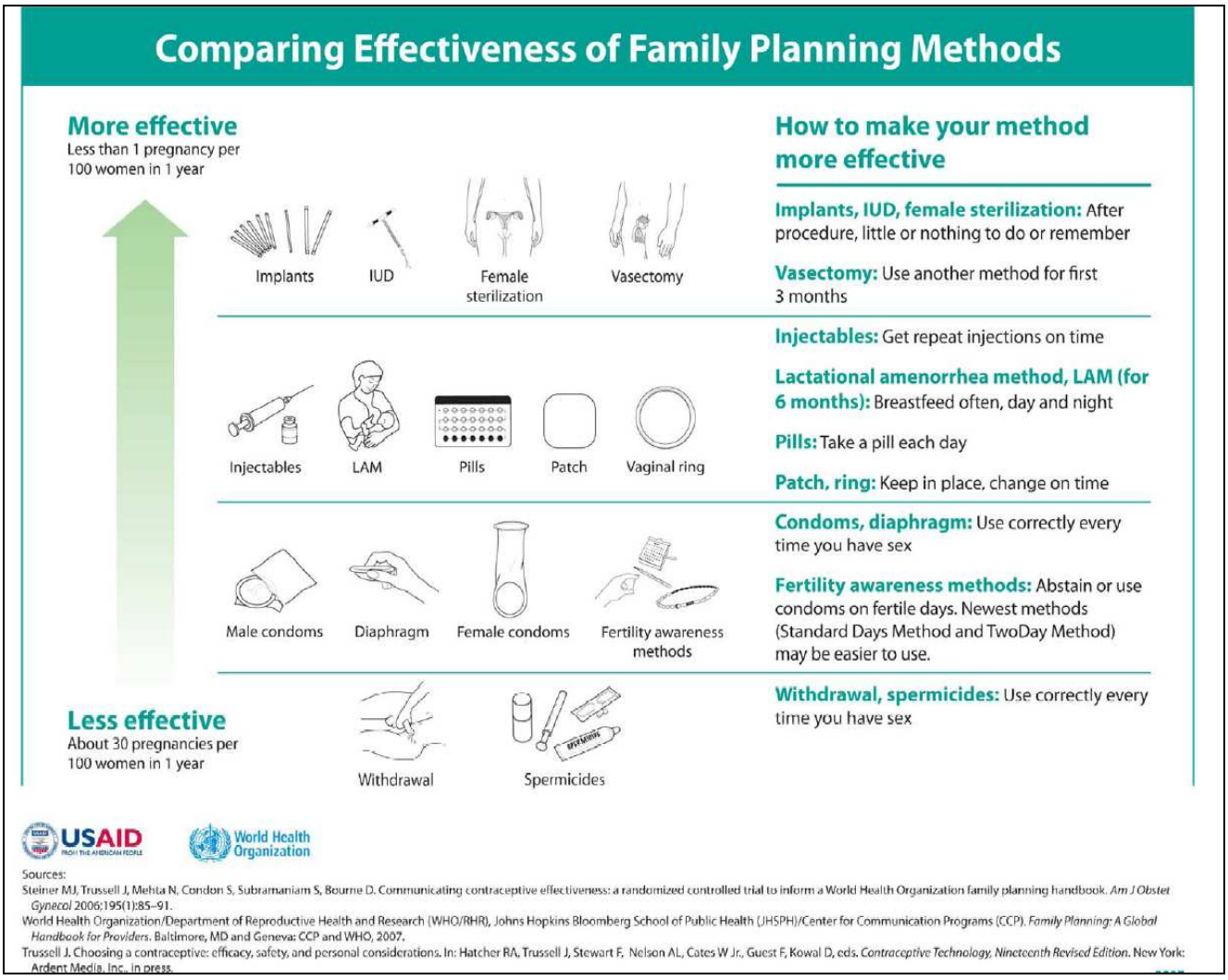
If the client answered **"yes"** to *at least one* of the questions, and she has no signs or symptoms of pregnancy, you can give her the method she has chosen.

(Note: This table is available in the Annex as Handout #10.)

31 *Family Planning: A Global Handbook for Providers*, World Health Organization Department of Reproductive Health and Research (WHO/RHR), and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. (2007)

Table 3.2 Contraceptive Effectiveness Comparison Chart[32]

This table compares the effectiveness of contraceptive methods and can be used to help women make decisions about using an FP method.



(Note: This chart is available in the Annex as Handout #11.)

32 World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. 2007. *Family planning: a global handbook for providers.* Baltimore and Geneva: CCP and WHO.

Table 3.3 Commonly Used Family Planning Methods

(Note: This chart appears in the Annex as Handout #12.)

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Fertility awareness methods Methods (in order from least effective to most effective at predicting the fertile period) include: • **Calendar method** • **Cervical mucus method** • **Symptothermal method** Intercourse is avoided during the phase of the menstrual cycle when conception is most likely.	• Can be used to avoid or achieve pregnancy • No method-related health risks • No systemic side effects • Inexpensive • Always available	• Depends on couple's willingness to follow instructions. • Considerable training required to use methods correctly. • Requires a trained provider to instruct in use • Requires abstinence (or use of condoms) during fertile phase. • Requires daily record keeping. • Vaginal infections make it difficult to interpret cervical mucus. • Basal thermometer needed for some methods. • Does not protect against STIs and HIV. • Women who are just starting to menstruate or whose cycles have become less frequent or stopped may have difficulty using calendar method to identify fertile period. • Women who have recently given birth or who are breastfeeding should delay use of calendar methods until she has had at least three menstrual cycles and cycles are regular again. • Women who recently had abortion or miscarriage should delay use until start of next monthly bleeding	• Women of any reproductive age • Women of any parity, including nulliparous women • Couples with religious or philosophical reasons for not using other methods • Women unable to use other methods • Couples willing to abstain from intercourse or use condoms for more than one week each cycle • Couples willing and motivated to observe, record, and interpret fertility signs each day • Women with HIV, AIDS and/or on ARVs can safely use fertility awareness methods	• Couples unwilling to abstain from intercourse or use condoms for more than one week each cycle • Couples unwilling to observe, record, and interpret fertility signs each day • Women in situations where negotiation for time of sexual intercourse is not possible

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Standard Days Method (SDM/Cycle Beads) Cycle beads are a string of colored beads that represent each day of a woman's menstrual cycle. They can help women know when they are likely to get pregnant if they have unprotected sexual intercourse.	• Same as other natural FP methods • Easy to teach and use	• Requires abstinence or barrier protection during the fertile phase. • Requires daily activity by the woman (movement of the bead marker). • Does not protect against STIs and HIV. • Women who are just starting to menstruate or whose cycles have become less frequent or stopped may have difficulty using calendar method/SDM to identify fertile period. • Women who have recently given birth or who are breastfeeding should delay use of calendar method/SDM until she has had at least three menstrual cycles and cycles are regular again. • Women who recently had abortion or miscarriage should delay use of SDM until start of next monthly bleeding	• Women with menstrual cycles 26 to 32 days long • Women with HIV/AIDS and those on ARVs can safely use SDM.	• Women with irregular menstrual cycles (less than 26 days or longer than 32 days) • Women unable to track the days of the cycle using cycle beads

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Condoms Condoms are barrier methods that physically prevent sperm from uniting with the egg. There are both male and female condoms. Male condoms are made of latex and are worn on the erect penis. Female condoms are usually made of plastic and fit inside of the vagina. Both male and female condoms work by forming a barrier that keeps sperm out of the vagina.	• Prevents STIs, including HIV/AIDS, as well as pregnancy, when used correctly during intercourse, i.e., provide dual protection • No effect on breast milk production • Protects against infection in the uterus • No hormonal side effects • Can be stopped at any time • No daily upkeep • Easy to keep on hand, little planning involved • Can be used by men of any age • Can be used without initially seeing a health care provider • Enables a man to take responsibility for preventing pregnancy and disease • Male condoms are usually readily available	• Latex condoms may cause itching for a few people who are allergic to latex. • Effectiveness as contraceptives depends on willingness to follow instructions. • A man's cooperation is necessary. • Many people connect condoms with immoral sexual activity • May embarrass people to buy, ask partner to use, put on, take off, or throw away condoms. • Supplies must be readily available before intercourse begins. • Condoms should not be reused and should be discarded after every act of intercourse. • Some men or women may feel that it interferes with their sexual pleasure. • Female condoms may not be readily available	• Men and women of all reproductive ages are good candidates for using condoms.	• People allergic to latex

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Lactational Amenorrhea Method (LAM) Method uses the temporary infertility that occurs immediately after childbirth. If women fully or nearly fully breastfeed, infertility may last as long as six months, as long as the woman's menses have **not** returned. Effective (1 to 2 pregnancies per 100 women during first six months of use) (For more information on LAM please see the end of this section.)	• Effective immediately • Does not interfere with intercourse • No systemic side effects • No medical supervision necessary • No supplies required • No cost • Promotes nutritional benefits to infant • Promotes mother and infant bonding	• Requires following instructions regarding breastfeeding practices. • May be difficult to practice due to social circumstances. • Effective only until menses returns or up to six months. • Does not protect against STIs and HIV. • Women with HIV/AIDS and/or are using ARVs can use LAM, however, there is a chance they can pass HIV to their infants through breastfeeding. Women with HIV are encouraged to use replacement feeding ONLY if it is acceptable, feasible, affordable, sustainable and safe. If replacement feeding cannot meet all of these five criteria, exclusive breastfeeding for the first six months is the safest way to feed and is compatible with LAM.	• Women who are fully breastfeeding or nearly fully, whose menses have not returned, and who are less than six months postpartum. • Women with HIV who use LAM should also be encouraged to use condoms.	• Women who are not fully or nearly fully breastfeeding • Postpartum women whose menses have returned • Women who are more than six months postpartum
Emergency Contraceptive Pill (ECP) Method works by possibly inhibiting ovulation, thickening cervical mucus and affecting transport of sperm or egg.	• Can help prevent pregnancy after rape, unprotected sex, or contraceptive method failure. • Process of getting ECPs may help woman to initiate another effective contraceptive method. • Can be taken up to 72 hours after unprotected intercourse.	• Must be taken within 72 hours of unprotected intercourse • Does not protect against STIs and HIV. • Availability may be limited due to bias or misunderstanding of how the method works, or the need for a prescription from a physician.	• All women who have had unprotected intercourse for any reason	• There are no contraindications to ECPs. • Women with strong contraindications to estrogen should use progesterone-only ECPs.

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Oral Contraceptive (Combined oral contraceptives or COCs) COCs contain the hormones estrogen and progesterone, which suppress ovulation. .	• Highly effective, reversible, easy to use. • Effective within first cycle. • Safe for most women. • Regulates the menstrual cycle. • Reduces menstrual flow (which may be useful to anemic women). • Decreases the risk of ovarian and uterine cancer, benign breast disease, and incidence of acne. • Does not interfere with sexual intercourse. • May be used after baby is 6 months old, if the woman decides not to continue to breastfeed the baby. • Pelvic exam not required before use. • Can be provided by trained non-medical staff. • May help women who experience painful menstruation.	• Must be taken every day. • Requires regular/ dependable supply. • Pills may cause side effects in some women, such as nausea, headache, break-through bleeding, or weight gain. • Does not protect against STIs and HIV. • Risk of developing cardiovascular disease in women over 35 years of age and who smoke.	• Women and couples who want an effective, reversible method. • Women with anemia due to heavy menstrual bleeding. • Women with an irregular menstrual cycle. • Women with family history of ovarian cancer. • Women with HIV/ AIDS • Women who are on ARVs.	• Women < 3 weeks postpartum • Breastfeeding women < 6 months postpartum • Women with moderate to severe hypertension • Diabetes, (advanced or long standing), with vascular problems, or central nervous system (CNS), kidney, or visual disease • Women who smoke > 15 cigarettes/day • Women with the following conditions: - Deep vein thrombosis (DVT) - Heart disease - Thrombogenic disorders - Liver disease or tumors - Recurrent migraine headaches with focal neurological symptoms - Unexplained abnormal vaginal bleeding - Breast cancer - Currently taking anticonvulsants for epilepsy

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Oral Contraceptive (Progestin Only Pills or POPs; also know as the "mini-pill") POPs contain a low dose of progestin, which is similar to the hormone progesterone. POPs work by thickening the cervical mucus and preventing ovulation. .	• Safe for nearly all women, especially women who cannot use COCs. • Highly effective, reversible, easy to use. • Regulates the menstrual cycle and reduces menstrual flow • Decreases risk of ovarian and uterine cancer, benign breast disease, and acne. • Does not interfere with sexual intercourse. • May be used after baby is 6 months old, if the woman decides not to continue to breastfeed • Can be provided by trained non-medical staff. • May be beneficial for women who experience painful menstruation.	• Must be taken every day. • Requires regular/ dependable supply. • Pills may cause side effects in some women, such as nausea, headache, changes in bleeding patterns, break- through bleeding, or weight gain. • Does not protect against STIs and HIV.	• Women and couples who want an effective, reversible method. • Breastfeeding women can begin this method as soon as six weeks post partum. • Can be used by women who smoke, have anemia now or in past, have varicose veins. • Women with HIV • Women who cannot use COCs	Women who: • are breastfeeding an infant less than six weeks old • have liver problems • have blood clots in legs or lungs • are taking medications for seizures or rifampicin for TB or other illness • have or have had breast cancer

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Injectable Contraceptive (Progestin Only) DMPA (Depot Medroxyprogesterone Acetate) contains the hormone progesterone, which suppresses ovulation. It is given by injection once every 12 weeks. The method has a grace period of effectiveness of 4 weeks before or after the scheduled date for the next injection.	• Very effective and easily reversible • Few side effects. • Does not interfere with sexual intercourse. • No daily pill-taking. • No effect on breast milk production • May help prevent ovarian cancer • For some women, may help prevent iron-deficiency anemia, reduce epileptic seizures. • Pelvic exam not required before use. ▪ Rapidly effective (<24 hours).	• May produce minor side effects such as light spotting, bleeding, amenorrhea, or weight gain. • Delayed return to fertility (for half of the users, it takes 6 to 9 months after discontinuation to get pregnant). • Requires regular injection every three months. • Does not protect against STIs and HIV. • Causes changes in menstrual bleeding patterns during the first year of use.	• Breastfeeding women (as soon as six weeks after childbirth) • Women of any reproductive age or parity, including adolescents • Women who have had an abortion or miscarriage • Women who have blood pressure <180/110 mm Hg, blood clotting problems, or sickle cell disease • Women who smoke (any age) • Postpartum women who are not breastfeeding • Women with HIV/AIDS • Women using ARVs	Women who: • Are pregnant • Are breastfeeding and < 6 weeks postpartum • Have high blood pressure (> 160/100 mm Hg) • Have diabetes with vascular disease • Have current or past ischemic heart disease • Have unexplained abnormal vaginal bleeding • Have or had breast cancer • Have liver disease • Have multiple risk factors for arterial cardiovascular disease (i.e., older age, smoking, diabetes, and hypertension.) • Have DVT, vascular or heart disease, or stroke

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Intrauterine Contraceptive Device (IUCD) Copper-releasing IUCDs (Copper T 380A) slows sperm movement A long-acting and highly effective method.	• Does not interfere with sexual intercourse. • No hormonal side effects with copper-bearing IUCDs. • Immediately reversible with no delay in return to fertility. • Does not interfere with breastfeeding. • No interactions with any medicines. • Helps prevent ectopic pregnancies (but does not prevent all). • Long-term method. • After initial follow-up visit, the woman needs to return to the clinic only if there is a problem. • Women do not need to purchase any supplies.	• Possibility of: - Longer and heavier menstrual periods; - Bleeding or spotting between periods; - More cramps or pain during periods. • Does not protect against STIs and HIV. • May increase risk of pelvic inflammatory disease (PID) and subsequent infertility in women at risk for STIs. • Requires a trained health care provider to insert and remove the IUCD. • May be spontaneously expelled.	Women who: • Have just had an abortion or miscarriage (if no evidence of infection) • Are breastfeeding • Have benign breast disease • Have or had breast cancer • Have headaches • Have high blood pressure (>140/90 mm hg) • Have heart disease • Have diabetes • Have liver or gallbladder disease • Have epilepsy • Have non-pelvic tuberculosis • Are HIV positive and/or AIDS who are clinically well.	Women with the following conditions: • Current PID, gonorrhea, or chlamydia • High risk for gonorrhea or chlamydia • Women with AIDS who are not clinically well. • Immediate post-septic abortion • Pregnancy • Pelvic tuberculosis • Distorted uterine cavity • Unexplained abnormal vaginal bleeding • Genital tract cancer (awaiting treatment) • Puerperal sepsis • 48 hours to less than 4 weeks postpartum • Malignant trophoblastic disease

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Female Tubal Ligation Permanent voluntary sterilization for women. Blocks the fallopian tubes by ligation, clips, or bands to prevent sperm and egg from uniting. Very effective (with pregnancy rates of less than 1% during the first year of use). A permanent method that is not easily reversible. Written consent is required from the woman undergoing the procedure.	• Simple surgery performed under local anesthesia. • Permanent procedure. • Nothing to remember, no supplies needed, no repeat clinic visits required. • Does not interfere with sexual intercourse. • No effect on breast milk production • No known long-term side effects or health risks. • Can be performed any time during the menstrual cycle when it is reasonably sure that the woman is not pregnant.	• Uncommon complications of surgery include: - Infection - Bleeding at the incision - Internal infection or bleeding - Injury to internal organs • Requires a trained provider. • Must be considered permanent. • Does not protect against STIs and HIV. • Short-term discomfort/pain following procedure.	• Any woman can use, but probably not appropriate for young women. • Women who just gave birth (within 2 days or after 6 weeks) • Women who are breastfeeding • Women with HIV or AIDS can safely have a tubal ligation, as long as universal precautions are followed.	Women with any of the following conditions should delay tubal ligation until the condition is resolved: • Current thromboembolic disorder • Current ischemic heart disease • Prolonged immobilization or leg surgery • Unexplained abnormal vaginal bleeding • Genital cancer • Current PID or within the past 3 months • Active viral hepatitis • Iron-deficiency anemia with a hemoglobin less than 7 g/dl • Acute bronchitis or pneumonia • Severe pre-eclampsia/ eclampsia • Prolonged rupture of membranes • Severe hemorrhage, sepsis, fever during or right after childbirth • Uterine rupture or perforation • Should not be performed on a woman with HIV/AIDS who is not clinically well.

METHOD MECHANISM OF ACTION	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Vasectomy Permanent voluntary sterilization for men Blocks the vas deferens and prevents sperm from entering the semen. A permanent method that is not easily reversible and is highly effective Written consent is required from the man undergoing the procedure.	• Permanent procedure. • Nothing to remember, except to use condoms for the first 3 months. • Does not interfere with sexual intercourse. • Simple surgery performed under local anesthesia. • No known long-term side effects. • No repeat clinic visits required, no supplies needed, except the use of condoms for the first 3 months. • Easier to perform than tubal ligation. • No change in sexual function. • No effect on hormone production.	• Must be considered permanent. • Delayed effectiveness (requires at least 3 months for procedure to be effective or more than 20 ejaculations). • Requires minor surgery by a trained provider. • Reversal surgery is difficult, expensive, and not available in most areas. • Does not protect against STIs and HIV.	• Men of any reproductive age (usually < 50 years). May not be appropriate for young men. • Men whose wives have age, parity, or health problems that might pose a serious health risk if they became pregnant • Men with HIV, AIDS or who are on ARVs can safely undergo vasectomy, as long as universal precautions are followed.	Men with any of the following conditions should delay vasectomy until the condition is resolved: • Current STI • Scrotal skin infection • Acute genital tract infection • Acute systemic infection • Symptomatic heart disease, clotting disorders, or diabetes • Men with AIDS who are not clinically well. The following conditions require a provider with extensive experience and skills in performing the vasectomy: • Previous scrotal surgery • Undescended testes and proven fertility • Inguinal hernia • Large varicocele

The Lactational Amenorrhea Method (LAM) of Family Planning

Lactational Amenorrhea Method (LAM) is a modern, temporary contraceptive method based on natural infertility resulting from certain patterns of breastfeeding.[33] LAM is effective for up to six months post partum if the mother is fully or nearly fully breastfeeding, which is recommended as the healthiest option for newborn nutrition up to six months of age. ***Fully breastfeeding*** includes both exclusive breastfeeding (the infant receives no other liquid or food than breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk). ***Nearly fully breastfeeding*** means that an infant receives some liquid or food in addition to breast milk but more than three-fourths of all feeds are breast milk.

The three conditions for successfully practicing LAM to prevent pregnancy are:
1. The mother's menstrual periods (monthly bleeding) have not resumed; **AND**
2. The baby is exclusively breastfed frequently, day and night; **AND**
3. The baby is under six months of age.

LAM is effective as a temporary contraceptive method **for only six months**. If the woman wants to space her next pregnancy by at least two years, she needs to adopt another FP method when any one of the three conditions are not met or the woman no longer wishes to rely on LAM for family planning. Appropriate methods for breastfeeding women include progestin only oral or injectable contraceptives, implants or an IUCD. All of these methods can be initiated six weeks postpartum. Breastfeeding women should not use combined oral contraceptives (COCs) or a combined injectable contraceptive because these methods decrease breast milk production.

A Note about Women with HIV/AIDS and Breastfeeding:
Women with HIV/AIDS and/or are using ARVs can use LAM, however, there is a chance they can pass HIV to their infants through breastfeeding. WHO recommends exclusive breastfeeding for HIV-positive women for the first six months of newborn life, unless replacement feeding is ***acceptable, feasible, affordable, sustainable and safe***.[34] If replacement feeding cannot meet **all** of these five criteria, exclusive breastfeeding for the first six months is the safest way to feed and is compatible with LAM.

(Note: Additional information on LAM is included in the Annex as Handout #8.)

Addressing Common Rumors about Family Planning Methods

There are many rumors and myths about family planning. Rumors about family planning are likely to be common because of issues concerning:

- The ability to bear children, have a healthy pregnancy and ensure that births are safely spaced for the health of both mothers and children are important to people, but often have not been clearly explained;
- There may no one available to clarify and correct the misinformation about FP; and
- People may be motivated to spread rumors about FP for political, religious, and cultural reasons.

As a provider of services that promote the use of FP for HTSP, you can help educate clients and correct misinformation. When a client expresses concern over an FP method based on rumors she has heard,

33 The Lactational Amenorrhea Method (LAM): A Postpartum Contraceptive Choice for Women Who Breastfeed, ACCESS-FP. (Updated 2008)

34 WHO Technical Consultation on Behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV. New data on the prevention of mother-to-child transmission of HIV and their policy implications. October 2000.

always listen politely and do not laugh at her concerns. Instead, provide her with correct information, using the following suggestions:

- Try to determine why this rumor might be common. For example, is it associated with side effects or problems with certain forms of contraception? Counteract rumors by giving the client correct information and clarifying any other questions s/he may have regarding the method.
- Make use of scientific facts about FP methods, and clearly explain the facts using demonstrations, models or other visual aids.
- Be honest and never dismiss the side effects or problems that might occur with a method. Counsel the client about all available methods so she can choose the best one for her.
- Reassure clients who are having problems and help them get appropriate medical attention if necessary.
- Show that you are concerned about the client's health and are willing to help her overcome worries and/or fears.

Table 3.4 lists some commonly held misperceptions and rumors and suggests appropriate responses.

Table 3.4 Rumors and Misconceptions—Facts and Realities about Family Planning

RUMORS AND MISCONCEPTIONS	FACTS AND REALITIES
• It is better to have your children closely spaced while you are young, because it is the time that the woman's body is strongest.	• Closely spaced pregnancies are not good for the health of any woman at any age. • Sufficient time between pregnancies will help women to be strong and healthy for the next pregnancy and to have time for proper care of the last-born child.
• It is more convenient to complete the family, and then use a permanent method of birth control.	• It is more important for the family to have a healthy mother and children, which is not possible if the births are not well-timed and spaced.
• If a condom slips off during sexual intercourse, it might get lost inside the woman's body.	• If a condom slips off during sexual intercourse, it is impossible for the condom to get lost inside the woman's body.
• A woman only needs to take the pill when she has sex with her husband • Pills make you weak. • The pill is dangerous and causes cancer. • The pill causes abnormal or deformed babies. • Women who take the pill are more likely to have twins or triplets. • The pill causes infertility. • The pill makes it more difficult for a woman to become pregnant once she stops using it.	• A woman must take her pills every day to not become pregnant. . • Sometimes women feel weak, and if they are taking the pill, they blame the weakness on the pill. Pills do not make a woman weak. See a health care provider to find out what else might be causing weakness. • Studies show that the pill can protect women from some forms of cancer, such as those of the ovary, uterus, and breast. • There is NO medical evidence that the pill causes abnormal or deformed babies. • The pill has no effect on multiple births. • Studies have clearly shown that the pill does not cause infertility or decrease a woman's chances of becoming pregnant once she stops taking it.
• Emergency Contraceptive Pills (ECPs) cause abortion.	• ECPs do not cause abortion. • ECPs will not end an established pregnancy, but it will prevent pregnancy by interrupting ovulation or implantation.

RUMORS AND MISCONCEPTIONS	FACTS AND REALITIES
• A woman who has a tubal ligation loses all desire for sexual intercourse. • A woman who has a tubal ligation becomes sick and unable to do any work. • A woman who has a tubal ligation has to be hospitalized.	• Tubal ligation has no physiological effect on the woman. Her sexual drive should remain the same as before. • A woman who has had tubal ligation can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work and does not make her weak or sick. • There is no need for hospitalization for a female tubal ligation. It is a short surgical procedure and the woman can return home after resting for some time at the hospital (approximately two hours).
• A man will lose his sexual drive after a vasectomy. • A vasectomy will make a man physically weak. • There will not be any semen production after a vasectomy.	• A vasectomy does not interfere with the man's reproductive physiology. His sexual drive remains. • A vasectomy does not make a man physically weak—he can get back to his regular work in 2 to 3 days' time. • Semen will be produced as usual; only the sperm will not be part of the semen.
• A woman who uses injectables (DMPA) will never be able to get pregnant. • Injectable contraceptives cause cancer. • A woman will not have enough breast milk if she uses injectables while breastfeeding. • Injectables stop menstrual bleeding which is bad for a woman's health. • Injectables cause abnormal or deformed babies. • Injectables cause irregular bleeding, which leads to anemia.	• Sometimes there is a delay of 6 to 9 months after the last injection for a woman's fertility to return to normal. • Research has clearly proven that injectables do not cause cancer. In fact, injectables have been shown to protect against ovarian cancer. • Studies show that the amount of breast milk does not decrease when breastfeeding women use injectables six weeks after birth. • Amenorrhea is an expected result of using injectables, because women using injectables do not ovulate. This kind of amenorrhea is not harmful and can help prevent anemia. • There is no evidence that injectables cause any abnormalities in infants. Studies done on infants who were exposed to DMPA while in the womb showed no increase in birth defects. • During the first 3 to 6 months of DMPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. This usually stops within a few months of continuous use of DMPA and rarely results in anemia.
• A woman who has an IUCD cannot do heavy work. • The IUCD might travel inside a woman's body to her heart or brain. • If a woman using an IUCD becomes pregnant, the IUCD will become embedded in the baby's forehead. • The IUCD rots in the uterus.	• Using an IUCD should not stop a woman from carrying out her regular activities in any way. • There is no passage of IUCD from the uterus to the other organs of the body. • The IUCD placed inside the uterus stays there until a trained health care provider removes it. • Rarely will an IUCD perforate the uterus, but the health worker can identify this and necessary actions can be taken to remove the IUCD. • If the IUCD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. • If a woman gets pregnant with an IUCD in place, the health care provider should remove the IUCD immediately. • If for some reason the IUCD is left in place during a pregnancy, there is no evidence that it will harm the baby in any way, and it is usually expelled with the placenta or with the baby at birth. • If there are no problems, the IUCD can remain in place and be an effective contraceptive method for 5 to 12 years[35]. The IUCD is made up of materials that cannot deteriorate in the body.

(Note: This Table appears in the Annex as Handout #13.)

35 The hormonal IUD is effective for five years while the copper 380A IUD is effective for up to 12 years

Section 4:
Counseling Skills for Healthy Timing and Spacing of Pregnancy and Family Planning

Counseling provides clients with the necessary information and opportunity to make an informed choice about their health. Informed choice is a client's decision which is based on accurate understanding of the full range of options and their possible results. Through counseling, health workers give clients accurate and truthful information and help them apply this information to their own situation and needs.

From *HTSP: A Reference Guide for Trainers*

4 COUNSELING SKILLS FOR HEALTHY TIMING AND SPACING OF PREGNANCY AND FAMILY PLANNING

Effective communication and counseling are critical components of FP service delivery that will ensure the adoption and continued use of FP. Good communication and high quality FP counseling will inform women and their families about the importance of FP in achieving HTSP. Through effective communication and counseling, providers give accurate information on available FP methods, and support clients in making decisions on whether or not to use FP to effectively time, space and limit their pregnancies.

Interpersonal Communication

A health care provider spends a great deal of time engaged in interpersonal communication with clients, their families, community members and colleagues. People communicate verbally through their words and their tone of voice, and nonverbally through their actions, facial expressions, and general "body language." Health workers must be conscious of using the right words and tone of voice, as well as open and friendly body language to communicate effectively.

While much communication is interpersonal, a health worker may also provide information and education to groups, such as women in the waiting area of the clinic, the marketplace, or community meetings. In these settings, the health worker should use the same interpersonal communication skills that s/he uses when speaking with individuals. The main difference is that s/he will not be providing information that is specific to an individual client.

To communicate effectively, the health care provider should:

- Listen carefully to what clients have to say and notice how they say it
- Convey interest, concern, and friendliness;
- Speak in a soft, gentle tone of voice;
- Use words that the client understands;
- Encourage the client to ask questions and express any concerns;
- Ask only one question at a time and wait with interest for the answer;
- Ask questions that encourage clients to express their needs;
- Treat each client as an individual;
- Keep silent sometimes and give clients time to think, ask questions, and talk;
- Every now and then, repeat what you have heard to make sure that you understand what the client is saying;
- Sit or stand comfortably and avoid distracting movements;
- Look directly at clients when they speak.

Counseling

Counseling is the *mutual* exchange of information and ideas between a counselor and a client. It is not meant to be a session in which providers tell clients what to do or direct them to a specific outcome. It should be client centered. Counseling is critical in building a satisfying provider-client relationship. Through skilled counseling, providers can validate the concerns of the client, empathize with their situation and build rapport which contributes to overall client satisfaction.

Counseling should take into account the context of women's lives. Counseling helps individuals examine personal issues and make plans for taking action. If a client decides that she is interested in pregnancy spacing, and would like to use an FP method to ensure adequate spacing, counseling will help the client choose the appropriate contraceptive method and learn how to use the method correctly.

An effective counselor will consider a woman's different needs throughout her reproductive life cycle, and the multiple factors that influence decision-making around practicing HTSP and using family planning. Most healthy women can use any method of contraception, but as she moves through the different stages of her reproductive life her contraceptive needs may change over time, based on factors such as her fertility intentions, desired family size and health status. Adolescents, post partum and post abortion women, breastfeeding women and women over the age of 35 are groups with special contraceptive and counseling needs.

For example, an adolescent of 16 may see herself as eventually having four children (desired family size) but has no intention of becoming pregnant right now (fertility intentions). A young married woman may feel conflicting emotions over becoming pregnant due to her own feelings and pressure from her husband and family, may fear opposition to family planning from her husband or mother-in-law and may be unclear about her desired family size. A woman who is post partum may want to have at least two more children, but does not want to become pregnant right away, while a woman who has just had a miscarriage may want to become pregnant again as soon as possible. A woman of 30 may have had all the children she intends to have and does not want to become pregnant again, while a peri-menopausal woman of 45 is convinced that she cannot become pregnant. All of these women have distinct situations, intentions and needs that must be addressed in educating and counseling women on the healthiest and safest options that are available to them in terms of HTSP and FP use. Box 4.1 provides tips on counseling for FP.

What Makes FP Counseling Effective?[36]

A good counselor:

- Treats all clients with respect, regardless of age, marital status, ethnicity or socio-economic status
- Maintains confidentiality
- Personalizes the content of counseling to the client's situation

Furthermore, a good family planning counselor:

- supports a client's informed choice.
- supplies accurate, complete technical information that is relevant to the client, including information on HTSP.
- addresses the negative about family planning (such as side effects) as well as the positive.
- discusses the client's childbearing intentions, including timing, spacing and limiting of pregnancies, sexual relationships, partners and STI/HIV risk-taking behavior.

A complete family planning session should cover the following:

- Information about all Family Planning methods
- Information on side effects and complications
- Advantages and disadvantages of a method from a client's point of view
- Method effectiveness
- Proper method use (once a method has been selected)
- What to do if the method fails or is not used properly
- The availability of emergency contraception
- STI and HIV prevention
- Information on return visits, resupply and unscheduled visits if there are problems

36 Heerey, M. et al. *Client-Provider Communication: Successful Approaches and Tools [CD-ROM]*. Baltimore, Maryland: Quality Associates and The Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (2003). www.rho.org/html/fpp_keyissues.html

(Note: This information appears in the Annex as Handout #14.)

While most counseling occurs between a provider and a client, in some situations it may be useful—indeed critical—to involve a woman's husband or other important decision-maker in counseling. Couples counseling that addresses FP and HTSP provides men with important information on the health, social and economic benefits of HTSP and FP, and an opportunity to discuss how they can act to protect their health and the health of their wives and children Good counseling, therefore, will provide clients with the opportunity to learn more about HTSP and FP, to decide if they want to practice HTSP through the use of FP, and choose and use the family planning method that best suits them at a particular point in their life.

Family planning clients differ, their situations differ, and they need different kinds of help at different stages of their life. There is no set script for counseling men and women about HTSP. There are however, certain key messages and tasks that counselors should keep in mind as presented in Table 4.1.

Table 4.1 Family Planning Counseling Strategies for Different Clients[37]

Client Type	Usual Counseling Tasks
Returning clients with no problems	• Provide more supplies or routine follow-up • Ask a friendly question about how the client is doing with the method. • Assess her intentions with regard to becoming pregnant; remind her of the benefits of HTSP, as appropriate.
Returning clients with problems	• Understand the problem and help resolve it—whether the problem is side effects, trouble using the method, an uncooperative partner, or another problem. • Help her choose another method, if she so desires, so that she does not discontinue the use of her method and risk an unplanned or closely spaced pregnancy • Remind her of the importance of using a FP method of her choice to ensure HTSP.
New clients with a method in mind	• Check that the client's understanding of the method is accurate • Support the client's choice, based on your assessment of the client's situation and if the client is medically eligible • Discuss how to use method and how to cope with any side effects • Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.
New clients with no method in mind	• Discuss the client's situation, where she is in her reproductive cycle, plans (such as fertility intentions, desired family size), and what is important to her about a method • Help the client consider methods that might suit her particular situation. If needed, help her reach a decision • Support the client's choice, give instructions on use, and discuss how to cope with any side effects • Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.

37 *Family Planning: A Global Handbook for Providers*, World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. (2007)

(Note: This information appears in the Annex as Handout #15.)

Proving Counseling on HTSP Using the GATHER Method[38]

Providing counseling on HTSP will help women, their families, and communities understand that a woman should wait until her youngest child is at least two years old before she gets pregnant again. When HTSP is practiced through the use of FP, women and their infants will enjoy better health and have fewer chances of adverse health outcomes. HTSP counseling should provide up-to-date information, correct rumors and misinformation and help clients learn how to use an FP method correctly and consistently to effectively space pregnancies.

When counseling a client, the provider should begin by informing the client about the benefits of HTSP, and how the use of FP can help her maximize that benefit. Next, the provider should explore if there are any obstacles that the client might face that would prevent her from using FP to practice HTSP, as well as whether or not there is support from her husband and/or family for her desire to space her children. The provider should keep in mind that the timing and spacing of women's pregnancies may be dictated by traditional norms and practices while still providing accurate information and counseling.

The provider can better consider the personal characteristics and situation of the client that will influence her ability to effectively use FP for HTSP by using GATHER method of counseling on HTSP.

Principles and Elements of Good Counseling

Counseling on FP and HTSP can be done by using the GATHER (Greet, Ask, Tell, Help, Explain, Return) approach to counseling.[39] Counseling, however, should always be tailored to the client. Not all clients need to be counseled following the steps of GATHER in exactly the same sequence. For example, with some clients, the counselor may need to repeat one or more steps. The counselor can change the order of the steps of GATHER according to the needs of the client, but it is good practice to follow the established GATHER sequence to avoid leaving out important steps.

The elements of GATHER, which has been adapted for HTSP, are presented on the following pages.

38 GATHER Guide to Counseling. Population Reports Series J, Number 48. December 1988, Johns Hopkins University School of Public Health/Center for Communication Programs, Baltimore Maryland

G Greet the client in a friendly way.

- ☐ As soon as you meet clients, give them your full attention.
- ☐ Be polite: greet them, introduce yourself, and offer them a seat.
- ☐ Conduct counseling where no one else can hear.
- ☐ Inform clients that you will not share their information with others.
- ☐ In clinics, explain what will happen during the visit. Describe physical examinations and laboratory tests, if any.
- ☐ If counseling is taking place at home, ensure that the client has some private time and/or place to participate in the counseling.

A

Ask the client why she has come in for a visit.

(e.g., is she interested in hearing how to delay, space or limit a pregnancy?)

- ☐ If the client is new, obtain a history, including the client's:
  - ❖ Age
  - ❖ Marital/union status
  - ❖ Basic medical information
  - ❖ Number of pregnancies and when
  - ❖ Number of births and when
  - ❖ Number and ages of living children
  - ❖ Family planning use for delaying, spacing or limiting pregnancies, now and in the past

- ☐ Probe for fertility intentions using the appropriate Fertility Intention Question Tree (see Handout #17). Explain that you are asking for this information to help the client make an informed choice about delaying, spacing and/or limiting a future pregnancy and to help her identify the most suitable family planning method.

- ☐ Keep questions simple and brief. Look at your client as you speak.

- ☐ Help clients talk about their needs, wants, doubts, concerns, or questions they may have about HTSP, FP and pregnancy

- ☐ Ensure that the client understands what you have to say. Encourage clients to ask questions.

- ☐ If the client is not new, ask her if anything has changed since her last visit.

T

Tell the client about the benefits of HTSP and the FP methods that are available meet her specific needs for spacing or limiting.

- ☐ As needed, probe to determine whether the client is more interested in becoming pregnant again or in limiting her childbearing.
    - ❖ For postpartum women, explain why spacing pregnancies at least two years and no more than five years is beneficial. Inform her how long a woman should wait from her last birth to her next pregnancy, if she wants to become pregnant again.
    - ❖ For postabortion or post-miscarriage women, explain that if she wants to become pregnant again, the she should delay getting pregnant for at least six months.
    - ❖ For adolescents, explain that it is important to wait until she is 18 before becoming pregnant.
- ☐ Explain the potential risks of not practicing HTSP.
- ☐ If the client is interested in HTSP, discuss available modern and fertility awareness based methods of family planning that she can use to practice HTSP, including LAM based on the client's fertility intentions. Inform your client about which FP methods are available and where she can obtain them, and ask if there are any methods that interest them.
- ☐ Ask your client what she already knows about the methods that interest her. Correct any misinformation.
- ☐ Briefly describe each method that the client wants to hear about. Talk about:
    - ❖ Effectiveness
    - ❖ How to use the method
    - ❖ Advantages and disadvantages, including information on return to fertility
    - ❖ Possible side effects and complications
- ☐ Use samples and other audiovisual materials, if available.
- ☐ If client is not interested in HTSP and wants to become pregnant again, provide counseling on the importance of antenatal care.
- ☐ If client is undecided, probe reasons for not spacing and discuss further. As appropriate use the information from Table 4 (below) **Is HTSP Right for Me?**

Table 4: IS HTSP RIGHT FOR ME? **COMMON REASONS CITED BY WOMEN FOR NOT PRACTICING HTSP AND POSSIBLE RESPONSES**	
Reasons for not waiting before youngest child is at least 2 years old:	**Possible Responses**
• It is best to have the children one after the other while young so the mother is strong enough to raise them.	• Even young mothers can be stressed and weakened by closely spaced pregnancies.
• It is best to have children one after the other so that they can have a companion close to their age with whom they can play.	• Children closely spaced together may demand more attention from the mother.
• It is easier to raise two children close to each other in age, because they can share clothes, toys, and the mother's time. It also saves money.	• All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization	• The mother can give the last-born child all the needed attention to grow healthy, be well fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give the last-born child enough attention.
• If a woman waits too long, she will be too old to have another child.	• It is better for the whole family if the mother and children are healthy, which may not happen if the births are closely spaced.
Common reasons for not practicing HTSP:	**Possible Responses**
• Her religion does not allow her to use FP.	• You can use fertility-based awareness methods and other natural methods to plan your family. You can also practice LAM by breastfeeding.
• Her husband is not interested in discussing family planning or pregnancy spacing and/or he feels that it is her responsibility, not his.	• Pregnancy spacing is a joint responsibility and there are many economic, social and emotional advantages to spacing children.
• The man's virility may be questioned if his wife does not become pregnant quickly.	• A responsible man knows that his family's health is important, and he is willing to take steps to ensure that his family is healthy by planning and spacing his children.
• The woman's fertility may be questioned if she is not able to become pregnant quickly.	• While it is important to acknowledge the concerns and expectations of her husband and family, they must also understand the risks of closely spaced pregnancies to the health of the woman, her current and future children.

Reasons for not waiting until age 18:	**Possible Responses**
• It is best to have children while young so the mother is strong enough to raise them.	• Married adolescents need time to physically and psychologically mature so that they are prepared for pregnancy and childbirth. Delaying the first child until a young woman is at least 18 increases the chances of having a healthy pregnancy and a healthy child.
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.	• Completing a family can be done quickly and safely after the age of 18, after which permanent methods and surgical sterilization are options.
• If a woman waits too long, she will be too old to a child.	• Waiting until you are 18 is not too long and women can have healthy children safely for many years after that.
• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as she marries, even if she is very young. In many cases, it is important to demonstrate her fertility and/or produce a male child as soon as possible.	• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.
Reasons for not waiting after a miscarriage or abortion:	**Possible Responses**
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.	• Waiting 6 months will not hinder your time to complete your ideal family size, after which permanent methods and surgical sterilization are options.
• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as possible. In many cases, it is important to demonstrate her fertility and/or produce a male child.	• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.

H

Help client choose a method that best suits her current situation, fertility intentions and desired family size.

- ☐ Help each client match her needs and preferences with a family planning method, especially in terms of her desire to delay, space or limit her next pregnancy.
- ☐ Ask the client if there is a method she would like to use. Some will know what they want, while others will need help to make a decision.
- ☐ Ask the client about her fertility intentions desired family size, and any future plans. Reinforce the benefits of HTSP and the use of FP.
- ☐ Ask client what her partner wants. What method would her partner like to use?
- ☐ Ask clients if there is anything they do not understand. Repeat and clarify information when necessary.
- ☐ Some methods are not safe for some clients. When a method is not safe, inform the client and explain clearly why it is not safe. Then help the client choose another method.
- ☐ Check whether the client has made a clear decision. Specifically ask, "What method have you decided to use?"

E Explain how to use the method.

- ☐ After the client has chosen a method, give her supplies, if appropriate.
- ☐ If the method cannot be given immediately, tell the client how, when, and where it will be provided. Provide a back up method, such as condoms.
- ☐ For some methods, such as voluntary surgical contraception, the client may have to sign a consent form which states that the client wants the method, has been given information about it, and understands the information (please refer to the procedures for voluntary sterilization in your country). Help the client understand the consent form.
- ☐ Ask the client to repeat the instructions on using and/or obtaining her method. Listen carefully to make sure she remembers and understands.
- ☐ Describe any possible side effects and warning signs. Clearly inform the client what to do if they occur.
- ☐ Ask the client to repeat this information and clarify as needed.
- ☐ If possible, give the client printed material about the method.
- ☐ Inform the client when to come back for a follow-up visit as needed, (e.g. for resupply, check up, etc)
- ☐ Remind the client that she should use the method for at least two years after the birth of her last child (for postpartum women); or for at least six months following a miscarriage or abortion; or until she is at least 18 years old.
- ☐ Inform the client to come back sooner if she wishes, or if side effects or warning signs occur.

R

Return for follow-up. Set up a date with the client for you to visit her for follow-up OR fix a date for the client to visit the facility for a follow-up visit.

- ☐ At the follow-up visit ask the client if she is still using the method.
- ☐ If yes, ask the client if she has any problems with the method.
- ☐ If the client has any side effects, ask her to list each side effect one at a time.
- ☐ If the client has experienced any side effects, find out how severe they are. Reassure clients with minor side effects that they are not dangerous, and often resolve on their own after a few months Suggest some ways to relieve side effects. If side effects are severe, refer them for treatment.
- ☐ Ask how the client is using the method to be sure she is using it correctly.
- ☐ Ask if the client has any questions.
- ☐ If a client wants to switch to another method, inform the client about other available methods and help the client to choose another method Remember, changing methods is not bad. No one can really decide on a method without trying it. Also, a person's situation can change so that another method may be better.
- ☐ If a client wants to have a child, help her to stop using her method. Explain any possible delay in return to fertility. Remind her of the importance of antenatal care and as needed inform the client where to go for antenatal care. Reinforce the benefits of HTSP.

Section 5:
Training for HTSP

Carefully designed training programs not only improve the performance of family planning providers and managers, but also have a favorable effect on client knowledge, compliance and contraceptive use.

From *HTSP: A Reference Guide for Trainers*

5 RESOURCES FOR TRAINING ON HTSP

This section provides ESD's recommendations for a four-day workshop for facility-based providers (e.g. nurses, midwives, clinic officers, etc), that is intended to build participant knowledge and skills in HTSP, family planning and counseling. The resources include a detailed training curriculum (Table 5.1), tools, case studies and role plays, and handouts.

Implementing an HTSP Workshop

The goal of HTSP training is to enhance the knowledge and skills of health workers to provide HTSP information to clients as part of FP and related health counseling and services. ESD recommends that 20-25 hours of training be provided to participants. To maximize training, there should be no more than 25 participants. Training can be implemented as a four-day training (recommended). Trainers, however, will use their best judgment based on the level of participant knowledge and skills and the availability of resources, and use the material here to develop training that is relevant to their audiences.

To facilitate trainers' efforts, ESD has included the following resources and tools in this Guide:

- A counseling skills checklist for practicing HTSP and FP counseling
- Case studies and role plays that can be used in sessions
- A standardized pre-test and post-test
- Evaluation forms
- Certificate of Completion of Training on HTSP Template

Suggested Learning Objectives:

By the end of the training, participants should be able to:

- Explain HTSP
- Understand the benefits and risks associated with HTSP
- Describe the FP methods that are available to facilitate HTSP
- Strengthen interpersonal communication skills on HTSP

Table 5.1 Model Course Outline for Facility-based Health Care Providers

DAY ONE			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
90 minutes	**1.1 Activity:** Welcome and Introductions Overview of training Participant Expectations Administration of pre-test	Welcome by official representatives Ice breaker for introductions Review training outline and discuss learning objectives Distribute materials Solicit participants expectations and record Distribute pre-test and allow 30 minutes for completion	• Overhead projector, screen • Flipchart with markers • Transparency film • Pre Test (Training Tools)
90 minutes	**1.2 HTSP** **Objectives:** • Describe the concept and principles of HTSP • Review country specific DHS, as well as locally available data on pregnancy spacing, morbidity and mortality related to closely spaced births, etc • List the 3 key messages of HTSP and Recommendations of 2006 WHO Policy Brief	**Lecture and Discussion** Present the information on the concepts and principles of HTSP and review the spacing recommendations from the 2006 WHO Policy Brief. Include recommendation on waiting until at least age 18 before becoming pregnant. Facilitate a discussion with the group to ensure that participants have a clear understanding of the principles and the terms used to explain HTSP. Answer any questions.	• Flipchart and markers • Section 2 of HTSP Reference Guide • Handout #1 • Other relevant information (e.g. data on maternal morbidity and mortality, etc)
90 minutes	**1.3 HTSP** **Objectives:** • Identify advantages and disadvantages of HTSP for women, infants, men and communities • Discuss benefits of HTSP for adolescents, post partum women and women who have experienced spontaneous or induced miscarriage • Identify opportunities to integrate HTSP information, education and counseling	**Small Group Work** Working in four groups, have participants discuss the advantages of practicing HTSP and disadvantages of not practicing HTSP for the four beneficiary groups: women, infants, men and communities and where HTSP could be integrated. Have participants report back to large group **In plenary**, discuss specific benefits of HTSP for adolescents, postpartum women and post-abortion women and feasibility of integrating HTSP into other services.	• Flip chart and markers • Section 2 of HTSP Reference Guide • Handouts #2, #3, #4, and #5
90 minutes	**1.4 HTSP** **Objectives:** • Identify common reasons for not practicing HTSP and suggest responses	**Brainstorm and discussion** Ask participants to brainstorm why women and couples may or may not practice HTSP. For reasons cited, ask participants to suggest responses. **Small Group Work** Break participants into three groups. Distribute a role play on HTSP to each group and ask each group to perform their role play for the larger group then discuss the issues raised in the larger group.	• Flip chart and markers • Section 2 of HTSP Reference Guide • Choose from Role play scenarios (Training Tools) or develop own. • Handout #6
30 minutes	Review of day's activities	Summarize content and answer questions	

Table 5.1 Model Course Outline for Facility-based Health Care Providers, cont.

DAY TWO: Family Planning Methods for HTSP			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
30 minutes	**2.1 Activity:** Review the agenda and reflection	Discuss what participants liked and didn't like on the previous day Review the day's agenda with the participants Conduct a warm up activity.	• HTSP Reference Guide for Trainers • Flipchart and markers
60 minutes	**2.2 Family Planning** **Objectives:** • Familiarize participants with national FP program guidelines and tools.	**Lecture and Demonstration**: Use the locally available relevant guidelines and quality assurance tools to discuss the delivery of FP services.	• National guidelines and Quality assurance tools (as available) • Flipchart and markers
60 minutes	**2.3 Review of FP methods** **Objectives:** • Discuss the importance of educating providers about FP for adolescents, postpartum and postabortion women, women over 35, women with HIV.	**Lecture and Discussion:** Use the relevant sections from the Trainer's Reference Guide and other resources to discuss the importance of FP for post partum women, post abortion women, adolescents and special groups, such as HIV + women and women over 35.	• Flipchart and markers • Section 3 of HTSP Reference Guide
90 minutes	**2.4 Review of FP methods** **Objectives:** • Discuss modern FP methods in terms of effectiveness, advantage and disadvantages • Identify commons rumors and misconceptions of FP and suggest responses	**Lecture and discussion** Use Reference Guide to discuss contraceptive methods, focusing on those that are most readily available. Then facilitate group discussion on common rumors and misconceptions about FP. Allow participants adequate time to clarify information. Promote a lively discussion that includes time for developing responses to rumors and misconceptions. Discuss how HTSP can promote greater access to and acceptance of FP.	• Flipchart and markers • Section 3 of Reference Guide • Handouts #7, #8, #9, #10 #11, #12, #13
90 minutes	**2.5 Review of FP methods** **Objective:** • Demonstrate current knowledge in modern family planning methods and their application in different situations.	**Case Study:** Break into small groups and assign case study on FP use to each group. Allow groups 15 – 20 minutes to discuss case study and then have each group make a five minute presentation to the larger group. .	• Flipchart and markers • Section 3 of Reference Guide. • Choose from Case Studies in Annex or develop your own.

Table 5.1 Model Course Outline for Facility-based Health Care Providers, cont.

DAY THREE: Communication and Counseling for HTSP			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
30 minutes	**3.1 Activity:** Review the agenda and reflection	Discuss what participants liked and didn't like on previous day Review the day's agenda with the participants Conduct a warm up activity.	• HTSP Reference Guide for Trainers • Flipchart and markers
30 minutes	**3.2 HTSP** **Objective** • Discuss opportunities for integrating HTSP information, education and counseling	**Lecture and Discussion:** Review again where HTSP information, education and counseling can be integrated. Allow participants to ask questions and clarify any misinformation.	• Flipchart and markers
150 minutes	**3.3 Communication and Counseling** **Objectives:** • Identify strategies for effective communication and counseling • Discuss barriers to communication • Practice using effective communication and counseling skills	**Lecture and discussion** Present an overview of communication and counseling **Small group work** Conduct an activity with participants to practice using verbal and non-verbal communication as part of counseling **Group discussion** on communication and counseling and their importance to promoting HTSP and FP	• Flip chart and markers • Section 4 of Reference Guide • Handouts #14, 15
90 minutes	**3.4 Counseling for HTSP** **Objective** • Improve HTSP counseling skills	**Lecture:** Use the materials from the Trainer's Reference Guide and participant contributions to make the presentation on counseling methods, skills, and the GATHER counseling approach.	• Flip chart and markers • Section 4 of Reference Guide • Role Plays (Training tools) • Handout on GATHER
30 minutes	Review of the day's activities	Involve participants in review and discussion of the topics and activities covered during the day. Encourage participants to ask questions and clarify any misinformation.	

Table 5.1 Model Course Outline for Facility-based Health Care Providers, cont.

DAY FOUR: Skills Development and Action Planning for HTSP			
TIME	**OBJECTIVES/ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
30 minutes	**4.1 Agenda:** Review of the agenda and reflection.	Discuss what participants liked and didn't like on previous day Review the day's agenda with the participants Conduct a warm up activity.	• Flipchart and markers • HTSP Reference Guide
90 minutes	**4.2 Counseling Skills** **Objective** Understand how GATHER can be used for addressing HTSP	**Present the Counseling Checklist and review with participants** **Role Play** Divide participants into four groups and distribute role plays. Allow participants time to develop skits on HTSP, using new information and skills, using all skills they have learned. Perform skits. Participants should use the Counseling Checklist to assess each role play to ensure key areas are addressed. Group discussion	• Flipchart and markers • Counseling Checklist (Training Tool #) • Use Role Plays from Annex or develop your own.
60 minutes	**4.3 Comprehensive Review and Post test** **Objective:** To address all questions, comments, and points of relevance prior to the post-test	**Group Discussion** Address any questions and comments. Administer post-test	• Flipchart and markers • Post-Test (Training Tools)
90 minutes	**4.4 Activity:** Prepare action plans	**Individual Work:** Divide participants into groups according to their districts or workplaces. Each group should prepare an action plan that they will implement when they return to their workplace. The action plan should include: 1) the activities that they propose to do, 2) time frame for implementation and 3) the persons responsible for action plan. Present action plans to group for review and feedback.	
40 minutes	**4.5 Activity:** Discussion of the post-test results with the participants Course evaluation	Share the overall results of the pre and post-test with the participants and provide correct answers to questions. Discuss the answers with the participants and clarify any questions. Request that the participants fill out the Course Evaluation Forms.	• Answer Key from • Training Tool
20 minutes	**Activity:** Closing session Certificate distribution Any feedback from participants.		• Training Tools

HTSP Training Tools

1. Checklist for HTSP and FP Counseling Skills
2. Case Studies and Role Plays
3. Pre/Post-Test Questionnaire
4. Course Evaluation Form

5. TRAINING TOOL #1

Checklist for HTSP and FP Counseling Skills			
TASK		**YES**	**NO**
1.	Greet client politely and give her or him your full attention.		
2.	Inform client that you will not tell others what they say during the discussion and conduct the counseling for HTSP and FP.		
3.	Ask client about her family's health and address concerns first before proceeding with FP counseling.		
4.	Ask client about his or her wellbeing and address his or her health concerns first before proceeding with FP counseling.		
5.	Obtain relevant client information, (e.g. name, age, etc.) and her pregnancy/reproductive history, marital statues, socio-economic situation, etc.		
6.	Obtain client's medical history, if appropriate.		
7.	Ask client what she knows about Healthy Timing and Spacing of Pregnancy.		
8.	Inform client about benefits of Healthy Timing and Spacing of Pregnancy.		
9.	Ask client about her desired family size and when she might like to become pregnant (fertility intentions)		
10	Ask client(s) which family planning methods s/he knows and inquire what s/he knows about these methods.		
11	Inform client about which family planning methods are available, including fertility-based methods.		
12	Briefly describe each method that the client wants to hear about, and describe any side effects and inform client what s/he needs to do if any side effects occur.		
13	Ask client which methods interest them and what s/he knows about these methods.		
14	Correct any misunderstanding about the methods.		
15	Explain how to use the method. Ask client to repeat the instructions and check if there is anything s/he does not understand.		
16	Check to make sure client has made a clear decision.		
17	Give client supplies, if appropriate.		
FOR POSTPARTUM CLIENTS, with children less than six months of age, also ask the following:			
18	Inform client about return to fertility following a full-term birth.		
19	Inform clients that for non-breastfeeding women, fertility will return as early as 45 days postpartum		
20	Inform client about lactational amenorrhea method and how it can be used for pregnancy spacing.		
21	Inform client which FP methods can be safely used during postpartum period.		
22	Identify with the client which methods are appropriate for breastfeeding mothers and for non-breastfeeding mothers		
23	Reinforce importance of HTSP		
FOR POSTABORTION CLIENTS, also ask the following			

24	Inform client that fertility can return within 10 days to 2 weeks following an abortion or miscarriage.		
25	Inform client that she should wait at least six months before trying to become pregnant again, if that is her intention.		
26	Inform client which FP methods can be safely used following an abortion or miscarriage for spacing or limiting pregnancy.		
FOR ADOLESCENT CLIENTS, also advise them			
27	To ensure the healthiest outcomes for both mother and baby, adolescents should wait until they are at least 18 before becoming pregnant		
FOR HIV POSITIVE WOMEN, also advise them			
28	The use of condoms prevents both pregnancy and HIV		
29	Family planning helps limit the spread of HIV by preventing unintended pregnancies among HIV + women, which decreases the likelihood of HIV infection in children.		
30	Women who are on ARVs can safely use most contraceptive methods		
31	HIV + women who want to have children can increase the chances of having a healthy pregnancy through improved use of HTSP and FP.		
32	It is very important that HIV + women who want to become pregnant seek antenatal care.		
33	HIV+ women are at risk of having a baby which is pre-term and of low birth weight. Pregnancy spacing is especially important to help prevent these outcomes.		
FOR WOMEN OVER 35 also advise them			
34	Pregnancy after 35 carries increased health risks for mothers and children.		
35	Ask if she has reached her desired family size. If so, is she using a method of contraception?		
36	If she does not want any more children, is she interested in using a long-acting or permanent method?		
37	Women remain fertile until menopause, which generally occurs between the ages of 45 and 55. The use of FP is recommended until one year after menstruation ceases.		

TRAINING TOOL #2 CASE STUDIES AND ROLE PLAYS

A number of the sessions in the training use case studies and role plays to help participants apply new learning and skills for HTSP and FP education and counseling. What follows are suggested case studies and role plays that the trainer can use and/or adapt for sessions.

Each case study includes suggestions for the trainer in terms of guiding the discussion of the case study.

Case Study #1

Situation:

Mariam is 17. She has just married a man who is about 10 years older than she is. She wants to wait at least a year before becoming pregnant.

Possible Responses:

- Inquire what Mariam knows about pregnancy and the menstrual cycle, and explain how fertility and conception work.
- Explain the health benefits of delaying the first pregnancy until she is at least 18 as well as the risks associated with early pregnancy.
- Ask her if there is pressure from her husband, family or community for her to get pregnant quickly. As needed, discuss how to deal with such pressure.
- Ask her what she knows about FP. What is her partner's attitude towards FP? Do her religious beliefs conflict with her desire to use FP? Do her beliefs support pregnancy spacing and breastfeeding?
- Discuss her contraceptive options for contraceptive methods, depending on local availability, her beliefs and the attitude of her partner.
- Fully explain the benefits and limitations of FP, correct use of FP method, and needed follow-up services.

Case Study #2

Situation:

Anna is 22. She has a six-month-old baby girl, but she is already thinking about having her next child, because she really wants a boy. Even though she realizes that closely spaced pregnancies are risky, she does not want to wait until her daughter is two before she starts trying to become pregnant.

Possible Responses:

- Determine why she is so anxious to get pregnant again.
- Clarify why she does not want to practice HTSP.
- Fully explain the benefits and risks to herself, her baby and the unborn child.
- As needed, help her think of ways to deal with the pressure from her husband and family.
- Assess her understanding and acceptance of FP.
- Support and encourage her decision and provide her with appropriate information (e.g. contraception or antenatal care)

Case Study #3

Situation:

Esther is 16 and is using injectables. She is not pregnant and does not want to become pregnant until she is older, but she is not happy with injectables because of some of the side effects.

Posssible Response:

- Assess her experience with injectables.
- As needed, correct any errors in its use and address issues of side effects.
- Determine if she wants to continue using this method, now that she has more information.
- If she doesn't want to continue with injectables, discuss other contraceptive options, including benefits, limitations, correct use and follow up.
- Assess her partner's support for FP
- Reinforce that she should not try to become pregnant until she is at least 18 and she should continue to use a reliable method of contraception.
- Explain the benefits of delaying the first pregnancy until the age of 18.

Case Study #4

Rita is 18. She has been living with HIV since she was born. She is doing well on her ARVs and is getting married soon. She is concerned about having children.

Possible Responses:

- Assess her fertility intentions and desired family size and let her know it is possible for her to have children even if she is HIV +ve.
- Advise her that pregnancy places a heavy burden on her body because of her HIV + status, so she should space and LIMIT the number of pregnancies. Because she is HIV+, she is already at risk for low-birth weight or pre-term birth. Spacing her pregnancies will help lower the risk of these outcomes.
- She should give her body time to rest between pregnancies. So she should SPACE the pregnancies through use of an appropriate method of family planning.
- There are medicines and methods of delivery that will reduce the chance of transmitting HIV to her child(ren).
- During pregnancy it is important for her to attend antenatal care
- She should discuss all the issues regarding her fertility intentions, number and spacing of pregnancies with her husband.

Role Play #1

A 22-year-old woman recently had a miscarriage when she was three months pregnant. She has one child: a girl who is one year old. She has come to the health worker with her mother-in-law for advice, because she feels very weak but wants to get pregnant again. She has lots of family pressure, both from her husband and her mother-in-law, to get pregnant again so that she can give them a son.

Directions for Participants
Three participants will volunteer for roles or will be assigned roles. One will be a health worker, one will be the client, and one will be the mother-in-law. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants' Roles:

> ***Health Worker.*** The health worker will assess the needs of the client and provide counseling on HTSP and FP. The health worker will explain the benefits of HTSP and also talk about the potential risks if HTSP is not practiced. She will then give information about different contraceptive methods.
>
> ***Client.*** The client is feeling pressure to get pregnant again so she can have a boy.
>
> ***Mother-in-Law.*** The mother-in-law mentions that they need a grandson to continue the family name.

Discussion Questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker's provide adequate information?
3. Were the client's concerns addressed?
4. Was it a good idea to involve the mother-in-law?
5. Were the benefits of HTSP and FP clearly communicated?
6. What else could the health worker have done?

Role Play #2

A 25-year old woman with two children, a boy and a girl, is using injectable contraceptives. Her last-born child is seven months old and she does not want to have another child right away. She has no problem with her current contraceptive method except that it is difficult for her to come in regularly for injections.

Directions for Participants
Two participants will volunteer for roles or will be assigned roles. One will be a health worker and the other the client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants' Roles

Health Worker. The health worker will assess the needs of the woman and provide counseling on HTSP and FP. She will then give information about different contraceptive methods.

Client. The client will ask questions and try to decide if she wants to practice HTSP ad what FP method she might use.

Discussion Questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker's provide adequate information?
3. Were the client's concerns addressed?
4. Were the benefits of HTSP and FP clearly communicated?
5. What else could the health worker have done?

Role Play #3

A 34-year old man has four sons. His wife is in poor health after the birth of their last child one month ago. The doctor advised them against having any more children. He is convinced, however, that contraceptive methods cause cancer.

Directions for Participants

Three participants will volunteer for roles or will be assigned roles. One will be a health worker and the other two will be husband and wife (clients). Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants' Roles

Health Worker. The health worker will assess the situation and give the couple information about different modern contraceptive methods and help them decide if they will use a method.

Clients. The clients (husband and wife) ask questions about FP. They are concerned about side effects.

Discussion Questions

1. Did the health worker approach the clients in a positive reassuring manner?
2. Did the health worker address the clients' needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and FP clearly communicated?
5. What else could the health worker have done?

Role Play #4

A 16-year-old woman is married to a 30 year old man. She wants to delay her first pregnancy but she is concerned because her mother-in-law wants her to get pregnant quickly.

Directions for Participants
Two participants will volunteer for roles or will be assigned roles. One will be a health worker and the other a client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants' Roles

Health Worker. The health worker will assess the situation, and will explain the benefits of HTSP. She will give information about different contraceptive methods to help her delay pregnancy until 18.

Client. The client asks questions about HTSP and FP and how she can convince her mother-in-law to delay her first pregnancy.

Discussion Questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker address the client's needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and FP clearly communicated?
5. What else could the health worker have done?

Role Play #5

A 28 year-old woman has three children: one son and two daughters. After the birth of her last child she was advised by the community health worker (CHW) to get an IUCD inserted. The last-born child is one year old, so she has come to the health worker to take out her IUCD because she wants to have another boy.

Directions for Participants
Two participants will volunteer for roles or will be assigned roles. One will be a health worker and the other the client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants Roles

Health Worker. The health worker will assess the situation, and explain the benefits of HTSP. She will then give information about different contraceptive methods.

Client. The client asks questions about HTSP and FP and mentions the pressure she is getting from her husband and family. She is worried that if she waits too long, she will have trouble conceiving.

Discussion Questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker address the clients needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and FP clearly communicated?
5. What else could the health worker have done?

Role Play #6

A 25-year old woman was recently diagnosed with HIV when she was pregnant with her second child. She was enrolled in a PMTCT program. The child is seven months old, and seems to be HIV-free. She is now taking ARVs and is feeling quite well. She does not want to become pregnant again.

Directions for Participants
Two participants will volunteer for roles or will be assigned roles. One will be a health worker and the other the client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so they can participate in the small group discussion following the role play. The observers can use the checklist to assess the counseling session.

Participants' Roles

> ***Health Worker.*** The health worker will assess the needs of the woman and provide counseling on HTSP, HIV and FP. She will then give information about different contraceptive methods.
>
> ***Client.*** The client will ask questions about HTSP, FP and HIV. She is worried about what others in the community might think if she does not have another child.

Discussion Questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker address the clients needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and FP clearly communicated?
5. What else could the health worker have done?

TRAINING TOOL #3

Pre/Post-Test Questionnaire

I. Healthy Timing and Spacing of Pregnancy

1. What is the key HTSP message for women who have recently given birth?

2. What are three benefits of practicing HTSP?

3. What are two risks if HTSP is not practiced?

4. When are opportunities to include HTSP education and interventions?
   a. Postpartum care visit
   b. Antenatal care visit
   c. Postabortion care visit
   d. Child health visit
   e. All of the above

II: Review of Family Planning Methods

5. Women must be menstruating to obtain an FP method

   True False

6. Injectable contraceptives are given after every two months.

   True False

7. An IUCD does not interfere with breastfeeding.

   True False

8. Women's contraceptive needs change over her life cycle

   True False

9. Breastfeeding women cannot use FP

   True False

10. Most FP methods are safe for women with HIV

    True False

11. Improved access to FP to prevent early can reduce the rate of death among adolescents who are sexually active..

    True False

12. The best FP method for most clients is:

a. The one that the health care provider thinks is best for the client.
b. The one that is most effective.
c. The one that is most convenient for the health care provider.
d . The one that the client chooses after learning about all available methods.

III. Counseling Skills for HTSP and FP

13. Counseling for HTSP can be given during:
a. Antenatal care
b. Postpartum care
c. Child health visit
d. All of the above

14. Explain what GATHER stands for.

15. Family planning counseling is basically the same for all clients
True False

16. FP Counseling is successful when a woman chooses an FP method
True False

17. Counseling for Family Planning should include education on HTSP
True *False*

5. Pre-/Post-Test Answer Key

I. Healthy Timing and Spacing of Pregnancy

1. What is the key HTSP message for women who have recently given birth.

For couples who decide to have another child after a live birth:
For the health of the mother and child, wait a minimum of 2 years, but not more than 5 years, before trying to become pregnant again. Use an FP method of your choice during that time.

2. What are three benefits to women of practicing HTSP?

Lower risk of death
Lower incidence of induced abortion
Lower risk of pre-eclampsia
Lower risk of miscarriage
Lower risk of anemia
Allows women to continue to breastfeed for two years.

3. What are three risks to newborns if HTSP is not practiced?

Greater risk of death
Greater risk of preterm birth
Greater risk of low birth weight
Greater risk of small for gestational age
Less likely to continue to be breastfed for two years.

4. When are opportunities to include HTSP education and interventions?
   a. Postpartum care visit
   b. Antenatal care visit
   c. Postabortion care visit
   d. Child health visit
   e. All of the above

Correct answer is **E.**

II: Review of Family Planning Methods

5. Women must be menstruating to obtain an FP method

True **False**

Correct answer is **FALSE**. Women do not need to be menstruating or have a negative pregnancy test. The pregnancy checklist can rule out pregnancy.

6. Injectable contraceptives are given once every two months.

True **False**

Correct answer is FALSE. Injectables are given once every three months.

7. An IUCD does not interfere with breastfeeding.

True False

Correct answer is TRUE. Breastfeeding women can safely use an IUCD to prevent pregnancy.

8. Women's contraceptive needs change over her life cycle

True False

Correct answer is TRUE. Women's reproductive lives span many years and their needs will change based on their age, marital status, health status, family size, and cultural norms, among others.

9. Breastfeeding women cannot use FP

True **False**

Correct answer is FALSE. Breastfeeding women can use many methods of FP. However, some methods are not appropriate for breastfeeding women because they decrease milk production.

10. Most FP methods are safe for women with HIV

True False

Correct answer is TRUE. Family planning is an important way of helping HIV + women prevent unplanned pregnancy.

11. Improved access to FP to prevent early can help reduce the rate of death among adolescents.

True False

Correct answer is TRUE. Pregnancy is the leading cause of death among adolescent women aged 15 – 19.

12. The best FP method for most clients is:

a. The one that the health care provider thinks is best for the client.
b. The one that is most effective.
c. The one that is most convenient for the health care provider.
d. The one that the client chooses after learning about all available methods.

Correct answer is D.

III. Counseling Skills for HTSP and FP

13. Counseling for HTSP can be given during:
a. Antenatal care
b. Postpartum care
c. Child health visit
d. All of the above

Correct answer is D.

14. Explain what GATHER stands for.

Greet, Ask, Tell, Help, Explain, Return

15. Family planning counseling is basically the same for all clients

True **False**

Correct answer is **FALSE.** Good family planning counseling will be tailored to the specific needs of each client.

16. Family Planning Counseling is successful when a woman chooses an FP method

True **False**

Correct answer is **FALSE.** Counseling is successful when clients:

- Feel that they got the help they wanted
- Know what to do
- Feel confident that they can do what needs to be done
- Feel respected
- Return as needed
- Are satisfied with their method, and
- Use their FP method effectively

17. Counseling for Family Planning should include education on HTSP.

True False

Correct answer is **TRUE**. HTSP is an important component of FP service delivery.

TRAINING TOOL #4

Course Evaluation Form

(To be completed by the participants)

Please indicate your opinion of the course using the following rating scale:

4 – Very satisfied 3 – Satisfied 2 – Dissatisfied 1 – Very Dissatisfied

QUESTIONS	RATING
1. Overall, how satisfied are you with the course?	
2. How satisfied are you that the course achieved its stated objectives?	
3. How satisfied are you with the trainers' ability to explain topics, clear up doubts, and respond to the needs of the participants?	
4. How satisfied are you with the duration of the course?	
5. How satisfied are you with the resource materials and training aids used?	
6. Give an example of how you would apply the knowledge and skills acquired in this course to your everyday work.	
7. Which course activities and features did you find most helpful?	
8. Which course activities and features did you find least helpful?	
9. What other reproductive health topics would you like included in the course?	
10. Do you have any other suggestions or recommendations for future courses?	

Training Handouts

1. WHO Policy Brief
2. Benefits of HTSP
3. HTSP Graphs
4. HTSP Messages
5. HTSP 101: Everything You Need to Know About HTSP
6. Benefits/Risks of HTSP
7. Long-acting and Permanent Methods (LAPM) Brief
8. Lactational Amenorrhea Method (LAM) Brief
9. The Facts: Adolescent Maternal Mortality
10. Pregnancy Checklist
11. Contraceptive Effectiveness Chart
12. Family Planning Methods Chart
13. Facts and Rumors about Family Planning
14. What Makes Family Planning Counseling Effective?
15. Family Planning Counseling Strategies
16. Counseling for HTSP Using GATHER and Is HTSP Right for Me?
17. Fertility Intention Trees
18. Tips for Family Planning Counselors

Department of Reproductive Health and Research

Department of Making Pregnancy Safer

Policy brief

Birth spacing – report from a WHO technical consultation[1]

The World Health Organization (WHO) and other international organizations recommend that individuals and couples should wait for at least 2–3 years between births in order to reduce the risk of adverse maternal and child health outcomes. Recent studies supported by the United States Agency for International Development (USAID) suggest that an interval of 3–5 years might help to reduce these risks even further. Programme managers responsible for maternal and child health at the country and regional levels have requested WHO to clarify the significance of the new USAID-supported findings for health-care practice.

To review the available evidence, WHO, with support from USAID, organized a technical consultation on birth spacing on 13–15 June 2005 in Geneva, Switzerland. The participants included 35 independent experts as well as staff of the United Nations Children's Fund (UNICEF), WHO and USAID. The specific objectives of the meeting were to review evidence on the relationship between different birth-spacing intervals and maternal, infant and child health outcomes, and to provide advice on recommended birth-spacing intervals.

Method of review and findings of the consultation

Prior to the meeting, USAID submitted to WHO for review six unpublished, draft papers emanating from studies the Agency had supported on birth spacing. These, along with a supplementary paper (also unpublished at the time), served as background papers for the technical consultation.

WHO sent the six draft papers to a selected group of experts, and received a total of 30 reviews. The reviewers' comments were compiled and circulated to all meeting participants. At the meeting, the authors of the background papers presented their findings, and selected discussants presented the consolidated set of reviewers' comments, including their own observations. Together, the draft papers and the various commentaries constituted the basis for the consultation's deliberations.

The background papers[2] (see list on the back page of this policy brief) were based on studies that had used a variety of research designs and data analysis techniques. The meeting participants noted that the length of the intervals analysed and the terminology used in the papers varied

[1] This policy brief is based on the report of the WHO technical consultation on birth spacing, held in Geneva, Switzerland, on 13–15 June 2005. This report can be found on the following Internet site: www.who.int/reproductive-health/publications

[2] It was planned that after the meeting the draft papers would be revised by the authors, taking into account the comments of the participants in the technical consultation.

World Health Organization

considerably, making it difficult to compare the results. They therefore agreed to use "birth-to-pregnancy interval" as a standard term in making their recommendations. Specifically, this term refers to the interval between the date of a live birth and the start of the next pregnancy.

The participants discussed the strengths and limitations of the studies, identified areas requiring further work and requested the authors to conduct additional analyses and research. The authors are currently responding to the reviewers' questions and undertaking the requested analyses. They are to revise their papers and resubmit them to WHO for a second review, following which WHO will issue a supplementary report.

Conclusions and recommendations

The group came to separate conclusions for the different health outcomes considered, i.e. one on birth spacing after a live birth, and one on birth spacing after an abortion. Details of the discussions, the process of achieving final agreement on the recommendations and the necessary caveats are documented in detail in the full report.

The participants emphasized that their recommendations (in bold below) must be read in conjunction with the following preamble:

In choosing the timing of the next pregnancy, individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health-care services, child-rearing support, social and economic circumstances, and personal preferences.

Recommendation for spacing after a live birth

- **After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.**[3]

Recommendation for spacing after an abortion

- **After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy should be at least six months in order to reduce risks of adverse maternal and perinatal outcomes.**

Caveat. The recommendation on spacing after an abortion is based on one Latin America study that examined hospital records of 258 108 women (delivering singleton infants) whose previous pregnancy had ended in an abortion. Because this was the only available study of this scale, it was considered important to use its findings, but with some qualifications. Abortion events in the study were of three types: safe abortion, unsafe abortion and spontaneous pregnancy loss (miscarriage). The relative proportion of each of these types was unknown. The study sample was taken from public hospitals only, with much of the data coming from only two countries (Argentina and Uruguay). Thus, the results may neither be generalizable within the Latin American region nor applicable to other regions, which have different legal and service contexts and conditions. Additional research was recommended to clarify these findings.

Suggestions for future research

The consultation made the following suggestions for further research in the area of birth spacing:

- Coherent theoretical frameworks need to be developed that can explain and analyse the possible causal relationships between birth-to-pregnancy intervals and maternal, perinatal and infant outcomes, particularly child mortality.

[3] Some participants felt that it was important to note in the report that, in the case of birth-to-pregnancy intervals of five years or more, there is evidence of an increased risk of pre-eclampsia, and of some adverse perinatal outcomes, namely pre-term birth, low birth weight and small infant size for gestational age.

- It would be useful to include in ongoing studies analyses of relationships between birth spacing and maternal morbidity. For instance, examination of the effects of multiple short birth-to-pregnancy intervals would be useful, as would be more detailed data on the effects of very long intervals. Further analysis of the relationship between birth spacing and maternal mortality would help confirm or refute existing findings, although it is acknowledged that this may not always be feasible as it may require a very large number of cases.
- There is a need to investigate the relationship between birth spacing and outcomes other than mortality – for instance, maternal and child nutrition outcomes, or impact on the psychological development of children. Also, it would be helpful to have information on possible benefits, as well as possible risks, of particular birth spacing intervals.
- More studies are needed on the effects of postabortion pregnancy intervals in different regions. A distinction between induced and spontaneous abortion, and between safe and unsafe induced abortion, would be particularly helpful in future studies.
- Good-quality longitudinal studies that take more potential confounding factors into account are needed to: (i) clarify the observed associations between birth-to-pregnancy intervals and maternal, infant and child outcomes; (ii) estimate the potential level of bias in the use of different measures of intervals (birth-to-birth vs. inter-pregnancy interval, for instance); and (iii) clarify the potentially confounding effect of short intervals following a child death, both because of shortened breastfeeding and because parents may seek to replace the dead child.
- Finally, there is a need to develop an evidence base for effective interventions to put recommendations on birth spacing into practice.

Papers reviewed at the meeting

1. Conde-Agudelo A (draft, 2004). Effect of birth spacing on maternal and perinatal health: a systematic review and meta-analysis. Report prepared for The Academy for Educational Development and The CATALYST Consortium.

   An amended and abridged version of this report (not reviewed by the WHO consultation) has now been published as follows:

   Conde-Agudelo A, Rosas-Bermúdez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA*, 2006, 295:1809–1823.

2. Conde-Agudelo A, Belizán, JM, Breman R, Brockman SC, Rosas-Bermúdez A (draft, 2004). Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America.

   This paper has now been published as follows:

   Conde-Agudelo A, Belizán, JM, Breman R, Brockman SC, Rosas-Bermúdez A. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Gynaecology and Obstetrics*, 2005, 89: S34–S40 (supplement).

3. DaVanzo J, Razzaque A, Rahman M, Hale L, Ahmed K, Khan MA, Mustafa AG, Gausia K (draft, no date). The effects of birth spacing on infant and child mortality, pregnancy outcomes and maternal morbidity and mortality in Matlab, Bangladesh.

4. Dewey KG, Cohen RJ (draft, 2004). Birth-spacing literature: maternal and child nutrition outcomes. Report prepared for The Academy for Educational Development and The CATALYST Consortium.

5. Rutstein SO (draft, no date). 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.

   This paper has now been published as follows:

   Rutstein SO. 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. *International Journal of Gynaecology and Obstetrics*, 2005, 89:S7–S24 (supplement).

6. Rutstein SO, Johnson K, Conde-Agudelo A (draft, 2004). Systematic literature review and meta-analysis of the relationship between interpregnancy or interbirth intervals and infant and child mortality. Report prepared for The CATALYST Consortium.

Supplementary paper

7. Zhu BP (draft, 2004). Effect of interpregnancy interval on birth outcomes: findings from three recent US studies.

   This paper has now been published as follows:

   Zhu BP. Effect of interpregnancy interval on birth outcomes: findings from three recent US studies. *International Journal of Gynaecology and Obstetrics*, 2005, 89:S25–S33 (supplement).

For more information contact:

Iqbal Shah, Department of Reproductive Health and Research
email: shahi@who.int

Annie Portela, Department of Making Pregnancy Safer
email: portelaa@who.int

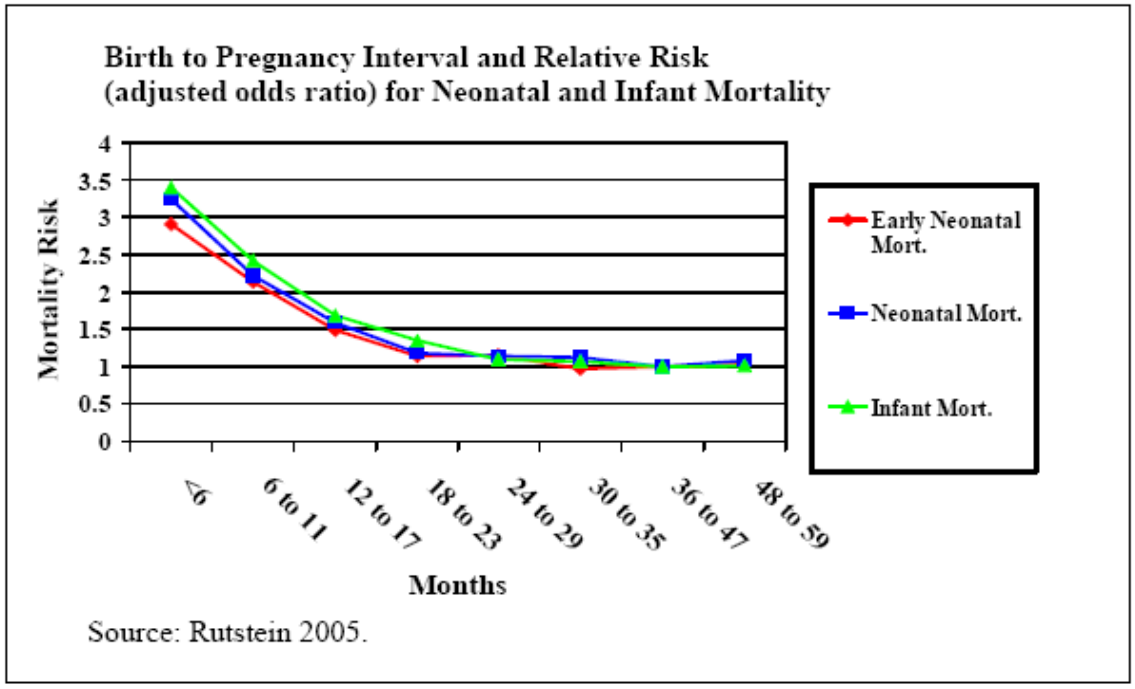
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
Tel: +41 22 791 2111

Internet addresses:
www.who.int/reproductive-health
www.who.int/making_pregnancy_safer

Benefits of Healthy Timing and Spacing for Infants and Mothers[40]		
For newborns/infants	**For all women**	**For adolescents**
● Lower risk of perinatal death. Infants of adolescent mothers are 1.5 times more likely to die before their first birthday than infants of older mothers,	● Lower risk of maternal death,	● Adolescents aged 15 – 19 are twice as likely to die during pregnancy or childbirth as those over 20; girls under 15 are five times more likely to die.
● Lower risk of neonatal death	● Lower incidence of induced abortion	● Each year, at least 2 million young women undergo unsafe abortion
● Lower risk of preterm birth	● Lower risk of pre-eclampsia	● Adolescents are more likely to experience pregnancy and delivery related complications such as pre-eclampsia and fistula
● Lower risk of low birth weight.	● Lower risk of miscarriage	● Adolescent mothers are more likely to delivery early or at low birth weight ●
● Lower risk of small for gestational age	● Lower risk of anemia	● Unmarried adolescents who give birth may be forced to marry the father, drop out of school, become a single mother or have an unsaf;e abortion, leading to multiple social or health consequences
● Increased benefits of extended breastfeeding	● Allows for two years of breastfeeding, which is linked with reduced risk of breast and ovarian cancer	● Delaying early childbearing saves lives.

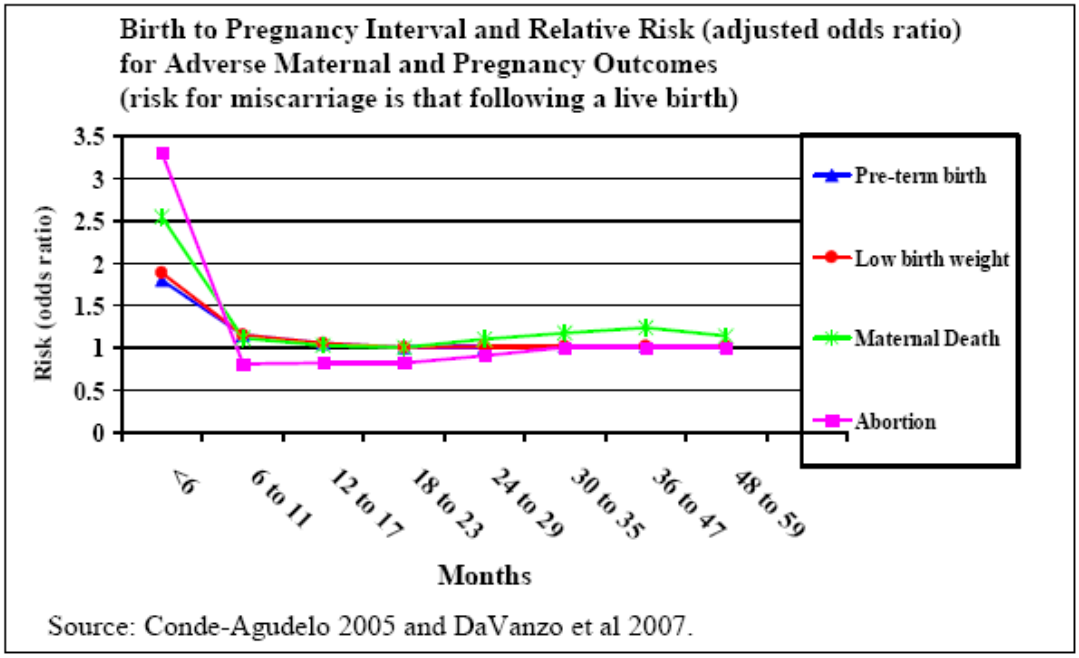
40 DaVanzo, Julie, Lauren Hale, Abdur Razzaque, and Mizanur Rahman, "Effects of Interpregnancy Interval and Outcome of the Preceding Pregnancy on Pregnancy Outcomes in Matlab, Bangladesh," *BJOG*, 2007.

Improved spacing of pregnancies reduces infant deaths.



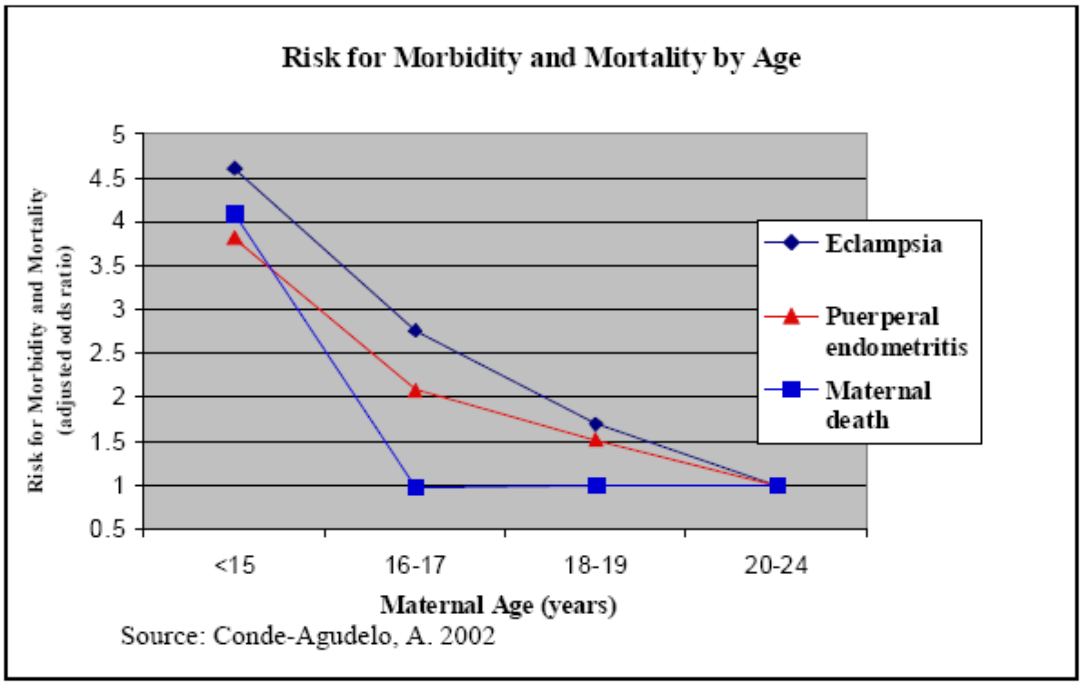
- A 24-month, birth-to-pregnancy interval is associated with reduced risks of newborn and infant mortality, based on data from developing countries in Africa, Asia, Latin America, and the Middle East.

Improved pregnancy spacing reduces maternal risks.



- A 24-month, birth-to-pregnancy interval is associated with reduced risks of multiple adverse health outcomes for mothers, newborns, and infants.

Young Women Under the Age of 20 Are at Higher Risk for Morbidity and Mortality*



**While first births always have higher risks, this analysis adjusts for parity.*

- Adolescents aged 15 - 19 are twice as likely to die during pregnancy and childbirth as those over 20 and girls under age 15 are five times as likely to die. Pregnancy is the leading cause of death for young women aged 15 - 19.

For couples who desire to have another child 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.

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]:

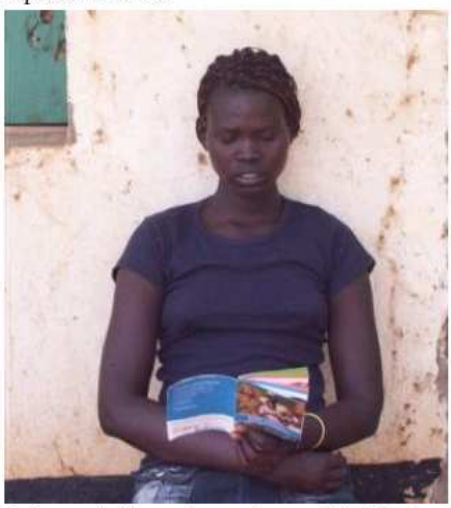
- *After a live birth, the recommended minimum interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.*
- *After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least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

What is HTSP?

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

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.

Please contact esdmail@esdproj.org for more information.

[1] Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.
[2] Conde-Agudelo A., et al., Birth Spacing and the Risk of Adverse Perinatal Outcomes: A Meta Analysis. *Journal of the American Medical Association*, 29, April 2006.
[3] Conde-Agudelo A., et al., Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.
[4] Married Adolescents: No Place for Safety. WHO and UN Population Fund: WHO, 2006.
[5] Shane Barbara (1997), cited in *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns.* Save the Children, 2006.
[6] Jansen, W., Existing Demand for Birth Spacing in Developing Countries: Perspectives from Household Survey Data. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.
[7] Jansen, W and L Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.
[8] Ross and Winfrey, Contraceptive use, intention to use and unmet need during the extended postpartum period, *International Family Planning Perspectives*, Vol. 27, No. 1, March 2001.
[9] Minia Village Household Survey; Communications for Healthy Living, Egypt, 2000-2005; PRACHAR Project, Pathfinder/India, 2001-2005; Results of the Household Survey, TAHSEEN/Pathfinder, Egypt, 2003-2005; Promoting Postpartum Contraception: Possible Opportunities, Population Council, New Delhi 2007; Solo et al. (1999), Kenya. Cited in Report of the PAC Technical Advisory Panel, USAID, April 2007. Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.
[10] Jansen, W. and L. Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level.

Benefits of HTSP vs. Risks of Not Practicing HTSP

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
For the Newborn Child	
• Newborns are more likely to be born strong and healthy. • Newborns may be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding. • Mother-baby bonding is enhanced by breastfeeding, which facilitates the child's overall development • Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns.	• Risk of newborn and infant mortality is higher. • There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age. • When breastfeeding stops before six months, the newborn does not experience the health and nutritional benefits of breast milk, and the mother-baby bond may be diminished, which may affect the baby's development.
For the Mother	
• The mother has a reduced risk of complications which are associated with closely spaced pregnancies. • She may have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy. • She may breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer. • She may be more rested and well-nourished so as to support the next healthy pregnancy. • She may have more time for herself, her children, and her partner, and to participate in educational, economic and social activities • She may have more time to prepare physically, emotionally, and financially for her next pregnancy.	• Women who experience closely spaced pregnancies are o At increased risk of miscarriage o Are more likely to experience iron-deficiency anemia o Are more likely to experience pre-eclampsia o More likely to induce an abortion

Benefits of HTSP vs. Risks of Not Practicing HTSP

For Men	

• His partner may find more time to be with him, which may contribute to a better relationship.
• Expenses associated with a new pregnancy will not be added to the expenses of the last-born child.
• More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.
• Men may feel an increased sense of satisfaction from:
  o Safeguarding the health and well-being of his partner and children; and
  o Supporting his partner in making healthy decisions regarding FP and HTSP.
	• The stress from closely spaced pregnancies may prevent couples from having a fulfilling relationship.
	• If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.

For the Family	
• Families can devote more resources to providing their children with food, clothing, housing, and education.	• A new pregnancy requires money for antenatal care, better nourishment for the mother, savings for the delivery costs and costs associated with the needs of a new baby. • Illness or a need for emergency care is more likely if the woman has closely spaced pregnancies • Unanticipated expenses may lead to difficult financial circumstances or poverty.
For the Community	
• HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children, which can contribute to reductions in poverty and improvements in the quality of life for the community • It may relieve the economic, social and environmental pressures from rapidly growing populations	• Lack of HTSP may result in a poorer quality of life for community residents • Economic growth may be slower, making it more difficult to achieve improvements in education, environmental quality, and health.

The Benefits of Long-Acting and Permanent Methods for Individuals

Long-acting and permanent methods (LAPMs) of contraception offer an untapped opportunity to meet the needs of a variety of people. They offer individuals and couples advantages that other methods of family planning do not, and their provision gives women who want to space or limit their pregnancies more choices. Use of LAPMs can also improve the health and well-being of entire families in several important ways.

Addressing diverse needs

For women and couples who want to delay or space their pregnancies, implants and intrauterine devices (IUDs) offer long-term effectiveness and reversibility. These reversible LAPMs are effective for three to 12 years,[1] depending on which method is chosen. Once either device is removed, a woman's fertility returns almost immediately. Implants and IUDs are also options for individuals and couples who want no more children. In addition, female sterilization and vasectomy effectively prevent pregnancies throughout the reproductive years.

At least 15 percent of all couples worldwide choose a method of family planning that men actively participate in using, such as condoms, withdrawal, periodic abstinence, or vasectomy.[2] **For men who have achieved their desired family size, vasectomy is the only method that offers highly effective, permanent protection from unintended pregnancies.** The procedure is simpler and safer than female sterilization. It generally takes 15 minutes or less when performed by a trained surgeon, is almost painless, and is usually not complicated.[3]

For the young people of Africa who are delaying marriage and parenthood, reversible LAPMs are safe and suitable options. Because they do not require any action on the part of a user, implants and IUDs are almost always used correctly, and they rarely fail. Pregnant adolescents are also at higher risk than other women of pregnancy-induced hypertension, anemia, and prolonged or obstructed labor.[4] So, young people who choose reversible LAPMs are also protecting themselves against these potential complications.

LAPMs are an option for women and couples who are living with HIV or AIDS and want to prevent unintended pregnancies.

Reversible LAPMs are an alternative for women who discontinue other methods of family planning but still want to avoid pregnancy. A woman who stops using short-acting hormonal methods because of estrogen-related side effects may prefer an IUD or implant. A woman using a short-acting method might also consider switching to an LAPM if she has trouble returning to the clinic for resupply, has difficulty using her method correctly and consistently, or wants to prevent pregnancy for a longer period.

Because they either do not contain hormones or contain only progestin, LAPMs can be used by lactating women immediately or soon after childbirth without affecting their milk supply. A woman can have an IUD inserted within the first 48 hours after giving birth. Or, she can safely undergo female sterilization within the first week after giving birth if she is certain she does not want any more children. Women who are breastfeeding can also safely initiate implants as soon as six weeks postpartum.[5]

LAPMs are an option for women and couples who are living with HIV or AIDS and want to prevent unintended pregnancies. IUDs, implants, and female sterilization can all be used by women with HIV or AIDS or at high risk of HIV. Vasectomy can be used by any man, regardless of his HIV status.

Offering unique advantages

LAPMs are the most effective methods for preventing pregnancies. Most modern methods of family planning are highly effective when used correctly and consistently during every act of sexual intercourse. In typical use, when people occasionally forget to use a method or use it incorrectly, many contraceptive methods are not as effective. During one year of typical use, **LAPMs are between three and 60 times more effective than most short-acting methods** (Table 1).

Table 1. Pregnancy Rates During One Year of Typical Use

Family planning method	Method type	Pregnancy rate (%)
Oral contraceptives	Short-acting	8.0
Injectables	Short-acting	3.0
Copper intrauterine device	Long-acting	0.8
Female sterilization	Permanent	0.5
Vasectomy	Permanent	0.15
Implants	Long-acting	0.05

Source: World Health Organization/Department of Reproductive Health and Research (WHO), Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs/INFO Project (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

LAPMs are convenient for users. Women who use oral contraceptives must remember to take their pills each day. Likewise, injectable users must have reinjections every one to three months, depending on the type of injectable they are using. Resupply often requires travel to a clinic, and the timing of clinic visits is critical for preventing pregnancies. LAPMs require almost no attention on the part of the user after they are initiated, and their effectiveness is not dependent on daily or monthly action.

LAPMs can be the most cost-effective option for users over time. Oral contraceptives and injectables may at first appear to be lower-cost options, but their cumulative costs due to return visits and resupply can be surprisingly high. On the other hand, LAPMs may have a higher one-time start-up cost, depending on the type of facility providing them, but are usually less expensive over time.

LAPMs can be the most cost-effective option for users over time.

People who use LAPMs are satisfied. In Kenya, more than 85 percent of women who choose the IUD[6] and approximately 97 percent of women who choose female sterilization[7] report being satisfied with their method. In both Nigeria and Zimbabwe, at least 96 percent of women using implants have said they are satisfied or very satisfied with their choice.[8]

Very few medical conditions limit LAPM use. No medical condition should restrict an individual's eligibility for vasectomy or female sterilization. Breast cancer is one of only a few medical conditions that makes a woman ineligible for implants. Certain conditions prevent initiation of the IUD. For example, the World Health Organization recommends that a woman with gonorrhea or a chlamydial infection should not begin using an IUD until her infection has been cured. However, like other LAPMs, the IUD is a safe option for most healthy women.[9]

LAPMs offer noncontraceptive health benefits. Implants and female sterilization protect against ovarian cancer, and use of an IUD or implant may lower a woman's risk of endometrial cancer. Use of an implant also decreases a woman's risk of anemia and reduces the amount of bleeding, pain, and cramps typically associated with menstruation.[10]

Benefiting family health and well-being

The use of LAPMs can improve maternal and child health. Healthy timing and spacing of births reduces the chance that a mother will become sick or die from complications related to pregnancy, unsafe abortion, or childbirth. When pregnancies are spaced too close together, babies can be born too early and too small, making them more likely to die before the age of five. Women are at higher risk of developing anemia, rupturing the sac of water surrounding the baby before the baby is ready to be born, or dying during childbirth. Spacing pregnancies also allows children to experience the substantial health benefits of breastfeeding for a full two years.[11]

Smaller families can invest more money in the health, nutrition, and education of each of their children. Women who decide how many children they would like to have and how far apart they would like to space them are also empowered. They have more opportunities to work, be educated, and participate in other activities.

When one or more parents are living with HIV or AIDS, LAPMs can provide highly effective protection from unwanted pregnancies and, thus, mother-to-child transmission of HIV.

---

1 World Health Organization/Department of Reproductive Health and Research (WHO), Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs /INFO Project (CCP). *Family Planning: A Global Handbook for Providers.* Baltimore, MD and Geneva: CCP and WHO, 2007.

2 United Nations. *World Contraceptive Use 2005. Wall chart.* New York: United Nations, 2005.

3 Family Health International. *Vasectomy: Evidence-Based Practices to Improve Effectiveness.* Research Triangle Park, NC: Family Health International, 2007.

4 Extending Service Delivery (ESD) Project. *Healthy Timing and Spacing of Pregnancies: A Pocket Guide for Health Practitioners, Program Managers, and Community Leaders.* Washington, DC: ESD Project, 2007.

5 World Health Organization (WHO). *Medical Eligibility Criteria for Contraceptive Use. Third Edition.* Geneva: WHO, 2004.

6 Sekadde-Kigondu C, Mwathe EG, Ruminjo JK, et al. Acceptability and discontinuation of Depo-Provera, IUCD and combined pill in Kenya. *East Afr Med J* 1996;73(12):786-94.

7 Ruminjo JK, Lynam PF. A fifteen-year review of female sterilization by minilaparotomy under local anesthesia in Kenya. *Contraception* 1997;55(4):249-60.

8 Haggai DNP. The Norplant experience in Zaria: a ten-year review. *Afr J Reprod Health* 2003;7(2):20-24; Mitchel MJ, Thistle P. Acceptability of levonorgestrel subdermal implants versus tubal ligation for long-term contraception in a rural population of Zimbabwe. *Contraception* 2004;70(6):483-86.

9 WHO.

10 U.S. Centers for Disease Control and Prevention (CDC). *Family Planning Methods and Practice: Africa. Second Edition.* Atlanta, GA: CDC, 2000.

11 ESD Project.

USAID FROM THE AMERICAN PEOPLE

access Family Planning Initiative
Addressing unmet need for postpartum family planning

THE LACTATIONAL AMENORRHEA METHOD (LAM):
A Postpartum Contraceptive Choice for Women Who Breastfeed

The purpose of this brief is to guide health care service providers in offering quality LAM services within their maternal and child health, reproductive health or family planning programs.

The **Lactational Amenorrhea Method (LAM)** is a modern, temporary contraceptive method based on natural infertility resulting from certain patterns of breastfeeding.

Lactational = related to **breastfeeding**

Amenorrhea = **no vaginal bleeding** (after two months postpartum)

Method = a modern, temporary (up to six months postpartum) contraceptive **method**

All postpartum women who meet the following **three criteria** can use LAM:

1. Menstrual periods have not resumed; **AND**
2. The infant is fully[1] or nearly fully[2] breastfed frequently, day and night[3]; **AND**
3. The infant is under six months of age.

Because LAM is a short-term, temporary contraceptive method, an essential component of LAM services is the timely introduction and ongoing use of another contraceptive method when any one of the three criteria is not met, **or** the woman no longer wishes to rely on LAM for family planning.

Key Elements of LAM Services

Key programmatic elements of quality LAM services for postpartum women who breastfeed include:

- Counseling on the criteria for effective LAM use,
- Offering encouragement and support to maintain exclusive breastfeeding for six months,
- Educating about return to fertility,
- Discussing reproductive goals/fertility intentions for spacing or limiting,
- Counseling about appropriate contraceptive methods, and
- Assisting in transition from LAM to another method by providing or linking to family planning services.

---

[1] A woman is said to be **fully breastfeeding** when she breastfeeds her infant:
- *exclusively*—meaning no water, other liquid or solid is given to infant; or
- *almost exclusively*—meaning vitamins, mineral water, juice or ritualistic feeds are given infrequently (i.e., NOT a regular part of the infant's diet) in addition to breastfeeds.

[2] A woman is said to be **nearly fully breastfeeding** when the vast majority of feeds given to her infant are breastfeeds (i.e., no other kind of feeding replaces a breastfeed).

[3] In this context, **frequently** means whenever the infant is hungry, both day and night. This concept is explained in more detail in the "Optimal Breastfeeding Behaviors" textbox below.

The following table summarizes the content of each of these elements.

ELEMENT	CONTENT DESCRIPTION
LAM criteria	▪ The three criteria for LAM use and what each means for ensuring contraceptive protection ▪ All three criteria must be met.
Breastfeeding support	▪ The optimal breastfeeding behaviors that help maximize the contraceptive effect of LAM (textbox below) ▪ When to contact a provider for support or management of breastfeeding difficulties
Return to fertility	▪ Chances of becoming pregnant during the postpartum period change according to breastfeeding status, intensity of breastfeeding and length of time postpartum ▪ If any one of the three criteria for LAM use is not met, pregnancy can occur even without the return of menses.
Reproductive goals/ fertility intentions	▪ The woman's or couple's desire for more children and for spacing or limiting births
Healthy timing and spacing of pregnancies	▪ Women/couples desiring another child should wait at least two years after a live birth before trying to get pregnant again.
Contraceptive choices	▪ The range of available contraceptive methods to consider for use by breastfeeding women ▪ Which methods are appropriate, depending on the timing of their use and the woman's need for protection from sexually transmitted infections and pregnancy ▪ Provide contraceptive methods or referrals as indicated.
Transition to another modern method	▪ The conditions that indicate a need to use, or transition to, another contraceptive method

OPTIMAL BREASTFEEDING BEHAVIORS

1. Allow the newborn to breastfeed as soon as possible after birth, and to remain with the mother for at least several hours following delivery.
2. Breastfeed exclusively for the first six months: no water, other liquids or solid foods.
3. Position and attach the infant correctly at the breast.
4. Breastfeed frequently, whenever the infant is hungry, both day and night. (As a counseling guideline for women using LAM, daytime feedings should occur at intervals of no longer than four hours. There should be at least one nighttime feeding at an interval of no longer than six hours.)
5. Offer the second breast after the infant releases the first.
6. Continue breastfeeding even if the mother or infant becomes ill.
7. Avoid using bottles, pacifiers (dummies) or other artificial nipples.
8. The lactating mother should eat and drink more than usual.
9. Breastfeeding mothers may need family or social support for continued exclusive breastfeeding for six months.
10. After the first six months, when complementary foods are introduced, breastfeed before each complementary feeding during the first year.
11. Continue to breastfeed for up to two years and beyond.

Timing and frequency of counseling for LAM: While LAM counseling during the antenatal period is highly desirable, there is evidence that two client visits during the postpartum period can bring about good LAM acceptance and compliance on the part of postpartum women, and can help ensure the effectiveness of the method.[4] Program experience indicates that the correct timing of these two visits is critical: one should take place during the immediate postpartum, the other at the time of transition (i.e., when a woman no longer meets all three LAM criteria **or** when she wants to transition to another family planning method). The purpose of the first visit is to determine whether breastfeeding has been well established and is sufficient for LAM to be effective. The purpose of the second visit is: to facilitate the transition to another modern contraceptive method, by helping the woman choose an appropriate method based on her fertility intentions; and to discuss the importance of exclusive breastfeeding for six months, child feeding after six months and continued breastfeeding for up to two years and beyond.

Transition from LAM to another modern contraceptive method: Transition from LAM to another modern contraceptive method is a critical aspect of effective programming for LAM—helping to ensure that every woman using LAM is able to achieve her reproductive goals for spacing or limiting. Recent research has indicated that a woman's understanding of LAM criteria may facilitate her transition to other modern methods at six months. It is also very important to counsel the woman on continuing to breastfeed her infant when she switches to another method.

Addressing Perceived Limitations

A common rationale for not promoting LAM is that it is a temporary method and represents a missed opportunity for women who might otherwise initiate another modern method in the first few months postpartum. However, 38% of women in the first 12 months postpartum who intend to use contraception are not doing so.[5] Moreover, a study in Jordan measured the transition rate from LAM to another modern method at one year postpartum and suggests that LAM attracts previous non-users to the modern method mix.[6]

Another concern is that LAM has decreased efficacy if mother and child are separated for extended periods. One study measured the efficacy of LAM among working women who were separated from their infants for about eight hours per day, but who expressed their breast milk at least every four hours. The six-month pregnancy rate among those working women who were amenorrheic, who expressed their breast milk every four hours and whose babies were under six months of age was 5.2%.[7] While less effective than typical or ideal LAM use (98% and 99.5%, respectively), this compares favorably to a 25–30% pregnancy rate for non-breastfeeding women not using contraception during the same period.[8]

---

[4] Peterson, A. 2000. Multicenter study of the lactational amenorrhea method (LAM) III: Effectiveness, duration, and satisfaction with reduced client-provider contact. *Contraception* 62: 221–230.
[5] Ross, J. A., Winfrey, W. L. 2001. Contraceptive use, intention to use and unmet need in the postpartum period. *International Family Planning Perspectives* 27(1): 20–28.
[6] Bongiovanni, A. et al. 2005. Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraception Use in the Extended Postpartum Period. The LINKAGES Project, Academy for Educational Development.
[7] Valdes, V. et al. 2000. The efficacy of the Lactational Amenorrhea Method (LAM) among working women. *Contraception* 62: 217–219.
[8] Gray, R. et al. 1987. Postpartum return of ovarian activity in nonbreastfeeding women monitored by urinary assays. *Journal of Endocrinology* 64(4).

Rationale for Including LAM in Maternal and Child Health, Reproductive Health and Family Planning Programs

- LAM effectiveness has been proven repeatedly in prospective clinical trials over the past two decades; LAM effectiveness is 99.5% for ideal use and 98% for typical use.[9]
- To promote informed choice, the contraceptive method mix should include LAM. LAM is simple to use and readily accessible, but requires effective counseling.
- LAM has child survival benefits. It supports exclusive breastfeeding for the first six months, which provides nutrients and immunological protection to the infant, as well as prevents pregnancies during the critical first months postpartum.
- LAM reaches the sub-population of women who have not been using modern contraception. Evidence suggests that LAM users within this group transition to become new acceptors of other modern methods.
- In countries with high fertility and low contraceptive prevalence, including LAM in the method mix can serve as an "entry point" for stimulating the use of other modern methods.
- Infant immunization visits provide opportunities to inquire about LAM criteria and counsel on the need to transition to other methods.

ADVANTAGES OF USING LAM

- Is more than 98% effective as a contraceptive
- Is provided and controlled by the woman
- Can be started immediately postpartum
- Motivates users to exclusively breastfeed throughout the first six months postpartum
- Facilitates transition by allowing time for decision to use/adoption of another modern contraceptive method during the postpartum period
- Facilitates modern contraceptive method use by previous non-users
- Prevents birth-to-pregnancy intervals of less than six months
- Supports and builds on newborn and infant feeding recommendations for exclusive breastfeeding for the first six months
- Provides health benefits for the mother:
  - Suckling action in the immediate postpartum stimulates uterine contractions
  - Less iron depletion due to no menses
  - Mother–baby relationship enhanced
- Provides health benefits for infant:
  - Provides the complete nutritional needs of the infant for up to six months
  - Improves infant growth and development
  - Enhances infant's immune system (less diarrhea and acute respiratory infections)
  - Is a source of Vitamin A, proteins, iron, minerals and essential fatty acids
- Builds on established cultural and religious practices
- Is non-invasive; does not require a gynecological exam
- Has no side effects

For more information about LAM, see the ACCESS-FP Web site: www.accesstohealth.org

The ACCESS-FP Program is a five-year, USAID-sponsored global program with the goal of responding to the significant unmet needs for family planning among postpartum women. As an Associate Award through the ACCESS Program, ACCESS-FP is implemented by JHPIEGO in partnership with Save the Children, Constella/Futures, the Academy for Educational Development, the American College of Nurse-Midwives and IMA World Health.

[9] World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. *Family Planning: A Global Handbook for Providers.* Baltimore and Geneva: CCP and WHO, 2007.

Advocates For Youth
Rights. Respect. Responsibility.®

Adolescent Maternal Mortality: An Overlooked Crisis

The Facts

Maternal mortality statistics underscore how societies have failed women, especially young women in developing countries. As many as 529,000 women die each year from complications of pregnancy and childbirth.[1] Pregnancy is the leading cause of death for young women ages 15 through 19.[2] The reproductive health of adolescent women depends on biological, social, cultural, and economic factors. Programs must provide education, family planning services, and pre- and postnatal care to reduce morbidity and mortality among young women.

Contraceptive Use and Pregnancy among Adolescents

- Modern contraceptive use has increased but remains low among sexually active young women in many developing countries.[3] For example in Haiti, 33 percent of single sexually active young women and nine percent of their married peers used a modern method of contraception.[4] Among sexually active female Nigerian high school students, 47 percent used the rhythm method of contraception; 21 percent, oral contraceptive pills; and six percent, condoms.[5]
- About 90 percent of adolescent births (12.8 million) occur each year in developing countries.[6] In sub-Saharan Africa and southern Asia, 28 to 29 percent of women give birth by age 18.[4]

Adolescent Women and Their Infants: at Risk for Injury, Illness, and Death

- Adolescents age 15 through 19 are twice as likely to die during pregnancy or child birth as those over age 20; girls under age 15 are five times more likely to die.[2,6,7]
- Each year, at least two million young women in developing countries undergo unsafe abortion.[6] Unsafe abortion can have devastating consequences, including cervical tearing, perforated uterus, hemorrhage, chronic pelvic infection, infertility, and death.[7,8]
- In Nigeria, complications from abortion account for 72 percent of *all* deaths in young women under age 19; moreover, half (50 percent) of all maternal deaths result from illegal abortions among Nigerian adolescents.[9]
- Infants of adolescents are at increased risk for death. In fact, the infants of adolescent mothers are more likely to die before their first birthday than are the infants of older mothers.[10]
- Complications during childbirth account for almost 25 percent of newborn deaths.[11] Preterm delivery and low birth weight are other reasons for deaths among infants born to adolescent mothers.[10]

Why Girls Are More Vulnerable than Older Women

- Many biological, economic, social, and cultural factors—such as poverty, malnutrition, immature reproductive tract, child marriage, and gender inequities may compromise the health of a pregnant adolescent.[6]
- Child marriage is one of the cultural factors that work against adolescent women. Married women under age 18 report being less able than older married women to discuss contraceptive use with their husband.[12] Thus child marriage is also associated with early childbearing. In Chad, Guinea, Mali, and Niger—where child marriage is prevalent—half of all teen women give birth before age 18.[12]
- Child marriage also puts young women at greater risk of HIV. Results from a study in Kenya and Zambia showed that married 16- to 19-year-old females were 75 percent more likely to have HIV than their sexually active unmarried peers.[12]
- Gender inequities put girls at greater risk than boys and affect many aspects of young women's lives[7] including reduced opportunities for education, employment, and control over their own reproductive health.[13] Lack of education can also affect health when it limits young women's knowledge about nutrition, birth spacing, and contraception.[13]

Family Planning Can Reduce Adolescent Maternal Mortality

Reproductive health care, including family planning services, can help women—including adolescents—to prevent unintended pregnancy, complications during pregnancy and delivery, and unsafe abortion.

- Worldwide, over 200 million women have no access to modern, effective contraception.[14] In the developing world, lack of access to family planning results in some 76 million unintended pregnancies each year.[7]
- Experts say that contraceptive use could prevent up to 35 percent of maternal deaths[7] and when contraceptive use increases, countries' infant mortality rates go down. In countries where less than 10 percent of women use contraception, the infant mortality rate is 100 deaths per 1,000 live births compared to 52 per 1,000 in countries where over 30 percent of women use contraception.[15]
- Worldwide, disapproving providers discourage young people from seeking reproductive health care.[13] Family planning services need to be "youth-friendly" in order to encourage young women to seek reproductive health care.[13]

Programs and Initiatives

- The World Health Organization says there is an urgent need for programs that address the health and safety of pregnant adolescents and that teach these young women the skills to build a successful future.[6] The U. S. Agency for International Development (USAID) identifies critical factors for improving adolescent maternal health: encouraging young women to use prenatal care to identify and treat malaria, anemia, and other health issues; providing obstetric care to ensure safe delivery for young mothers and their infants; and postnatal care to identify post-partum health issues, provide newborn care, and offer contraception to accomplish birth spacing.[16]
- One effective, comprehensive program increased knowledge of contraception and reproductive health among Chilean school girls age 12 to 17. The program decreased pregnancy rates among students by providing information about both abstinence and contraception, being youth-friendly, offering referral for reproductive health care, and encouraging open dialogue between parents, teachers, health care professionals, and youth.[17]
- In India, Reproductive Health of Young Adults in India (RHEYA) focused on educating youth about delaying marriage and pregnancy and about using contraception. Fifteen percent of young couples who were exposed to RHEYA used contraception to delay their first child compared to just over one percent of young couples in the control group.[18]
- In Nepal, the Adolescent Girls Initiative for Reproductive Health focused on improving reproductive health information and dialogue and access to services. Baseline data indicated that 63 percent of girls ages 10 through 14 were aware of family planning methods compared to 99 percent at the end of the project.[19]
- Programs in Burkina Faso offered peer educators and reproductive health services at some Youth for Youth centers. Compared to other centers where most clients were male, these centers recorded that 77 percent of attendees were young women.[13]
- Profamilia, a Columbian family planning association, incorporated a youth focus into its services and documented an increase of 37 percent in adolescent clinic visits.[13]

References

1. World Bank. *Maternal Mortality* [Public Health at a Glance] 2006; http://www.worldbank.org; accessed 4/5/2007.
2. UNFPA (2004). *State of World Population,* 2004; http://www.unfpa.org/swp/2004/english/ch9/page5.htm; accessed 3/21/2007.
3. National Research Council & Institute of Medicine, Lloyd CB, ed. *Growing Up Global: the Changing Transitions to Adulthood in Developing Countries*. Washington, DC: National Academies Press, 2005.
4. Population Reference Bureau. *The World's Youth 2006 Data Sheet;* http://www.prb.org/pdf06/WorldsYouth2006DataSheet.pdf; accessed 2/21/2007.
5. Okpani AOU, Okpani JU. Sexual activity and contraceptive use among female adolescents: a report from Port Harcourt, Nigeria. *African Journal of Reproductive Health 2000;* 4(1): 40-47.
6. World Health Organization, UNFPA. *Pregnant Adolescents*. Geneva: WHO, 2006.
7. UNFPA (2005). *State of World Population 2005: The Promise of Equality.* New York: Author.
8. Zabin LS, Kiragu K. The health consequences of adolescent sexual and fertility behavior in sub-Saharan Africa. *Studies in Family Planning* 1998; 29:210-232.
9. Airede LR, Ekele BA. Adolescent maternal mortality in Sokoto, Nigeria. *Journal of Obstetrics &Gynaecology* 2003; 23:163-165.
10. Phipps MG *et al.* Young maternal age associated with increased risk of neonatal death. *Obstetrics & Gynecology*, 2002; 100:481-486.
11. Save the Children. *State of the World's Mothers, 2006*. Washington, DC: Author, 2006.
12. International Center for Research on Women. *Too Young to Wed*. Washington, DC: ICRW, 2006.
13. UNFPA (2003). *State of World Population 2003*. New York: Author.
14. USAID (2006). *USAID's Family Planning Services* [Family Planning]; http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/fpservices.html; accessed 4/5/2007.
15. Alan Guttmacher Institute. *Family Planning Can Reduce High Infant Mortality Levels* [Issues in Brief, 2002, no. 2] New York: Author.
16. USAID (2005).Technical Areas: Adolescent Maternal Health. [Maternal and Child Health]; www.usaid.gov/our_work/global_health/mch/mh/techareas/adolescent.html; accessed 1/17/2007.
17. Toledo V *et al.* Impacto del programa de educación sexual: Adolescencia Tiempo de Decisiones. *Sogia* 2000; 7(3); http://www.cemera.uchile.cl/sogia/sogia.html.
18. Pathfinder International. *Reproductive Health of Young Adults in India: the Road to Public Health*, 2006; http://www.pathfind.org/site/DocServer/Pathfinder_Rheya.pdf?docID=7401; accessed 3/27/2007.
19. Centre for Development & Population Activities (CEDPA). *A Gift for RH Project, Nepal: Endline Evaluation*. Washington, DC: Author, 2002.

Written by Kathryn Graczyk

Advocates For Youth
Rights. Respect. Responsibility.®

2000 M Street, NW, Suite 750 • Washington, DC 20036 USA • Phone: 202.419.3420 • Fax: 202.419.1448 • www.advocatesforyouth.org

Pregnancy Checklist

This checklist is a simple and low-cost way for a provider rule out pregnancy in a client, so that she may begin using a method immediately without having to wait for a return visit. This checklist eliminates the need for women to be menstruating or for blood or urine pregnancy tests.

To use the checklist, ask the client questions 1–6. As soon as the client answers "yes" to any question, stop and follow the instructions below.

NO		YES
	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and had no monthly bleeding since then?	
	Have you abstained from sexual intercourse since your last monthly bleeding or delivery?	
	Have you had a baby in the last 4 weeks?	
	Did your last monthly bleeding start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	
	Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if the client is planning to use an IUD)?	
	Have you been using a reliable contraceptive method consistently and correctly?	

If the client answered **"no"** to *all* questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test.

If the client answered **"yes"** to *at least one* of the questions, and she has no signs or symptoms of pregnancy, you can give her the method she has chosen.

Source: Family Health International (FHI), "FHI - Pregnancy Checklist." http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/pregnancy/index.html (24 Mar. 2008)

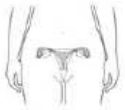
Comparing Effectiveness of Family Planning Methods

More effective

Less than 1 pregnancy per 100 women in 1 year

Implants

IUD

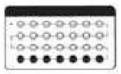


Female sterilization

Vasectomy

Injectables

LAM



Pills

Patch

Vaginal ring

Male condoms

Diaphragm

Female condoms

Fertility awareness methods

Less effective

About 30 pregnancies per 100 women in 1 year

Withdrawal

Spermicides

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

Withdrawal, spermicides: Use correctly every time you have sex

USAID FROM THE AMERICAN PEOPLE

World Health Organization

Sources:

Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized controlled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol* 2006;195(1):85–91.

World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Cates W Jr., Guest F, Kowal D, eds. *Contraceptive Technology, Nineteenth Revised Edition*. New York: Ardent Media, Inc., in press.

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS[41]	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Fertility awareness methods Methods (in order from least effective to most effective at predicting the fertile period) include: • **Calendar method** • **Cervical mucus method** • **Symptothermal method** Intercourse is avoided during the phase of the menstrual cycle when conception is most likely.	Consistent and Correct Use: N/A Typical Use: 25 Moderately effective (9 to 20 pregnancies per 100 women during the first year of use)	• Can be used to avoid or achieve pregnancy • No method-related health risks • No systemic side effects • Inexpensive • Always available	• Depends on couple's willingness to follow instructions. • Considerable training required to use methods correctly. • Requires a trained provider to instruct in use • Requires abstinence (or use of condoms) during fertile phase. • Requires daily record keeping. • Vaginal infections make it difficult to interpret cervical mucus. • Basal thermometer needed for some methods. • Does not protect against STIs and HIV. • Women who are just starting to menstruate or whose cycles have become less frequent or stopped may have difficulty using calendar method to identify fertile period. • Women who have recently given birth or who are breastfeeding should delay use of calendar methods until she has had at least three menstrual cycles and cycles are regular again. • Women who recently had abortion or miscarriage should delay use until start of next monthly bleeding	• Women of any reproductive age • Women of any parity, including nulliparous women • Couples with religious or philosophical reasons for not using other methods • Women unable to use other methods • Couples willing to abstain from intercourse or use condoms for more than one week each cycle • Couples willing and motivated to observe, record, and interpret fertility signs each day • Women with HIV, AIDS and/or on ARVs can safely use fertility awareness methods	• Couples unwilling to abstain from intercourse or use condoms for more than one week each cycle • Couples unwilling to observe, record, and interpret fertility signs each day • Women in situations where negotiation for time of sexual intercourse is not possible

[41]Rate of unintended pregnancies per 100 women using the method. Data taken from *Family Planning: A Global Handbook for Providers*, USAID 2007.

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Standard Days Method (SDM/Cycle Beads) Cycle beads are a string of colored beads that represent each day of a woman's menstrual cycle. They can help women know when they are likely to get pregnant if they have unprotected sexual intercourse.	Consistent and Correct Use: 5 Typical Use: N/A Moderately effective (4 to 12 pregnancies per 100 women during the first year of use)	• Same as other natural FP methods • Easy to teach and use	• Requires abstinence or barrier protection during the fertile phase. • Requires daily activity by the woman (movement of the bead marker). • Does not protect against STIs and HIV. • Women who are just starting to menstruate or whose cycles have become less frequent or stopped may have difficulty using calendar method/SDM to identify fertile period. • Women who have recently given birth or who are breastfeeding should delay use of calendar method/SDM until she has had at least three menstrual cycles and cycles are regular again. • Women who recently had abortion or miscarriage should delay use of SDM until start of next monthly bleeding	• Women with menstrual cycles 26 to 32 days long • Women with HIV/AIDS and those on ARVs can safely use SDM.	• Women with irregular menstrual cycles (less than 26 days or longer than 32 days) • Women unable to track the days of the cycle using cycle beads

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Condoms Condoms are barrier methods that physically prevent sperm from uniting with the egg. There are both male and female condoms. Male condoms are made of latex and are worn on the erect penis. Female condoms are usually made of plastic and fit inside of the vagina. Both male and female condoms work by forming a barrier that keeps sperm out of the vagina.	Male condoms: with consistent and correct use: 2 typical use: 15 Female condoms: with consistent and correct use: 5 Typical use: 21 Moderately effective (2 to 12 pregnancies per 100 women during the first year of use)	• Prevents STIs, including HIV/AIDS, as well as pregnancy, when used correctly during intercourse, i.e., provide dual protection • No effect on breast milk production • Protects against infection in the uterus • No hormonal side effects • Can be stopped at any time • No daily upkeep • Easy to keep on hand, little planning involved • Can be used by men of any age • Can be used without initially seeing a health care provider • Enables a man to take responsibility for preventing pregnancy and disease • Male condoms are usually readily available	• Latex condoms may cause itching for a few people who are allergic to latex. • Effectiveness as contraceptives depends on willingness to follow instructions. • A man's cooperation is necessary. • Many people connect condoms with immoral sexual activity • May embarrass people to buy, ask partner to use, put on, take off, or throw away condoms. • Supplies must be readily available before intercourse begins. • Condoms should not be reused and should be discarded after every act of intercourse. • Some men or women may feel that it interferes with their sexual pleasure. • Female condoms may not be readily available	• Men and women of all reproductive ages are good candidates for using condoms.	• People allergic to latex

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Lactational Amenorrhea Method (LAM) Method uses the temporary infertility that occurs immediately after childbirth. If women fully or nearly fully breastfeed, infertility may last as long as six months, as long as the woman's menses have **not** returned. Effective (1 to 2 pregnancies per 100 women during first six months of use) (For more information on LAM please see the end of this section.)	Consistent and Correct Use (for 6 months): 0.9 Typical Use: 2	• Effective immediately • Does not interfere with intercourse • No systemic side effects • No medical supervision necessary • No supplies required • No cost • Promotes nutritional benefits to infant • Promotes mother and infant bonding	• Requires following instructions regarding breastfeeding practices. • May be difficult to practice due to social circumstances. • Effective only until menses returns or up to six months. • Does not protect against STIs and HIV. • Women with HIV/AIDS and/or are using ARVs can use LAM, however, there is a chance they can pass HIV to their infants through breastfeeding. Women with HIV are encouraged to use replacement feeding ONLY if it is acceptable, feasible, affordable, sustainable and safe. If replacement feeding cannot meet all of these five criteria, exclusive breastfeeding for the first six months is the safest way to feed and is compatible with LAM.	• Women who are fully breastfeeding or nearly fully, whose menses have not returned, and who are less than six months postpartum. • Women with HIV who use LAM should also be encouraged to use condoms.	• Women who are not fully or nearly fully breastfeeding • Postpartum women whose menses have returned • Women who are more than six months postpartum

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Emergency Contraceptive Pill (ECP) Method works by possibly inhibiting ovulation, thickening cervical mucus and affecting transport of sperm or egg.	Consistent and Correct Use: (progestin only) 1 (combined) 2 Typical Use: N/A Moderately effective (Use of ECPs within 72 hours of unprotected intercourse reduces the risk of pregnancy by at least 75%.)	• Can help prevent pregnancy after rape, unprotected sex, or contraceptive method failure. • Process of getting ECPs may help woman to initiate another effective contraceptive method. • Can be taken up to 72 hours after unprotected intercourse.	• Must be taken within 72 hours of unprotected intercourse • Does not protect against STIs and HIV. • Availability may be limited due to bias or misunderstanding of how the method works, or the need for a prescription from a physician.	• All women who have had unprotected intercourse for any reason	• There are no contraindications to ECPs. • Women with strong contraindications to estrogen should use progesterone-only ECPs.

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Oral Contraceptive (Combined oral contraceptives or COCs) COCs contain the hormones estrogen and progesterone, which suppress ovulation. .	Consistent and Correct Use: 0.3 Typical Use: 8 Effective (almost 100%) if used according to directions	• Highly effective, reversible, easy to use. • Effective within first cycle. • Safe for most women. • Regulates the menstrual cycle. • Reduces menstrual flow (which may be useful to anemic women). • Decreases the risk of ovarian and uterine cancer, benign breast disease, and incidence of acne. • Does not interfere with sexual intercourse. • May be used after baby is 6 months old, if the woman decides not to continue to breastfeed the baby. • Pelvic exam not required before use. • Can be provided by trained non-medical staff. • May help women who experience painful menstruation.	• Must be taken every day. • Requires regular/ dependable supply. • Pills may cause side effects in some women, such as nausea, headache, break- through bleeding, or weight gain. • Does not protect against STIs and HIV. • Risk of developing cardiovascular disease in women over 35 years of age and who smoke.	• Women and couples who want an effective, reversible method. • Women with anemia due to heavy menstrual bleeding. • Women with an irregular menstrual cycle. • Women with family history of ovarian cancer. • Women with HIV/ AIDS • Women who are on ARVs.	• Women < 3 weeks postpartum • Breastfeeding women < 6 months postpartum • Women with moderate to severe hypertension • Diabetes, (advanced or long standing), with vascular problems, or central nervous system (CNS), kidney, or visual disease • Women who smoke > 15 cigarettes/day • Women with the following conditions: - Deep vein thrombosis (DVT) - Heart disease - Thrombogenic disorders - Liver disease or tumors - Recurrent migraine headaches with focal neurological symptoms - Unexplained abnormal vaginal bleeding - Breast cancer - Currently taking anticonvulsants for epilepsy

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Oral Contraceptive (Progestin Only Pills or POPs; also know as the "mini-pill") POPs contain a low dose of progestin, which is similar to the hormone progesterone. POPs work by thickening the cervical mucus and preventing ovulation.	Consistent and correct use among breastfeeding women: <1 Typical Use: 1 Consistent and correct use among non-breastfeeding women: <1 Typical use: 3 - 10 POPs are most effectively used by breastfeeding women	• Safe for nearly all women, especially women who do not tolerate or cannot use COCs. • Highly effective, reversible, easy to use. • Effective within first cycle. • Safe for most women. • Regulates the menstrual cycle. • Reduces menstrual flow (which may be useful to anemic women). • Decreases the risk of ovarian and uterine cancer, benign breast disease, and incidence of acne. • Does not interfere with sexual intercourse. • May be used after baby is 6 months old, if the woman decides not to continue to breastfeed the baby. • Pelvic exam not required before use. • Can be provided by trained non-medical staff. • May be beneficial for women who experience painful menstruation.	• Must be taken every day. • Requires regular/ dependable supply. • Pills may cause side effects in some women, such as nausea, headache, changes in bleeding patterns, break- through bleeding, or weight gain. • Does not protect against STIs and HIV.	• Women and couples who want an effective, reversible method. • Breastfeeding women can begin this method as soon as six weeks post partum. • Can be used by women who smoke, have anemia now or in past, have varicose veins. • Women with HIV • Women who cannot use COCs	Women who: • are breastfeeding an infant less than six weeks old • have liver problems • have blood clots in legs or lungs • are taking medications for seizures or rifampicin for TB or other illness • have or have had breast cancer

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Injectable Contraceptive (Progestin Only) DMPA (Depot Medroxyprogesterone Acetate) contains the hormone progesterone, which suppresses ovulation. It is given by injection once every 12 weeks. The method has a grace period of effectiveness of 4 weeks before or after the scheduled date for the next injection.	Consistent and Correct Use: 0.3 Typical Use: 3 Very effective (with pregnancy rates of less than 1% when used according to instructions)	• Very effective and easily reversible • Few side effects. • Does not interfere with sexual intercourse. • No daily pill-taking. • No effect on breast milk production • May help prevent ovarian cancer • For some women, may help prevent iron-deficiency anemia, reduce epileptic seizures. • Pelvic exam not required before use. ▪ Rapidly effective (<24 hours).	• May produce minor side effects such as light spotting, bleeding, amenorrhea, or weight gain. • Delayed return to fertility (for half of the users, it takes 6 to 9 months after discontinuation to get pregnant). • Requires regular injection every three months. • Does not protect against STIs and HIV. • Causes changes in menstrual bleeding patterns during the first year of use.	• Breastfeeding women (as soon as six weeks after childbirth) • Women of any reproductive age or parity, including adolescents • Women who have had an abortion or miscarriage • Women who have blood pressure <180/110 mm Hg, blood clotting problems, or sickle cell disease • Women who smoke (any age) • Postpartum women who are not breastfeeding • Women with HIV/AIDS • Women using ARVs	Women who: • Are pregnant • Are breastfeeding and < 6 weeks postpartum • Have high blood pressure (> 160/100 mm Hg) • Have diabetes with vascular disease • Have current or past ischemic heart disease • Have unexplained abnormal vaginal bleeding • Have or had breast cancer • Have liver disease • Have multiple risk factors for arterial cardiovascular disease (i.e., older age, smoking, diabetes, and hypertension.) • Have DVT, vascular or heart disease, or stroke

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Intrauterine Contraceptive Device (IUCD) Copper-releasing IUCDs (Copper T 380A) slows sperm movement A long-acting and highly effective method.	Consistent and Correct Use: 0.6 Typical Use: 0.8	• Does not interfere with sexual intercourse. • No hormonal side effects with copper- bearing IUCDs. • Immediately reversible with no delay in return to fertility. • Does not interfere with breastfeeding. • No interactions with any medicines. • Helps prevent ectopic pregnancies (but does not prevent all). • Long-term method. • After initial follow-up visit, the woman needs to return to the clinic only if there is a problem. • Women do not need to purchase any supplies.	• Possibility of: - Longer and heavier menstrual periods; - Bleeding or spotting between periods; - More cramps or pain during periods. • Does not protect against STIs and HIV. • May increase risk of pelvic inflammatory disease (PID) and subsequent infertility in women at risk for STIs. • Requires a trained health care provider to insert and remove the IUCD. • May be spontaneously expelled.	Women who: • Have just had an abortion or miscarriage (if no evidence of infection) • Are breastfeeding • Have benign breast disease • Have or had breast cancer • Have headaches • Have high blood pressure (> 140/90 mm hg) • Have heart disease • Have diabetes • Have liver or gallbladder disease • Have epilepsy • Have non-pelvic tuberculosis • Are HIV positive and/or AIDS who are clinically well.	Women with the following conditions: • Current PID, gonorrhea, or chlamydia • High risk for gonorrhea or chlamydia • Women with AIDS who are not clinically well. • Immediate post-septic abortion • Pregnancy • Pelvic tuberculosis • Distorted uterine cavity • Unexplained abnormal vaginal bleeding • Genital tract cancer (awaiting treatment) • Puerperal sepsis • 48 hours to less than 4 weeks postpartum • Malignant trophoblastic disease

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Female Tubal Ligation Permanent voluntary sterilization for women. Blocks the fallopian tubes by ligation, clips, or bands to prevent sperm and egg from uniting. Very effective (with pregnancy rates of less than 1% during the first year of use). A permanent method that is not easily reversible. Written consent is required from the woman undergoing the procedure.	Consistent and Correct Use: 0.5 Typical Use: 0.5	• Simple surgery performed under local anesthesia. • Permanent procedure. • Nothing to remember, no supplies needed, no repeat clinic visits required. • Does not interfere with sexual intercourse. • No effect on breast milk production • No known long-term side effects or health risks. • Can be performed any time during the menstrual cycle when it is reasonably sure that the woman is not pregnant.	• Uncommon complications of surgery include: - Infection - Bleeding at the incision - Internal infection or bleeding - Injury to internal organs • Requires a trained provider. • Must be considered permanent. • Does not protect against STIs and HIV. • Short-term discomfort/pain following procedure.	• Any woman can use, but probably not appropriate for young women. • Women who just gave birth (within 2 days or after 6 weeks) • Women who are breastfeeding • Women with HIV or AIDS can safely have a tubal ligation, as long as universal precautions are followed.	Women with any of the following conditions should delay tubal ligation until the condition is resolved: • Current thromboembolic disorder • Current ischemic heart disease • Prolonged immobilization or leg surgery • Unexplained abnormal vaginal bleeding • Genital cancer • Current PID or within the past 3 months • Active viral hepatitis • Iron-deficiency anemia with a hemoglobin less than 7 g/dl • Acute bronchitis or pneumonia • Severe pre-eclampsia/ eclampsia • Prolonged rupture of membranes • Severe hemorrhage, sepsis, fever during or right after childbirth • Uterine rupture or perforation • Should not be performed on a woman with HIV/AIDS who is not clinically well.

METHOD MECHANISM OF ACTION	CONTRACEPTIVE EFFECTIVENESS	BENEFITS	LIMITATIONS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Vasectomy Permanent voluntary sterilization for men Blocks the vas deferens and prevents sperm from entering the semen. A permanent method that is not easily reversible and is highly effective Written consent is required from the man undergoing the procedure.	Consistent and Correct Use: 0.1 Typical Use: 0.15	• Permanent procedure. • Nothing to remember, except to use condoms for the first 3 months. • Does not interfere with sexual intercourse. • Simple surgery performed under local anesthesia. • No known long-term side effects. • No repeat clinic visits required, no supplies needed, except the use of condoms for the first 3 months. • Easier to perform than tubal ligation. • No change in sexual function. • No effect on hormone production.	• Must be considered permanent. • Delayed effectiveness (requires at least 3 months for procedure to be effective or more than 20 ejaculations). • Requires minor surgery by a trained provider. • Reversal surgery is difficult, expensive, and not available in most areas. • Does not protect against STIs and HIV.	• Men of any reproductive age (usually < 50 years). May not be appropriate for young men. • Men whose wives have age, parity, or health problems that might pose a serious health risk if they became pregnant • Men with HIV, AIDS or who are on ARVs can safely undergo vasectomy, as long as universal precautions are followed.	Men with any of the following conditions should delay vasectomy until the condition is resolved: • Current STI • Scrotal skin infection • Acute genital tract infection • Acute systemic infection • Symptomatic heart disease, clotting disorders, or diabetes • Men with AIDS who are not clinically well. The following conditions require a provider with extensive experience and skills in performing the vasectomy: • Previous scrotal surgery • Undescended testes and proven fertility • Inguinal hernia • Large varicocele

Rumors and Misconceptions—Facts and Realities about Family Planning

RUMORS AND MISCONCEPTIONS	FACTS AND REALITIES
• It is better to have your children closely spaced while you are young, because it is the time that the woman's body is strongest.	• Closely spaced pregnancies are not good for the health of any woman at any age. • Sufficient time between pregnancies will help women to be strong and healthy for the next pregnancy and to have time for proper care of the last-born child.
• It is more convenient to complete the family, and then use a permanent method of birth control.	• It is more important for the family to have a healthy mother and children, which is not possible if the births are not well-timed and spaced.
• If a condom slips off during sexual intercourse, it might get lost inside the woman's body.	• If a condom slips off during sexual intercourse, it is impossible for the condom to get lost inside the woman's body.
• A woman only needs to take the pill when she has sex with her husband • Pills make you weak. • The pill is dangerous and causes cancer. • The pill causes abnormal or deformed babies. • Women who take the pill are more likely to have twins or triplets. • The pill causes infertility. • The pill makes it more difficult for a woman to become pregnant once she stops using it.	• A woman must take her pills every day to not become pregnant. . • Sometimes women feel weak, and if they are taking the pill, they blame the weakness on the pill. Pills do not make a woman weak. See a health care provider to find out what else might be causing weakness. • Studies show that the pill can protect women from some forms of cancer, such as those of the ovary, uterus, and breast. • There is NO medical evidence that the pill causes abnormal or deformed babies. • The pill has no effect on multiple births. • Studies have clearly shown that the pill does not cause infertility or decrease a woman's chances of becoming pregnant once she stops taking it.
• ECPs cause abortion.	• ECPs do not cause abortion. • ECPs will not end an established pregnancy, but it will prevent pregnancy by interrupting ovulation or implantation.

RUMORS AND MISCONCEPTIONS	FACTS AND REALITIES
• A woman who uses injectables (DMPA) will never be able to get pregnant. • Injectable contraceptives cause cancer. • A woman will not have enough breast milk if she uses injectables while breastfeeding. • Injectables stop menstrual bleeding which is bad for a woman's health. • Injectables cause abnormal or deformed babies. • Injectables cause irregular bleeding, which leads to anemia.	• Sometimes there is a delay of 6 to 9 months after the last injection for a woman's fertility to return to normal. • Research has clearly proven that injectables do not cause cancer. In fact, injectables have been shown to protect against ovarian cancer. • Studies show that the amount of breast milk does not decrease when breastfeeding women use injectables six weeks after birth. • Amenorrhea is an expected result of using injectables, because women using injectables do not ovulate. This kind of amenorrhea is not harmful. It helps prevent anemia and frees women from the discomfort and inconvenience of monthly bleeding. • There is no evidence that injectables cause any abnormalities in infants. Studies done on infants who were exposed to DMPA while in the womb showed no increase in birth defects. It is worth noting that in past years, DMPA was used to prevent miscarriage. • During the first 3 to 6 months of DMPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. This usually stops within a few months of continuous use of DMPA and rarely results in anemia.
• A woman who has an IUCD cannot do heavy work. • The IUCD might travel inside a woman's body to her heart or brain. • If a woman using an IUCD becomes pregnant, the IUCD will become embedded in the baby's forehead. • The IUCD rots in the uterus.	• Using an IUCD should not stop a woman from carrying out her regular activities in any way. • There is no passage of IUCD from the uterus to the other organs of the body. • The IUCD placed inside the uterus stays there until a trained health care provider removes it. • Rarely will an IUCD perforate the uterus, but the health worker can identify this and necessary actions can be taken to remove the IUCD. • If the IUCD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. • If a woman gets pregnant with an IUCD in place, the health care provider should remove the IUCD immediately. • If for some reason the IUCD is left in place during a pregnancy, there is no evidence that it will harm the baby in any way, and it is usually expelled with the placenta or with the baby at birth. • If there are no problems, the IUCD can remain in place and be an effective contraceptive method for 5 to 12 years[42]. The IUCD is made up of materials that cannot deteriorate in the body.

42 The hormonal IUD is effective for five years while the copper 380A IUD is effective for up to 12 years.

RUMORS AND MISCONCEPTIONS	FACTS AND REALITIES
• A woman who has a tubal ligation loses all desire for sexual intercourse. • A woman who has a tubal ligation becomes sick and unable to do any work. • A woman who has a tubal ligation has to be hospitalized.	• Tubal ligation has no physiological effect on the woman. Her sexual drive should remain the same as before. • A woman who has had tubal ligation can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work and does not make her weak or sick. • There is no need for hospitalization for a female tubal ligation. It is a short surgical procedure and the woman can return home after resting for some time at the hospital (approximately two hours).
• A man will lose his sexual drive after a vasectomy. • A vasectomy will make a man physically weak. • There will not be any semen production after a vasectomy.	• A vasectomy does not interfere with the man's reproductive physiology. His sexual drive remains. • A vasectomy does not make a man physically weak—he can get back to his regular work in 2 to 3 days' time. • Semen will be produced as usual; only the sperm will not be part of the semen.

What makes FP counseling effective?

A good counselor:

- Treats all clients with respect, regardless of age, marital status, ethnicity or socio-economic status
- Maintains confidentiality
- Personalizes the content of counseling to the client's situation

Furthermore, a good family planning counselor:

- supports a client's informed choice
- supplies accurate, complete technical information that is relevant to the client, including information on HTSP
- addresses the negative about family planning (such as side effects) as well as the positive
- discusses the client's childbearing intentions, including timing, spacing and limiting of pregnancies, sexual relationships, partners and STI/HIV risk-taking behavior.

A complete family planning session should cover the following:

- information on side effects and complications
- advantages and disadvantages of a method from a client's point of view
- method effectiveness
- proper method use (once a method has been selected)
- what to do if the method fails or is not used properly
- the availability of emergency contraception
- STI and HIV prevention
- Information on return visits, resupply and unscheduled visits if there are problems

Source: www.rho.org/html/fpp_keyissues.html

Family Planning Counseling Strategies for Different Clients

Client Type	Usual Counseling Tasks
Returning clients with no problems	• Provide more supplies or routine follow-up • Ask a friendly question about how the client is doing with the method. • Assess her intentions around becoming pregnant to ensure she continues to practice HTSP, where appropriate.
Returning clients with problems	• Understand the problem and help resolve it—whether the problem is side effects, trouble using the method, an uncooperative partner, or another problem. • Help her choose another method, if she so desires, so that she does not discontinue the use of her method and risk an unplanned or closely spaced pregnancy • Remind her of the importance of practicing HTSP.
New clients with a method in mind	• Check that the client's understanding of the method is accurate • Support the client's choice, based on your assessment of the client's situation and if the client is medically eligible • Discuss how to use method and how to cope with any side effects • Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.
New clients with no method in mind	• Discuss the client's situation, plans (such as fertility intentions, desired family size), and what is important to her about a method • Help the client consider methods that might suit her particular situation. If needed, help her reach a decision • Support the client's choice, give instructions on use, and discuss how to cope with any side effects • Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.

The elements of GATHER, which has been adapted for HTSP are presented below:

G Greet the client in a friendly way.

- ☐ As soon as you meet clients, give them your full attention.
- ☐ Be polite: greet them, introduce yourself, and offer them a seat.
- ☐ Conduct counseling where no one else can hear.
- ☐ Inform clients that you will not share their information with others.
- ☐ In clinics, explain what will happen during the visit. Describe physical examinations and laboratory tests, if any.
- ☐ If counseling is taking place at home, ensure that the client has some private time and/or place to participate in the counseling.

A

Ask the client why she has come in for a visit.

(e.g., is she interested in hearing how to delay, space or limit a pregnancy?)

- ☐ If the client is new, obtain a history, including the client's:
  - ❖ Age
  - ❖ Marital/union status
  - ❖ Basic medical information
  - ❖ Number of pregnancies and when
  - ❖ Number of births and when
  - ❖ Number and ages of living children
  - ❖ Family planning use for delaying, spacing or limiting pregnancies, now and in the past
- ☐ Probe for fertility intentions using Fertility Intention Question Tree (Figure 6). Explain that you are asking for this information to help the client make an informed choice about delaying, spacing and/or limiting a future pregnancy and to help her identify the most suitable family planning method.
- ☐ Keep questions simple and brief. Look at your client as you speak.
- ☐ Help clients talk about their needs, wants, doubts, concerns, or questions they may have about HTSP, FP and pregnancy
- ☐ Ensure that the client understands what you have to say. Encourage clients to ask questions.
- ☐ If the client is not new, ask her if anything has changed since her last visit.

T

Tell the client about the benefits of HTSP and the FP methods that are available meet her specific needs for spacing or limiting.

- ☐ As needed, probe to determine whether the client is more interested in becoming pregnant again or in limiting her childbearing.
    - ❖ For postpartum women, explain why spacing pregnancies at least two years and no more than five years is beneficial. Inform her how long a woman should wait from her last birth to her next pregnancy, if she wants to become pregnant again.
    - ❖ For postabortion or post-miscarriage women, explain that if she wants to become pregnant again, the she should delay getting pregnant for at least six months.
    - ❖ For adolescents, explain that it is important to wait until she is 18 before becoming pregnant.
- ☐ Explain the potential risks of not practicing HTSP.
- ☐ If the client is interested in HTSP, discuss available modern and fertility awareness based methods of family planning that she can use to practice HTSP, including LAM based on the client's fertility intentions. Inform your client about which FP methods are available and where she can obtain them, and ask if there are any methods that interest them.
- ☐ Ask your client what she already knows about the methods that interest her. Correct any misinformation.
- ☐ Briefly describe each method that the client wants to hear about. Talk about:
    - ❖ Effectiveness
    - ❖ How to use the method
    - ❖ Advantages and disadvantages, including information on return to fertility
    - ❖ Possible side effects and complications
- ☐ Use samples and other audiovisual materials, if available.
- ☐ If client is not interested in HTSP and wants to become pregnant again, provide counseling on the importance of antenatal care.
- ☐ If client is undecided, probe reasons for not spacing and discuss further. As appropriate use the information from Table 4 (below) **Is HTSP Right for Me?**

IS HTSP RIGHT FOR ME?

COMMON REASONS CITED BY WOMEN FOR NOT PRACTICING HTSP AND POSSIBLE RESPONSES

Reasons for not waiting before youngest child is at least 2 years old:	**Possible Responses**
• It is best to have the children one after the other while young so the mother is strong enough to raise them.	• Even young mothers can be stressed and weakened by closely spaced pregnancies.
• It is best to have children one after the other so that they can have a companion close to their age with whom they can play.	• Children closely spaced together may demand more attention from the mother.
• It is easier to raise two children close to each other in age, because they can share clothes, toys, and the mother's time. It also saves money.	• All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization	• The mother can give the last-born child all the needed attention to grow healthy, be well fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give the last-born child enough attention.
• If a woman waits too long, she will be too old to have another child.	• It is better for the whole family if the mother and children are healthy, which may not happen if the births are closely spaced.
Common reasons for not practicing HTSP:	**Possible Responses**
• Her religion does not allow her to use FP.	• You can use fertility-based awareness methods and other natural methods to plan your family. You can also practice LAM by breastfeeding.
• Her husband is not interested in discussing family planning or pregnancy spacing and/or he feels that it is her responsibility, not his.	• Pregnancy spacing is a joint responsibility and there are many economic, social and emotional advantages to spacing children.
• The man's virility may be questioned if his wife does not become pregnant quickly.	• A responsible man knows that his family's health is important, and he is willing to take steps to ensure that his family is healthy by planning and spacing his children.
• The woman's fertility may be questioned if she is not able to become	• While it is important to acknowledge the concerns and expectations of her

IS HTSP RIGHT FOR ME?

COMMON REASONS CITED BY WOMEN FOR NOT PRACTICING HTSP AND POSSIBLE RESPONSES

pregnant quickly.	husband and family, they must also understand the risks of closely spaced pregnancies to the health of the woman, her current and future children.
Reasons for not waiting until age 18:	**Possible Responses**
• It is best to have children while young so the mother is strong enough to raise them.	• Married adolescents need time to physically and psychologically mature so that they are prepared for pregnancy and childbirth. Delaying the first child until a young woman is at least 18 increases the chances of having a healthy pregnancy and a healthy child.
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.	• Completing a family can be done quickly and safely after the age of 18, after which permanent methods and surgical sterilization are options.
• If a woman waits too long, she will be too old to a child.	• Waiting until you are 18 is not too long and women can have healthy children safely for many years after that.
• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as she marries, even if she is very young. In many cases, it is important to demonstrate her fertility and/or produce a male child as soon as possible.	• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.
Reasons for not waiting after a miscarriage or abortion:	**Possible Responses**
• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.	• Waiting 6 months will not hinder your time to complete your ideal family size, after which permanent methods and surgical sterilization are options.
• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as possible. In many cases, it is important to demonstrate her fertility and/or produce a male child.	• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.

H

Help client choose a method that best suits her current situation, fertility intentions and desired family size.

- ☐ Help each client match her needs and preferences with a family planning method, especially in terms of her desire to delay, space or limit her next pregnancy.
- ☐ Ask the client if there is a method she would like to use. Some will know what they want, while others will need help to make a decision.
- ☐ Ask the client about her fertility intentions desired family size, and any future plans. Reinforce the benefits of HTSP and the use of FP.
- ☐ Ask client what her partner wants. What method would her partner like to use?
- ☐ Ask clients if there is anything they do not understand. Repeat and clarify information when necessary.
- ☐ Some methods are not safe for some clients. When a method is not safe, inform the client and explain clearly why it is not safe. Then help the client choose another method.
- ☐ Check whether the client has made a clear decision. Specifically ask, "What method have you decided to use?"

E Explain how to use the method.

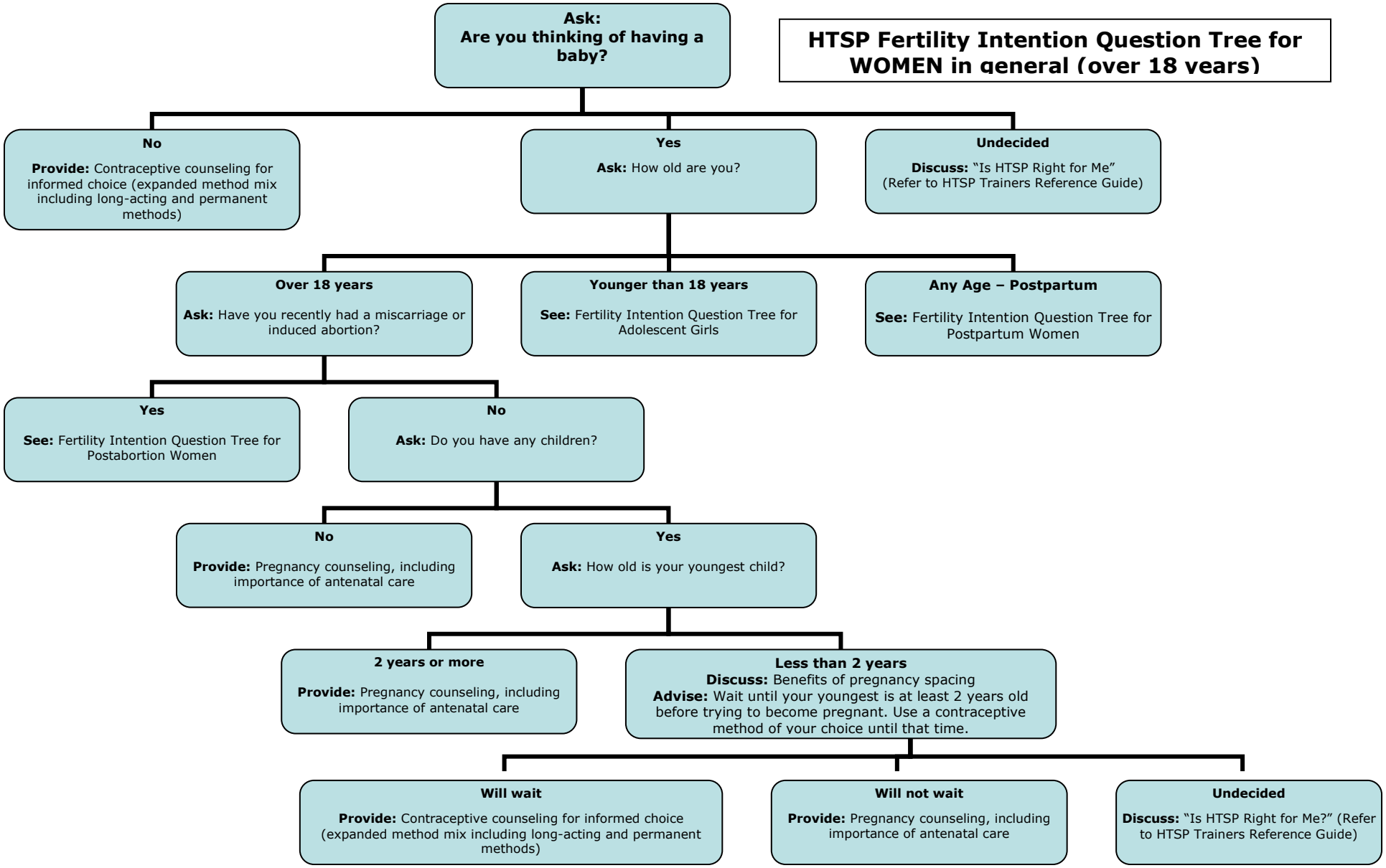
- ☐ After the client has chosen a method, give her supplies, if appropriate.
- ☐ If the method cannot be given immediately, tell the client how, when, and where it will be provided. Provide a back up method, such as condoms.
- ☐ For some methods, such as voluntary surgical contraception, the client may have to sign a consent form which states that the client wants the method, has been given information about it, and understands the information (please refer to the procedures for voluntary sterilization in your country). Help the client understand the consent form.
- ☐ Ask the client to repeat the instructions on using and/or obtaining her method. Listen carefully to make sure she remembers and understands.
- ☐ Describe any possible side effects and warning signs. Clearly inform the client what to do if they occur.
- ☐ Ask the client to repeat this information and clarify as needed.
- ☐ If possible, give the client printed material about the method.
- ☐ Inform the client when to come back for a follow-up visit as needed, (e.g. for resupply, check up, etc)
- ☐ Remind the client that she should use the method for at least two years after the birth of her last child (for postpartum women); or for at least six months following a miscarriage or abortion; or until she is at least 18 years old.
- ☐ Inform the client to come back sooner if she wishes, or if side effects or warning signs occur.

R

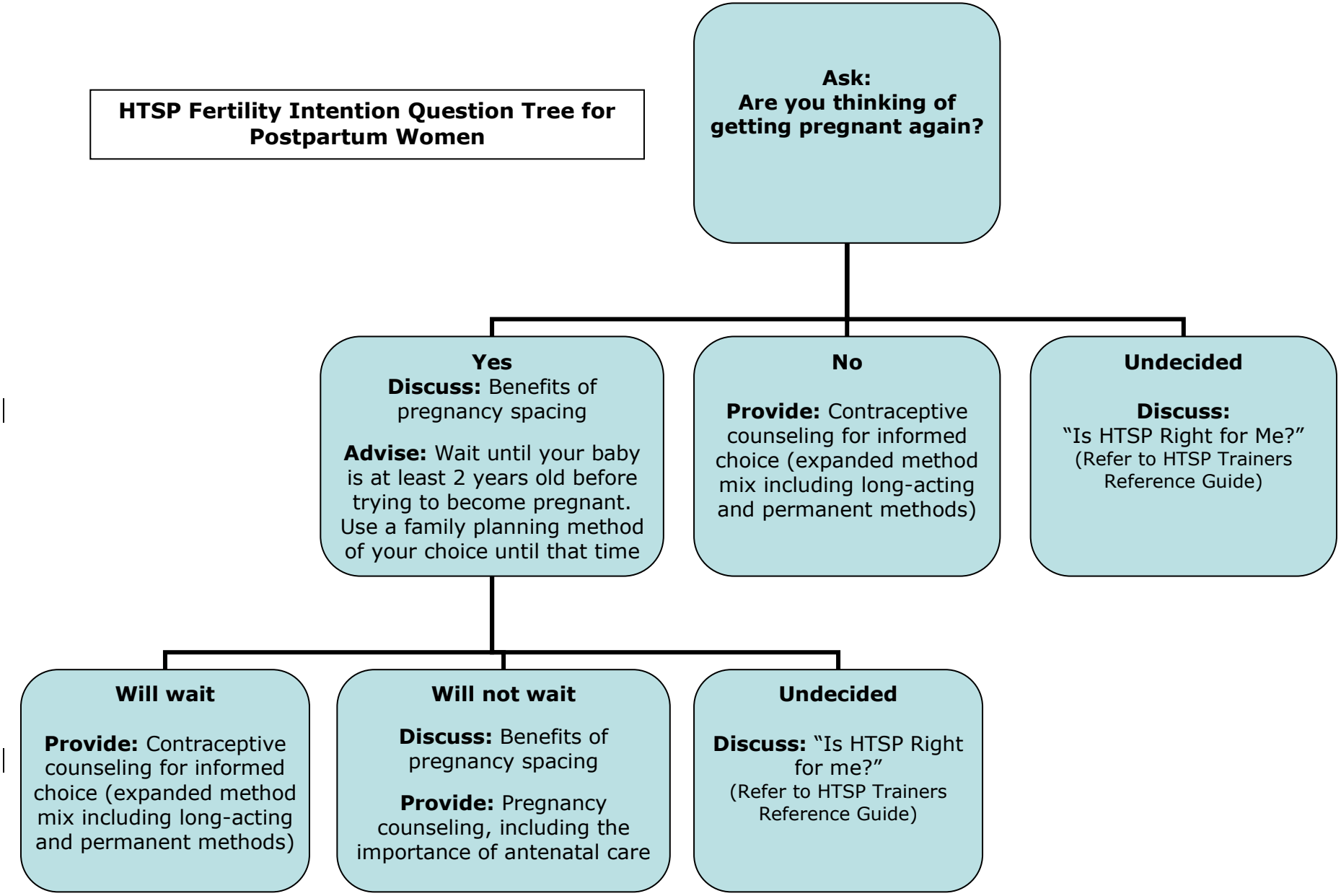
Return for follow-up. Set up a date with the client for you to visit her for follow-up OR fix a date for the client to visit the facility for a follow-up visit.

- ☐ At the follow-up visit ask the client if she is still using the method.
- ☐ If yes, ask the client if she has any problems with the method.
- ☐ If the client has any side effects, ask her to list each side effect one at a time.
- ☐ If the client has experienced any side effects, find out how severe they are. Reassure clients with minor side effects that they are not dangerous, and often resolve on their own after a few months Suggest some ways to relieve side effects. If side effects are severe, refer them for treatment.
- ☐ Ask how the client is using the method to be sure she is using it correctly.
- ☐ Ask if the client has any questions.
- ☐ If a client wants to switch to another method, inform the client about other available methods and help the client to choose another method Remember, changing methods is not bad. No one can really decide on a method without trying it. Also, a person's situation can change so that another method may be better.
- ☐ If a client wants to have a child, help her to stop using her method. Explain any possible delay in return to fertility. Remind her of the importance of antenatal care and as needed inform the client where to go for antenatal care. Reinforce the benefits of HTSP.

HTSP Fertility Intention Question Tree for WOMEN in general (over 18 years)



HTSP Fertility Intention Question Tree for Postpartum Women



HTSP Fertility Intention Question Tree for Adolescent Women
(women <18 years old, sexually active, without children)

Ask:
Are you thinking of having a baby?

No

Provide: Contraceptive counseling for informed choice (expanded method mix including long-acting and permanent methods)

Yes

Advise: Wait until you are 18 years old before trying to become pregnant. Use a family planning method of your choice during that time.

Undecided

Discuss: "Is HTSP Right for Me" (Refer to HTSP Trainers Reference Guide)

Will wait

Provide: Contraceptive counseling for informed choice and discuss the benefits of delaying first pregnancy (expanded method mix including long-acting and permanent methods)

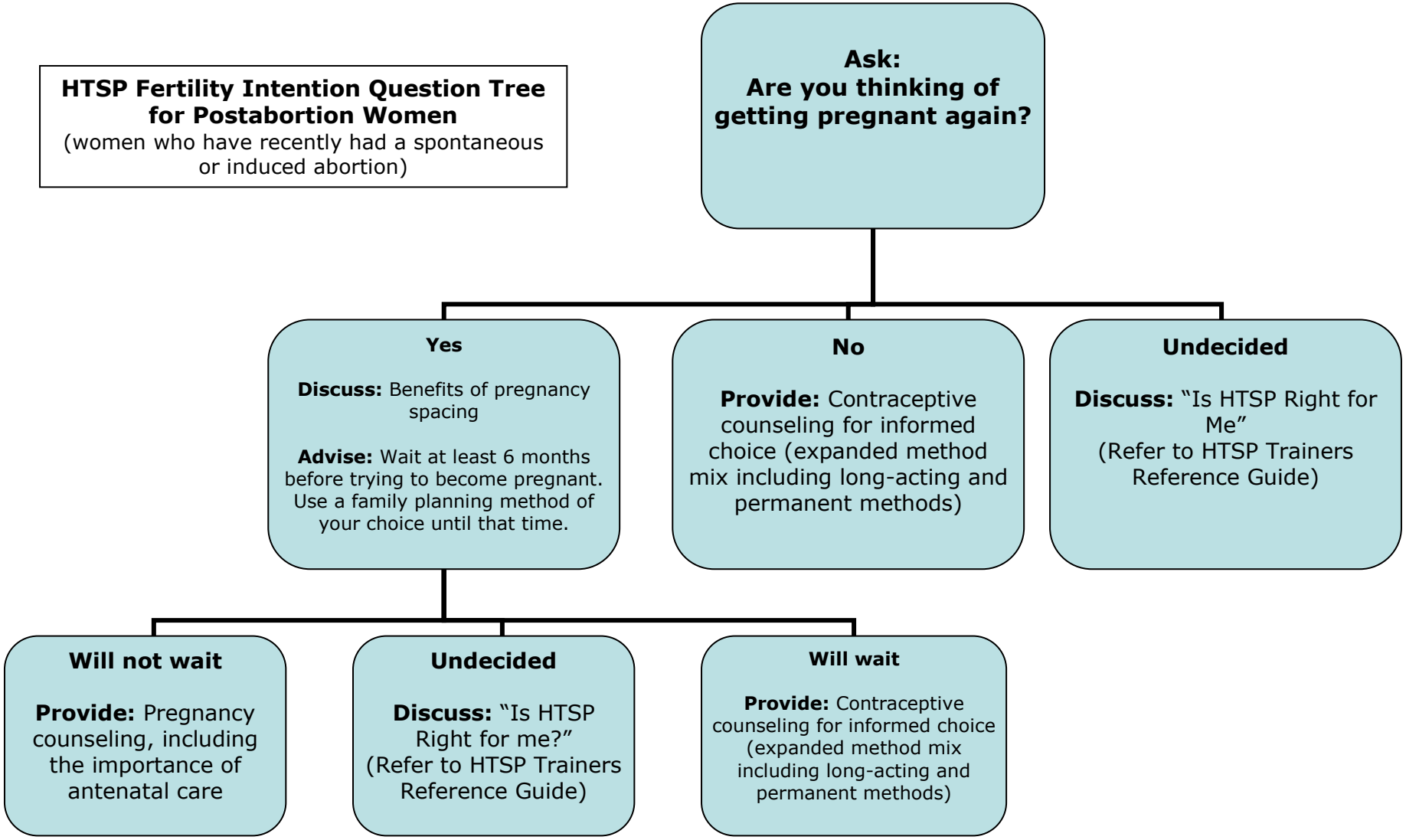
Will not wait

Provide: Pregnancy counseling, including the importance of antenatal care and risks of early pregnancy

Undecided

Discuss: "Is HTSP Right for Me?" – focusing on the benefits of delaying first pregnancy (Refer to HTSP Trainers Reference Guide)

HTSP Fertility Intention Question Tree for Postabortion Women
(women who have recently had a spontaneous or induced abortion)



Tips for Successful FP and HTSP Counseling	Counseling is successful when clients:
➢ Show respect and help the client feel at ease ➢ Encourage the client to discuss needs, express concerns and ask questions ➢ Let the client's needs guide the discussion ➢ Be alert to related issues, such as risk for STIs and HIV ➢ Listen carefully. This helps you better respond to the needs of the client ➢ Give just key information. Use words the client understands ➢ Respect and support the client's decisions ➢ Address both the positive aspects of FP and the negative ones, such as side effects ➢ Check to be sure the client has understood you ➢ Invite the client to come back at any time for any reason	➢ Feel that they got the help they wanted ➢ Know what to do ➢ Feel confident that they can do what needs to be done ➢ Feel respected ➢ Return as needed ➢ Are satisfied with their method, and ➢ Use their FP method effectively

REFERENCES

Adair, L. et al. 1998. Philippines: Cebu longitudinal follow-up survey and in-depth interviews. Family Health International: Women's Studies Project, Research Triangle Park, North Carolina.

Advocates for Youth. 2007. The facts: adolescent maternal mortality: an overlooked crisis. Advocates for Youth, Washington, D.C.

Blumenthal, P.D. and N. McIntosh.1996. *Pocket guide for family planning service providers, 1996-1998*. 2nd ed. Baltimore: JHPIEGO Corporation.

Brockman, S., I. Stout, and K. Marsh. 2003. The public health impact of optimal pregnancy spacing: new research from Latin America and the Caribbean." CATALYST Consortium, Washington, D.C.

CATALYST Consortium. 2004. Best practices in Egypt: mobilizing religious leaders. CATALYST Consortium, Washington, D.C.

CATALYST Consortium. 2003. Optimal pregnancy spacing: an activity of the CATALYST consortium. Fact Sheet. CATALYST Consortium, Washington, D.C.

Agustin Conde-Agudelo, et al. 2005. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Obstetrics and Gynecology* 89 (April): S34-S40.

Agustin Conde-Agudelo, et al. 2006. Birth spacing and the risk of adverse perinatal outcomes: a meta-analysis. *The Journal of the American Medical Association* 29 (19 April): 1809-1923.

Conde-Agudelo Agustin, A., J. Belizan and C. Lammers. 2005. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: cross-sectional study. *American Journal of Obstetrics and Gynecology*, Vol. 192: 3429.

Conde-Agudelo, A. and J. Belizan. 2000. Maternal mortality and morbidity associated with interpregnancy interval: a cross-sectional study. *British Medical Journal*. 321: 1255-1259.

DaVanzo Julie, et al. 2007. The effects of birth spacing on infant and child mortality, pregnancy outcomes, and maternal morbidity and mortality in Matlab, Bangladesh. *British Journal of Obstetrics and Gynecology* 114, 9 (Sept):1079-1087.

Dewey KG, Cohen RJ. 2004. Birth-spacing literature: maternal and child nutrition outcomes. Report. The Academy for Educational Development and The CATALYST Consortium, Washington D.C.

Ekpo, Gloria, BASICS Project, personal communication.

Family Health International (FHI). 2008. Pregnancy checklist. http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/pregnancy/index.html.

Fields, Rebecca, IMMUNIZATIONBasics, personal communication.

Gillespie, Duff. 2004. Whatever happened to family planning and, for that matter, reproductive health? *International Family Planning Perspectives*. 30, 1 (March).

Gray RH et al. 2005. Increased risk of incident HIV during pregnancy on Rakai, Uganda: a prospective study. *Lancet*. 366 (9492):1182-8.

Hale, Lauren, Julie DaVanzo, Abdur Razzaque, and Mizanur Rahman. 2006. Why are infant and child mortality rates lower in the MCH-FP area of Matlab, Bangladesh? Are the differences due to differences in reproductive patterns? *Studies in Family Planning*. 37, 4 (Dec): 281-292.

Homsy et al. 2006. Determinants of pregnancy among women receiving HAART in rural Uganda. The 2006 HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief. Durban, South Africa, abstract 98.

Jansen, W. et al. 2002. Demand for birth-spacing in young, low-parity women: an analysis of fifteen developing countries. OBSI Regional Workshop. Washington, D.C.

Jansen, W. and L. Cobb. 2004. USAID birthspacing programmatic review: an assessment of country-level programs, communications and training materials (POPTECH publication No. 2003-154-024). Population Technical Assistance Project, Washington, D.C.

Jansen, W. 2004. Existing demand for birth spacing in developing countries: perspectives from household survey data. *International Journal of Obstetrics and Gynecology*. 89, S1 (April), S50-S60.

Huntington, Dale and Aristide Aplogan. 1994. The integration of family planning and childhood immunization services in Togo. *Studies in Family Planning*. 25, 3 (May/June): 176-183.

Khan, K.S., Chien, P.F.W., Khan, N.F. 1998. Nutritional stress of reproduction. *Acta Obstet Gynecol Scand*. 77: 395-401.

Labock, M. 2003. Espaciamiento entre nacimientos: Impacto en la supervivencia del niño y el estado nutricional. Presented at the USAID-Sponsored Conference on Optimal Pregnancy Spacing for Central America. Guatemala.

McCauley A.P, and Salter, C. 1995. Meeting the needs of young adults. http://www.infoforhealth.org/pr/j41edsum.shtml#top.

Mohohlo M, et al. 2006. Pregnancy-related events in an antiretroviral treatment program." The 2006 HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, abstract 113.

Mpangile G et al. 2006. Sexual and child-bearing needs of people on ART: The forgotten agenda. The 2006

HIV/AIDS Implementers Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, abstract 116.

Pareja, R. 2003. Five Countries' FG findings on pregnancy spacing. OBSI Regional Workshop. CATALYST Consortium: Washington, D.C.

PATH. Family planning programs: key issues. http://www.rho.org/html/fpp_keyissues.html.

Rinehart, W., et al. 1998. *GATHER Guide to Counseling*. Population Reports, Series J, No. 48. Baltimore: Johns Hopkins University School of Public Health/Center for Communication Programs.

Rutstein, S. 2003. Effect of birth intervals on mortality and health: multivariate cross country analyses. Presentation to the USAID-Sponsored Conference on Optimal Pregnancy Spacing for Central America. Guatemala.

Rutstein, S. 2005. Effects of proceeding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys. *International Journal of Gynecology and Obstetrics*. 89, 1 (April): S7-S24.

Rutstein, S. et al. Systematic literature review and meta-analysis of the relationship between interpregnancy or interbirth intervals and infant and child mortality. Forthcoming.

United Nations Population Fund (UNFPA). State of the World Population, 2004. http://www.unfpa.org/swp/2004/english/ch9/page5.html.

WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe. 2006. Policy brief on birth spacing: report from a World Health Organization technical consultation. World Health Organization (WHO), Geneva.

World Health Organization (WHO). 1988. Natural family planning: a guide to provision of services. World Health Organization, Geneva.

World Health Organization (WHO). 2006. Report of a WHO technical consultation on birth spacing. World Health Organization, Geneva.

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. 2007. *Family planning: a global handbook for providers*. Baltimore and Geneva: CCP and WHO.

World Health Organization (WHO). Infant and young child nutrition: global strategy on infant and young child feeding. http://www.who.int/gb/ebwha/pdf_files/WHA55/ea5515.pdf.

World Health Organization (WHO). 2000. New data on the prevention of mother-to-child transmission of HIV and their policy implications. Technical Consultation on Behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV.

Zhu, B.P. et al. 2001. Effect of the interval between pregnancies on perinatal outcomes among white and black women. *American Journal of Obstetrics and Gynecology.* 185: 1403-1410.

Zhu, B.P. et al. 1999. Effect of the interval between pregnancies on perinatal outcomes. *The New England Journal of Medicine.* 340: 589–594.